

## **4 Preparedness and Response- India not affected**

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If India remains unaffected, there is a small window of opportunity to review and test the plans. The strategy appropriate to this phase would be enhanced surveillance, implementing border, port, and airport control and communicating risk to the community. There is evidence from the past pandemics that implementing these strategies may delay the arrival of the pandemic and the time earned would be crucial for putting in place preparedness measures.

### **4.1 Planning and Coordination**

The NDMA, NCMC and the Crisis Management Groups of individual ministries would review the preparedness to fill critical gaps if any. The Inter Ministerial Task Force in MOHFW would decide on sectoral issues and lay down policy pertaining to pandemic preparedness. It would also evaluate the components of the plan including procurement of medical stockpiles of antiviral drugs and personal protection equipments. The SDMA and DDMA would review the preparedness of their respective states and districts. Subsequent review meetings would ensure implementation of the decisions.

The technical inputs / recommendations would be provided by the Joint Monitoring Group at the Central level and similar technical advisory groups / committees at the State level.

MOHFW would issue guidance to States on the steps to be taken in the event of pandemic.

### **1.2 Components of Pandemic Preparedness Plan**

#### **1.2.1 Surveillance**

In short term, the surveillance of influenza would be strengthened as one network pooling in the resources from NICD and ICMR. The structure of Integrated Disease Surveillance Project would be used for enhancing the influenza surveillance. The existing sentinel sites and laboratories would continue routinely testing samples to keep track of the current strain and to detect variance.

India would continue to monitor the emerging global situation. It would network with the global influenza networks to share information. WHO could assist in getting information to understand the containment/ mitigation measures adopted by the affected countries.

As an interim measure, the health departments of the States would issue directions to all health facilities including private practitioners, nursing homes, and private hospitals to report clusters of influenza like illness and severe acute respiratory illness. The services of professional bodies in the state such as Indian Medical Association and Indian Academy of Paediatrics etc would be

ensured. The 24x7 Call Centre of the IDSP would be strengthened for reporting of clusters of ILI.

The trained Rapid Response Teams of the States and the Districts would be on alert to investigate the outbreak. Public health measures need to be instituted as per the district plan and micro planning done for the affected area.

In long term, National Influenza Surveillance Network would be set up integrating the NICD, IDSP and identified sentinel sites and the laboratories of medical colleges etc. There would be at least four National Influenza Centres (NIC) representing the country on regional basis. The capacity development would ensure the country in generating appropriate data to define the morbidity and mortality due to seasonal influenza and that caused by novel strains. Further, animal health surveillance would be integrated with human health surveillance to move towards 'one health concept'.

### **1..2.2. Laboratory Support**

National Institute of Virology, Pune is an existing WHO reference laboratory for avian influenza H5. This laboratory along with NICD would be the apex laboratories testing influenza A H1N1 or any other novel influenza virus. There would be two other BSL-3 laboratories namely the NICED, Kolkata and RMRC, Dibrugarh that would be used if the sample load requires additional laboratories. NICD and NIV, Pune would ensure availability of diagnostic kits and viral transport media. Protocols would be drawn up for sample collection, transportation and testing. The transportation of samples in particular would get due attention. NICD would employ courier services to ensure correct and timely delivery of samples.

As a long term strategy both NICD and NIV, Pune would acquire Bio-Safety level- 4 laboratories to test novel viruses that require this capability. The Bio Safety level -3 laboratories would also be enhanced both in human and animal health sector.

### **1..2.3. Hospital facilities.**

During pandemic phase 5 and 6 the hospital preparedness is crucial. Small clusters to widespread infection can be anticipated. All health facilities in the community (PHC, CHC), District and Sub-District Hospitals, medical colleges, private nursing homes and hospitals need to be prepared.

For clinical management, isolation and critical care facilities would be set up in identified hospitals that would be attached to the International airports. Cases, as and when they emerge in the community, need to be managed in hospitals with an isolation facility, the objective being to contain the spread. Hence the states would identify isolation facilities in medical colleges and district hospitals and strengthen them.

Sustained and wide spread infection would imply the need for surge capacity by using every available space, discharging routine cases and only entertaining emergencies in generic and super specialties. The services of private hospitals may have to be taken by an executive order. The hospitals under the administrative control of Ministry of Defence, Labour and Railways need to contribute to case management and surge capacity. For a worst case scenario, sites such as school buildings, Panchayat offices / community spaces need to be identified to set up temporary hospitals. Facilities available with alternate system of medicine would also be put to use. Infection control practices and waste management protocols need to be ensured at all health facilities to protect the health personnel. All hospitals would have hospital disaster manual which would enlist action as brought out above.

The health care providers are at increased risk. There could be large scale absenteeism especially if the virus is lethal. The hospital disaster manual would have a sub plan drawn up for continuity of operations anticipating large scale work absenteeism.

In long term, states would work towards strengthening existing state and district hospitals to treat cases of emerging and remerging disease that require isolation and critical care.

#### **4.2.4. Domiciliary Treatment**

A large number of cases could be managed in domestic settings if the health workers or volunteers are trained for triage. The CRB-65 clinical tool would be used to assess the severity of cases. The health workers, volunteers from Red Cross and Civil Defence would be trained on domestic triage and management.

The clinical judgment should be used by practicing physicians to assess severity of disease. Mild cases should be encouraged to stay at home.

#### **4.2.5. Pharmaceutical Interventions**

##### 4.2.5.1. Drugs

Oseltamivir is the WHO recommended drug and the only one available with the Government for treating Influenza H1N1. The drug would have application in three scenarios:

- For individual treatment :
  - o The recommended dose is 75 mg twice daily for adults. For adolescents and paediatric age group, the dosage is based on body weight and recommended schedule is:
    - For weight <15kg      30 mg twice daily for 5 days
    - 15-23kg                      45 mg twice daily for 5 days
    - 24-<40kg                    60 mg twice daily for 5 days
    - >40kg                         75 mg twice daily for 5 days

- o For children below one year and for pregnant women, the administration of oseltamivir would be based on risk –benefit analysis. The recommended dose for children less than one year is:
    - Age <3 months — 12 mg twice daily
    - Age 3 to 5 months — 20 mg twice daily
    - Age 6 to 11 months — 25 mg twice daily
  - o Supportive therapy : For secondary complications including bacterial infections, appropriate treatment may be provided as indicated.
  - For chemoprophylaxis :
    - Chemoprophylaxis for health care workers at high risk
    - o The treating physicians and other paramedical personnel at the isolation facility would be put on chemoprophylaxis.
    - Chemoprophylaxis for contacts
      - o Chemoprophylaxis is advised for those contacts with high risk (with underlying systemic diseases; extremes of age [ $< 5$  years and  $> 65$  Years]).
      - o In phase -5, if the clusters are reported for the first time, and given that those exposed are known and can be traced easily, then family, social and community contacts should be given chemoprophylaxis.
    - Mass Chemoprophylaxis:
      - o The strategy of containment by geographic approach by giving oseltamivir to every individual in a prescribed geographic limit of 5 km from the epicenter (The village / city where the cluster is reported) would be applied :
        - If the virus is lethal and causing severe morbidity and high mortality.
        - Though affecting humans, is not efficiently transmitting in our population.
        - If the cluster is limited by natural geographic boundaries
- This strategic decision would be taken by the RRT in consultation with State Health Department/ MOHFW, Government of India.
- o Modelling studies suggest that antivirals would need to reach a sizeable proportion of affected persons (80%-90%) to be supported by non pharmaceutical interventions.

MOHFW would work out the requirement of oseltamivir and stock pile the required drug. Efforts would be for ICMR and ICIR to develop technology to synthesize the base drug and other potential anti virals.

#### 4.2.5.2 Vaccines

If available, the vaccine is the best preventive strategy to combat a pandemic. However, the lead time required to prepare a candidate vaccine and further putting it for commercial production would take at least six months. Hence the vaccine may not be available to combat the first wave of the pandemic. However, it may just be available to mitigate the second wave.

WHO has identified a global network of manufacturers that includes Serum Institute of India (Pune, Maharashtra). As seasonal Influenza is not considered a public health problem in this country, there is no policy for seasonal influenza vaccine. Such a policy can only be evolved, if the morbidity and mortality due to seasonal influenza is known. This needs to be done through an effective influenza surveillance network. Uptake for seasonal influenza vaccine would see vaccine manufacturers pitching for seasonal influenza vaccine. This only would facilitate switching over to vaccine for the pandemic strain. Public private partnership could be established to meet this objective.

The Drug Controller General and the ICMR would facilitate in establishing this capacity at the earliest.

### **4.2.6 Non-pharmaceutical interventions**

#### 4.2.6.1 Entry screening / exit screening

Border, port and airport screening would facilitate detection of a symptomatic case entering the country from an affected area. The surveillance through entry screening would be enhanced at these places.

The health screening desks would be put ahead of the immigration check points. The Ministry of Civil Aviation and the Airport Authority would facilitate the health screening. A proforma [health screening card] would be used to screen all persons disembarking in India for symptoms of suspected pandemic influenza with novel virus. This proforma would be printed and widely distributed to all airlines with instructions by Ministry of Civil Aviation to make these forms available at the point of embarkation. It would have an advisory for the passengers informing them about the entry screening and the point of contact if they develop symptoms subsequently.

Under Indian Aircraft (Public Health) Rules 1954, the Captain of the aircraft is required to submit the details of sick passengers on board in the general declaration form to the APHO. The

airline crew needs to be sensitized to make announcement / personal enquiry of the fever cases and to certify the same on the general declaration. Guidelines to be issued to airlines are at **Annexure-II**.

The airport health organization infrastructure at International airports and ports would be strengthened by deploying additional doctors, nurses and paramedics. Central Government Health Scheme or the State Government would provide additional doctors and staff nurses for the international airports and ports. All medical personnel, immigration staff and the ground staff would follow standard infection control practices.

A standard operating protocol (**Annexure-III**) would be followed for screening passengers. The screening would require an enquiry into the travel history, signs and symptoms and recording of body temperature manually using digital thermometers or thermal scanners to ascertain whether the case conform to the case definition.

#### 4.2.6.2 Quarantine and isolation

##### 4.2.6.2.1. Airport / Port Quarantine

The quarantine facilities at ports and airports should be strengthened. Quarantine would be used as a disease containment measure during the early stages of an outbreak. This involves possible restrictions on movement, and cohorting a group of exposed passengers to makeshift quarantine facility such as earmarked hotels in the proximity of the airports or to military airbases that could accommodate full flight load of passengers. Such decision would also depend upon the transmissibility and lethality of the virus.

##### 4.2.6.2.2. Community wide quarantine

Community wide quarantine as a strategy could be used to stamp out clusters appearing for the first time. The prerequisites as stated in strategic approach are that the virus is not yet fully adapted and is not transmitting efficiently and the natural geographic boundaries support containment operations. The procedure involves putting physical barriers restricting entry / exit of the population from a defined geographic area of 0-5 km. This could only be attempted, if legal instruments support it, law and order and perimeter control could be enforced, essential services are maintained and are sustained by other pharmaceutical and non-pharmaceutical interventions. Central to enforcing community wide quarantine would be a well drilled micro planning at the operational level. Every district authority would develop the micro plan and test it through mock drill.

##### 4.2.6.2.3 Home quarantine

In the initial phase of the outbreak, all those known to be exposed in closed space environment such as aircraft, bus, train coach, theatre, school, office etc need to be requested to remain on home quarantine for a period of seven days. In phase 5&6, the family and social contacts of a

suspect case also need to be under home quarantine. They would be self monitoring their health and reporting to the identified health authorities. Public would be made aware of the need to self quarantine through well managed risk communication strategy using print and visual media. Help lines need to be established and widely circulated and made available on the web site. The IDSP toll free number 1075 can be identified.

#### 4.2.6.2.4. Isolation

During the initial part of the pandemic when India has few clusters, cases would be isolated in identified health facilities. With widespread infection, when containment is not possible, cases would be triaged and those who could be managed at home would be dealt accordingly.

#### 4.2.6.3 Social distancing measures

Inter personal interactions and thereby transmission risks can be reduced by social distancing measures. Historical data from previous pandemics suggest that these measures applied early during the phase 5 and 6 of the pandemic would reduce the impact. School closure should be immediate and a priority if there is high morbidity among children. Mass gatherings such as festivals; sporting, religious, political events need to be discouraged and cancelled. Funeral gatherings, in particular, needs to be discouraged. General public entry to airports and railway stations etc would be restricted. Public transportation may have to be restricted.

Business work place, market closure and ‘weekend market’ closure need to be considered in a worst case scenario. But before taking such decision it should be ensured that essential commodities are available and families are maintaining essential ration for two weeks.

Enforcing social distancing measures also necessitates maintaining law and order. The micro plan at the operational level would specify the responsible officer and the framework for enforcing and monitoring social distancing measures. All the administrative orders required for enforcing such non-pharmaceutical interventions would be prepared in advance and kept ready to be executed during response phase.

#### 4.2.6.4. Infection control practices

##### 4.2.6.4.1 Infection control practices at individual and community level

There should be a culture among the community to adopt certain simple public health measures that would restrict transmission in the community and safeguard their health. These include hand washing especially after touching nose or mouth, staying at least arms length away from those having cough and sneeze, and applying a handkerchief or tissue paper over mouth while you cough. The attitude needs to be changed through sustained behavioral change communication to be achieved through mass media campaigns and social mobilization.

This would be an integral part of both short term and long term media strategy to be dealt under communication.

#### 4.2.6.4.2 Infection Control Practices in Health Care Settings

All health care facilities need to review their infection control practices. This should be important part in all planning documents. The planning for infection control practices should consider all points of human to human contact. Appropriate PPE should be decided and the personnel trained. A generic principle would be to stratify the personnel according to the risk profile. The risk stratification may change according to the environmental contamination and clustering of human cases. This would be decided by RRT on case to case basis. The table below is only indicative of risk profiles (assuming that the virus is not highly lethal) and levels of PPE to be used by various types of personnel/close household contacts of cases.

| <b>Identified Human Resource</b>   | <b>Risk Profile</b> | <b>Nature of PPE</b>   |
|--|---------------------|--|
| Paramedical staff involved in public health screening at the airports.                           | Medium Risk         | Three layered surgical mask  |
| Medical and nursing staff involved in clinical examination at airport and quarantine centre      | High risk           | Full complement of PPE   |
| Immigration and other ground staff   | Low risk            | Three layered surgical mask  |
| Passengers in the same row, three rows in front and tree layers behind a suspect case            | Medium risk         | Three layered surgical mask.   |
| Medical personnel involved in sample collection  | High Risk           | Full complement of PPE and N 95  |
| Health workers involved in surveillance  | Low Risk            | Three layered surgical mask  |
| RRT during supervisory field operations  | Low risk            | Three layered surgical mask  |
| RRT while attending suspect case in the community  | Medium risk         | Full complement of PPE   |
| RRT while transporting suspect case in the ambulance   | High risk           | Full complement of PPE<br>Driver to be provided three layered surgical mask.       |
| Health staff involved in managing a suspect case at the health facility                          | High Risk           | Full complement of PPE including N95 Respirator                                    |
| Staff handling dead body of a suspect/ probable/ confirmed case                                  | Medium Risk         | Full complement of PPE/<br>Three layered surgical mask / N95 Respirator and gloves |
| Security personnel involved in quarantine, social distancing measures, law and order maintenance | Low risk            | Three layered surgical mask  |

|   |          |                              |
|---|----------|------------------------------|
| Personnel providing essential services  | Low risk | Three layered surgical mask. |
| Close household contacts of a suspect/ probable/confirmed cases                                       | Low Risk | Three layered surgical mask  |
| <b>Note:</b> Suspect / Probable / Confirmed cases should also be offered three layered surgical masks |          |                              |

Isolation facility need to have negative pressure, air control (10-12 air changes per hour), double door entry and dedicated staff. If dedicated isolation room is not available, then patients can be cohorted in a well ventilated isolation ward with beds kept (at least ) one metre apart. Such facilities need to be identified in state capitals. The districts need to plan for the scaled down version of isolation facility. All health care personnel should follow frequent hand wash and standard infection control practices as stipulated in the guidelines. All such facilities should adhere to strict waste management protocols with in the ambit of the Waste Management Rules.

The requirement of PPE, disinfectants (soap, alcoholic rubs, sodium hypochlorite and quaternary ammonium compounds or other locally available substitutes) would be worked out and procured.

#### 4.2.6.5 Travel advisory

During this phase, India would issue travel advisory to its nationals to defer non-essential travel to the affected country.

#### 4.2.7 Logistic support

MOHFW would enhance the stockpile of Oseltamivir for phase 5/6 from the existing one million to at least 10 million. This amount may need to be further enhanced if it decides for a containment strategy. For worst case scenario, the stockpile held by WHO would also be tapped. To prevent microbial resistance by indiscriminate use, it would continue to be made available through the public health system. For rapid access by the state governments, some stock would be decentralized to regional offices. State RRT teams would also have a deterrent stock to be taken along with them when proceeding to investigate a cluster.

Existing central stockpile of PPE sets, N-95 masks, three layered surgical masks would be reviewed and necessary procurement affected. The stock would be sufficient to manage at least 10,000 cases.

The State Government would also review their requirement of PPE sets, N-95 masks, three layered surgical masks and maintain appropriate stock.

#### 4.2.8 Risk communication

The risk and actions required for risk reduction need to be conveyed to the community in clear and consistent terms. For adoption of the non pharmaceutical interventions at individual and

community level, an attitudinal change is required, to be brought out through behavior change communication. There need to be short term and long term communication strategy to address this issue.

In short term the objective of the communication would be to create wide scale public awareness and sensitize communities to appropriate behaviors before pandemic. This will help in building public trust and will lead to community and societal compliance of these safe practices (this includes respiratory etiquettes, hygiene practices and treatment seeking behavior).

The aim of the long term strategy will be to instill safe practices, increase availability and access of essential services, timely reporting of cases and high level of compliance with regard to self care taking behaviors/ home based care.

The technical content of the messages would be vetted by the Joint Monitoring Group and Task Force in the I&B Ministry. The task force in I&B Ministry would facilitate operation of this strategy. UNICEF would assist in developing the strategy and the campaign. The material prepared by MOHFW in collaboration with WHO and UNICEF would be translated into vernacular languages and given to the State Governments.

#### **4.2.9. Capacity Development**

State Plans have been reviewed through Table Top Exercises. A critical gap identified was lack of planning for the pandemic phase 5/6. Most of the states had state plans for managing the human cases of avian influenza only. Those States that have revised the plans need to conduct mock drills to test the plans.

Capacity in human resources needs to be enhanced for investigating the outbreak, instituting public health measures and for clinical, respiratory and ventilatory management of the cases. MOHFW has already undertaken training of trainers of the RRTs of the states. The physicians have been trained in clinical management protocols. Some states have taken this training to the district level. This need to be replicated in all the states. To facilitate this, standardized training materials could be provided.

Phase 6 would require large number of volunteers for triaging and domiciliary care. The IMA, CISF, Civil Defence, NSS/NCC and Red Cross Volunteers would be trained in addition to the existing cadre of health workers.

To provide correct information and mobilizing communities, interpersonal communication training module and aids on pandemic influenza will be developed for all grass root health workers with partners/ UNICEF/WHO.

#### **4.2.10 Psycho social issues**

If the virus is lethal resulting in large number of morbidity and mortality, socio economic disruption would ensue with associated psycho social issues. The existing community based

interventions planned for disaster settings would be used. Further, the response to an influenza pandemic will pose substantial physical, personal, social, and emotional challenges to health care providers, other emergency and essential service providers. Special programmes need to be planned to ensure that such category of workers are prepared to cope with, and recover from the social and psychological challenges of emergency work. National Institute of Mental Health and Neuro Sciences, Bangalore would be the nodal agency to plan and implement community based interventions and those specific for the emergency responders. Other institutions will also be identified for wider coverage.

#### **4.2.11. Research**

Department of Health Research (DHR) would be the nodal agency for basic, applied and translational research. Focus areas would be surveillance, drugs and vaccines. DHR would collaborate with research institutions for answering key research questions that is expected due to the unknown nature of the virus.

#### **4.2.12. Public Private Partnership**

MOHFW would explore areas in private sector that can contribute substantially to the programme delivery. Those concerning production and stockpiling of drugs, PPE, vaccines and diagnostic reagents would be of interest.

#### **4.2.13. Non-Governmental Organizations**

The community level actions such as triage, treatment, non-pharmaceutical intervention, risk communication and social mobilization could be implemented with support from non governmental organizations. The District Collector, based on the NGO resources available, could involve NGOs such as Red Cross, professional bodies like district units of Indian Medical Association, Indian Academy of Paediatrics etc. As for private voluntary Organizations, those already working in the district in social sectors can work synergistically with the district authorities.

#### **4.2.14. Monitoring and Documentation**

The situation would be monitored by the Joint Monitoring Group. Daily data generated would include the exit screening at various air ports, details of passengers quarantined, surveillance data on cluster identification, and laboratory report on those tested. Best practices and constraints need to be identified and documented.

#### **4.2.15 International agencies**

Basic strategic framework for action is based on WHO framework. MOHFW would continue to pursue the WHO advisories and seek co-operation for garnering information on situation in neighboring countries. UN agencies namely WHO and UNICEF have been contributing to the capacity development and continue to do so. Under the Indo-US agreement, our laboratories would continue to collaborate with CDC, Atlanta. In a worst case scenario, India may seek technical and logistic support from WHO.

### **4.3. Preparedness at State Level.**

The Chief Secretary convenes a meeting of Secretaries of Health, Revenue, Home, Finance, Panchayati Raj, Local Self Governance, Public Works, Transport and Education Departments where the Health Secretary will apprise everybody of the Government of India Guidelines / Treatment Protocols and the State Control and Containment Plans. The role of each department would be outlined for communication to field level officers. The state level preparedness and response would thereafter be reviewed on a fortnightly or as and when required basis by the Chief Secretary. The reviews would go into setting up and training RRTs and physicians, stock of medicines, PPEs and other critical care equipment, public awareness, movement control/ restriction orders, etc.

Chief Secretary will call a state level meeting of District Collectors/ District Magistrates to outline the control and containment plan and ask them to prepare district action plans and micro plan. The meeting will be attended by concerned Secretaries, DHS and other technical officers.

State Level Officers of Department of Health, Revenue, Police, Home, PWD, Education and Panchayati Raj will ensure familiarization of their ground level staff in all aspects of preparedness, control and containment in accordance with the Action Plan and Guidelines.

Each State would develop a State Plan with the components listed from point no 4.2.1 to 4.2.14. as above. The plan would specify the Institutional mechanism envisaged under section-2. It would sensitize administrators on pandemic and actions to be taken in health and beyond health. Liaison would be maintained with the Central Government and the neighboring States.

The surveillance for Influenza like illness would be done through the State IDSP. The medical colleges and other health institutions beyond IDSP would be involved to detect influenza like illness and that of severe acute respiratory illness. State Government would review the hospital preparedness especially in the context of isolation facility and critical care facility and they would be strengthened. State Government would ensure that all hospitals would have hospital disaster manual with sub sections on the pandemic preparedness, modalities for surge capacity and for continuity of operations.

The State would ensure that the teams trained by the MOHFW would train the district RRTs and physicians of the district and sub-district hospital, CHCs and PHCs on clinical management. Oseltamivir would be from the central stockpile whereas the State would factor in its own stock

of PPE, N-95 mask and three layered surgical masks. State would plan large scale IEC campaign through print and visual media. The behavioral change for adopting hand wash and respiratory etiquettes and community based non pharmaceutical interventions would be popularized through social mobilization.

#### **4.4. The District Level**

The experience of organizing the control in disease outbreak / epidemic / pandemic situations has shown that it is necessary for the District Collector/ District Magistrate to assume over all coordination of the operations at the District level. Inherent to the success of the containment / pandemic mitigation operations are the activity planning and its execution at the grass root level. Familiarization of the key aspects and the preparedness measures would enable the district machinery to respond promptly and efficiently to the emerging situation. This requires that the important functionaries in the district, particularly the Chief Medical Officer, Superintendent of the Police, Chief Executive of the Panchayat Raj and Urban Local bodies and the Rapid Response teams are aware of their roles and responsibilities.

Every District will have an action plan that should have all the components from point 4.2.1 to 4.2.14 appropriate to the District level and the operational aspects from the forgoing sections.

District collectors will hold meetings in their districts with SP, CMO, Revenue, PWD, Forest, Education and Panchayati Raj/ Local Self Governance Departments where the District Action Plan on preparedness and response ( in case of an outbreak)will be presented.

The role of District Collector is at **Annexure-IV**.

District Level Officers of Department of Health, Revenue, Police, Home, Environment and Forest, PWD, Education and Panchayati Raj will ensure familiarization of their ground level staff in all aspects of preparedness, control and containment in accordance with the Action Plan and Guidelines.

The Chief Medical Officer (CMO) of the District would be responsible for the health sector actions. The role of the CMO is at **Annexure-V**.