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National Health Mission-HP
SDA Complex, Kasumpti, Shimla-9
Himachal Pradesh
Dated: Shimla-171009, the

MISSION DIRECTOR (NHM)
18 MAY 2021
Shimla-9 (H.P.)

Circular

Attached is the SOP/advisory issued by Government of India, Ministry of Health & Family Welfare regarding COVID-19 Containment & Management in Peri-urban, Rural & Tribal Areas.

This SOP outlines the containment and clinical management practices to be put in place in Peri urban, Rural and Tribal areas with respect to COVID-19 management. All concerned to take note and initiate appropriate action accordingly.

MISSION DIRECTOR (NHM)
18 MAY 2021
Shimla-9 (H.P.)

Secretary (Health) to the
Govt. of Himachal Pradesh

Endst. No. As above. Dated Shimla-9 the
Copy for information and necessary action to:

1. The Principal Secretary, Urban Development to the Government of Himachal Pradesh.
2. The Principal Secretary (Tribal) to the Government of Himachal Pradesh.
3. The Secretary, Rural Development to the Government of Himachal Pradesh.
4. All the Deputy Commissioners, in Himachal Pradesh.
5. The Director Medical Education, Himachal Pradesh.
6. The Director Health Services, Himachal Pradesh
7. The Director Health Safety & Regulation, Himachal Pradesh.
8. The Director, Urban Development, Himachal Pradesh.
9. The Direct, Rural Development, Himachal Pradesh.
10. All the Chief Medical officers in Himachal Pradesh.
11. All the Principals, Medical Colleges in Himachal Pradesh.
12. All the Senior Medical Superintendents in Himachal Pradesh.
13. All the Nodal Officer DCCC, DCHC & DCH, Himachal Pradesh.
14. All the District Surveillance Officers, IDSP, Himachal Pradesh.

Secretary (Health) to the
Govt. of Himachal Pradesh

16th May 2021

Government of India
Ministry of Health & Family Welfare

SOP on COVID-19 Containment & Management in Peri-urban, Rural & Tribal areas

1. Background

COVID-19 outbreak in the country is still predominantly an urban phenomenon. However, besides urban areas reporting a large number of cases, a gradual ingress is now being seen in peri-urban, rural and tribal areas as well. In view of this there is a need to enable communities, strengthen primary level healthcare infrastructure at all levels to intensify COVID-19 response in peri-urban, rural & tribal areas, while continuing to provide other essential health services.

2. Scope

With larger spread of COVID-19 cases in peri-urban, rural and tribal areas, it is important to ensure that community-based services and primary level health infrastructure in these areas are equipped and oriented to manage COVID-19 cases. Primary healthcare facilities and health facilities in the private sector in these areas play a significant role in delivering health services to population. This document outlines the containment & clinical management practices to be put in place in these areas with respect to COVID-19 management.

3. Surveillance, screening, isolation and referral

- In every village, active surveillance should be done for influenza-like illness/ severe acute respiratory infections (ILI/SARI) periodically by ASHA with help of Village Health Sanitation and Nutrition Committee (VHSNC). Symptomatic cases can be triaged at village level by teleconsultation with Community Health Officer (CHO), and cases with comorbidity/low oxygen saturation should be sent to higher centres. Every subcentre should run an ILI/SARI OPD for a dedicated time slots/days.
- Identified suspected COVID cases should link for testing to the health facilities either through COVID-19 rapid antigen testing or by referral of samples to nearest COVID-19 testing laboratory, in accordance with ICMR guidelines for the same (available at: https://www.icmr.gov.in/pdf/covid/strategy/Advisory_COVID_Testing_in_Second_Wave_04052021.pdf)
- CHOs and ANMs should be trained in performing Rapid Antigen Testing. Provision of Rapid Antigen Test (RAT) kits should be made at all public health facilities including Sub-centres (SCs)/ Health and Wellness Centres (HWCs) and Primary Health Centres (PHCs). These patients should also be counselled to isolate themselves till test results are available.
- Those asymptomatic but having history of high-risk exposure to COVID patients (exposure of more than 15 mins without a mask within 6 feet distance) should be advised quarantine and tested as per ICMR protocol.
- Depending upon the intensity of surge and number of cases, as far as feasible, contact tracing should be done as per Integrated Disease Surveillance Programme's (IDSP's) guidelines for

contact tracing of COVID-19 cases in community settings; (available at: https://www.ncdc.gov.in/showfile.php?lid=570).

4. Home and community-based isolation:

- Nearly 80-85% COVID-19 cases are asymptomatic/ mildly symptomatic. These patients do not require hospitalization and may be managed at home or in Covid care isolation facilities. Home isolation shall be allowed as per the guidelines available at: https://www.mohfw.gov.in/pdf/RevisedHomeIsolationGuidelines.pdf
- The family members shall undertake quarantine as per the guidelines available at: https://www.mohfw.gov.in/pdf/Guidelinesforhomequarantine.pdf.

4.1. Monitoring of active case in home- isolation:

- Monitoring of oxygen saturation is important for monitoring of COVID patients. For this it is desirable for each village to have adequate number of pulse oximeters and thermometers. The VHSNC through local PRI and administration should mobilize resources to make provisions for these equipments. A system of providing the pulse oximeters and thermometers on loan to families with a confirmed case of COVID should be developed through ASHA/ Anganwadi workers and village-level volunteers. The pulse oximeters and thermometers should be sanitized after each use with cotton/cloth soaked in alcohol-based sanitizer. Follow-ups for patients undergoing isolation/ quarantine could be done through household visits by a frontline worker/ volunteers/ teacher duly following required infection prevention practices including use of medical mask and other appropriate precautions.
- A Home Isolation kit shall be provided to all such cases which should include required medicines such as Paracetamol 500 mg, Tab. Ivermectin, cough syrup, multivitamins (as prescribed by the treating doctor) besides a detailed pamphlet indicating the precautions to be taken, medication details, monitoring proforma for patient condition during the home isolation, contact details in case of any major symptoms or deterioration of health condition and the discharge criteria.
- Patient / Caregiver will keep monitoring their health. Immediate medical attention should be sought if serious signs or symptoms develop. These could include-
    - Difficulty in breathing,
    - Dip in oxygen saturation (SpO2 < 94% on room air)
    - Persistent pain/pressure in the chest,
    - Mental confusion or inability to arouse,
- If SpO2 goes below 94%, the patient should be referred to a facility with an oxygen bed (DCHC or DCH depending on the SpO2 level).

Patients under home isolation will stand discharged and end isolation after at least 10 days have passed from onset of symptoms (or from date of sampling for asymptomatic cases) and no fever for 3 days. There is no need for testing after the home isolation period is over.

5. Planning for Health infrastructure for managing COVID at rural level

Earlier, a 3-tier structure was devised for management of COVID-19 cases. These are:

(i) **COVID Care Centre** (CCC) to manage mild / asymptomatic cases

(ii) **Dedicated COVID Health Centre** (DCHC) to manage moderate cases

(iii) **Dedicated COVID Hospital** (DCH) to manage severe cases.

The health infrastructure so planned for peri–urban, rural and tribal areas shall be aligned to the above mentioned 3-tier structure

5.1. COVID Care Centre (CCC)

5.1.1. Infrastructure

Peri-urban and rural areas may plan a minimum of 30-bedded CCC. The COVID Care Centres shall offer care for asymptomatic cases with comorbidities or **mild cases** (Upper Respiratory Tract symptoms, without breathlessness, with oxygen saturation of more than 94%) where home isolation is not feasible. It could admit a COVID suspect or confirmed case. CCC should have separate areas for suspected and confirmed cases with preferably separate entry and exit for each. Suspect and confirmed cases should not be allowed to mix under any circumstances.

The CCCs are makeshift facilities under the supervision of nearest PHC/CHC. These may be set up in schools, community halls, marriage halls, panchayat buildings in close proximity of hospitals/healthcare facilities, or tentage facilities in Panchayat land, school ground, etc. The isolation beds should be placed at a minimum distance of one metre from each other to maintain physical distancing. Adequate natural room ventilation shall be ensured. Putting up exhaust fans to vent out air from the facility to an open area is desirable. The CCCs must have provisions for drinking water and toilets.

These CCCs should be mapped to one or more Dedicated COVID Health Centres (DCHC) and at least one Dedicated COVID Hospital (DCH) for referral purposes.

Such COVID Care Centres should also have a Basic Life Support Ambulance (BLSA) networked among such CCCs equipped with sufficient oxygen support on 24x7 basis, for ensuring safe transport of patients to dedicated higher facilities if the symptoms progress from mild to moderate or severe. In addition, the districts may consider providing additional ambulances for networking among nearby CCCs for referral services.

5.1.2. Human Resource

The Community Health Officer or the ANMs/Multipurpose Health Worker (Male) should be the nodal person for the CCC from the Health sector and ASHA/ Anganwadi Worker will be supporting them. **Gram Panchayats supported by** Village Health, Nutrition and Sanitation Committee (VHNSC) in rural areas **and MAS in urban areas** will be responsible for the implementation and upkeep of such facilities. The facility will work under the overall guidance of the **Medical Officer of the local PHC-Health and Wellness Centre, supported by CHO of the SHC-HWC**. Panchayats may have to hire additional staff for sanitation.

The human resource to man these Care Centre facilities may also be drawn from Volunteers selected by the VHNSCs**/GPs in rural areas/MAS in urban areas**.

Qualified AYUSH doctors/ Final year AYUSH students/ Final year BSc nurses may be considered by VHNSC to run the CCC.

5.1.3. Training

The nodal officers will be trained in performing Rapid Antigen Detection Kit. The Volunteers selected by VHNSC (School Teacher, Staff, Village Officer etc) will be trained in basics of COVID, infection prevention control, use of Personal protective equipment, medical waste management, monitoring of temperature using infrared thermo-meter, recording respiratory rate, use of Pulse Oximetry and identification of early warning signs and referral. Training modules available on the website of MoHFW (https://www.mohfw.gov.in/) or iGOT Diksha portal (https://diksha.gov.in/igot/) for these activities shall be used.

5.1.4. Logistics

The equipment and consumables required for the rural CCC is placed at **Annexure-1.**

5.1.5. Risk Communication

Risk Communication materials available on infection prevention and COVID appropriate behaviour will be displayed at strategic locations in the village and in the CCC.

5.1.6. Clinical Management at CCC

A. Patients at CCC should be provided symptomatic management for fever, running nose and cough, as warranted.

B. Patients should perform warm water gargles or take steam inhalation twice a day.

C. If fever is not controlled with a maximum dose of Tab. Paracetamol 650mg four times a day, PHC doctor may be consulted who may consider advising other drugs like non-steroidal anti-inflammatory drug (NSAID) (ex: Tab. Naproxen 250 mg twice a day).

D. Consider Tab Ivermectin (200 mcg/kg once a day, to be taken empty stomach) for 3 days.

E. Inhalational Budesonide (given via inhalers with spacer at a dose of 800 mcg twice daily for 5 to 7 days) to be given if symptoms (fever and/or cough) are persistent beyond 5 days of disease onset.

F. Systemic **oral steroids** not indicated in mild disease. If symptoms persist beyond 7 days (persistent fever, worsening cough etc.) then only consult the PHC doctor for treatment with low dose oral steroids.

G. In case of low oxygen saturation (<94%) or shortness of breath, the patient should be put on oxygen immediately before arranging referral transport. 2 oxygen cylinder/ concentrator may be dedicated at each CCC for this purpose

5.2. Planning for Dedicated COVID Health Centre (DCHC)

The Primary Health Centre/ Community Health Centre/ Sub District Hospital in these areas shall be the Dedicated COVID Health Centre for management of COVID-19. The facility may plan a minimum of 30 bedded DCHC. District should be prepared to increase DCHC beds as per the case trajectory & expected surge of cases.

These centres shall offer care for all cases that have been **clinically assigned as moderate** (Patient breathless; Respiratory Rate more than 24 per minute; Saturation between 90 to <94% on room air). The infrastructure shall be redesigned to function as DCHC, while retaining non-COVID essential services. Preferably, a separate block of PHC/CHC shall be designated as DCHC with separate entry, exit and zoning. Private hospitals may also be designated as COVID Dedicated Health Centres. Dedicated COVID Health Centre shall be re-designed for admitting both the confirmed and suspect cases clinically assigned as moderate while avoiding mixing of the two.

DCHC would have beds with assured Oxygen support. Every Dedicated COVID Health Centre should be mapped to one or more Dedicated COVID Hospitals. Care should be taken to locate these DCHCs in a manner that ensures availability of Oxygen supported beds in relative close vicinity to the patients.

5.2.1. Infrastructure Planning

(a) Outpatient Department (OPD)

With the intention to minimize the potential interaction between COVID and non-COVID patients visiting such facilities, it is necessary to redesign available infrastructure (or if feasible make suitable temporary arrangements) to carve out following areas:

1) Separate entry and exit point/s with provision for hand washing/hand sanitization stations at entry point/s.

2) Screening area: It should be a large area (preferably in open) enough to accommodate inflow of patients while maintaining a physical distancing of 6 feet. If required, specific markings may be made with sufficient distance to manage the queue and ensure physical distancing in the premises.

3) Screening area can have one or more screening desks where incoming patients may be screened into Acute Respiratory Illness (ARI) and non-ARI cases. These stations should have provisions for temperature recording as well as pulse oximetry.

4) The ARI and non-ARI patients shall be segregated into separate waiting areas.

5) The waiting area shall have adequately spaced sitting arrangement.

6) There shall be a separate consultation room with examination areas for ARI. These room/s should be well ventilated, preferably with an exhaust fan.

7) Ensure separate sampling area for ARI cases.

8) It shall have a separate pharmacy counter for ARI cases stocked with routinely prescribed drugs like paracetamol, antihistamines, cough syrups, multivitamin, Ivermectin, hydroxy-chloroquine, etc.

9) Dedicated areas for blood sampling and dedicated time slots for radiological investigations should be available.

(b) Inpatient Department (IPD)

A minimum of 30 bed Isolation ward with oxygen supported beds (with separate areas for suspect and confirmed cases) in existing facility or as annexe through tentage/ temporary structure shall be planned and equipped to admit mild/ moderate cases and shall be made functional on 24x7 basis.

1) No intermixing of suspect and confirmed cases shall be allowed. Confirmed cases can be kept in isolation ward earmarked for confirmed cases.

2) The beds shall be placed with spatial separation of at least 1 meter (3 feet) from one another.

3) Adequate natural room ventilation shall be ensured. Putting up exhaust fans to vent out air from the facility (to open area) is desirable.

4) The facility should have a separate toilet for suspect and confirmed cases with proper cleaning and supplies.

5) Signages may be put up in the perimeter and on the entry indicating that the space is a COVID-19 isolation area.

6) Separate donning/ doffing room (changing room) would be created with partitions for wearing and taking off Personal Protective Equipment (PPE) for the staff.

A suggestive scheme for patient movement at a PHC/CHC is at **Annexure 2**

5.2.2. Human Resource

Adequate number of dedicated trained staff shall be deployed at (i) Entry point/s, (ii) Screening desks and (iii) ARI consultation rooms, (iv) ARI sampling stations and (v) ARI pharmacy counter, (vi) Isolation ward. The number of persons shall be in accordance with the type of facility and patient load. If required, district administration may depute trained COVID warriors to man these facilities (Available at covidwarriors.gov.in).

A normative guidance on HR required is as detailed below:

S. No.	Station	Type of healthcare personnel	Number per shift

1	Entry point	Multi-skilled Group D worker/ Trained community volunteer	One per entry point
2	Screening desk	Health Worker (Male/Female)/ Trained community volunteer	One per desk
3	ARI consultation room	Medical officer (MBBS/AYUSH) Staff Nurse/ Trained community volunteer	One per room One per room
4	ARI sampling station	Staff Nurse Trained community volunteer	One per station One per station
5	ARI pharmacy counter	Pharmacist (allopathic/AYUSH)	One per counter
6	Isolation ward	Medical officer (MBBS/AYUSH) Staff nurse/ / Trained community volunteer (separate for suspect and confirmed sections)	Depending on number of beds

5.2.3. Training

The designated healthcare personnel assigned different tasks as brought out in the table above, shall be trained by Medical Officer in-charge of PHC/CHC on COVID basics, Infection Prevention and Control (IPC) protocol, sample collection, packaging and transportation, rapid antigen testing, clinical assessment & management and bio-medical waste management. The medical officers, other healthcare workers and volunteers can make use of training resources made available on the website of MoHFW (https://www.mohfw.gov.in/) or iGOT Diksha portal (https://diksha.gov.in/igot/) for all of these activities.

The medical officers shall network with Centre of Excellence in their States and attend regular webinars on various aspect of COVID-19 case management. Medical officers can also make use of "COVID-19 National Teleconsultation Centre" (CoNTeC) by AIIMS-Delhi by calling +91-9115444155 or any similar state-level initiative being undertaken. Wherever feasible, use of tele-medicine services may be made by treating doctors (detailed Telemedicine Practice Guidelines have been made available at: https://www.mohfw.gov.in/pdf/Telemedicine.pdf). To that extent the e-Sanjeevani telemedicine application launched by Union Health Ministry may also be utilised.

The above trainings shall be coordinated by the district administration preferably in local language by duly preparing a detailed plan of action in that direction.

5.2.4. Infection Prevention and Control Practices

PHC/CHC medical officer in-charge should familiarise himself/herself with MoHFW's guidelines for infection prevention and control in healthcare facilities (available at: https://www.mohfw.gov.in/pdf//National%20Guidelines%20for%20IPC%20in%20HCF%20-%20final%281%29.pdf)

All personnel being deployed at (i) entry points, (ii) screening desks, (iii) consultation rooms, (iv) sampling area and (v) pharmacy counter and (vi) isolation ward should be provided with requisite PPEs and hand sanitizers. Choice of PPE shall be in accordance with MoHFW guidelines on rational use of personal protective equipment (available at: https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdf)

In addition to ARI screening and treatment areas, personnel working in other parts of the facilities should be provided with suitable PPEs. This shall be in accordance with the MoHFW's Additional guidelines on rational use of Personal Protective Equipment (setting approach for Health functionaries working in non-COVID areas) (available at: https://www.mohfw.gov.in/pdf/UpdatedAdditionalguidelinesonrationaluseofPersonalProtectiveEquipmentsettingapproachforHealthfunctionariesworkinginnonCOVID19areas.pdf)

In addition, proper provision of covered bio-hazard bins for disposal of used PPEs should be made available at these locations. Used PPEs, masks etc. should necessarily be disposed of in accordance with the guidelines issued by Central Pollution Control Board (available at: https://cpcb.nic.in/uploads/Projects/Bio-Medical-Waste/BMW-GUIDELINES-COVID_1.pdf)

5.2.5. Logistics

PHCs/ CHCs identified for COVID management needs to have 24x7 assured oxygen supply (oxygen cylinders, Oxygen concentrators or other means), and necessary equipment for oxygen administration (nasal prongs, bag and mask, non-re-breathable bag and mask).

The equipment and material requirements for PHC/CHC functional for managing COVID cases are as given at **Annexure-3**. The CMO In-charge of PHC/CHC will ensure that these equipment/devices/consumables are available in requisite quantities. If not, a requisition should be made with district administration.

Necessary logistics arrangements for such facilities shall be coordinated by the district administration on a regular basis.

5.2.6. Risk communication

Suitable provisions for posters, standees and (if feasible) AV media may be made available throughout the facilities to create awareness among general public on (i) simple preventive health measures like use of mask/face cover, hand and respiratory hygiene, physical distancing, (ii) common signs and symptoms of COVID, (iii) need for early reporting of cases, (iv) National/State/district helpline numbers etc.

In addition, adequate signage and information notices (in local language) should be displayed prominently at all entrances, corridors, designated areas, wards etc. to prevent inter-mixing of patients and stream ARI patients away from regular clinical areas.

5.2.7. Cleaning and disinfection

Suitable provisions for disinfection of floors and surfaces should be done at least twice a day by cleaning with 1% sodium hypochlorite solution. This includes entrance area, screening area, waiting area, consultation area, designated area for suspected COVID-19 cases, laboratory, pharmacy, etc. All frequently touched surfaces shall be cleaned frequently (at least twice a day) with 1% sodium hypochlorite solution. Washrooms and hand washing stations shall be deep cleaned at least four times a day.

In addition, disinfection of ambulances transporting suspected/confirmed COVID-19 cases must be done after every visit.

5.2.8. Clinical management

Clinical management of cases admitted in these facilities shall be in accordance with the Clinical Management Protocol Algorithm for COVID-19 (available at:

https://www.mohfw.gov.in/pdf/COVID19ManagementAlgorithm22042021v1.pdf.

Paediatric cases may be managed as per the protocol available at:

https://www.mohfw.gov.in/pdf/ProtocolforManagementofCOVID19inthePaediatricAgeGroup.pdf

5.2.8.1. Management of COVID cases in facilities not having specialist services (PHC/ Health Posts etc.)

- Mild cases of COVID-19 (with $SpO_2 \geq 94\%$) that cannot be managed at home (those who do not qualify for home isolation and treatment) or mild cases with co-morbidities and can be managed at this level.
- Moderate cases with or without controlled co-morbid conditions (on currently prescribed medication) can be managed at these centres provided patient is stable with administration of up to 10 litre/ minute Oxygen therapy through non-rebreathing face mask to target SpO2 of 92-96%.
- Awake proning encouraged in all patients requiring supplemental oxygen therapy [Detailed procedure is available at:
    - https://www.mohfw.gov.in/pdf/COVID19ProningforSelfcare3.pdf]
- Cases should be managed based on symptoms (hydration, antipyretics, antitussive, multivitamins). If fever is not controlled with a maximum dose of Tab. Paracetamol 650mg four times a day, may consider advising other drugs like non-steroidal anti-inflammatory drug (NSAID) (ex: Tab. Naproxen 250 mg or ibuprofen 400 mg as required).In mild cases, if symptoms persist beyond 7 days (persistent high-grade fever/ worsening cough) low dose oral steroids (dexamethasone 6 mg once daily/ Methylprednisolone 32mg once daily) may be considered.

- Specific therapies based on the assessment of treating doctor that can be administered in these facilities are:
    - Tab Ivermectin (200 mcg/kg once a day for 3-5 days) (Avoid in pregnant and lactating women).

      Or

      Tab HCQ (400 mg BD for 1-day f/b 400 mg OD for 4 days) unless contraindicated.
    - Inhalational Budesonide (given via Metered dose inhaler/ Dry powder inhaler) at a dose of 800 mcg BD for 5 days) to be given if symptoms (fever and/or cough) are persistent beyond 5 days of disease onset.
    - Moderate cases as mentioned above may be given Inj. Methylprednisolone 0.5 to 1 mg/kg in 2 divided doses (or an equivalent dose of dexamethasone) usually for a duration of 5 to 10 days. Patients may be initiated or switched to oral route if stable and/or improving.
- Monitoring of temperature and oxygen saturation (by applying a SpO2 probe to fingers) four-hourly shall be undertaken for the patients. Maintain charting as per proforma given below:

Day of symptoms and time (every 4 hourly)	Temperature	Respiratory Rate	Blood Pressure	SpO2 %	Heart rate	Remarks

- In mild and stable moderate cases admitted to these facilities, if saturation dips below 90% even with the above prescribed oxygen therapy, the patients will be referred to higher centre in the referral framework.
- There could be a possibility of a severe case in respiratory distress reporting to these facilities. Till such time an ambulance (with oxygen support) is arranged , the patient should not be refused and stabilized in the health facility on oxygen with flow rate that would maintain a saturation of ≥ 90 % in those without chronic respiratory co-morbidities (in patients with Chronic Obstructive Pulmonary Disease SpO2 of 88-92% may be targeted).
- Every facility identified for COVID management should also have a dedicated Basic Life Support Ambulance (BLSA) (equipped with sufficient oxygen support) on 24x7basis with established linkages with nearest Dedicated COVID Health Centre and Dedicated COVID Hospital.
- Discharge of mild cases shall be as per discharge policy of MoHFW (available at: https://www.mohfw.gov.in/pdf/ReviseddischargePolicyforCOVID19.pdf)

5.2.8.2. Management of COVID cases at facilities with specialist services (CHC/private hospitals etc.)

- Identified facilities will manage mild cases requiring facility care as well as moderate cases.
- Management of mild cases requiring facility care and moderate cases with stable co-morbidities will be as per protocol delineated in para 5.1.
- Oxygen Therapy for moderate cases should target saturation of 92-96% (88-92% in patients with Chronic obstructive pulmonary disease (COPD). Non-rebreathing face mask will be the preferred devices for oxygenation. Awake proning shall be encouraged in all patients requiring supplemental oxygen therapy.
- All moderate cases shall be given Inj. Methylprednisolone 0.5 to 1 mg/kg in 2 divided doses (or an equivalent dose of dexamethasone) usually for a duration of 5 to 10 days. If a patient is stable or improving, steroids may be initiated or switched to oral route.
- Anticoagulation shall be provided by giving conventional dose prophylactic unfractionated heparin or Low Molecular Weight Heparin (weight based e.g., enoxaparin 0.5mg/kg per day SC once daily). There should be no contraindication or high risk of bleeding.
- Monitoring

o Clinical Monitoring: Work of breathing, hemodynamic instability, change in oxygen requirement.

o Serial CXR to be done only if there is indication of pneumonitis.

o Lab monitoring: Inflammatory markers, such as CRP and D-dimer (48 to 72 hourly); CBC, KFT, LFT (24 to 48 hourly) to be done on the recommendation of the treating medical officer.

- Antibiotics should not be prescribed routinely unless there is clinical suspicion of a bacterial infection. However, Antibiotics (as per local antibiograms) should be available at these facilities for treatment of secondary bacterial infections.,
- Management of co-morbidities, if any, should also be addressed.
- Patients should be monitored for signs and symptoms of complications that should prompt urgent referral.
- Patients with risk factors for severe illness should be monitored closely, given the possible risk of deterioration. If they develop any worsening symptoms (such as mental confusion, difficulty breathing, persistent pain or pressure in the chest, bluish coloration of face/lips, dehydration, decreased urine output etc.), they should immediately be referred to a Dedicated COVID Hospital.
- Every such facility must also have a dedicated Advance Life Support Ambulance (ALS) on 24x7basis with established linkages with nearest Dedicated COVID Hospital.
- Discharge of mild to moderate cases shall be as per discharge policy of MoHFW (available at: https://www.mohfw.gov.in/pdf/ReviseddischargePolicyforCOVID19.pdf)

5.3. Dedicated COVID Hospital (DCH)

District Hospital or other identified private hospitals or a block of these hospitals shall be converted as the dedicated COVID Hospitals. In addition, Sub-district/ Block level hospitals fulfilling the requirements may also be designated as the Dedicated COVID Hospital for the identified CCC and DHCC in their catchment area. The upgradation in health facilities shall be undertaken based on case trajectory or the surge in cases.

6. Post COVID management

Medical officers in these facilities will also follow with recovered patients for post-COVID complications. Post COVID management protocol available at https://www.mohfw.gov.in/pdf/PostCOVID13092020.pdf shall be followed.

On discharge, patients should be counselled for post-COVID management at home and leaflets regarding danger signs (e.g. breathlessness, chest pain, recurrence of fever, low oxygen saturation, etc.), precautions and various respiratory exercises.

Patients with other comorbidities should also be followed up and primary assessment of other co-morbidity (e.g. measuring blood pressure, blood glucose level) should be arranged and any modification treatment if necessary should be decided by a PHC medical officer. Telemedicine services may also be utilized for providing post-covid follow-up care.

7. Community mobilization and behaviour change communication

- A multi-pronged approach, led by Gram Panchayat (GP) and engaging health sector, ICDS, School teachers, Self-help group (SHG) of women and other community-based organizations, should be utilized for mobilizing the community in the fight against COVID-19 pandemic. Gram Panchayats will play the prime responsibility of coordinating community action and awareness creation at village level and the Block Development Officer (BDO) at Taluka level.
- The efforts in the medical care side will be coordinated by VHSNC along with the PHC/Sub Centre.
- VHSNC will be primarily responsible for the preparedness at village level for timely action for prevention of COVID-19. Major tasks will include preventive measures for the control of pandemic, help in surveillance activities, support quarantine and isolation facilities, availability of items of daily needs including food items, ensure continued provision of essential health services including referral transport. as well as to support needy families. The committees will also help in promoting COVID-appropriate behaviour and for limiting community rumours/fake news at village level.

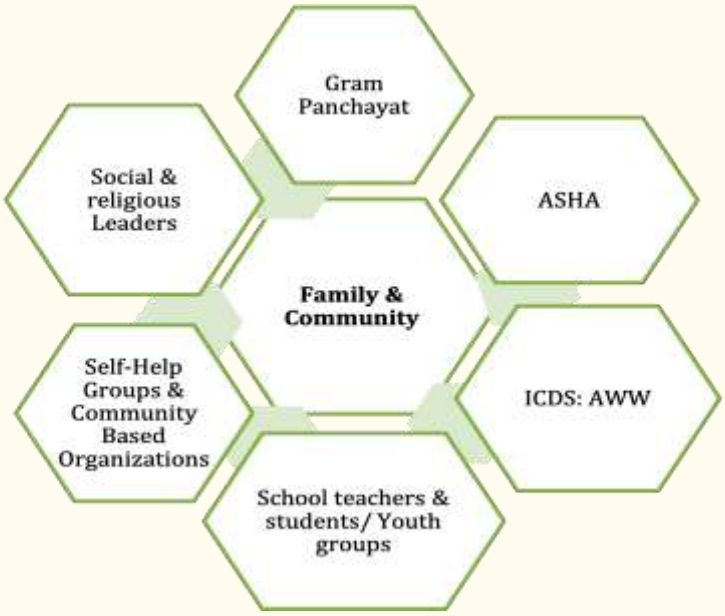


Fig. 1. Key stakeholders within the village community that could be mobilized for COVID-19 management

- A checklist for community preparedness for COVID-19 response should be utilised after local adaptation based on the need (**Annexure 4**).
- Standard Behaviour Change Communication (BCC) materials developed in local language and approved by the health department should be circulated through all available platforms.
- Village Health Nutrition Sanitation Committee (VHNSC) will act as a centre of local level community health action for decentralized health planning. Preventive strategies like physical distancing and containment can be implemented in a better way if planned and organized strategically at village level by local stakeholders. Surveillance and its compliance will also be better. Members of women Self-help groups (SHGs) may be engaged actively in many activities like ensuring the supply of essential services in the community, providing food and other essentials to the needy families, supporting preventive measures, making masks, running kitchens for quarantine/ isolation facilities, etc. Religious leaders are trusted by the community. They may help to facilitate the COVID appropriate behaviour.
- The Block Development Officer (BDO) /Village Development Officer (VDO) will identify mentors from health, Integrated Child Development Scheme (ICDS) and other related departments to mentor the team at Gram Panchayat level. Each such mentor will have 5-10 villages to supervise. Village level resource mapping exercises should be conducted at each Gram Panchayat level. The mentors assigned by the BDO/VDO will ensure that village-wise resource mapping exercise, regular filling of the checklist and community dialogue for COVID-19 response happens regularly. A fortnightly review of community preparedness and progress should be undertaken at block and district level.
- A successful decentralized model of care for managing the COVID-19 would include:
    i) Involvement of Gram panchayat (GP) at the forefront of pandemic management with financial allocation and administrative empowerment;
    ii) Mobilization and involvement of SHGs for creating awareness for COVID-appropriate behaviours and for providing essential services, especially if there is a mass movement restriction;

iii) Protect the high-risk vulnerable group and limit the spread of virus by advance payment of pension benefits to older adults, disabled and widows under national and state pension schemes;

iv) Opening up Temporary Medical Centres (TMCs) at GP levels and COVID Care Centres; and

v) Strengthening community-based management engaging frontline workers (i.e. Auxiliary Nurse Midwife (ANMs), Accredited Social Health Activist (ASHAs) and Anganwadi Workers) and support of other village/ Gram Panchayat level functionaries.

8. Mental health support at community level

Besides fear of contracting the disease, the fear of quarantine, isolation, lockdown, loneliness, loss of livelihoods and challenges with education of kids can cause widespread mental health problems during the COVID pandemic. Increased risk of depression, suicides and other mental health problems are reported frequently from different parts of the country. Provision of psychological support to enable people to remain mentally healthy during the difficult time should be one of the important elements of COVID response.

9. Adequate provision of support services and intersectoral coordination

- Community should ensure that basic needs of all the families including migrants are fulfilled. Attempts should be made for alternative employment opportunities including MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act).
- The dead bodies should be managed duly following the guidelines available at https://www.mohfw.gov.in/pdf/1584423700568_COVID19GuidelinesonDeadbodymanagement.pdf)

10. Undertaking of public health functions by PHC/ CHC in COVID containment operations

A PHC/CHC lying within or close to a containment/buffer zone shall be actively involved in COVID containment operations. The medical officer/nodal officer of the said health facility will also be in charge of COVID-19 surveillance activities in the allotted area. He shall:

- Familiarize with COVID-19 cluster containment plan (available at: https://www.mohfw.gov.in/pdf/Containmentplan16052020.pdf) and containment plan for large outbreaks (available at: https://www.mohfw.gov.in/pdf/UpdatedContainmentPlanforLargeOutbreaksofCOVID19Version3.0.pdf)
- Familiarize with the containment and surveillance manual for supervisors (available at: https://www.mohfw.gov.in/pdf/ContainmentandSurveillanceManualforSupervisorsincontainmentzones.pdf) and manual for surveillance teams functionaries (available at: https://www.mohfw.gov.in/pdf/ManualforSurveillanceTeamsforcontainmentzones.pdf)
- Train and retrain all PHC/CHC and field level (including ASHAs, ANMs, MPWs etc.) staff engaged in COVID management.

- Estimate the requirement of logistics for field operations including Personal Protective Equipment kits, N-95 mask, triple layer medical mask, gloves, sanitizers, pulse oximeters, thermometers, disinfectants etc. and arrange for the same for field-based teams.
- Divide the area under jurisdiction (in containment zone) into sectors [in coordination with district Rapid Response Team (RRT)] and allot supervisors and surveillance teams for each of the sectors.
- Collect lists of homes for each of the sector from district RRT and distribute among supervisors for house to house surveillance and follow up of cases and contacts
- Provide field-based teams with appropriate risk communication materials for effective awareness creation.
- Facilitate contact tracing of confirmed COVID cases along with supervisors and surveillance teams as per IDSP's guidelines for contact tracing of COVID-19 cases in community settings (available at: https://www.ncdc.gov.in/showfile.php?lid=570)
- Supervise the activities of surveillance teams and their supervisors.
- Certify appropriateness of residential facility for allowing Home Quarantine as per MoHFW's guidelines for home quarantine (available at: https://www.mohfw.gov.in/pdf/Guidelinesforhomequarantine.pdf)
- Certify residential facility appropriateness and clinically examine the cases to allow for home isolation as per MoHFW's guidelines for Home Isolation of very mild/pre-
- symptomatic/asymptomaticCOVID-19 cases (available at: https://www.mohfw.gov.in/pdf/RevisedHomeIsolationGuidelines.pdf)
- Collect data from field units and submit to district RRT/Control room daily.
- Liaison with field units, district RRT/Control room, COVID testing laboratory, nearest CHC/Dedicated COVID Health Centre/Dedicated COVID hospital, ambulance service provider etc.
- Identify suspect COVID cases, ensure testing of all ILI/SARI cases reporting to the health facilities either through COVID-19 rapid antigen testing or by referral of samples to nearest COVID-19 testing laboratory, in accordance with ICMR guidelines for the same (available at: https://www.icmr.gov.in/pdf/COVID/strategy/Testing_Strategy_v6_04092020.pdf)

11. Preparedness for rapid coverage with COVID vaccination

Ensuring high coverage with vaccination is a pivotal strategy for preventing future surge in COVID cases. Appropriate strategies for achieving high coverage with COVID vaccination in rural areas need to be devised. Frontline Line Workers along with community leaders will mobilize the beneficiaries for vaccination in compliance with the guidelines by the Government of India. Proper IEC efforts should be made using various channels for this purpose and to address vaccine hesitancy.

12. Non-COVID essential healthcare delivery services

While focusing on COVID 19 related activities is crucial, ensuring continuity of other (non-COVID) essential health services is equally vital. Essential health services such as reproductive, maternal, new-born and child health, prevention and management of communicable diseases, treatment of prevalent

non-communicable diseases and addressing emergencies also need to be continued and use of telemedicine etc. shall be promoted for the same.

In this regard, MoHFW's guidance note on enabling delivery of essential health services during the COVID 19 outbreak may be referred to (available at: **https**://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf)

13. Establishment of COVID-specific call centres at district level and utilization of telehealth facilities

- Setup a central District level portal for information and help desk to provide information regarding availability of health facilities, available beds, ambulance, vaccination centers, home isolation guidelines and other relevant guidelines related to COVID-19 management.
- Utilize telemedicine/ e-Sanjeevani OPD services for both COVID and non-COVID essential services

14. Tribal COVID-19 care and response strategies for tribal area

Besides the proposed health care strategies as above , tribal areas pose additional challenges and hence additional focus. Tribal communities are geographically and socioeconomically relatively segregated and may have poor access to health care. Strengthening community-based management through Gram Sabha should be taken and they should be involved at every stage of planning and executing COVID-care activities.

Integration of COVID-care with Mobile Medical Units (MMUs) under NHM in tribal areas: Mobile Medical Unit (MMU) under NHM to facilitate access to public health care in tribal areas. MMUs have an existing medical team (medical officers, pharmacist, staff nurse and lab technician). This team may be utilised to create awareness regarding COVID-appropriate behaviour, carry out Rapid Antigen Testing (RAT), take samples for RT-PCR, provide treatment for mild illness, and help establish referral linkage with DCHC and DCH.

Telemedicine/Teleconsultation should be utilized to bridge the geographical inaccessibility in tribal areas as per feasibility.

Non-governmental organizations (NGOs) working in these areas can play a crucial role in provisioning of public health services in tribal/remote areas due to their community rapport and local existence.

Annexure-1-A

List of Equipment for Covid Care Centre

Sr. No	Equipment COVID Care Centre (CCC)	
1	Beds	Standard Hospital Beds
2	Pulse oximeter	1 Per 10 beds
3	Crash cart	1
4	Self-Inflating resuscitation bag	1
5	Glucometer	2
6	BLS ambulance	1
7	Stethoscope	2
8	Digital B.P Apparatus	1 per 15 beds
9	Digital Thermometer	6
10	Mattress	1 per bed
11	Refrigerators 165 Litres	1
12	LED Torch Light	1
13	Blankets/mattress/bed sheet	As per requirements of the beds
14	Automated External Defibrillator (AED) (if not already included in crash cart)	1
15	Mobile bed screens	2
16	Sputum can, bed pan, urine pot	One per 10 beds
17	Wheelchair/ patient transfer trolley with side rail	One each
18	5 litre oxygen concentrator or oxygen cylinder	2

Annexure-1 B

List of Consumables for Covid Care Centre

Sr. No	Consumables for COVID Care Centre (for 1 month's consumption)	
1	Complete PPE kit	200
2	N-95 masks	200
3	Medical triple layer masks	3000
4	Non sterile Gloves, examination	200
5	Gloves, heavy duty	60
6	Face shield	200
7	Bio-hazardous bags	150
8	Glucometer strips (1000 strips with each glucometer in packets of 50 and lancets)	1
9	Oxygen Cylinders B Type with trolley, regulator, flow meter humidifier	2
10	Ortho Toludine Solution for refill (1 litre Bottle)	1
11	Soap/ handwash	10 (as per requirement)
12	IV stands	2
13	Oxygen face mask, nasal prongs, Non-rebreather mask	5 each
14	Commode chair	1

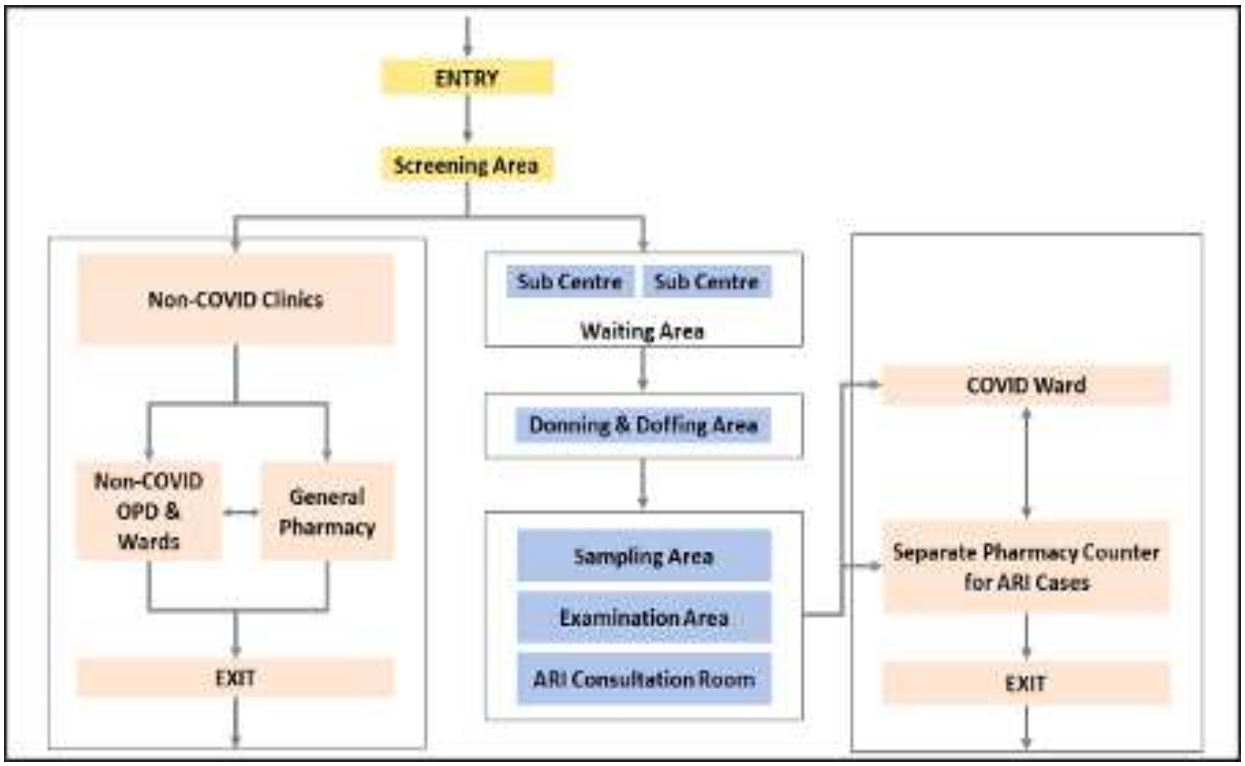
Annexure 1 C

Drugs, testing kits and other consumables

Sr. No	Drugs, testing kits and other consumables for COVID Care Centre (for 1 month's consumption)	
1	Paracetamol (650 mg)	5000
2	Hydroxychloroquine (400 mg)	500
3	Ivermectin (12 mg)	200
4	Antihistamines / Anti-tussives / multivitamins/ IV fluids	As per requirement
5	MDI / DPI Budesonide / respules	50
6	Drugs for management of non-communicable diseases	As per requirement
7	Rapid antigen testing kits	1000
8	Alcohol-based hand sanitizer (250 ml)	50
9	1% Sodium Hypochlorite solution (1 litre)	30
10	Standard IEC materials on COVID-19	1 set per center
11	Drugs for GI symptoms (drugs for gastric acidity e.g. PPIs, anti-emetics, anti-diarrheals, ORS)	As per requirement
12	Analgesic antipyretic (Ibuprofen 400 mg, naproxen 250 mg)	As per requirement

Annexure-2

Suggestive scheme for patient movement at a PHC/CHC



Annexure-3 A

List of Equipment for Dedicated COVID Health Centre (30 beds)

Sr. No	Equipment for Dedicated COVID Health Centre (DCHC)	
1	Beds	Standard Hospital Beds
2	Oxygen Source (Cylinder/ piped medical oxygen supply/ Oxygen concentrator)	1 Per bed
3	Suction source	3
4	Transport Ventilator	1
5	Pulse oximeters	30
6	AED (if not already included in crash cart)	1
7	ECG (5 channel machine)	1
8	Crash cart	1
9	Self-Inflating resuscitation bag	5
10	X-ray unit	1
11	Facility for haematology and Biochemistry tests	Mandatory
12	Glucometer	2
13	ALS ambulance	1
14	Stethoscope	5
15	Digital B.P Apparatus	5
16	Digital Thermometer	4
17	IV Stand	30
18	Mattress and linen, and blanket	As per requirements of the beds
19	Refrigerators 165 Litres	1

Sr. No	Equipment for Dedicated COVID Health Centre (DCHC)	
20	LED Torch Light	1
21	Laryngoscope set	1
22	Table top NIBP and SpO2 monitor	10% of beds
23	Oxygen delivery devices (Nasal cannula, oxygen face mask, Venturi, NRBM)	✓
24	Patient transfer trolley with side rail	two per 50 patients
25	Portable suction pump	One per 25 patients
26	Bain circuits	one per 50 patients
27	10 liter oxygen concentrator/ oxygen cylinder	✓
28	Nebuliser machine, MDI spacer	✓
29	Syringe pump	2 per 50 patients
30	Multipara monitor	1 per 50 patients
31	Wheel chair	One per 50 patients
32	Commode chair	One per 25 beds

Sr. No	Equipment for Dedicated COVID Health Centre (DCHC)	
33	Sputum can, bed pan, urine pot	One per 5 beds
34	Computer with internet and printer	1
35	Portable non-invasive ventilator (BIPAP) with 0-30 oxygen bleed flow with high flow meter	2
36	Biomedical waste bins	2 of each colour

Annexure- 3 B

List of Consumables for Dedicated COVID Health Centre

Sr. No	Consumables for Dedicated COVID Health Centre	
1	Oxygen mask with reservoir	100
2	Nasal prongs (all sizes)	100
3	Endotracheal tubes cuffed (all sizes)	3 sets
4	Endotracheal tubes non-cuffed (all sizes)	3 sets
5	LMA (laryngeal mask airway) of different sizes	1 each
6	Oropharyngeal Airways (all sizes)	3 sets
7	Complete Personal protection kits	500
8	N-95 masks	500
9	Medical masks	3000
10	Gloves, examination	5000
11	Gloves, heavy duty	100
12	Face shield	500
13	Oxygen tubings	100
14	IV Catheters (all sizes)	100
15	Stopcock, 3-way, for infusion giving set, with connection line, sterile, single use	100

Sr. No	Consumables for Dedicated COVID Health Centre	
16	Syringes, Luer (all sizes)	500
17	Needles, hypodermic (all sizes)	500
18	IV Drip set	100
19	Bio-hazardous bags	150
20	Urinary Catheters with urobag	50
21	Glucometer strips (1000 strips with each glucometer in packets of 50 and lancets)	1
22	Nebulizer Mask Disposable Kit Adult	10
23	Nebulizer Mask Disposable Kit Pediatrics	10
24	Oxygen Cylinders B Type with trolley, regulator, flow meter humidifier	40
25	Oxygen face mask adult	100
26	Oxygen face mask Pediatrics	100
27	Ortho Toluidine Solution for refill (1 litre Bottle)	1
28	Suction Catheter	200
29	Nasogastric Tube	100
30	Yankauer suction set	10
31	HME filter	20

Annexure-3 C

Drugs, testing kits and other consumables for Dedicated COVID Health Centre

Sr. No	Drugs, testing kits and other consumables for Dedicated COVID Health Centre (for 1 month's consumption)	
1	Paracetamol (650 mg)	5,000
2	Hydroxychloroquine (400 mg)	1,000
3	Ivermectin (12 mg)	500
4	Dexamethasone – Injectable	200
5	Dexamethasone – Tablets 6/ 4/ 2 mg	2,000
6	Methylprednisolone – Injectable	200
7	Prednisolone – Tablets 40/20/10 mg	2,000
8	Antihistamines / Anti-tussives / multivitamins IV fluids	As per requirement
9	MDI / DPI Budesonide / respules	100
10	Resuscitative drugs (adrenaline, sodium bicarbonate, frusemide, deriphyllin, dopamine, dobutamine, etc.)	10 Ampules each
11	Low Molecular Weight Heparin (LMWH) / Ultra-fractionated heparin (UFH)	200
12	Drugs for management of non-communicable diseases (including Ischemic heart disease, hypertension, COPD, asthma,diabetes mellitus)	As per requirement
13	Rapid antigen testing kits	2,000

Sr. No	Drugs, testing kits and other consumables for Dedicated COVID Health Centre (for 1 month's consumption)	
14	Alcohol-based hand sanitizer (250 ml)	100
15	1% Sodium Hypochlorite solution (1 litre)	60
16	Standard IEC materials on COVID-19	2 set per center
17	Antibiotics	As per local antibiogram
18	Newer oral anticoagulants (dabigatran 110 mg or rivaroxaban 10 mg or apixaban 2.5 mg)	As per requirement
19	Inj Enoxaparin 40 mg and 60 mg	As per requirement
20	Analgesic antipyretic (Ibuprofen 400 mg,, naproxen 250 mg)	As per requirement
21	Drugs for GI symptoms (drugs for gastric acidity e.g. PPIs, anti-emetics, anti-diarrheals, ORS)	As per requirement
22	Sedation agents (Inj midazolam,)	As per requirement
23	Paralytic agents (scoline, atracurium,)	As per requirement
24	Other: Inj KCL, Calcium gluconate, Magnesium sulphate, sodium bicarbonate	As per requirement

Annexure 4

Checklist for community preparedness for COVID-19 response

COMMUNITY PREPAREDNESS CHECKLIST

FOR ACTION AGAINST COVID-19 PANDEMIC

This modified checklist has been developed for use by Gram Panchayat/ Village Health and Sanitation Committee to assess the preparedness at Gram Panchayat level. This filled in checklist will help the gram panchayat for timely action for prevention of COVID 19.

The checklist should be filled by the nodal person identified by the Gram Panchayat in consultation with the members of the Gram Panchayat fortnightly and the information so collected should be used for strengthening community action against the pandemic. It will the responsibility of the Gram Panchayat Secretary to see that the checklist is filled regularly and to share the information with Extension Officer (Health) at Block Development Office. The Block Development Officer will take appropriate action and share the information at Zilla Parishad or District Panchayat Officer and the District Collector

Name of the Gram Panchayat: **Block:** **District:**

Date of filling checklist:

No.	**Assessment item**	**Status**	**Remarks**
I.	***Preventive measures for control of Coronavirus pandemic***		
1	Is the Village Health and Sanitation Committee constituted in your Gram Panchayat?	Yes/ No	
2	Did the committee identify a nodal person among members?		
3	Did the committee motivate and enrol volunteers to participate in COVID-19 activities?	Yes/ No	
4	Did the committee ensure participation of Self-help groups and other community-based organisations in COVID-19 activities?	Yes/ No	
5	Do the committee members and volunteers have knowledge regarding the following:		

	• Modes of transmission/spread of COVID-19? • Importance of using mask/ cotton cloth? • Maintaining physical distance • Thoroughly washing hands with soap and water • Cough etiquettes • Home quarantine • Cleaning and disinfection of frequently used surfaces • Cleaning and disinfection of public places • Local and State level corona helpline numbers (1075, 011-23978046, 020-26127394)	Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No	
6	Did the Committee impart information about preventive and control measures against COVID-19 to the villagers?	Yes/ No	
7	Have the committee identified and used locally relevant modes of mass communication (e.g. Dawandi/ Announcement accompanied by beating drums)?	Yes/ No	
8	How good is compliance of villagers with the following? · Physical distancing · Use of mask/handkerchief/ cotton cloth · Washing hands with soap and water	Very good/ Good/ Poor/ Very poor Very good/ Good/ Poor/ Very poor Very good/ Good/ Poor/ Very poor	

9	Is there a system to check the compliance with the above?	Yes/ No	
10	Did the committee identify places or events when the village gathers e.g., weekly market, festival etc.	Yes/ No	
11	Have measures been taken to control the such gatherings? If yes, specify measures taken?	Yes/ No	
12	Have you enlisted the elderly and person with comorbidities in your village?	Yes/ No	
13	Do the committee have plan to ensure adequate care of elderly and persons with comorbidities	Yes/ No	
II. ***Solidarity at community level and address any stigma associated with the disease***			
14	Does the committee have adequate representation of all sections of the society (including minority groups)?	Yes/ No	
15	Did the committee make adequate efforts to reach out and address concerns of all sections of the society (including minority groups)	Yes/ No	
16	Do the committee members/ villagers understand the importance of supporting individuals and their families, in case they get the disease?	Yes/ No	
17	Does the committee take any steps to address stigma associated with the disease?	Yes/ No	
III. ***Help in surveillance activities related to Coronavirus pandemic***			
18	Did the committee prepare a list of following?		
	· Elderly above 60 years of age	Yes/ No	

	· People with hypertension & diabetes · Pregnant women	Yes/ No Yes/ No	
19	Does the committee have a plan to ensure adequate care of the above groups of people?	Yes/ No	
20	Does the committee have a plan to keep a watch on the people suffering from cough, cold or fever?	Yes/ No	
21	Do the committee members help the ASHA/ AWW in conducting survey for cough, cold or fever?	Yes/ No	
22	Does the committee keep vigilance on arrival of any outsider in the village and take measures for prevention of COVID-19 transmission?	Yes/ No	
IV. ***Support quarantine/ isolation***			
23	Do the committee members keep a watch on the people who have been quarantined in home?	Yes/ No	
24	Do the committee members advice and support the families having home quarantined person/s to take necessary precautions?	Yes/ No	
25	Has the committee make provision for doorstep delivery of essential items and services to the families with home quarantined person/s?	Yes/ No	
26	Has any arrangement been made for village level quarantine facility wherever and whenever home quarantine is not possible?	Yes/ No	
V. ***Ensure continued provision of essential health services at village level***			

27	Are routine health care services at village level (including Village Health and Nutrition Days) being conducted regularly?	Yes/ No	
28	Are ASHA/ Anganwadi workers in regular contact with pregnant and lactating women to ensure continuity of care?	Yes/ No	
29	Are ASHA/ Anganwadi workers in regular contact with all high-risk cases of communicable and non-communicable diseases to ensure continuity of care?	Yes/ No	
30	Does the village committee ensure adequate stock of medicines for all individuals with hypertension and diabetes at village level?	Yes/ No	
31	Is transport facility available in village for referral in case of emergency?	Yes/ No	
32	Are the committee aware about the government ambulance services i.e. 108 for COVID-19 patients and 102 and other ambulances for other essential health services as the case may be?	Yes/ No	
33	Is the committee aware about the following COVID 19 related Services? · Referral facility for suspected COVID 19 Patients · Helpline Number/ Nodal persons for availability of beds for COVID 19 Patients? · COVID 19 Testing Centres facility. Ambulance services for Covid 19 Patients	 Yes/ No Yes/ No Yes/ No Yes/ No	
VI. *Prompt response, in case Coronavirus positive case/s are detected* *(This section needs to be filled, only if containment or micro-containment zones are declared OR there are large number of cases in the village)*			
34	Is there single entry/ exit for the containment zone?	Yes/ No	
35	If Yes, are adequate IEC materials displayed at the entry?	Yes/ No	

36	Did the team ensure villagers are getting right information regarding risk?	Yes/ No	
37	Are traditional cremation ground/ burial attendants trained and equipped for safety precautions during all deaths during this period?	Yes/ No	
38	Does the village have a plan to ensure the safety and well-being of everyone during the process of last rite?	Yes/ No	
39	Has the committee ensured effective communication with the community for eliciting their support in ensuring required protocol management during containment?	Yes/ No	
40	Has the committee ensured that required house to house active case search is conducted by the special teams formed for the purpose?	Yes/ No	
41	Has the committee helped the surveillance efforts through providing required volunteers from the community?	Yes/ No	
VII. Ensure Hygiene and sanitation in the Gram Panchayat			
42	Is there adequate facility for washing hands with water and soap in primary school/ upper primary schools/ educational institutions/ market places, and Other public places?	Yes/ No	
43	Is regular fumigation of the village also being undertaken by the Gram Panchayat to prevent breeding of mosquitoes? If yes, indicate periodicity and chemical used? If not, why not?	Yes/ No	
44	Is the Gram Panchayat taking steps to ensure collection and disposal of solid waste? If yes, specify system put in place?	Yes/ No	

45	Are the drains cleaned regularly in the village?	Yes/ No	
46	Has the Gram Panchayat taken steps to ensure that there are no stagnant pools of water in the village? If yes, specify measures taken?	Yes/ No	
47	Has the community undertaken voluntary service to keep the village and its environment clean? If yes, please provide details.	Yes/ No	
VIII. COVID 19 Vaccination			
48	Have the committee identified and used locally relevant modes of mass communication for creating awareness regarding vaccination (e.g. Dawandi/ Announcement accompanied by beating drums)?	Yes/ No	
49	Does the committee prepare line list of eligible individuals from the community?	Yes/No	
50	Did the committee members try to motivate individuals who are eligible for vaccination and have not taken it till now for vaccination?	Yes/ No	
51	Did you make special arrangement for the needy person to take him to vaccination site?	Yes/No	
52	Did the committee seek support from influential person in society/religious leaders or groups for supporting the vaccination drive?	Yes/No	
	IX. If the lockdown has been implemented in district/ state		
53	Has the committee ensured effective communication with the community for eliciting their support in ensuring required protocol management during lockdown?	Yes/ No	

54	Has the committee ensured that the relief measures provided by government are reaching to the most needy in the community?	Yes/ No	
55	Does the Committee have plans to deliver essential commodities to the needy people?	Yes/ No	
56	If yes, do you have identified resources to execute that plan?	Yes/ No	
57	Has the committee made any arrangement for accommodation and other essential services for migrants?	Yes/ No	
58	Has the committee made any plan to give work to the laborers under the schemes like MGNREGA?	Yes/ No	
59	In case of any migrant workers returning to the village, having any notifiable disease like TB etc., or any other comorbid conditions, has committee provided required support to them in consultation with Health officials?	Yes/ No	