Preparedness and Response to COVID-19 for Urban Settlements

June 2020

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Executive Summary

Control of COVID-19 in high density populations in India, especially in the urban settlements, requires differential strategic approaches and a comprehensive and well-coordinated response, to ensure that the most vulnerable are protected both from the health as well as socio-economic shocks due to the disease.

Overcrowding, inadequate infrastructure, poor nutrition, a high prevalence of respiratory and other infectious diseases as well as low risk perception accompanied with extensive stigma and discrimination and limitations to follow physical distancing measures among the slum population makes them more susceptible to COVID-19. This requires additional interventions, both at the individual as well as the societal level, to ensure preventive behavior as well as early health care seeking. The community sensitization and engagement should be included as a standard intervention across all high-density populated areas like urban settlements even before the disease affects a particular area and overwhelms the local response capacity.

Community involvement and participation, understanding, and cooperation with what the government is doing, is prerequisite for any successful public health intervention. Engaging communities and creating an enabling environment for appreciating and understanding the risks of exposure to COVID-19, as well as preparing the families to respond to a scenario where a family member or more would be in quarantine/isolation, will be critical, to ensure that key practices such as adherence to physical distancing, frequent hand washing with soap and respiratory etiquette (including safe use of face cover / mask etc.) are adopted consistently. Appropriate, and sensitive risk communication through the community leaders/influencers/faith leaders etc. and using the preferred networks and channels of communication, will need to be continued through all phases of the preparedness, response and recovery.

Microplanning for COVID-19 response, requires a risk-based (informed) approach, and adaptation/iteration to the individual urban settlement. Municipalities need to identify areas for isolation and quarantine in public or temporary structures located outside the settlements to cater to health needs for the community. Factoring in and planning for other needs, in addition to those linked to health-related aspects of COVID-19, would also be critical (delivery of essentials, staples, nutritional supplies, essential health services and social security etc.) especially, wherein hotspots are already established. Additional interventions for infection prevention and control (IPC) and WASH need to be calibrated, based on the needs and settings.

The response needs to be well-coordinated across all agencies/actors, to ensure the collective strengths of the line Ministries, NGOs, partners and volunteers can be well leveraged. Data and health information systems need to be well harmonized to ensure that evidence-based decisions, can be made in a timely manner.

Public health and enforcement agencies need to deliver their interventions in cognizance of the familial and societal needs, necessitating that community influencers be engaged in both the planning as well as the execution. Campaigns for stigma reduction against COVID-19 affected families/individuals,

health and other providers, would need added impetus, to ensure people do not hide their symptoms, and the fear and other concerns linked to the disease can be allayed.

Additional needs of mental health and psychosocial care of the community and providers, addressing gender and other vulnerabilities, inclusion of the most marginalized, would require careful considerations, and additional focus.

Safety, protection and morale of health care and other essential providers needs to be given continued due attention, given their vital role in delivery of key interventions. Mapping skills and capacity building of the workforce would be crucial, before assigning, additional roles to non-health personnel, and create capacity as needed through targeted training packages. Surge capacity for a longer-term response, Incentives for responders and supporting them to keep their morale high would need to be planned, given the operational challenges of cluster containment in these settings.

In addition, planning considerations need to also factor in a double-disease burden amidst COVID-19 pandemic as the coming monsoon / flood season in India may trigger a surge in outbreak prone diseases, such as diarrhoea, dengue, leptospirosis and typhoid fever, which may further complicate surveillance and response efforts and strain the already overburdened healthcare system.

This document, jointly prepared by WHO and UNICEF, is intended to complement the *Preparedness and response to COVID-19 in Urban Settlements*[1], issued by the Ministry of Health and Family Welfare on the 16th of May 2020, offering a practical guidance to policy makers, managers, service providers, development agencies and NGOs/CBOs about the practical steps that should be undertaken, in both the preparedness and the response to COVID-19 in urban settings.

Background

The urban population growth in India represents the 2-3-4-5 syndrome: in the last decade India grew at an average annual growth rate of two percent, urban India grew at three percent, mega cities at four percent, and the slum population rose by five to six percent[2]. The population projections by United Nations indicate that by 2030, India's urban population will grow to 590 million, accounting for nearly 40 percent of the total population of the country. As per the 2011Census, 17% of urban people (about 65 million people) live in slums that are not notified by the government, which led to limited availability of any welfare service and social protection.

The COVID-19 pandemic is likely to greatly add to hardships of a large number of people in urban setting. A large proportion of India's workforce, both rural and urban, is employed in the informal sector and residing in urban settlements. With inadequate provision of health care facilities, families of these workers are likely to face greatest difficulty in accessing health care services at a time of such a pandemic. With little social security coverage, and little possibility of paid leave and other benefits, closure of

[1] Preparedness and response to COVID-19 in Urban Settlements, MoHFW: https://www.mohfw.gov.in/pdf/PreparednessandresponsetoCOVID19inUrbansettlements.pdf

[2] Chatterjee G. Consensus versus confrontation: Local authorities and State Agencies form Partnerships with Urban Poor Communities in Mumbai. Nairobi: UNHABITAT; 2002

enterprises and institutions could result in severe economic hardship, encouraging this class to still work despite restrictions.

Factors to be taken in account while planning for preparedness and response to COVID-19 in urban settlements

Urban settlements, both formal and informal, pose serious threats to their dwellers due to various types of vulnerability of infrastructural, occupational, spatial, physical and psycho-social origin[3]. Their day-to-day struggle with housing conditions, lack of safe drinking water in premises, poor sanitation (dependency on shared toilets and waste water flowing in the open), poor access to formal health services, mushrooming of informal health care providers, risk of various forms of infections etc. constitute multiple concurrent risk factors to which slum dwellers are exposed, which further gets compounded by limited availability of welfare service by the governments.

The topology of every settlement is also different in terms of the social-cultural and economic context, diversity of the roles and responsibilities of various local stakeholders, including government, non-government organization, local social networks. Therefore, there is no standard approach to any intervention in slums: understanding the local context and adapting to it is fundamental.

A more invisible but direct impact of poor living conditions in slums is on children. Children in urban settlements are also far more vulnerable to abuse and violence including domestic violence. These risks increase during COVID-19. With the lack of access to other basic services, children are also under stress and anxiety and can lead to negative coping mechanisms like substance abuse and indulging in violence themselves. In addition, for girls, the risk of child labour or early marriage and even at times trafficking can be a real threat.

Regarding public health, the following challenges pose the greatest risks:

- Limited stratification of primary, secondary or tertiary care in terms of access to health care;
- Mix of service providers like municipalities, state government, ESIS, CGHS, armed forces, PSU, corporates, informal service providers, high end state of the art health care facilities.
- Specific groups of people such as laborer's, housemaids, shelter home migrants and daily wage workers are not primarily targeted in the risk communication and community engagement strategy.
- Timings to access health service may be limited to- daytime consultation, and this poses threat to daily wage loss for those requiring care.
- Mushrooming of informal health service providers/ quacks- usually they are first point of contact
- Front-line worker workforce is exposed to high risk of contagion and to stigma and discrimination, and which has specific fears in engaging in the ongoing context.

[3] Guidelines and Tools for vulnerability mapping & assessment for urban health, 2017, Urban Health Division, Ministry of Health Family Welfare, Government of India.

- Poor health seeking behavior due to limited information and knowledge, low risk perception and enabling environment to practice safe behaviors at family and community levels. Perceptions on direct COVID risk is skewed/masked with various fears and overbearing survival needs such as Food Security, access to PSS, soap, shelter etc.
- Seasonal migration makes it more challenging to restrict spread of infectious diseases.
- Lack of documentation to claim entitlement-based services.
- The housing conditions has challenges to follow on the SOPs for home quarantine and isolation.
- Most settlements are located in geographically high-risk areas such as low lying, water-logging prone pieces of land, hence get flooded during monsoon, or on hills prone to landslides.
- Water supply (like other services) is erratic, costly and storage of water at home is limited. Significant, daily effort of women and children goes in collecting and storing water. Dependency on communal water points and limited operating hours creates crowding.
- Dependency on shared toilets or open defecation is a challenge. Community toilets are overcrowded, and operation and maintenance are often neglected.
- Majority of household's release wastewater in open drain or directly on the streets.
- Perceptions on direct COVID-19 risk is low and get skewed/masked with various fears and overbearing survival needs such as food security, access to PSS, soap, shelter etc.
- Disease and water quality surveillance in slums remain suspect in term of coverage and quality. Real-time availability of information on emerging needs and vulnerabilities is low and difficult to collect.
- An increased risk of violence against children and domestic violence which also impacts children and their mental health adversely.

Residential segregation is alive in cities. Majority of the inhabitants of the slums are migrants. The proportion of Scheduled Castes, Scheduled Tribes, Other Backward Castes, Minority religions, is more in slums in comparison to non-slum urban areas. However, community-based/led engagement interventions have been successful if designed and oriented for this section of the society. A number of interventions as below can be used in the strategy for urban settlements and crowded places taking in multi-stakeholder and multi-agency perspectives.

If there is a high demand for locally made masks and sanitizers, these localities can act as a mass multiplier for production of essential supplies and will also help them engage socially and financially. Entrepreneurial initiatives for production of soap, hand sanitizer and masks by SHGs and supported by livelihood missions have already started and can be a great way to create livelihood opportunities while ensuring local access to these critical supplies.

Way forward

A comprehensive, tailored public health plan needs to be timely prepared for urban settlements through a combined effort from MC & Health and other line departments and other stakeholders. The plan should focus on the vulnerable areas and the high-risk population, and encompass aspects of both preparedness and response to COVID-19. Due consideration ought to be given to unnotified slums. Close

linkage to be developed between various service delivery institutions being govern by MC & Health Department.

The plan should be informed by epidemiological data and a rapid assessment at ward level considering health, WASH and RCCE issues that need to be addressed. The plan should be funded and have clear timelines and responsibilities, to ensure implementation.

Target Audience

This guidance note and programming framework is intended to policy makers, managers and technical staff of Urban local bodies, health and allied authorities, UN Agencies, development partners and non-state actors (NGO, CSO)etc.

Disclaimer

This live document, jointly developed by UNICEF and WHO, is intended to provide a menu of interventions and actions that require action by stakeholder agencies involved in programming in urban settings. It is drafted in line with the MoHFW guidance on Preparedness & Response to COVID -19 in Urban Settlements.

A. Preparedness plan for COVID-19 in Urban Settlements

PREPRAREDNESS FOR URBAN SETTLEMENTS FOR PREVENTION AND CONTROL OF COVID-19			
	Strategy	**Key activities**	**Departments/Responsibility**
A.1	**Institutional mechanisms, Incident Response System, Coordination Mechanisms**	▪ Identification of key stakeholders including those from Municipal corporation (MC), municipalities, Urban Local Bodies (ULBs), Departments of Health, Urban Health Mission, ICDS, ICPS, Housing & Urban Affairs, Swachh Bharat Mission, CSOs, Department of Preventive and Social Medicine of Medical College, Elected representatives, Eminent epidemiologists from the State, Private health service providers, informal labor unions etc. ▪ Establishment of a committee/incident response system under the Chairmanship of the Municipal Commissioner; the Incident commander should report to municipal commissioner. ▪ The Incident Commander will identify its planning, operation, logistics and finance teams to implement the preparedness measures to respond to a COVID -19 outbreak. ▪ The ToR of the committee will include all community, facility and systems level response to COVID-19 ▪ The periodicity of committee meetings to be decided based on the consensus made according to degree of efforts to be put in for COVID-19 response. ▪ Multi-stakeholder platforms will be created for review and monitoring of COVID-19 response; ▪ Establishing and implementing accountability and feedback mechanisms for the vulnerable population ▪ The tollfree number (1075) provided by States to be widely disseminated within the community; and calls from slum areas to be given preference in response; ▪ All stakeholders to be made aware about their time-bound roles and responsibilities; ▪ Rational allocation of resources to be done between MC & Health Department; ▪ ULB representative to be made accountable for ward level interventions	Municipal Corporation/ Municipalities/ ULBs and Department of Health
A.2	**COVID-19 containment plan**	▪ Develop a COVID -19 containment plan outlining core capacities, activities, resource needs and actors to address key challenges specific for the outbreak in urban settlement. The containment plan will include the following components: Surveillance; Hospital preparedness and clinical management; Pharmaceutical interventions; Non-pharmaceutical interventions; Quarantine facilities; Logistics; Community Volunteers; Risk communication and community engagement; and Capacity building ▪ The containment plan will be complemented by a thorough and participatory process of microplanning, that	Municipal Corporation/ Municipalities/ ULBs and Department of Health **CSOs, Elected representatives,**

		will encompass: ▪ Settlement-wise counts of available and trained human resources qualified to manage fever clinics/camps. A list of pharmacists; doctors and nurses on clinical duty; trained AYUSH doctors and practitioners, private sector staff from medical and nursing colleges; and health staff NGOs, etc. trained and available; ▪ Settlement-wise list of Urban ASHA, ANMs, LHVs; NGOs, youth groups—Nehru Yuva Kendra (NYK), National Cadet Corps (NCC), National Service Scheme (NSS), youth clubs, etc.; ▪ Settlement-wise identification and setting-up of quarantine facilities (hotels, lodges, empty schools and playground) within/close to slums so the confirmed cases/contacts are close to their families and personal assets.	
A.2.1	**Surveillance**	▪ Strengthen surveillance and contact tracing mechanisms ▪ SARI / ILI surveillance and sample collection for COVID -19 testing as per MoHFW and ICMR guidelines ▪ Improve sample collection from slum areas by expanding sample collection centers / kiosks ▪ Community level structures to be transformed into sample collection facilities and / or laboratories with proper IPC and WASH conditions - information on such structures is available with MC/ City Program Management Units (CPMUs) under NUHM. ▪ The candidates from employment exchange will be scanned and those having qualifications that are fit as laboratory technicians / assistants shall be recruited for working in laboratories if required ▪ Surveillance efforts will include identification of the health workers in the health posts/dispensaries, ANMs, ASHAs, Anganwadi Workers, municipal health staff, sanitation staff, community health volunteers and other volunteers (NSS/NYK/IRCS/NCC and NGOs) etc. The trained manpower available on www.covidwarriors.gov.in will be contacted for their readiness to deployment at short notice. ▪ An orientation training will be organized by the City Health Officer/Executive Health Officer to train the identified surveillance workers	Municipal Corporation/ Municipalities/ ULBs and Department of Health
A.2.2	**Hospital preparedness and clinical management**	▪ All UPHCs will be activated for 24×7; ▪ Morning and evening OPDs to be ensured at all UPHCs and Dispensaries with quick prehospital care and referral mechanism. ▪ All community and facility level service providers under Municipal Corporation and Health Department to be oriented on referral protocols for COVID-19 suspects; ▪ Community level structures to be transformed into quarantine facilities with proper IPC and WASH conditions - information on such structure is available with MC/ City Program Management Units (CPMUs)under NUHM. these settlements shall be earmarked as COVID Care Centers, Dedicated COVID Health Center and Dedicated COVID Hospital. ▪ Map gaps in COVID-19 designated facilities and invest in essential procurement and supplies as per identified gaps (PPE, oxygen concentrators, ventilators, test kits etc.)	Municipal Corporation / Integrated Child Development Services (ICDS)/ Health Department/ Nehru Yuva Kenda (under Ministry of Sports & Youth Affairs) etc.

		▪ Requisite civil work in the community structures to be ensured, putting temporary partition to ensure the privacy of suspects; ▪ Community level cadre, including Urban ASHA, AWW, ANM and local doctors to be trained to ensure compliance of protocols during isolation. Deputation on special duty may also be considered. ▪ Isolation facilities need to be safe zones and community leaders can be designated to be a reporting point for any incidents. ▪ Display of all requisite information- IPC practices by the community, designated hospitals & labs, toll free numbers especially 1075 etc. ▪ The earmarked COVID-19 health facilities will identify teams for sample collection of suspect cases. ▪ Ambulances for referral to be stationed within or at the perimeter of these localities, will be identified. ▪ The toll-free number shall be widely disseminated in the community	
A.2.3	**Pharmaceutical intervention**	▪ Prophylaxis, flu vaccination and other community-based mass care interventions as recommended by GoI	Municipal Corporation/ Municipalities/ ULBs and Department of Health
A.2.4	**Non-pharmaceutical interventions**	▪ Identify high risk population i.e. elderly who are diabetic, hypertensive, living alone. Plan for access to food, social protection schemes and medicines and ensure their PSS. ▪ Common mask distribution and disposal sites. Distribution sites should consider physical distancing measures and disposal sites should ensure proper collection, treatment and disposal measures. ▪ Community cleaning and disinfection drive to be initiated by Municipal Corporation ▪ Promotion of essential RMNCHA+N services	Municipal Corporation/ Municipalities/ ULBs and Department of Health
A.2.5	**Quarantine facility**	▪ Identify quarantine facilities (school, communal space) in a nearby area to accommodate high risk contacts. ▪ Have a contingency plan to relocate high risk contact to these quarantine facilities ▪ Identification and marking of quarantined households/buildings ▪ Maintain confidentiality and removing stigma from these quarantined households/buildings	Department of Health / District Surveillance units
A.2.6	**Logistics**	▪ Community level special camps/days and Urban Health & Nutrition Days (UHNDs) to work as first level of triaging for suspects ▪ Adequate arrangement for soaps (in public toilets), disinfectants (bleaching powder, 1% sodium hypochlorite) will be ensured at the civil dispensaries, health posts, health & family welfare centers catering to the area. Similarly, availability of triple layer medical masks and gloves for healthcare workers will be ensured. ▪ The civil dispensaries, health posts, health & family welfare centers will also be used as depot holder for, masks household disinfectants etc.	

A.2.7	**Governance mechanisms and Community Volunteers**	▪ Identification of key stakeholders including stakeholders from – Municipal corporation (MC), municipalities, Urban Local Bodies (ULBs), Departments of Health, ICDS, ICPS, Housing & Urban Affairs, Swachh Bharat Mission, CSOs, Elected representatives, Private health service providers, informal labor unions etc. ▪ Notification of the committee under the Chairmanship of Municipal Commissioner. ▪ The ToR of the committee to include all community, facility and systems level response to COVID-19 ▪ The periodicity of meeting to be decided based on the consensus made according to degree of efforts to be put in for COVID-19 response. ▪ Action points emerged from the meetings to be closely followed up ▪ A comprehensive plan to be prepared for AWWs, ASHAs, ANMs, MASs (Mahila Arogya Samiti), Swachhagrahis, etc. with clearly defined roles and responsibilities to rendering routine services and extending support to the community in COVID-19 response. ▪ Free distribution of bleach / sodium hypochlorite etc. in the community ▪ Bringing out best practices and local example setters	Municipal Corporation/ Municipalities/ ULBs and Department of Health
A.2.8	**Risk communication and community engagement**	**Planning** ▪ Preparation of settlement specific, tailored made IEC & SBCC (Social Behaviour Change Communication with focus on risk communication and community engagement) plan on COVID-19 based on mapping and vulnerability assessment done by NUHM. **Materials development – Training and IEC** ▪ Tailoring all COVID-19 specific and sensitive messages in local languages ▪ Spread of awareness, educate, engage and empower people in slums through local political and religious leaders', local doctors' and ANMs involvement and use of Local radio jingles and targeted ads on TV and digital communication materials on WhatsApp. ▪ Posters should be put up outside in the community area, toilets, water points, handwashing stations. Local cable TV channels may be utilized to create community awareness**.** ▪ Materials development and dissemination of Early psychosocial interventions and stigma removal messages. **Community Engagement and Social Mobilisation** ▪ Tailored community engagement approach to increase awareness, knowledge and understanding and to generate demand to practice public health measures to vulnerable groups like young children involved in daily wages, rag pickers, homeless etc. This will include Psycho-Social care, E-VAC and mental health. ▪ Social Mobilisation by community-based volunteers and management of community help desk/information corner manned by etc. ▪ Establishment of CWC (Communicating with Communities) groups through NGOs for monitoring of social distancing measures, social mobilisation and local media approaches.	Municipal Corporation/ Municipalities/ ULBs and Department of Health

		▪ Community groups should also popularize Increase adoption of Aarogya Setu application through partnerships with CBOs. ▪ Monitor outreach by community workers and volunteers through online dashboard ▪ Installation and promotion of Practical based hand washing and demonstration stations within slums.	
A.2.9	**Capacity building**	▪ Capacity building of community cadres, including community leaders, local doctors on risk communication and community engagement, caring of at-risk individuals, violence prevention including referrals to CHILDLINE 1098 ▪ Training for front line workers on how to protect themselves while doing RCCE activities, and providing them with personal protective equipment's ▪ The District IDSP unit will also map field workers that can be used for surveillance and contact tracing. This includes ANMs, ASHAs, AWWs, corporation health staff, and community level volunteers (NSS, NCC, IRCS, NYK). Their trainings would focus on surveillance, contact tracing, home quarantine, IPC, managing quarantine and isolation centers, supply of ration to homes etc. ▪ Training of identified local volunteers (Indian Red Cross, NYKS, NSS, AYUSH Doctors/CBOs and NGOs) on joint micro-planning including communication and information related to COVID 19 Response and Containment ▪ Include COVID 19 patient management, Inter-personal communication skills in training of Health workers/staff managing mohalla clinics in the slums ▪ Training of WASH service providers on COVID-19 prevention and control measures, including orientation on how to protect themselves. Trainings should be focused on the target group and should ensure continuation of safe access to WASH services. Trainings can be provided to water supply operators / engineers, sanitation workers / waste pickers, sweepers, community toilet operators, de-sludgers, and other WASH personnel. High risk groups should be prioritized.	Municipal Corporation/ Municipalities/ ULBs and Department of Health

B. Response plan for COVID-19 in Urban Settlements

RESPONSE TO COVID-19 OUTBREAK IN URBAN SETTLEMENTS			
	Response strategy	**Key activities**	**Departments/Responsibility**
B.1	**Trigger for Action**	The trigger for action would be reporting of a suspect/confirmed case from routine ILI/SARI surveillance or cluster of cases of similar ILI/SARI observed by the health post/practitioners etc. It could also be a contact of a known confirmed case.	District IDSP
B.2	**Activation of coordination mechanism**	▪ Activate Incident command system and control room for response planning, coordination, monitoring and implementation of activities for Urban slums and informal settlements ▪ Coordination meetings mechanism at slum/informal settlement level to be established and functional under Ward officer, involving Local CBO/CSO/ NGO/ local medical officer/DSO-IDSP/ Police ▪ Coordination amongst multiple health agencies that provide health/public health services in various parts of the City to be established and maintained ▪ Involve NUHM, Department of Education, WCD & ICDS (MASs (Mahila Arogya Samiti), AWW, Dept. of Home and DIOs. ▪ Department of AYUSH, NYKS and NSS to be involved for deployment of volunteers in slums and informal settlements.	DC/Municipal Corporation office with the support of Department of Health, DDMA, CGHS. ICDS (WCD), Education/ Police/Urban Development With the support WHO-India (NPSP), UNICEF, Red Cross, Civil defense, home guards, Aapda Mitra, Mental Health Workers
B.3	**Implementation of COVID Containment Plan and other response activities**	<u>COVID Cluster Containment Plan in Urban Settlement must include</u> ▪ Area of operation with reliable estimates of the population, classification of categories and categorization in high/low risk ▪ Hotspots zonation ▪ Active surveillance of cases and contacts, ▪ Link-up with testing all suspects high risk contacts and SARI cases; ▪ Coordinate treatment of all suspects and SARI cases; ▪ Triage of patients should be carried out before referring them to isolation or quarantine facilities. ▪ Designated COVID hospitals and COVID care centers identified by the government should be first choice to isolate the cases. In case the number of cases surge, then community level structures must be used. ▪ Community level structures to be transformed into quarantine facilities: e.g. Schools, religious places, hotels,	DC/Municipal Corporation office, Various Health agencies DDMA, Local NGOs, CSOs, Law Enforcement Department of Urban Affairs, Local Leaders, Police for enforcement of containment zone, currently poor enforcement Urban Local Bodies (ULBs), LHVs, ICDS, Lab teams and extended health workforce

		lodges, guest house, small hospitals. shelters, banquet & marriage halls, open parks with mobile toilet facilities etc. to be converted to COVID-19 surge treatment facilities / COVID 19 care centers. ▪ Provision of adequate PPE for all healthcare workers (based on MoHFW guidelines) ▪ Identification of intervention points and setting-up of Testing kiosks (per kiosk: xxxx population), fever and SARI clinics/camps and community handwashing stations (per clinic: xxxx population) (per station: xxxx population) ▪ Early Identification of cases and referral to isolation centers through household level screening. House visit rounds as per local policy ▪ Contact tracing and shifting the contacts to quarantine facilities ▪ Team of ASHA, AWW and ANM to work in the field. Incentives for field work planned ▪ Supportive supervision to be implemented. ▪ Identification of cold storage facilities for storage of dead bodies in case of large number of deaths that may overwhelm mortuaries ▪ Food supplies, groceries, vegetables, milk and other essential supplies to be provided to the households in the containment zones, as per the micro plans ▪ Essential supplies distribution following stringent social distancing and IPC norms ▪ Functional Civil Dispensaries, Health Posts, HFW Centers, UPHCs etc. and opening of all these centers for extended hours for providing non COVID 19 related essential medical services ▪ Promotion of continuity of non COVID 19 essential medical services within the slums ▪ Adaptation and implementation of protocols for the provision of essential health care services (including clinical guidelines, IPC practices, referral, etc.) ▪ Identification of individuals at high risk during community surveys in containment zones ▪ COVID-19 community workers to promote linkages with rehabilitation centers	Local administration with support of CSO and Community volunteers DWCD, DOE, DOMA Key Partner: WHO, UNICEF
B.3.1	**Defining areas of operation:**	▪ Meeting with CDMO leads of other health agencies and District / City Surveillance Officer for District / City MICRO Plans ▪ Include MOs in the development of COVID-19 Cluster Containment micro-plans with special emphasis on managing slums and informal settlements classification of the populations (permanent/rented/migrants) and designing innovative approaches for containment hotspots/high risk areas and further spread in high risk populations ▪ District surveillance unit will undertake rapid identification of other cases and contacts to define containment and buffer zones. If data for mapping is not readily available, for small clusters the containment zone can be mapped as the administrative boundaries of residential colony/mohalla, surrounded by a buffer zone ▪ Outline coordination mechanisms for district and wards including daily meetings, reporting of data, and challenges population wise.	Various Health agencies Municipal Corporations DC/DM DDMA

B.3.2	**Applying strict perimeter control:**	▪ Map of entry and exit points and implement movement control measures for perimeter and buffer zone including Section 144 of the Code of Criminal Procedures ▪ Clear and capillary communication to concerned populations about enforced measures, entitlements, and provisions to access to essential services ▪ The routine medical needs of the population (immunization, RCH, TB, Dialysis, NCDs) must be catered to. ▪ If feasible, the relief centers in the containment zone may be geo-tagged and information may be made available through mobile applications.	Law enforcement, community volunteers, ward counselors, local corporators and Mohalla samitis, representatives of Youth bodies, Kotedar, other local influencers, community volunteers, partner agencies
B.3.3	**Active and Passive Surveillance**	▪ Daily reporting through CIF ▪ Training of Medical Association doctors to fill CIFs, orders already in place for doctors referring cases for lab test to private facilities to fill CIFs ▪ Daily reporting ULB health posts, ward level, district surveillance unit, IDSP cell through Web portal/ predefined XL sheets from both public and private healthcare setups. ▪ The key activities for surveillance workers during house to house visits are: i. Active case search through questionnaire ii. Listing and tracking of contacts iii. Coordinating sample collection as per criteria iv. Recording temperature with handheld thermometer, recording oxygen saturation with pulse oximeter v. Identification of high-risk individuals based on contact history, age, and co- morbidities vi. Inter-personal communication with households for creating awareness on COVID-19 and other essential health services (immunization, RCH, nutrition, NCDs etc.) vii. Address stigma, health seeking behavior and other issues	▪ District Surveillance unit / IDSP cell, partner agencies
B.3.4	**Clinical management**	▪ Those undergoing treatment at the identified COVID care centers shall be monitored using pulse oximetry and a provision for early oxygen supplementation and referral to Dedicated COVID Health Centers shall be made for those showing low/declining oxygen saturation. ▪ Transportation of confirmed cases to be set-up for each settlement, based on the population size/no. of hotspots. ▪ Referral system has to be clearly defined and it shall be ensured that there are no delays in transferring patients from one facility to another as per need including availability of sufficient ambulances. ▪ Transportation details are available at Fever and SARI Clinics ▪ All CATS ambulance staff to be trained in Infection, Prevention and control, use of PPE and protocol to be followed for disinfection of ambulances (by 1% sodium hypochlorite solution using knapsack sprayers) ▪ Train all healthcare staff in designated COVID care facilities in clinical management, IPC and BMW protocols. ▪ Follow Discharge, retesting, Home isolation post discharge protocols ▪ Tagging of each slum with COVID care centre ▪ Train all healthcare staff in designated COVID care facilities in clinical management, IPC and BMW protocols.	COVID-19 hospitals and staff CATS Municipal Corporation and DC/DM, Ambulance and Mortuary services and Extended Workforce, CSO, NGO

		▪ Dead body management and burial as per MOHFW guidance and Local state advisories	
B.3.5	**Psychosocial support**	▪ Training of Mental Health workers in PSS care for COVID 19 19 patients, impacted families, children and other vulnerable groups. ▪ Clinical psychology departments of University College and other Medical Colleges ▪ Psychiatry departments to be involved. Helpline for psycho-social care to be set up ▪ Setting up and promote PSS helpline within slums ▪ Devise local level strategies to address stigma targeting healthcare workers and other auxiliary services ▪ Promote use of PSS mobile application developed by NIMHANS / UNICEF ▪ Connect / create local network with Indian Psychiatric society and other psychiatric and psychological social volunteers to provide online mental health services ▪ Identification of individuals at high risk during community surveys in containment zones ▪ COVID-19 community workers to promote linkages with rehabilitation center ▪ A provision for psycho-social counselling (including addressing issues like stigma, discrimination etc.) through inter-personal communication or helplines should be made available to such communities by trained personnel.	Department of Health with Municipal Corporation Key Partner: WHO and UNICEF
	Continuity of non-COVID 19 essential services such as maternal, newborn, and childcare, dialysis, TB, HIV, and child protection services	▪ Communication to slums population on available entitlements (e.g. cash transfers, food items, etc.), and available provisions and means to access essential services ▪ Food supplies, groceries, vegetables, milk and other essential supplies to the households as per the micro plans ▪ Essential supplies distribution following stringent social distancing and IPC norms ▪ Functional Civil Dispensaries, Health Posts, HFW Centers, UPHCs etc. and opening of all these centers for extended hours for providing non COVID 19 related essential medical services ▪ Promotion of continuity of non COVID 19 essential medical services within the slums, including with private care providers ▪ Adaptation and implementation of protocols for the provision of essential health care services (including clinical guidelines, IPC practices, referral, etc.) ▪ Linkages with ICPS functionaries like DCPU, CWC, JJB, Police and also CHILDLINE 1098 to ensure that any child protection concerns are also treated as emergent and needing immediate attention	
B.3.6	**Access to WASH services as part of COVID-19 prevention and control**	**Capacity building** ▪ Training of WASH service providers on COVID-19 prevention and control measures, including orientation on how to protect themselves. Trainings should be focused on the target group and should ensure continuation of safe access to WASH services. Trainings can be provided to water supply operators /	Local Public Health Authorities, Fire Dept, PWD dept. and Municipalities , informal service providers

		engineers, sanitation workers / waste pickers, sweepers, community toilet operators, de-sludgers, and other WASH personnel. High risk groups should be prioritized. **(Bio Medical) Waste Management and solid and liquid waste management** ▪ Follow disposal of bio-medical waste for home and healthcare facilities according to BMW Management Rules ▪ Regular disposal of waste from the slums following CPCB guidelines ▪ Training of waste collectors on implementation of guidelines, use of personal protective equipment and provision of supplies for these service providers ▪ Cover open drains and connect wastewater outlets to covered drains **Handwashing** ▪ Installation of foot operated / no touch hand washing stations with soap within slums at high risk, high traffic locations ▪ Ensure physical distancing (through nudges or signages) at all communal handwashing stations ▪ Provide soap to BPL households or include soap in food rations **Sanitation** ▪ Desludging of the toilets and ensuring proper treatment of fecal sludge as per guidelines (ensure sludge is not disposed in environment without treatment) ▪ Installation of additional portable toilet on need basis. (ideally reach 1 seat per 15 people) ▪ Develop and implement SOPs and cleaning protocols for community toilets, and training of toilet operators on these protocols, with provision of personal protective equipment ▪ Ensure handwashing before and after use of toilets, if possible, have separate entry and exit points ▪ Ensure physical distancing (through nudges or signages) at all communal toilets **Water supply – increase access to water supply and avoid overcrowding at communal water points; multiple options can be considered with priority for 1 and 2:** ▪ Installing additional stand-post connections on an urgent basis in areas where municipal supply network exists ▪ installing large capacity water tanks with multiple taps that are recharged once or twice a day by water tankers ▪ in areas where both (1) and (2) are not feasible, tanker supply must be arranged on a regular basis (at least twice daily) (The first two options are recommended since continued service throughout the day can be provided, which reduced crowding at water points) ▪ Water should be chlorinated with FRC of 0.5 mg/l ▪ Ensure physical distancing (through nudges or signages) at all communal water points ▪ Provide additional water storage containers to households in case continuous supply is not possible **WASH in institutions** ▪ Ensure access to water, toilet and handwashing facilities in anganwadis, schools and shelters, quarantine	WASH agencies Jal shakti/JJM CPWD, Ward officer, Swacchagrahi, SBM, partner agencies

		centers, etc.	
B.3.7	**Risk Communication and community engagement**	**Advocacy and Governance** ▪ COVID Response and Containment pre-implementation (virtual/telephonic/Community Radio) meeting by Local MLA/Local Leaders ▪ Prepare high risk and low risk population for relocation to an alternate/ temporary site through notification and health workers house visits (as per local policies). Education dept to be roped in to provide school buildings for quarantine in slum areas. ▪ Development of practical guidelines (spitting, urban health facilities, access to services, PSS, mental health, resources for engaging children and young people) ▪ Advocate to support/establish locally led alternatives (neighbourhood and community-based groups) to collect data (counts of households, access to services, physical infrastructure and space and community mapping). ▪ MCD authorities to be trained on prevention mechanisms and monitoring during waste collection. **Social Mobilisation, Capacity building and Community Engagement** ▪ Introductory Briefings (Virtual) on the local containment plan and operational approach with local media, influencers, School representatives, public representatives, medical network, religious leaders etc. ▪ Settlement based RCCE plans and implementation through Urban ASHA/AWW/NYKS, NSS, AYUSH Doctors/Indian Red Cross/CBOs and NGOs for advancing key public health measures (social/ physical distancing, respiratory and hand hygiene, home quarantine and relocation of low/high contacts) ▪ Social mobilization by engaging local religious groups, social and community, local women networks, CBOs and NGOs also targeting urban health facilities, access to services, PSS, mental health, resources for engaging children and young people. This will include virtual meetings and announcements from religious institutions/mosques/churches/temples etc. ▪ Refresher) orientation to volunteers and social mobilisers on practical orientation of key messages, access to services (hotlines), heat/irritation ▪ Mapping of networks and info channels (including miking, loudspeakers for w. collection vehicles) ▪ Engage community leaders, SHGs and influencers to facilitate local solutions so that control measures such as physical distancing, home care, self-isolation or movement controls are contextually appropriate. These groups may be trained on counselling sessions for suspected patient and families. ▪ All platforms and networks oriented to monitor and ensure physical distancing (through nudges or signages), respiratory and hand hygiene, at all communal points and handwashing stations **Development of RCCE materials and Media outreach** ▪ Design and implementation of creative signages for social distancing across the slums and places of high congregation ▪ Local media (POP materials/promotion at PDS shops, retail outlets in slums, public toilets) and local cable/Radio announcements	DC/Municipal Corporation office Various health agencies DDMA, Local NGOs, CSOs and CBOs Slum wing of Development Authority DDMA, partner agencies (WHO and UNICEF)

		▪ Leverage radio, cable TV and social media to communicate, manage misinformation and rumors, support community responses, capture crisis alerts from communities and facilitate timely response. ▪ Culturally appropriate RCCE materials - adapted for audio, video, digital, online and print ▪ Social Media (differentiated) Strategy and Plan (WhatsApp, FB etc.) **Monitoring and Accountability** ▪ Monitor Social Distancing and Stigma – by community influencers/youth groups ▪ Establishing and implementing accountability and feedback mechanisms for the vulnerable population ▪ Work closely with local surveillance teams to ensure targeted RCCE interventions are informed by consolidated surveillance data. An example includes activation of Zonal and Assembly coordinator mechanism to support the District Surveillance Officers.	
B.3.8	**Supervising, monitoring and reporting**	▪ The Control rooms shall analyze the information on a daily basis and necessary guidance in turn will be provided to the teams at field level as per the information so collated regularly. ▪ Multi-stakeholder platform to be created for review and monitoring of COVID-19 response; ▪ Establishing and implementing accountability and feedback mechanisms for the vulnerable population ▪ All stakeholders to be made aware about their time-bound roles and responsibilities; ▪ ULB representative to be made accountable for ward level interventions ▪ Host bi-weekly meetings to understand challenges in COVID 19-response and containment management.	Various Health agencies Municipal Corporation, DC/DM and partner agencies