PANDEMIC PREPAREDNESS PLAN
AVOLY PANCHAYATH

MESSAGE FROM PRESIDENT

ആവോലി ഗ്രാമപഞ്ചായത്തിലെ ആരോഗ്യവിഭാഗം എല്ലാ കാലത്തും പകർച്ചവ്യാധികളെ പ്രതിരോധിക്കുന്ന കാര്യത്തിൽ നല്ലരീതിയിലുള്ള സേവനമാണ് കാഴ്ചവെക്കുന്നത്. COVID പോലുള്ള മഹാമാരികളെ ചെറുക്കുന്നതിന് വലിയ രീതിയിലുള്ള മുൻകരുതലുകൾ എടുക്കേണ്ടതുണ്ട്. കഴിഞ്ഞകാലങ്ങളിലെ പകർച്ചവ്യാധി അനുഭവങ്ങളിൽ നിന്ന് പഠിച്ച കാര്യങ്ങൾ ഉൾക്കൊണ്ട്, വരാൻ പോകുന്ന ഏത് ആരോഗ്യപരമായ ബുദ്ധിമുട്ടുകളെയും നേരിടാൻ നമ്മുടെ പഞ്ചായത്തിനെ തയ്യാറാക്കി എടുക്കേണ്ടതുണ്ട്. ആരോഗ്യ പ്രവർത്തകർ, ജനപ്രതിനിധികൾ, സന്നദ്ധ പ്രവർത്തകർ എന്നിവരുടെ ഒരുമിച്ചുള്ള പ്രയത്നത്തിലൂടെ പ്രതിരോധ പ്രവർത്തനങ്ങൾ കൂടുതൽ ശക്തമാക്കുകയും അത്യാവശ്യ സമയങ്ങളിൽ ഇവരുടെ സേവനം ലഭ്യമാക്കുകയും വേണം. വിഭവങ്ങളുടെ കൃത്യമായ ഉപയോഗം, ബോധവൽക്കരണം, അടിസ്ഥാന സൗകര്യങ്ങളുടെ വികസനം എന്നിവയ്ക്ക് പ്രാധാന്യം നൽകി ആവോലി പഞ്ചായത്തിലെ ആളുകളുടെ ആരോഗ്യ സംരക്ഷണത്തിന് ഈ PANDEMIC PREPAREDNESS PLAN ഒരു പ്രധാനപ്പെട്ട കാൽവെപ്പാണ്. ഇതിന് ആവോലി ഗ്രാമപഞ്ചായത്ത് ഭരണസമിതിയുടെ എല്ലാ സഹായങ്ങളും ഉറപ്പു നൽകുന്നു.

-ശ്രീ .ജോജി കെ ജോസ്

ആവോലി പഞ്ചായത്ത് പ്രസിഡന്റ്

MESSAGE FROM HEALTH STANDING COMMITTEE CHAIRMAN

ആവോലി ഗ്രാമപഞ്ചായത്തിൽ പകർച്ചവ്യാധികൾക്കെതിരെയുള്ള പ്രതിരോധ പ്രവർത്തനങ്ങളിൽ ഭരണസമിതിക്കൊപ്പം ആരോഗ്യവിഭാഗവും നല്ല രീതിയിൽ പ്രവർത്തിക്കുന്നുണ്ട്. മഹാമാരികളും മറ്റ പകർച്ചവ്യാധികളും തടയുന്നതിന് അത്യാവശ്യമായ മുൻകരുതലുകൾ എടുക്കേണ്ടതുണ്ട്. വരാൻ പോകുന്ന ഏത് ആരോഗ്യപരമായ ബുദ്ധിമുട്ടുകളും നേരിടാൻ പഞ്ചായത്തിലെ ആരോഗ്യ പ്രവർത്തകരെയും, സന്നദ്ധസേവകരെയും ജനപ്രതിനിധികളുടെ നേതൃത്വത്തിൽ സജ്ജമാക്കണം. എല്ലാ സൗകര്യങ്ങളും ഉപയോഗപ്പെടുത്തി വരാനിടയുള്ള മഹാമാരികളെ ചെറുക്കുന്നതിനുള്ള പ്രവർത്തനങ്ങൾക്ക് ആവോലി ഗ്രാമപഞ്ചായത്ത് ഭരണസമിതിയുടെ എല്ലാ സഹായങ്ങളും ഉണ്ടായിരിക്കും.

ശ്രീ. ഷാനവാസ് കെ വി

ആരോഗ്യ വിദ്യാഭ്യാസ സ്റ്റാൻഡിംഗ് കമ്മിറ്റി ചെയർ പേഴ്സൺ
ആവോലി ഗ്രാമപഞ്ചായത്ത്

MESSAGE BY MEDICAL OFFICER

ആവോലി ഗ്രാമപഞ്ചായത്തിലെ എല്ലാത്തരം ജനങ്ങളുടെയും ആരോഗ്യവും സുരക്ഷയും ഉറപ്പാക്കുന്നതിന് വേണ്ടി തയ്യാറാക്കിയ ഒരു വിശദമായ കർമ്മപദ്ധതിയാണിത്. ഇതിനുമുൻപ് ഉണ്ടായ നിപ്പ, കോവിഡ്-19 പോലുള്ള പകർച്ചവ്യാധികളുടെ അനുഭവങ്ങളിൽ നിന്ന് നേടിയ അറിവുകളുടെ അടിസ്ഥാനത്തിലാണ് ഈ പ്രിപ്പയർഡ്നെസ്സ് പ്ലാൻ ഉണ്ടാക്കിയിരിക്കുന്നത്. വരാൻ പോകുന്ന ഏത് ആരോഗ്യപരമായ അത്യാഹിതങ്ങളെയും ശാസ്ത്രീയമായും സംയോജിതമായും നേരിടാൻ നമ്മുടെ പഞ്ചായത്തിനെ തയ്യാറാക്കുക എന്നതാണ് ഇതിന്റെ പ്രധാന ഉദ്ദേശം. ആരോഗ്യ പ്രവർത്തകർ, ജനപ്രതിനിധികൾ, സന്നദ്ധ സേവകർ എന്നിവരുടെ ഒരുമിച്ചുള്ള സഹായത്തോടെ പ്രതിരോധ പ്രവർത്തനങ്ങൾ ഓരോ വാർഡിലും കൃത്യമായി നടപ്പിലാക്കാൻ ഈ പ്ലാൻ സഹായിക്കുന്നു. ആവശ്യമായ സാധനങ്ങൾ കരുതിവെക്കൽ, പെട്ടന്നുള്ള വിവരശേഖരണം, ശരിയായ ബോധവൽക്കരണം എന്നിവയ്ക്ക് ഈ പദ്ധതി പ്രാധാന്യം നൽകുന്നു. സുരക്ഷിതവും പ്രതിരോധിക്കാൻ കഴിവുള്ളതുമായ ഒരു ആവോലി കെട്ടിപ്പടുക്കുന്നതിൽ പഞ്ചായത്ത് ഭരണസമിതിക്കും ഓരോ ഗ്രാമത്തിലെ ആളുകൾക്കും ഒരുപോലെ ഉത്തരവാദിത്തമുണ്ടെന്ന് ഈ പ്ലാൻ എടുത്തുപറയുന്നു.

ഡോ .പ്രീതി പീറ്റർ ,മെഡിക്കൽ ഓഫീസർ
കുടുംബാരോഗ്യ കേന്ദ്രം ആവോലി

EXECUTIVE SUMMARY

Primary Health Centre (PHC) functions as the primary public healthcare institution serving the population of Avoly Grama Panchayath. The PHC plays a pivotal role in delivering comprehensive, accessible, and affordable healthcare services, with a strong focus on preventive, promotive, curative, and rehabilitative care in accordance with national and state health programmes.

The PHC caters to a predominantly rural population, addressing key public health priorities such as maternal and child health, communicable and non-communicable disease control,

immunization, family welfare, adolescent health, and geriatric care. Regular outpatient services, home-based care through field health staff, and outreach activities ensure healthcare coverage even in geographically challenging areas. The institution actively implements national health missions, including the National Health Mission (NHM), National Tuberculosis Elimination Programme, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), and other disease surveillance initiatives.

Avoly PHC works in close coordination with the Grama Panchayath, ASHA workers, Anganwadi centres, schools, and community-based organizations to strengthen community participation and improve health awareness. Emphasis is placed on early detection, timely referral, health education, and lifestyle modification to reduce disease burden and improve overall health outcomes.

Despite constraints related to infrastructure, manpower, and increasing service demand, the PHC continues to enhance service delivery through effective planning, data-driven decision-making, and community engagement. Strengthening facilities, upgrading digital health systems, and expanding preventive services remain key focus areas for future development.

Overall, Avoly Primary Health Centre stands as a vital institution in safeguarding public health and improving the quality of life of the residents of Avoly Grama Panchayath

LIST OF ABBREVIATIONS

LSGD/LSGI	**Local Self Government Department / Local Self Government Institution**
BMO	**Block Medical Officer**
IDSP	**Integrated Disease Surveillance Programme**
NDMA	**National Disaster Management Authority**
PPE	**Personal Protective Equipment**
ICMR	**Indian Council of Medical Research**
CD	**Communicable Diseases**
NCD	**NON-COMMUNICABLE Diseases**

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INTRODUCTION

- **Background of the PPP**

Avoly Panchayath, under the Muvattupuzha Block Panchayat in Ernakulam district, Kerala, places strong emphasis on its **Pandemic Preparedness Plan** as a central pillar of local governance and public health protection. Considering its semi-rural setting, dispersed wards, and dependence on nearby health institutions in Muvattupuzha, the Panchayat has adopted a proactive and community-based approach to managing infectious disease threats.

The plan focuses on early detection through strengthened ward-level surveillance, close coordination with the Primary Health Centre, and active involvement of ASHA workers, Anganwadi staff, and local volunteers. It emphasizes timely risk communication, prevention of misinformation, and rapid response measures including isolation support and assistance to affected families. Special care is given to vulnerable groups such as the elderly and chronically ill, ensuring uninterrupted access to medicines, food, and essential services. By integrating community participation with Kerala's decentralized public health system, **Avoly** Panchayath aims to build lasting grassroots resilience and ensure an effective response to future public health emergencies.

LSGD AT A GLANCE

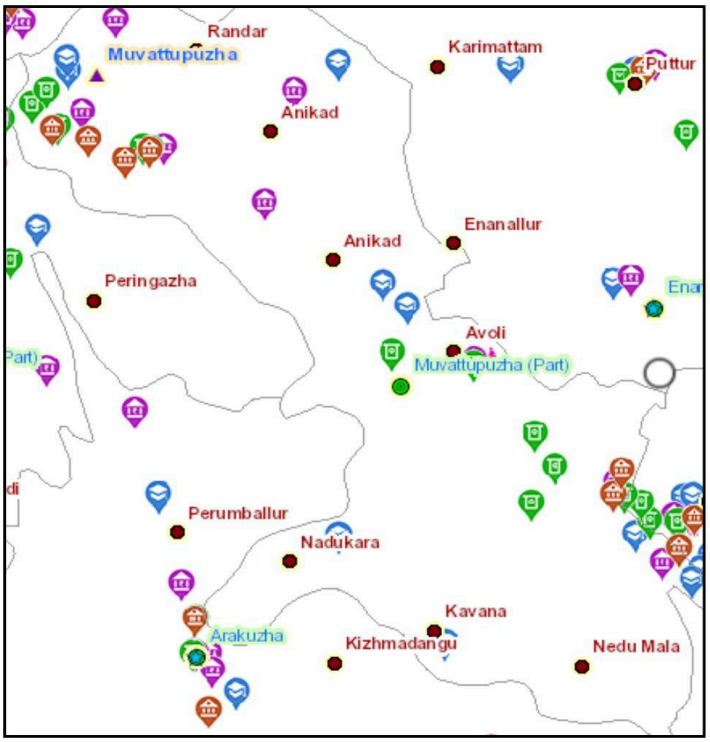
- Geographical boundaries with political map (based on latest delimitation)
- Baseline data
- Ward division -

Ward	Houses	Population	Migrants	Wells	Hot spots	Ed. Institutions	Hosp pvt/govt.
15	5653	22425	477	3332	2	9	2

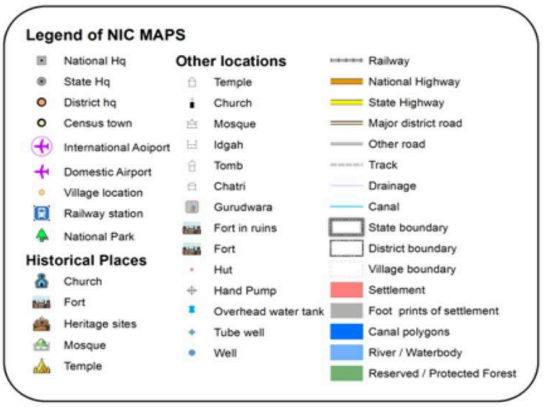
- Risk stratification among wards in the context of Communicable diseases and hazards
- Major Roads/rivers
- Major establishments with geospatial mapping
- occupational groups, socio cultural groups, migration & mobility patterns
- *Vulnerability mapping*
- Disaster prone areas (geographic vulnerability)

Maps - ward-based (Mention source also)

1. Geographical boundaries - ward boundaries map
2. Health infrastructure map
3. roads and rivers map
4. major establishments map
5. disaster-prone areas map
6. hotspot map - CD & disasters



AVOLY



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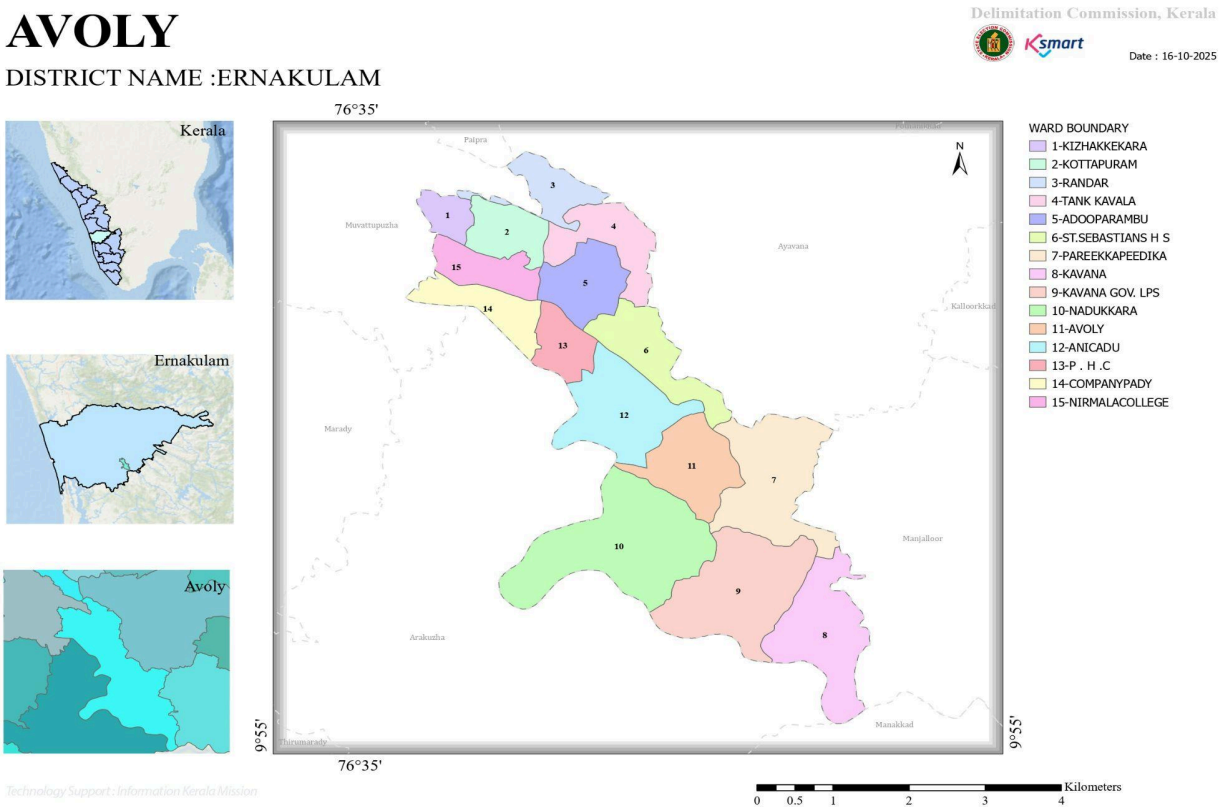
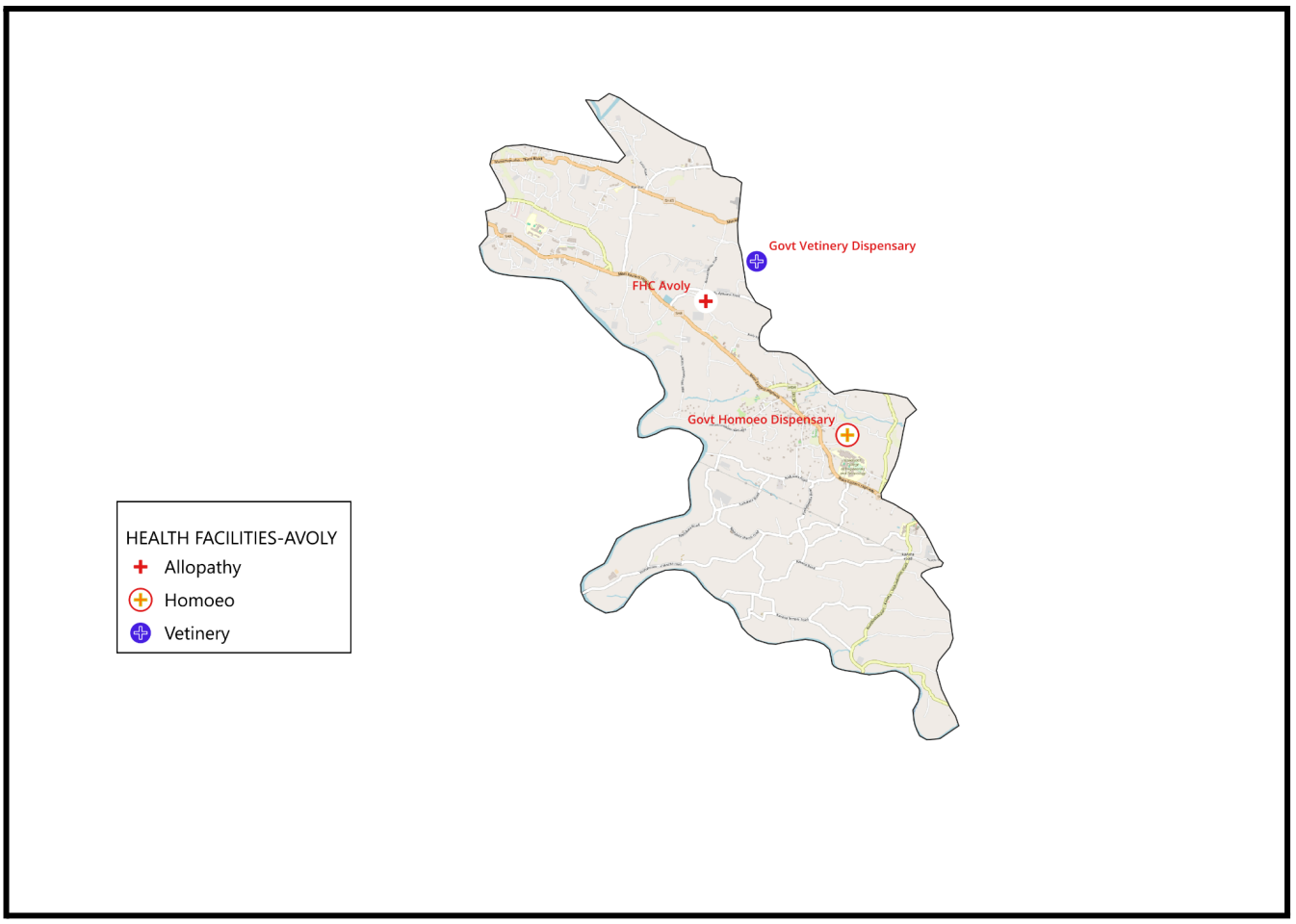
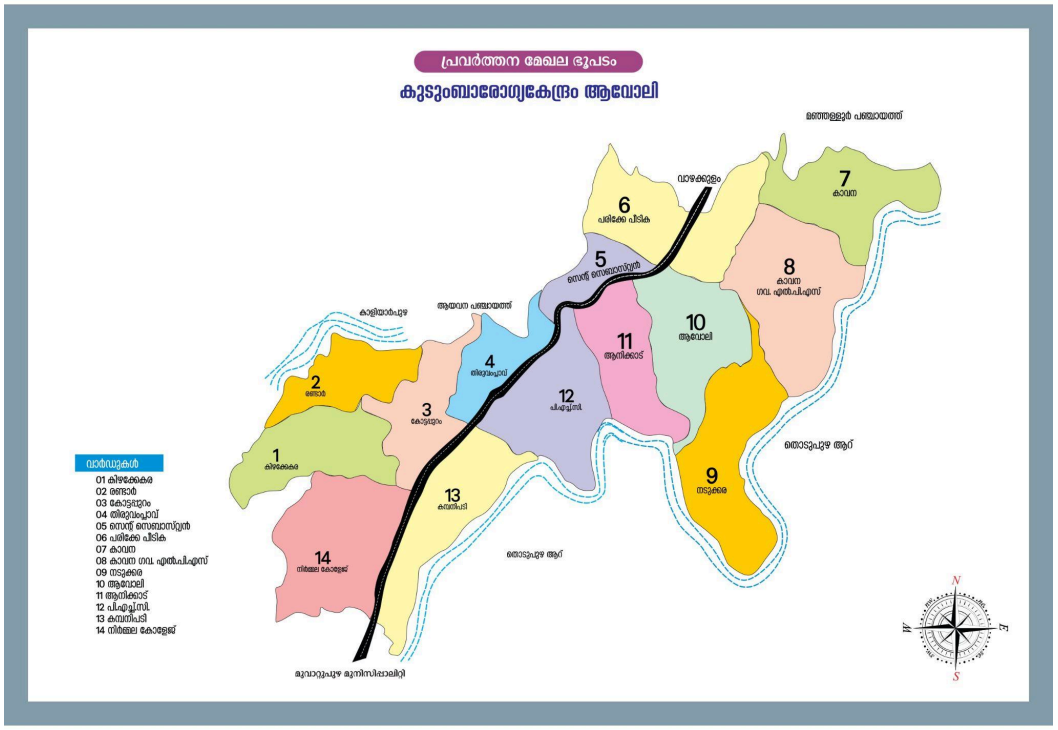


INTEGRATED HEALTH INFRASTRUCTURE MAP OF AVOLY PANCHAYAT





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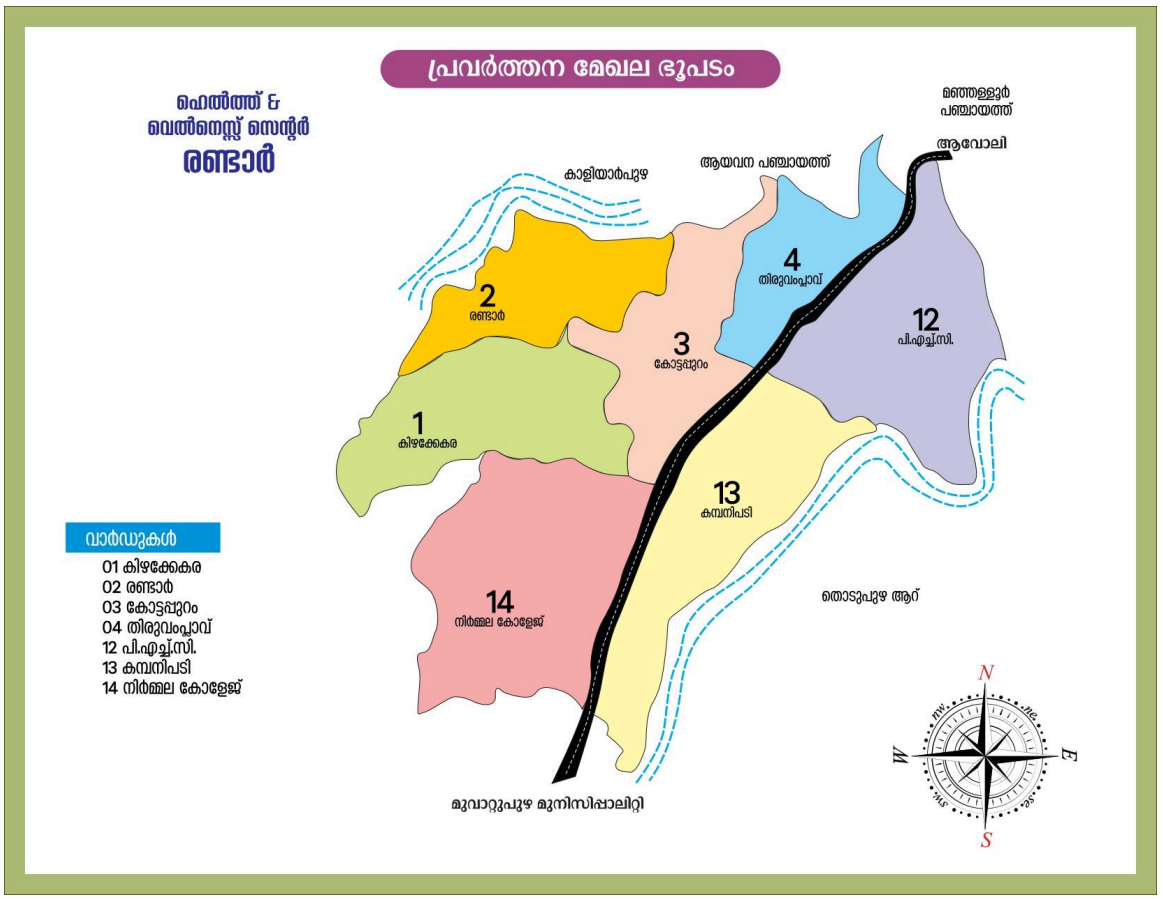
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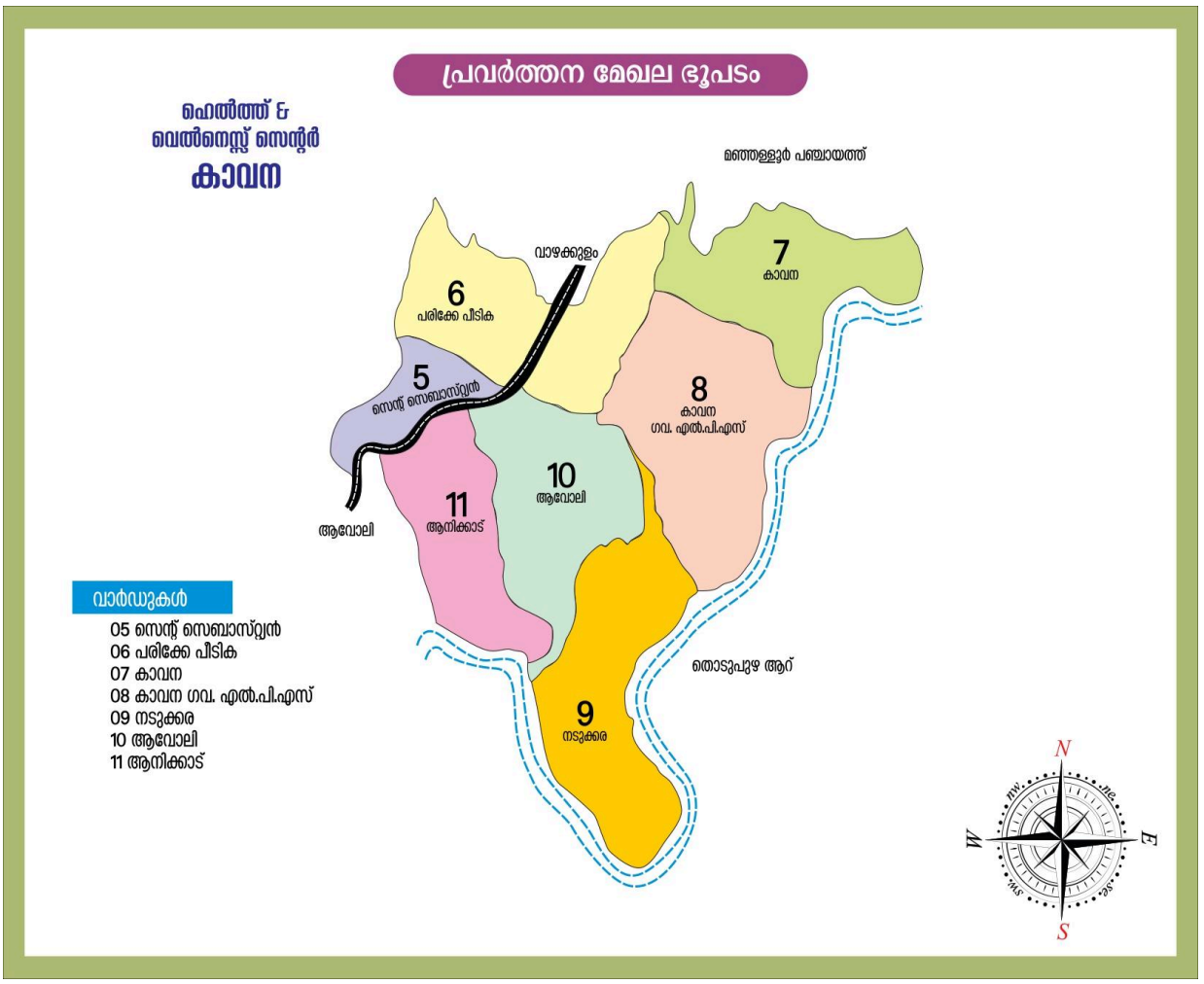
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GENERAL PROFILE OF THE LSGI'S

Background of the LSGI

Avoly Grama Panchayat is situated in the east of Ernakulam district, Kerala. The geographical landscape of the Panchayat is predominantly low-lying, characterized by extensive paddy fields (Kole lands) and a dense network of rivers, canals, and backwaters. This unique terrain plays a significant role in shaping the local microclimate and poses distinct challenges to transportation, emergency response, and service delivery, particularly during monsoon seasons and flood events.

The Panchayat is administratively divided into multiple wards, with a population largely dependent on traditional livelihoods. Agriculture—especially paddy ,Pineapple cultivation, includes rubber plantations and allied activities form the backbone of the local economy. In recent years, tourism-related activities and service-sector employment have also shown gradual growth. The area hosts a diverse workforce, including a presence of migrant labourers, particularly in construction, agriculture, and allied sectors. In 2018 flood disaster significantly impacted life, livelihoods, and infrastructure within the Panchayat. These recurring emergencies have underscored the importance of strengthening local preparedness, response mechanisms, and inter-departmental coordination.

In this context, the development of a localized, data-driven Auxiliary Infrastructure and Logistical Resource Map is essential to support effective planning, timely emergency response, and sustainable development initiatives. Such mapping enables the Panchayat to identify critical resources, improve accessibility during disasters, and enhance overall resilience of the community.

Table 1: Background of LSGD

Description	Details
Name of LSGI	Avoly
Type (GP/Municipality / Corporation etc.)	Grama Panchayath
Block	Muvattupuzh
District	Ernakulam
Number of wards	15(Old wards-14)
Total area (sq. km)	18.6 km.sq.
Population(Projected)	22425

Table 1: Background of LSGD	
Description	**Details**
Population density	1205 persons/sq km
Terrain (coastal/low-lying/backwaters/foothills, etc.)	No.
Number of rivers passing through LSGI	2
Number of water bodies in the LSGI	1
Number of educational institutions	12
Factories / small-scale industries	14
Flood-prone wards	2
Landslide-prone wards	0
Death Management and Disposal Facilities (mortuaries/crematorium, including electric)	0
Auditoriums/Marriage halls/convention centres/community halls	0

Demographic and Vulnerable Population

Understanding the demographic composition and vulnerable population groups is essential for pandemic preparedness. Children, elderly, economically deprived families, migrant workers, and socially vulnerable groups are at increased risk during public health emergencies due to higher exposure, limited access to services, and dependency on public systems..

Description	**Details (in numbers)**
DEMOGRAPHIC PROFILE	
Total population	22425
Male	11120

Description		Details (in numbers)
DEMOGRAPHIC PROFILE		
Female		11305
Transgender		0
Children under 5		955
Adolescent		2315
Elderly (>60)		3147
SOCIAL/LIVELIHOOD VULNERABILITY		
Previous EPEP family		7
BPL family		1216
Tribal communities		17
Migration	Immigrant	316
	Emigrant	521
Socio-economically deprived		7
Fisherfolk		-
SC Community		935
ST Community		65

Graphs: Population pyramid (if possible) for seeing if your LSGI has a high "dependency ratio" (lots of children and elderly compared to working adults).

Clinical Vulnerability

Certain population groups need priority healthcare & are at higher risk of severe illness, complications, and mortality during pandemics. Patients with chronic diseases, those requiring regular medical care, and individuals with mobility or functional limitations face challenges in accessing timely care during

emergencies. Mapping these groups helps in prioritizing continuity of treatment, medicine stock planning, oxygen support, referral transport, and targeted home-based care.

Description	Details in numbers
Pregnant women	140
Lactating mothers	388
Bedbound patients	93
Patients under palliative care other than bedbound	12
Patients on Haemodialysis	19
Patients on CAPD	1
Cancer patients (currently on treatment)	54
Haemophilic patients	0
Mentally challenged	29
Differently abled	33
Diabetic patients	6182
Hypertensive patients	7058
TB patients	4

Major Festivals & Events specific to the LSGI (with the possibility of a public gathering)

Sl. No.	Name of festival	Month detailing the periodicity
1	Thiruvanplavil temple festival	February

INFRASTRUCTURE & RESOURCE INVENTORY

Health Facility Directory & Basic Capacity in the LSGD

This section provides an overview of the healthcare infrastructure available within the LSGD area. It outlines the distribution and basic capacity of health facilities that form the backbone of service delivery during routine times and public health emergencies.

Family Health Centres (FHCs) and Community Health Centres (CHCs) generally function as the first point of contact for the community, providing essential outpatient and inpatient services. General Hospitals (GH) and Medical College Hospitals (MCH), where accessible, serve as the main referral centres for advanced diagnostics, specialist care, and critical services during public health emergencies. This inventory helps identify existing strengths, gaps, and potential surge capacity that can be mobilised during a pandemic or disaster.

Table 5. Health Facility Resource Summary

Sl.no.	Health Facility	Type of Facility (MCH/GH/CHC/FHC/SC etc.)	Contact Number	Total beds	ICU Beds	Oxygen-Supported Beds	No. of Ventilator Support Beds	No. of ambulances
Government Healthcare Facilities								
1	FHC Avoly	FHC	Dr Preethi Peter-9495060461	0	0	0	0	0
Private Healthcare Facilities								
	–							
AYUSH Healthcare Facilities								
1	GAD AVOLY	Dispensary	Dr Robin K Joseph 9447527247	0	0	0	0	0

Table 5. Health Facility Resource Summary								
Sl.no.	**Health Facility**	**Type of Facility (MCH/GH/CHC/FHC/SC etc.)**	**Contact Number**	**Total beds**	**ICU Beds**	**Oxygen-Supported Beds**	**No. of Ventilator Support Beds**	**No. of ambulances**
2	Govt.Homoeo Dispensary	Dispensary	Dr	0	0	0	0	0

Private Clinics

Private clinics are an essential part of pandemic preparedness, as they are often the first place people seek care when symptoms begin. In many communities, private clinics manage a significant share of outpatient visits and therefore play a critical role in early case detection, timely referrals, and disease surveillance. Having an up-to-date understanding of where these clinics are located, the services they provide, and how they are linked to the public health system helps ensure that no cases are missed during an outbreak. It also allows health authorities to engage private practitioners more effectively for reporting, risk communication, and coordinated response, strengthening the overall capacity of the health system to manage public health emergencies.

Table 6. Private Clinic Resource Summary								
Sl No.	**Name of Clinic**	**Registered (Y/N)**	**Clinic (General / Specialty)**	**Specialty (if any)**	**Address**	**Contact Number**	**Diagnostic Facility (Y/N)**	**Ambulance Linkage (Y/N)**
1	LIFE LINE ADOOPARAMBU	Y	Clinic	NA	LIFELINE CLINIC, ADOOPARAMBU	Sr.Soumya 8547550032	Y	N

Healthcare Education & Training Institutions

This section tracks the educational infrastructure available, which is vital for human resource planning in the health sector.

Category of Institution	Govt	Private	AYUSH	Total
Medical Colleges	0	0	0	0
Nursing Colleges	0	0	0	0
Dental Colleges	0	0	0	0
Para-medical / Allied Health	0	0	0	0
Pharmacy Colleges	0	1(Nirmala College of Pharmacy)	0	0

Specialized Services & Emergency Inventory

This section provides a detailed view of the specialized medical resources available to the community, focusing on emergency response and critical care capabilities. This table tracks the vital assets required for managing severe illnesses and emergencies across Government, Private, and AYUSH sectors.

Item	Govt	Private	AYUSH	Total
Hospital beds	0	0	0	0
Oxygen-generating systems(Y/N)	0	0	0	0
Oxygen-supported beds(Numbers)	0	0	0	0

Item	Govt	Private	AYUSH	Total
Ventilator-supported beds	0	0	0	0
ICU beds	0	0	0	0
Burns units	0	0	0	0
Blood centres	0	0	0	0
BLS ambulances	0	0	0	0
ALS ambulances	0	0	0	0
Dialysis facilities	0	0	0	0
Dispensaries	0	0	0	0
Medical store	0	0	0	0
Industrial establishments(**Medium-scale industries/small-scale industries establishments to whom we can depend in a worst-case scenario)**	0	0	0	0

Oxygen & Diagnostic Capacity

Monitoring **oxygen and diagnostic capacity** is a critical component of public health preparedness, ensuring that the LSGD can handle both chronic care and sudden surges in respiratory or infectious diseases.

Name of Health Facility	Oxygen-generating System (Y/N)	Backup Oxygen Source (Y/N)	Diagnostic Facilities Available(Y/N)				
			Lab	USG	X-ray	CT/MRI	RT-PCR
Government Healthcare Facilities							
FHC Avoly	Y -3 B Cylinders	0	Y	0	0	0	0

Diagnostics facility mapping at the LSGI level

The diagnostic capacity of **AVOLY G.P** represents the "intelligence network" of our healthcare system. The speed and accuracy of disease identification depend entirely on the distribution and technical level of these facilities.

Item	Govt	Private	AYUSH	Total
General labs	1	3	0	3
Microbiology labs	0	0	0	0
RT-PCR labs	0	0	0	0
USG units	0	0	0	0
CT/MRI units	0	0	0	0
Research labs	0	0	0	0
Labs of other departments that can be repurposed	0	0	0	0

Laboratory Identification & Basic Details

Sl. No.	Name of Laboratory	Ownership (Govt / Private / Academic)	Address	Contact No.	24×7 Services (Yes/No)	NABL / Govt Approved (Yes/No)
1	Hearts diagnostic centre	p	chirappady	9961872386	N	N
2	Asco diagnostic clinical Lab	P	Chirappady	7902833543	N	Y
3	Lotus diagnostic centre	P				

Social and Community Infrastructure for surge plan

This table serves as our **logistics and shelter inventory.** By mapping these locations, quickly we can identify where to house displaced citizens, where to set up temporary medical clinics, and how to manage the deceased with dignity during a crisis.

Category	Total Count	Ward	Est. Capacity (Persons)	Contact details
Educational Institutions				
Anganwadis	16	1 - 14	30	ICDS Supervisor - Sreeja Gopinath-9544131613
Schools	9	14,2,	200	HM -
Colleges	3	2,14,9	300	Management details attached in Annexure
Healthcare Educational Institutions				
Medical colleges (Govt/Private)	0	0	0	0
Nursing colleges (Govt/Private)	0	0	0	0
Dental colleges (Govt/Private)	0	0	0	0
Paramedical institutes (Govt/Private)	1	14	50	Management details attached in Annexure
Community Gathering Spaces				
Community halls	2	10,4	120	Panchayath Secretary

Auditoriums	1	10	300	Owner
Religious buildings	15	2,5,7,9,12,13,10	-	Management
Vulnerable Group Support Facility				
Destitute homes	0	0	0	0
Elderly homes	2	9,5	51	
LSGD owned other buildings	2	4,10	200	Panchayath Secretary
Mass Fatality Management (MFM) Infrastructure				
Mortuary	0	0	0	0
Crematorium	1	0	0	St Sebastian Church,Anicadu

*refer annexure 1 for contact details

HUMAN RESOURCES

This section focuses on the **human capital** available within the LSGI. In any emergency—be it a pandemic, flood, or industrial accident—infrastructure is only as effective as the people operating it.

Medical & Clinical Personnel

This table tracks the "Frontline" providers responsible for diagnosis, treatment, and clinical management. Narrative sentence: eg., "Total health workforce: 450 personnel, with 60% in government facilities serving as primary surge capacity." A detailed directory with the contact numbers of all workers is maintained (**Annexure in 1**).

Cadre	Govt (No.)	Private (No.)	Total
Doctors—Modern Medicine	2	5	6
Doctors – AYUSH	0	3	3
Doctors – Veterinary	0	0	0
Doctors – Dental	0	2	2
Nursing officers	2	15	17
Lab technicians	0	3	3
Optometrist	0	0	0
Pharmacists	0	3	0
Psychologists	0	1	1
Counsellors	0	1	1

Public Health & Field-Level Workforce

These individuals are the backbone of surveillance, maternal-child health, and decentralized care.

Cadre	Health services	Municipal common services	Total
HS (Health Supervisors)	1	0	1
HI (Health Inspectors)	1	0	1
LHS (Lady Health Supervisor)	1	0	1
LHI (Lady Health Inspectors)	1	0	1
JPHN (Jr Public Health Nurses)	2	0	2
JHI (Jr Health Inspectors)	2	0	2
MLSP (Mid-Level Service Providers)	2	0	2
Palliative Nurses	1	0	1
RBSK Nurses	1	0	1
PRO	1	0	1
Epidemiologist	1	0	1

Cadre	Health services	Municipal common services	Total
Data Manager	1	0	1

Community & Support Cadre

This group represents the surge capacity of the LSGI—people who can be called upon for logistics, rescue, and specialized support.

Cadre	Number
ASHA Workers	14
AWW (Anganwadi Workers)	16
Emergency Medical Volunteers (Trained)	2
Kudumbashree	163
MNREGS	421
Purusha Swayam Sahaya Sangham	0
Ex-Servicemen	8

Cadre	Number
Retired Police Officers	5
NCC/NSS Volunteers	13
Red Cross volunteers	5
One Health Community Volunteers	14
One Health Community Mentors	0

Community Organizations

This section details the presence of community-based organisations (CBOs), non-governmental organisations (NGOs), faith-based organisations (FBOs), Kudumbashree Self-Help Groups (SHGs), and Ayalkootams within the Local Self-Government Institution (LSGI). These groups enhance grassroots mobilization, resource distribution, and support networks crucial for pandemic response and community resilience.

Category	Total Count
NGOs	5
Religious based organizations	5
Foreign based organizations	1

Category	Total Count
Sports Club/youth clubs	11
Kudumbashree SHGs	163
Ayalkootams	110
Political organizations	5
Residential organizations	7

Administrative & Emergency Services

This section outlines the availability of key non-health emergency support services and infrastructure within the LSGI, which are essential for effective pandemic preparedness and response. These facilities support law enforcement, disaster response, water supply, logistics, mobility, and community-level interventions during public health emergencies.

Category	Total Count	Contact details
Police Stations	0	9497980499
Fire & Rescue Stations	0	0485 2832727
Water Pumping Points	3	-
Public Distribution System (PDS)	7	-

Information regarding resources

The availability of essential transport and support resources plays a quiet but critical role in saving lives. Equipment such as ambulances, mobile mortuaries, amphibian ambulances, and motorized boats ensures that patients, samples, and healthcare teams can move swiftly—even in flooded, remote, or difficult terrains. Heavy vehicles like JCBs, cranes, tractors, and torus lorries support logistics, waste management, emergency infrastructure, and rapid conversion of spaces into care or isolation facilities. Taxis, four-wheel-drive vehicles, and trucks help maintain continuity of essential services, reach vulnerable populations, and support home-based care and supply delivery.

Means of transportation	Total Count
JCB	8
Crane	1
Heavy Trucks	2
Tractor	2
Ambulances	0
Mobile mortuaries	0
Boats	0
Taxi service	25

Note: For specific details regarding vehicle owners and contact information, please refer to **Annexure [X]**.

ONE HEALTH & ENVIRONMENTAL SURVEILLANCE

The One Health method integrates environmental, animal, and human health to enable proactive pandemic preparedness. Panchayat-level surveillance needs to be improved in order to detect and treat zoonotic and environmentally generated diseases early. Surveillance is strengthened through systematic assessment of animal populations, veterinary infrastructure, poultry and slaughter facilities, inter-sectoral coordination, and specialised tools like avian influenza seasonality mapping using GIS in previous outbreaks to enable predictive alerts and ward-specific sampling to support effective pandemic preparedness in high-risk areas .

Animal & Bird Population

Mapping animal and bird populations at the Panchayat level is essential for identifying and prioritising zoonotic disease hazards like rabies, avian influenza (H5N1), leptospirosis, anthrax, and Nipah-like spillover occurrences. Risk classification, targeted surveillance, vaccination planning, and early epidemic detection made feasible by comprehensive population mapping all enhance One Health-based pandemic preparedness.

Category	Item	Estimated Population	Wards
Animal Population	Livestock (Cattle/Goats/Buffalo)	275	2,5,4,7,8,12,13,10,1,5
	Pet Animals (Dogs/Cats)	657	13,10,1,5,2,5,4,7,8,12
	Stray Dog Population	21	5,4,7,8,12,13,10,1,5,2
	Pig Farms (Number of heads)	1	11
	Small Units (Sheep / Goats – clustered)	5	13,10,1,5

Category	Item	Estimated Population	Wards
Bird Population	Poultry Units (Birds)	5	13,10,1,5,2,5,4,7,8,12
	Poultry- (FOWL)	0	-
	Wild/Migratory Birds (Observed)	0	-
	Crow Mortality Events (Reported)	0	-

The main risk of zoonotic diseases is concentrated in any **Ward 2** , which is explained by the high density of pig farms, cattle congregation areas, and poultry units. The stray dog population in **market areas,, bus stations** continues to be a substantial problem for rabies surveillance and bite prevention. There is a considerable risk of influenza introduction and amplification during **November - December** due to the seasonal presence of migratory and resident water birds near **ponds/ canal / river / backwater / paddy field**. Clusters of pig farms and animal shelters vulnerable to flooding further raise the risk of leptospirosis and other zoonoses mediated by the environment, especially during monsoon floods.

Veterinary Infrastructure

Veterinary institutions are a core pillar of One Health surveillance, enabling early zoonotic disease detection through vaccination, investigation of unusual animal illness or deaths, sample collection, and timely outbreak reporting. A well-mapped and responsive veterinary network strengthens coordination with human health and LSGI systems, ensuring rapid response during zoonotic events and pandemics.

Facility Type	Name of Facility	Ownership Govt / Pvt	Location(Ward No)	Contact number
Veterinary Dispensary	Govt.Veterinary Dispensary	1	4	Dr Asha Abraham -9497874435
Veterinary Hospital / Polyclinic	0	0	0	0
Private Veterinary Clinics	0	0	0	0
Mobile / Emergency Vet Service (incl. night services)	0	0	0	0
Pet Homes / Animal Shelters	0	0	0	0
Slaughterhouse-linked Veterinary Inspection Unit	0	0	0	0

Veterinary Doctors & Workforce

Early detection, diagnosis, reporting, and reaction to animal illness epidemics depend on the availability and accessibility of qualified veterinary specialists. By identifying unusual animal morbidity or mortality promptly, collecting samples promptly, and coordinating efficiently with human health and LSGI systems—especially during zoonotic outbreaks and pandemic-prone situations—a clearly defined veterinary workforce enhances One Health surveillance.

Category	Number Available	Type (Govt/Pvt)	Contact number
Government Veterinary Doctors	0	-	Dr Asha Abraham -9497874435
Private Veterinary Doctors	0	0	0
Livestock Inspectors	0	0	0
Para-veterinary Staff / Attenders	0	0	0
Contract / On-call Veterinary Support (if any)	0	0	0

High-Risk Interface Points (Surveillance Sites)

High-risk interface points for zoonotic disease surveillance in **Avoly** Grama Panchayath include *wetland–livestock–human contact zones, backyard poultry farms, cattle sheds near water bodies, fish markets, and areas of high human–animal interaction such as community slaughter points and migratory bird congregation sites*. These are the primary surveillance sites where zoonotic spillover risks are elevated.

Type of Habitat	Type of High risk interface	Geographical vulnerability
Wetlands & Backwaters	0	NA

Backyard Poultry Farms	0	NA
Cattle Sheds near Water Bodies	0	NA
Fish & Meat Markets	3	NA
Community Slaughter Sites	0	NA
Migratory Bird Congregation Areas	0	NA
Rodent-Infested Grain Storage	0	NA

Category	Total Count	Key Locations (wards)
Poultry Farms	5	5,6,3,2,9
Backyard / Clustered Poultry Units	0	0
Duck Rearing Units (open water access)	0	0
Slaughterhouses/ Slaughter Points	4	6,8,9,12
Meat/Fish Markets	4	5,8,9,2
Live Bird Sale Points	0	-
Cattle Markets / Weekly Animal Fairs	0	-
Pet Shops / Breeders	0	-
Animal Shelters / Pet Homes	0	-
Waste Disposal Sites near Animal Units	0	-

Environmental Risk Mapping

Environmental risk mapping identifies monsoon/flood hotspots for vector-borne (dengue, chikungunya), water-borne (leptospirosis, diarrhoea), and zoonotic diseases in Kerala's wetlands. Systematic surveillance supports early warnings, targeted interventions, and Panchayat pandemic preparedness.

Waterborne exposure: Flood-prone areas and stagnant water bodies facilitate *leptospira survival*, raising leptospirosis risk.

Traditional practices: Informal slaughter and fish markets lack standardized hygiene, creating *spillover opportunities*.

Risk Factor	High-Risk Wards	Key Locations	Risk Level (High/Med/Low)
Flood-prone areas	2, 12	Ward-2-Adooparamb Ward 12 -PHC ward	Medium
Water bodies/wetlands	0	-	-
Solid waste accumulation	0	-	-
Animal waste disposal issues	0	-	-
Rodent infestation zones	0	-	-
Industrial effluent discharge	0	-	-
Construction sites / abandoned buildings	7	2,8,11,14,5	Medium
Poor drainage/blocked canals	0	-	-
Drinking water source contamination risk	2,10	• Ward2 -Adooparamb • Ward 10-Avoly	

Disease Seasonality Mapping

1, **Flooding & waterlogging** → amplifies leptospirosis, malaria, diarrheal diseases.

2, Migratory bird influx (Nov–Feb) →Less influenza risk.

3, Mosquito breeding cycles → vector-borne disease peaks in monsoon.

4, Agricultural practices → close human–animal contact in paddy fields.

Disease	Peak Risk Season	Key Drivers	High-Risk Locations	Surveillance Focus
Avian Influenza	0	-	-	-
Leptospirosis	1	Rodent infestation	Ward 2	-
Dengue/Chikungunya	5	Pineapple, Rubber Plantaion	Ward 6	Yes
Acute Diarrheal Diseases	3	-	-	
Rabies	0	-	-	-
Anthrax (rare)	0	-	-	-

Vulnerability Mapping

Vulnerability mapping pinpoints high-risk populations, occupations, and areas exposed via environment, livelihoods, socio-economics, and poor service access. Paired with environmental/seasonality mapping, it enables risk-based surveillance, targeted actions, and optimal resource use in One Health and pandemic planning.

Vulnerability Factor	High-Risk Wards	Key Groups / Locations	Risk Level
Flood-prone households	8,2,12	Ward-8,2,12	Medium level(2018)
Wetland-adjacent communities	0	-	-
Backyard poultry / duck rearing households	0	-	-
Livestock-rearing households	152	4,3,2,7,8,9,10,12 ,13	-
Slaughterhouse & meat market workers	11	-	-
Fisherfolk & fish market workers	7	-	-
Sanitation workers	3	-	-
Daily wage / migrant workers	577	-	-
Elderly & chronically ill populations	112	-	-
Pregnant Women	140	-	-
Children (schools, Anganwadi's)	4315	-	-
Limited access to safe water & sanitation	62	-	-

EPIDEMIOLOGICAL TRENDS (2021–2025)

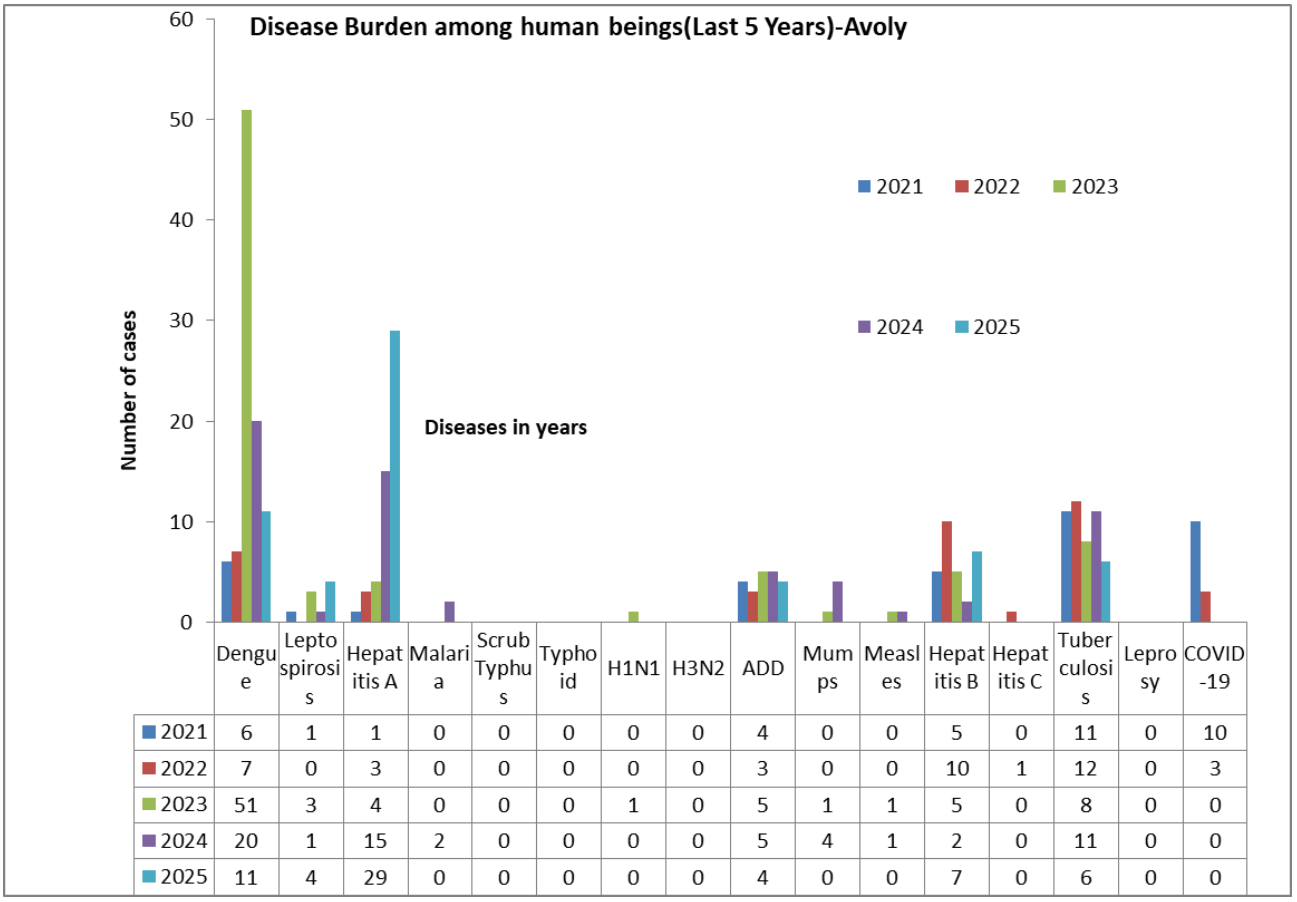
Disease surveillance is the systematic collection, analysis, and interpretation of health data for planning, implementation, and evaluation of public health practice. This section presents the disease surveillance profile of the LSGI based on routine reporting systems and outbreak investigations to identify priority diseases, seasonal patterns, and emerging public health threats.

Disease Burden among human beings(Last 5 Years)

Analysis of disease-wise data for the last five years helps identify persistent public health problems, emerging diseases, and changes in disease burden. This information supports prioritisation of prevention, preparedness, and response activities at the Panchayat level.

Disease	2021	2022	2023	2024	2025	Trend(Increasing/Stable/Decreasing)
Dengue	66	77	5151	2020	1111	Decreasing
Leptospirosis	11	00	33	11	44	Increasing
Hepatitis A	11	33	44	1515	2929	Increasing (Outbreak ward 9)
Malaria	00	00	00	22	00	Decreasing
Scrub Typhus	00	00	00	00	00	-
Typhoid	20	0	00	10	00	-
H1N1	00	00	11	00	00	Stable

H3N2	00	00	00	00	00	-
ADD	314	453	415	365	394	Stable
Mumps	00	20	51	44	30	Stable
Measles	00	00	11	11	00	-
Hepatitis B	55	1010	55	22	77	Increasing
Hepatitis C	00	01	00	00	00	-
Tuberculosis	1111	1212	88	1111	66	stable
Leprosy	00	00	00	00	00	-
COVID-19	10	3	0	0	0	-



	Dengue	Leptospirosis	Hepatitis A	Malaria	Scrub Typhus	Typhoid	H1N1	H3N2	ADD	Mumps	Measles	Hepatitis B	Hepatitis C	Tuberculosis	Leprosy	COVID-19
2021	6	1	1	0	0	0	0	0	4	0	0	5	0	11	0	10
2022	7	0	3	0	0	0	0	0	3	0	0	10	1	12	0	3
2023	51	3	4	0	0	0	1	0	5	1	1	5	0	8	0	0
2024	20	1	15	2	0	0	0	0	5	4	1	2	0	11	0	0
2025	11	4	29	0	0	0	0	0	4	0	0	7	0	6	0	0

***(use the above table data to create the graph/diagram)**

Seasonal Trend Analysis

Seasonal analysis helps anticipate surges (e.g. dengue in monsoon, leptospirosis after floods, influenza in cooler months) and plan pre-emptive vector control, stockpiling of IV fluids, and awareness campaigns at Panchayat level.

DENGUE

Dengue is a major seasonal vector-borne disease strongly associated with rainfall, water stagnation, and increased mosquito breeding during the monsoon period.

Peak: July–November

Dengue – Ward-wise Yearly Distribution (2021–2025)

Ward	Dengue – Ward-wise Yearly Distribution					
	2021	**2022**	**2023**	**2024**	**2025**	**Total**
1	10	10	60	20	00	**0**
2	2	0	37	25	23	**17**
3	10	2	10	30	11	**3**
4	0	21	50	20	30	**1**
5	10	3	23	13	22	**11**
6	2	10	30	10	1	**3**
7	20	10	50	30	10	**0**

8	2	1	44	20	11	**8**
9	20	0	50	10	0	**0**
10	0	20	30	10	11	**1**
11	0	0	0	0	0	**0**
12	0	0	10	5	0	**15**
13	0	0	15	4	0	**19**
14	0	0	12	3	2	**17**

LEPTOSPIROSIS

Leptospirosis cases are closely linked to monsoon rains, flooding, and occupational exposure, particularly in low-lying and waterlogged areas.

Peak: June - August

Leptospirosis – Ward-wise Yearly Distribution (2021–2025)

Ward	**Leptospirosis – Ward-wise Yearly Distribution**					
	2021	**2022**	**2023**	**2024**	**2025**	**Total**
1	10	0	0	0	0	**0**

2	0	0	10	01	20	**31**
3	0	0	0	10	0	**10**
4	10	0	10	0	10	20
5	1	0	0	0	01	**2**
6	0	0	0	0	2	**2**
7	0	0	10	0	0	**10**
8	0	0	0	0	0	**0**
9	0	0	0	0	0	**0**
10	0	0	0	0	10	**10**
11	0	0	0	0	0	**0**
12	0	2	0	0	1	**3**
13	0	0	0	0	0	**0**
14	0	1	0	0	0	**0**

VIRAL HEPATITIS - A

Hepatitis A cases are commonly associated with unsafe drinking water, food contamination, and breakdowns in sanitation, often presenting as clusters or outbreaks.

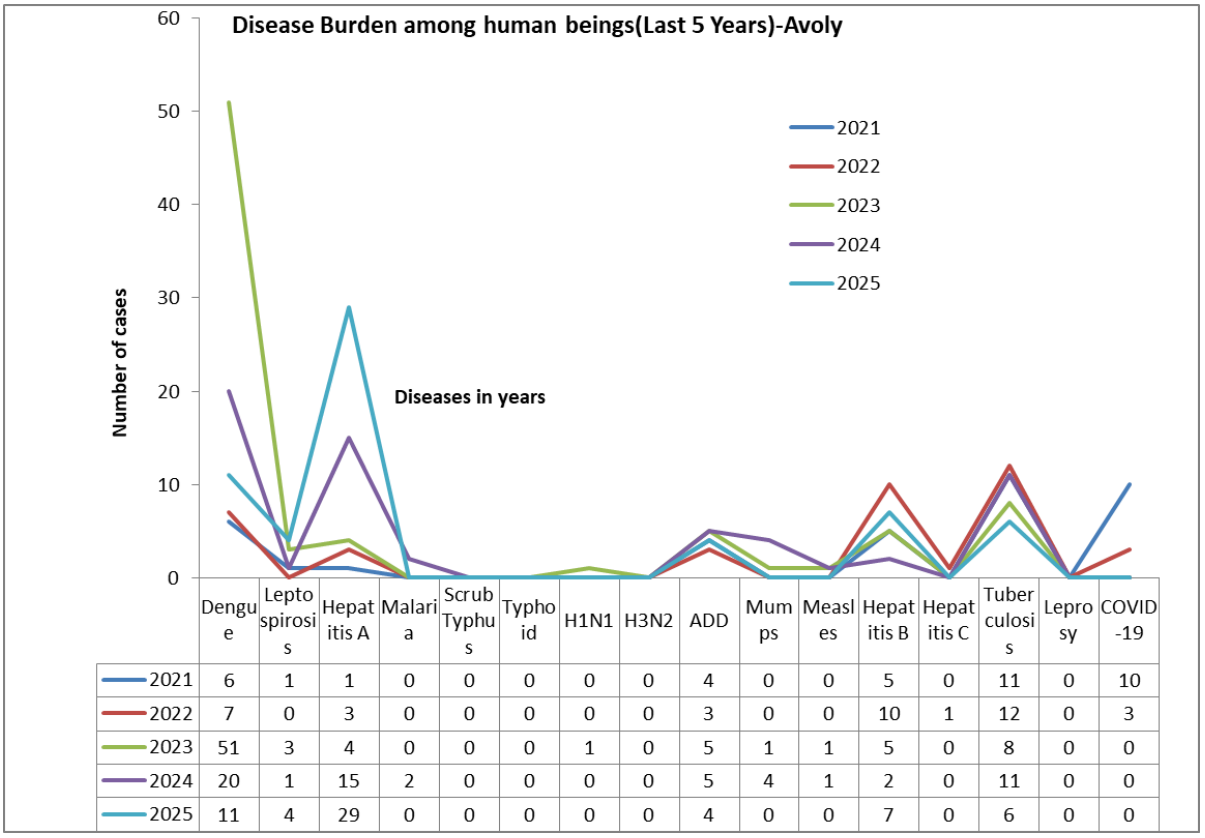
Peak: October - December

Hepatitis A – Ward-wise Yearly Distribution (2021–2025)

Ward	Hep A – Ward-wise Yearly Distribution					
	2021	**2022**	**2023**	**2024**	**2025**	**Total**
1	00	00	10	00	0	**0**
2	00	02	00	00	0	**2**
3	00	00	01	32	0	**3**
4	10	11	00	1213	0	**14**
5	01	00	01	00	2	**4**
6	00	00	00	00	0	**0**
7	00	10	10	00	0	**0**
8	00	00	11	00	2	**3**
9	00	00	00	00	25	**25**

10	00	00	11	00	0	**1**
11	00	10	00	00	0	**0**
12	00	00	00	00	0	**0**
13	00	00	00	00	0	**0**
14	0	0	0	0	0	**0**

Outcome-Based Trend Analysis- 2025



	Dengue	Leptospirosis	Hepatitis A	Malaria	Scrub Typhus	Typhoid	H1N1	H3N2	ADD	Mumps	Measles	Hepatitis B	Hepatitis C	Tuberculosis	Leprosy	COVID-19
2021	6	1	1	0	0	0	0	0	4	0	0	5	0	11	0	10
2022	7	0	3	0	0	0	0	0	3	0	0	10	1	12	0	3
2023	51	3	4	0	0	0	1	0	5	1	1	5	0	8	0	0
2024	20	1	15	2	0	0	0	0	5	4	1	2	0	11	0	0
2025	11	4	29	0	0	0	0	0	4	0	0	7	0	6	0	0

Transmission Trend- 2025

For effective management of public health issues, it is important to track the trend of disease transmission mode. It helps identify the population or place at high risk that can be used to predict outbreaks and implement targeted interventions as quickly as possible. Understanding these kinds of trends enables authorities to allocate resources efficiently and change the strategies adequately based on the trend that follows.

Mode of Transmission	No. of cases	No. of Deaths
Vector Borne Diseases	15	0
Water Borne Diseases	29	0
Air Borne Diseases	0	0
Blood Borne Diseases	0	0
Food Borne Diseases	0	0
GB Syndrome	2	1

Vector-Borne Disease

Disease	No. of Cases	No. of Deaths
Dengue	11	0
Malaria	0	0

Chikungunya	0	0

Water Borne Disease

Disease	No. of Cases	No. of Deaths
Cholera	0	0
Typhoid	0	0
Hep- A	29	1
Dysentery	0	0
Amoebiasis	0	0
E- Coli infections	0	0

Air Borne Disease

Disease	No. of Cases	No. of Deaths
Influenza	0	0
H1N1	0	0
TB	6	0

Chickenpox	24	0
Measles	0	0
Covid-19	0	0
Pertussis	0	0
Mumps	0	0

Blood-Borne Disease

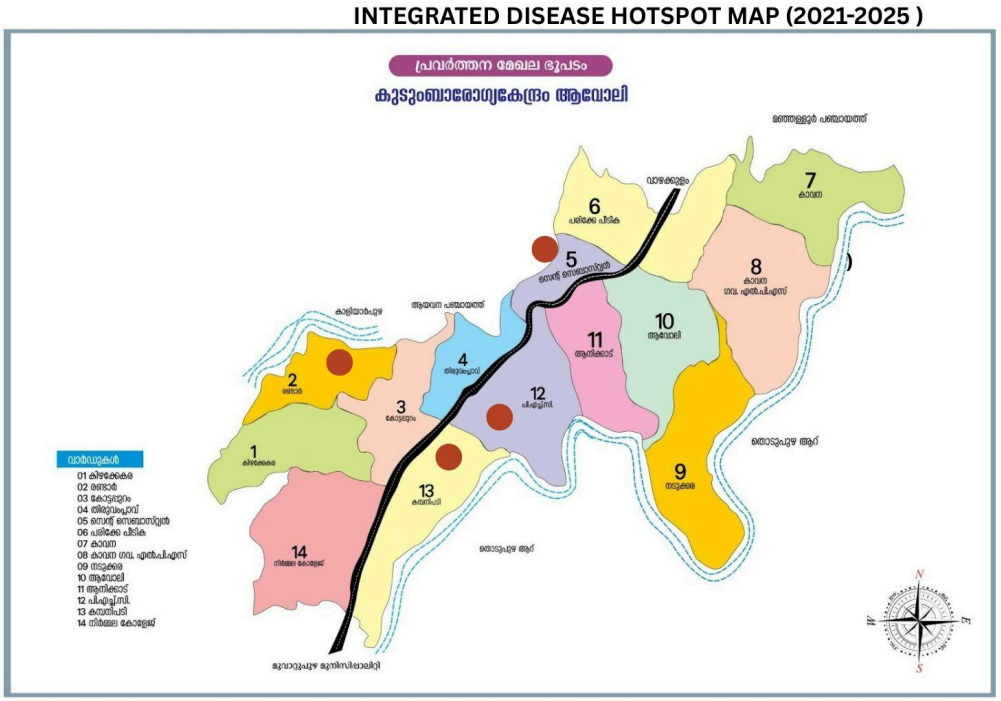
Disease	**No. of Cases**	**No. of Deaths**
AIDS	0	0
Hep- B	7	0
Hep- C	0	0

Zoonotic Disease

Disease	**No. of Cases**	**No. of Deaths**
Rabies	0	0

Leptospirosis	4	0
Avian influenza	0	0
West nile	0	0
Anthrax	0	0
Nipah	0	0
Scrub Typhus	0	0
Tropical Fever	1	1

Integrated Disease Hotspot Map (2021–2025)



- Ward 2-Randar
- Ward 5- St.Sebastian
- Ward 12 -PHC
- Ward 13- Company Padi

Communicable Diseases (2021-2025)

Ward No	Dengue Total (2021-25)	Leptospirosis Total (2021-25)	Hepatitis A Total (2021-25)	Mumps (2021-25)	ADD (2021-25)	Total Cases
1	0	0	0	0	0	**0**
2	17	1	2	0	4	**24**
3	3	0	3	0	3	**9**

AVOLY PANCHAYATH

4	1	0	14	0	0	**15**
5	11	2	4	3	3	**23**
6	3	2	0	2	3	**10**
7	0	0	0	0	4	**4**
8	8	0	3	0	3	**14**
9	0	0	25	0	1	**26**
10	1	0	1	0	0	**2**
11	0	0	0	0	0	**0**
12	15	3	0	0	0	**18**
13	19	0	0	0	0	**19**

14	17	0	0	0	0	**17**
TOTAL	103	8	52	5	21	

By overlaying five years of data, we have identified **Ward 2 ,5,12, 13 '**Red Zone' Wards. These are wards where at least two different categories of diseases (e.g., Dengue and Lepto) recurred in consecutive years. Ward **2** is categorized as the **Highest Priority Hotspot** due to its combination of flood vulnerability and ward 12, 13 high vector density. Future health infrastructure, such as the proposed **R.O plants at Avoly** should be prioritized.

PREPAREDNESS AND RESPONSE PROTOCOL AT LSG LEVEL

This section describes the operational framework for the LSGI once a pandemic is declared. It explains how the LSGI and health system will move from routine data collection to active response, using a One Health approach.

Constitution of One Health Committee

The LSGD shall constitute a One Health Committee comprising the LSGI President, Medical Officers (Modern Medicine, AYUSH, and Veterinary), the Health Inspector, and the Veterinary Surgeon.

Objective: The One Health Committee coordinates human, animal, and environmental health to prevent and control pandemics.

Sl No	Name	Designation	Department/Institution	Role in Committee	Contact Number
1	Joji K Jose	Panchayat President	LSGD	Chairperson	9656130180
2	Dr Preethi Peter	Medical Officer (PHC/CHC)	Health Dept	Member Secretary	09495060461
3	Dr Asha Abraham	Veterinary Officer	Animal Husbandry	Member	9497874435
4	Dr Sharon Anna Thomas	Epidemiologist	Health Dept	Member	8919974013
5	Binu E P	Health Inspector/PHN	Health Dept	Surveillance	9495061324
6	Basheera	ASHA Supervisor/LHI	Health Dept	Community link	9446410461
7	Sreeja N	ICDS Supervisor	Social Welfare	Vulnerable groups	9544131613
8	Vazhakulam	Police Station Officer	Police Dept	Law & order	9497980499
9	Shahina Nisar	Ward Councillor Representative	LSGD	Community coordination	9605509538
10	Smitha Vinu	Kudumbashree CDS	Kudumbashree	Community mobilisation	8086493819

11	NSS/NCC	NGO/Volunteer rep	Civil Society	Support services	Schools

Key Responsibilities:

- Review disease surveillance data (human + animal)
- Conduct ward-wise risk assessment and vulnerability mapping
- Approve quarantine/isolation centre locations
- Coordinate with district for resources (PPE, oxygen, ambulances)
- Periodically review health system surge capacity, including beds, oxygen, human resources, and ambulances.
- Approve and monitor risk communication and community engagement strategies, including rumour management.
- Ensure protection and service continuity for vulnerable groups (elderly, persons with disabilities, dialysis patients, coastal populations).
- Conduct quarterly mock drills
- Monitor equity measures for vulnerable groups

Meeting Schedule:

Quarterly (normal times) | Weekly (outbreak alert) | Daily (pandemic phase)

Pandemic Response Workforce

To ensure a coordinated and timely response during a pandemic, a dedicated Pandemic Response Workforce shall be constituted at the LSG level. The workforce will function under the overall supervision of the One Health Committee and in close coordination with the health authorities. Team-based deployment will enable efficient surveillance, case management, quarantine and isolation management, logistics support, and risk communication. Each team shall have a clearly designated team leader, defined roles, and an identified pool of personnel to allow rapid activation, rotation of duties, and continuity of services during prolonged emergencies.

Total Response Workforce Available: 300 persons

Team Name	Composition	Key Responsibilities	Team Leader

Surveillance and Contact Tracing Team	HI, JHI, JPHN, ASHAs and Volunteers	Case detection, contact listing, home visits, reporting	HI
Case Management Team	Doctors, Nurses, MLSP, Palliative Nurses	Patient care & referral	DOCTOR
Quarantine & Isolation Team	LSGD staff, Volunteers	Facility management	JHI
Psychosocial support			
Logistics & supply chain Team	LSGD staff, Storekeepers, Drivers 3	Supplies & transport [PPE, medicines, oxygen, transport, waste management]	Ward Member
Communication Team	Ward members, Kudumbashree, Youth clubs, AWW workers and other self help groups	IEC, community meetings, countering misinformation	M.O in charge
Transportation	KSRTC, educational institutional buses	-	-
Media Surveillance	-	-	
Intersectoral coordination and convergence	-	-	-
Collaborative surveillance	-	-	-

All teams shall be activated immediately upon outbreak alert or pandemic declaration and shall report daily to the LSG Incident Commander/Medical Officer, with consolidated reporting to the Block PHC. Duty rosters and alternate personnel shall be maintained to ensure uninterrupted services during staff shortages or prolonged response periods. Team composition and numbers may be revised based on the magnitude of the outbreak and availability of human resources.

Activities and Measures before and during Pandemic

PHASE 1 - Alert / Preparation

Surveillance and Reporting-Enhanced syndromic surveillance:

1. **Data sources for surveillance:**
2. **Event-based triggers (to be monitored and reported):**
3. **Zoonotic and animal health surveillance**
4. Logistics and Stock Preparedness

- Identify and empanel local vendors and define emergency procurement mechanisms in accordance with existing LSGD and Health Department norms.

ESSENTIAL ITEMS	VENDOR	CONTACT
Surgicals	KMSCL	9809426004
Medicines	KMSCL	9809426004

- **Prepare and maintain an essential logistics checklist covering medical supplies, consumables, and support equipment.**

SL.NO	ESSENTIAL LOGISTICS CHECKLIST	Y/N
	Personal Protection	
1	Respiratory protection -N95, Face Mask	Y
2	Body protection -Disposable gown/Apron/Scrub	Y
3	Hand/Eye protection - Latex gloves,Safety googles, Face shield	Y

4	Sanitation & Hygiene -hand sanitizer,disinfectanct wipes/spray,soap	Y
	Diagnostic &Laboratory supplies	
1	Testing Kits -ELIZA,RTPCR,Influenza test kit	N
	Dengue-NS1,IgM Malaria HbsAg	Y
	waste management	
1	Biohazard Bags	Y
2	Sharp containers	Y
	Sample collection	
1	Hub and spoke	Y
	Respiratory support & critical care	
1	oxygen cylinder	3B
2	Oxygen concentrators	Y
3	High flow nasal canulas	N
4	ventilators	N
5	suction devices	N
	Monitoring	
1	vital sign monitors	5
2	pulse oxymeters	5
3	BP cups	3
	Medical consumables & pharmaceuticals	

- **Pre-identify secure storage locations for emergency stocks and ensure maintenance of stock registers with regular updating.**

STORAGE LOCATIONS	STOCK REGISTER
Pharmacy Store Room	Y
Nursing Station	Y

- Finalise emergency transport arrangements, including availability of vehicles and identified drivers for rapid deployment during alerts.

AVAILABILITY OF VEHICLES	CONTACT NUMBER
ASCO	8111988866
-	-

- Designate a Nodal Officer for Logistics to enable prompt decision-making, coordination, and communication during emergencies.

NODAL OFFICER	CONTACT NUMBER
Dr Preethi Peter , Medical Officer	9495060461

- Conduct rapid stock verification and ensure availability of minimum buffer stock, including:

  - PPE kits : **0** numbers
  - Gloves :530 numbers
  - Pulse oximeters :5 numbers
  - Hand sanitizers –5 litres

- Masks, gloves, disinfectants – 500 adequate quantity

Identify critical gaps in logistics and immediately communicate requirements to the Block and District authorities for timely replenishment and support. Monitor expiry dates and stock rotation.

➢ **Identification of Quarantine and Isolation Facilities**

- Identify and list suitable buildings for quarantine and isolation (schools, hostels, community halls, etc.).
- Categorise cases as per the severity and allocate to appropriate facilities (for instance, severe cases to classrooms, mild cases to an assembly hall in case of a school).
- Facility readiness checklist needed (beds, toilets, ventilation) etc.
- Find an alternate site if the primary sites are not available or not in use.
- Identify facility managers and support staff
- Prepare basic SOPs for:
  - Admission and discharge
  - Food, water, sanitation
  - Infection prevention and waste disposal
- Ensure availability of basic amenities: water, sanitation, electricity, ventilation, and waste disposal. Prepare a rapid activation plan for these facilities if case numbers increase.

SL.NO	BUILDINGS FOR QUARANTINE (with ward number)	ISOLATION FACILITIES (with ward number)	NO: OF BEDS	NO: OF TOILETS	NO: OF VENTILATION	FACILITY MANAGER/SUPPORTING STAFF	WATER (Y/N)	SANITATION(Y/N)	ELECTRICITY(Y/N)	WASTE DISPOSAL (Y/N)	INFECTION PREVENTION MECHANISM (Y/N)
1	SABTM School,Randar	y	200	15	y	y	y	y	y	y	y
2	Panch	y	20	2	y	y	y	y	y	y	y

	ayath Hall, Chira pdy										

➢ **Risk Communication and Community Preparedness**

- Disseminate **e**arly warning messages on symptoms, preventive measures, and reporting mechanisms. Display IEC materials both in English and the local language in public places and ensure ward-level awareness.
- Sensitize elected representatives and community leaders on preparedness measures.
- Establish a rumour tracking and misinformation response mechanism to identify, verify, and promptly counter false or misleading information.
- Engage trusted local persons (ward members, ASHA workers, religious leaders, teachers, community volunteers) to communicate official public health messages and reinforce correct practices.
- Develop and deploy targeted IEC materials for:
  - Schools and educational institutions
  - Markets and commercial areas
  - Work sites and labour settings
- Conduct community sensitization meetings at the ward level to promote preventive behaviors, address concerns, and strengthen community participation in preparedness and response.

Sl.no	**IEC Material (Y/N)**	**Rumour Register(Y/N)**	**Community Sensitization meetings(Y/N)**
1	Y	Y	Y

➢ **Protection of Vulnerable Groups**

Vulnerable populations require priority protection through targeted line-listing, service continuity, and delivery mechanisms.

- Prepare and regularly update **line-lists** of vulnerable populations, including:
  - **Elderly persons living alone (Total:29)**

Sl No	No of Elderly alone	Ward Number
1	0	1
2	3	2
3	3	3
4	4	4
5	3	5
6	2	6
7	3	7
8	4	8
9	3	9
10	1	10
11	0	11
12	1	12
13	1	13
14	1	14

  - **Persons with disabilities (Total -29)**

Sl No	No of Persons with Disabilities	Ward Number
1	0	1
2	3	2
3	3	3

4	4	4
5	3	5
6	2	6
7	3	7
8	4	8
9	3	9
10	1	10
11	0	11
12	1	12
13	1	13
14	1	14

- **Pregnant women (Total :163)**

Sl No	No of Pregnant Women	Ward Number
1	19	1
2	18	2
3	23	3
4	16	4
5	12	5
6	7	6
7	10	7
8	17	8
9	5	9
10	6	10
11	10	11
12	7	12

13	4	13
14	9	14

- **Migrant workers(Total - 668)**

Sl No	No of Migrant Workers	Ward Number
1	5	1
2	85	2
3	20	3
4	51	4
5	113	5
6	49	6
7	74	7
8	0	8
9	112	9
10	145	10
11	0	11
12	7	12
13	0	13
14	7	14

- **Dialysis patients**

Sl No	No of Dialysis Patients	Ward Number
1	1	1
2	2	2
3	1	3

4	**3**	**4**
5	**1**	**5**
6	**0**	**6**
7	**2**	**7**
8	**1**	**8**
9	**3**	**9**
10	**0**	**10**
11	**0**	**11**
12	**1**	**12**
13	**0**	**13**
14	**0**	**14**
15	**1**	**15**

The detailed line-lists shall be maintained as **Annexure** ___ and updated periodically.

➢ **Clinical Dependency Mapping**

Develop ward-wise dependency and vulnerability maps to identify households requiring regular support during emergencies. Ensure continuity of essential health services for vulnerable groups, including

- Dialysis services (facility mapping, transport arrangements, and scheduling)
- Continuity of treatment for TB, HIV, and other chronic conditions requiring uninterrupted medication
- Mental health and psychosocial support services

Establish **delivery mechanisms** for food, essential commodities, and medicines to vulnerable households through coordinated action involving ASHAs, JPHNs, Kudumbashree, volunteers, and local administration.

Sl No	Dialysis services(Institute with place)	Continuity of treatment for TB, HIV	Mental health and psychosocial support services
1	Nirmala Hospital,Muvatupuzha	GH Muvatupuzha	DMHP-CHC Pandappilly
2	GH Muvatupuzha	FHC Avoly	-
3	Al Azhar MC,Ezhallor -Thodupuzha	-	-
4	St. George Hospital ,Vazhakulam Soujanya Dialysis	-	-

PHASE 2 - Active Response

1. **Case Identification and Contact Tracing**

   Case detection and contact tracing activities will be carried out in coordination with the Health authorities, following disease-specific SOPs and IDSP guidelines.

   Field Staff Involved

   - Health Inspector (HI)
   - Junior Health Inspector (JHI)
   - Junior Public Health Nurse (JPHN)
   - ASHAs and ASHA Supervisors
   - Ward-level volunteers and Kudumbashree members (as required)

2. **Screening Checkpoints**

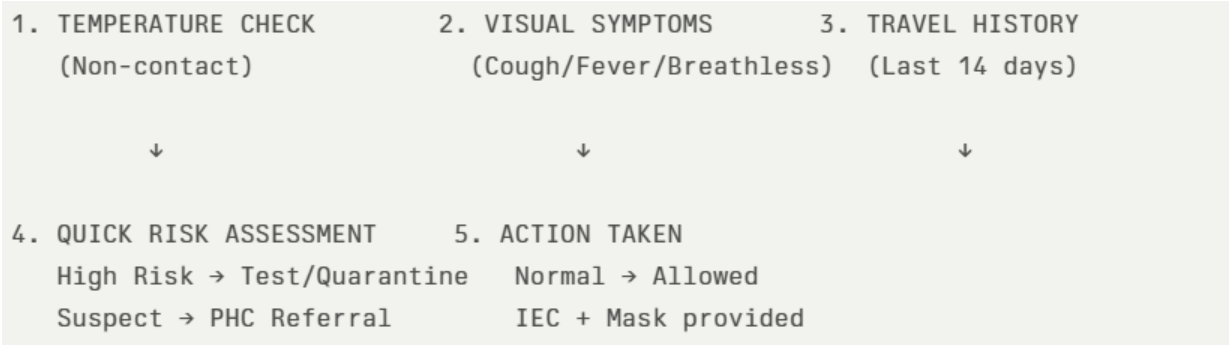
   Screening checkpoints at high-traffic locations (transport hubs, markets, religious gatherings) for early detection of symptomatic travellers and crowd screening during

outbreaks. Potential locations include bus stands, market entry points, and boat jetties, based on local context and risk assessment.

Screening activities will be carried out by trained personnel such as ASHAs, ward members, and volunteers, with support from Health Department staff. Necessary equipment, including non-contact thermometers and appropriate PPE, shall be ensured prior to activation.

Location	Type (Bus stand/Jetty/Market/Railway)	Staff Deployed (ASHAs/Volunteers)	Screening Method	Reporting authority
Nil Bus stand	Transport hub	One JHI One ASHA One health Mentors	1.Swab Collection. 2. Blood smears collection (RDT) 3.Thermal Scanners	Surveillance Nodal Officer in control room
Nil Market entry	Market	One JHI One ASHA Male health volunteers	1.Swab Collection. 2. Blood smears collection (RDT) 3.Thermal Scanners	Surveillance Nodal Officer in control room
Nil Boat jetty	Water transport	One JHI One ASHA Male health volunteers	1.Swab Collection. 2. Blood smears collection (RDT) 3.Thermal Scanners	Surveillance Nodal Officer in control room

Standard Screening Protocol



The screening protocol shall include temperature screening, observation for visible symptoms, and inquiry regarding recent travel or exposure history. Individuals identified as suspects during screening shall be immediately referred to the nearest PHC/FHC for further evaluation, testing, and appropriate action as per prevailing guidelines.

3. Pandemic Control Room

The Pandemic Control Room (PCR) serves as the central nerve center for real-time coordination, data aggregation, decision support, and communication during outbreaks. It consolidates information from all LSGD teams, health facilities and community sources to enable rapid response decisions.

Control Room Infrastructure and Location

Primary Location: Avoly Panchayath Office.

Backup Location: Community Hall in **Avoly** G.P.

Health System Control Room Framework

The PCR is organized into **seven functional pillars** to ensure no aspect of the response is overlooked:

1. ***Rapid Response Team (RRT)***
    - Provides immediate intervention during emergencies, clusters, and field alerts.
    - Coordinates urgent actions such as case investigation, contact tracing, isolation, and inter-facility referrals.
2. ***Data Management & Analytics Team***
    - Collects, validates, and manages key health system indicators (cases, tests, beds, HR, supplies).

- Analyzes data trends, generates projections, and supports evidence-based decision-making for local authorities.

3. ***Human Resource Deployment Team***
    - Allocates healthcare staff efficiently based on workload and need
    - Ensures adequate and equitable workforce distribution across facilities
4. ***Laboratory Surveillance Team***
    - Oversees diagnostic testing coordination, sample transport, and timely reporting of results.
    - Monitors lab indicators (testing volume, positivity rate, turnaround time) for early detection of outbreaks
5. ***Vaccination Cell (If Required)***
    - Plans and executes vaccination campaigns, including micro-planning and session scheduling.
    - Tracks coverage, identifies gaps, and coordinates corrective actions with field teams and outreach services.
6. ***Infrastructure & Patient Occupancy Team***
    - Monitors facility capacity, earmarked beds, oxygen and critical care resources across all linked facilities.
    - Ensures optimal patient distribution and referral management using updated bed-status and resource data.
    - BMWM
7. ***Communication team***
8. ***Logistics and supply chain***
9. ***Transportation (interfacility & emergency transport)***
10. ***Media surveillance Call centre***
11. ***Management of the deceased***
12. ***Intersectoral coordination and convergence***

Key Control Room Team

The Control Room Team coordinates all pandemic response activities within the LSGD and serves as the single command and communication hub during activation. It integrates information, field actions, logistics, and policy execution across all participating departments and health facilities.

Role	Name	Designation	Contact Number	Responsibility

In-charge/Nodal Officer	Dr Preethi Peter	Medical officer	9495060461	Overall coordination, decision-making, and reporting to the District level.
Data Operator	**Gigi Mathew**	Data Manager	8086414154	Managing the line list, updating dashboards, and tracking testing results.
Communication Officer	Shahina Nisar	Ward Member	9605509538	Handling the public helpline, coordinating ambulance dispatch, and contact tracing calls.
Logistics Coordinator	Seema G	Staff Nurse	7907926460	
Technical Support *(IT/Data)*	**Gigi Mathew**	Data Manager	8086414154	

SOP for alert escalation/trigger point with mapping of responsibilities.

Key Points:

- The Control Room shall be staffed with a designated In-charge, data entry personnel, and communication staff with clearly defined roles and shift arrangements.
- It shall maintain updated records on daily monitoring indicators including new cases, persons under active quarantine, and hospital bed occupancy.
- All reports and situation updates shall be shared daily with the Block and District Surveillance Unit.
- The Control Room shall act as a single point of contact for coordination with response teams, health institutions, and other departments.
- Contact details of the Control Room shall be widely communicated to field staff and stakeholders during activation.

Daily Monitoring Indicators

To ensure timely decision-making and effective response, the following key indicators shall be monitored and updated on a daily basis by the Pandemic Control Room:

1. **Epidemiological Indicators:**

   New cases reported today, Total active cases, Test Positivity Rate (TPR), Case Fatality Rate (CFR)

2. **Surveillance Indicators:**

   Persons under home quarantine, High-risk contacts identified, Fever, ILI, SARI or other symptoms (syndromic surges), Travellers (symptomatic or high-risk arrivals),Animal husbandry surveillance (zoonotic alerts, unusual animal deaths, poultry/bird flu signals), Mortality surveillance (excess deaths, unexplained fatalities, verbal autopsy reports)

3. **Logistics and Infrastructure Indicators:**

   Hospital / CFLTC beds occupied, Oxygen cylinders/concentrators available, Ambulances on standby

4. **Alert Findings**

   The following table outlines category-specific **trigger points (red flags)** from surveillance indicators and corresponding immediate actions for the Pandemic Control Room. These enable rapid response to alert findings like testing anomalies, positive cases exceeding thresholds, clusters, and WGS reports.

Category	Trigger Point (Red Flag)	Immediate Action
Clusters	**Geographical or facility-based:** 5+ cases linked to one location (office, school, street).	Declare a micro-containment zone; perimeter control and active case finding.

Testing	Sudden drop in testing volume / delay in reporting / unusual testing trends	Review the sample collection process, address lab bottlenecks, deploy additional testing teams, and notify the District Lab.
Lab	Test Positivity rate increases	Increase testing sites in that ward.
Hospital	>80% Oxygen bed occupancy	Activate backup/CFLTC beds.
Travel	Cluster of cases from a single flight/train or high-risk arrival group.	Trace all passengers in adjacent seats; implement mandatory institutional quarantine.
Animal	Mass poultry/wildlife death or unusual sickness	Notify Animal Husbandry, sample the area, and dispatch RRT for environmental sampling and zoonotic check.
Mortality	Sudden spike in home deaths or brought-in-dead (BID) cases	Audit the deaths and Active Case Search drive
Additional investigations like Whole Genome Sequencing (WGS)	Detection of a **Variant of Concern (VOC) or Variant of Interest (VOI)**	Implement strict micro-containment; update clinical protocols to match variant severity.

4. Communication of Public Health Information

A Community Communication Hub shall be established to ensure timely, accurate, and consistent dissemination of information during a pandemic. The Hub will function under the coordination of Nodal officers of the control room and act as the nodal point for public communication, risk messaging, and community engagement. **It will support dissemination of official advisories, promote preventive behaviors, address rumors and misinformation, and ensure that messages reach all sections of the population through trusted local channels and leaders.**

Key communicators

Channel	Responsible Person	Contact
Ward-level announcements	Shahina Nisar	9605509538
Social media	-	-
Local Cable TV/Radio	-	-

- All messages disseminated through the Hub shall align with advisories issued by the Health Department and District authorities.

- Community leaders shall be sensitized to support behavior change, reduce stigma, and counter misinformation.

- Special efforts shall be made to reach vulnerable and hard-to-reach populations using locally appropriate communication methods.

Rumor Tracking: A designated volunteer will monitor local social media/WhatsApp groups daily to identify misinformation and issue official clarifications via the Communication Hub.

5. Coordination with District/State Authorities & Other Organisations

Effective coordination with Block, District, and State authorities is essential to ensure timely reporting, technical guidance, and uninterrupted supply of essential resources during a pandemic. The LSG shall establish clear communication channels, designate responsible officers, and adhere to prescribed reporting timelines to support coordinated public health action and efficient resource mobilisation.

Key Details:

- **Nodal Officer for Reporting:** Dr Preethi
- **Contact Number:** 9495060461

Reporting Schedule and Protocols:

To Whom	What to Report	Frequency	Nodal Person
Block PHC	Complete Situation Report (Cases, Quarantine, Beds, Screening, Deaths)	Daily	Dr Preethi Peter 09495060461
District IDSP Unit	Outbreaks/Clusters/Unusual Events (>5 cases same ward)	Daily	DSO
Veterinary Officer	Animal health events/Zoonotic alerts	Weekly	Dr Asha Abraham 9497874435
State Cell	Zoonotic cross-sector events		

Supply Chain Coordination

The LSG shall coordinate closely with Block, District, and State authorities (KMSCL) to ensure uninterrupted availability of essential goods, medical supplies, and logistics during a pandemic. Supply requirements shall be assessed regularly based on case load and communicated promptly to the appropriate authorities for timely replenishment.

Key Points:

- Maintain updated contact details of District and Block nodal officers for health logistics, oxygen supply, ambulances, and essential medicines.
- Submit timely indent requests for PPE, testing kits, medicines, oxygen, and other critical supplies through prescribed channels.

- Monitor stock levels at LSGD facilities, quarantine/isolation centres, and field teams through daily stock registers and dispensing logs to prevent shortages.
- Coordinate with District authorities, Karunya/Neethi medical shops, and local purchase committees for funds allocation and emergency procurement.
- Ensure regular monitoring of dispensing registers at all facilities to track usage, expiry, and pilferage—shortages being a perennial issue requiring proactive weekly audits.
- Activate surge procurement protocols during high caseloads, leveraging local purchase powers under LSGD funds alongside state supplies.

Resource Inventory and Contacts

Resource Category	Source (District/State/Private)	Contact
PPE Kits/Masks/Gloves	KMSCL	9809426004
PPE Kits/Masks/Gloves	Local Vendors	Vincita Muvatupuzha
Oxygen Cylinders/Concentrators	KMSCL	9809426004
Medicines/Antivirals	KMSCL	9809426004
Medicines/Antivirals	Neethi Shops	-
Test Kits (RTPCR/Rapid)	KMSCL	9809426004

Collaboration with NGOs, PPP, and CSR

To augment government efforts during a pandemic, the LSG shall collaborate with NGOs, voluntary organisations, and private sector partners through public–private partnerships and Corporate Social Responsibility (CSR) initiatives, in coordination with District authorities.

Key Points:

- Engage NGOs and community-based organisations for community outreach, awareness, and support to vulnerable populations.
- Leverage CSR support for procurement of medical equipment, PPE, oxygen concentrators, food kits, and sanitation materials, as permitted.
- Ensure all collaborations align with government guidelines and are routed through approved administrative and financial procedures.
- Maintain transparency and documentation for all external support received and utilised.

Organization	Type	Support Offered	Contact Person
Youth Clubs/Student Unions	CBO	NSS	schools

Interdepartmental Coordination

Coordination among departments during a pandemic shall be ensured through regular review meetings convened by the LSGD President. These meetings will provide a structured platform for sharing situational updates, assessing resource availability, resolving operational gaps, and taking joint decisions to ensure a coordinated and timely response.

Department	Representative	Key Role	Contact
Health (PHC)	Staff Nurse :	Case management	Dr Preethi Peter - 9495060461
Veterinary	Veterinary Surgeon:	Animal surveillance	Dr Asha Abraham 9497874435

ICDS	Supervisor:	Nutrition support	Sreeja Gopinath-9544131613
Education	Head Teacher:	School coordination	school management
Police	Vazhakulam	Containment enforcement	9895483247
Water Authority	Not available	Water supply	Not available
LSGD Engineering	AE	Quarantine infrastructure	Ratheesh Bhaskaran - 9747594537

PHASE 3 - Surge Capacity

Phase 3 is activated when there is a rapid increase in cases, high test positivity rates, or when existing health facilities and quarantine arrangements approach saturation. The focus of this phase is to expand isolation capacity, augment clinical care services, and mobilise additional resources through district and state support mechanisms.

Conversion of Community Facilities

To manage increased case load, the LSGD shall activate additional isolation facilities by repurposing identified community infrastructure such as community halls, auditoriums, schools, hostels, or other suitable buildings.

Name of facility	Facility Type	No. of Buildings	Ward	Surge Capacity (Beds)	Nodal Person
Community Hall,Chirapady	community Hall	1	4	20	Panchayath Secretary
SABTM School Randar	**school management**	2	2	150	Headmaster

- **Recovery and rehabilitation phase**
- **Recovery**
    - Damage & impact assessment
    - Restoration of health services
    - Rehabilitation of affected population
    - Psychosocial & mental health support
    - Disease surveillance during recovery phase
    - Environmental cleanup & sanitation
    - Livelihood restoration
    - Community engagement & confidence building
    - Documentation & after-action review
    - Lessons learned & best practices
    - Health system strengthening
    - Policy revision & preparedness enhancement
    - Research

CONCLUSION

In conclusion, Avoly Panchayath has established a comprehensive and well-coordinated Pandemic Preparedness Plan that ensures the Municipality is fully equipped to respond to any public health emergency. With strengthened ward-level surveillance, close coordination with health institutions including , active participation of ASHA workers, Anganwadi staff, and community volunteers, and special protection for vulnerable populations, all necessary systems and arrangements are in place. Through proactive planning, community engagement, and effective resource management, the Avoly Panchayath stands prepared to prevent, contain, and manage any future infectious disease outbreak efficiently and responsibly.

Additional points

- tech support
- relief based commodities
- ham reading operators
- hazard vulnerability mapping
- Kseb & other power source
- HR specific responsibility

RECOMMENDATIONS

1. Strengthening Healthcare Infrastructure

- Establish a primary health response unit within the Panchayat with trained staff.
- Ensure availability of basic medical supplies (masks, sanitizers, PPE kits, oxygen cylinders).
- Create tie-ups with nearby hospitals in Avoly for emergency referral and transport.

2. Community Awareness & Education

- Conduct regular awareness campaigns on hygiene, vaccination, and preventive measures.
- Use local communication channels (community radio, WhatsApp groups, notice boards) to spread verified information.
- Train volunteers to act as health ambassadors in each ward.

3. Emergency Response & Coordination

- Form a Pandemic Preparedness Committee at Panchayat level including health workers, ward members, and NGOs.
- Develop a clear action plan for lockdowns, quarantine, and distribution of essentials.
- Maintain a database of vulnerable groups (elderly, differently-abled, chronically ill) for targeted support.

4. Supply Chain & Food Security

- Identify and support local suppliers and farmers to ensure uninterrupted food supply.
- Create community kitchens during emergencies to serve vulnerable populations.
- Stockpile essential commodities in Panchayat-run outlets for crisis periods.

5. Digital Preparedness

- Promote digital platforms for telemedicine consultations.
- Use Panchayat's website/social media for real-time updates on health advisories.
- Encourage online grievance redressal to reduce crowding in offices.

6. Training & Capacity Building

- Organize mock drills for pandemic response in schools, offices, and public spaces.
- Train Panchayat staff and volunteers in first aid, infection control, and crowd management.
- Collaborate with NGOs and health departments for capacity-building workshops.

7. Long-Term Resilience

- Integrate pandemic preparedness into the Panchayat Development Plan.
- Allocate a dedicated budget for health emergencies.
- Encourage community participation in planning and monitoring preparedness measures.

MOCKDRILL SCENARIOS

Sl.No	Incident	Activities Conducted(Y/N)
1	Fire & Safety	No
2	Civil Defence Exercise -May 7,2025	1. Air Raid Sirens 2. Blackout stimulations 3. Evacuation Procedures 4. critical infrastructure Protection 5. Emergency service drills 6. Awareness to staff

ANNEXURE

1. IMPORTANT PHONE NUMBERS

Phone numbers and particulars of persons responsible for providing guidance, assistance, and support for pandemic preparedness operations may be provided here in a manner that allows easy reference at a glance. The information recorded here could be exhibited elsewhere at the time of emergencies. LSG institutions shall give special attention to collect and record the above data of persons and institutions who/which are supposed to give technical and co-ordination support to reduce the impact of pandemic.

1.1. **Details of grama panchayat/municipality/corporation wards**

Sl.No	Name of the ward	Ward number	Name of the ward member	Contact number
1	Kizhakekara	1	Shanavas	7012875659
2	Kottapuram	2	Shijina Mansoor	8139883690
3	Randar	3	Femina Ashraf	8137962925
4	Tank Kavala	4	Soumya Johny	7591950873
5	Adooparamb	5	Nisar K B	9645362354
6	St Sebastian HS	6	Sivan CA	9947448579

7	Pareeka peedika	7	Remya Thomas	9562938177
8	Kavana	8	Shins mon Thomas	944627511
9	Kavana Govt LPS	9	Dominic John	9446897848
10	Nadukara	10	Joji K Jose	9656130180
11	Avoly	11	Shibu Jose	9895483247
12	Anikad	12	Jeena Abraham	9497219963
13	PHC	13	Shahina C A	9605509538
14	Company padi	14	Sofiya Jacob	9747265772
15	Nirmala College	15	Valsa Joy	9495041851

1.2. **Other important phone numbers of grama panchayat/municipality/corporation area**

Sl. No.	**Name**	**Contact number**
1.	Joji K Jose,GP President	9656130180
2.	Shanavas, Health Standing Chairperson	7012875659
3.	Shibu Jose,Development standing committee	9895483247
4.	Dr Asha Abraham ,Vetinery officer	9497874435

5.	Soumya Johny,Welfare Standing commitee	7591950873
6.	Haseena Moideen ,Panchayat Secretary	8606152298
7.	Excise department	
8.	Forest department	
9	Ratheesh Bhaskar,AE	9747594537

1.3. **Important offices of grama panchayat/municipality/ corporation**

Sl.No	Name of the office	Contact person	Contact number
1.	Village Office	Village Officer	Shobha- 9400816079
2.	Agriculture Office	Agriculture Officer	Sujina P -9846896175
3.	Animal Husbandry Office	Animal Husbandry Doctor	Dr Asha Abraham 9497874435
4.	Police Station	Police Officer	Vazhakulam-9895483247
5.	BSNL Office	Officer	7947141417
6.	Block Office	Officer	Muvatupuzha 0485-2812714
7.	KSEB Office	Officer	Vazhakulam -914852261500

8.	Fisheries Office	Officer	-
9.	Fire and Rescue	Officer	Muvatupuzha- 0485 2832727

1.4. **Health Services**

Sl. No	Name of the hospital/institution	Location	Phone number
1.	Government hospitals/PHC	FHC Avoly	Dr Preethi Peter- 9495060461
2.	Private hospitals	Lifeline Adooparambu	Soumya -8547550032
3.	Clinical laboratories	-	-
4.	Chemist/pharmacy	-	-
5.	Blood donors	-	-
6.	Other language experts (Bihari, Hindi, Bengali, Asamees ……)	-	

1.5. **Veterinary Services**

Sl. No	Name of the Clinic	Name of the Surgeon/Doctor	Place/location	Phone number

1	Govt.Veterinary Hospital	Dr Asha Abraham	Ward 5 ,Anikad	9497874435

1.6. **Helpline numbers**

Helpline	Phone number
Police	vazhakulam -9895483247
Fire and Rescue	Muvatupuzha- 0485 2832727
KSEB	Vazhakulam -914852261500

1.7. Public and Private Schools Contact details

S.No	Name of School	Institution type	Phone number
1	Govt. LPS Kavana	Govt	Celine T R -8075504580
2	St. Sebastian, Anicadu	Aided	Sr.Sini-8281912556
3	St.Antonys LPS Anicadu	Aided	Rasheeda-9744840269
4	St. Thomas LPS Nadukara	Aided	Jeena- 7560961085
5	SABTM Randar	Aided	Fousiya-7510277823
6	Nirmala Public School (Junior & senior)	Private	Fr Paul- 7012418961
7	HM training (School & college)	Private	Sainaba-8547370349

1.9. **Anganwadi Contact Details**

Ward No	Name of Anganwadi Teachers	Phone number
1	Shyla N P	8113944327
2	Raseena	9656260047
2	Sunitha	9847319951
3	Rasheda	8330009138
4	Shyla TN	9747953571
6	Shibi CB	9497555703
6	Sini Antony	9747433484
7	Usha	9946154523
7	Nisha	9188255684
8	Preethi	8606858580
9	Sreekala	9249272267
10	Beena	6238240299
11	Liji	9847601154
12	Anitha	9020021028
14	Beena T P	8139038057

1.12. Information regarding resources

Means of transportation	Name of Owner	Phone Number
Heavy Trucks	-	-

Tractor	–	
Ambulances	1	ASCO
Boats	0	0
Taxi service	0	0

Annexure 1: LSG Baseline Data Collection Format

A. Baseline data

Sl. No.	Indicator / Field	Baseline Data	Source / Remarks
1	Name of LSG	Avoly	
2	District	Ernakulam	
3	Block / Taluk	Muvatupuzha	
4	Type of LSG (Gram Panchayat / Municipality / Corporation)	GP	
5	Area (sq. km)	18.6 sq.km	
6	No. of wards	15	
7	GIS boundary file available	(Yes/No)	
8	Key contact person & phone	Panchayath President	

B. Demography

Indicator / Field	Baseline Data	Source / Remarks
Total population	22425	
Males	11120	
Females	11305	
Transgender population	0	
Age distribution (<5, 5–14, 15–59, ≥60)	<5= 955 15-59 =2315 >60= 3147	
No. of households	3950	
Population density (persons/sq.km)	538/Sqkm	
No. of migrant workers	477	

Major occupational groups	Agriculture,small scale industries	

C. Vulnerable Populations & Social Risks

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	No. of elderly (≥60)	3147	
2	No. of persons with disability	29	
3	No. of bedridden persons	92	
4	No. of chronic disease cases (DM/HTN/COPD/CKD etc.)	112	
5	Pregnant women (current estimate)	163	
6	Children <5 years	955	
7	Tribal population (if any)	SC-235 families(945) ST-17 families(65)	
8	Fisherfolk / coastal vulnerable groups (if any)	-	
9	Urban slums / unnotified settlements (if any)	-	

10	Homeless population	12	
11	Orphanages / old age homes (number & capacity)	2	
12	Hostels / prisons / shelters (number & capacity)	-	
13	Poverty / BPL estimate	1216	
14	Food insecurity hotspots	-	
15	Any history of stigma/discrimination issues (Yes/No)	-	

D. Health System & Service Readiness

Sl. No.	**Indicator / Field**	**Baseline Data (Value / Description)**	**Source / Remarks**
1	No. of health facilities in LSG (PHC/CHC/TH/DH/Private)	1 FHC	
2	PHC/Family Health Centre details (name, location)	1 FHC	
3	Subcentres / Health & Wellness Centres (number)	2 HWC	

4	Private clinics / hospitals (number)	1	
5	Labs available (public/private)	1	
6	Availability of ambulance services (Yes/No, number)	YES-ASCO	
7	Availability of isolation/quarantine facilities (Yes/No, details)	Y	
8	Cold chain facilities (Yes/No, details)	Y	
9	Stockpile space available (Yes/No)	Y	
10	PPE / mask / sanitizer availability plan (Yes/No)	Y	
11	Surveillance staff available (JHI/JPHN/ASHA count)	Y	
12	Existing emergency referral pathways (Yes/No)	Y	

E. Points of Entry & Mobility

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks

1	Bus stands / depots (number)	0	
2	Railway stations (number)	0	
3	Boat jetties / fishing harbours (number)	0	
4	Ports / airports nearby (specify distance)	0	
5	Major highways/roads passing through	NH -49	
6	Border crossings (state/district)	N	
7	Major markets / weekly markets	N	
8	Tourism hubs / major event venues	N	
9	Schools/colleges with hostels (number)	9 School ,2College	
10	Factories / large workplaces (number)		

F. Water, Sanitation & Hygiene (WASH)

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Major drinking water sources (piped / wells / borewells / springs)	well	
2	No. of public wells	3332	
3	No. of households with piped water connection		
4	Water quality testing routine (Yes/No)	Y	
5	Common contamination risks (flooding, salinity, industrial waste)	Flooding	
6	Open defecation free status (Yes/No)	yes	
7	Solid waste management system (Yes/No)	yes	
8	Bio-medical waste disposal mechanism (Yes/No)	yes	
9	No. of public toilets	0	
10	Handwashing stations in public places (Yes/No)	yes	

G. Zoonotic Risks & One Health

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Livestock population (cattle/goats/pigs/poultry) – estimates	-	
2	No. of dairy farms / poultry farms / pig farms	1	
3	Slaughterhouses / meat shops (number)	-	
4	Animal markets (Yes/No, details)	-	
5	Veterinary dispensaries (number)	1	
6	History of zoonotic outbreaks (rabies, leptospirosis, avian flu etc.)	No	
7	Stray dog population management measures (Yes/No)	Yes	
8	Rodent infestation hotspots (Yes/No)	No	
9	Wetlands / waterlogged areas prone to leptospirosis	No	
10	Bat roosting areas / caves / fruit orchards (if any)	No	

11	Human-animal interface hotspots (farms near residences)	No	

H. Climate & Disaster Risks (Pandemic Amplifiers)

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Flood-prone wards (list)	2,12	
2	Landslide-prone wards (list)	-	
3	Cyclone/sea surge risk (Yes/No)	-	
4	Heatwave risk zones (Yes/No)	-	
5	Waterlogging areas (list)	-	
6	Shelter homes / relief camps (number, capacity)	-	
7	Past disaster displacement history	-	
8	Disruption to water supply/transport common (Yes/No)	-	

I. Critical Infrastructure & Logistics

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Schools (number)	9	

2	Anganwadis (number)	15	
3	Colleges (number)	2	
4	Community halls (number)	1	
5	Places of worship with large gatherings (number)	15	
6	Large markets / shopping areas (number)	-	
7	Warehouses / cold storages (number)	-	
8	Telecom/mobile network coverage gaps (Yes/No)	Yes	
9	Power outage frequency (high/medium/low)	Medium	
10	Availability of generators in key facilities	No(Invertor)	

J. Risk Communication & Community Networks

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Ward-level rapid response teams (Yes/No)	Yes	

2	Jagratha samithis / committees active (Yes/No)	Yes	
3	Kudumbashree presence and strength (number of units)	Yes	
4	Volunteer network (number, coverage)	45	
5	Community-based surveillance mechanisms (Yes/No)	Yes	
6	IEC dissemination channels (WhatsApp groups, community radio, PA systems)	Yes	
7	Rumour tracking mechanisms (Yes/No)	Yes	
8	Languages spoken / literacy considerations	Yes	
9	Vulnerable groups communication strategy available (Yes/No)	Yes	

K. Preparedness Planning & Governance

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	LSG emergency plan available (Yes/No)	Yes	

2	Pandemic preparedness plan available (Yes/No)	Yes	
3	Incident Command System identified (Yes/No)	Yes	
4	Rapid procurement mechanism available (Yes/No)	Yes	
5	Emergency fund available (Yes/No, amount)	Yes	
6	Past outbreak response experience (Yes/No, details)	Yes	
7	Intersectoral coordination mechanism (Health, Police, LSG, Veterinary, Education)	Yes	
8	Mock drills conducted in last 12 months (Yes/No)	No	
9	Training coverage for staff/volunteers (Yes/No)	Yes	

L. Surveillance & Data Systems

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Digital reporting tools used (e.g., DHIS2, portals)	yes	

2	Availability of line-listing format (Yes/No)	yes	
3	Contact tracing team identified (Yes/No)	yes	
4	Mapping of high-risk households available (Yes/No)	yes	
5	Testing sample transport mechanism (Yes/No)	yes	
6	Reporting timeline adherence (good/average/poor)	Yes	
7	Data sharing between departments (Yes/No)	Yes	
8	Availability of dashboard for monitoring (Yes/No)	Yes	

M. Additional Notes & Observations

Sl. No.	Indicator / Field	Baseline Data (Value / Description)	Source / Remarks
1	Key challenges perceived by LSG		
2	Top 5 high-risk wards (reason)	2,12	Flood prone area
3	Any unique local risks (industrial pollution, refugee camps, etc.)	No	

4	Recommendations for preparedness strengthening	-Early Surveillance and Reporting -Coordination with Health Department Emergency Response Teams	

ANNEXURE 3 : Admission SOP (At Community Level/Primary Health Center)

- **Screening and Referral:**

ASHA/RRT conducts house-to-house surveillance to detect symptomatic individuals.
Cases with mild symptoms are advised home isolation, while moderate-to-severe cases are referred to higher-level COVID Care Centres (CCC) or hospitals.

- **Triage and Isolation:**

Symptomatic cases (ARI/ILI) should be immediately separated from non-ARI patients at the PHC.
Establish dedicated, separate entry/exit points for suspect cases.

- **Documentation:**

Maintain a detailed register (line-listing) for all suspected/confirmed cases, including contact details and address.
Create a patient folder with a unique ID for tracking.

- **Safety Measures:**

Ensure the ambulance/transport vehicle is disinfected after every trip.
Mandatory use of masks by both patients and staff

ANNEXURE 4: Discharge SOP (From Community Care Centres/Isolation)

Discharge Criteria: Patients are discharged based on medical protocols (e.g., no fever for 3 days, 10 days since symptom onset, or negative test results).

- Discharge Summary: Provide a written summary detailing:
- Diagnosis and treatment given.
- Medication instructions.
- Mandatory further home isolation period (if required).
- Safe Transportation: Ensure safe, dedicated transport for patients leaving the isolation facility to their homes.

- Post-Discharge Follow-up: The RRT/ASHA should monitor the patient for any recurrence of symptoms.
- Final Disinfection: Deep cleaning and fumigation of the vacated room/unit

ANNEXURE 5: Water Safety & Supply SOP

- **Source Protection:** Immediately inspect and protect all public water sources (wells, borewells, taps). Ensure hand pumps are at least 20 feet away from any toilet or soak pit.
- **Chlorination & Testing:**
  Maintain a residual chlorine level of 0.5 mg/L during the outbreak (increased from the normal 0.2 mg/L).
  The Village Water and Sanitation Committee (VWSC) must conduct daily testing using Field Test Kits (FTKs) and report results to the PHC.
- **Safe Handling:** Distribute Information, Education, and Communication (IEC) materials advising households to boil water for 20 minutes and store it in narrow-necked, covered containers.
- **Alternative Supply:** If a source is contaminated, the GP must provide tanker water or seal the source and provide disinfection tablets (e.g., halogen tablets)

ANNEXURE 6: Food Hygiene & Security SOP

- **Surveillance:** The GP, in coordination with the Food Safety Officer (FSO), must inspect local eateries and markets.
- **Vendor Guidelines:**
  Enforce the FSSAI "Five Keys to Safer Food": keep clean, separate raw and cooked, cook thoroughly, keep food at safe temperatures, and use safe water.
  Prohibit the sale of cut fruits or exposed food in local markets during the outbreak.
- **Distribution:** For households in isolation, the GP should facilitate door-to-door delivery of dry rations or cooked meals to minimize movement.
- **Institutional Food:** Ensure mid-day meal kitchens and Anganwadis follow strict disinfection protocols.

ANNEXURE 7: Sanitation & Waste Management SOP

- **Public Area Disinfection**: Regularly disinfect public places (markets, GP office, religious sites) using 1% Sodium Hypochlorite solution.
- **Community Toilets:**
  Clean Community Sanitary Complexes (CSCs) at least twice daily with disinfectants.
  Provide soap and running water at all public toilet entries.
- **Waste Management:**
- Separate "hazardous/medical waste" (masks, gloves) from household waste. This should be collected in yellow bags and handed over to the PHC or designated facility.
  Prohibit open defecation strictly, especially near water bodies.
- **Worker Safety:** All sanitation workers must be provided with Personal Protective Equipment (PPE), including gloves, masks, and boots.