OFFICE OF THE REGISTRAR

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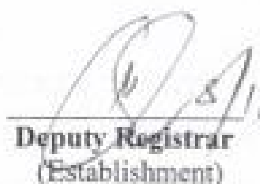
F. No: 2(2) UH/Reg/Estb/2020/ 10347 November 05, 2020

CIRCULAR

As per directive of the **Higher Education, Archives & Libraries Department**, Government of Khyber Pakhtunkhwa, in pursuance of Letter No. SO (Estt.) RR&SD/2-49/2020/157 dated October 9, 2020 along with National Command and Operation Centre (NCOC), Islamabad's Letter No. 801/A/NCOC-01 dated October 7, 2020, it is notified for the information of all that strict compliance of SOPs shall be ensured in **The University of Haripur** in order to avoid/mitigate the 2nd wave of Covid-19.

This has been issued with the approval of The Competent Authority.



Deputy Registrar
(Establishment)

Copy to:

1. All Deans, Chairpersons, Heads of Academic Departments & Sections
2. Directorate of IT Services (Display on website)
3. PS to Vice Chancellor
4. PA to Registrar
5. Relevant Files

GOVERNMENT OF KHYBER PAKHTUNKHWA

RELIEF REHABILITATION & SETTLEMENT DEPARTMENT

No. SO (Estt:) RR&SD/2-49/2020
Dated Peshawar the 9th October, 2020

To

The Secretaries to, Govt: of Khyber Pakhtunkhwa,

i. Home Department.
ii. Health Department.
iii. E&SE Department.
iv. Higher Education Department.
v. Local Govt: Department.
vi. Industries Department.
vii. Transport Department.

Subject: **QUANTIFIED TRIGGERS & CORRESPONDING NPIS – GUIDELINE.**

Dear Sir,

I am directed to refer to the subject noted above and to forward herewith copy of letter No. 801/A/NCOC-01 dated 17.10.2020 alongwith Guideline and quantified Triggers & Corresponding NPIs, for information and strict compliance, please.

Yours faithfully,

Encl: As Above

SECTION OFFICER (ESTT:)

Endst: No. & Date
Copy for information to the:

1. PSO to Chief Secretary, Khyber Pakhtunkhwa.
2. PS to Secretary, RR&S Department.
3. Master File 2020.

SECTION OFFICER (ESTT:)

(P-T-O)

PS/C.S Khyber Pakhtunkhwa
Diary No. 3955
Date 07-10-2020

Government of Pakistan
National Command and Operation Centre (NCOC)
ISLAMABAD
Fax 051-9224710

Subject: **Quantified Triggers & Corresponding NPIs - Guideline**

Guidelines on the subject are attached as *Annexure A* for information / necessary compliance, please.

Deputy Director (Operations)
Major
(Salman Iftikhar Cheema)

To
Chief Secretary Punjab
Chief Secretary Sindh
Chief Secretary Balochistan
Chief Secretary KP
Chief Secretary AJK
Chief Secretary GB
Chief Commissioner Islamabad Capital Territory
Health Secretary Punjab
Health Secretary Sindh
Health Secretary Balochistan
Health Secretary KP
Health Secretary AJK
Health Secretary GB
Deputy Commissioner Islamabad
District Health Officer Islamabad

Letter No. 801/A/ /NCOC-01 dated 07 October 2020

CC
Ministry of National Health Services, Regulation & Coordination
GHQ, MO-4A
NCOC Ops and Plans Branch

Chief Secretary
Govt. of Khyber Pakhtunkhwa

Secy: Rlts
Health Secy

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Annexure A

QUANTIFIED TRIGGERS & CORRESPONDING NPIs

1. Context
   a. Pakistan's positivity continues to remain about 2 % despite opening up of all sectors while a number of countries across the world are experiencing 2nd wave of disease.

Peak	Date	Spain	UK	Netherlands	France	Poland
1st	Cases / Positivity (Mar/April)	9181 (18%)	5450 (33%)	1119 (20%)	7578 (19%)	545 (3.4%)
2nd	Cases / Positivity	12,272 (12.5%)	6873 (3%)	7382 (9%)	13072 (9%)	1584 (8.5%)

   b. Slight increase in number of cases observed during recent past- 799 & 798 Cases on 24 & 25 Sep (highest since 18th August 20).
   c. Delayed Post Muharram effect, urban flooding, temperature drop and opening up of all sectors could be possible reasons for 2nd wave.
   d. General sense of complacency prevails and SOPs are being ignored.
   e. Despite substantial efforts on implementation of SOPs, opening of educational institutes with approaching winter season may have its effects on disease spread.
   f. Proactive disease control measures are essential to control spread and hence no room for complacency.

2. Conclusions from Institutional Memory
   a. Pattern of disease spread will never be uniform across the country. Major urban centers will have maximum disease burden.
   b. Disproportionate, ill considered & impulsive responses cause enormous socio-economic cost – Targeted actions in areas with maximum disease burden.
   c. Disease control strategy which worked was: -
      (1) Bold / broad SLDs & Extensive contact tracing.
      (2) Quarantine and SOP enforcement.
      (3) Consistent pursuance / pressure on provinces to stringent implementation of the strategy.
   d. Major cities with better health infrastructure attract patients from other cities / provinces and therefore caused saturation effect.
   e. Saturation / near saturation of hospitals result into panic amongst Doctors / HCWs coupled with media hype & disinformation creates a sense of "Paralysis of state machinery"; following is essential: -
      (1) Efficient management at health facilities.
      (2) Efficient working of Nigh ban App and its usage by ambulance services.
      (3) Management of COVID patients at THQs / DHQs.

(P-T-O)

(4) Lateral shifting of patients to appropriately utilize health facilities [illegible] Vents.

	Total Active Cases	Total Admitted	On Oxygen	On V[illegible]
1st Peak Hospitalization Experience	66000	6000	2500	60[illegible] sa[illegible]
		9% of Total Active Cases	(a) 41% of Admitted Pts (b) 3.7% of Active Cases	(a) 10% Admi[illegible] (b) 0.9% [illegible] Cases
Current Hospitalization	8400	684	334	85
	684	12% of Total Active Cases	(a) 48% of Admitted Pts (b) 3.9% of Active Cases	(a) 12.4% Admitted P[illegible] (b) 1.01% Active Cas[illegible]

f. Doctors / HCWs & RRTs were infected. Therefore, contingency plans to be formulated to ca[illegible] for deficiency.

g. Information domain – load of disinformation about disease spread, COVID deaths, hospital saturation, hospital.

h. management, bribery etc – need for strategy to manage and dominate info space.

i. Official quarantine facilities help in isolation of IPs which do not have suitable arrangements for home quarantine.

j. Timely capacity building of health facilities in essential to sustain disease burden – Oxygenated beds.

3. **Objective** A precise, targeted and proportionate response to control disease spread through graduated and incremental NPIs based empirical evidence while minimizing socio economic cost.

4. **Planning Parameters**

a. National / provincial level lockdowns not viable/sustainable due to socio economic cost. Targeted actions in precise localities, cities & sectors where positivity is observed (Top 10 or 15 cities).

b. Incremental application of NPIs corresponding to disease spread to retard transmission / disease spread in identified hotspots / cities & specific sectors.

c. While Quantified triggers for educational institutes shall remain in place; lockdown of any particular area would essentially mean closure of schools in that area as well.

d. Targeted action in high risk activities (educational institutes, shopping malls, recreational parks, marriage halls, tourist spots etc) for specified time period.

e. Two set of data drivers for decision making and implementation of NPIs:-

(1) Average positivity spread over two weeks to address the issue of erratic reporting, lab contamination and low testing quantum in certain provinces such as GB, Sin & AJK.

(2) Hospital admissions data.

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5. **Quantified Triggers & Corresponding NPIs**

Triggers	Actions
3-5% positivity	1) Massive media campaign for sensitization – Risk communication by SAPM health & Warning of stringent NPIs / closures. 2) Implementation of MSLDs & Quarantine Enforcement. 3) Increase in testing Aggressive contact tracing, Quarantine enforcement of 100 % IPs. 4) Strict actions against SOP violations – Schools, marriage halls, shopping centers/markets etc. 5) Enforcement of mask wearing – fines.
6-9 % positivity	**In Addition to Actions Listed Above: -** 1) Risk communication increases in frequency & magnitude – Warning for imminent implementation of NPIs. 2) Imposition of broad based SLDs in hotspot cities with stringent enforcement of protocols. **(Appendix I to Annexure A)** 3) Targeted actions (based on empirical evidence) against specific sectors in specific cities e.g. closures of cinemas / tourist spots / public parks etc. 4) Closure of shopping malls & marriage halls & educational institutions in specific cities based on positivity. 5) Work from home be encouraged. 6) Ban on mass gatherings – processions / entertainment / cultural activities in specific cities 7) Closure of selected educational institutes (based in localized risk assessment) in specific cities.
10-12% Positivity	**In Addition to Actions Listed Above** 1) Increase in number & size of SLDs i.e. Colony / UC / Town Level SLDs 2) Work from home to be enforced in hotspot cities. 3) Reduced timing for commercial activities in specific cities based on positivity. 4) 25 % increase in RRTs.
13% or beyond	**In Addition to Actions Listed Above** 1) Smart lockdown at city, tehsil & district levels. 2) All markets / shops closed – only essential services to function in hotspot cities for specific periods based on local assessment. 3) Closure of identified industries in specific cities (policy decision to be made based on prevalent environment). 4) Armed forces in aid of civil power if required.

(P-T-O)

6. Policy Level Decision Points

Decision Points	Actions	Triggers
Decision Point -1 Large Size Closures	1) Policy level review of disease control strategy for NPIs / closures of specific sectors at Divisional or Provincial or national level e.g. a) Closure of tourism b) Closures of hotels / restaurants c) Closures of schools d) Closures of industries e) Closures of markets / shopping centers	When Health Facilities are filled up to 25% in a province or major urban center or district / based on recommendation by NCOC
Decision Point-2 Capacity enhancement	2) Execution of contingency plans a) Enrolment / earmarking & training of staff for increasing RRTs. b) Enrolment of Doctors / paramedics. c) Provision of doctors/paramedics to other provinces facing more disease burden. d) Inter district shifting of resources / Patients	When Health Facilities are filled up to 35-40 % in a province or major urban center or district / based on recommendation by NCOC

7. Implementation Guidelines

a. Actions by Provinces

(1) Do not allow positivity to rise beyond 3%.

(2) Hospital admission should never cross 50% of capacity – Lateral shifting of patients.

(3) Official quarantine facilities to be kept functional.

(4) Increase testing quantum.

(5) Ensure 100% functioning (including availability of HR) of existing COVID Beds, Oxygenated Beds & Vents.

(6) COVID patients' management / admissions at THQs/DHQs.

(7) Improvement in hospital management.

(8) Prep of contingency plans for RRT. Paramedics / Doctors enrollment on short notice.

b. Actions by NDMA

(1) Contingency plans for Hospital Ramp up if required.

(2) Emergency procurement of critical medical equipment & medicine on short notice.

(7)

Appendix I to
Annexure A

SLD PROTOCOLS

1. Total restriction on movement except extreme emergencies – residents will remain closed in their houses.
2. All markets / shops / commercial activities will remain closed except grocery & medical stores/clinics.
3. There will be no transport plying within / to/from the area under locked down.
4. All educational & vocational institutes will be closed.
5. Metro stations located in SLDs to remain closed.
6. Local administration to issue prior notification (about 24-48 hours before imposition) about SLD imposed in an area.
7. Duration of lockdown should be minimum 10-14 days, on termination may be reviewed by provincial government.
8. Exit control through LEAs – Entry / exist may be controlled by employing local community under arrangement of LEAs.
9. Local community may be employed for logistic support if required.
10. Notification of the smart lockdown by government so as to serve as authority for employees for not attending places of duty.
11. Announcement at local levels to inform population in the same area and surrounding areas. Announcement to be made in Masjid, Local Print/Cable/Electronic Media & through Posters.
12. Coverage in national media.
13. Supervision by Local Administration for ensuring compliance.