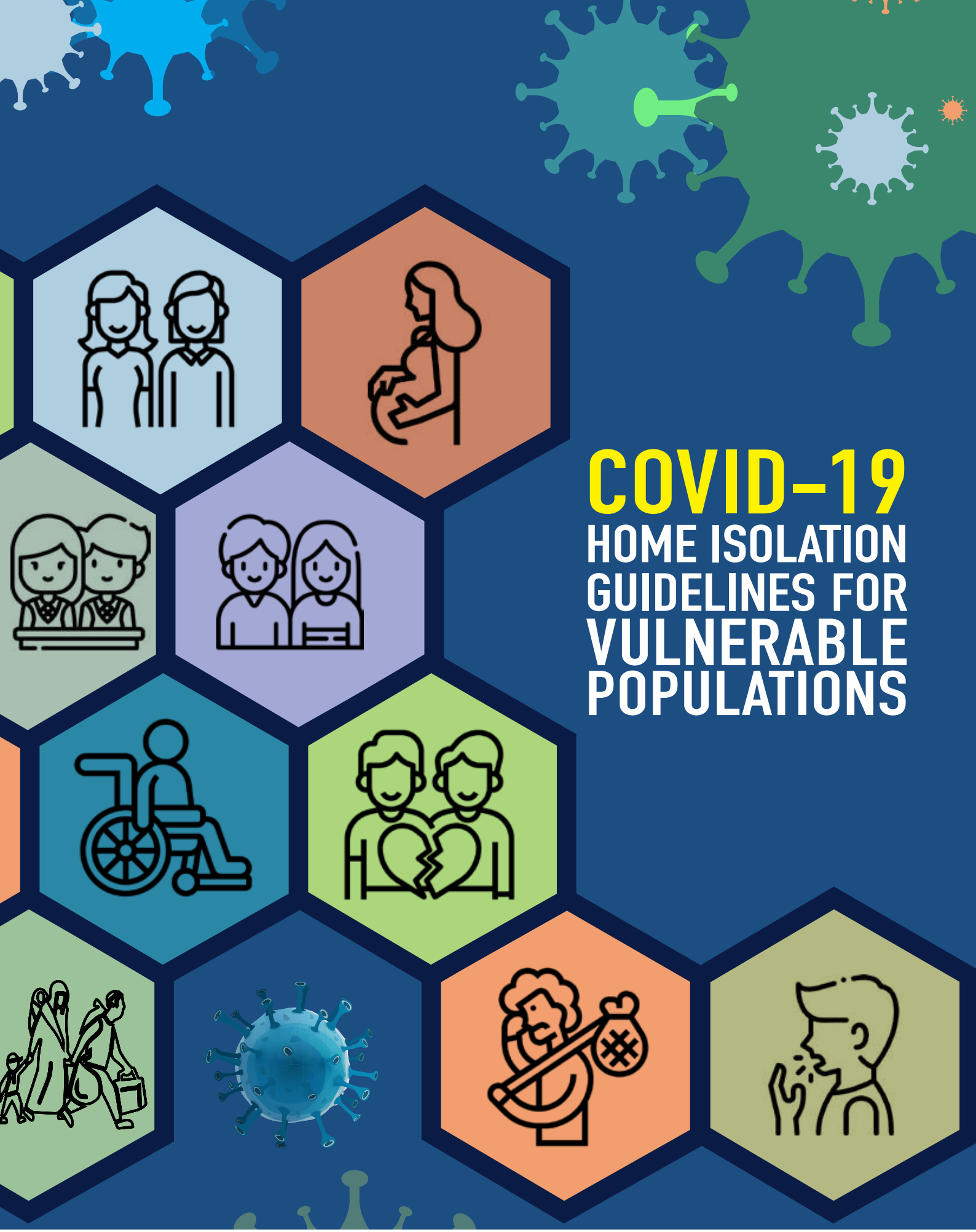

# COVID-19
# HOME ISOLATION GUIDELINES FOR VULNERABLE POPULATIONS

USAID FROM THE AMERICAN PEOPLE

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IAPSM
Indian Association of Preventive & Social Medicine

# COVID-19
# HOME ISOLATION GUIDELINES FOR VULNERABLE POPULATIONS

Developed by USAID-NISHTHA/Jhpiego and IAPSM

# FOREWORD

# DR. SUNEELA GARG

**National President, IAPSM and Organized Medicine Academic Guild (OMAG)**

The COVID-19 pandemic brought in unprecedented challenges across the country over the two years. The pandemic highlighted the importance of public health response during health emergencies. During this time state governments responded quickly and innovatively to face this unprecedented crisis despite structural limitations due to limited resources. One such important and innovative practice was providing home-based care to a large number of patients. Given the large number of cases, the Government of India developed home based care guidelines to reduce the burden on health systems and enable treatment of mild cases within the comfort of their homes. Home-based care can significantly augment health systems capacity with the help of digital tools. Treatment and care provided at home can significantly reduce complications, improve recovery, reduce spread of infection, and reduce hospital admissions.

However, it is important to note that the pandemic has impacted different sets of population differently. Marginalized and vulnerable groups such as the urban poor, tribal populations, pregnant and lactating women, children, people with mental illnesses; persons with disabilities, LGBTQIA+ population among others have traditionally suffered from inequitable distribution of health services and resources. The COVID-19 pandemic has further exacerbated these differences leaving these groups all the more vulnerable.

In view of this, the operational guidelines for home management of vulnerable populations was conceptualized and developed by IAPSM in collaboration with USAID's flagship health system strengthening project NISHTHA, implemented by Jhpiego in consultation with various experts to supplement the Government of India's guidelines on home isolation. This document aims to provide additional insights on home isolation/ management of these sub-groups of population and help and empower the program managers and health functionaries at various levels in ensuring better home management of COVID-19 for vulnerable populations. We are hopeful that these guidelines will long a way in ensuring effective implementation of home isolation among the marginalized and vulnerable populations in the country.

**Dr. Suneela Garg**

# FOREWORD
# DR. BULBUL SOOD

**Senior Strategic Advisor, Jhpiego**

The COVID-19 pandemic has impacted populations at large across the world. However, the impact on the marginalized and vulnerable populations is much more severe and devastating. COVID-19 exacerbated many of the challenges already faced by vulnerable populations. Further, the physical distancing norms and lockdowns not only restricted their movements but also had an impact on their livelihoods. These vulnerable populations also face an increased risk of contracting COVID-19, greater demand for services and social supports, and reduced access to treatment.

During the second wave of the pandemic, home isolation emerged as one of the most critical strategies and components to address the current pandemic. In view of this, Government of India developed an elaborate home isolation guideline which highlighted the when, what, how of home-based care for the public at large. However, it is important to take into account the varied needs of the population especially the vulnerable and marginalized groups to ensure that they are well protected from the pandemic.

In view of this, USAID's flagship health system strengthening project NISHTHA, implemented by Jhpiego in collaboration with IAPSM and in consultation with various experts developed a detailed home isolation guideline for vulnerable populations to supplement the Government of India's guidelines. These guidelines highlight the various home-based care practices that can be adopted for these vulnerable populations in ensuring better home management of COVID-19 for vulnerable populations and providing decentralized care. We are hopeful that this guidelines will help other partners and implementing organizations in ensuring effective delivery of home based care for these vulnerable populations, thereby ensuring that no one is left behind.

Bulbul Sood.

Dr. Bulbul Sood

# ACKNOWLEDGEMENTS

This guidelines on Home Isolation for Vulnerable Populations has been developed by USAID's flagship health system strengthening project NISHTHA, implemented by Jhpiego in collaboration with IAPSM. These guidelines have been developed to supplement the Government of India's home isolation guidelines and to ensure effective implementation of home-based care for vulnerable populations.

We would like to especially thank the USAID team – Ms. Sangita Patel, Director, Health Office; Dr. Amit Shah, Deputy Director, Health Office and Dr. Anuradha Jain, Technical Advisor, Health System Strengthening for their overall guidance and support in developing these guidelines.

This document was developed in consultation with various experts including Maj Gen (Prof) Atul Kotwal, Executive Director, National Health Systems Resource Centre (NHSRC), New Delhi; Dr A M Kadri, Executive Director, State Health Systems Resource Centre, Gujarat, Secretary General, IAPSM; Dr T Sundararaman, Independent Consultant, Puducherry, India, Former, ED, NHSRC, New Delhi; Dr Abhay Bang, Founder, Director, Society for Education, Action and Research in Community Health (SEARCH), Maharashtra; Dr Bulbul Sood, Senior Strategic Advisor, Jhpiego, New Delhi; Dr Sanjana Mohan, Director (Nutrition), Basic Healthcare Services, Udaipur, Rajasthan; Ms Mirai Chatterjee, Self Employed Women's Association (SEWA), Ahmedabad, Gujarat; Dr Vaishali Kolhe, Assistant Professor, Centre for Disability Studies and Action, Tata Institute of Social Sciences (TISS), Mumbai, Maharashtra; Dr Basavaraju, Deputy Director, Grassroots Research and Advocacy Movement (GRAAM), Karnataka; Dr Yogesh Jain, Founding Member, Sangwari, Chhattisgarh; Dr Kishore Kumar, The Banyan, Chennai; Dr Santosh Kumar Giri, Executive Director, Kolkata Rista, Kolkata, West Bengal; Mr Amulya Nidhi, Founder, Co-convener, Swasthya Adhikar Manch, Madhya Pradesh.

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Lastly, we would like to thank Dr. Chandrakant Lahariya for supporting the NISHTHA team in developing and finalizing these guidelines. We are hopeful that this document will aid in showcasing the various home-based care interventions for vulnerable populations during these testing times and help in cross learning between states.

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# Index

# ABOUT THE **GUIDELINES**

The COVID-19 pandemic has impacted millions of lives irrespective of age, gender, nationality or race. However, it is important to note that the impact has been more devastating on certain vulnerable and marginalized groups. Marginalized and vulnerable groups such as the urban poor, tribal populations, pregnant and lactating women, children, people with mental illnesses; persons with disabilities, LGBTQIA+ population among others have traditionally suffered from inequitable distribution of health services and resources. The COVID-19 pandemic has further exacerbated these differences leaving these groups all the more vulnerable. In view of this, the operational guidelines for home management of vulnerable populations has been developed by USAID's flagship health system strengthening project NISHTHA, implemented by Jhpiego and IAPSM in consultation with various experts to supplement the Government of India's guidelines on home isolation. This document aims to provide additional insights on home isolation/management of these sub-groups of population and highlight a few best practices to help and empower the program managers and health functionaries at various levels in ensuring better home management of COVID-19 for vulnerable populations. This document intends to be a working document which may be updated based on field experience, expert inputs and changing guidelines based on the changing needs of the pandemic. The document is recommendatory in nature and aims to supplement the existing home isolation guidelines developed by Government of India for better implementation of the COVID-19 response.

## Target audience

This document is intended to be beneficial for policy makers, administrators, healthcare providers, as well as communities and families in effectively planning and executing home/community-based isolation and management of asymptomatic/mildly symptomatic COVID-19 patients.

## Methodology

The necessity for a detailed granular approach for home isolation of vulnerable groups has been suggested by subject experts and community members. Subsequently, an exploratory and informal focused discussion was held in mid-May 2021 to understand the requirements and identify vulnerable groups.

Thereafter, in late May 2021, a list of vulnerable groups was prepared and relevant available details on home isolation for vulnerable populations were collated. This was followed by an active engagement session with subject matter experts, who were invited for two webinars, held on June 1 and 3 2021. The experts shared insights on how to effectively implement home isolation for each of the vulnerable groups. These webinars were conducted under the broader theme of "**Leaving no one behind**".

The inputs from 13 experts and select suggestions from nearly 450 participants in these two webinars were synthesized. Thereafter, a revised draft was prepared and circulated to a wide list of experts who shared detailed inputs in writing. The draft was reviewed in a virtual expert consultation held on June 16, 2021. The consultation was attended by 35 experts across professional associations, public health experts, academicians and a range of specialists relevant to guidelines such as clinical medicine, pediatrics, tribal health, disability and LGBTQIA+ etc. Following the consultation, inputs were incorporated and the guidelines was finalized jointly by USAID-NISHTHA and IAPSM. With new information emerging about the disease, the document was reviewed in January 2022.

# LEAVING NO ONE **BEHIND IN COVID-19 PANDEMIC**

## Context

Home isolation of COVID-19 patients, who are asymptomatic or have mild symptoms, has been recognized as an important strategy for COVID-19 case management in India. This reduces the burden on the healthcare establishments and results in efficient utilization of scarce resources for moderate and severe COVID-19 patients.

Home isolation under appropriate guidance provides some distinct benefits such as care in a familiar home environment, reduced burden on healthcare services, lesser risk of healthcare associated infections and reduced cost of care to the family. In view of this, home isolation has been scaled up as effective strategy for management of mild and asymptomatic patients in India.

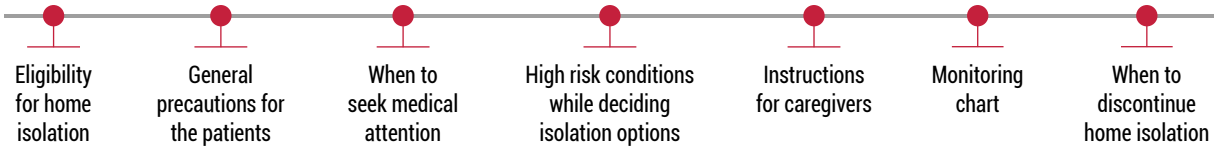
Given that the pandemic has impacted the vulnerable and marginalized groups disproportionately, it important to contextualize COVID-19 management strategies for these groups to ensure no one is left behind in COVID-19 pandemic. Therefore, in spite of distinct advantages of home isolation, there are few vulnerable population groups, for whom the generic home isolation strategy may not be feasible.

## Government of India's Home Isolation Guidelines

Home isolation guidelines were first released by Ministry of Health and Family Welfare (MoHFW) in July, 2020, and were revised in May, 2021 and January, 2022. Further, on May 16, 2021, an additional document on 'Management and containment of COVID-19 in rural and peri-urban areas' was released, which elaborates and provides additional details on home isolation.

Operational guidelines for home management of vulnerable populations is a guiding document, developed with an intention to operationalize and strengthen home isolation strategy, particularly for vulnerable population in India. This document aims to work as 'add-on' expert guidance for anyone who is implementing the government strategy on home isolation.

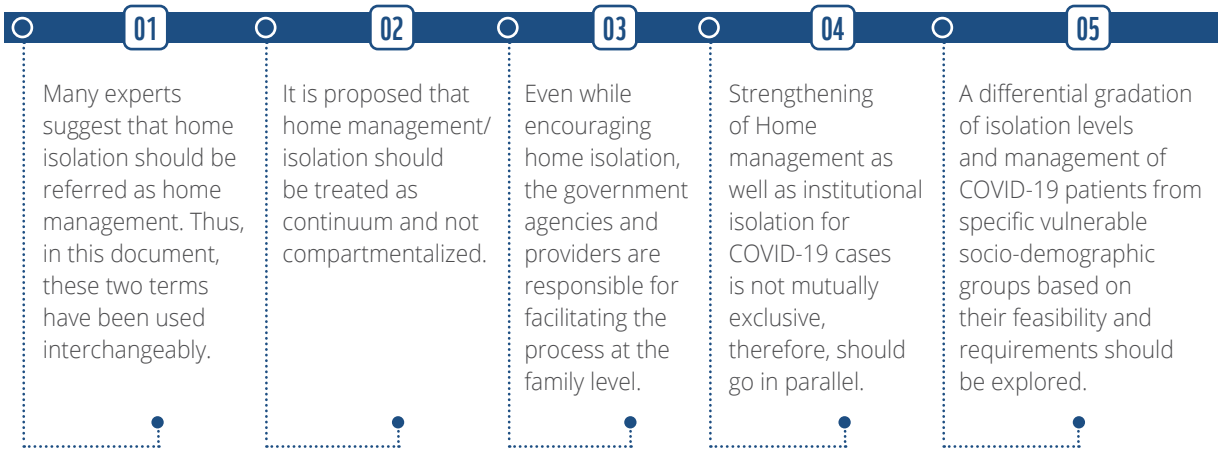
Key features of the home isolation guidelines are –




*Refer to Annexure 1 for more details*

# How to read/use this document?

This document is the outcome of multiple iterative consultations between experts from various domains of health policy and implementation. To anyone who read this document, we want to highlight following points:




The document is a comprehensive guide where attempts have been made to cover all broader aspects of home isolation/management. However, it has been structured to permit access to specific sections of information if needed. The next section describes the broader principles, which are applicable to all vulnerable population groups listed thereof. Therefore, while planning home management for any vulnerable population group, the broader principles should be referred to first followed by the specific strategies for each of the vulnerable group.

# HOME ISOLATION FOR **VULNERABLE POPULATIONS**

Socio-economically disadvantaged groups such as migrants, urban poor (urban homeless and slum population), women, informal workers, tribal and rural population have been disproportionally impacted by the pandemic given their socio-economic conditions and are often the ones that are 'left out' from any response. In view of this, it is important to adopt and implement a contextualized approach for management of COVID-19 among these groups. The following sections of the document proposes differential operational approaches for each of these vulnerable groups along with overarching broader principles of care to encourage effective implementation of home isolation guidelines. Though this is not an exhaustive list, an effort has been made to cover the concerns of a wide range of sub-groups.

## Vulnerable groups

Vulnerability refers to "the increased risk of exposure of the community toward hazards". Vulnerable and key populations include populations that live in poverty with limited access to basic amenities such as safe housing, water, sanitation and nutrition and are often the ones who are stigmatized, discriminated against, and marginalized by the society. In alignment with the proposal and strategies recommended by the Government of India and the latest MoHFW guidelines, recommendations for following sub-populations have been covered in this document:

- **Urban poor (+ homeless)**
- **Migrant population**
- **Tribal population**
- **Pregnant & lactating women**
- **Children/pediatric age group**
- **Persons with disabilities**
- **LGBTQIA+ & female sex workers**
- **Persons with medical conditions TB & HIV**
- **Persons in occupational environment**

# Broader principles for operationalizing differential home management[1]

These guidelines suggest a graded approach to isolation and management – from home-based to community based, and finally institution-based. However, the approach needs to be based on triaging, taking in to consideration, both clinical and socio-economic parameters. Thus, in order to ensure successful home/community-based management of mild COVID-19 patients, following considerations should be of key focus:


## Empowering Individuals and Communities

- **A shared responsibility needs to be built among the community, healthcare workers, patients and their families** for extending care to the patient. The community can play a crucial role in ensuring supply of essential and non-essential consumables – dry ration or cooked meals, soap and masks, etc. to the isolated patients.
- **Community and family members should have access to information on COVID management guidelines** which need to be communicated in a clear, concise, and simple language, understandable to the target population. It is essential to communicate the do's and don'ts of home/community-based isolation and management, including information on appropriate medication and supplementary treatment.
- **Existing community structures and local NGOs or community volunteers should be leveraged** to address and resolve the stigma, misinformation and fear surrounding the disease. Brief, unambiguous and simply phrased information about the disease and its epidemiology should be disseminated through these community-based social support groups and NGOs.
  - Pre-existing social groups, such as Mahila Aarogya Samiti (MAS), Self Help Groups (SHGs), etc. can play a vital role in providing much-needed support.
  - IECs, radio jingles, and involving the panchayats, farmer organizations, community elders and opinion leaders can also spread awareness and reduce stigma associated with getting tested.
  - Law enforcement agencies can be sensitized as a deterrent to pre-empt and discourage stigmatization and discrimination within the community.
- **Home/community-based isolation and management to be considered as complementary to institutional care.** Individuals experiencing mild/asymptomatic COVID-19 symptoms should be able

[1] While 'home isolation' has been technically used to describe the process of confining and managing asymptomatic/mildly symptomatic COVID-19 patients at home, experts have argued that there are merits in calling it 'home management' or 'home-care' of patients, which reflects the essence of this approach. Consequently, in the present document we have used home/community-based isolation and management as replacement term to encompass its broader aspects and nullify some of the undesirable connotations associated with the term "home isolation".

to make an informed choice – based on triaging done on a pre-defined criterion, laid by MoHFW, for opting for institutional or home/community-based isolation and management.

## Ensuring Access to Services

- Setting up **Dedicated Mobile Medical Units (MMUs)** for visiting target settlements on fixed days or as required. These MMUs should be staffed by trained and skilled healthcare personnel to provide basic treatment for COVID-19.
- The concept of **Mobile Testing Units (MTUs)** should also be explored to maximize the reach of testing facilities for vulnerable groups who face difficulty to access care. These MTUs may be staffed with personnel/technicians who are trained to perform Rapid Antigen Tests.
- **Telemedicine initiatives can be put in place** to facilitate early identification and triaging of the affected individuals and communities at the village/community level. Panchayat Bhavans/schools/community halls/other community spaces can be utilized for conducting these sessions with the Community Health Officers (CHOs). Health and Wellness Centres (HWCs) at sub-centre level should be encouraged to run dedicated Influenza Like Illnesses/ Severe Acute Respiratory Illnesses (ILI/SARI) tele-OPD with fixed time slots every day to cater to telemedicine requirements.
- A **home/community-based isolation and management information kit** may be provided to every family where case(s) have been identified for home isolation. This kit should include IEC materials like pictorial pamphlets elaborating the guidelines on precautions to be taken and when to seek medical care, medication details, monitoring devices such as pulse oximeters, thermometers, monitoring proforma during home/community-based isolation and management, along with discharge criteria, and contact details of frontline worker and nearest health facility in case of any emergency.

## Active Monitoring and Establishing Linkages

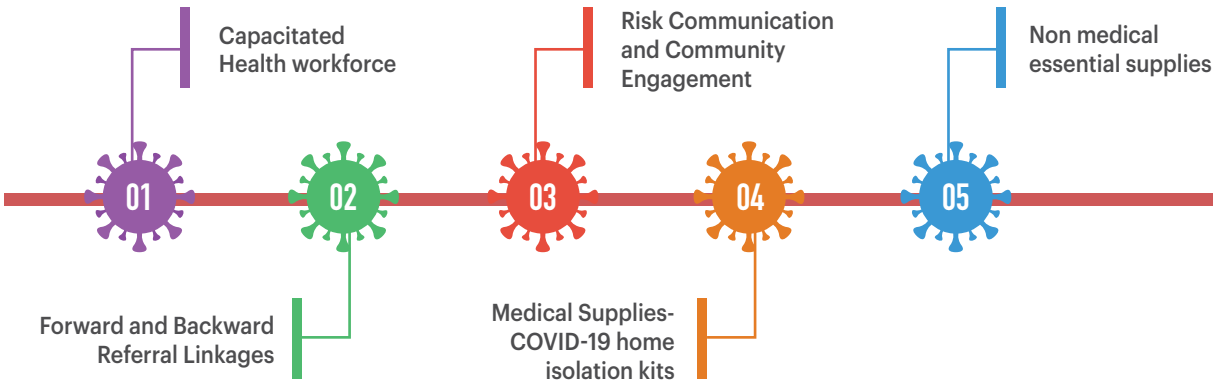
- **Contact tracing and other surveillance activities** must be continued even for cases under home/community-based isolation and management.
- **Early identification of danger signs and symptoms of COVID-19** should be facilitated by informing caregivers, in order to ensure timely referral of critical cases to reduce complications and mortality.
- **Periodic home visits by the frontline worker/community volunteers** would ensure adherence to guidelines of home isolation, COVID appropriate behavior, delivering medication and need for timely and higher level of care.
- Frontline workers/community volunteers, undertaking these visits may be provided with **COVID-19 monitoring kits** comprising of two to three pulse oximeters and thermometers each. These devices can also be given to patients under home-isolation for regular monitoring for the duration of their isolation.
- **Regular two-way communication** between points of contact in villages and mobile medical units/community health officers/ANMs can encourage active surveillance and sensitization of when and where to seek healthcare.
- **Private practitioners, pharmacy owners, unregistered medical practitioners, etc. can be leveraged** for strengthening surveillance efforts. These practitioners can also support in improving linkages of the patients with the appropriate facilities for treatment and management. As these local practitioners are usually well connected within their communities, they can play a vital role in community mobilization

and sensitization, thereby enhancing early identification and reporting of COVID-19 cases. Volunteers or organization especially working for marginalized and vulnerable groups can be involved, as deemed appropriate.

- **State helplines can be a vital link between isolated patients and the formal healthcare system.** Platforms such as video calls, tele-callers, Integrated Voice Response Systems can be leveraged for active monitoring of patients on home isolation. Patients in community-based isolation spaces can be contacted through installed landline facilities.

## Emphasizing Overall Wellbeing

- Ensuring focus on maintaining proper nutrition and diet for patients under isolation. Provision of dry ration or cooked meals to be explored through community kitchens, local NGOs or other SHGs.
- Creating awareness on maintaining proper nutrition and being physically active needs to be done at the community level by tapping on various medium of communication such as print media, mass media. Local community structures and influencers and traditional media. Persons under isolation and their family members should be sensitized regarding the importance of proper diet and physical wellbeing in recovering from COVID-19 infection.
- Home/community-based isolation and management should also account for provisions to provide emotional, psychological and social support. Isolated patients often feel excluded; therefore, **communication between individuals and their families/communities** before, during and after the completion of home isolation to be encouraged. Concept of **community-based models for mental health** can be explored by states and districts.
- In special cases of COVID-19 where the patient needs support in routine activities, isolation of such patients, accompanied by a caregiver to be explored. For instance, isolation of children or persons with disabilities etc.
- **Telehealth and helplines** have been used extensively during the first and second wave of COVID-19 for improving access to healthcare. The existing telehealth platforms and helplines should be publicized and leveraged to ensure that the persons affected by COVID have access to healthcare and are able to seek timely healthcare in case of worsening of symptoms or complications. In addition, similar helplines may be established to provide psycho-social support to COVID-19 patients under home isolation.



# Five components of successful implementation of home/community-based isolation and management

1. **Capacitated Health Workforce:** Training and skill building of health workforce on basic principles of COVID-19 treatment and management, surveillance and monitoring of cases under home isolation for early identification of critical patients is pertinent to establish a robust mechanism to reduce mortality and contain the spread of infection. Capacity building of ASHAs, Multi-Purpose Workers (MPWs), Anganwadi Workers (AWWs), Community Health Officers (CHOs), local pharmacists, other registered and non-registered medical practitioners, private practitioners, community volunteers and local NGOs on surveillance, contact tracing, monitoring and management should be done on a regular basis as per the changing needs of the pandemic.

2. **Forward and Backward Referral Linkages:** A well-functioning referral system is essential for ensuring adequate, appropriate and timely care for patients. The referral system should be linked to community-based monitoring and surveillance systems to reduce response time. In addition, a well-equipped ambulance facility should be on stand-by for timely transportation of critical patients to referral health facilities for better clinical care. Strengthening of tele-consultation services should be done by training tele-callers for providing concise, clear, and uniform messages for effectively connecting the patients with appropriate level of facility for care. In continuation, focus on backward referral, that is ensuring care and follow up of patient on return to home/ community after discharge from higher facility should also be prioritized. This can be achieved by training and sensitizing the frontline functionaries for regular monitoring of COVID-19 recovered patients for any post-COVID complications.

3. **Risk Communication and Community Engagement:** Building trust among the communities is integral for ensuring a successful COVID mitigation plan. A successful home isolation plan needs to incorporate strategies around mitigating risk through active communication and community engagement. This should include rolling out IEC/BCC campaigns around infection prevention and control, COVID appropriate behaviors, early identification of COVID signs and symptoms etc. through various mediums. Community engagement through dialogues with community opinion leaders can be practiced to design culturally appropriate communication modules, and IEC/BCC campaigns with the help of local NGOs which work with communities. Use of traditional and folk media also to be leveraged based on the preferred and common sources of information for the different groups.

4. **Medical Supplies- COVID-19 home isolation kits:** Management of COVID patients under home isolation can be supplemented with provision of home isolation kits. These kits may comprise of pulse oximeters, mercury/digital thermometers, and essential medicines [paracetamol, ORS, zinc (for diarrhea in children), etc.]. Further, where resources are scarce and limited, a floating home isolation bank may be created wherein the kits are lent to the patients and taken back once their isolation period is over. These kits are then sanitized and kept ready for future re-use. Similarly, equipment such as sphygmomanometers, glucometers, etc. can also be provided to the monitoring teams of frontline workers or community volunteers which can be accessed by patients with comorbidities, if required.

5. **Non-medical essential supplies such as** dry ration, food and financial support can be made available for individuals and families affected with COVID-19, belonging to vulnerable groups to reduce the devasting impact on families. Uninterrupted supply of at least three nutritious meals a day should be ensured. Community kitchens can be set up to support such patients/families. They may also be provided with masks and soaps (to ensure proper hygiene), dry rations and nominal financial support, especially if the breadwinner of the family has taken ill. At the same time, biomedical waste collection should also be mandated through a pre-agreed, segregated process to further avoid the spread of infection in the community.

# Home Management for Vulnerable Populations at a Glance

| POPULATION GROUP |  **Urban Poor - Includes Slum Dwellers, Migrants, Homeless, Destitute, And Street Children Among Others** |  **Migrant Population** |
|---|---|---|
| VULNERABILITIES | - High population density<br>- Overcrowded living conditions<br>- Poor sanitation and hygiene<br>- Poor nutrition<br>- Restricted and limited access to healthcare<br>- Poor purchasing capacity<br>- Lack of financial (social) security access to resources and quality healthcare facilities | - Mobile at-risk population<br>- Unemployment<br>- Unorganized sector or blue-collar jobs<br>- Overcrowded living conditions with shared spaces<br>- Financial constraints<br>- Limited access to social security schemes |
| SPECIFIC PRINCIPLES OF CARE | - Strengthening established linkages to health facilities<br>- Bringing health care closer to communities through MMUs, telemedicine, helplines, home based visits etc<br>- Strengthening surveillance to curb spread of infection<br>- Improve access to<br>» quality health care<br>» essential medicines and equipment<br>» nutritious food<br>» hygiene and sanitation<br>» correct information | - Strengthening health care and bringing it closer to community through MMUs, rapid testing centers etc<br>- Provision of correct information about the disease, treatments and referral mechanism.<br>- Community mobilization<br>- Provision of financial support<br>- Ensuing availability of basic amenities:<br>» Nutritious food and water<br>» Hygiene and sanitation |
| HOW TO PROVIDE CARE | - Upgrade community-based isolation spaces<br>- Enable community mobilization through frontline functionaries and community volunteers<br>- Establish Mobile Medical Units (MMUs), local rapid testing centers and telehealth services to bring health care closer<br>- Leveraging existing local private practitioners, registered medical practitioners or local NGOs to strength surveillance | - Strengthen community-based isolation spaces<br>- Bringing care closer by setting up mobile medical units, mobile rapid testing centers<br>- Improvised access of care<br>- Provisioning of amenities like food, water and shelter spaces for family and non-positive individuals<br>- Ensuring provisioning of financial support in case of wage loss due to illness |
| WHO WILL PROVIDE CARE | - Family members Frontline functionaries (ASHAs, AWWs, and ANMs)<br>- Local NGOs<br>- Community volunteer | - Employers<br>- Government<br>- Opinion leaders<br>- Frontline functionaries (ASHAs, AWWs, and ANMs)<br>- Local NGOs<br>- Community volunteers |

| POPULATION GROUP | Tribal Population | Pregnant and Lactating Women |
|---|---|---|
| VULNERABILITIES | - Difficult terrains<br>- Inaccessible topography which makes service delivery challenging<br>- Low literacy levels<br>- Traditional cultural practices which render home isolation undesirable and stressful | - Increased vulnerabilities due to the physiological condition of the woman<br>- Sensitive development period for both mother and child<br>- Additional responsibilities such as household chores, taking care of family and other children making it difficult to take complete care of themselves<br>- Possibility of poor ANC care especially during lockdowns |
| SPECIFIC PRINCIPLES OF CARE | - Strengthening established linkages to health facilities.<br>- Special focus on referral and provisions to enable referral<br>- Strengthening surveillance to curb spread of infection<br>- Community mobilization to improve uptake of services through IEC that is contextualized to cultural settings<br>- Improve access to<br>» essential medicines and equipment<br>» nutritious food | - Focus on timely and regular access to care<br>- Nutritional support<br>- Access to essential medication and basic diagnostics<br>- Counselling support on ANC, PNC breastfeeding etc.<br>- Linkages to appropriate facility for care. |
| HOW TO PROVIDE CARE | - Upgrade community-based isolation spaces.<br>- Enable community mobilization through frontline functionaries and community volunteers.<br>- Establish MMUs, local rapid testing centers and telehealth services to bring health care closer.<br>- Leveraging local private registered practitioners and local NGOs to strength surveillance.<br>- Establishing services for tele-consultation.<br>- Provisioning of financial support in case of loss of wages. | - Tagging of the pregnant women with trained care givers for regular check-ups and timely referral.<br>- Training frontline workers on counselling support on breastfeeding, Kangaroo mother care, COVID appropriate behaviors.<br>- Pre-identified non-COVID facilities for deliveries.<br>- Enable referral through ensuring transport.<br>- Leveraging local NGOs for provisioning of nutritious meals. |
| WHO WILL PROVIDE CARE | - Tribal leaders<br>- Local healers<br>- Family members,<br>- Frontline functionaries (ASHAs, AWWs, and ANMs)<br>- Local NGOs<br>- Community volunteers | - Family members<br>- Midwives and frontline functionaries (ASHAs, AWWs, and ANMs),<br>- Local NGOs<br>- Community volunteers |

| POPULATION GROUP | Children and Adolescents | Persons with Disabilities |
|---|---|---|
| VULNERABILITIES | - Sensitive period of physical, social, cognitive and emotional development<br>- Dependency on caregivers for basic needs | - Limited access to healthcare services due to inaccessible environments<br>- Attitudinal, physical and financial barriers<br>- Increased vulnerabilities for persons with severe disabilities<br>- Communication barriers making it difficult e to understand their specific needs and requirements<br>- Inaccessible communication materials leading to low awareness and knowledge<br>- Higher risk of contracting COVID-19 and developing severe complications |
| SPECIFIC PRINCIPLES OF CARE | - Focus on early identification with special attention to co-existing morbidities<br>- Mental health support<br>- Strong referral linkages for hospitalization<br>- Access to<br>» Nutritious food<br>» Hygiene and sanitation<br>» Counselling support | - Disabled friendly healthcare services<br>- Prioritized referral linkages for hospitalization<br>- Ensuring financial security<br>- Access to<br>» Nutritious food<br>» Hygiene and sanitation<br>» Counselling support to patient and care-givers |
| HOW TO PROVIDE CARE | - Ensure isolation with care-givers<br>- Provision of nutritional support<br>- Provision of supply of sanitation material<br>- Access to essential medicines and diagnostics for children with pre-existing health conditions<br>- Training of care givers and health workers for care of children<br>- Strong referral linkages to be established for hospitalization.<br>- Counselling of mothers for continuation of breast feeding for 0-2 years children. | - Making community-based isolation spaces disabled friendly<br>- Training caregivers and health care staff for providing special care without discrimination.<br>- Disability friendly IEC material for information dissemination through media mix (use of audios, closed captioning, braille etc)<br>- Home based visits for regular monitoring<br>- Provision of financial aid in case of wage loss.<br>- Psycho-social support to care giver and patient<br>- Ensure supply of<br>» dry ration/cooked food;<br>» Assisted devices<br>» supply of sanitation products to ensure good hygiene practices, |
| WHO WILL PROVIDE CARE | - Parents, caregivers, family members,<br>- Frontline functionaries (ASHAs, AWWs, and ANMs)<br>- Local NGOs<br>- Community volunteers | - Care givers<br>- Doctors, psychiatrists, psychologists/ counsellors, doctors – subject matter experts<br>- Frontline functionaries (ASHAs, AWWs, and ANMs)<br>- Local NGOs<br>- Opinion Leaders<br>- Community volunteers |

| POPULATION GROUP |  **Persons with Medical conditions Like HIV and TB** |  **LGBTQIA+** |
|---|---|---|
| VULNERABILITIES | - Higher risk of contracting COVID-19 and developing severe complications<br>- Attitudinal, physical and financial barriers<br>- Stigma and discrimination remain major barriers to accessing healthcare services | - One of the most marginalized and stigmatized communities in India<br>- Attitudinal, physical and financial barriers<br>- Higher prevalence of STIs/RTIs<br>- Mental health challenges<br>- Stigmatization and ostracization<br>- Lack of access to avail basic services |
| SPECIFIC PRINCIPLES OF CARE | » Continuum of care – continued treatment for existing conditions.<br>» Tele-medicine services for consultations<br>» Address stigma and discrimination through trainings and IECs.<br>» Focus on nutrition<br>» Counselling and psycho-social support for patient and care-givers. | - Improved access to quality health care<br>- Essential medicines and diagnostics<br>- Strengthen referral linkages for testing and treatment/ hospitalization.<br>- Safe isolation spaces for community isolation<br>- Awareness and sensitization to curb stigma and discrimination through IEC<br>- Financial security<br>- Counselling and psycho-social support<br>- Training of healthcare workers for surveillance and monitoring |
| HOW TO PROVIDE CARE | - Ensuring continued treatment through ART centres and DOTs.<br>- Training of frontline workers to curb stigma and discrimination.<br>- Nutritional support for proper recovery.<br>- Establishing support groups for caregivers to seek active advice and address stigma & discrimination against the patient.<br>- Development and dissemination of appropriate communication and IEC material. | - Designated safe spaces for community isolation<br>- Establishing linkages to appropriate health facilities in case of hospitalization with provision for transport.<br>- Ensure provision and access to essential medicines diagnostic procedures.<br>- Ensure supply of dry ration or cooked food<br>- Financial aid in cases of loss of wage<br>- training of health workers on catering to special needs of the group.<br>- Community awareness generation and sensitization to reduce stigma and discrimination. |
| WHO WILL PROVIDE CARE | - Medical practitioners, care givers, community volunteers | - Care givers, community volunteers, frontline functionaries (ASHAs, AWWs, and ANMs) |

**POPULATION GROUP**

**Persons in occupational settings**

**VULNERABILITIES**

- Poor socio-economic conditions
- Unorganized sector of work resulting in uncertainty and poor working conditions
- Migrant population
- Low literacy levels

**SPECIFIC PRINCIPLES OF CARE**

- Strengthening access to health care
- Provision of correct information about the disease, treatments and referral mechanism.
- Community mobilization
- Provision of financial support
- Ensuring availability of basic amenities:
  - » Nutritious food and water
  - » Hygiene and sanitation

**HOW TO PROVIDE CARE**

- Strengthen community-based isolation spaces
- Bringing care closer by setting up mobile medical units, mobile rapid testing centers
- Ensure provision and access to essential medicines diagnostic procedures.
- Establishing linkages to appropriate health facilities in case of hospitalization with provision for transport.
- Provisioning of amenities like food, water and shelter spaces for family and non-positive individuals.
- Ensuring provisioning of financial support in case of wage loss due to illness.
- Training of frontline workers community volunteers to strengthen surveillance for early identification.
- Community awareness generation and sensitization to reduce stigma and discrimination

**WHO WILL PROVIDE CARE**

- Employers, contractors, overseers, family members

# OPERATIONAL APPROACHES FOR HOME ISOLATION AT A GLANCE
## Asymptomatic/Mild Symptomatic Cases

### HOME ISOLATION


**Suitable Vulnerable groups**

1. Urban Poor
2. Pregnant and lactating women
3. Pediatric age group
4. People with mental Illness
5. People with disabilities
6. People living with TB or HIV

**Key Features**

- Isolation with family or within home environment
- Better psycho-social support during the illness
- Reduced exposure to infections in hospital settings
- Appropriate for patients with ample facility (separate room, toilet) for isolation at home.

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### COMMUNITY COVID ISOLATION CENTRES (CCIC)


**Suitable Vulnerable groups**

1. Migrant workers
2. Occupational environment
3. Trial population
4. Urban Poor - Homeless
5. People with mental illness

**Key Features**

- Community based Isolation Centres
- 20 to 50 bedded facility without oxygen support
- Led by community or local authorities
- Provision of supervised care
- Better psycho-social support
- Improved access to hygiene and sanitation facility
- Appropriate for patients living in cramped households or having large family size

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### COVID CARE CENTRES (CCC)


**Suitable Vulnerable groups**

1. Occupational environment
2. Migrant Workers
3. Urban Poor- Homeless
4. LGBTQIA+
5. People living with HIV or TB

**Key Features**

- Government run Isolation Centres
- 50 to 100 bedded facilities without oxygen support
- Provision of supervised clinical care
- Access to medicines and diagnostics
- Improved access to hygiene and sanitation facility
- Improved access to referral facilities
- Appropriate for patients living in cramped households or having large family size

# Urban Poor

## Why this population is important?

India's urban population constitutes 31.16% of the total population, which amounts to ~377 million[2]. Around 25% of urban population is estimated to be living below the poverty line[3]. This includes slum dwellers, migrants, homeless and destitute along with street children among others.

The urban poor deals with multiple overlapping vulnerabilities including high population density, cramped living conditions, poor sanitation and hygiene, inadequate nutrition, and restricted access to resources and healthcare facilities in their daily lives.

## What experts working in this area suggest?

Home isolation provision for the urban poor is virtually impracticable as they often reside in overcrowded informal hutments/shanties with poor ventilation, and have to rely on communal resources of sanitation and hygiene. Moreover, overcrowding can lead to rapid transmission of COVID-19, giving rise to foci of transmission. Therefore, a nuanced and coordinated approach to home/community-based isolation is crucial for this population sub-group.

## How to make home/community-based isolation and management work?

### Health interventions

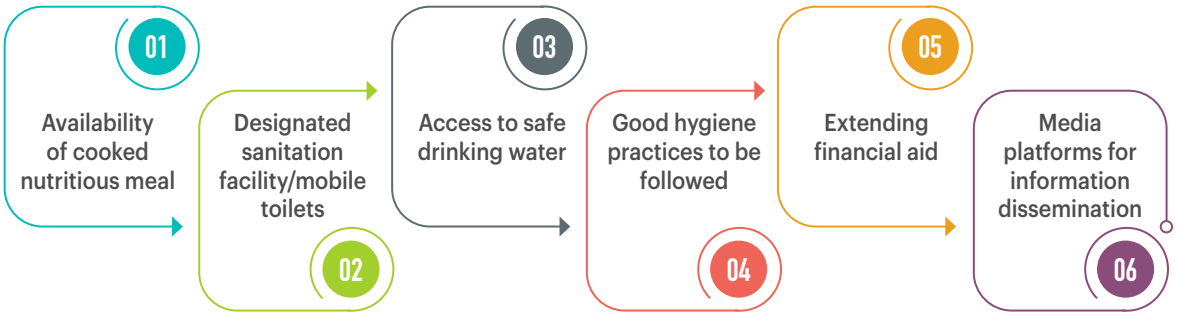

- **Upgrade temporary community-based housing and emergency isolation spaces with ventilation,** for homeless and other inadequately housed individuals. Explore options such as repurposing vacant schools, hostels, panchayat buildings, community halls and unoccupied residential facilities. In absence of pre-existing infrastructure as mentioned above Jhuggi-Jhopadi clusters/slums, an isolation space comprising of 2 – 3 rooms with separate sanitation facilities may be identified for every settlement of 50-200 families. These isolation spaces can be fitted with tele-medicine equipment for regular monitoring and follow-up.
- **Upgrade Sub-centres/Urban Primary Health Centres (PHCs) to include a Public Health Pandemic Clinics (PHPC).** The existing UPHC/Government fever clinic within the vicinity should be strengthened

[2] Accessed from: Census of India 2011 Provisional Population Totals: Urban Agglomerations and Cities. 2011.
[3] Accessed from: India-Urban Poverty Report 2009

and upgraded to provide required support. These can become first contact and referral points for patients in home isolation.

- Since much of the urban poor are unable to secure access to existing physical healthcare infrastructure, **Mobile Medical Units (MMUs) can be established to visit homeless clusters and informal settlements** frequently or as requested by community liaisons to identify symptomatic patients and treat those suffering from illness.
- Ensure regular monitoring of isolated patients for early warning signs of COVID-19 by **proactively engaging frontline workers such as ASHAs, AWWs, and MPWs, local NGOs and community volunteers** and link them with nearest healthcare services/mobile medical units.
- **Local rapid testing centres** can be set up within the community for testing closer to home followed by home isolation and management, if required. These centres can be interlinked through telemedicine to the nearest PHC for rapid triaging and isolation/referral as needed.
- Patients can be followed up through **call and coordination centres,** which can either be set up or be run from existing tele-health centres which also serve as a focal point to disseminate important information to the patients and care givers.
- **Granular data on COVID-19 can be utilized** in order to enable local ward-level graduated response to curb spreading of infection.

## Non-health interventions




- **Provide cooked food for the home-isolated** patients is essential for recovery from COVID-19. Supply of cooked food thrice daily at their doorstep via Government/Anganwadi Centre (AWC) /locally identified NGOs/community kitchens would ensure recovery of patient through improved immunity. Identification cards should not be mandated for access to these services.
- Most of the individuals residing in slums access public toilets for daily use. **Ear-marking a particular public toilet for exclusive use by COVID-19 home isolated patients/use of mobile toilet facility can reduce spread of infection.** Mobile toilets/portable toilets procured under the Swachh Bharat Abhiyan can be stationed in the vicinity. Care should be taken to ensure that these toilets are cleaned and sanitized on a regular basis.
- Ensure **supply of clean water in all homeless shelters and informal settlements.** Water tankers can be stationed at designated points across cities/towns, which are easily accessible to the urban poor. Social distancing protocols should be followed while accessing shared facilities.
- Ensure **regular distribution of soap, sanitizers, disinfectants, and masks** (to those who require them). Handwashing stations can be established across such settlements with supply of running water from overhead tankers and liquid soap to encourage COVID appropriate hand hygiene.

- **Extending financial support for period of home isolation** is necessary as most individuals in this sub-group are engaged in the unorganized sector. Identification cards should NOT be made mandatory for availing these services
- The governments may make **use of media platforms** to disseminate information such as announcements by garbage collection trucks, door-to-door campaigns by community workers while distributing essentials, or information dissemination through locally active NGOs may be employed.
- Encourage regular communication between isolated patients, their families and the community to reduce emotional and psychological distress during isolation. Vulnerable groups within the urban poor, such as the homeless, elderly and children can be isolated in close proximity to a caregiver for appropriate care and emotional support.

# Migrant population

## Why this population is important?

According to Census 2011, around 30% of the Indian population migrates from their place of birth[4]. Most of these migrants travel from their home towns and villages to other cities for better livelihood opportunities, mostly being employed in the unorganized sector or blue-collar jobs.

Migrants were hit hard during the COVID-19 pandemic due to loss of jobs/work as a result of the nationwide lockdown. Consequently, many migrants were forced to walk hundreds of kilometers to their hometowns increasing their vulnerabilities. Though the aftermath of this vast exodus led to issuing of advisory by the National Commission for Human Rights to initiate mapping of such migrant workers to create databases, these migrant workers still face the extreme vulnerabilities, risking their survival.

Even though many of the challenges that they face do resonate with the challenges faced by urban poor, in unique ways they are also at times at a distinct disadvantage. The urban poor usually have established ties in the community – they usually have families, jobs and a home. Migrants, employed in the unorganized sector and blue-collar jobs often leave behind their families in their native places. They often live in shared accommodations in crowded conditions along with slum clusters, peri-urban settings and industrial areas.

### Rural and reverse migration in context of COVID-19

**Reverse migration and COVID-19:**

The first and second wave of COVID-19 and subsequent lockdowns led to mass reverse migration from cities and towns (urban) to villages (rural). Once back, these reverse migrants were subjected to ostracization and exclusion; many were not allowed entry in their villages, and some were even sprayed with harsh disinfectants

Since reverse migration is a COVID-specific phenomenon, measures can be taken at the rural and peri-urban level. These would include:

- **Identification and testing** of reverse migrants as soon as possible. Community volunteers and frontline workers can keep track of any new returnee and alert the healthcare system. Rapid Antigen Test can be employed for testing, diagnosing and triaging returnees.
- Provision for **isolation facilities** within their communities for quarantine – these can be schools, hostels, community halls, guest houses, etc.
- Provision for maintaining **respiratory and hand hygiene** while being quarantined.

[4] Accessed from: Census of India Website: Office of the Registrar General & Census Commissioner, India. Census of India 2011. Available from: https://censusindia.gov.in/2011census/migration.html

- **Food and water** should be ensured for the period of quarantine.
- Enlisting and recording demographic information of rural migrants by Panchayat members, which can then be passed on to frontline workers? The employers should be tasked with getting their employees registered at the Panchayat office.
- Community isolation spaces can be utilized for isolating COVID-19 positive rural migrants.

## How to make home/community-based isolation and management work?

While everything recommended for urban poor in section 2.1 is applicable for the migrant population, a few additional considerations are listed in paragraphs to follow:

- **Opinion leaders from within migrant communities** should be identified and sensitized for anchoring information dissemination to community members on appropriate COVID-19 behavior. They can also be linked to frontline workers/formal healthcare system for increasing the sensitivity of surveillance.
- **Accessible COVID-19 care and isolation centres** to be mapped for suspected/confirmed asymptomatic or mild COVID cases. The contact information for these centres should be provided to frontline workers/opinion leaders/NGOs working with the community.
- Employers should maintain and regularly update **migrant worker records** – names, local and permanent addresses and mobile numbers which should be regularly shared with the local law enforcement officers.
- The responsibility of home/community-based isolation and management of migrant workers should be shared between the employers, the government and civil society representatives (NGOs in the community). The government can encourage increased participation by employers by incentivizing steps such as making provisions for isolation spaces, food, and financial support under Corporate Social Responsibility (CSR) Act. Dedicated point person in government agencies and departments should be responsible for making necessary arrangement for the migrant.

# Tribal Population

## Why this population is important?

Tribal people constitute approximately 8% of India's total population accounting for 110 Million[5]. Much of tribal population resides in difficult terrains, and the inaccessible topography poses as a challenge for the healthcare functionaries in providing care and physical aid to the communities. In addition, social and cultural practices and beliefs among the population sub-group render home isolation undesirable and stressful.

## How to make home/community-based isolation and management work?

### Health interventions


[5] Accessed from: http://tribalhealthreport.in/expert-committee/

- **Community-based isolation spaces** can be explored for tribal population, similar to the concept of community-based isolation spaces as recommended for urban poor. Upgrading and utilizing vacant huts, community halls, courtyard, verandah and basa/bathaan/machaans in tribal areas may help to expand isolation spaces in the community. These isolation spaces can also be equipped with tele-medicine capacity for regular monitoring and follow-up of isolating patients.
- Much of the tribal population live in far-flung difficult-to-reach areas, which remains inaccessible to formal healthcare systems. **Mobile medical units can be established to visit tribal villages and clusters** regularly or as required by the community, to check symptoms and treat those suffering from illness. The availability of referral transport should be prioritized and strengthened in these settings to improve access.
- **Train frontline functionaries** including Primary Health Care teams at HWCs/NGO workers/community volunteers for **active monitoring of isolated patients** and alerting healthcare services, if required. They can in turn be linked to the nearest SHC-HWC/PHC-HWC and Mobile Medical Units (MMUs).
- **IEC and job aids** can be used extensively for health counselling. Developing the multilingual communication tools and simple infographics on 'what to do, when to seek care' etc. can be added as a part of communication strategy. Use of traditional media or folk art can also be explored for disseminating information to the communities. It is important to understand what resonates with the communities and tap on platforms and mediums from which they seek information on a regular basis.

## Non-health interventions


- Availability of separate toilets may be difficult in rural and tribal settlements. They also remain inaccessible to organizations supplying temporary sanitation solutions such as portable latrines etc. **Allocated funds from PMSA (Pradhan Mantri Sauchalaya Yojana) can be utilized for building toilets.**
- **Provide cooked food for the home-isolated patients** thrice daily at their doorstep via the Government/ AWC/locally identified NGOs/community kitchens. Identification cards should not be mandated for access to these services.

- Ensure **supply of clean water** to isolation spaces. Settlements especially in the sylvatic and peri-sylvatic regions may not have piped water facilities. Dedicated covered pitchers and pots may be kept in the facilities which can be filled up on a daily basis by community volunteers.
- Ensure **regular distribution of soap, sanitizers, disinfectants, and masks.** The ASHAs/ANMs may be entrusted with a depot of sanitary supplies which they would be able to pass on to those in need.
- **Extending financial support for period of home isolation** is necessary as most of these people are engaged in the unorganized sector and get paid on daily work basis.
- **Locally aligned communication messages** should be designed keeping in mind cultural sensibilities, and local language proficiency. Since many tribal languages are oral and do not have a written script, audio recordings can be made available to the message disseminators in order to minimize confusion. **Pictorial representations on posters** of COVID-19 appropriate behavior at prominent locations in communities can promote appropriate practices.

# Pregnant and Lactating Women

## Why this population is important?

Every year in India, ~30 million women enter the cycle of childbirth[6]. There is a slightly smaller proportion of lactating or breastfeeding women with children one year or younger.

## What experts working in this area suggest?

There are many cultural and social factors which may prevent pregnant women to opt for institutional isolation. Institutional isolation may hinder breastfeeding for lactating mothers. Pregnancy and lactation are therefore special situations which need to be given due consideration on case-to-case basis.

## How to make home/community-based isolation and management work?

### Health interventions


[6] Accessed from: Indian Association of Preventive and Social Medicine (IAPSM) Maternal Health Committee. http://iapsm.org/maternal-health.html

- **Initial assessment or triage for home isolation** should be conducted by trained medical professionals prior to advising home/community-based isolation and management. Alternatively, telephonic medical triage can be done through an empaneled agency.
- **Caregivers should be identified and trained** with the skills necessary for managing pregnant/lactating COVID-19 patient at home/community. These caregivers should in turn be linked to community workers (frontline workers/ NGOs/community volunteers etc.), or directly to the nearest healthcare centres, for prompt notification and referral. Telemedicine consultations can also be utilized for regular monitoring and follow-up.
- COVID-19 infection and isolation can be stressful, which may have adverse pregnancy outcomes and reduced lactation. Thus, **stress reduction** through recreational activities and meditation can be encouraged. The caregiver and family members must be informed that while pregnant women may have severe COVID-19 outcomes, there is no risk to the fetus as long as the mother remains asymptomatic/mildly symptomatic. They should also be informed that there is no risk of transmitting COVID-19 through breastmilk.
- **Thorough post-COVID examination** should be mandated for all pregnant/lactating women who have been in home/community-based isolation/management.
- Frontline functionaries/community volunteers should **continue monitoring children and adolescents infected by COVID and their caregivers** with due precautions.

***Specific guidelines for lactating women:***[7]

- **Lactating mother should be encouraged to breastfeed** and practice Kangaroo Mother Care all the while following COVID appropriate behaviours. There is no evidence of the virus being transmitted via breast milk so far. Therefore, if the mother prefers to feed the child at breast or feed expressed milk by herself, she should wear mask and follow respiratory etiquette.
- At all times, the three Ws need to be followed:
  - Wash hands before and after touching the baby
  - Wipe all surfaces with disinfectant/sanitizer
  - Wear a mask – while breastfeeding/feeding with spoon and bowl
- The newborn has to be tested only if the mother has had infection within 14 days of delivery or up to 28 days after birth and the baby is symptomatic.
- If a lactating mother is diagnosed with COVID-19 and the breastfeeding infant is still asymptomatic, infant should be observed for symptoms until 14 days after the initial contact (i.e., from the time the lactating mother started showing symptoms). If at any point within the 14 days after contact, the child develops symptoms like a fever, cough, runny nose, vomiting, loose stools, etc. then they should be tested for COVID-19.

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[7] Information sourced from:
CDC Guidelines on Breastfeeding and COVID-19. https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/covid-19-and-breastfeeding.html
World Health Organization. Breastfeeding and COVID-19: Scientific Brief. 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Breastfeeding-2020.1
Breastfeeding during the COVID-19 pandemic. https://www.unicef.org/eap/breastfeeding-during-covid-19

- The Ministry of Health and Family Welfare, the Government of India has recommended the COVID-19 vaccination of lactating women and pregnant women.

### Non-health interventions


- **Nutritional support should be extended** to pregnant and lactating women. In addition to the continuation of IFA and calcium supplementation, dietary supplementation from Anganwadi centres can be provided, especially those from marginalized sections of society. Identification cards should not be mandated for access to these services.
- **Supply of sanitation materials** such as masks and soaps should be ensured, and their regular use should be mandated.
- Pregnant and lactating women at the intersections of socio-economic disadvantages, such as urban poor, tribal and migrants should be extended all the measures applicable for these vulnerable groups in addition to measures designed for them specifically.

# Children and adolescents

## Why this population is important?

Available data suggests that the rate of infection among children and adolescents is the same as that in any other age group. However, unlike other age groups, children tend to remain asymptomatic or develop mild symptoms[8]. Therefore, home/community-based isolation and management should be the approach of choice.

## What experts working in this area suggest?

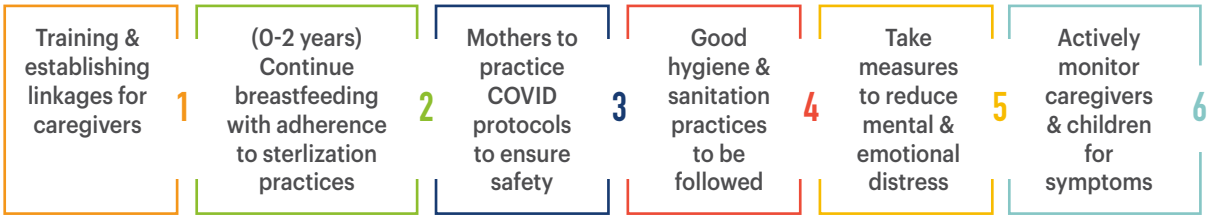
Children affected with COVID-19 infection usually do not experience severe symptoms, majority of them being asymptomatic or mildly symptomatic. Asymptomatic children are usually identified while screening, if family members are identified. Mostly children do not require any treatment except monitoring for development of symptoms and subsequent treatment according to assessed severity. However, children with mild disease may experience sore throat, rhinorrhea and cough without breathing difficulty. These cases can be managed with home isolation and symptomatic treatment. COVID-19 Vaccination for adolescents in the age-group of 15-18 years has been initiated by GoI from January 2022. The eligible adolescents may be vaccinated as per the guidelines by MoHFW[9].

[8] Guidelines for COVID-19 vaccination of children between 15-18 years and precaution dose to HCWs, FLWs & 60+ population with co-morbidities. Chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.mohfw.gov

[9] Information accessed from:
COVID-19 and children. https://www.unicef.org/india/coronavirus/covid-19/covid-19-and-children
COVID-19 treatment guidelines: Special Considerations for Children. https://www.covid19treatmentguidelines.nih.gov/special-populations/children
CDC: Information for paediatric healthcare providers. https://www.covid19treatmentguidelines.nih.gov/special-populations/children/
Guidelines on operationalization of COVID care services for children and adolescents. https://www.mohfw.gov.in/pdf

## How to make home/community-based isolation and management work?

### Health interventions




- All children (and preferably adolescents) should be **isolated with a caregiver** – preferably their mother (especially if they are breastfeeding).
- **Caregiver should be identified and trained** prior to rooming them with the infected children. They should be trained and linked to frontline functionaries/community volunteers or directly to nearest healthcare centre for timely referral of critical cases.
- Frontline functionaries/community volunteers should **continue monitoring children and adolescents infected by COVID-19 and their caregivers** with due precautions.

***0-2 years***

- Breast feeding to be continued and strict adherence to sterilization practices should be followed.
- Kangaroo Mother Care should be encouraged, especially for neonates and infants.
- The mother is advised to actively monitor and follow COVID-19 appropriate behaviors and practices to ensure safety of their child.

***2-10 years***

- Since younger children are usually not aware of hygienic practices, they should be taught and repeatedly encouraged to inculcate good hygiene and sanitation practices such as washing hands with soap and water before and after eating, and after going to the toilet, covering mouth with the elbow while coughing and sneezing, etc.
- Special attention should be provided to ensure mental and emotional support as they are at risk of experiencing psychological distress due to anxiety caused by isolation and parental separation. The children can be engaged in some activities such as indoor games, reading pictorial or story books as deemed appropriate, to reduce separation anxiety.

***Home isolation for adolescent 11-18 years:***

The standard home isolation guidelines or sub-population specific guidelines need to be followed.

- Choice of isolating alone or along with a caregiver should be provided. While choosing a caregiver, prior identification and training as mentioned earlier needs to be kept in mind.
- Considerations which are put in place for children aged 2 to 10 years should also be practiced here.
- Adolescents are highly connected to their peers and isolation may lead to an abrupt sense of disconnect which would be detrimental for their mental and emotional health. Measures can be taken to ensure

that they remain connected, viz. via social media, video calls, direct person-to-person communication while maintaining COVID appropriate distance and safety measures.

- Adolescents may struggle when asked to change their routines – from choosing to skip in-person gatherings, to consistently wear masks. In the absence of peer support, caregivers need to provide positive reinforcement in order to ensure COVID appropriate behaviours.

## Non-health interventions


- **Nutritional support should be extended** to all children. Dietary supplementation from Anganwadi centres can be provided, especially those from marginalized sections of society. Mid-day meals may also be delivered through community volunteers. Identification cards should not be mandated for access to these services.
- **Supply of sanitation materials** such as masks and soaps should be ensured, and their regular use should be mandated (unless contra-indicated). Children at the intersections of socio-economic disadvantages - urban poor, tribal, migrants, and street children should be extended all the measures applicable for these vulnerable groups in addition to measures designed for them specifically.
- Caregivers should focus on providing a **supportive environment for the children** under their supervision as they are isolated. Actively share details on the reason for isolation, and clearly stating the do's and don'ts.
- It has been found that in **children with pre-existing health conditions, long term treatment or immune-compromised health status** increase their risk of developing severe diseases. Therefore, such children **should be prioritized for institutional care**.

### COVID-19 and orphans

**Orphanages and COVID-19**

Orphanages, half-way homes, borstals, etc. can become epicenters of COVID-19 infection if not carefully monitored.

- Every such institution should be provided with adequate number of thermometers and pulse oximeters to ensure timely and frequent monitoring of residents.
- Symptoms suggestive of COVID-19 should be elicited actively. This is especially important for children who are too young to be able to identify them.
- Separate rooms in these institutions can be identified for isolation of suspected/asymptomatic/mildly symptomatic patients.
- Since it is virtually impossible to isolate children on their own, caregivers who will isolate themselves along should be identified and trained to cater to their needs, and raise escalations for critical patients.

**Orphanages and COVID-19**

Orphanages, half-way homes, borstals, etc. can become epicenters of COVID-19 infection if not carefully monitored.

- Linkages with child helpline number 1098 for such children should be established. Since most children themselves cannot be expected to ensure getting linked, community volunteers/frontline workers may do the same.
- In absence of immediate take-over by relatives, these children can be homed with willing caregivers/ responsible or reputed members of the community till they get adopted/taken-over. Government may also provide financial support to these caregivers for upkeep of these children.

# Persons with disabilities

## Why this population is important?

Around ~2.68 crore individuals in India live with one or the other form of physical disability. Of this, 69% live in rural areas, while the rest reside in urban settlements[10]. Although the risk of acquiring COVID-19 in most persons with disabilities is not more than the rest of the population, there are three important differences:

- Access to healthcare services in persons with disabilities is significantly curtailed when compared to most able-bodied people
- A significant number of persons with disabilities may not be able to communicate their needs and problems effectively (such as deaf and mute people, people with intellectual disabilities, cerebral palsy, etc.) which may lead to a delay in seeking healthcare.
- A sizeable section of persons with disabilities (intellectual disabilities, cerebral palsy etc.) are at a higher risk of contracting COVID-19[11].
- Adults with disabilities are three times more likely than adults without disabilities to have heart disease, diabetes, cancer, or a stroke, which increases their vulnerabilities towards complications of COVID-19.

It is therefore necessary to ensure appropriate and adequate monitoring of people living with disabilities in home/community-based isolation and management.

## What experts working in this area suggest?

The Department of Empowerment of Persons with Disabilities (DEPwD) under Ministry of Social Justice and Empowerment has issued "Comprehensive Disability Inclusive Guidelines" to States and Union territories for protection and safety of people living with Disabilities in light of the COVID-19 pandemic. Refer to Annexure 2 for salient features of the guidelines.

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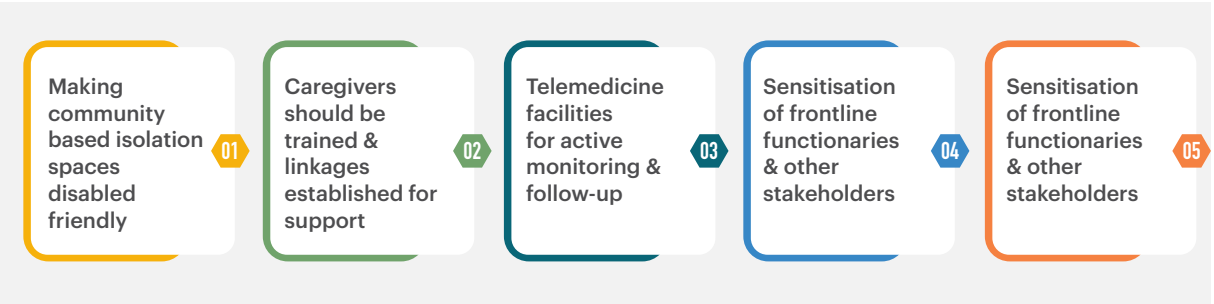
[10] Accessed from: Disabled Persons in India – A Statistical Profile (2016). http://mospi.nic.in/sites/default/files/publication_reports/Disabled_persons_in_India_2016.pdf

[11] Accessed from:
Intellectual and developmental disability and COVID-19 case-fatality trends: TriNetX analysis. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245650/
Triple jeopardy: disabled people and the COVID-19 pandemic. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00625-5/fulltext

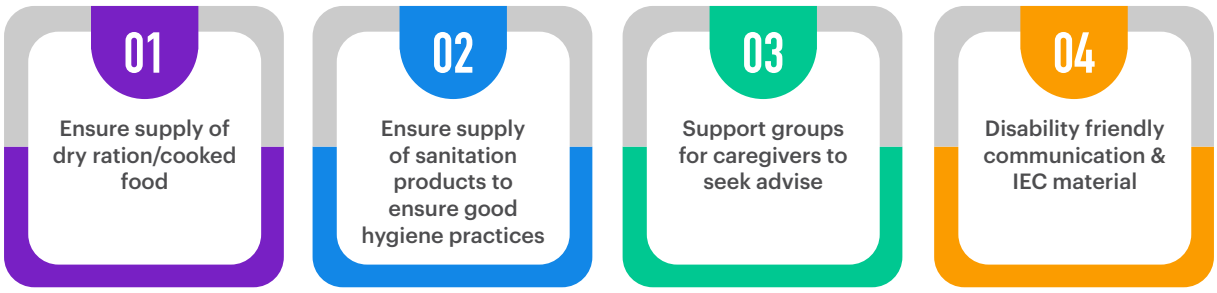
## How to make home/community-based isolation and management work?

### Health interventions




- It should be mandated that certain sections of **every community-based isolation space are disabled-friendly and accessible** – this includes entries and exits, disabled friendly bathrooms and lavatories, disabled friendly information material (brochures in Braille for example), among others.
- Some patients, especially those with intellectual disabilities may not be able to adjust to the sudden change in daily routine. The caregiver may be mandated with taking these individuals out onto roofs/ verandahs/other isolated but open spaces for a fixed amount of time daily.
- Persons with disabilities must be **isolated accompanied by a caregiver**. This caregiver should be identified and trained beforehand, especially if the isolated patient's disability renders effective communication. These caregivers should be linked to the nearest healthcare provider and a two-way communication should be encouraged.
- Isolation spaces (home-based/community-based) should be equipped with **telemedicine** facilities to allow direct follow-up and monitoring. The district/state authorities may formulate a team comprising of doctors, psychologists, psychiatrists and counsellors, who will be trained to cater to needs of such patients and will ensure regular follow ups.
- **Frontline functionaries/community volunteers/NGO workers should be especially sensitized** to monitor for warning signs in people living with disabilities as they might be unable to communicate effectively.
- Any incapacitated person or others **unable to remove the mask without assistance should not be masked**, to avoid risk of suffocation. Similarly, people with hearing and speech impairments or disabilities and their caregivers may choose not to wear masks/wear transparent masks/face shields made of transparent plastic to allow communication via lip reading.
- **Access to healthcare services and products** should be ensured. Individuals with disabilities may need diapers, catheters, urine bags, disposable sheets, bandages, cotton, medicines etc. and these should be made available to them preferably at their doorstep at a subsidized/no cost.

### Non-health interventions




- Isolated patients with the caregiver should be **regularly supplied with dry rations/cooked food** by frontline workers/community volunteers, especially if they do not have any other family members or caregivers, no social support circle, or are from the marginalized section.
- Similarly, the isolated patient and their caregiver should also be **supplied with soaps and masks to ensure good hygiene practices**.
- **Financial compensation** should be considered, especially if the disabled person/caregiver was the sole bread-earner, or if they belong to any other vulnerable community.
- COVID-19 and intermittent lockdowns has had significant implications on emotional and psychological well-being of the patients and caregivers. Local **support groups for caregivers** may be established and linked through WhatsApp groups. They may also be linked with **counsellors/psychologists** for easy approach. De-stressing of caregivers may act as a safety valve against abuse of disabled peoples.
- Communication modules for relaying information on isolation guidelines have to be tailored according to the target demography and **made accessible for persons with disabilities**. Therefore, people with hearing or speech impairments might be supplied with paper pamphlets with mostly pictorial representation of the guidelines. In addition, videos with isolation guidelines displayed in sign languages should be displayed. Similarly, the visually challenged may be supplied with pamphlets in 'easy read' format or Braille. At the same time, simple audio-visual videos/cartoon videos may be developed for people with intellectual disabilities.
- Many people with disabilities may exists at the intersections of socio-demographic disadvantages– such as disabled people within the urban poor, or tribal disabled. They should be extended all the measures applicable for these vulnerable groups in addition to measures designed for them specifically.

# HIV and TB patients

## Why this population is important?

India has a sizeable population of HIV/AIDS infected individuals. Their needs might not be different, but owing to their pre-existing health condition they require special attention to reduce the chances of exacerbation and development of complications of COVID-19.

## How to make it home/community-based isolation work?

### Health interventions


- Separate isolation rooms/isolation spaces should be located within the house/community, making sure that they are **well-ventilated**, with separate toilets.
- It should be ensured that **regular medication is continued** during the period of isolation, viz. ART or MDT (whichever is applicable).
- One **caregiver should be identified for catering to the needs of the isolated patient** and they should be trained to allow early recognition of warning signs. They can be in turn linked to the formal healthcare system.
- Frontline functionaries/community volunteers can be tasked with **following up on these patients regularly for early flagging of warning signs and prompt referral** to nearest healthcare centre.
- **Telemedicine** can be employed to ensure continued follow-up and monitoring of the patient.
- System to **ensure reporting and redressal mechanisms** for adverse drug reaction among RRTB and DRTB patients should be strengthened.

### Non-health interventions


- **Nutritional support should be extended** to all such patients in home-isolation. Dietary supplementation from Anganwadi centres or community kitchens can be provided to them, especially those from marginalized sections of society. Mid-day meals may also be delivered to them via community volunteers or local NGOs. Alongside the dedicated community kitchen for the vulnerable as well DBT (Direct Benefit Transfer) for nutritional support should be actively considered by local administration.

- HIV and TB patients at the intersections of socio-economic disadvantages, such as Transgenders or Female Sex Workers (FSWs) living with HIV, urban poor TB patients, etc. should be extended all the measures applicable for these vulnerable groups in addition to measures designed for them specifically.

- **Supply of sanitation materials** such as masks and soaps should be ensured, and their regular use should be mandated.

- All high-risk contacts (children <6 years in age, HIV-infected, diabetic, immunocompromised otherwise) must be screened for tuberculosis and started on isoniazid preventive therapy.

- Stigma and discrimination remain major barriers to accessing healthcare services in patients of TB and HIV, and they may get further aggravated if they are infected by COVID-19. There is a need to create awareness among communities for anti-stigma and discrimination of these groups

# LGBTQIA+

## Why is this population group important?

Although combined under an umbrella term, the LGBTQIA+ comprises of diverse groups of people, who represents various gender and sexual minorities. Their non-normative sexual and gender expression puts them at a distinct disadvantage when it comes to accessing their social and health capital. The LGBTQIA+ community remain one of the most marginalized and stigmatized communities in India. In addition, systemic marginalization has left a devastating effect on their mental health, as a result leading to increased incidence of depression, anxiety, stress etc. among this population sub-group. Stigmatization and ostracization by the society have also left many individuals from this section of the society to exist at the margins of the community, thus inhibiting meaningful social or economic relationships.

## What experts working in this area suggest?

Although the risk of acquiring COVID-19 is no more in this socio-demographic group than in the general population, the exacerbated social and health inequities makes it difficult for them to access timely, appropriate treatment.

## How to make home/community-based isolation and management work?

### Health interventions

01 Create safe isolation spaces for LGBTQIA+

02 Sensitization & education of healthcare workers

03 Monitoring of patients isolated at home by NGO workers/community leaders

04 Encourage & make accessible telemedicine platform

05 Make consultation for mental health accessible to cope with stress

06 Make consultation for mental health accessible to cope with stress

- **Safe isolation spaces** need to be established ensuring community-based isolation in case home isolation is not feasible. These spaces need to ensure that the isolated LGBTQIA+ members feel safe. The authorities might choose to establish these safe spaces in and around the localities with a relatively higher population of transgender population.
- **Sensitization and education of healthcare workers** including frontline workers, nursing officers, and doctors is essential. This would help in reducing stigma, in turn foster trust, thereby enabling better follow-up and monitoring.
- **Regular monitoring of isolated patients by peer educators/NGO workers/community leaders** can be established after identifying and training them. They can in turn be provided with the COVID-19 monitoring and management kit for easy lending to those in need.
- **Telemedicine** as a platform can facilitate regular monitoring and follow-up with isolated patients.
- Owing to the high prevalence of psychiatric illnesses in the community, it can be safely assumed that the LGBTQIA+ would be hard hit psychologically and emotionally once they are isolated. In the spirit of community-based and community-led approach, bi-directional communication between the isolating individual and their commune/family/peer-group should be encouraged. Also, **medical officers who are engaged in providing tele-consultation should be trained to identify possible psychological distress** and intervene accordingly.
- **Medications which were being taken prior to diagnosis or any co-morbidity should be continued** throughout the duration of isolation– these may include HAART and hormone-therapy.

## Non-health interventions

- Isolating patient should be **regularly supplied with dry rations/cooked food** by frontline workers/ community volunteers, especially if they do not have family members or caregivers, have no social support circle, or are marginalized. Identification cards should not be mandated for access to these services. Similarly, the isolated patient should also be supplied with soaps and masks.
- **Financial compensation** should be considered, through mechanisms such as Direct Benefit transfer.

### Sex workers and COVID-19

Many sex workers straddle the unique intersection of being urban poor, migrant, and a single working woman/gender or sexual minority. The ongoing COVID-19 has deprived them of their livelihood, which essentially depends on close human contact, and has rendered them financially and socially vulnerable. With an estimated ~8,00,000 female sex workers in India, the total number of sex workers can be assumed to be higher11. It is recommended that interventions which have been suggested for the urban poor, migrants and LGBTQIA+ community may also be contextually applied for sex workers with respect to home/community-based isolation during COVID-19.

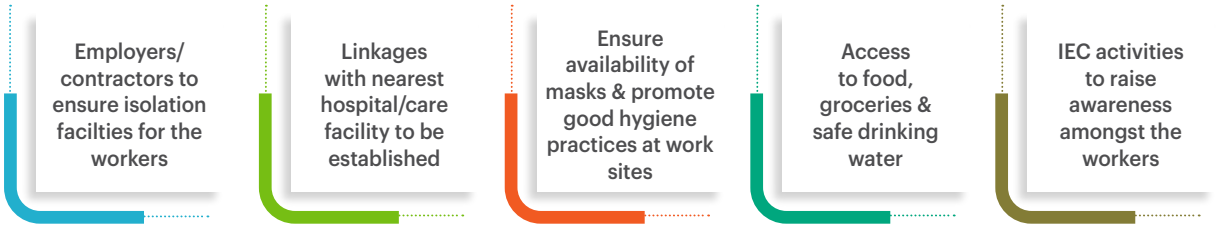
# Persons in occupational settings

## Why this population is important?

There are nearly 500 million[12] workers in formal and informal sectors in India, many of whom do not have access to affordable healthcare. Although many of these workers overlap previously covered demographics – urban poor, migrants, there still are some vulnerable sub-groups which pose unique challenges to the guidelines proposed thus far. Workers like construction workers, brick kiln workers, and domestic helps are rendered more vulnerable due to the unorganized nature of their profession.

## How to make home/community-based isolation and management work?

Previous interventions suggested for the urban poor, migrants, pregnant and lactating women can be applied contextually to this sub group. In addition, the following recommendations may be considered where applicable:




- The **responsibility of making arrangements for isolation** for workers and their family members should be with the site owners/overseers/contractors.
- Before applying for any approval for initiation/resumption of work, submission of a **plan for provision of home isolation of the workers and their family members** to local health and enforcement authorities should be made mandatory. Such facility should be able to handle at least 2 individuals in home isolation. It may also be a combined facility by a group of employers; however, the responsibility should not be on workers.
- **Necessary tie ups with nearest hospitals** to be made for treatment of COVID-19 affected patients.
- **Masks to be supplied to the workers by the employer**, and the supervisor should be instructed to ensure strict adherence to COVID appropriate behaviours. Additional hand washing stations with clean running water and soaps should be installed at common locations on site.
- Arrangements should be made by the employer to **ensure the supply of all essential items like food, groceries, water and grains** at the isolation facility.
- In spite of strict laws and guidelines, many construction sites employ unregularized laborers to work on sites. In addition, it is difficult to track down small-time constructers and contractors. Many NGOs work with unregularized laborers in a host of health-related domains. These can be taken in the loop to conduct IEC activities.

[12] Accessed from: Labor force, total – India (The World Bank). https://data.worldbank.org/indicator/SL.TLF.TOTL.IN?locations=IN

# BEST PRACTICES AND **INNOVATIVE APPROACHES**

## Ottakalla Oppamundu

### Geography: Kerala

**About the Model:** Ottakalla Oppamundu was launched in Kerala for providing last mile connectivity care to COVID-19 affected individuals under home isolation. The State created a pool of 1143 Mental Health Personnel including Psychiatrists, Psychiatric Social Workers, Clinical Psychologists, and Counsellors for tele-consultation and tele-counselling services. They have made psycho social support calls to 4,80,504 people in home isolation. In addition to this, Psycho Social Support calls were made to persons with mental illness and children with special needs who do not have access to adequate health facilities. Counselling services were also given to alleviate stress and create an enabling environment for personnel working in corona outbreak activities at the grass root level. A total of 11,42,701 Psycho Social Support and Counselling Calls have been made to all such categories till date. The government has now deployed healthcare staff for providing support to the patients and health workers through this platform.

**Proposed Vulnerable Population:** This model can cater to persons with mental illness and children with special needs.

## Kudumbashree's initiative

### Geography- Kerala

**About the Model:** Women self-help groups named Kudumbashree in Kerala formed around 1.9 lakh WhatsApp groups which involved close to 22 lakh neighboring groups living in rural areas to spread awareness on COVID appropriate behaviors, key safety measures, information on supplementary nutrition and standard treatment protocol. This empowerment has led to clarity of information amongst the rural people in Kerala. These SHG groups under the Local Self Government department set up Community Kitchens which helped in providing near about 86,51,627 safe meals to labourers in home isolation patients during the second wave of COVID. Apart from cooked meals, Kudumbashree distributed free ration under the Public Distribution Scheme to laborers and their families.

**Proposed Vulnerable Population:** This model can be implemented for labourers, miners etc falling under the category of occupational environment.

# CINI (Child in Need institute) community initiative's Nutrimix

## Geography- West Bengal

**About the Model** -CINI developed a nutritious supplement named nutrimix keeping in mind the nutrient requirement of adolescents, pregnant women and lactating mothers. CINI distributed 2 kits – Wellness kit containing nutrimix and grocery kit including dry ration for 240 nutritious meals to around 2800 families. These kits substituted the nutritional needs of adolescent, pregnant and lactating women. Hence, this was a very crucial and much needed assistance needed in times of the pandemic.

**Proposed Vulnerable Population:** This practice can be implemented for home management of pregnant and lactating women groups during COVID and post COVID.

# AMRIT clinics

## Geography- Southern Rajasthan

**About the Model -** Nurse led AMRIT clinics were set up by Basic Healthcare Services (BHS) in the remote areas of southern Rajasthan to provide primary healthcare services to the tribal communities. The nurses did weekly home visits to keep a check on the tribal families affected by COVID and provided them with the required medicines to combat COVID-19. BHS also trained a group of community volunteers and deployed them in the local community to ensure continuity of health services and address the fear and stigma of tribal communities. The continued presence of the team in the community ensured continuity of community's access to quality preventive, promotive, curative and referral services incorporated with social distancing norms.

**Proposed Vulnerable Population:** Similar healthcare set up could be replicated for home management of COVID in tribal communities.

# Floating Home Isolation Kits

## Geography - Nagaland

**About the Model-** Most of the states are struggling with availability of COVID Home Isolation Kits comprising basic state approved medicine for COVID management, self-monitoring device like pulse oximeter, thermometer and personal hygiene products to provide quality care for home isolated patients. To address this challenge, NISHTHA in collaboration with the state government of Nagaland has developed an innovative model of Floating Home Isolation Kit Bank across two high burden districts i.e. Dimapur and Kohima by creating a pool of CHIKs on a return after use basis. This mechanism is being implemented in coordination with district health authorities, districts surveillance officers, local NGOs and district health task forces at district level. The CHIKs are delivered to the COVID positive patients at the beginning of their home isolation period by a local NGO in coordination with district health authority and DSO. Once the patient is recovered, the CHIK is being picked up, sanitized, replenished and reissued to the next patient by the local NGO staff. NISHTHA Tele-Track is also implemented across these two districts for effective monitoring and tracking of COVID patients during their prescribed home isolation period of 10 days. Through this initiative, we intend to ensure quality healthcare for home-based care/

management of asymptomatic and mild COVID-19 cases, by bridging the gaps in availability of drugs, supplies and necessary equipment.

**Proposed Vulnerable Population:** Tribal population living in remote areas and where the resources are scarce.

# Home isolation kits

## Geography- Goa

**About the Model-** The Health Department of Goa had made a customised COVID-19 kit for home isolation. The kit contains Pulse Oximeter (1 no.), Digital Thermometer (1 no.), Paracetamol tablets (15 nos.), Vitamin C tablets (30 nos.), Multivitamin tablets with Zinc (30 nos.), Vitamin D3 tablets (2 packs), Ivermectin 12mg tablets (10 nos.), Doxycycline 100mg tablets (10 nos.), Three-ply face masks (5 nos.), N-95 Masks (2 nos.), Sanitizer (100ml), Alcohol based Wipes (1 box with 20 plies) and Gloves (2 pairs). This kit was made readily available at all PHCs and UPHCs of the State. These kits provided aid to around 3500 home isolated families. Apart from the kit, the MPWs have been instructed to make regular phone calls to the COVID affected patients to check on the oxygen saturation of the patients. This helped Goa to monitor and keep a check on the COVID pandemic in the state.

**Proposed Vulnerable Population:** Such kits and phone call facility could be implemented for COVID home management of LGBTQIA+ community.

# Smart Wrist Bands

## Geography- Abu Dhabi

**About the Model-** Abu Dhabi government used electronic wrist bands for all the passengers entering the city. The wrist band helped the government to monitor and assess the vitals of the passengers. This device also serves as a tracing tool for self-isolating people. The smartwatch helps to identify and track the geographical location of the patient and ensure that he or she does not leave home and jeopardise public health. These smart tools are provided to the patients free of cost. Around 10 lakh people have been successful monitored through this digital solution.

**Proposed Vulnerable Population:** Similar low-cost devices could be used to monitor the movements and vitals of the migrants.

# Home isolation through red tapes

## Geography- Populated urban areas of Bengaluru

**About the Model-** The Karnataka administration sealed several houses across Bengaluru with red tape to indicate they contained patients in home isolation and also had a notice of 14-day home isolation pasted on their gates. This practice was done to create micro-containment zones in slums. Following this, the sealed area was sanitized every alternative day. Such slums were also survey weekly once by the ASHA and doctors are contacted in case of need. Till date around 4000 slums have been red taped. This model was successfully implemented by the collaboration of the Karnataka health workforce and the district administration.

**Proposed Vulnerable Population:** This intervention could be planned for urban slums

# 4-T model of Dharavi

## Geography: Dharavi

**About the Model:** Asia's largest slum- Dharavi has become a global model for controlling the spread of COVID-19 by implementing the 4T strategy which is tracing, tracking, testing and treating strategy. The BMC sealed the border of the slum and set up 24 check-posts at entry points of the slum to contain the spread of cases. Rigorous door to door screening of around 700,000 people was done by measuring oxygen saturation. Dharavi was successful in managing COVID-19 due to the multi-sectoral approach which involved the administration, health department, civic bodies and NGOs.

**Proposed Vulnerable Population:** This intervention could be used in urban slums.

# Micro-plan Strategy

## Geography: Chennai

**About the Model:** The Greater Chennai Corporation adopted a micro-plan strategy to control COVID-19 by involving assistant engineers and junior engineers in as part of the response team. The response teams were formed for 8 divisions as 50% of the rising cases were from these 8 divisions. The response teams were responsible for- contact tracing, sanitization, intensive door-to-door surveillance and regular check on temperature, oxygen saturation for patients in home isolation. They also distributed paracetamol, zinc and vitamin C tablets and masks to these patients.

**Proposed Vulnerable Population:** This intervention could be used in densely populated migrant communities

# COVID hotline

## Geography: Taipei

**About the Model:** Taipei in Taiwan created telephone hotlines where quarantined individuals can connect with hospitals, doctors, government and media to answer their queries. The individuals can call 'disease prevention taxis' to take them for routine treatme`nts to the nearest hospital. This chatbot helped in accessing COVID information and eased the transportation to nearest health centre.

**Proposed Vulnerable Population:** This intervention can be used for communities which face a lot of stigma around like- sex workers or LQBTQIA+.

# Multi stakeholder approach

## Geography: Beunos Aires

**About the Model:** In Beunos Aires's Barrio 31, the authorities implemented a multi-stakeholder approach by engaging local community and opinion leaders for disseminating clear, concise messages, establishing heath checkpoints in each community for early reporting, testing and isolation (connected to health centres telephonically), establishing new health centres, developing targeted plans for at-risk population, engaging with people directly via social media and establishing a call centre for victims of domestic violence. This helped people seek clarity and awareness on COVID-19.

**Proposed Vulnerable Population:** This could be done for all vulnerable populations.

# Panchatantra Gram Mantra

## Geography: Rural Karnataka

**About the Model:** 5 steps were adopted by GRAAM for COVID free panchayat in rural areas.

- Strengthening the Gram Panchayat (GP) taskforce by devising a 90-day specific action plan for COVID-19 and other infectious disease.
- ICAN team (Information, Care and Network): Identifying and deploying 5-6 volunteers in each village for bridging the information-socio-economic- health care barriers.
- **Involving community-based organizations -** SHGs, farmer organizations, dairy co-operatives and front-line functionaries to build a proper support system for the workers.
- Increasing social capital and resources availability by mapping the civil society organizations in the area to the panchayats for a complementary and collaborative action instead of duplication of efforts. Providing both on-field and tele counseling support along with Frontline workers.

Provision of basic necessities should be made available to persons affected by COVID-19 including transport to the local healthcare facilities, as people in the rural area cannot store large amount of required materials, need to depend on public transport to go to nearly by town to procure, which fails the very basic concept of isolation.

**Proposed Vulnerable Population:** This could be done for all vulnerable populations.

# Approach of 3-pronged strategies

## Geography: Rural Rajasthan

**About the Model:** Basic Health Services (BHS) has adapted 3-pronged strategies to deal with COVID-19:

- Community Care: creating awareness on COVID-19 and providing community level COVID care.
  - Awareness on COVID-19: Key focus areas include personal protection to reduce exposure to infection, appropriate behavior, avoid large gatherings, importance of vaccination and early identification and home isolation for COVID-19.
  - Community care for COVID-19: includes early identification of people with COVID-19 (syndromic definition), provision of medicine kits to patients with mild symptoms, regular follow ups and extending support for home isloation, identification and referral for severe COVID-19 cases amongst the community.
- **COVID-19 care centers at block level:** BHS has supported the admission and treatment of moderate COVID-19 cases at block level public COVID care centers.
- **Telephone helpline:** support to patients in home isolation has been ensured by BHS home-based care and also admission in hospitals telephonically. They are also focusing on spreading awareness through various channels and information dissemination within the community.

**Implementation Structure:**

| Block Team | Regional Team | Village based Volunteers |
|---|---|---|
| • Prepare the roll out plan<br>• Identification and capacity building of ground teams<br>• Liaise with the government<br>• Ensure documentation and analysis of the intervention | • Identification and training of volunteers<br>• Ensure provision of supplies<br>• Connect and engage local influencers<br>• Supervise and support the ground teams<br>• Data collection | • Awareness generation<br>• Identification of COVID-19 cases and supporting them with medicine kits, home care, identification of danger signs, referral etc. |

# WAY **FORWARD**

- Home isolation is difficult operationally, however, it is one of the options in COVID-19 case management. Therefore, home isolation should not be considered as a rigid approach and implementation should flexible. It should follow the concept of home care or home management facilitated by the health system. Focusing on home management of cases, a balance has to be established between home-based care and home isolation.
- The concept of home isolation/management has its own set challenges which can be addressed with active communication, provision for tele-consultation and strengthening forward and backward referral linkages to timely manage critical cases.
- While giving attention and priority to home isolation, it will be beneficial that care givers and health functionaries are better equipped and have the correct set of information to tackle the challenge.
- The community isolation/management has distinct advantage over home isolation/isolation, owing to the fact that a better clinical monitoring and treatment can be provided at such community isolation spaces as compared to that under home isolation.
- At the community level, people make their own choices based on the available facilities and healthcare options, limited testing facility along with other resources, and availability of doctors. Guidelines should factor in grass-root realities and challenges.
- Home isolation should be looked at from a holistic approach. Government strategy on identification, isolation, testing and treatment should go as a collective approach rather than a piecemeal approach.
- A strict home isolation as per the guideline may not be feasible for any vulnerable population groups and locally adapted, innovative and blended home-institutional isolation approaches need to be developed.
- There is need for documentation of innovative measures learn, unlearn and be better prepared. The models and approaches for home isolation need to be further documented and shared to be available at scale.

# ANNEXURE 1: **GoI GUIDELINES ON HOME ISOLATION**

**I. Patients eligible for home isolation:**

1. The patient should be clinically assigned as mild/ asymptomatic case by the treating Medical Officer. Further, a designated control room contact number at the district /sub district level shall be provided to the family to get suitable guidance for undertaking testing, clinical management related guidance, assignment of a hospital bed, if warranted.

2. Such cases should have the required facility at their residence for self-isolation and for quarantining other members of the family.

3. A caregiver (ideally someone who has completed his COVID-19 vaccination schedule) should be available to provide care on 24 x7 basis. A communication link between the caregiver and a Medical Officer is a prerequisite for the entire duration of home isolation.

   Note: While a patient is allowed home isolation, all other members in the family including other contacts shall follow the home quarantine guidelines available at: https://www.mohfw.gov.in/pdf/Guidelinesforhomequarantine.pdf

**II. Who is NOT eligible for home isolation**

1. Patients suffering from immune compromised status (HIV, Transplant recipients, Cancer therapy etc.) are not recommended for home isolation and shall only be allowed home isolation after proper evaluation by the treating Medical Officer.

2. Elderly patients aged more than 60 years and those with co-morbid conditions such as Hypertension, Diabetes, Heart disease, Chronic lung/liver/ kidney disease, Cerebro-vascular disease etc shall only be allowed home isolation after proper evaluation by the treating medical officer.

**III. General precautions for the patients:**

1. Patient must isolate himself/herself from other household members in an identified room, away from other members of the households, especially elderly and those with co-morbid conditions like hypertension, cardiovascular disease, renal disease etc.

2. The patient should stay in a well-ventilated room with cross ventilation and windows should be kept open to allow fresh air to come in.

3. Patient should at all times use triple layer medical mask. They should discard mask after 8 hours of use or earlier if the mask becomes wet or is visibly soiled.

4. In the event of Caregiver entering the room, both Caregiver and patient may preferably consider using N-95 mask.
5. Mask should be discarded after cutting them to pieces and putting in a paper bag for a minimum of 72 hours.
6. Patient must take rest and drink lot of fluids to maintain adequate hydration.
7. Patient must follow respiratory etiquettes at all times.
8. Undertake frequent hand washing with soap and water for at least 40 seconds or clean with alcohol-based sanitizer.
9. The patients shall not share personal items including utensils with other people in the household.
10. There is a need to ensure that frequently touched surfaces in the room like table tops, doorknobs, handles, etc. are cleaned regularly with soap/detergent & water. The cleaning can be undertaken either by the patient or the caregiver duly following required precautions such as use of masks and gloves.
11. Self-monitoring of blood oxygen saturation with a pulse oximeter for the patient is advised. The patient shall self-monitor his/her health with daily monitoring and recording of temperature and SpO2 in the monitoring chart provided below. In case of any deterioration of symptom, immediate reporting should be done to the treating Medical Officer as well as surveillance teams/Control room.

**IV. Monitoring chart:**

| Date & time | Tempera-ture | Heart rate(-from pulse oximeter) | SpO2 % (from pulse oximeter) * | Feeling (better/ same/ worse) | Breathing (better/ same/ worse) ** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

* For self-monitoring blood oxygen saturation with a pulse oximeter, place the index finger (after cleaning hands and removing nail polish, if any) in the pulse oximeter. Probe and take the highest steady reading after a few seconds.

** The patient may self-monitor breathing rate/respiratory rate in sitting position, breathe normally and count the number of breaths taken in 1 full minute.

**V. When to seek medical attention:**

Patient/ Care giver will keep monitoring their health. Immediate medical attention must be sought if serious signs or symptoms develop. These could include:

1. Unresolved High-grade fever (more than 100° F for more than 3 days).
2. Difficulty in breathing.
3. Dip in oxygen saturation (SpO2 _ 93% on room air at least 3 readings within 1 hour) or respiratory rate > 24/min.
4. Persistent pain/pressure in the chest.
5. Mental confusion or inability to arouse.
6. Severe fatigue and myalgia.

## VI. Instructions for caregivers:

### 1. Mask:

a. The caregivers should wear a triple layer medical mask. N95 mask may be considered when in the same room with the ill person.

b. Front portion of the mask should not be touched or handled during use.

c. He/she should avoid touching own face, nose or mouth.

d. Mask should be discarded after cutting them to pieces and putting in a paper bag for a minimum of 72 hours. If the mask gets wet or dirty with secretions, it must be changed immediately.

e. Perform hand hygiene after disposal of the mask.

### 2. Hand hygiene:

a. Hand hygiene must be ensured following contact with ill person or his immediate environment.

b. Use soap and water for hand washing at least for 40 seconds. Alcohol-based hand rub can be used, if hands are not visibly soiled.

c. After using soap and water, use of disposable paper towels to dry hands is desirable. If not available, use dedicated clean cloth towels and replace them when they become wet.

### 3. Exposure to patient/ patient's environment:

a. Avoid direct contact with body fluids respiratory, oral secretions including saliva) of the patient. Use disposable gloves while handling the patient.

b. Avoid exposure to potentially contaminated items in his immediate environment (e.g. avoid sharing eating utensils, dishes, drinks, used towels or bed linen).

c. Food must be provided to the patient in his room. Utensils and dishes used by the patient should be cleaned with soap/detergent and water while wearing gloves. The utensils may be re-used only after proper cleaning.

d. Perform hand hygiene before and after removing gloves.

e. Use triple layer medical mask and disposable gloves while cleaning or handling surfaces, clothing or linen used by the patient.

### 4. Biomedical Waste disposal:

a. Effective and safe disposal of general wastes such as disposable items, used food packets, fruit peel offs, used water bottles, left-over food, disposable food plates etc. should be ensured. These should be collected in bags securely tied for handing over to waste collectors.

b. The used masks, gloves and tissues or swabs contaminated with blood / body fluids of COVID-19 patients, including used syringes, medicines, etc., should be treated as biomedical waste and disposed of accordingly by collecting the same in a yellow bag and handed over to waste collector separately so as to prevent further spread of infection within household and the community.

c. Alternatively, these can be disposed of by putting them in an appropriate deep burial pits which are deep enough to prevent access to rodents or dogs etc.

### VII. Treatment for patients with mild/ asymptomatic disease in home isolation

1. Patients must be in communication with a treating Medical Officer and promptly report in case of any deterioration.
2. The patient must continue the medications for other co-morbidities/ illness after consulting the treating Medical Officer.
3. Patient may utilize the tele-consultation platform made available by the district/state administration including the e-Sanjeevani tele-consultation platform available at https://esanjeevaniopd.in/
4. Patients to follow symptomatic management for fever, running nose and cough, as warranted.
5. Patients may perform warm water gargles or take steam inhalation thrice a day.
6. If fever is not controlled with a maximum dose of Tab. Paracetamol 650 mg four times a day, consult the treating doctor.
7. Information floating through social media mentioning non-authentic and non-evidence-based treatment protocols can harm patients.
8. Misinformation leading to creation of panic and in-turn undertaking tests and treatment which are not required has to be avoided.
9. Clinical management protocol for asymptomatic/mild patients as available on the website of Ministry of Health & Family Welfare ( https://www.icmr.gov.in/pdf/covid/techdoc/COVIDManagementAlgorithm23092021.pdf ) may be referred to by the treating Medical Officer to aid management of the case.
10. Do not rush for self-medication, blood investigation or radiological imaging like chest X ray or chest CT scan without consultation of your treating Medical Officer.
11. Steroids are not indicated in mild disease and shall not be self-administered. Overuse & inappropriate use of steroids may lead to additional complications.
12. Treatment for every patient needs to be monitored individually as per the specific condition of the patient concerned and hence generic sharing of prescriptions shall be avoided.

### VIII. When to discontinue home isolation:

- Patient under home isolation will stand discharged and end isolation after at least 7 days have passed from testing positive and no fever for 3 successive days and they shall continue wearing masks.
- There is no need for re-testing after the home isolation period is over.
- Asymptomatic contacts of infected individuals need not undergo COVID-19 test & monitor health in home quarantine.

### IX. When to take your COVID-19 vaccination after infection:

- The patient should defer receiving the COVID-19 Vaccination for 3 months after recovery.
- In case the patient has already received at least 1st dose and got COVID-19 infection before completion of the dose schedule, the 2nd dose should be deferred by 3 months from clinical recovery from COVID-19 illness.

# ANNEXURE 2: **KEY FEATURES ON HOME ISOLATION FROM DEPARTMENT FOR EMPOWERMENT OF PERSONS WITH DISABILITY**

- All information about COVID 19, services offered and precautions to be taken should be available in simple and local language in accessible formats; i.e. in Braille and audible tapes for persons with visual impairment, video-graphic material with sub-titles and sign language interpretation for persons with hearing impairment and through accessible web sites.
- Sign language interpreters who work in emergency and health settings should be given the same health and safety protection as other health care workers dealing with COVID19.
- All persons responsible for handling emergency response services should be trained on the rights of persons with disabilities, and on risks associated with additional problems for persons having specific impairments.
- Relevant information on support to persons with disabilities should be a part of all awareness campaigns
- The persons with disabilities may seek assistance for rectification of fault in their wheelchair and other assistive devices.
- To ensure continuation of support services for persons with disabilities with minimum human contact, due publicity needs to be given to ensuring personal protective equipment for caregivers.
- Persons with disabilities should be given access to essential food, water, medicine, and, to the extent possible, such items should be delivered at their residence or place where they have been quarantined.
- Additional protective measures should be taken for persons with disabilities based on their impairment who need to be given travel pass during the emergency period and should also be sensitized for their personal safety and protection.
- Persons with disabilities should be given priority in treatment; instead they should be given priority. Special care should be taken in respect of children and women with disabilities.
- Employees with blindness and other severe disabilities in both public and private sector should be exempted from essential services work during the period as they can be easily catch infection.
- On-line counselling mechanism should be developed to de-stress persons with disabilities as well as their families to cope with the quarantine period.

# ANNEXURE 3: KEY RECOMMENDATIONS FROM THE STAKEHOLDER CONSULTATION

## Key Recommendations

### Background:

The COVID-19 pandemic has impacted millions of lives irrespective of age, gender, nationality or race. However, it is important to note that the impact has been more devastating on certain vulnerable and marginalized groups. Marginalized and vulnerable groups such as the urban poor, tribal populations, pregnant and lactating women, children, people with mental illnesses; persons with disabilities, LGBTQIA+ population among others have traditionally suffered from inequitable distribution of health services and resources. The COVID-19 pandemic has further exacerbated these differences leaving these groups all the more vulnerable.

The Ministry of Health and Family Welfare (MoHFW) recently issued guidelines prescribing home isolation for mild or asymptomatic COVID-19 cases, which has surfaced as an important strategy during the second wave of COVID-19. Home isolation has contributed significantly to reduce the burden on health systems through optimized utilization of health resources in pandemic response. However, with all sub-groups in the population being equally susceptible to the infection, it becomes pertinent to acknowledge the additional challenges that the vulnerable sections of the population face in accessing care or in adopting home isolation. In view of this, the operational guidelines for home management of vulnerable populations has been developed by USAID's flagship health system strengthening project NISHTHA, implemented by Jhpiego and IAPSM in consultation with various experts to supplement the Government of India's guidelines on home isolation.

As a first step, USAID-NISHTHA in collaboration with IAPSM organized a virtual consultation on 'COVID-19 home isolation and vulnerable population' on June 16, 2021. The consultation served as a forum for around 35 subject experts across the country to discuss on the challenges faced by the vulnerable groups during the pandemic and identify strategies to mitigate these challenges.

Based on the discussions during the consultation, recommendations were made by the experts to make home isolation a successful strategy for managing mild cases among vulnerable sections of the population. Given below are a summary of the key recommendations:

**Key Recommendations:**

1. Many of the experts highlighted that the term '**home management**' is more suitable as against the current terminology of 'home isolation'

2. There is a felt **need to formulate innovative, context specific and blended home isolation approaches** for the vulnerable groups. Given the adverse resource constraints that many of the vulnerable populations face at both individual and community level, it is important to have different approaches for home isolation/home management. These include community based COVID care

centers with/without a caregiver depending on specific needs of the population, government run isolation centers for populations who may not have the requisite space at their homes or permanent housing facilities.

3. A more **decentralized approach while planning and implementing home isolation** among vulnerable populations needs to be considered. With national guidance in place, states should encourage flexibility in norms for implementation of home isolation protocols for the vulnerable groups, however ensuring adherence to appropriate clinical COVID-19 protocols.

4. **Home isolation should not be viewed as a stand-alone approach** for managing mild COVID-19 cases. Rather, it should be regarded as a step in the multi-layered approach of home, community and facility isolation, which ensures continuum of care to provide a holistic management of the disease.

5. Concept of **Community Isolation/Management**, having distinct advantage over home isolation should be considered as a mid-way approach between home and facility level isolation. Mechanisms for enhanced community and stakeholder participation to devise acceptable and workable solutions for creating such community isolation centres should be established.

6. **Leveraging and engaging local community institutions** and structures such as PRIs, SHG groups, village rehabilitation workers is key in building local level ownership for planning, prevention and management of mild cases at the community level.

7. **Choice of opting the level of care** for mild cases i.e. home isolation, community isolation or facility isolation, should lie with the patient and family. This should be a facilitated process of informed choice made by the patient or family. However, this process should be guided in a way that it adheres to the standard clinical triaging protocols.

8. **Strengthening health systems** in terms of improving access to care through approaches like building strong referral linkages to ensure continuum of care, provision of telemedicine/teleconsultations, door step delivery of essential medical and non-medical supplies and development of locally customized IEC material, builds a strong foundation for implementing home isolation/management for vulnerable groups.

9. **Empowered and informed Frontline Functionaries, Communities and Families** form three pillars in management of COVID-19 under home isolation. Thus, focus should be given on enhancing communication and building capacities of these three groups, to ensure successful implementation of home isolation for vulnerable groups.

10. **Tailored and context specific robust IEC and Social Behaviour Change Communication** strategies catering to different vulnerable groups needs to be adopted to ensure that key messages on COVID Appropriate Behaviours, signs and symptoms of COVID and most importantly when to seek medical care are communicated to these vulnerable groups.

11. **Use of innovative approaches** such mobile medical units for testing at hard-to-reach areas and kiosks for pulse oximeters and other instruments at community level can be explored for better management of mild cases at the community level

12. **Active surveillance,** contact tracing and strict operationalization of containment activities are key for early identification of cases and thus limiting the spread of infection. Thus, special attention should be given to strengthen surveillance activities for the vulnerable groups.

13. **Partnerships** with private organizations, local NGOs or civil society organisations, working with vulnerable groups to be explored to leverage their expertise and local presence to enable smooth implementation of home isolation.

14. **Documenting innovative approaches and best practices** implemented at states should be encouraged for wider cross-learning and sharing. Tailoring such innovative models to meet the needs of specific vulnerable groups may serve a possible solution for tackling the subsequent waves of COVID-19. Platforms facilitating real time learning and sharing of information and knowledge based on learnings should be created.

    Detailed document on 'Operationalization of COVID-19 Home Isolation Guidelines for Vulnerable Populations' has been developed by USAID-NISHTHA and IAPSM through a systematic approach of desk review, webinars and consultation.

# ANNEXURE 4: **ROLES AND RESPONSIBILITIES**

V

| S. No. | Tasks | | Responsible Staff |
|---|---|---|---|
| **1.** | Awareness generation | • Community awareness on signs and symptoms of the COVID | AWW, ASHA, MPWs |
| | | • Awareness on prevention and COVID appropriate behaviours including social distancing, hand hygiene, respiratory hygiene etc. | AWW, ASHA, MPWs |
| | | • Sensitization to reduce stigma and discrimination | ASHA, MPWs, CHOs<br>Self Help Groups and Local NGOs |
| | | • Addressing myths and misconceptions around COVID | ASHA, MPWs, CHOs<br>Self Help Groups, Civil Bodies and Local NGOs |
| | | • Creating awareness among high risk and vulnerable groups with focus on infection hot spots. | ASHA, MPWs, CHOs<br>Self Help Groups, Civil Bodies and Local NGOs |
| | | • Awareness on measures for Infection prevention for patients under home isolation. | ASHA, MPWs, CHOs<br>Self Help Groups, and Local NGOs |
| **2** | Active Case Search | • Identification of High-Risk Groups for probable cases | ASHA, MPWs, CHOs, Staff Nurse PHC-MOs |
| | | • Community survey/screening for identification of symptomatic individuals | ASHA, MPWs, CHOs, Staff Nurse, PHC-MOs, Sanitary Inspectors |
| | | • House to house screening for suspected or probable cases in infection hot spots. | ASHA, MPWs, Local NGOs |
| | | • Active case search for suspected cases in containment zones | AWW, ASHA, MPWs, Sanitary Inspectors |
| **3** | Mobilization for testing | • Mobilization of suspected or probable cases for COVD-19 testing. | MPWs, CHOs, Staff Nurse PHC-MOs |
| | | • Navigating close contacts of COVID-19 patients to nearest COVID testing sites. | ASHAs, MPWs, CHOs<br>Local NGOs |
| **4** | Contact Tracing | • Undertaking tracing of close contacts of COVID positive patients | ASHAs, MPWs, Sanitary Inspectors<br>Volunteers from Self Help Groups and Local NGOs |

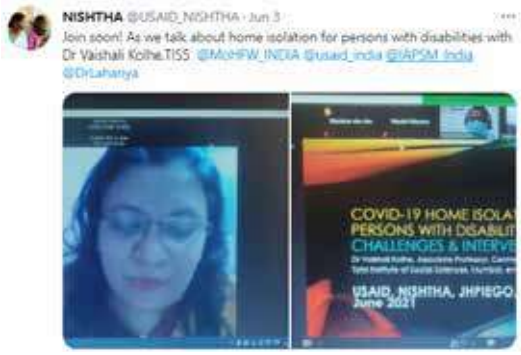
| | | | |
|---|---|---|---|
| **5** | Triaging | • Classification of COVID-19 positive patients in Mild/Moderate/ or Severe based on the severity of their symptoms. | CHOs, Staff Nurses, and MOs |
| | | • Navigating patients to appropriate health facilities for seeking care as per GoI or State guidelines. | CHOs and MOs |
| **6** | Monitoring | • Regular monitoring of COVID positive patients (telephonic) under home isolation for new signs and symptoms. | ASHA, MPWs, CHOs |
| | | • Monitoring of close contacts of positive patients for any signs and symptoms. | ASHA, MPWs |
| | | • Monitoring for availability of Home Isolation Kits (Medicines) | ASHAs, MPWs |
| **7** | Follow up | • Follow up of recovered patients for new symptoms or complications. | MPWs, CHOs, MOs |

# ANNEXURE 5: **GLIMPSES FROM THE WEBINAR AND STAKEHOLDER CONSULTATION**




Dr. Suneela Garg, IAPSM speaking during the webinar


Dr. Abhay Bang, SEARCH talking during the webinar




Dr. Vaishali Kolhe, TISS presenting during the webinar


Dr. Atul Kotwal, NHSRC at the event

# NOTES

# NOTES

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Jhpiego and do not necessarily reflect the views of USAID or the United States Government.