World Health Organization
REGIONAL OFFICE FOR Africa

COVID-19 RESPONSE

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR AFRICA SUPPORTS THE COVID-19 RESPONSE

INTERIM GUIDANCE FOR HOME BASED AND ISOLATION CARE OF PATIENTS WITH COVID-19 FOR MEMBER STATES

16 NOVEMBER 2021

A. Overview

Since the beginning of the COVID-19 pandemic in Africa in 2020, the number of COVID-19 cases has continued to rise with each wave. On the 25th October 2021, WHO African region has experienced 3 waves so far with 6.1 million cases tested positive and more than 150,441 deaths (1). This increase in the number of cases has exacerbated the pressure on the already strained health systems. However, this strain could be eased by eligible patients who are assessed to have non-severe COVID-19, followed up in their homes where feasible, or community isolation centers which could be, hotels or other community infrastructure in situations where home based care is not suitable as per the recommendation (2).

The Home-Based Isolation and Care (HBIC) strategy is important if implemented well. It will not only help to relieve congestion in health facilities but also ensure appropriate monitoring of patients and timely detection of those with risk factors for disease severity and progression, thus avoiding late presentation and decreasing morbidity and mortality among COVID-19 patients. Appropriate implementation will also help break the chain of COVID-19 transmission.

Nonetheless, implementing the management of patients on HBIC has proven to be challenging as there are variable home settings and insufficient resources (human, infrastructure, equipment, and finances) to allow effective and close monitoring of patients with appropriate referral to health facilities. Incidentally, this has resulted in COVID-19 worsening health care conditions in communities and increasing community transmission and deaths. Against this backdrop, we seek to develop standard guidance on HBIC implementation through a cross pillar approach that can be easily contextualized in various countries.

B. Goal

To Increase survival of COVID 19 through a better implementation of Home-Based Isolation and Care in countries within the WHO African Region

C. Objectives of HBIC

1- To enroll all newly diagnosed COVID-19 patients with a non-severe disease without delay and link them to the appropriate level of care
2- To follow-up/monitor all patients enrolled into HBIC while prioritizing those with co-morbidities
3- To identify patients progressing to severe diseases early and urgently refer these patients to treatment facilities.
4- To ensure appropriate infection and prevention control (IPC) measures are implemented in all HBIC sites
5- To follow all close contacts of patients on HBIC appropriately.
6- To address false rumours, myths and misinformation around HBIC
7- In collaboration with vaccine pillar, advocate for vaccine uptake in patients on home isolation.

D. Methods

The implementation of these guidance is based on 7 main steps:

1- Adaptation of guidance for countries
2- Integrated services with other pillars including Laboratory, Surveillance, IPC, Vaccination, and Risk Communication and Community Engagement (RCCE)
3- Training of Health Care Workers and Community Health Volunteers on HBIC
4- Collaboration with partners, civil society organizations and community leaders
5- Gradual implementation of HBIC in districts and expand HBIC in urban areas
6- Incorporation of existing and innovative technologies for information, evaluation and monitoring

The implementation of sustainable and effective HBIC management will be achieved through collaboration with the other pillars, namely laboratory, surveillance, IPC, vaccination, and communication. Support from these 5 pillars will contribute to the effective management of COVID-19 patients at home and in Community Isolation Centers.

The pathway for patient flow based on home, community or facility-based isolation and care is determined depending on the patient's context's suitability. It will be important to define and adapt the patient pathway to the context of each population within the country. In this light, good counselling as soon as the results are reported to the patient and immediate linking of the patient to the health care system will reduce the number of patients who miss an adequate assessment of their clinical status, living environment and follow-up. Thus, a clear patient flow should be defined.

I- Develop guidance for countries adaptation

Guidelines(2,3) have been developed and disseminated to the countries. These guidelines are also available on the WHO website and in WHOA(4)

II- Integrated services with other pillars including Laboratory, surveillance, IPC, vaccination, RCCE

An integration of pillars should be encouraged. If properly implemented, it will reduce the number of patients to be monitored at home and in health facilities. Reduce the burden of the COVID 19 infection on the health system in general which suffers from the lack of resources.

a) Case management

The case management team comprises clinical, nursing and emergency transport workers linked closely to an identified treatment facility. The decision to manage a patient at home should be made in accordance with the guidance of a medical team/professional (2) and only if their homes and caregivers have been assessed to be adequate. Otherwise, we strongly recommend the patient be managed in a Community Isolation Center. Follow-up at home can be contextualized and may be carried out either by a trained community health worker, nurse or doctor. It can be done remotely through phone calls or in person. Particular emphasis will be placed on patients with co-morbidities because they are at higher risk of progressing to severity.

Managing COVID- 19 cases include physical, clinical, laboratory and radiology assessments. However, for non-severe cases, only physical and clinical assessments may be required. This is the baseline triage and screening that should be done for all patients with suspected or confirmed COVID-19 and should include measurement of their temperature, respiratory rate and effort, level of consciousness, oxygen saturation, blood pressure, blood sugar measurement and other clinical parameters. Results should then be documented using tools such as the 'Assessment Tool for HBIC' (annexed) or can be adapted. A patient with non-severe COVID-19 disease could have symptoms of fever, headache, cough, coryza, weakness, loss of smell or taste patient, red eyes, diarrhea, sore throat or general malaise, among other symptoms. When needed, these symptoms can be self-limiting or may be relieved using approved medications such as analgesics and antipyretics. Antibiotics are usually unnecessary and ineffective since COVID-19 is a viral illness unless the patient has a concomitant bacterial infection (cf. image 1). Indiscriminate use of antibiotics increases the risk of drug interactions and antimicrobial resistance. Hydroxychloroquine and Ivermectin use are also discouraged as they have also been shown to be ineffective. Patients should be instructed to report any symptoms during isolation and the clinical team should monitor these symptoms for progression or clinical deterioration(3).

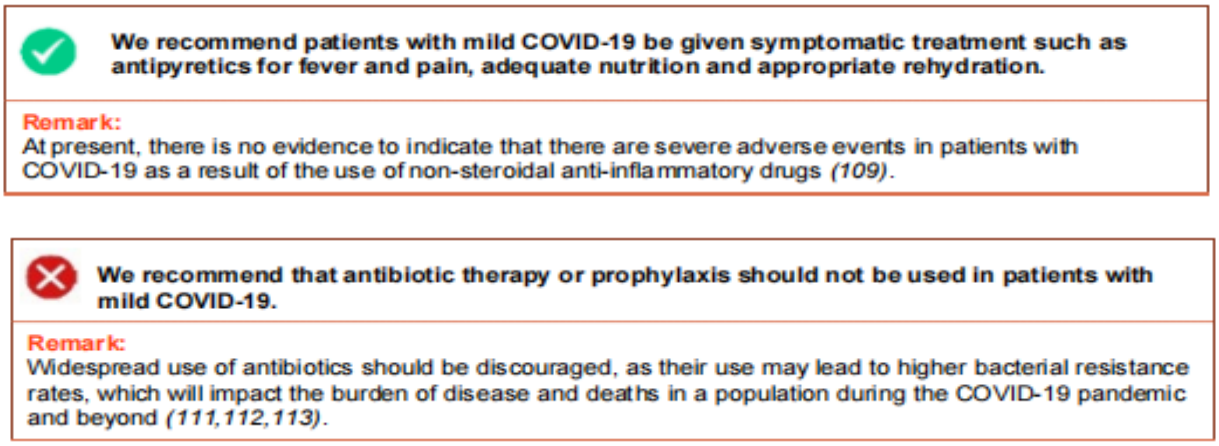

Image 1: Recommendations on the management of mild COVID 19: symptomatic patient
Source: COVID-19 Clinical management: Living guidance

Daily evaluation through digital applications, phone calls, or home visits is required throughout the patient's isolation period. Patients at higher risk of deterioration, such as the elderly and those with co-morbidities, should be monitored more closely with on-site visits every 24-48 hours. In all cases, efforts should be made to ensure the patients' respiratory statuses, including monitoring their oxygen saturation at baseline and regularly while on HBIC. Where feasible, patients, their caregivers or visiting HCWs or CHWs should have pulse oximeters and be conversant with their appropriate use (cf image 2). For patients with risk factors such as advanced age, hypertension, diabetes mellitus, obesity, chronic organ disease, HIV and other immunosuppressive states, provision or acquiring a pulse oximeter is recommended. Whenever possible, monitoring of blood glucose levels (5) and blood pressure is also highly recommended due to emerging evidence that hyperglycemia at the time of admission for COVID-19 is associated with poor prognosis, while hypertension and diabetes in patients with COVID-19 are also linked to poor

outcomes. Otherwise, monitoring these clinical parameters at the nearest health facility or community pharmacies can be recommended with strict adherence to IPC measures.

Image 2: A pulse oximeter
Source: WHO/AFRO Interim guidance on the use of pulse oximetry in monitoring COVID19 patient under Home Based Care Isolation and Care

Education on warning signs such as saturation levels being below 94%, shortness of breath, chest pain, lightheadedness or dehydration should be done. Use of pamphlets for ease of reference, with emergency contacts listed, should be encouraged. Mechanisms should be put in place, e.g., through the establishment of COVID-19 hotlines, universal emergency numbers, mobile applications triggering response teams, or other linkages with nearby health facilities, to ensure that patients with warning signs receive timely assistance and are referred to facilities that can provide them with the appropriate level of care. If any sign of deterioration is noted, the patient should be transferred to a treatment center without delay for proper management.

A patient should be monitored for 10 days minimum from the time they test positive. The decision to discharge a patient from home, community or facility isolation should be made based on the WHO COVID-19 discharge criteria(6) as elaborated in the WHO COVID-19 Clinical Management Living Guidance(3) (images capture excerpt below).

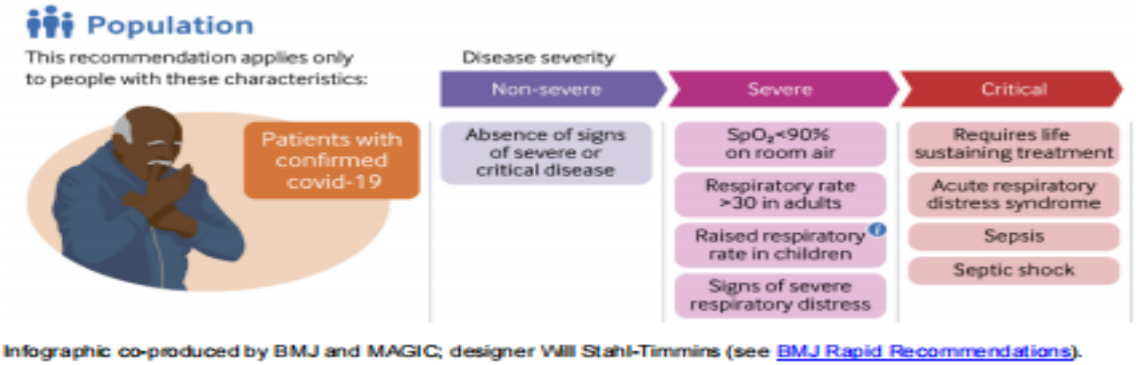

Image 3: WHO severity definitions (3)
Source: COVID-19 Clinical management: Living guidance

We recommend that patients with suspected or confirmed mild COVID-19 be isolated to contain virus transmission according to the established COVID-19 care pathway. This can be done at a designated COVID-19 health facility, community facility or at home (self-isolation).

Remarks:

1. In areas with other endemic infections that cause fever (such as malaria, dengue, etc.), febrile patients should be tested and treated for those endemic infections per routine protocols *(65,66,69)* irrespective of the presence of respiratory signs and symptoms. Coinfection with COVID-19 may occur.
2. The decision to monitor a suspect case with mild COVID-19 in a health facility, community facility or home should be made on a case-by-case basis based on the local COVID-19 care pathway. Additionally, this decision may depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and conditions at home, including the presence of vulnerable persons in the household.
3. If managed at home in self-isolation, refer to WHO guidance on home care for patients with COVID-19 presenting with mild symptoms and management of their contacts *(108)*.

Image 4: Recommendation for suspected or confirmed mild COVID-19 to be isolated

Discontinue transmission-based precautions (including isolation) and release from COVID-19 care pathway as follows.

Remarks:

1. Criteria for discharging patients from isolation (i.e. discontinuing transmission-based precautions) without requiring retesting:
   - For symptomatic patients: 10 days after symptom onset, plus at least 3 additional days without symptoms (including without fever and without respiratory symptoms).
   - For asymptomatic cases: 10 days after positive test for SARS-CoV-2.
2. For example, if patient had symptoms for 2 days, then the patient could be released from isolation after 10 days + 3 = 13 days from date of symptom onset; for a patient with symptoms for 14 days, then the patient can be discharged 14 days + 3 days = 17 days from date of symptom onset; for a patient with symptoms for 30 days, the patient can be discharged 30 days + 3 days = 33 days after symptom onset.
3. Countries may choose to continue to use testing as part of the release criteria. If so, the initial recommendation of two negative PCR tests at least 24 hours apart can be used.
4. Some patients may experience symptoms beyond the period of infectivity. See Chapter 24. Care of COVID-19 patients after acute illness.
5. Please note that the clinical pathway needs to be clearly outlined by countries to follow each patient until outcome, including full recovery. Discharge criteria from clinical care need to take into account the patient's condition, disease experience and other factors.
6. Release from the COVID-19 care pathway is not the same as clinical discharge from a facility or from one ward to another. For example, some patients may still require ongoing rehabilitation, or other aspects of care, beyond release from the COVID-19 care pathway, based on clinical needs in the COVID-19 care pathway. If release from the COVID-19 care pathway coincides with clinical discharge, then several clinical considerations, such as medication reconciliation, plan for follow up with clinical provider in place, review of routine immunization status, among others, should be taken into account.
7. See scientific brief *Criteria for releasing COVID-19 patients from isolation* for more details *(13)*.

Image 5: Release from COVID-19 care pathway

Table 6.1 Symptoms associated with COVID-19

Presenting signs and symptoms of COVID-19 vary.

Most persons experience fever (83–99%), cough (59–82%), fatigue (44–70%), anorexia (40–84%), shortness of breath (31–40%), myalgias (11–35%). Other non-specific symptoms, such as sore throat, nasal congestion, headache, diarrhoea, nausea and vomiting, have also been reported *(28,77,78,79)*. Loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms has also been reported *(31,80,81)*.

Additional neurological manifestations reported include dizziness, agitation, weakness, seizures, or findings suggestive of stroke including trouble with speech or vision, sensory loss, or problems with balance in standing or walking *(32,33)*.

Older people and immunosuppressed patients in particular may present with atypical symptoms such as fatigue, reduced alertness, reduced mobility, diarrhoea, loss of appetite, confusion, and absence of fever *(62,63,64)*.

Symptoms such as dyspnoea, fever, gastrointestinal (GI) symptoms or fatigue due to physiologic adaptations in pregnant women, adverse pregnancy events, or other diseases such as malaria, may overlap with symptoms of COVID-19 *(82)*.

Children might not have reported fever or cough as frequently as adults *(83)*.

Table 6.2 Risk factors associated with severe disease

Age more than 60 years (increasing with age).

Underlying noncommunicable diseases (NCDs): diabetes, hypertension, cardiac disease, chronic lung disease, cerebrovascular disease, dementia, mental disorders, chronic kidney disease, immunosuppression, obesity and cancer have been associated with higher mortality *(84,85)*.

In pregnancy, increasing maternal age, high BMI, non-white ethnicity, chronic conditions and pregnancy specific conditions such as gestational diabetes and pre-eclampsia *(53)*.

Smoking.

Image 6: Symptoms and risk factors associated with COVID-19
Source: COVID-19 Clinical management: Living guidance

Counselling patients and family members

Counselling should have a pretest and posttest component with a focus on the identification of disease progression and breaking of the transmission chain. Patients who test positive for COVID19 should be managed promptly and advised to isolate till the results are ready. Once the patient's test is returned, the

health worker/ psychosocial worker /counsellor must provide counselling. Well-conducted counselling will contribute to good patient and family compliance with the provider's instructions.

The health worker will then triage the patient based on disease severity and risk factors for disease progression, including oxygen saturation, blood pressure, blood sugar measurement, and other parameters (refer to the Assessment tool for HBIC). This information should be well recorded and used for home/isolation follow-up or referral without delay (enrolment should be on the same day of positive result confirmation). A good counselling session is essential and will ensure that the patient understands the following:

- What is COVID-19 infection?
- Why is he/she classified as eligible for home-based care or not?
- How will he be monitored at home or in an isolation center? By whom?
- What are the warning signs he should watch out for?
- What should the patient do if he has warning signs?
- Means of transfer to a treatment center should be discussed.
- What treatment should the patient take and why?
- What should the patient do to avoid infecting others?
- Check the vaccination status of the patients and the members of his household.
- Answer the patient's questions and address false rumors or misinformation circulating within the community.
- Provide pamphlets or other material to help further answer the patient’s questions and direct them on the next steps, including emergency contacts and where to seek further care.

Mental health and psychosocial support

We recommend providing basic mental health and psychosocial support (MHPSS) for all persons with suspected or confirmed COVID-19 by asking them about their needs and concerns, and addressing them *(176)*.

Remarks:

1. Basic psychosocial support skills are essential for management of all patients and they represent an integral part of the care to be provided for different groups, including children, older adults, pregnant women and others affected by COVID-19 *(177)*.
2. This recommendation is consistent with the Inter-Agency Standing Committee briefing note about mental health and psychosocial aspects of COVID-19 *(176)*, and guidance on basic psychosocial skills for COVID-19 responders *(177)*, and WHO recommendations on providing access to support based on psychological first aid principles to people in acute distress exposed recently to a traumatic event *(178)*.
3. Ask people about their needs and concerns around diagnosis, prognosis, and other social, family or work-related issues. Listen carefully, try to understand what is most important to the person at this moment, and help them work out what their priorities are and link them with relevant resources and services.
4. Give accurate information on the person's condition and treatment plans in easily understood and non-technical language, as lack of information can be a major source of stress. Help people address urgent needs and concerns, and help with decision-making, as necessary. Help connect people with loved ones and social support, including through phone or internet as appropriate.
5. MHPSS and follow up should continue after the person is discharged from hospital to ensure their symptoms are not worsening and they are continuing to do well. This can be provided through telehealth, where available and appropriate.
6. Given the stress that COVID-19 may create at individual and family levels, the high prevalence of common mental health conditions among women in the antenatal and postpartum period, and the acceptability of programmes aimed at them, interventions for MHPSS targeted to mothers need to be more widely implemented. Prevention services should be available in addition to services that treat mental health conditions.
7. Parents and caregivers who may need to be separated from their children, and children who may need to be separated from their primary caregivers, should have access to appropriately trained health or non-health workers for MHPSS. MHPSS should be appropriately adapted for the needs of children, taking into consideration their social and emotional development, learning and behaviour *(176)*.

Image 7: Recommendation for basic mental health and psychosocial support.

Source: COVID-19 Clinical management: Living guidance

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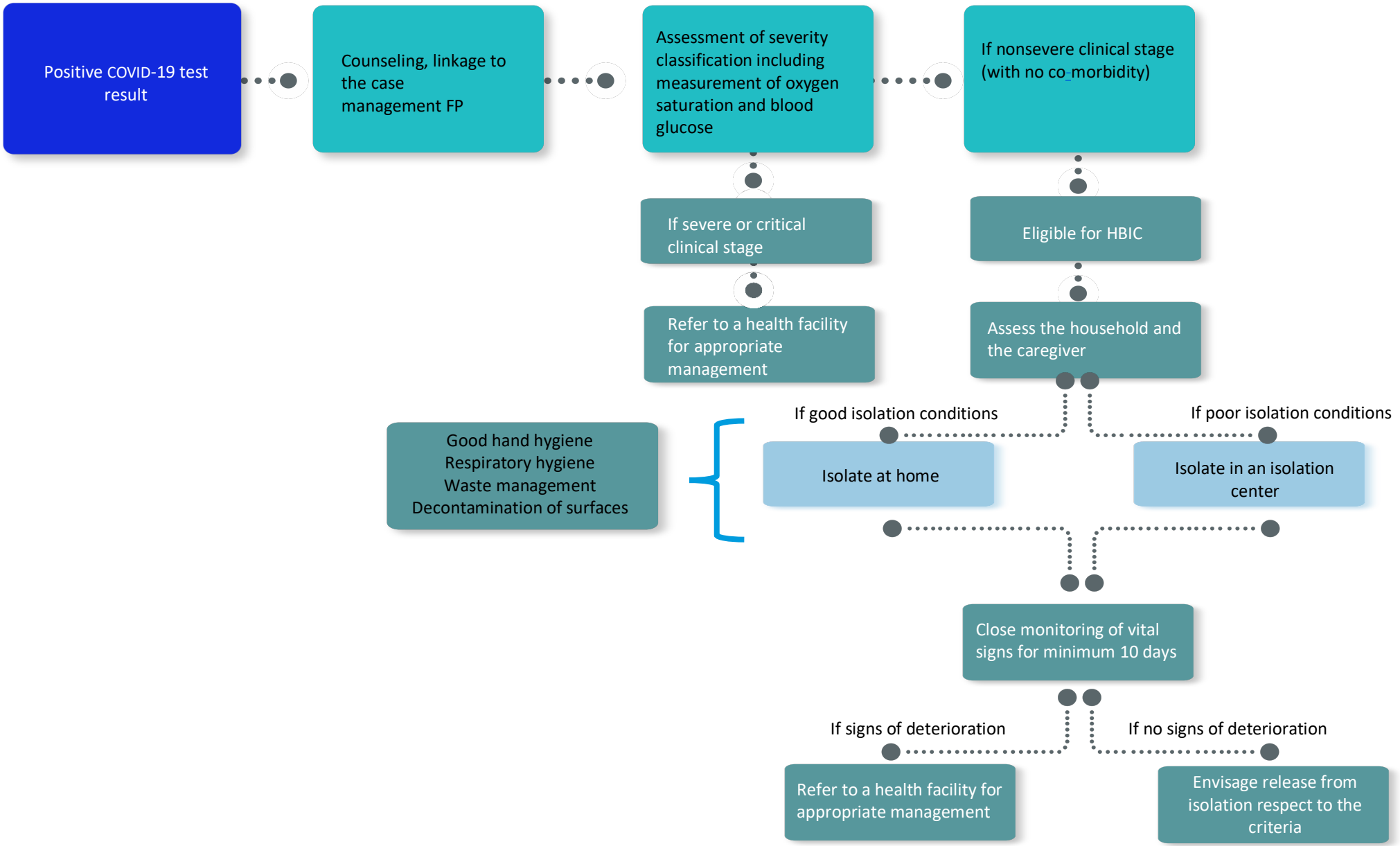
Patient flow



b) Laboratory and surveillance

The laboratory is a key component in making the management of COVID-19 successful in both HBIC and management in facilities as it is where a diagnosis is made. Many patients may be lost to follow up if no steps are made to create linkages between laboratories, contact tracers, HBIC teams and health facilities. Once a patient tests positive, their details, including contacts, should be recorded and communicated to surveillance teams in charge of contact tracing in the area. Additionally, patients should receive counselling after testing positive for COVID-19 as above, including direction on next steps for care-seeking even when they are asymptomatic or have mild disease. Triage and decision making on the appropriate setting for management of the patients should be made to minimize loss to follow up.

Collaboration between laboratories, surveillance, HBIC management, and COVID-19 treatment centers should be established in advance with clarity of the pathways for information flow on both positive and negative cases to minimize the number of patients lost to follow up.

Surveillance systems should ensure that contacts close contacts of cases are listed as much as possible. Where there is widespread community transmission, contact tracing and testing for close contacts of patients on HBIC should be prioritized to minimize household transmission and wider community transmission. Close contacts and household members that test negative should still be encouraged to self-quarantine for 14 days. At the end of this period, a control test can be carried out on them.

c) IPC

For home-based and isolation care to be effective, good community IPC is important not only to prevent the spread of infection from the patient to those around him. Good IPC also helps to assist the caregiver in his task of taking care of the patient. Guidance in this regard should be made available for the community, staff working in the treatment centers, community health workers or any other staff working in the fight against COVID-19. The patient, the caregiver, the CHW, the health personnel and all those involved in the management of a patient infected with COVID-19 should:

- Should wear a medical mask fitted tightly to the face when in the same room with the ill person
- Perform hand hygiene following all contact with ill persons or their immediate environment
- Clean and disinfect frequently touched surfaces
- Physical distance
- Respiratory hygiene should be practised by all, especially ill persons, at all times

All these measures must be taught to the patient, his caregiver, members of his household.

d) RCCE

The contribution of communication is crucial. Support will be needed to combat misinformation and false rumors on the one hand; and on the other hand, to raise awareness of the practices to be adopt by the patient and his or her caregiver if follow-up at home is recommended. The necessity to use health services

in the event of a deterioration of the patient's clinical condition is crucial. As the risk of progression of the disease to a severe and critical stage is higher in people with co-morbidities, additional support will also be needed to raise awareness among this population group on the benefit of vaccination in the fight against COVID-19.

e) Vaccination

Vaccination should be highly recommended to all close contacts, caregivers, and other members of the patient household without delay. Vulnerable persons, such as those with co-morbidities are more predisposed to develop severe COVID-19 disease and should therefore be prioritized for vaccination.

f) Incorporation of existing and innovative technology for information, evaluation and monitoring

The use of telemedicine facilities should be encouraged to facilitate documentation and monitoring of patients' parameters and monitoring and evaluation of the home-based strategy. Mobile phone apps, electronic data collection tools may be used. Their use should take into consideration the local context, including availability and accessibility of the internet and mobile phones.

III- Train Health care workers and community health volunteers on HBIC

For the implementation, a cross pillar approach is recommended. It is advised for each district to have teams with members well known by everyone. During training, the focus should be to:

- Train health care workers on management of patients on home care
- Train community health volunteers on follow-up and reporting on patients on HBIC
- Develop an algorithm for linkages and referrals of patients on HBIC to nearby treatment facilities
- Provide pulse oximeters, sphygmomanometers, glucometers and recording books to aid in monitoring
- Develop a database of all patients on HBIC at the districts/ community level
- Develop targeted messages to encourage vaccination, the adherence of patients and their caregivers on HBIC and mitigate myths, misconceptions and stigma surrounding COVID 19 disease
- Provide adequate and sustainable IPC measures for patients on home care
- Involve community members in patient well-being and community watch
- Provide adequate resources to support isolated patients for the duration of isolation
- Alert laboratory in. time for sample collection and results
- Provide psychosocial counselling to patients, families and caregivers

IV- Gradual implementation of HBIC in districts and expand HBIC in urban areas

Generally, it is recommended that the above methods are gradually implemented at districts/sub-national levels or rolled out in phases as implementing HBIC nationwide might not be feasible due to insufficient human and financial resources. Focus can be directed towards areas with high attack rates, high caseloads, and high case fatality rates, depending on the available resources.

V- Enabling factors

Successful implementation of Home-Based Isolation and Care will depend on enabling factors, including advocacy, partnership and community engagement, provision of adequate funding for establishment and procurement of needed equipment.

E. Conclusion

The strategy for Home-Based Isolation and Care aims to ensure that care for COVID-19 patients with the non-severe disease is provided in a manner that helps to decongest health care facilities breaks the chain of transmission, and is practical and feasible in the context of the setting is applied. Implementation targeted to population-specific needs must be prioritized for successful implementation. The services provided should be preventive, curative and support to rehabilitation.

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ANNEXES

ANNEX 1: ASSESSMENT TOOL FOR HOME BASED ISOLATION CARE

Date	-----/-----/-----	
Name of Health Worker		
Reference Health Facility		
Patient's Name	----------	
Age:	---------- Years	
Phone number:	----------	
District / Province/County	----------	
Physical Address:	----------	
Diagnostic test for COVID-19	Ag RDT test result- positive	Yes / No
	PCR test result - positive	Yes / No
Date of diagnosis	----/------/------	
Next date of testing	----/------/------	
Symptoms		
	Fever	Yes / No
	Asthenia	Yes / No
	Headache	Yes / No
	Muscle pain	Yes / No
	Rhinorrhoea	Yes / No
	Loss of smell	Yes / No
	Loss of taste	Yes / No
	Loss of appetite	Yes / No
	Sore throat	Yes / No
	Nausea	Yes / No
	Diarrhoea	Yes / No
	Cough	Yes / No
	Shortness of breath	Yes / No
	Difficulty breathing	Yes / No
	Chest pain	Yes / No
	Dizziness	Yes / No
	Confused /altered mental state	Yes / No
	Conjunctivitis	Yes / No
	Rash on skin	Yes / No
	Others	
Co-morbidities (risk factors for severe disease and mortality)		
	Age ≥ 60	Yes / No
	Obesity	Yes / No
	Hypertension	Yes / No
	Diabetes	Yes / No
	Cardiac diseases	Yes / No
	Chronic Lung disease	Yes / No

	Chronic Kidney disease	Yes / No
	Immunosuppression and cancer	Yes / No
	Sickle cell disease	Yes / No
	HIV	Yes / No
	Tuberculosis	Yes / No
	Cancer	Yes / No
	Others	
Vital signs		
	Fever (®c)	---------
	Weight	--------- kg
	height	--------- m
	Blood Pressure	----/----- mmhg
	Heart rate	------ bpm
	Random Blood Sugar	--------- mmol/l
	Respiratory rate	------ breaths/min
	Oxygen saturation	------ %
Clinical stage of the patient		Asymptomatic / mild / Moderate / severe / critical
	Asymptomatic	No symptoms
	Mild	Symptoms presents No evidence of pneumonia
	Moderate	Clinical signs of pneumonia with no signs of severity (cough, fever, fast breathing, dyspnoea, oxygen saturation ≥ 92-94% on room air).
	Severe	Clinical signs of pneumonia plus one of the following (respiratory rate › 30 breaths/min, severe respiratory distress, oxygen saturation < 92 % on room air).
	Critical	All signs of severe clinical stage, Sepsis, septic shock, respiratory failure, organ dysfunction, acute thrombosis.
Patients with risk factor(s) must be categorised under one level above their symptoms		
Final clinical stage after assessment **IMPORTANT: P**atients diagnosed with severe or critical stage, or patients in moderate stage with co-morbidities, must be immediately referred to a treatment facility.		Asymptomatic / mild / Moderate / severe / critical
Assessment of household and caregiver		

1. Infrastructure	Functioning mobile phone?	Yes / No
	Any other mean to communicate with the health system?	Yes / No
	Safe drinking water is available at any time?	Yes / No
	Water for hand washing and other hygienic purposes is available at all times?	Yes / No
	Access to a toilet (frequently cleaned and disinfected)?	Yes / No
	Sewerage system	Yes / No
	Cooking source (and fuel)	Yes / No
	Operable electricity	Yes / No
	Operable heat source when required	Yes / No
	Is the patient room well ventilated?	Yes / No
2. Accommodation	Separate room or bedroom for the patient	Yes / No
	Accessible bathroom	Yes / No
3. Resources (Please check feasibility of training patient and household contacts on use of PPE and basic preventive measures)	Food for the patient available everyday?	Yes / No
	Recommended medication is available?	Yes / No
	Medical masks (patients)	Yes / No
	Medical masks (care providers, household contacts)	Yes / No
	Gloves	Yes / No
	Hand hygiene items (soap, alcohol-based hand rub)	Yes / No
	Household cleaning and disinfectant products	Yes / No
4. Primary care and support	Designated Person or person to provide care and support	Yes / No
	Do the patient and caretaker have a reference medical contact and the means to contact in case of further complication	Yes / No

	Who is this reference medical contact?	Name:
	Any at risk people at home (e.g. children under 2 years, elderly with more than 65, immunocompromised people)	Yes / No
Final decision upon agreement with the patient		Home isolation / Isolation center / refer to treatment facility
If the final decision is to proceed to Home isolation and treatment, IPC measures should be implemented with the collaboration of IPC team (see annex attached). Activities for the management of contacts should be undertaken with collaboration of Surveillance team		
Patient monitoring		
Has a clinician / nurse/ CHW been assigned to the patient?		Yes / No
Is a referral pathway identified for the patient?		Yes / No
How often would the patient be clinically checked?		Every ------ days for ----- days

Vital signs monitoring chart

Parameter	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**	**Day 8**	**Day 9**	**Day 10**
HR (bpm)										
BP (mmHg)										
RR (Bpm)										
Temp (*C)										
SpO_2 (%)										
FBS/ RBS										
New symptoms and health status										

Final outcome: Discharged / refer to treatment facility / Died

Date of final outcome: ____/_____/_____

ANNEX 2: IPC MEASURES FOR HOME BASED CARE

- Place the patient in a single room with sufficient openings a well-ventilated single room for ventilation (at least one window ajar, partially opened at all times)
- Limit the number of caretakers of the patient; ideally assign one person (Two persons, if available so that one doesn't get run down) who is in a good health without risk conditions. No visitors
- Household members should stay in a different room or, if that is not possible, maintain a distance of at least 1 m from the ill person (e.g. sleep in a separate bed: exception of a breastfeeding mother).
- Limit the movement of the patient and minimize shared space. Ensure that shared spaces (e.g. kitchen, bathroom) are well ventilated (e.g. keep windows open)
- The caregiver should wear a medical mask fitted tightly to the face when in the same room with the ill person. Masks should not be touched or handled during use. If the mask gets wet or dirty with secretions, it must be changed immediately. Discard the mask after use and perform hand hygiene after removal of the mask
- Perform hand hygiene (2) following all contact with ill persons or their immediate environment. Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty. If hands are not visibly soiled, alcohol based hand rub can be used. Perform hand hygiene using soap and water when hands are visibly soiled. Address safety concerns (e.g. accidental ingestion and fire hazards) before recommending alcohol-based hand rubs for household use
- When using soap and water, disposable paper towels to dry hands is desirable. If not available, use dedicated cloth towels and replace them when they become wet
- Respiratory hygiene should be practiced by all, especially ill persons, at all times. Respiratory hygiene refers to covering the mouth and nose during coughing or sneezing using medical masks, cloth masks, tissues or flexed elbow, followed by hand hygiene
- Discard materials used to cover the mouth or nose or clean them appropriately after use (e.g. wash handkerchiefs using regular soap or detergent and water)
- Avoid direct contact with body fluids, particularly oral or respiratory secretions, and stool. Use disposable gloves to provide oral or respiratory care and when handling stool, urine and waste. Perform hand hygiene before and after removing gloves
- Gloves, tissues, masks and other waste generated by ill persons or in the care of ill persons should be placed in a lined container in the ill person's room before disposal with other household waste
- Avoid other types of possible exposure to ill persons or contaminated items in their immediate environment (e.g. avoid sharing toothbrushes, cigarettes, eating utensils, dishes, drinks, towels,

washcloths or bed linen). Eating utensils and dishes should be cleaned with either soap or detergent and water after use and may be re-used instead of being discarded

- Clean and disinfect frequently touched surfaces such as bedside tables, bedframes, and other bedroom furniture daily with regular household disinfectant containing a diluted bleach5 solution (1-part bleach to 99 parts water)
- Clean and disinfect bathroom and toilet surfaces at least once daily with regular household disinfectant containing a diluted bleach6 solution (1-part bleach to 99 parts water)
- Clean clothes, bedclothes, bath and hand towels, etc. of ill persons using regular laundry soap and water or machine wash at 60–90 °C with common household detergent, and dry thoroughly. Place contaminated linen into a laundry bag. Do not shake soiled laundry and avoid direct contact of the skin and clothes with the contaminated materials
- Use disposable gloves and protective clothing (e.g. plastic aprons) when cleaning or handling surfaces, clothing or linen soiled with body fluids. Perform hand hygiene before and after removing gloves
- Persons with symptoms should remain at home until their symptoms are resolved based on either clinical and/or laboratory findings (two negative RT-PCR tests at least 24 hours apart)
- All household members should be considered contacts and their health should be monitored according to local policy surveillance
- If a household member develops symptoms of acute respiratory infection, including fever, cough, sore throat and difficult breathing, local policy recommendations should be followed

Healthcare workers providing home care should do risk assessment to select the appropriate PPE