



Interim Guidelines for Home Based Isolation & Care of Confirmed COVID-19 Cases

(Version 2.0)
January 2021

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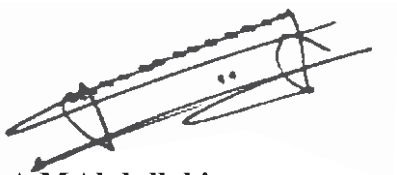
ACKNOWLEDGEMENT

I wish to thank the individuals, organizations and partners for their dedication and commitment in the revision of the Interim Guideline for Home-Based Isolation and Care of COVID-19 Confirmed Cases.

The Ministry wishes to specially appreciate the World Health Organization (WHO), Clinton Health Access Initiative (CHAI), United Nations Children's Fund (UNICEF), and the United States Centre for Disease Control (USCDC) who provided technical and financial support to ensure that this document saw the light of the day. Their unflinching support in the fight against COVID-19 has no doubt impacted positively on the Nigerian healthcare system.

The contributions of staff of the Department of Hospital Services of the Federal Ministry of Health, the Nigeria Centre for Disease Control (NCDC), the National Primary Health Care Development Agency (NPHCDA) and the State COVID -19 Case Managers are highly commendable.

Finally, I wish to acknowledge the Commissioners of Health for Lagos and Edo States, whose contributions were highly beneficial to the development of this document.



A.M Abdullahi
Permanent Secretary,
Federal Ministry of Health

FOREWORD

COVID -19 was declared a pandemic on 11th March, 2020 by the World Health Organization (WHO), after the index case was recorded in Nigeria on 27th February 2020, as a case imported from Italy.

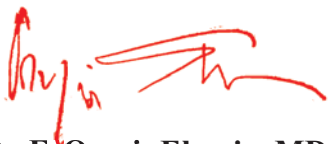
Prior to that, the Federal Ministry of Health had developed guidelines for accreditation of Isolation Centres and also designated centres for isolation and treatment. Health workers and the public were educated on symptoms of the disease and points of entry were on alert to detect cases that may be arriving. Hospitals were also equipped with relevant personal protective equipment and triage protocols.

Confirmed cases were admitted in designated isolation/ treatment centres for treatment and to forestall community transmission. Other public health measures were taken to prevent spread of the disease, such as lock down, and non-pharmaceutical interventions (NPIs) which remain pertinent in the fight against the pandemic. NPIs include use of face masks, hand washing, use of hand sanitizers as well as proper respiratory hygiene. Awareness of the disease was created on social and print media, and health workers were trained on Case Management, Infection, Prevention and Control (IPC), Sample Collection, and various guidelines and protocols.

Nigeria is presently in community transmission, since many cases have no clear epidemiological link with a confirmed or imported case and current data shows most cases are asymptomatic or mild, and requiring only isolation and supportive management to recover.

The first version of the Interim Guideline for Home Care of COVID-19 Confirmed Cases was developed at the beginning of the pandemic, bearing in mind that hospitals might at a time be unable to cope with the burden of the pandemic. The second version of the Interim Guideline for Home-Based Isolation and Care of COVID-19 Confirmed Cases was developed to reduce pressure on the health system, and to ensure that patients with other disease conditions receive more attention, while tackling the pandemic. It was put together bearing in mind lessons learned so far, and international best practices.

I hope that use of this document will further strengthen the management of mild or asymptomatic cases of COVID-19 in the country, thereby reducing morbidity and mortality of confirmed cases.



Dr. E. Osagie Ehanire MD, FWACS
Honourable Minister of Health

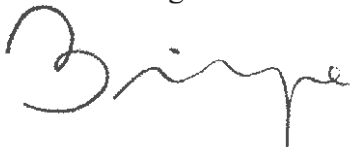
EXECUTIVE SUMMARY

Homebased care for suspected or confirmed COVID -19 patients is the holistic and integrated care provided for asymptomatic and symptomatic confirmed cases of COVID-19 in the comfort of their homes. It encompasses biomedical, physical, psychosocial, palliative, and other aspects of care provided by patients, family members, community volunteers and /or healthcare workers under the supervision of a treatment centre with appropriate facilities for evaluation when necessary.

As majority of patients are asymptomatic or mild and require minimal interventions for care, the home is an ideal place to manage such patients in a cost-effective manner with satisfactory outcomes. This allows the focus of institutional care to the management of moderate to severe cases.

Patients who meet the criteria for home- based isolation and care after assessment of clinical risk, home risk, Infection Prevention and Control, adherence to guidelines, waste management and other factors are enrolled into a specific home- based care team attached to an isolation/treatment centre for supportive care. They are followed up to discharge after a minimum of 10 days after exposure, confirmation of test positivity, or onset of symptoms. The frequency of follow up is mainly based on the clinical risk assessment. Patients whose clinical risk or condition deteriorate are evacuated preferably to their supervising treatment centre. Specific roles of all stakeholders and personnel are clearly delineated with protocols and procedures for data management also well spelt out.

Ultimately, it is envisaged that this revision of the home -based care guideline for management of asymptomatic and mild suspected or confirmed cases of COVID-19 would ensure efficient and effective management of covid-19 patients in their home with improved outcomes.



Dr. Adebimpe Adebisi, mni

National Case Management Pillar Lead for COVID-19 &
Director, Department of Hospital Services

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Target audience: Patients, patients' household, health care workers, case managers

Purpose of the guidance

This rapid advice is intended to guide public health and infection prevention and control (IPC) professionals, health facility managers, health workers and other trained community-based providers when addressing issues related to home care for patients with suspected or confirmed COVID-19, and thus refers to a patient with suspected or confirmed COVID-19 throughout the document.

In many contexts, health services are delivered at community level and in the home by community health workers, traditional medicine practitioners, social care workers, or a variety of formal and informal community-based providers, including caregivers. For the purpose of this document, “caregivers” refers to parents, spouses and other family members or friends providing informal care as opposed to the care provided by formal health-care providers (*1*). It is therefore critical to ensure that caregivers have appropriate training and guidance on how to care for patients as well as how to minimize the risk of infection, including training on important hygiene procedures and on recognizing signs that the COVID-19 patient's condition is worsening and that he or she needs to be sent to a health facility.

In addition, health workers and caregivers providing support in the home should be provided with the appropriate personal protective equipment (PPE) for the tasks that they are expected to perform and trained in PPE use and removal.

This guidance is based on the latest available evidence on the clinical management of COVID-19, the feasibility of implementing safe care at home, including IPC measures, the capacity for communication between home-based caregivers and community health providers, as well as home-based patients' access to health facilities. The appendix provides implementation strategies for care in the home setting.

This interim guidance has been updated with advice on safe and appropriate home care for patients with coronavirus disease 2019 (COVID-19) and on the public health measures related to the management of their contacts.

The main differences from the previous version include:

- Considerations for clinicians when identifying and supporting patients who could receive care at home.
- Clinical monitoring and treatment of COVID-19 patients at home.
- Clinical data reporting framework for home-based care.
- Consideration for mental health and psychological support in homebased care
- Waste management and IPC in the home setting in the context of COVID-19.
- Identification of operational framework, and responsibilities of key stakeholders in home-based care.
- Key Performance Indicators for evaluation of home-based care.
- An appendix on the effective implementation of home-care policies and guidelines for patients with COVID-19.
- An appendix of various checklists for patient classification for home-based care.

Guiding Principle

It is recommended that clinicians prioritize the use of designated treatment areas, according to severity and acute care needs, to care for confirmed COVID -19 patients; home care should only be recommended in patients after an appropriate risk assessment has been done and following appropriate counselling and patient information.

Key recommendations for Health care workers

- *Thoroughly assess the confirmed COVID-19 patient and determine if they do not require hospitalization (i.e. medically stable and can receive care at home – see checklist in the Annex)*
- *Consider home care for patients with no symptoms, mild symptoms or for patients without concern for rapid deterioration as determined by a managing physician.*
- *Ensure follow-up and care by a family member; If and where feasible, a communication link between the patient and health care provider and/or public health personnel should be established.*
- *Clinical judgment should be used and informed by an assessment of the patient's home and environment as well as socio-cultural considerations by a trained health care worker, if and where feasible.*
- *Educate patients and household members about personal hygiene, infection prevention and control (IPC) measures, waste management and how to care for the patient.*

Key recommendations for the patient the at household level

- *Remain isolated and limit contact with all other people, including household members, until all symptoms have resolved and/or a healthcare worker has cleared the patient.*
- *Stay alone in a well-ventilated room and if possible, with bathroom ensuite).*
- *Limit movement in the house or minimise use of shared space.*
- *Ensure shared spaces are well ventilated.*
- *Follow cleaning and disinfecting guidance at home.*
- *Limit the number of caregivers.*
- *Seek care urgently if there is a change in your condition.*

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1.0 Background

Following the outbreak of COVID-19 outbreak in Nigeria on 27th February 2020, the country has been managing confirmed cases in government designated isolation/ treatment centres in order to ensure recovery of cases as well as prevent community transmission. There is now evidence of community transmission in the country, as over 50% patient of cases have no clear epidemiological link with a confirmed case. Most cases of COVID-19 in Nigeria from current data are mild, with several having no symptoms (asymptomatic). These cases require only isolation and supportive management to recover. Median duration of stay for admitted cases is about 11 days' hospitalisation (range of hospitalisation is 4 -37 days). Almost all the deaths recorded had co-morbidities such as hypertension, diabetes, dyslipidaemia, amongst others.

As part of measures to control the outbreak, pharmaceutical and non-pharmaceutical measures have been implemented which include personal hygiene (hand washing, cough etiquette), physical distancing and restriction of movement in some states. Over 90% of cases are currently managed under homebased care.

To reduce pressure on the health system, cases which are asymptomatic or have mild symptoms may remain in isolation at home (*see Guidance on Self-Isolation*) with access to clinicians to monitor their health condition and have access to quick evacuation to a treatment centre should they need urgent medical intervention. This assessment will be based on the infrastructure of the state and health seeking behaviour of its citizens.

Whereas WHO recommends all laboratory confirmed COVID-19 cases to be managed within institutionalized care when and wherever possible, it also recognizes the need for countries to consider home based care in situations where management of all confirmed COVID-19 cases in healthcare facilities is impossible.

The Home-Based Isolation and Care (HBIC) Guideline for asymptomatic and mild confirmed cases of COVID-19 cases was developed after careful consideration and review of the outbreak/epidemiological situation of the disease. This represents a strategic but significant shift in our COVID-19 Case Management response strategy as well as the overall pandemic response plan. FMOH recognizes the implications of this strategic shift and has developed a clear implementation guidance for better management and effective operation of home -based isolation and care across the country.

This “National Implementation Guide for COVID-19 Home Isolation and Care” is developed with the hope to provide clear guidance, recommendation, procedures as well as practical considerations to enable all the concerned bodies and stakeholders to effectively and efficiently implement the Home Isolation and Care. This document will be periodically reviewed based on available evidence and the outbreak situation.

2.0 Scope

The document provides guidance and recommendations with regards to laboratory confirmed COVID-19 patients who are asymptomatic or have mild symptoms. It should be applied in all facilities (non-health care settings) or health care settings, and homes by all persons including health care workers and home caregivers involved in providing care to COVID-19 patients who are asymptomatic or have mild symptoms.

Recommendations provided here do not address the management of moderate and severe COVID19 patients (Please see Guideline- for treatment of COVID-19 case moderate and severe category).

Home care settings for home isolation and care does not by any standard confer the status of a “COVID-19 Treatment Centre” to the applicable home setting.

The document does not provide for the treatment of non-COVID related morbidities and disease conditions that a patient may have. Such persons should and can access care at existing health facilities.

3.0 Objectives

In the context of community transmission, depending on testing strategy and capacity, patients with mild or moderate illness who are not tested should be advised to self- isolate at home or stay in an isolation centre. Home care should also be considered patients that meet the criteria and or when inpatient care is unavailable or unsafe (e.g. limited capacity, resources).

The objective of this document is to -

1. Clarify the categories of patients that can be recommended for home care.
2. Provide guidance on provision of home care for persons with confirmed COVID-19 infection who are asymptomatic or who have mild symptoms.
3. Outline the steps and procedures for better management and effective implementation of home isolation and care.
4. Describe the roles and responsibilities of the different stakeholders during implementation of national home isolation and care guide.
5. Provide detailed technical and administrative guidance on clinical monitoring, support and referral links for asymptomatic and mild confirmed COVID-19 cases during home isolation and care.
6. Data gathering for monitoring and evaluation.

4.0 Governance of National COVID-19 Home Based Care and Isolation

Responsibilities for governance during the implementation of HBIC will be shared among the relevant stakeholders including the National Emergency Operation Centre (EOC), Department of Hospital Services (DHS) of the Federal Ministry of Health, Nigeria Centre for Disease Control (NCDC), State EOC, State Ministries of Health, Health departments of LGA, and National Primary HealthCare Development Agency.

- The DHS of FMOH is expected to lead/Chair the coordination of the Nationwide Multisectoral Implementation Platform based on the advice forwarded by the National EOC that will provide Technical Leadership.
- DHS of FMOH is expected to assign or establish a National COVID-19 Home based Care Coordinating and Support Team/Unit which should be given clear mandates with known roles and responsibilities for better management and monitoring of national COVID-19 Home Based Care performances.
- State Home based care monitoring unit is to be set up by the SMoH under the guidance of the State EOC and is expected to assign or establish a State COVID-19 Home based Care Coordinating and Support Team/Unit in the EOC, and the Team/Unit should be given clear mandates with known roles and responsibilities for better management and monitoring of national COVID19 Home Based Care Performances in the states.
- Where feasible, a similar structure should be established in each LGA under the guidance of the NPHDA and local government department of health.
- Each supervisory level should be directly linked to the next level to ensure efficient referral and exchange of data.
- All levels should utilise a single clinical data management platform as guided by the DHS of the FMOH with data available to that level of coordination and supervisory levels.
- All levels are expected to establish clear guidelines and procedures for reporting and accountability.
- The Local government/NPHDA will lead the coordination and implementation of the National Home-Based Isolation & Care Guideline.

4.1 Roles & Responsibilities of Stakeholders

The relevant stakeholders should be involved at all levels of the implementation of this guideline ranging from Federal to local government Level.

4.1.1. National Case Management Pillar

- The National Case Management Pillar is expected to engage all states and LGA administrators in the coordination of the Nationwide Implementation Platform led by DHS of the FMOH.
- It is expected to lead the active engagement of all stakeholders and partners Nationwide.

4.1.2. DHS, FMOH

- Distribute national implementation guideline for home -based Isolation and care.
- Advocate and provide all the necessary technical and relevant support to all states and LGAs for effective implementation of national covid-19 home based care guide.
- Coordinate and monitor the overall management and performances on their follow-ups and monitoring of HBIC.

- Regular evaluation of the implementation of protocols and procedures.
- Outline the Roles & Responsibilities of each stakeholder.
- Provide guidance to use of available technology in collaboration with relevant stakeholders to enhance home based isolation and care.
- Periodically collect and analyse performance reports to enhance decision-making, planning and improvement of care.

4.1.3. State Ministry of Health

- Adapt and disseminate all documents regarding Home- Based Isolation & Care to all Local government areas as released by the DHS of the FMOH.
- Draft an action plan based on the implementation guideline that can be cascaded down to the State and LGA level.
- Provide all the necessary technical, financial and material supports to State and/or LGA. In addition, support the establishment of necessary units at the State, LGA and facility level. Facilities should establish counselling unit for COVID positive patients who are eligible for HBIC. The DHS of FMOH would provide such services to federal tertiary centres.
- Support states in the facilitation of pre-hospital care & patient referral with provision of necessary materials/equipment such as ambulances.
- Periodically collect and analyse performance reports from states and LGA offices and provide feedback for timely action. State Home based care team is expected to share the weekly State HBIC activity performance report to DHS of FMOH.
- Provide technical leadership for the State level coordination of stakeholders based on the directive forwarded by DHS of FMOH and National EOC.
- Give periodic feedback to the National Case Management Lead on implementation of HBIC.

4.1.4 Roles and responsibilities of the State Case Management Team Lead

- Coordinate case management pillar in the state
- Liaise with case management leads at facilities
- Represent case management at State EOCs
- Drive the response with regards to case management
- Collate state management data for submission to national case management pillar lead
- Provide periodic as needed reports on case management to national case management pillar lead

4.1.5. LGA/PHCDA

- Coordinate and engage all relevant health facilities such as Health Centres, Health Posts and Private Institutions in the implementation.
- Identify, train and guide professionals such as HCW, HEW, RRT, Volunteers, etc....to be deployed at LGA level.
- Map all the Health facilities, Treatment Centres including Community Care Centres, and Isolation/Quarantine Centres and facilitate pre-hospital care, patient transfer and referral.
- Collect data daily about Case Status Update for those on follow up at COVID-19 Health Care Settings; Home Care, Community Care Centres, Treatment Centres, and Isolation Centres (for those who will be transferred to Home Care or Treatment Centres).
- Provide regular update to the Regional Counterpart on Performance Report.

- Establish Non-Health Facility Community Care Centres with full resources for those who do not have the capacity for HBIC. Example: school, universities, etc.
- Ensure consents are signed and enforced.
- Give periodic feedback to the State Case Management Lead or State EOC on implementation of HBIC.
-

4.1.6. Health facility

- Implement the HBIC protocol. For example, establish a counselling/ consulting unit.
- Approve patients for home-based isolation & care based on the protocol and link with responsible team/follow up team at LGA level assigned for this purpose.
- Receive referred patients who are on home-based isolation & care.
- Receive patients referred from LGA/PHC based on protocol.

4.1.7. Case management team

Patients under homebased care are linked to the respective treatment facilities and responsible facility lead case manager who in turn reports to the Covid-19 case management Pillar lead of the state.

Mental and psychosocial support framework to be provided by designated member of team who would report to the supervising doctor to evaluate and consider referral to a mental health specialist when appropriate.

4.1.7.1 Composition

The case management team for homebased care should consist of at least Four (4) members, one from each of the four (4) groups listed below:

1. Supervising healthcare worker at facility (Doctor)
2. Dedicated healthcare worker to follow up a particular patient (Nurse/CHEW)
3. Epidemiologist/Contact tracer/Community volunteer for contact tracing, risk communication and community engagement
4. Mental and psychosocial support provided by social worker, social welfare department staff of facility, staff of ministry of women affairs and social development

4.1.7.2 Roles

The case management team should follow the FMOH guidance on Case Management of COVID-19

A dedicated health worker should:

- Be assigned to monitor the confirmed COVID-19 case.
- Conduct a risk assessment of the intended area where the ill person would be accommodated for the period of homecare.
- Conduct a baseline and risk assessment of patient at the start of care.
- Monitor and physical visit patient to assess for clinical progression based on risk categorization and recommended care
 - Patients requiring mild caution can be followed up by CHEW/community volunteer every two days by home visits or phone calls
 - Patients requiring moderate caution can be followed up by a nurse/doctor every other day with home visits.
- Re-categorize risk on every visit.
- Provide regular update to the supervising healthcare worker at the supervising facility on their

- respective activities daily for prompt decision making by the supervising healthcare worker.
- Follow the treatment modalities as seen in the National Interim Guidelines for Case Management of COVID-19 Version 4 as summarised below:
 - Ensure monitoring of vital signs including but not restricted to temperature, respiratory rate, oxygen saturation,
 - Ensure adequate hydration through liberal fluid intake
 - Appropriate management of symptoms
 - Adjunctive treatment with multivitamins if appropriate
 - Definitive treatment based on clinical judgement of supervising clinician
 - Maintain daily communication with the confirmed case throughout the duration of care.
 - Virtual modes of consultations e.g. video conferencing can be employed to limit contact time between patient and healthcare worker.
 - Educate the patient and their household members on the importance of hand hygiene, respiratory hygiene, social distancing and basic infection prevention and control measures.
 - Supervising healthcare worker or dedicated healthcare worker at facility to enter CM clinical data into CM clinical database and or ensure that this is done.
 - Certify that symptoms have cleared, and discharge criteria has been met (see Case Management Guidelines for COVID-19).

4.1.8. Follow-up Team

- Follow up patients enrolled in HBIC on regular basis using phone communication (daily) and house visit (at least twice a week excluding the day when eligibility was assessed).
- Provide Health Education including basic IPC practices in each household.
- Address any complaints and concerns and refer to the Health Facility when necessary.
- Provide medications or prescriptions and refer to the Health Facility when necessary.
- Report daily to the LGA and Health Facility

4.1.9. Private Facilities

N.B. Applies for Private Health Facilities and Home Care Service Providers licensed to provide COVID-19 related services

The facilities/service providers are obliged to perform the roles and responsibilities stated above for Health Facilities and Follow up Teams

4.1.10 State Epidemiologists

- Ensure that the patient is assigned an epi-number and assigned to a treatment centre for supervision of care and clinical follow-up.
- Should be able to account for the location of ALL active cases whether in isolation and treatment centres or in homebased care.
- Coordinate surveillance team to review and update key recommendations for situations where surveillance team need to intervene.
- The patient should be followed up from the commencement of isolation/home care

4.1.121. Home Isolated Individual

- Properly isolate from other family members.
- Take full responsibility in prevention of transmission.
- Strictly adhere to the National Interim Guideline for Home-Based Isolation & Care.
- Provide reliable information during regular follow up either by phone or home visit.
- Contact nearest health facilities/follow up team in case of any emergency, appearance of new symptoms or worsening of existing symptoms.

5.0. Guidance for home care

This provides recommendations for precautions and safety measures to be taken by the patient, household members and occupants

5.1. Patient

- Avoid physical contact with household members
- Avoid sharing of space as much as possible and stay in a designated, well ventilated room
- Wear a facemask appropriately, change the medical/cloth face mask every day or when indicated such as if it is soiled/torn/wet or compromised in any way.
- Clean hands accordingly as frequent as possible with alcohol-based hand sanitizers, dry them with a towel designated for the patient.
- Use dedicated eating and drinking utensils which will be cleaned accordingly.
- Stay in a well-ventilated single room alone where possible or maintain a minimum of 2 metres if staying in the same room with anyone.
- Limit the movement of the patient in the house and minimize shared space. Ensure that shared spaces (e.g., kitchen, bathroom) are well ventilated (keep windows open) and physical distancing is maintained amongst the individuals (keep windows open)
- Regularly wash hands with soap and water.
- Respiratory hygiene should be practiced always.
- Discard tissues used to cover nose or mouth during coughing or sneezing into a lined bin, which has a well-fitted lid placed in patient room.
- Wear masks to cover the nose and mouth when caregiver enters room. Mask can be removed when alone in a room. Once the mask is dirty or soiled, remove immediately and discard in a lined bin with well-fitted lid.

Ensure that you have adequate food, drinking water, hygiene provisions and appropriate medical treatment for any existing medical conditions while in self-isolation



Ensure that you have the necessary communication facilities e.g. mobile telephone to communicate with family members and other people while in self-isolation

5.2. Household members

- Assign one person who is in a good health without risk conditions to care for the ill person (called the ‘assigned caregiver’).
- All household members should regularly wash their hands with soap and water.
- Stop receiving visitors into the house/accommodation where the ill person is staying.
- Reduce contact with people outside the household until 14 days after the ill person is discharged from home care.
- Provide dedicated personal items e.g. Toothbrushes, eating utensils, dishes, drinks, towels, wash cloths, or bed linen for the patient.
- Respiratory hygiene should be practiced always
- Discard tissue used to cover nose or mouth during coughing or sneezing into a lined bin, which has a well-fitted lid placed in the patient’s room.
- To contain respiratory secretions, a medical mask should be provided to the patient and worn as much as possible and changed daily. If that is not possible, provide face covering/cloth mask. Materials used to cover the mouth and nose should be discarded or cleaned appropriately after use (e.g., wash handkerchiefs using regular soap or detergent and water).
- Wear medical masks to cover the nose and mouth. Once the mask is dirty or soiled, remove immediately and discard in a lined bin with well-fitted lid
- Perform hand hygiene after any type of contact with patients 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 dirty, an alcohol-based hand rub can be used. For visibly dirty hands, use soap and water.
- When washing hands with soap and water, it is preferable to use disposable paper towels to dry hands. If these are not available, use clean personal cloth towels and replace them frequently.
- Clean and frequently disinfect frequently touched surfaces such as bedside tables, bed frames, chairs, doorknobs, door handles and other bedroom furniture including bathroom and toilet daily with regular household disinfectant (see NCDC IPC for COVID-19 Guidance)
- Household members should stay in a different room or, if that is not possible, maintain a distance of at least 2 meters from the ill person (e.g. sleep in a separate bed).

5.3. Assigned caregiver

The assigned caregiver should:

1. Avoid close contact with the patient and keep a distance of at least 2 meters.
2. Sanitize hands with alcohol-based solutions and wash hands frequently, especially after contact with the patient and with any item that has been in contact with the patient
3. Wear a facemask appropriately when sharing a room or in close contact with the patient.
4. When the facemask is taken off, it should be removed by touching only the elastic bands or strings; front and inside parts should never be touched. Hands should be washed/cleaned immediately (and thoroughly) after mask removal.
5. Wear gloves when providing care to the patient or when coming in contact with bodily fluids. Gloves should be changed every time they are worn or when they become soiled, or if their integrity is compromised. Hands should be washed/ cleaned immediately after removing the gloves.
6. Caretakers should quarantine for 14 days after the patient has recovered and self-monitor for COVID-19-like symptoms while following strict precautions.
 - Physical distancing of 2 meters,
 - Wear a mask,
 - Hand hygiene,
 - Avoid nonessential movement

- Caregivers must wear a medical mask/cloth mask that covers their mouth and nose when in the same room as the patient. Masks should not be touched or handled during use. If the mask gets wet or dirty from secretions, it must be replaced immediately with a new clean, dry mask. Remove the mask using the appropriate technique – that is, do not touch the front, but instead untie it. Discard the mask immediately after use and perform hand hygiene.
- Avoid direct contact with any and all body fluids, particularly oral or respiratory secretions, and stool. Use disposable gloves and a mask when providing oral or respiratory care and when handling stool, urine, and other waste. Perform hand hygiene before and after removing gloves and them ask.
- Do not reuse medical masks or gloves. But cloth masks/face covering can be washed and reused
- Use dedicated linen and eating utensils for the patient; these items should be cleaned with soap and water after use and may be re-used instead of being discarded.
- Daily clean and disinfect surfaces that are frequently touched in the room where the patient is being cared for, such as bedside tables, bed frames, and other bedroom furniture. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.5% sodium hypochlorite, bleach should be applied.
- Clean and disinfect bathroom and toilet surfaces at least once daily. Regular household soap or detergent should be used first for cleaning, and then, after rinsing, regular household disinfectant containing 0.5% sodium hypochlorite should be applied. Close toilet while flushing
- Clean the patient’s clothes, bed linen, and bath / hand towels using regular laundry soap and water or machine wash at 60–90 °C (140–194 °F) with common household detergent, and dry thoroughly. If there is not laundry machine, wash with soap & water and then sock with 0.5% Sodium Hypochlorite, bleach for 30 minutes; then continuously rinse with water. Place contaminated linen into a laundry bag. Do not shake soiled laundry and avoid contaminated materials coming into contact with skin and clothes.
- Gloves and protective clothing (e.g., plastic aprons) should be used when cleaning surfaces or handling clothing or linen soiled with body fluids. Depending on the context, either utility or single-use gloves can be used. After use, utility gloves should be cleaned with soap and water and decontaminated with 0.5% sodium hypochlorite solution. Single-use gloves (e.g. nitrile or latex) should be discarded after each use. Perform hand hygiene before putting on and after removing gloves.
- Gloves, masks, and other waste generated during homecare should be placed into a waste bin with a lid in the patient’s room before disposing of it as infectious waste. The onus of disposal of infectious waste resides with the local municipal waste collection system.
- Use personal protective equipment when caring for after the ill person.
- This should include, wearing a well fitted medical mask when in the same room with the ill person
- Always use disposable gloves to avoid direct contact with body fluids, particularly oral or respiratory secretions, and stool. Dispose gloves in a closed waste bin immediately after exiting patient room and practice hand hygiene.
- Wash hands with soap and water or alcohol-based hand sanitizers following all contact with ill persons or their immediate environment as well as before wearing and after removing gloves.
- Use disposable paper towels to dry hands after washing. If paper towels are not available, use dedicated cloth towels and replace them when they become wet or dirty.
- Gloves, tissues, masks, and other waste generated by ill persons or used in the care of ill persons should be placed in a lined container in the ill person’s room before disposal.
- Use disposable gloves and protective clothing (e.g. plastic aprons) when cleaning or handling surfaces, clothing or linen soiled with body fluids
- If the assigned caregiver supports the individual with laundry, then they should **not** shake dirty laundry before washing. This minimizes the possibility of dispersing virus through the air. Wash have a washing machine, wait a further 72 hours after the isolation period has ended; the laundry can then be taken to a public laundromat or washed using the standard precautions.

- Avoid other types of exposure to contaminated items from the patient's immediate environment (e.g. do not share toothbrushes, cigarettes, eating utensils, dishes, drinks, towels, washcloths, or bed linen)

Items heavily soiled with body fluids, for example, vomit or diarrhoea, or items that cannot be washed, should be disposed of, with the owner's consent.

6.0 Waste Management

Several types of waste are generated from various activities in the care of the covid 19 patient. Most of these wastes are infectious and are usually mostly used PPE. Provision of PPE, waste disposal bags and bins should be made for the patient where feasible. New personal protective equipment (PPE) must be used for each episode of care such as Aprons, gloves, and fluid repellent surgical masks. Facemasks and gloves used by caretaker should be immediately put in the waste bag of the patient. It is essential that used PPE is stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely, and kept separate from other waste within the room. This should be put aside for at least **72 hours** before being put in the usual household waste bin or where possible sent to hospital incinerators at the treatment Centre. Patient waste bag should be closed when they are removed from the patient room and never be emptied in another bag. After handling waste bag, appropriate and strict hand hygiene should proceed. All solid waste must be treated with 0.05% of Chlorine/bleach before disposal from home. Arrangement should be made by the supervising facility/team for waste evacuation every three days.

Sanitation and Waste Management

Clean and disinfect frequently touched surfaces such as doorknobs/handles, bedside tables, bed frames and other bedroom furniture daily with regular household disinfectant, soap or spray containing at least 70% alcohol



Clean and disinfect bathroom and toilet surfaces at least once a day with regular household disinfectant or soap



Disinfect floors and bathrooms with Lysol, Dettol or 0.5 % household bleach (If using an agent with hypochlorite concentration of 3.5% such as JIK, dilute as 1 part of bleach with 6 parts of water. If hypochlorite concentration is 5%, dilute 1 part of bleach with 10 parts of water).



All domestic wastes should be doubled bagged, well tied and disposed appropriately (please don't drop it on the road)



2. Please refer to ncdc iPc guidelines for more information

Recommended type of personal protective equipment (PPE) to be used in the context of COVID-19 disease, according to the setting, personnel, and type of activity			
Setting	Target personnel/patient	Activity	Type of PPE
Home	Patient with respiratory symptoms	Any	Maintain spatial symptoms distance of at least 2 metres. Provide medical mask if tolerated, except when sleeping.
	Caregiver	Entering the patient's room but not providing direct care or assistance	Medical mask
	Caregiver	Providing direct care or when handling urine, stool, or waste, from COVID-19 patient being care for at home	Gloves Medical mask Apron (if risk of splash)
	Health Care Worker	Providing direct care or assistance to a COVID-19 patient at home	Medical mask Gown gloves Eye protection

7.0 Practical Guidance on Procedures of HBIC

7.1 Result Notification or Transfer

The process for the implementation of the HBIC starts when there is a Laboratory confirmed positive result of COVID-19 for a suspected patient who fits the eligibility criteria for HBIC as stated in this document. The laboratory releases the result through the central result notification system to the patient, LGA DSNO who informs focal person at the LGA/Facility of the Laboratory result for the patient.

Confirmed COVID-19 positive patients who are initially in a treatment centre and are qualified for discharge can be discharged to HBIC after approval of the treating physician. The facility would notify the LGA DSNO of the transfer and continue monitoring the patient through its homebased care team.

7.2 Clinical criteria to distinguish disease severity

There is a range of symptoms for COVID-19. Patients with non-severe disease present with mild symptoms, which include fever, anosmia, headache, aguesia, fatigue, myalgia, cough (with or without sputum), catarrh, and sore throat. These are generally symptoms of uncomplicated upper respiratory tract viral infection. Rarely, patients may also present with hiccups, anorexia, diarrhoea, nausea, and vomiting. Elderly and patients with immunosuppression may present with atypical symptoms.

MILD

- Fever $<38^{\circ}\text{C}$ or (maybe afebrile)
- No difficulty in breathing
- Presence or absence of cough
- No underlying chronic diseases, e.g. heart, lung, asthma and kidney diseases

MODERATE /SEVERE CASE

- Difficulty in breathing
- Crackles in lungs
- Reduced/decreased breath sounds
- Dullness in percussion
- Increased or decreased vocal resonance
- Presence of co morbid conditions such as diabetes, asthma, hypertension, malignancies, etc.
- Age above 60years
- Pregnancy

CRITICAL CASE

Critical cases are defined as respiratory failure requiring mechanical ventilation, shock or other organ failures that require intensive care. e.g.: kidney failure, cardiac failure, etc.



A PULSE OXIMETER
(Critical for classification of disease severity and patient monitoring)

WHO Severity definitions

- **Critical COVID-19:** Defined by the criteria for acute respiratory distress syndrome (ARDS), sepsis, septic shock, or other conditions that would normally require the provision of life sustaining therapies such as mechanical ventilation (invasive or non-invasive) or vasopressor therapy.
- **Severe COVID-19:** Defined by any of:
 - Oxygen saturation < 90% on room air.
 - Respiratory rate > 30 breaths/min in adults and children > 5 years old; ≥ 60 breaths/min in children < 2 months old; ≥ 50 in children 2–11 months old; and ≥ 40 in children 1–5 years old.
 - Signs of severe respiratory distress (accessory muscle use, inability to complete full sentences, and, in children, very severe chest wall indrawing, grunting, central cyanosis, or presence of any other general danger signs).
- **Non-severe COVID-19:** Defined as absence of any criteria for severe or critical COVID-19.

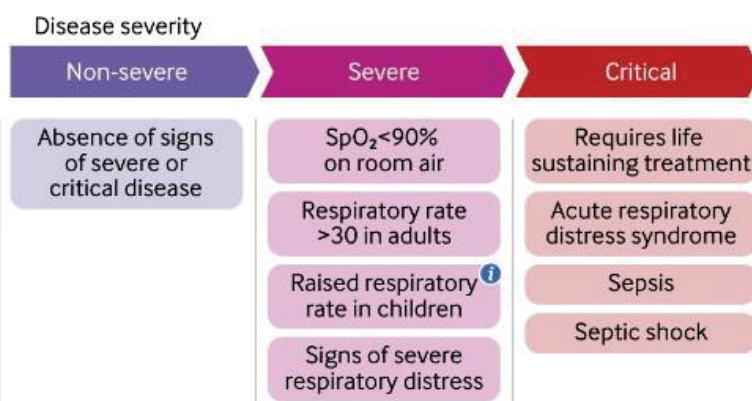
Caution: The panel noted that the oxygen saturation threshold of 90% to define severe COVID-19 was arbitrary and should be interpreted cautiously. For example, clinicians must use their judgment to determine whether a low oxygen saturation is a sign of severity or is normal for a given patient with chronic lung disease. Similarly, a saturation > 90–94% on room air is abnormal (in patient with normal lungs) and can be an early sign of severe disease, if patient is on a downward trend. Generally, if there is any doubt, the panel suggested erring on the side of considering the illness as severe.

The infographic illustrates these three disease severity groups and key characteristics to apply in practice, for a recommendation within this guideline.

Counsel patients about signs and symptoms of severe COVID-19 disease and advise them to seek care through national referral systems if these symptoms develop.

Population

This recommendation applies only to people with these characteristics:



Infographic co-produced by BMJ and MAGIC; designer Will Stahl

-Timmins (see [BMJ Rapid Recommendation](#) s).

7.3 Basic requirements and eligibility criteria for COVID-19 Home management.

- A patient should be asymptomatic or mildly symptomatic (non-severe disease).
- Must have a designated case management team.
- Should preferably have a separate apartment/room from other members of the family and a separate convenience/utility where feasible.
- Caregiver (spouse, family member or other person) must be trained by IPC team on safe decontamination (daily) practices and appropriate use of facemasks and gloves, safe burning/burial of used PPE. Caregiver must take full responsibility of this process.
- Guarantee of regular follow up (Day 5, 10 and 14) – either remotely leveraging technology or in-person.
- Guarantee nil outdoor /social engagement until certified discharged by management team.
- Guarantee adherence to the treatment protocol, follow up and investigation.
- Guarantee regular reporting of patient health care response (Clients are also encouraged to call dedicated case managers if or when need arises in course of care).

7.4 Recommended criteria for home care for COVID-19

These interim recommendations for home care are based on the current epidemiology of the disease in Nigeria¹.

7.4.1 With mild caution

- Below **50 years** old who clinically stable, Stable/well controlled (defined in the checklist) comorbidities or absence of co morbidities such as but not limited to Hypertension, Diabetes Mellitus, and Chronic obstructive airway disease
AND
- Asymptomatic or mild symptoms
- Normal oxygen saturation (**SpO₂ ≥ 95%** on room air)
- Available space for optimal self-isolation
- Can be followed up by CHEW/community volunteer every two days with home visits or phone call.

7.4.2 With moderate caution

- Over 50 years who is clinically stable AND with NO history of any co-comorbidity
- Asymptomatic or mild symptoms
- Normal oxygen saturation (SpO₂ ≥ 95% on room air)
- Available space for optimal self-isolation
- Should be followed up with home visits by nurse/doctor every other day.

7.4.3. Not recommended

- Any age with moderate/severe symptoms
- Lack of adequate self-isolation facilities e.g. inadequate home accommodation
- Elderly Patients above 60 years
- Any 'high risk' patient such as patients with complications from co-morbidities like renal impairment, heart disease, sickle cell anaemia, chronic obstructive airway disease etc. based on a clinical risk assessment done by a qualified clinician

1. *Based on epidemiological data on mortality of cases in Nigeria*

7.5. Eligibility for Home-Based Isolation and Care

The HCW at receiving facility will evaluate the patient's clinical and household condition for eligibility of Home-Based Isolation & Care in the following areas:

Assessment of Eligibility for HBIC

- Clinical assessment checklist
- Home assessment checklist
- IPC checklist
- Waste management checklist
- Relevant basic care processes for HBIC
- Follow –Up and Referral
- Discharge

Below are points to consider for the eligibility of the patient;

7.5.1. Patient Assessment

2. Patient must be Laboratory confirmed COVID-19 positive individual
3. Patients with mild symptoms or are asymptomatic for COVID-19
4. Patient must be willing to self-isolate and adhere to recommended precautions
5. Stable/well controlled (defined in the checklist) comorbidities or absence of co morbidities such as but not limited to Hypertension, Diabetes Mellitus, and Chronic obstructive airway disease.
6. Shows symptomatic improvement with mild or no symptoms for consecutive 72 hours and treating physician decided to discharge to home care (for patients in treatment centre).
7. A care giver is not mandatory in all conditions. However, care giver is mandatory in the following conditions: paediatric + minor (<18 years) & geriatric (>65 years) age group, disabled, psychiatric or anyone with mental disability.

7.5.2 Home/Household Assessment:

A rapid assessment of the home environment will be conducted by a trained health care worker to ascertain that the home environment meets the minimum criteria for HBIC using the HBIC eligibility assessment check list. Key consideration will include the following:

1. Presence of Community health volunteer/appropriate care giver at home, who is able to provide relevant information about the patients' condition.
2. Proper setup preventing infection spread. If applicable, separate room with toilet, bathroom, and kitchen should be prepared. If separate facility is not applicable, the patient's resting area should

be 2 meters apart from other household members and, toilet/bathroom facility and kitchen should be cleaned after every use.

3. Access to adequate basic PPE (Personal Protective Equipment) for the patient, caregiver and family members. E.g. (Face masks, Gloves(optional))
4. Ability to adhere to the standard droplet precautions e.g., appropriate cough etiquette
5. Availability of food and other necessities.
6. Special precautions should be in place for high-risk family members. (Individuals greater than 60 years old, children <2, Pregnant woman and individuals with co morbidities).
7. If the patient is eligible, he/she must sign the consent form. The HCW must make sure that the patient sanitizes his/her hands' or washes appropriately with soap and water before and after signing the consent form.

N.B The household assessment must be conducted by a trained health care worker. The professional must visit the setting in person before making any decision. The decision of the eligibility status should be filled out and signed by the professional.

7.6. Instructions for HCW on commencement of the HBIC:

The HCW will do the following:

1. Educate patients and household members on relevant aspects of personal hygiene, and basic IPC measures.
2. Educate on basic care activities and precautions to safely care for confirmed cases to prevent the infection from spreading to household contacts.
3. Provide guidance to patient and household members with ongoing support and education, and monitoring should continue for the duration of home care.
4. Provide a designated Phone number for the family members to call for daily follow up or any emergency.
5. Document all relevant patients' information in the HBIC Admission Register and open a follow-up register.
6. Provide basic psychological support for patient and family and arrange for professional support when necessary (see MHPSS support for HBIC)
7. Educate the patient and family members on relevant risk associated with COVID-19 infection and disease (see RCCE).

7.7 Follow –Up and Referral

7.7.1. Follow-Up:

On commencement of HBIC

1. The patient will be followed up by a health care team consisting of a member of household who had volunteered for this assignment, an assigned HCW- who may be a Community Health Volunteer (CHV) or Health Extension Worker (HEW) and a facility based HCW (nurse, or medical officer). The Household member conduct regular checks –like asking if there is fever or any symptoms and provides such information to the CHV /HEW.
2. It should be noted that basic level healthcare workers should be trained for follow-up of home-based care to report to higher level HCW (doctors and nurses) to allow the latter group care for moderate and severe cases as well as ensure continuity of other healthcare services.
3. The CHV/HEW conducts regular follow up by phone calls to the patient and or assigned family member. Daily follow up checks is documented in a Follow-up register for HBIC which is provided to the CHV/HEW.
4. Frequency of other follow up is as stated above.

7.7.2. Conditions for HCW Intervention and Referral:

- If patient's condition worsens; the patient, caregiver, supervising community or worker depending on who notices the change in condition first, should immediately notify the supervising team at the facility who would evaluate and initiate process for evacuation.

Where there challenge reaching the facility team or there is no immediate response from the facility team, the state hotline numbers should be contacted.

(see Annex 1: State Hotline Numbers)

- Either the facility team or the state rapid response team would coordinate evaluation and urgent transfer patient to the supervising treatment centre and or available nearest treatment centre *(see annex 2: SOP for Transfer of Patients)*

During the follow-up of the patient on HBIC, the patient and family will be informed to CALL the HCW (CHV/HEW) if:

1. The patient develops new symptom (s) and or the patient's symptom(s) worsens
2. The home care giver or other family member(s) develop symptoms

In both cases above (1 and 2),

- The caregiver/ patient must inform the HCW/follow up team As soon as possible
 - HCW will conduct an appropriate evaluation of the patient either in person or by phone and notify the case management lead of the facility supervising the homecare
 - The HCW will notify the RRT
 - The RRT will conduct protocol-based assessment and act accordingly.
 - Each facility supervising home care should have a rapid response team (RRT) which should have a functional ambulance, driver, HCW(s), hygienist. Average response time should be thirty (30) minutes. There should be at least one RRT per district.
 - The symptomatic contact should isolate oneself with adherence of the IPC protocol.
 - The household contacts should be able to fill the symptom-monitoring schedule (see appendix) for the 14-day isolation period for the monitoring system.
3. There is need for Mental Health and Psychosocial Support (MHPSS)
 - Caregiver/mental and psychosocial support designate/HCW should notify the case management lead of the facility supervising the homecare for professional Mental Health and Psychosocial Support (MHPSS) Assessment
 - If professional MHPSS is required, the case management link would refer to appropriate MHPSS professional for further evaluation and management.

7.8. Discharge:

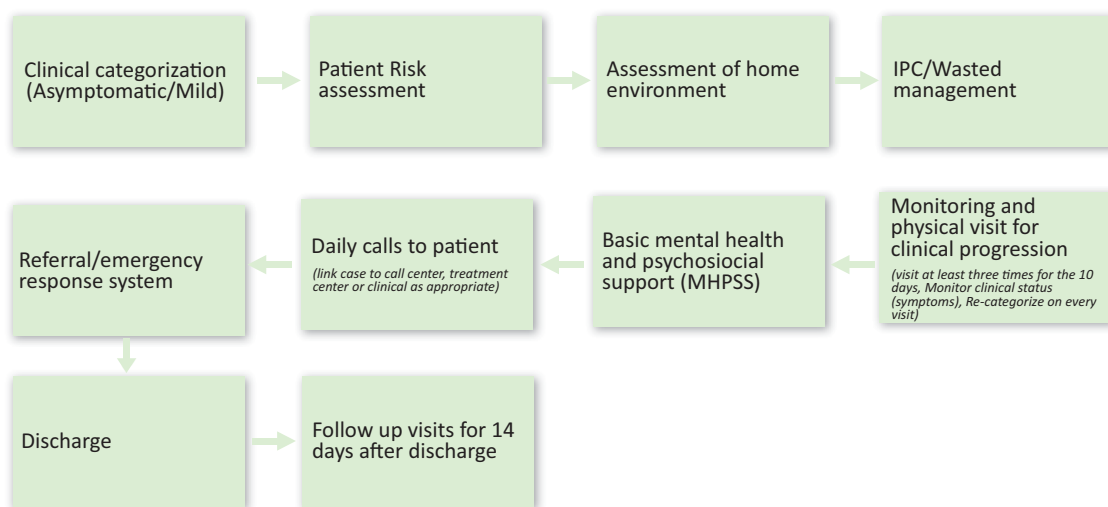
When to end the Home Isolation & Care

- For asymptomatic patients -
 - Isolation should be maintained until 10 days from the date the patient tested positive
- For symptomatic cases
 - Isolation should be maintained until 10 days from the date of first positive test or and from 10 days after symptom onset, plus at least 3 days without symptoms (fever and respiratory symptoms)
 - SpO₂ ≥ 95% in room air for 3 days

NB: A negative laboratory test is no longer required to discharge a COVID-19 patient discharge unless in special circumstances like travel or other specific requirements approved by national EOC.

Upon discharge, the supervising treatment centre is expected to provide a discharge letter, stating that the patient was managed as HBC for a stated amount of time, has clinically recovered and is discharged (Annex 6)

Home-Based Care Process



7.9 Death

If a confirmed patient on HBIC dies, which should be very rare, the caregiver or household member should communicate with the supervising facility for appropriate management of the dead body according to the national protocols.

7.10. Interpersonal Communication guide

This part is designed to achieve the following objectives

- To empower affected individuals, families or community to comply with recommended behaviours/actions.
- To reduce panic/outrages and tensions during moving confirmed cases, result notification, contact tracing and case follow up activities.
- To get the necessary support from affected individuals, families and community members for tracing contacts, providing follow up and moving symptomatic cases to treatment center.

a) General Considerations

- Identify cultural sensitivities that might arise when working in the community and discuss potential solutions with key members of the community.
- Ensure professionals wear badges/ID, the unmarked ambulance siren is off, no hazard lights which can cause panic/tension in the village.
- Inform the local political or administration and social structure before planned activities.
- Be sure to pay careful attention to minimize marginalization of vulnerable groups and tensions between ethnic or religious groups.
- Make efforts to avoid coercive or persuasive communications without allowing individuals to make an informed decision regarding testing or treatment, isolation, hospital care or home care.

b) Result notification/Disclosure

- Inform health extension workers or their coordinators to liaise and continue their RCCE activities with the families and community members in the villages
- Greet the individual or family members and introduce yourself
- Properly communicate with the relevant individuals from family or community members:
- Introduce yourself and your organization
 - Briefly explain why you go there or calling
 - Explain the why do the activities you are going to do
- Explain the process, information flow, from where patients will acquire information about the types of care required, and the general benefit of communicating with the follow up team
- Be conscious about your energy, emotion/feelings and thought
- Inform the client all the relevant information/results politely and clearly
- Ask the patient what the situation and explanation to them and their families.
- Inform that the follow up team will ensure his/her wellbeing and the HCW will act appropriately when necessary.
- Clarify why the patient needs to move to a treatment centre (if necessary)
- Ensure that the community, family or individual clearly understands what is going on. Clarify on how long the patient will stay home, when he/she will be discharged or moved to a treatment centre
 - Give the patient time to think about and reflect on his/her feelings regarding the information provided.
 - Address the concerns, rumours and misperceptions of the individual, family members, community.
 - Ensure feed backs and questions are addressed simply and clearly

c) Communication with patients on Follow up

During follow up or home-based isolation & care, consider the following points:

- Greet the individual or family members and introduce yourself (I am ----- from NPHDA/LGA/MoH ----- section/unit/team. I came here for the ----- purpose)
- Properly communicate with the confirmed cases or individuals referred by him/her from family or community members:
 - Introduce yourself and your organization (I am ----- from NPHDA/LGA/MoH ----- section/unit/team. I came here for the ----- purpose)
 - Briefly explain why you are visiting or calling
 - Explain the reason for the activities you are performing
 - Remember that patients are dealing with stress, fear and stigma:

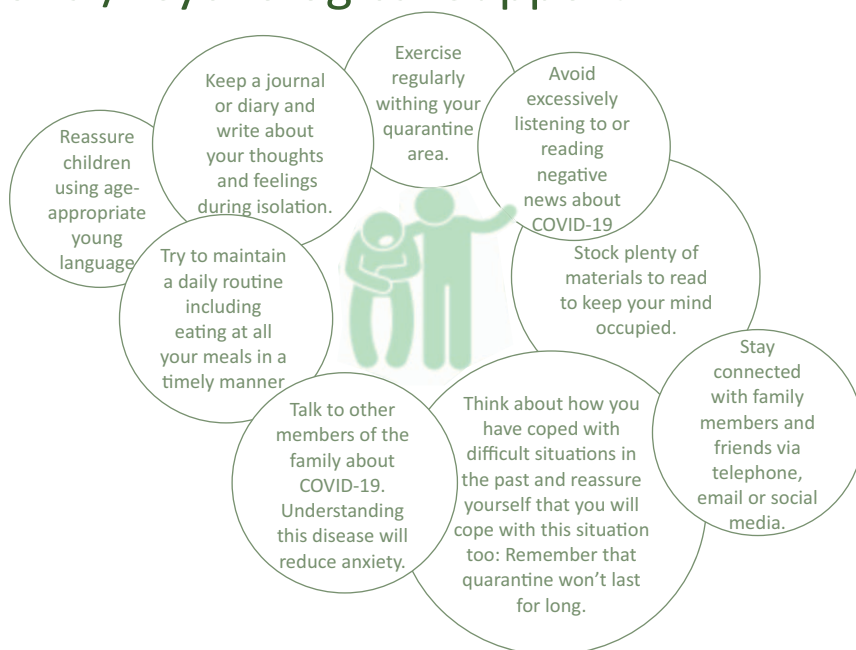
- Treat them with respect and try to understand the reasons behind their behaviours or reactions.
- If they refuse follow up, work with trusted community or family members to clearly communicate the benefits and address any concerns.
- Engage with psychosocial teams so that they can provide mental health and psychosocial support

8.0 Mental Health and Psycho-Social Services to COVID-19 in Nigeria

Mental Health and Psychosocial support is an integral part of this response as there are increased reports of distress among people infected, their families as well as other first responders. The overall goal of the initiative is to prioritize mental health and psychosocial support. Psychological First Aid would be the one of the main stays of care to people with COVID19 infection that would affirmatively influence the outcome of the disease. This includes the following : Promote mental health and psychosocial support and mitigate COVID-19 related stressors including stigma and discrimination against persons affected and health workers; Raise awareness of healthcare workers and community leaders on the importance of mental health and psychosocial support in the COVID-19 response ; Enable health workers and community leaders to provide basic mental health services and particularly psychosocial support and psychological first aid, and refer difficult cases for further support; Increase availability and access for mental health and psychosocial care to people who are in need.

Relevant components of Implementing Mental Health and Psychosocial support for HBIC is captured within the logical framework for nationwide MHPSS services in COVID-19 (See Annex 7)

Emotional/Psychological Support



9.0 Proposed Strategic Interventions

9.1. Health Care Workers

Role and responsibilities:

- Assessment and evaluation of people with COVID-19 at home management for mental and psychological needs
- Provide basic psychosocial support and psychological first aid to people in need
- Evaluate and establish registries of people who need referral and facilitate the referral service

Program Activities:

1. Capacity building of health workers (online based and/or onsite training)
2. Provide clinical guideline and job aids, health information management tools
3. Supportive supervision and mentoring from higher level

9.2 Communities and Community Leaders

Role and responsibilities:

- Target providers included volunteers, community elders, gate keepers
- Provide basic psychosocial support and psychosocial first aid
- Evaluate and establish registries of people who need referral and facilitate the referral service

Program Activities:

1. Awareness raising and capacity building of selected community leaders and gatekeepers
2. Provide awareness raising educational materials
3. Supportive supervision and mentoring from higher level

9.3 Establish HOTLINE

Considering that mental health and psychosocial support would be one of the main stays of management in the COVID-19 response, and that majority would be self-isolating and managed at home following the HBIC guidelines, establishing a National MHPSS independent hotline would be necessary for support. In addition, regional hotline medium with local languages shall also be established.

9.4 Integrate home-based care support program

1. Announce results to patients, DSNO, treatment centre
2. Assessment and integration to telemedicine program and Case Management (CM) clinical data base of the FMOH
3. Assessment and enrolment into social support program if eligible for care package in collaboration with the Ministry of humanitarian affairs
4. Commencement of the virtual outpatient clinic
5. Commencement of care package for those that qualify (poor and vulnerable)
6. Care packages should be distributed by a logistics company and should contain drugs and supplies
7. Electronic prescriptions would be given to those that can afford
8. Physical follow up by CHW and Case Manager

9.5. Media campaign

Working closely with Risk Communication and Community Engagement (RCCE) pillar, media would play an important role in the dissemination of accurate messages to the larger public. As such, large scale media campaign and awareness raising activities shall be coordinated at the federal level and cascaded to the regional levels.

9.5.1. Coordination and Program Leadership

Provision of standardized and coordinated mental health and psychosocial care during this COVID-19 response requires rigorous planning, budgeting, resource mobilization, coordination, monitoring and evaluation. The DHS of FMOH and the EOC at National and state levels will be primarily responsible in leading the MHPSS nationwide scale-up. Whereas the mental health clinical advisory group at the FMOH will play a paramount role in providing clinical and technical advisory based on the locally available evidence and scientifically acceptable standards.

10.0 Monitoring & Evaluation

Process Indicators

S/N	Indicator	No	Reporting Freq.	Remarks
1	Number of New asymptomatic COVID-19 patients in Home-Based Care		Daily	
2	Number of New mildly symptomatic COVID-19 patients in Home-Based Care		Daily	
3	Total No of COVID-19 patients in Home- Based Care		Daily	
5	Number of households assessed for eligibility for HBIC		Daily	
6	No of households that met the criteria for HBIC		Daily	
7	Number of mildly symptomatic patient referred due to worsening symptoms		Daily	
8	No of Asymptomatic patient that developed symptoms, while on HBIC.		Daily	

Outcome Indicators

S/N	Indicator	No	Reporting Freq.	Remarks
1	Number of asymptomatic patients recovered and discharged from HBIC.		Daily	
2	% of Asymptomatic patients that developed symptoms		Daily	
3	No of symptomatic patients that recovered and discharged		Daily	
4	number of patients hospitalised after starting HBIC		Daily	
5	Number of those on HBIC who defaulted home isolation before discharge".		Daily	
6	No of Home care givers (family) members that developed symptoms		Daily	
7	% of referrals to the Treatment or Community care center		Daily	

N.B The implementation process will be regularly reviewed (probably every 90 days.) in the context of the outbreak. Findings and Lessons learnt will be used to update relevant components and operations of this document.

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4. Public Health England, 'COVID-19: Guidance on Home Care Provision,' May 5 2020. [Online]. Available: <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-home-care-provision>

Annex 1: Determination of type of care: checklist for triaging confirmed COVID-19 patients

Date of triaging:

A. Demographic data

1	Name of patient	
2	Age	
3	Sex	
4	Address	
5	Epid no.	
6	Phone number	
7	Name of next of kin	
8	Phone number of next of kin	
9	Weight	
10	Height	
111	Blood group	

B. Epidemiological data

1. Date of sample collection:
2. Any symptom(s) before sample was collected? a] Yes
 b] No
 a. If yes, date of symptom onset.....
 b. If yeas, list of symptoms

3. Any symptom(s) after sample was collected? a] Yes
 b] No
 a. If yes, date of symptom onset.....
 b. If yes, list of symptoms

4. Any symptom(s) currently? a] Yes
 b] No a. If yes, list of symptoms

C. Clinical Symptoms

Indicate if the following symptoms are ongoing (O) or have resolved (R). (tick as appropriate)

Sn.	Symptoms	Yes	No
1	Fever		
2	Headache		
3	Fatigue		
4	Myalgia/body pains		
5	Anorexia		
6	Sore throat		
7	Catarrh/nasal congestion		
8	Loss/decrease in sense of smell		
9	Loss/decrease in sense of taste		
10	Diarrhoea		
11	Cough		
12	Hiccups		
12	Shortness of breath		
13	Other symptoms		

D. Clinical Signs

Sn.	Signs	Value	ND
1	Body temperature		
2	SPO2		
3	GCS		
4	Blood pressure		
5	Blood sugar		
6	Signs of pneumonia		

ND-not done

E. Classification of disease (tick as appropriate)

Stage	Description	Initial Assessment
Asymptomatic disease	No symptom before sample collection to date	
Mild	Symptomatic but no evidence of viral pneumonia or hypoxia (SPO ₂ >95%)	
Moderate	Signs of pneumonia but no signs of severe pneumonia and with oxygen saturation (SpO ₂) ≥ 90% while breathing normal room air.	
Severe	Signs of severe pneumonia: plus, respiratory rate > 30 breaths/min; or severe respiratory distress; or SpO ₂ < 90% room air	
Critical	Acute respiratory distress syndrome (ARDS), sepsis, life-threatening organ dysfunction	

F. Risk factors for disease progression (tick as appropriate)

Sn	Risk factors	Yes	No	Don't know
1	Age>60years			
2	History of diabetes			
3	History of hypertension			
4	Other Cardiovascular disease (e.g., Ischaemic heart disease, heart failure)			
5	Cerebrovascular disease e.g., stroke			
6	Cancer			
7	Obesity			
8	Chronic pulmonary disease, e.g., tuberculosis			
9	Immunosuppressive conditions (e.g., HIV/AIDS)			
10	Smoking			
11	Pregnancy with complications			

G. Decision matrix (tick as appropriate for case)

Sn.	Class of Disease	Type of care recommended	Remarks (as at time of visit)	Tick
1	At least 13days after sample collection plus asymptomatic in prior 3 days plus SPO2>94%	Consider Discharge	Repeat PCR and follow up in designated isolation facility in one week.	<input type="checkbox"/>
2	Asymptomatic and no risk factor for progression	Consider Home care	Consider hospitalisation if patient's household is not suitable for home isolation or patient desires hospital care or there is high risk of exposure of vulnerable family member during home care.	<input type="checkbox"/>
3	Asymptomatic but risk factors for progression	Consider Hospital care	Home care if case is cooperative and able to move to isolation facility at any time of the day and sample was collected > 7days	<input type="checkbox"/>
4	Mild disease and no risk factor for progression	Consider Home care	Consider hospitalisation if patient's household is not suitable for home isolation or patient desires hospital care or there is high risk of exposure of vulnerable family member during home care	<input type="checkbox"/>
5	Mild disease but risk factor for progression	Consider Hospital care	Consider home care if symptoms have resolved for more than 2days and if patient is cooperative, home environment suitable for safe isolation and vehicle available to move patient to isolation facility at any time of the day.	<input type="checkbox"/>
6	Moderate, Severe and Critical Disease	Hospital Care	Home care may only be considered for moderate cases if bed spaces are not available in isolation facility. Also consider Home care if symptoms have resolved for more than 2days and sample collected >7days.	<input type="checkbox"/>

NB: If patient currently has cough, fever, and shortness of breath, consider hospitalisation, especially if SPO2 is <94%

H. Final Decision

- a. Home care []
- b. Hospital Care: patient should be moved to isolation facility []
- c. Qualified for discharge []

Name of attending Physician:

Signature/Date:

I. Line list of contacts (use additional sheet as necessary)

Sn.	Name of contact	Type of contact (low or high-risk contact)	Address	Phone number	Remarks

Name of surveillance officer.....

Signature/date.....

Annex 2: Commitment Form

This commitment is exercised with the full knowledge of the patient's and Health-Care worker's obligations. When additional care is needed, urgent referral would be made to designated local Treatment centre.

The patient agrees to comply with all other Government Regulations regarding the management and control of COVID-19 and other existing laws of Federal Republic of Nigeria.

Date: _____

Patient Name: _____

Signature: _____

Care giver name (if available): _____

Signature: _____

Health Care Worker name _____

Signature: _____

Annex 3: HBIC COVID 19 Case Patient Follow-up Sheet

1. IDENTIFICATION

Epid No: _____	State _____			
Full Name _____	LGA _____ / City _____		House Number _____	
Age _____ Sex _____	Phone Number _____			
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Health care worker	<input type="checkbox"/> No <input type="checkbox"/> Yes			

2. DATE OF COVID-19 CONFIRMATION

Date of sample taken _____	Date of sample result received _____
----------------------------	--------------------------------------

3. DAILY CLINICAL FEATURES FOLLOW UP

Write Symptoms, Temperature and Progress in the Space below every day for 14 Days				
Day	Date (MM/DD/YY)	Symptoms	Temperature /RR/O2 saturation (Objective or Subjective **twice a day	Progress
Day 0	Date of positive test result			
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				
Day 8				
Day 9				
Write Symptoms, Temperature and Progress in the Space below every day for 14 Days				

Day 10				
Day 11				
Day 12				
Day 13				
Day 14				

SPECIFIC SYMPTOMS

- A. Fever
- B. Headache
- C. Fatigue
- D. Myalgia/body pains
- E. Anorexia
- F. Sore throat
- G. Catarrh/nasal congestion
- H. Loss/decrease in sense of smell
- I. Loss/decrease in sense of taste
- J. Diarrhoea
- K. Cough
- L. sneezing
- M. Hiccups
- N. Shortness of breath
- O. Other symptoms

I- IMPROVING

S-SAME

W-WORSENING

4. *COVID -19 Symptom tracker*

Write Not applicable (N/A) if symptom not present throughout illness

Sn.	Symptoms	Date of onset of symptom	Date symptom subsided
1	Fever		
2	Headache		
3	Fatigue		
4	Myalgia/body pains		
5	Anorexia		
6	Sore throat		
7	Catarrh/nasal congestion		
8	Loss/decrease in sense of smell		
9	Loss/decrease in sense of taste		
10	Diarrhoea		
11	Cough		
12	Hiccups		
12	Shortness of breath		
13	Other symptoms		

Date of onset of first symptom _____	Date last symptom subsided _____
--------------------------------------	----------------------------------

5. CARE GIVER RELATED QUESTION

Has the care giver developed any COVID-19 specific symptoms? Yes/no

Mention symptoms (Tick all that apply)

- A. Fever
- B. Headache
- C. Fatigue
- D. Myalgia/body pains
- E. Anorexia
- F. Sore throat
- G. Catarrh/nasal congestion
- H. Loss/decrease in sense of smell
- I. Loss/decrease in sense of taste
- J. Diarrhoea
- K. Cough
- L. sneezing
- M. Hiccups
- N. Shortness of breath
- O. Other symptoms

Date of Recovery _____

Name of Physician/HO/Nurse who declare recovery _____

Signature _____

Annex 4: HBIC COVID 19 Case HCW Follow-up Report Sheet

Indicate if the following symptoms are ongoing (O) or have resolved (R). (tick as appropriate)

Sn.	Symptoms	1 st visit		1st Follow up		2 nd Follow up		3 rd Follow up		4 th Follow up	
		R	O	R	O	R	O	R	O	R	O
1	Fever										
2	Headache										
3	Fatigue										
4	Myalgia/body pains										
5	Anorexia										
6	Sore throat										
7	Catarrh/nasal congestion										
8	Loss/decrease in sense of smell										
9	Loss/decrease in sense of taste										
10	Diarrhoea										
11	Cough										
12	Hiccups										
12	Shortness of breath										
13	Other symptoms										

G. Clinical Signs

Sn.	Signs	1 st visit		1st Follow up		2nd Follow up		3rd Follow up		4th Follow up	
		Value	ND	Value	ND	Value	ND	Value	ND	Value	ND
1	Body temperature										
2	SPO2										
3	GCS										
4	Blood pressure										
5	Blood sugar										
6	Signs of pneumonia										

ND-not done

H. Classification of disease (tick as appropriate)

Stage	Description	1st visit	1st Follow up	2nd Follow up	3rd Follow up	4th Follow up
Asymptomatic disease	No symptom before sample collection to date					
Mild	Symptomatic but no evidence of viral pneumonia or hypoxia (SPO ₂ >95%)					
Moderate	Signs of pneumonia but no signs of severe pneumonia and with oxygen saturation (SpO ₂) ≥ 90% while breathing normal room air.					
Severe	Signs of severe pneumonia: plus, respiratory rate > 30 breaths/min; or severe respiratory distress; or SpO ₂ < 90% room air					
Critical	Acute respiratory distress syndrome (ARDS), sepsis, life-threatening organ dysfunction					

Annex 5: Discharge Letter

To whom it may concern

.....

The above-named person, after being confirmed positive for COVID -19, was followed up for _____ days according to the National Interim clinical Management Guideline/ National Interim Guideline for Home Based Isolation and Care from..... till

Patient was discharged on with proper education on infection prevention measures according to the guideline.

Named

Designation:

Signature:

Date:

Annex 6: State Hotline Numbers

1.	Abia State	0700 224 2362	0700 ABIA DOC
2.	Abuja, FCT	0809 993 6312	0809 993 6314 0809 993 6313 0708 063 1500
3.	Adamawa State	0803 123 0359	0904 423 5334 0708 060 1139 0811 585 0085 0811 585 0085 0702 504 0415 0702 504 0415 0904 423 5334
4.	Akwa Ibom State	0818 941 1111	0802 844 2194 0904 557 5515 0803 793 4966 0703 521 1919 0902 333 0092
5.	Anambra State	0903 472 8047	0914 543 4416 0903 466 8319 0811 756 7363 0816 359 4310 0903 380 5959 (<i>WhatsApp</i>) 0903 466 3273 0907 428 5546 (<i>SMS</i>)
6.	Bauchi State	0708 829 2249	0809 5227003 0815 095 3486 0704 340 2122
7.	Bayelsa State	0803 921 6821	0815 169 3570 0701 930 4970
8.	Benue State	0901 860 2439	0702 503 1214 0803 369 6511
9.	Borno State	0808 815 9881	0800 9999 9999
10.	Cross River State	0903 628 1412	0805 0907 736 (<i>WhatsApp</i>) 0803 123 0527
11.	Delta State	0803 123 0480	0901 099 9933 0803 123 0481 0901 099 9934 0803 123 0528 0803 123 0021 0803 123 0529 0800 500 0100
12.	Ebonyi State	0902 033 2489	0704 591 0340 0815 927 9460 0708 576 3054
13.	Edo State	0808 409 6723	0803 583 5529 0806 425 8163

14.	Ekiti State	0906 297 0434 0906 297 0435	0906 297 0436
15.	Enugu State	0818 255 5550	0902 233 3833
16.	Gombe State	0810 337 1257 0702 625 6569 0704 525 7107 0702 522 7843	0702 676 1392 0702 679 9901 0704 214 5504
17.	Imo State	0809 955 5577	0708 711 0839
18.	Jigawa State	0803 599 7118 0803 644 0532 0806 932 3005 0803 880 6682 0703 599 7118 0803 862 9331	<i>Jigawa State Covid-19 Tasks Force Hot/Toll-free Lines:</i> 0806 872 5224 0803 486 4266
19.	Kaduna State	0803 587 1662 0802 508 8304	0803 240 1473 0803 780 8191
20.	Kano State	0803 970 4476 0803 703 8597	0909 399 5333 0909 399 5444
21.	Katsina State	0903 503 7114	0904 709 2428
22.	Kebbi State	0803 678 2507 0803 607 4588 0803 290 7601 0703 5606 421 0806 767 7723 0816 759 7029 0808 340 0849	<i>Case Management, Kebbi State Medical Centre, Kalgo:</i> 0704 635 2309 0704 640 7663 0704 693 5560
23.	Kogi State	0708 829 2249 0815 095 3486	0809 522 7003 0704 340 2122
24.	Kwara State	0906 201 0001	0906 201 0002

25. Lagos State	0802 316 9485 0805 975 8886 0803 356 5529 0803 538 7653 0805 281 7243 0800CORONA 0802 8971 864
26. Nasarawa State	0803 601 8579 0803 620 1904 0803 587 1718 0803 291 0826 0803 325 4549 0812 124 3191
27. Niger State	0803 824 6018 0807 721 3070 0909 309 3642
28. Ogun State	0818 897 8393 0818 897 8392
29. Ondo State	0700COVID19 0800COVID19 (07002684319) (08002684319) 0701COVID19 (07012684319)
30. Osun State	0803 502 5692 0805 645 6250 0803 390 8772
31. Oyo State	0809 539 4000 0807 828 8999 0809 596 3000 0807 828 8800
32. Plateau State	0703 286 4444 0806 548 6416 0803 542 2711 0803 577 9917
33. Rivers State	0805 610 9538 0803 312 4314 0803 188 8093
34. Sokoto State	0803 231 1116 0703 193 5037 0802 206 9567 0803 639 4462 0803 507 4228
35. Taraba State	0806 550 8675 0803 935 9368 0803 250 1165 0803 745 0227
36. Yobe State	0813 183 4764 0704 111 6027
37. Zamfara State	0803 562 6731 0806 540 8696 0803 516 1538 0810 500 9888 0816 133 0774 0806 307 5385

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**Interim Guidelines for Home Based
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