Standard Operating Procedures for Management of Child Development Centres during COVID-19

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Version 1.0

Dated:

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Foreword

We are in the midst of an unprecedented scenario with extraordinary circumstances. COVID-19 has severely affected RMNCHA services and children have been deprived of essential services. In India, with the second largest global population, the growing epidemic of Coronavirus requires that special efforts have to be made to continue the essential services for all children. The COVID-19 outbreak has placed unprecedented demands on our health system. Focusing on COVID-19 related activities, and continuing to provide essential services to children is very important. The coronavirus pandemic has created unique concerns for caregivers and people with intellectual and developmental disabilities. Individuals with disabilities likely have the same risk factors as the general population. Additionally, anyone with intellectual disability, moderate to severe developmental delay may also be more susceptible to severe illness from COVID-19 and need ongoing care for their developmental concerns.

The Care of Children with Special Needs at District Early Intervention Centers and Child Development Centers requires special attention. They need ongoing care for their developmental issues, ensuring that the facilities are safe and adhering to Covid norms. Ministry of Health & Family Welfare (MOHFW) is regularly releasing advisories, guidelines and recommendations related to COVID. However, there have been no specific guidelines for care of Children with Special Needs. UNICEF is happy to collaborate with Fernandez Foundation to prepare the Standard Operating Procedures for Management of Children with Special Needs. The group of experts have put in their best efforts to prepare a comprehensive module to address all concerns related to management of Children with Special Needs.

I congratulate Fernandez Foundation and Govt of Telangana for successfully taking up this endeavour and thank my colleague Dr Srikrishna RSV for the coordination.

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Introduction

The COVID-19 pandemic brought the world to a standstill and disrupted the routine for everyone across the globe. The disruption caused by the pandemic is further amplified for families of children with disabilities. With schools and therapy centers closed, families are left to fend for themselves with limited support and provide round the clock care.

Most families have shown profound resilience perhaps because they know how to adapt to uncertainties and navigate through hardships. Families across support groups are helping each other manage day-to-day challenges by sharing experiences and exchanging information. Several parents and practitioners alike have found innovative ways of engaging children in home-settings. There are a lot of children who have blossomed in home-settings with the love and care from their family. But many children are struggling without the therapeutic interventions. For some, the progress has come to a halt while some have increased incidences of aggression and meltdowns as they are unable to process the new world. Additionally, primary caregivers are beginning to feel the "burn-out" as the crisis continues to evolve. The stress and anxiety associated with providing care puts the caregivers at a higher risk of psychological distress.

As the government announces the unlock guidelines, families are feeling the pressure to evaluate their intervention options for their children. While studies have shown that children are at a very low risk of catching the virus, one cannot forget that children with disabilities have compromised immune systems and need extra care. Parents of children with disabilities have to tread a thin line between accessing essential therapies and protecting the child and oneself from the virus. Those of us working with children need to ensure a safe environment for the children, their caregivers, and the staff.

This SOP details the guidelines for reopening of centers in a variety of settings. It provides best practices for infection control, face-to-face consultations, online consultations, and triage. The basic principles of physical distancing, avoiding overcrowding, wearing masks, and washing hands frequently should not be compromised. As schools and centers reopen, it is important that they follow all the safety precautions and hygiene measures not only for the children but also for the caregivers, teachers, therapists, and the staff working with the children. Families visiting the center are equally accountable and must adhere to the guidelines to curb the spread of the virus. Last but not the least, the pandemic has highlighted the importance of providing family-centric care. It is an opportunity for organizations to empower families so that they feel assured and can actively participate in providing interventions. Together, families and practitioners can draw upon each other's strength to provide children with the support they deserve and help them successfully navigate through the COVID-19 crisis!

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Executive Director,
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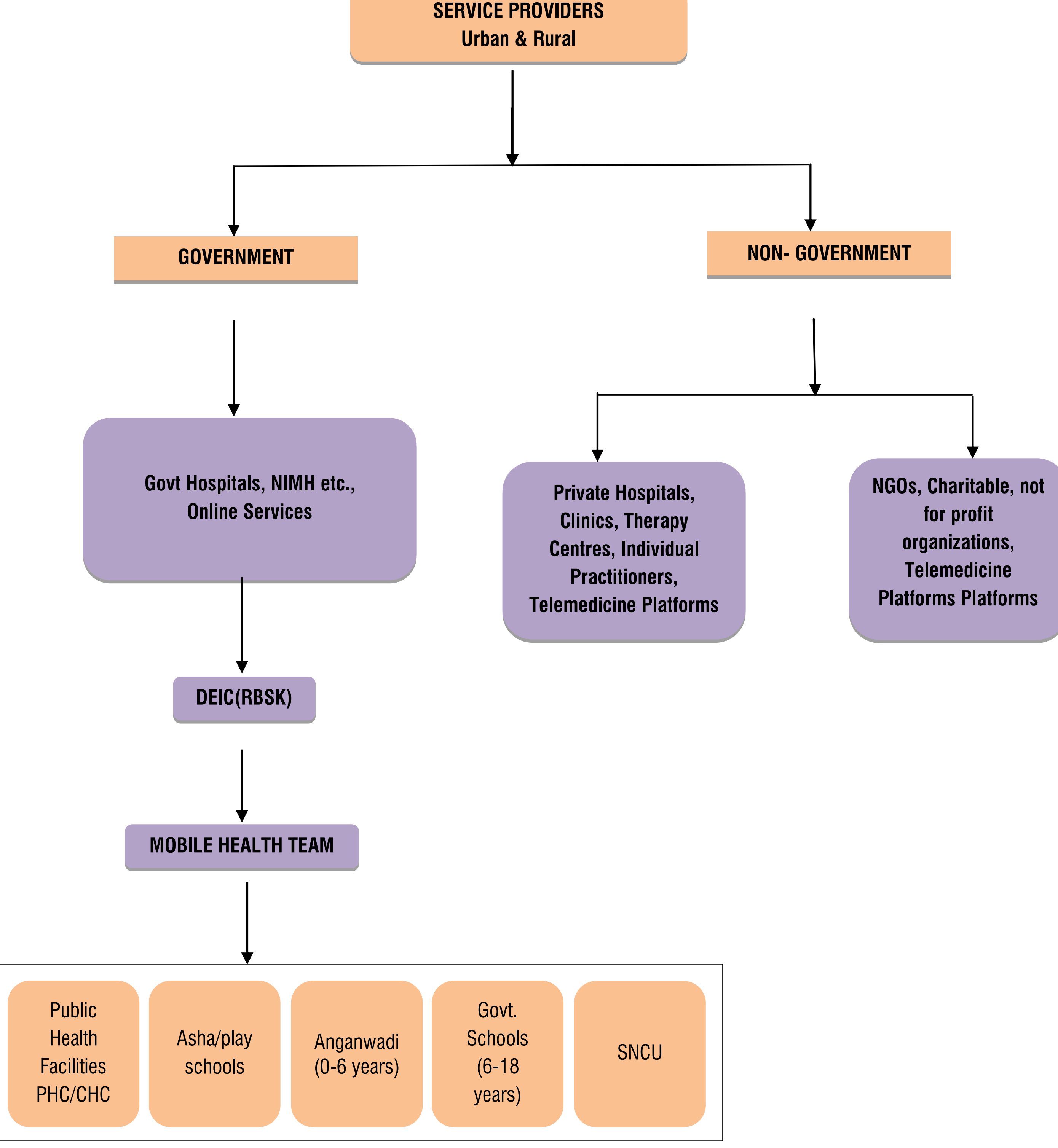
1. Landscape of Service Providers in Telangana

In Telangana state, the service providers for paediatric interventions can be categorized as Government supported and Non - Government entities as is shown in the following diagram.



Under the Non-Government category there are several hospitals (including corporate hospitals), clinics, therapy centres and individual practitioners across the State, who charge fees for their services. There are also several organizations that may or may not charge fees for their services and are run on not for profit basis. Rest are spread thinly in the urban and semi-urban areas across the State.

The for-profit entities seem to have presence predominantly in the urban areas barring the exception of a few for-profit and mainly not for profit organizations working in the remote areas of the State. There are around 500 or more private service providers in Hyderabad and Secunderabad put together (source: justdial.com, docprime.com & credithealth.com).

The State government of Telangana and the Government of India supports several hospitals and Institutes like the National institute of Mental Health (NIMH) in the state capital as well as a few in the districts. Apart from these, under the National Rural Health Mission, ten District Early Intervention Centres (DEIC) were established and they were modified into Rashtriya Bal Swasthya karyakram (RSBK) by adding few more features to the programme.

1.1 Introduction to DEIC

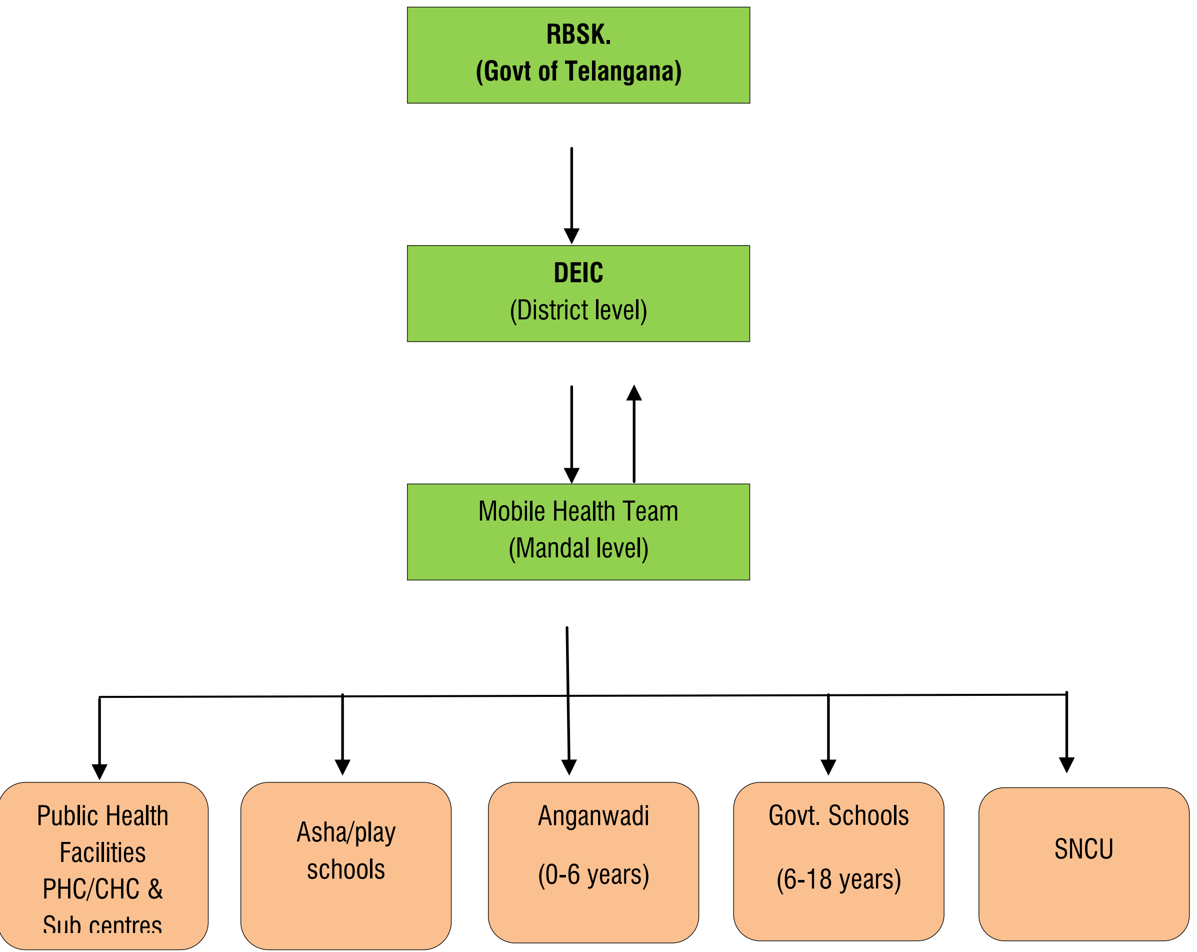
Under RBSK Programme, centre DEICs are established at district headquarters. They are supposed to cater to both urban and rural areas of the state. At present 10 DEIC centres are functioning in Telangana located at Adilabad, Hyderabad, Karimnagar, Khammam, Mahbubnagar, Nalgonda, Nizamabad, Ranga Reddy, Sanga Reddy and Warangal.

Today, in this newly formed state, there are 33 Districts, and all of these are covered by the ten DEICs started originally at the ten old District headquarters. Proposal is in the pipeline to start more DEICs soon.

DEICs aim to provide early identification and early intervention services for children from birth to 18 years to cover 4 Ds viz. Defects at birth, Deficiencies, Diseases, and Developmental delays including disability.

DEICs receive referrals from government as well private service providers in the urban as well as remotest rural areas such tribal habitations with the presence of only sub centres under the umbrella of Primary Health Care Centres. DEICs also send referrals to State level service providers for more specialized care.

1.2 Organogram of DEIC



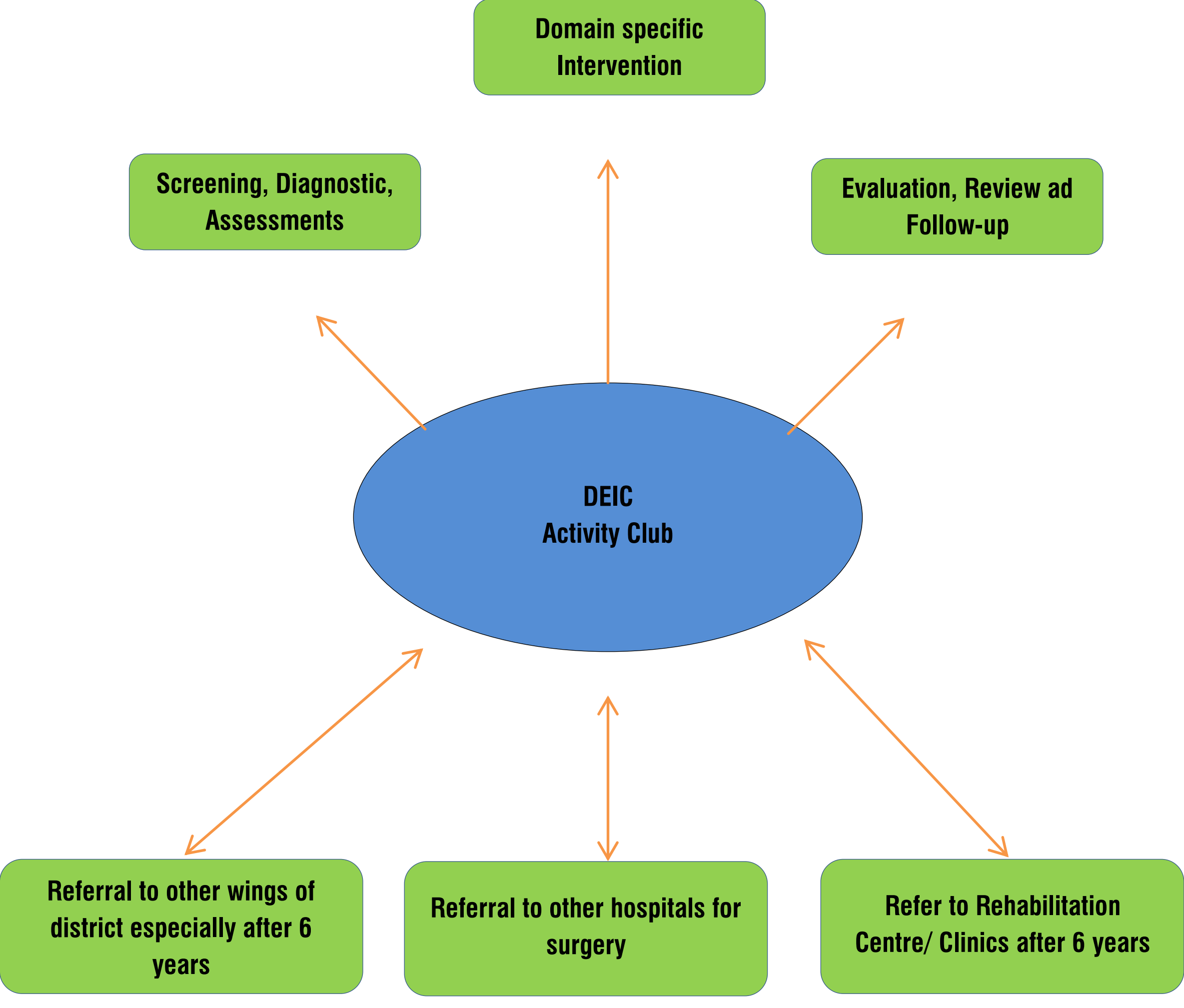
PHC & Sub centres - Public Health Centre. In the remote areas, there are centre subcentres that substitute for services provided by other entities like; Anganwadi, SNCU etc.

CHC - Community Health Centre

SNCU - Special newborn care unit

Mobile Health Team is a team of two doctors, one nurse and pharmacist, the team screens children at government facilities and refers to DEIC, and DEIC refers the children to specialized centres.

1.3 DEIC Activity Club



1.4 Services Provided by DEIC

CORE SERVICES

Medical services

Dental services

Occupational therapy & Physical therapy

Psychological services

Cognition services

Audiology

Speech-language pathology

Vision services

Health services

Lab services

Nutrition services

Social support services

Psychosocial services

Transportation and related costs

SUPPLEMETARY SERVICES

1. Disability division of Ministry of Social Justice and Empowerment (MoSJE):

Assistive technology devices and services

Special Education services

Aids and appliances

Rehabilitation of the differently abled child above 6 years of age

Family support services

Guardianship

Parent Associations

Promoting advocacy for right-based society

Social security's such as disability scholarship and disability pension

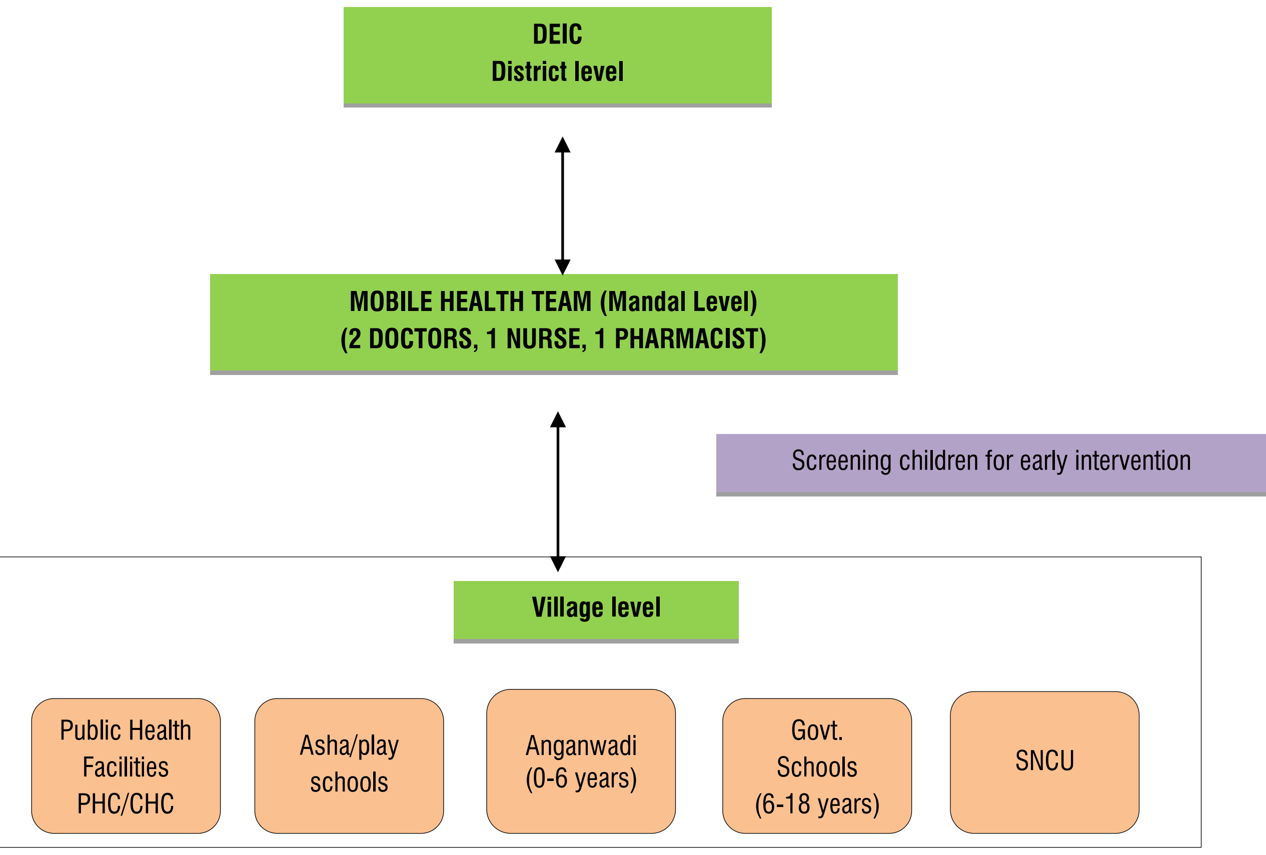
2. Linkages with Ministry of Human Resource Development (MoHRD)

Provide inclusive education and support to children from age of 6 -14 years

Provide Aids and appliances to school going children

To provide home based educational services

1.5 Ground Level Functionaries



1.6 Common Problems Expected to be Evaluated and Treated at DEIC in Children from Birth to 6 Years

1.6.1 Motor:
Cerebral Palsy, Neuromuscular disorders, Progressive Degenerative disorders

1.6.2 Speech and Hearing:
Hearing Impairment, Autism Spectrum Disorders (ASD), Cleft lip & palate, childhood aphasias, specific language disorders, functional speech disorder, voice / fluency disorders, articulation disorder

1.6.3 Cognition:
Cognitive developmental delay, Mental Retardation.

1.6.4 Vision:
Amblyopia, Squint, cataracts, refractory errors, Nystagmus, Vitamin A deficiency, Congenital glaucoma, cerebral visual impairment, total blindness, ROP, Degenerative Disorders.

1.6.5 Behavioral / Learning:
ASD, Attention deficit hyperactivity disorder (ADHD), Specific learning disability (SLD), and other childhood behavioral disorders.

1.6.6 Dental:
Early childhood carries or gingivitis.

1.7 DEIC Staff

Professionals	Number	To be deputed from the existing pool
PAEDIATRICIAN	1	
MO, MBBS	1	
MO, DENTAL	1	
PHYSIOTHERAPIST	1	
AUDIOLOGIST & SPEECH THERAPIST	1	
PSHYCHOLOGIST	1	
OPTOMETRIST	1	
EARLY INTERVENTION CUM SPECIAL EDUCATOR	1	
SOCIAL WORKER	1	
LAB TECHNICIAN	1	
STAFF NURSE	1	
DENTAL TECHNICIAN	1	
DEIC Manager		
Nutritionist		1
Paediatrician trained for ECHO in smaller children		1
Nurses		Two on all days
Visiting Medical specialists-		
ENT specialist		Twice a Week
Ophthalmologist		Twice a Week
Orthopaedic specialist		Twice a Week
Neurologist		Once a Week
Psychiatrist		Twice a Week

1.8 Activities of District Early Intervention Centre

- Screening all infants discharged from Sick Newborn Care Units (SNCU) who are at-risk of developmental delays and Neuro-motor impairment
- Monitor development of all infants discharged from the SNCUs to track whether their development trajectories are within normal limits up to the age of 2 years
- To confirm diagnosis of the children referred for Defects at Birth, Deficiencies, Diseases & Developmental delays including disabilities, by the Mobile Health Teams, delivery points, ASHAs private medical practitioners and self-referral
- To coordinate tertiary level treatment
- To act as a resource centre for Block Early Intervention Centres (BEIC)
- Assessment, intervention and parent counseling for the children who have confirmed diagnosis of Neuro-motor impairment. Therapies will be provided till 6 years. Any child within 6 years of age having Neuro-motor problem will be able to avail therapy services at DEICs (both referred and self-referral)

- To maintain records of every child who will attend DEICs for therapies and education
- Children beyond six years of age with Neuro-motor impairments will be referred for further continuation of therapy and education to the Rehabilitative and Educational institutions
- To develop BCC materials and strategies for the purpose of creation of awareness of this new concept among the public.
- Laboratory for the clinical and programmatic improvement through exercising evidence based approach

1.9 Current Service Delivery Pattern and Associated Challenges

As per the normal practice, after the initial screening by the mobile team (as shown in the diagram above), the children with positive scores are taken to the DEICs for further assessment followed by treatment/therapies. Average number of 10-15 children are transported in a vehicle to DEIC once or twice a week for this purpose. On an average, each child undergoing treatment/receiving therapy visits the DEIC at least once a month after the first assessment and consultation.

In case of excess burden on Mobile team, Anganwadi, ASHA, PHC, CHC or SNCU staff can also be trained for this facilitation depending on their capabilities and availability too.

In some of the tribal areas, Mobile team does not have outreach. Neither do they have Anganwadi workers. Most of them are equipped only with sub-centres under the umbrella of the Primary Health Centres. Children in these areas are referred by the PHC doctors to the DEIC. Thus, training of PHC staff for online screening, consultation facilitation and treatment/therapy sessions is crucial too.

Special Educators of the Bhavita Centres of the Education Department are placed at the Mandal level in every District. They are trained as caregivers for children with disabilities. Their services could also be mobilized in the case of inadequate staff at the village level.

In case of Government facilities at the ground level, the Education Department has trained special educators of the Bhavita Centres at the Mandal level. Their services could be mobilsed in case of shortage of staff.

In addition, to that not all DEICs are well equipped and adequately staffed as is recommended by the National Rural Health Mission & RBSK guidelines.

1.9 Tele-Medicine

Many studies, especially in the developed part of the world, where accessibility to computers and smartphones is not an issue, observe that **Telehealth increases access to healthcare due to:**

- Increased access to therapy for individuals with physical, medical and/or mobility disabilities.
- Increased access to disability specialists regardless of geographic area.
- Access to care in a native language.
- More time to collect information about thoughts and feelings and behaviors outside of office appointments.
- More flexible scheduling of sessions.
- Reduction in travel stress and costs.
- Telehealth is especially convenient to individuals with chronic and episodic conditions.

Source: http://www.eparent.com/features-3/telehealth-and-children-with-disabilities/

Today, during the COVID pandemic crisis, in order to avoid the risk of contagion and yet maintain continuity of services Telemedicine offers a promising solution.

2. Assessment of Readiness to Reopen the Child Development Facility

Overview *– This document provides a decision tree that will help centres determine their readiness to reopen the facility after a shutdown during a lockdown.*

2.1 Guidelines to be followed and measures to be considered prior to reopening

2.1.1 Ensure that reopening be consistent with the applicable state and local orders

2.1.2 Implement measures to protect children from unnecessary exposure to infection

2.1.3 Consider delineating roles that can be performed online /remotely and those that have to be performed in person

2.1.3 Implement screening measures for children and employees upon arrival for symptoms and history of exposure

2.2 Prepare staff and facility for reopening

2.2.1 Promote healthy hygiene practices such as hand washing and employees wearing a cloth face covering, as feasible

2.2.2 Intensify cleaning, disinfection, and ventilation

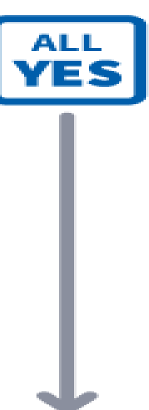
2.2.3 Encourage social distancing through increased spacing, small groups and limited mixing between groups, if feasible

2.2.4 Train all employees on health and safety protocols

2.2.5 Identify roles that need to be performed face-to-face and those that can be performed remotely

2.2.6 Create a contingency plan for staffing in the event that several of the staff members test positive and need to be either quarantines/ admitted for treatment

2.2.7 Provide mental health support within the centre or identify external resources for offering mental health support. (Mental health support available at 108 Helpline number Emergency Management and Research Institute)



2.3 Ongoing monitoring once the centre has reopened

2.3.1 Develop and implement procedures to check for signs and symptoms of children and employees daily upon arrival, as feasible

2.3.2 Encourage anyone who is sick to stay home

2.3.3 Plan for children or employees who get sick

2.3.4 Regularly communicate and monitor developments with local authorities, employees, and families regarding cases, exposures, and updates to policies and procedures

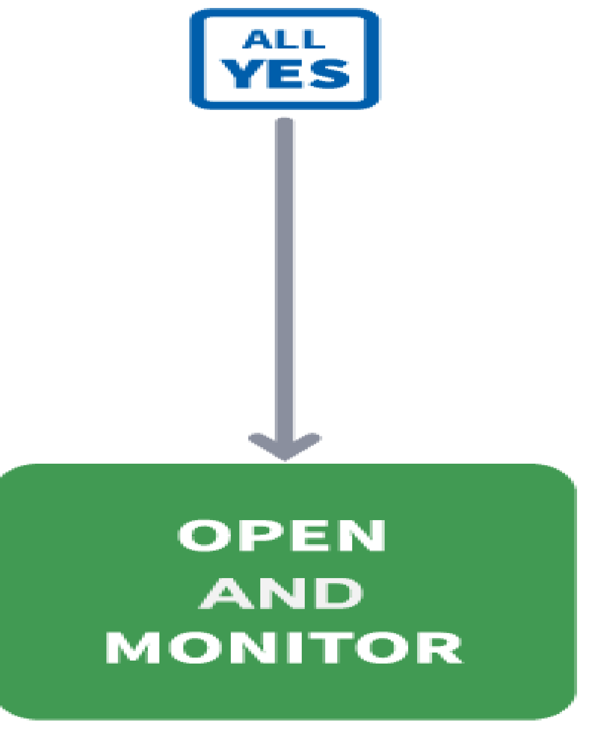
2.3.5 Monitor absences of children, their caregivers and the employees and have flexible leave policies and practices

2.3.6 Develop a plan for what to do if someone becomes ill with suspected COVID-19 at one of your workplaces

2.3.7 The plan should cover putting the ill person in a room or area where they are isolated from others in the workplace, limiting the number of people who have contact with the sick person, and contact the local health authorities.

2.3.8 Consider how to identify persons who may be at risk, and support them, without inviting stigma and discrimination. This could include persons who have recently travelled to an area reporting cases or other personnel who have conditions that put them at higher risk of serious illness (e.g. diabetes, heart and lung disease, older age).

2.3.9 Be ready to consult with the local health authorities if there are cases in the facility or an increase in cases in the local area



If your responses to all the questions is a YES, you can reopen the centre and monitor

In addition, to these guidelines, centers may have to consider institutional and area specific guidelines while making decisions about reopening or continuing operations.

3. Best Practices for Infection Control

3.1 General precautions

3.1.1 All health care personnel working can be done-in to hospital scrubs (if provisions are available)

3.1.2 Restrict the use of mobile phones, laptops inside the therapy room

3.1.3 Limit your personal belongings inside the therapy rooms (like wallet)

3.1.4 100% hand hygiene compliance to be ensured

3.1.5 Proper hand washing is the key to the prevention of infections. Follow the steps of hand hygiene as per WHO policy for hand rubs and hand wash

3.1.6 Use non dominant hand for opening doors, switching on and off the fans, warmers, lights

3.1.7 Social distancing of minimum 1 meter should be maintained between the team members (doctors/nurses/support staff, mothers and patient attendants). The following steps will help organizations adhere to social distancing norms

- 3.1.7a Separate Entry and Exit areas for patients as well as the staff
- 3.1.7b Consider installing physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between personnel and patients
- 3.1.7c Staff performing thermal screening should also wear protective gear (refer to MOHFW guidelines in the document)
- 3.1.7d Designated donning and doffing areas for the staff
- 3.1.7e Ensure the corridor used is planned to avoid direct face-to-face contact between patients
- 3.1.7f The therapy rooms should be well-ventilated
- 3.1.7g Creating physical barriers between the staff and clients when possible, such as adding freestanding, mobile plexiglass in each area to be used during interventions that do not require direct hands-on assistance by the therapist/ other practitioner
- 3.1.7h Clinics running from basements should preferably remain closed, or if opened, air conditioning should allow at least 12 air exchanges/ hour
- 3.1.7i Safely relocate interventions outside (e.g., therapeutic gardens)
- 3.1.7j Increase hours of operation of the clinic; running the clinic in shifts /stagger appointment times to decrease client-to-client contact
- 3.1.7k Scheduling the same number of patients as rooms to eliminate treating multiple clients in the same room during the initial reopening

3.1.8a Allow staff to work partially from home (preliminary concerns, documentation including evaluation of already available investigations and report writing can be done from home)

3.1.8b Restrict the number of family members who accompany a child (preferably one caregiver/child). Under circumstances where the child is older and has significant motor disabilities and or behavioral challenges, 2 caregivers can accompany the child

3.1.9 Instruct the caregivers to do hand washing before entering the center and also to wear mask. Consider a video based orientation for caregivers as they enter the center on disinfection procedures. Caregivers and staff should be cautioned against stigmatizing those who test positive for COVID. Staff should be sensitive to the caregivers and their children. Instructions related to sanitization and social distancing need to be shared respectfully and compassionately at all times

3.1.10 Any aids, appliances that are brought by the family should be taken into the center after disinfection

3.2 General guidelines for infection control in special schools:

3.2.1 The schools may need to increase the staff as needed. Cleaning staff also needs to be properly trained on disinfection

3.2.2 The use of hand sanitizers and proper use of cloth masks should be promoted by the schools. Schools should inform caregivers about disinfection protocols in advance and also have video based orientation at the center. This is a trying and anxious time for all; School personnel should be trained in communicating with caregivers and children patiently and respectfully

3.2.3 Perform social distancing during tabletop activities by placing seats 6 feet apart and avoiding face-to-face sitting positions

3.2.4 Use visual aids where appropriate versus physical contact

3.2.5 Stagger the rejoining of children who are at high risk of infection, those who are unable to control their respiratory secretions, and children with severe maladaptive behaviours like spitting or biting. Refer these children for clinic-based management

3.2.6 Provide school leaders with clear guidance to establish procedures if students or staff become unwell. Guidance should include monitoring student and staff health, maintaining regular contact with local health authorities, and updating emergency plans and contact lists

3.2.7 Schools should also ensure there is space to temporarily separate sick students and staff without creating stigma. Share procedures with staff, parents and students, including advising all sick children, their caregivers and staff to remain home

3.2.8 Implement large-scale remedial programs to mitigate learning loss and prevent exacerbation of learning inequality after school closures, with a focus on literacy and numeracy for primary-age children and accessibility accommodations for children with disabilities

3.2.9 Conduct a risk assessment for therapists, teachers and other staff (considering age, chronic conditions and other risk factors including mental health conditions that can get aggravated), then implement a staggered approach for returning to school

3.3 Disinfection protocol

3.3.1 Floors, chairs, tables, door handles, telephone, light switches, reception - Once every shift, with 0.5% sodium hypochlorite

3.3.2 Stethoscope, BP cuff, thermometer, injection tray - After every use, 70 % ethyl alcohol

3.3.3 Follow routine biomedical waste disposal handling, segregation, transport as per biomedical waste disposal guidelines

3.3.4 Use of toys / Cleaning of toys

3.3.4a Ask parents to bring calming toys or favorite toys of the child for observation during the session.

3.3.4b Advise the parents not to share the personal toys with any other children in the clinic.

3.3.4c In case parents don't bring their own toys, you may provide a clean set of toys from the clinic.

3.3.4d It will be preferable to have multiple sets of commonly used toys so that a clean set is always available.

3.3.4e Toys provided to infants and young children should have smooth solid surfaces, and should be easy to clean.

3.3.4f Toys used once for any child should not be used for another without being cleaned.

3.3.4g Avoid toys with small pieces and crevices, stuffed toys and toys made of fabric or plush.

3.3.4h Toys that are awaiting cleaning should be stored in a box labelled as 'dirty toys' and kept in an area that children cannot access.

3.3.4i Any toy that is visibly soiled or comes into contact with mucous membranes or body fluid must be cleaned and disinfected immediately.

3.3.4j Cleaning of toys can be done using detergent and water, and air dried.

3.3.4k For disinfection, 1:100 diluted bleach, isopropyl alcohol, or disinfectant wipes can be used.

3.3.4l After recommended contact times for disinfectants, toys must be rinsed in water and air-dried.

3.4 Display infection control guidelines

Cleaning And Disinfecting Your Facility

Everyday Steps, Steps When Someone is Sick, and Considerations for Employers

How to clean and disinfect

Wear disposable gloves to clean and disinfect.

Clean

- **Clean surfaces using soap and water.** Practice routine cleaning of frequently touched surfaces.

High touch surfaces include:

Tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc.

Disinfect

- Clean the area or item with soap and water or another detergent if it is dirty. Then, use a household disinfectant.
- **Recommend use of EPA-registered household disinfectant. Follow the instructions on the label** to ensure safe and effective use of the product.

Many products recommend:

- Keeping surface wet for a period of time (see product label).
- Precautions such as wearing gloves and making sure you have good ventilation during use of the product.

- **Diluted household bleach solutions may also be used** if appropriate for the surface. Check to ensure the product is not past its expiration date. Unexpired household bleach will be effective against coronaviruses when properly diluted.

  Follow manufacturer's instructions for application and proper ventilation. Never mix household bleach with ammonia or any other cleanser.

  Leave solution on the surface for **at least 1 minute**

  Bleach solutions will be **effective** for disinfection **up to 24 hours.**

  To make a bleach solution, mix:

  - 5 tablespoons (1/3rd cup) bleach per gallon of water

  OR

  - 4 teaspoons bleach per quart of water

- **Alcohol solutions with at least 70% alcohol.**

Soft surfaces

For soft surfaces such as **carpeted floor, rugs, and drapes**

- **Clean the surface using soap and water** or with cleaners appropriate for use on these surfaces.

CS316270A 05/15/2020

cdc.gov/coronavirus

- **Launder items** (if possible) according to the manufacturer's instructions. Use the warmest appropriate water setting and dry items completely.

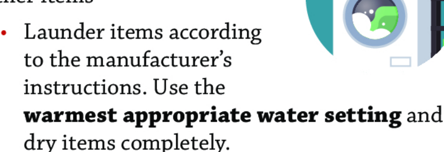
OR

- **Disinfect with an EPA-registered household disinfectant.** These disinfectants meet EPA's criteria for use against COVID-19.

Electronics

- For electronics, such as **tablets, touch screens, keyboards, remote controls, and ATM machines**
- Consider putting a **wipeable** cover on electronics.
- **Follow manufacturer's instruction** for cleaning and dinfecting.
  - If no guidance, **use alcohol-based wipes or sprays containing at least 70% alcohol**. Dry surface thoroughly.

Laundry



For clothing, towels, linens and other items

- Launder items according to the manufacturer's instructions. Use the **warmest appropriate water setting** and dry items completely.
- **Wear disposable gloves** when handling dirty laundry from a person who is sick.
- Dirty laundry from a person who is sick **can be washed with other people's items**.
- **Do not shake** dirty laundry.
- Clean and **disinfect clothes hampers** according to guidance above for surfaces.
- **Remove gloves,** and wash hands right away.

Cleaning and disinfecting your building or facility if someone is sick

- **Close off areas** used by the person who is sick.
- **Open outside doors and windows** to increase air circulation in the area. **Wait 24 hours** before you clean or disinfect. If 24 hours is not feasible, wait as long as possible.

- Clean and disinfect **all areas used by the person who is sick**, such as offices, bathrooms, common areas, shared electronic equipment like tablets, touch screens, keyboards, remote controls, and ATM machines.
- If **more than 7 days** since the person who is sick visited or used the facility, additional cleaning and disinfection is not necessary.
  - Continue routing cleaning and disinfection.

When cleaning

- **Wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash.**
  - Additional personal protective equipment (PPE) might be required based on the cleaning/disinfectant products being used and whether there is a risk of splash.
  - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
- **Wash your hands often** with soap and water for 20 seconds.
  - Always wash immediately after removing gloves and after contact with a person who is sick.

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- Hand sanitizer: If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

- **Additional key times to wash hands** include:
  - After blowing one's nose, coughing, or sneezing.
  - After using the restroom.
  - Before eating or preparing food.
  - After contact with animals or pets.
  - Before and after providing routine care for another person who needs assistance (e.g., a child).

Additional Considerations for Employers

- **Educate workers** performing cleaning, laundry, and trash pick-up to recognize the symptoms of COVID-19.
- Provide instructions **on what to do if they develop symptoms within 14 days** after their last possible exposure to the virus.
- Develop **policies for worker protection and provide training** to all cleaning staff on site prior to providing cleaning tasks.
  - Training should include when to use PPE, what PPE is necessary, how to properly don (put on), use, and doff (take off) PPE, and how to properly dispose of PPE.
- Ensure workers are **trained on the hazards of the cleaning chemicals** used in the workplace in accordance with OSHA's Hazard Communication standard (29 CFR 1910.1200).
- **Comply** with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste, and PPE (29 CFR 1910.132).

3.5 Guidelines for wearing protective equipment in an outpatient or ambulatory clinical setting issued by the Ministry of Health and Family Welfare, India

Outpatient Department (Respiratory Clinic / Separate screening area)#

S. No.	Setting	Activity	Risk	Recommended PPE	Remarks
1	Triage area	Triaging patients Provide triple layer mask to patient	Mild risk	Triple Layer mask Latex Gloves	Patients get masked
2	Screening area help desk/ Registration counter	Provide information to patients	Mild risk	Triple Layer mask Latex Gloves	
3	Temperature recording station	Record temperature with hand held thermal recorder	Mild risk	Triple Layer mask Latex Gloves	
4	Holding area/ waiting area	Nurses / paramedic interacting with patients	Mild risk	N 95 mask Latex Gloves	Minimum distance of one meter needs to be maintained
5	Doctors chamber	Clinical management (doctors, nurses)	Mild risk	N 95 mask Latex Gloves	No aerosol generating procedures should be allowed
6	Sanitary staff	Cleaning frequently touched surfaces/ Floor/ cleaning linen	Mild risk	N 95 mask Latex Gloves	

7	Visitors accompanying young children and elderlies	Support in navigating various service areas	Low risk	Triple layer medical mask	No other visitors should be allowed to accompany patients in OPD settings. The visitors thus allowed should practice hand hygiene
8	ASHA, Anganwadi and other field staff	Home visits	Low risk	Triple Layer mask Latex Gloves	Minimum distance of one meter to be maintained

All hospitals should identify a separate triage and holding area for patients with Influenza like illness. If there is no triage area/holding area for patients due to resource constraints, such hospitals will follow the above guidelines for general OPD.

Face shields and goggles should be part of the PPE equipment outlined for healthcare workers in a center working with children with disabilities on account of the higher risk to exposure to droplet infection

3.6 Personal Protective Equipment (PPE)

Personal Protective Equipments (PPEs) are protective gear designed to safeguard the health of workers by minimizing the exposure to a biological agent.

Components of PPE

Components of PPE are goggles, face-shield, mask, gloves, coverall/gowns (with or without aprons), headcover, and shoe cover. Based on MOFFW recommendations for Outpatient area

3.6.1 Face shield and goggles

Contamination of mucous membranes of the eyes, nose, and mouth is likely in a scenario of droplets generated by cough, sneeze of an infected person, or during aerosol-generating procedures carried out in a clinical setting. Inadvertently touching the eyes/nose/mouth with a contaminated hand is another likely scenario. Hence protection of the mucous membranes of the eyes/nose/mouth by using face shields/ goggles is an integral part of standard and contact precautions. The flexible frame of goggles should provide a good seal with the skin of the face, covering the eyes and the surrounding areas and even accommodating for prescription glasses.

3.6.2 Masks

Respiratory viruses that include Coronaviruses target mainly the upper and lower respiratory tracts. Hence protecting the airway from the particulate matter generated by droplets/aerosols prevents human infection. Contamination of mucous membranes of the mouth and nose by infective droplets or through a contaminated hand also allows the virus to enter the host. Hence the droplet precautions/airborne precautions using masks are crucial while dealing with a suspect or confirmed case of COVID-19/performing aerosol-generating procedures.

Masks are of different types. The type of mask to be used is related to the particular risk profile of the category of personnel and his/her work. There are two types of masks which are recommended for various categories of personnel working in hospital or community settings, depending upon the work environment:

1. Triple-layer medical mask
2. N-95 Respirator mask

3.6.2.1 Triple layer medical mask

A triple layer medical mask is a disposable mask, fluid-resistant, provide protection to the wearer from droplets of infectious material emitted during coughing/sneezing/talking.

3.6.2.2 N-95 Respirator mask

An N-95 respirator mask is a respiratory protective device with high filtration efficiency to airborne particles. To provide the requisite air seal to the wearer, such masks are designed to achieve a very close facial fit.

Such mask should have high fluid resistance, good breathability (preferably with an expiratory valve), clearly identifiable internal and external faces, duckbill/cup-shaped structured design that does not collapse against the mouth.

If correctly worn, the filtration capacity of these masks exceeds those of triple layer medical masks. Since these provide a much tighter air seal than triple layer medical masks, they are designed to protect the wearer from inhaling airborne particles.

3.6.3 Gloves

When a person touches an object/surface contaminated by COVID-19 infected person, and then touches his own eyes, nose, or mouth, he may get exposed to the virus. Although this is not thought to be a predominant mode of transmission, care should be exercised while handling objects/surface potentially contaminated by suspect/confirmed cases of COVID-19.

Nitrile gloves are preferred over latex gloves because they resist chemicals, including certain disinfectants such as chlorine. There is a high rate of allergies to latex and contact allergic dermatitis among health workers. However, if nitrile gloves are not available, latex gloves can be used. Nonpowdered gloves are preferred to powdered gloves.

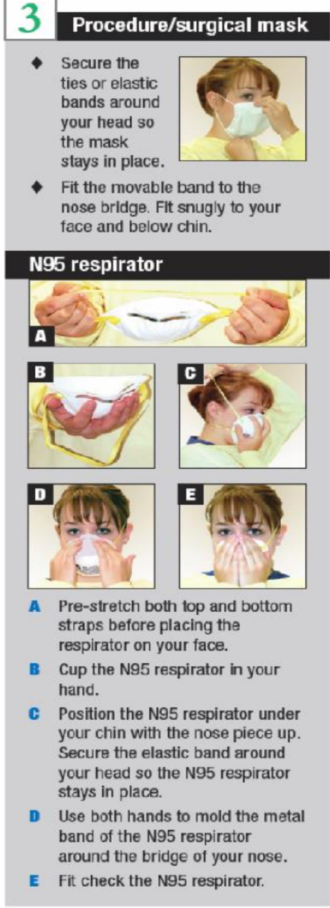
3.7 Best practice for donning and doffing protective gears

Putting on (Donning) Personal Protective Equipment (PPE)

1 HAND HYGIENE

A Using an alcohol-based hand rub is the preferred way to **clean your hands.**

B If your hands look or feel dirty, soap and water must be used to wash your hands.



4. SOP Triage

Overview – The triage process helps a center decide on when and to whom face to face consultations may be offered after weighing the pros and cons for the children with special needs, their caregivers and the service providers. Once face to face consultation is deemed necessary for a particular child, the call can be used to prepare the family for what to expect (with new safety and hygiene measures), risks and benefits and to get their informed consent for the consultation (recommended).

This document provides a step by step guide to help clinicians and program managers decide who maybe the best candidates for face to face and or online consultations.

4.1 Triage

4.1.1 Who can conduct triage

The centre needs to identify professionals who could be part of the triage team

4.1.2 The identified team needs to be oriented to and trained in the triage questions and should be well versed with the criteria for whom to offer face to face and online consultations to

4.1.3 Criteria for deciding which child needs face to face consultations

- Multiple disabilities
- Physical disabilities (contractures, severe stiffness, abnormal movements)
- High risk newborns and infants requiring early intervention
- Visually-impaired children:

As they may rely on touch based activated measures of hand hygiene should be facilitated for them. Stress should be given to sanitise the assisted devices

- Hearing concerns: Masks can make routine communication difficult. Alternate arrangements should be considered like transparent masks. Face to face interaction should be reduced and text-based communication should be encouraged. suspected hearing loss where a diagnosis will alter outcomes, urgent need to reprogram existing hearing aids or cochlear implants
- Any condition where immediate intervention would alter the prognosis.

4.1.4 Criteria for deciding which caregiver needs face to face consultations

- Caregiver very anxious/other mental health concerns
- Lack of internet for online communication
- The decision of whether the child should be continuing face to face consultation and the number of sessions would be decided based on factors like the length of the commute, preexisting health conditions in the child/family, whether the family lives in a containment area

4.1.4 Risk factors for children and caregivers

Preexisting health condition in the child, caregiver or both predisposes them to relatively poorer outcomes if they are infected. Hence it is important to weigh the risks and benefits of an online consultation in such a situation

4.1.5 After evaluating the indication (caregiver, child), associated risks, inconveniences once the triage team deems it necessary to offer face to face consultations, it is important to explain the rationale to the caregivers. Informed verbal/written consent for the same is recommended but not mandated at the time of framing these guidelines. The triage team can make note of the family's consent in the case notes

4.2 Preparing a family for a visit to the center for face to face consultation

4.2.1 Inform the family about new hygiene and social distancing measures instituted at the center

4.2.2 When possible share a video /handout in advance on best practices for hand hygiene and wearing a mask

4.2.3 Orient the family to hygiene practices at the centre through prerecorded videos

4.2.4 The triage team can provide caregivers with strategies involving visual schedule, social stories that can help them

4.2.5 Prior to the day of the scheduled appointment confirm the absence of symptoms in the child and the caregiver

4.2.6 Request caregivers to download Aarogya Setu app and complete details prior to the day of the appointment

4.2.7 Request that not more than one or where needed, two caregivers accompany each child

4.3 Pre-consultation documentation:

In case the Centre and the parents are equipped, it is advisable to send a history form beforehand where the child's history including comorbid conditions will be filled by their parents, and they will have to provide any prior developmental assessment information (resources CDC milestone tracker app, track and act). This will help in minimizing the contact time in the hospital

4.3.1 Any family support that is needed can also be enquired for

4.4 On the day of the appointment (please refer to best practices document for face to face consultations for detailed guidelines)

- Ensure that patients are coming on their allotted appointment time
- Reminders to be sent to parents about the session appointments
- Try to complete protocols within stipulated time period to avoid unnecessary crowding inside the premises
- Any walk-in with suspected Covid symptoms must not be attended to and should be referred to the appropriate team.
- Persons with disabilities with additional medical issues coming to institutions are more likely to contract the virus.
- Declaration / consent form will have to be taken (wherever applicable).
- Weight, head circumference if taken within the last month need not be repeated

4.5 Suspected or confirmed Covid infection in a child/caregiver who visited the center

In case we come to know that a child/caregiver have tested positive after a visit to the centre contact tracing and self-quarantine advisory to those exposed must be issued. If adequate staff are available, they can follow rotation duty so that if one team has exposure or symptoms the services can proceed, and the overall risk of more people can be minimized.

4.6 Precautionary Measures

4.6.1 Travel

- Employees/staff commuting to the organization are to avoid public transport. Organizations can arrange for transport facilities for staff who avail public transport for commuting to work (if possible).
- If possible, encourage work from home as far as possible to avoid travel and exposure to the outside environment.
- Recommend that all staff members travelling to the center must enter their details on the Aarogya Setu app

4.6.2 Screening form for COVID-19.

*For the Form, please refer to Annexure – II

4.7 Structure of fee (as per MCI)

In case we come to know that a child/caregiver have tested positive after a visit to the centre contact tracing and self-quarantine advisory to those

The fee for tele-consultations will be the same as the fee for face-to-face consultation. Professionals will obtain the consent and explain the fees that will be charged to the families before the consultation

Family income must be considered while charging the fees.

Ref: https://www.cdc.gov/ncbddd/actearly/pdf/Grow-Up-Healthy-Chart-2017_LTSAE_PRESS_updated-2019-P.pdf

4.7.1 New case: For new assessments, the provider can use standardized apps for screening of the child (refer to annexure of Best Practices for Online consultation for further details)

4.8 Follow-up Case: If the child has been assessed then they can go for a review with the concerned clinician and they will decide the further plan of action.

- Suspected Covid: would be guided to a Covid centre and will be advised for taking online services
- Covid negative /asymptomatic children: would be decided if they would be requiring an online or a face-to-face consult.

4.9 Children requiring face-to-face consultation/services

4.10 Online services:

- Should be recommended for all children as far as possible.
- These have an advantage over face to face counselling as they provide specialist services which can be accessed from the convenience of people's home without endangering the health professional and larger community.
- If parents or any family members are sick, they are not to travel to the centre accompanying the child for services and opt for tele-services as much as possible

Assessing family readiness:

- Screening of Covid symptoms
- Consent / declaration form
- Fee structure
- Mode of consultation
- Prerequisites for visiting the centre
- Training of children and parents to use masks, washing hands, physical distancing.

*For more information, please refer to Annexure II

5. Best Practices for Face to Face Consultation

5.1 Best Practices to be followed before scheduling face to face sessions:

5.1.1 The centre must follow COVID-19 Infection Prevention and Control (IPC) guidelines.

5.1.2 The centre must provide and use appropriate Personal Protective Equipment (PPE) and have systems and policies in place that govern its use.

5.1.3 A 'virtual first' approach must remain standard practice during this period.

5.1.4 The clinician, health care worker continues to advise that all initial contact and triage assessment should be conducted via remote means.

5.1.5 The clinician/health care worker must undertake a risk assessment and make a clinically reasoned decision for offering either an in-person or a virtual consultation for each clinical encounter. Risk of exposure to infection versus Benefit of face to face consultation analysis must be conducted on a case by case basis. The clinician must engage caregivers in discussions regarding the rationale for remote or face-to-face consultations. If both parties deem it necessary to proceed with face-to-face care, the patient should be made aware of all current risks associated with this approach. Client consent must be given to proceed with virtual meeting (verbally and/or written) and should be documented these discussions and the outcome. This can be documented by the provider in the case file and conveyed to the family. Explaining the possible risk versus benefits of face to face consult is recommended as a best practice.

5.1.5 Type of patients who need Face to Face consultation:

Some of the children who may require face to face consultations will be:

5.1.5a High risk newborns [e.g. Birth Asphyxia with HIE II-III, IVH, Extreme Preterm babies, Bilirubin Induced Neurological Damage (BIND)] and infants requiring Early Intervention - for these babies early intervention measures like positioning and carrying techniques can be explained at time of discharge from SNCU/ NICU and parents should be asked to follow these measures at home, till the baby can be called for follow-up.

5.1.5b Children with Cerebral Palsy requiring hands on intervention by Occupational/Physical Therapists who may develop complications like contractures or hip dislocation

5.1.5c Children with severe or worsening behavioural problems or associated medical issues who need assessment and treatment including initiating or upgrading medications.

5.1.5d Children who require initiation or continuation of regular therapy but do not have access to technology for teleconsultation

5.1.6 When a face to face consultation is deemed necessary, it must be established whether the need is URGENT or can be deferred for another 2 to 3 months

5.1.6a If it can be deferred, the parents are advised to continue with the pre-existing rehab plans, and further exposure to the centre is avoided, minimum for 3 months.

5.1.6b If the need is urgent, such patients may be called once and a follow-up plan may be given, based on their needs. An effort must be made that the plan is given for the next 3 months, so that the child may not require to revisit the centre, thereby minimizing his exposure.

5.1.6c If the child's needs cannot be met through a long-term plan and requires frequent therapy inputs, such a child would require face to face direct therapy

5.1.7 Those children, families or employees who are deemed as extremely vulnerable on account of their pre-existing health condition should be counselled regarding their heightened risk status, and as far as possible advised to avoid/minimize the number of visits to the centre

5.1.8 Classify children and families who are scheduled to be seen face to face according to their level of vulnerability:

1. No health risks in child and parent
2. Health risks in parent/caregiver
3. Health risks (comorbid conditions) in the child

This type of classification may help the health care worker provide advice regarding who should accompany the child and how often the child needs to be seen face to face.

Centres may become legally liable if they fail to risk manage treatments and their clinical environment to safeguard patients for example with insufficient PPE, sanitization, social distancing, and other reasonable safety measures.

5.1.9 If a child is residing in a containment zone, all therapy services are deferred, whatsoever may be the condition of child; only tele rehab is allowed.

- If the child is not in containment zone, it must be found if the child's needs may be met in a nearby centre; no unnecessary travel should be done.
- If no local service is available, the child must be called to the DEIC/ Child Development Clinic

5.1.10 Provide strategies to caregivers on ways to prepare a child for an impending face to face visit - younger children and those with severe cognitive, communication and behavioural challenges may not understand why they and others have to wear protective gear and follow hygiene measure. Use of strategies like a visual schedule, preparation, and training at home for following hand hygiene measures in the centre may minimize unpleasant experiences for the child and the caregiver

5.1.11 Clear guidelines should be provided to the parent regarding how often the child will be seen (this decision will be aided by the risk classification) and the duration of the sessions.

Wherever feasible, a questionnaire-based, pre-visit evaluation should be done telephonically to aid in prior planning of treatment goals and documentation, and reduce the duration of face to face contact

5.2 Best Practices during the child and caregiver's visit to the centre

5.2.1 Instruct all staff members to be sensitive to caregiver needs for information and support. Social distancing and disinfection protocols should be implemented respectfully without compromising on the dignity of the caregiver or the child with disability.

5.2.2 Physical distancing (minimum 6 feet apart) before and after a session

- Eliminate use of waiting rooms
- Schedule transition time between sessions
- Relocating interventions that could safely be done outside, weather permitting
- No walk-in patients to be allowed, only patients with prior appointment to be seen at the scheduled time.

5.2.3 Duration of session - plan the session in advance especially if it is likely to be a shorter session.

5.2.3a Number of individuals who can be present during a session- Use of observation room/ 2-way mirror facility where possible- encourage use of a 2-way mirror/observation room to reduce the number of persons in a given area

5.2.3b Limit the exchange of paper documents. When possible share electronic records of reports. When paper reports are unavoidable, place the report within a clear plastic folder. The plastic folder can be externally sanitized using disinfectants.

5.2.3c Share the detailed plan with the mobile health worker in a DEIC setup. The mobile health worker may be able to explain/track the plan to the caregiver in person/through phone/video calls

5.2.4 Maintain social distancing norms for aspects of assessment that do not require proximity

5.2.5 Avoid aerosol generating examinations e.g. assessing the oromotor functioning by oral cavity examination and palpation. If necessary, wear gloves (see guidelines for PPE equipment) if the child drools; please place a disposable sheet/mat on top of the therapy surface. This can be disposed at the end of the session. All therapy surfaces, equipment and instruments that have been handled by the child, caregiver or the healthcare worker have to be disinfected after each session (recommendations of disinfection provided in the chapter on infection control)

5.2.6 Limit the number of toys/equipment provided to the child during session. Whenever possible, have separate sets of toys for each appointment. At the end of each assessment, send the toys for disinfection.

5.2.7 Avoid use of equipment like ball pool which are very hard to disinfect after every session

5.2.8 Confirm that aids and appliances that are used/examined during the session have been sanitized prior to the session

5.2.9 Use the face to face consultation as an opportunity to guide and coach the caregiver. Whenever possible demonstrate positions, manoeuvres, exercises or strategies once/few times as needed and encourage the caregiver to practice. Consider providing video clips, handouts outlining these strategies. This will give them the confidence to implement it at home and limit the number of face-to-face sessions that are needed once a caregiver feels confident

5.2.10 Supplement the coaching provided in face-to-face sessions with a virtual session whenever possible to assist the caregiver in adapting the strategy for their home situation

5.3 Best Practices to be followed after the session

5.3.1 Limit the exposure between one family and another who are at the centre for sessions. Whenever possible have separate entry and exit points

5.3.2 Accept electronic payments and provide electronic receipts to minimize contact with and exchange of contaminated material

5.3.3 Encourage use of sanitizer on the way outside the centre as well

5.4 Best practices for home visits conducted by Mobile Health Teams that are a part of the DEICs

5.4.1 Mobile Health Teams should consider whether visits are necessary. Use telemedicine tools as much as possible. This may include telephone consultations or similar, depending on the resources available

5.4.2 A pre visit triage call must be made to identify the need, associated risks, and current urgency for a home visit

5.4.3 If the child has a condition /home situation that required a home visit, do evaluate the risk versus benefit for the child, family members and the health care worker. If any of them have a pre-existing health condition defer the home visit

5.4.4 A health care worker with a pre-existing health condition must be involved in telework as much as possible

5.4.5 Do not offer home visits to children living in containment zones

5.4.6 If a visit is deemed necessary after the triage call, the health worker should follow all the precautions outlined for face to face consultations at a child development centre/DEIC (5.2.3-5.2.10)

6. Best Practices for Online/Telephonic Consultations during the Pandemic

6.1 Overview:

Many studies, especially in the developed parts of the world, where accessibility to computers and smartphones is not an issue, have observed that Tele-health increases access to healthcare:

- Increased access to therapy for individuals with physical, medical and/or mobility disabilities.
- Increased access to disability specialists regardless of geographic area.
- Access to care in a native language.
- More time to collect information about thoughts and feelings and behaviours outside of office appointments.
- More flexible scheduling of sessions.
- Reduction in travel stress and costs.
- Tele-health is especially convenient to individuals with chronic and episodic conditions.

Source: http://www.eparent.com/features-3/telehealth-and-children-with-disabilities/

Today, during the COVID pandemic crisis, in order to avoid the risk of contagion and yet maintain continuity of services for the entire population (those who have access and those who don't have access to the internet), the two following models for tele-consultation are proposed.

Model A – To cater to the population that has access to internet via smart phones or computers.

Model B – As per India's Internet 2019 report, Internet has reached only 31% of Telangana as compared to 54 % in Kerala and 47 % in Tamil Nadu & 37% in Karnataka (Source: Indian Express, 9th Nov, 2019).

This model is meant for those who don't have direct access to laptops or smartphones and will have to rely on the laptops/computers of the mobile teams of their District Early Intervention Centre (DEIC) under the Government's Rashtriya Bal Swasthya Karyakram (RBSK) programme. Today, at least one member of the family tends to have a mobile phone even if not a smartphone. Thus, the scheduling of appointment and if possible, follow-up and monitoring can be done via text messages in vernacular language.

6.2 Best Practices to be followed while setting up a session for models A & B

6.2.1 When caregivers are approached by a centre with the option of providing tele-consultation, the rationale, advantages, and limitations of tele-consultation must be duly explained, and consent taken. This will be done by the staff responsible for scheduling appointments in Model A and the mobile team in Model B.

6.2.2 When the caregivers approach a centre for services, the consent is implied (Source: MOHFW Guidelines for tele-consultation, March 2020), if the service provider approaches the patient, duly filled in consent form shall be obtained (online/text-message) from the patient before the commencement of the treatment.

6.2.3 Tele-consultation platforms must be decided based on the ease of use, internet bandwidth (for both the provider and the caregiver), and encryption and safety parameters (Please see annexures I & II for samples).

6.2.4 Payment of fees for consultation and options should be discussed in advance where relevant. In Model B where the Govt employees are the service providers, this option is not relevant.

6.2.5 The staff at the centre will have to help the caregivers get familiarised with the platform chosen and help them download the application. The link for the meeting will be sent on the day prior to the consultation. In case of Model B, the mobile team member will be the facilitator and will use his own tablet/laptop or smartphone for this purpose. Thus, the link for meeting should be sent to him or her.

6.2.6 For new assessments, the provider can use standardized apps for screening child development (https://www.cdc.gov/ncbddd/actearly/milestones-app.html, or the Track and Act app. The latter is available in Hindi, English, Kannada and Tamil)

6.2.7 In case of Model B, initial screening in the normal course is done by the mobile team. That practice can continue during COVID times.

6.3 Best practices to be followed during a consultation

6.3.1. The provider can obtain a detailed relevant history about the concerns of the family, their priorities, and challenges in the current scenario (during the pandemic). The results of the initial screening can be discussed during the consultation, or the provider can choose to use observations of the child in his/her natural surroundings to supplement findings on history.

6.3.2 Discussion of caregiver and child priorities, strategies to address concerns and a summary of the recommendations should be done during follow up consultations (children who have been assessed earlier in face-to-face consultations).

6.3.3 The provider should summarize and document recommendations at the end of the session and share an electronic copy of the report where feasible via email, WhatsApp. Where this is not feasible a detailed a relevant summary should be provided verbally and later a hard copy of the report can be provided during a face to face consult.

6.3.4 For consultations that happen over phone, caregivers may have shared some information via text/video prior to the consultation. Ensure that the provider discusses these by referring to the specific content, shares observations and recommendations based on these in the phone call.

6.4 Model B – In addition to the above best practices some additional recommendations specifically for Government facilities:

6.4.1 In case of Model B, after the first screening, the first clinical assessment, diagnosis and treatment consultation can be done at the DEIC face-to-face or online with the facilitation of the mobile team member.

6.4.2 If the consultation is face-to-face at the DEIC, all of these tasks can be completed the only face-to-face visit by the child and the parent/caregiver to DEIC. All the follow up treatment and monitoring can be done online with the help of the mobile team or other personnel at the village level using their smartphones or tablets or laptops.

6.4.3 Mobile teams are given tablets or laptops by the Government. These can be used for facilitation of online consultation. If that is not possible, the mobile team members can use their smartphones as well.

6.4.4 The mobile teams can act as conduit/channel between the therapist/doctor/expert at the DEIC and the parent. They can arrange and facilitate therapy sessions by connecting the parents to the concerned therapists. This facilitation by the mobile team member will not be limited to technical option (use of tablet/laptop) only. Mobile team members will help the caregiver and child understand the discussion and recommendations by the provider at the DEIC.

6.4.5 As long as the Mobile team continues to be the mediator, he or she will follow the relevant protocol of face-to-face consultation, such as all three (the child, parent & the mobile team members are wearing masks, they disinfect the equipment such as laptop, smart phone etc.)
(Please refer to the section on face-to-face consultation for details.)

6.4.6 The expert at the DEIC will follow the above mentioned (6.3.1 to 6.3.4) best practices for effective communication.

6.4.7 Mobile team members will also follow up and monitor the progress of the child, face-to-face or over the phone as per the DEIC provider's suggestion. Thus, mobile team will play a crucial role for successful treatment. Thus, rigorous online training is recommended for the mobile team.

6.4.8 On an average, each child undergoing treatment/receiving therapy, visits the DEIC at least once a month after the first assessment and consultation.

6.4.9 On an average, 10-15 children are transported in a vehicle to DEIC once or twice a week. During COVID times, to avoid any risk of contagion, many of these services can be provided online with the help of the Mobile team.

6.4.10 On the day of the visit of the parents and child to the DEIC, they will follow the protocol for face-to-face consultation.

6.4.11 In case of excess burden on mobile teams, Anganwadi, ASHA, PHC, CHC or SNCU staff can also be trained for this facilitation, depending on their capabilities and availability too.

6.4.12 In some of the tribal areas, mobile teams do not have the required outreach. Neither do they have Anganwadi workers. Most of them are equipped only with sub-centres under the umbrella of the Primary Health Centres (PHCs). Children in these areas are referred by the PHC doctors to the DEIC. Thus, training of PHC staff for online screening, consultation facilitation and treatment/therapy sessions is crucial too.

6.4.13 In case of Government facilities at the ground level, the Education Department has trained special educators of the Bhavita Centres at the Mandal level. Their services could be mobilised in case of shortage of staff.

6.5 Best Practices for Effective Communication during Consultation

6.5.1 The clinician should make sure that he/ she can be seen and heard clearly. e.g., that their head and shoulder is visible on the centre of the screen during a video call.

6.5.1 The clinician's background should be clutter free and professional. A busy background can distract the family/child with whom you are consulting. If this is not possible, please consider using the 'virtual background' option on zoom (if the call is being conducted on zoom) to change the background.

6.5.2 The clinician should start with introducing himself/herself, state their role (e.g., paediatrician, occupational therapist, counsellor, etc.) and what kind of service they offer.

6.5.3 Define what could be possible in an online session so that the family knows what to expect and agrees with it.

6.5.4 The clinician should maintain eye contact with the parent/child. By looking alternately at the camera and at the video of the child/parent the clinician will be able to ensure that appropriate eye contact is maintained

6.5.5 The clinician should not solely rely on non-verbal communication/ use expansive but out-of-frame gestures to communicate. These would not be adequately understood by the caregiver.

6.5.6 The clinician must clarify frequently and repeat what he/she has understood to ensure that the family and the clinician are on the same page.

6.5.7 It is easier to build a connect online with someone one has met face to face before. The following pointers may be useful to keep in mind while establishing rapport:

6.5.7a Pay attention to the families', children's tone of voice as the clinician may not be able to see their body language – this is especially important in a telephonic consultation.

6.5.7b Use concrete statements, use fewer open-ended questions as it may not be possible to facilitate a discussion in the same way in an online consult as in a face-to-face session.

6.5.7c The clinician should use what he/ she can see about the home environment to guide the discussions.

6.5.7d The clinician should check if the family is understanding their recommendations and summarize (and share visually via whiteboard whenever possible) at the end of the session.

6.5.8 The clinician should use documents/templates that they use in face-to-face consultations to structure the session.

6.5.9 The clinician can use features such as whiteboard on zoom to document/draw to clarify/explain an idea or a concept being discussed in the session.

6.5.10 The clinician must reassure families when they are concerned about missing out on 'therapy time'. Reinforce steps that they are already taking to ensure their own and their family's well-being, to bring them a sense of agency.

6.6 Best practices after a tele-consultation

6.6.1 Schedule a follow up visit

6.6.2 Share a plan for what will be done between visits

6.6.3 Further monitoring and follow-up for each case can be done via mobile phone calls with the parents.

6.7. Some more tips for smooth facilitation of online therapy sessions and support calls, especially relevant for the Government facilities

6.7.1 Orientation/ short training regarding online consultation to providers as well as caregivers.

6.7.2 Clarity regarding role of therapists, facilitators (mobile team or other ground level workers) and parents.

6.7.3 Consent from the parents & time commitment

6.7.4 Clarity with respect to expectations of all concerned members.

6.7.5 Individual plan for every child and setting of goals.

6.7.6 Use of respectful language and respect for time given by each member involved in the process, including the caregivers.

6.7.6.1 Prior appointments for future sessions well in advance and prior intimation in case of cancellations.

6.7.6.2 Reminders to parents about the session appointments

6.7.6.3 Training of children and parents to use masks, wash hands, physical distancing through social stories.

6.7.6.4 Sensitivity towards the mental state of all parties involved as these are difficult times and each one is likely to carry their own baggage. Clinicians and families may have many common experiences/reflections about the lockdown period. Be open to the possibility of using these to connect with families and children.

6.7.7.5 The clinician may find newer ways of connecting with families. An observation/comment about their new hobby, sharing what they have been doing, being interested in what the family wants to show/discuss are all great ways to connect.

6.8 For better outreach

6.8.1 As seen in the overview above, tele-health improves accessibility due to the removal of several barriers such as: physical accessibility, reduction in travel cost, flexibility in time scheduling, convenience of getting treatment in a home- based environment etc. What is needed the most is initial awareness and announcement of services of online services.

6.8.2 In the initial stages, until the people are used to tele-services, service providers can reach out to the target population by sending text messages, emails, and telephone calls. In case of populations with poor access to smartphones or computers, text messages can be sent in local languages on mobile phones or telephone calls can be made for initial scheduling of appointments.

7. Promoting Well-being and Mental Health of Providers

Health and well-being are important aspects of life. These enhance productivity, performance, self-satisfaction and overall happiness in life. But constant stress can affect one's health and well-being. In the current scenario, health care providers are at risk not only for COVID-19 infection, but also for long working hours, fatigue, occupational burnout, stigma, psychological distress, and physical and psychological violence. Stigma around mental health problems prevent the health care workers from seeking help (Selamu, M. et al, 2017). Hence it is essential that professionals working in the health and disability sector and the support staff members are given early and adequate mental health interventions in the workplace.

7.1 Psychological Well-being: focuses on prevention, promotion, and guidance

7.1.1 Create Awareness:

7.1.1a Display awareness posters on importance of mental health, early warning signs and ways to maintain psychological well-being.

7.1.1b Encourage employees to attend workshops/talks/seminars on mental well-being.

7.1.2 Strengthen internal support

7.1.2a Recruit/Designate already available Psychologist/Clinical Psychologist/Rehabilitation Psychologist/Psychiatric Social worker to provide ongoing counselling for the employees.

7.1.2b Allocate a separate space for counselling.

7.1.2c Ensure documentation and confidentiality.

7.1.3 Screening & Intervention

7.1.3a Ensure to screen for signs of burnout, early warning signs of mental stress and signs of relapse in individuals with pre-existing mental health condition. Common symptoms include confusion, anxiety, fear, anger or mood swings, irritability, disturbances in sleep and appetite, disturbed daily routine, withdrawal, depression, preoccupation, worthlessness, hopelessness, crying spells, etc (ICMR, 2020). General Health Questionnaire (GHQ-12) by Goldberg & Williams, 1988 (copyrighted) can be used as a screening tool.

7.1.3b Refer the employees who are distressed to the internal mental health team. Encourage referral to mental health centres if required. Maintain the record of helplines and support services available in the state. Refer annexure 1 for helpline numbers.

7.1.3c Encourage the employees with pre-existing mental health conditions to continue the medications and other therapies.

7.1.4 Lowering the risk of stress

7.1.4a Provide training to the staff members to handle clients in the critical situation.

7.1.4b Prepare the roster to ensure juniors staff to work with senior colleagues.

7.1.4c Ensure to rotate staff members from high stress provoking job to low stress provoking job and vice-versa.

7.1.4d Consider option of work from home for high risk staff members like people with pre-existing physical and mental health condition, pregnant women, lactating women, etc.

7.1.4e Motivate the employees to maintain regular working hours.

7.1.4f Encourage the staff members to take breaks and leaves as eligible.

7.1.4g Allow stress leaves if required.

7.1.4h Encourage employees to talk about their distress to colleagues maintaining confidentiality related to patient details.

7.1.4i Conduct regular meetings to solve problems or difficulties faced by the staff members. Ensure mutual support and encouragement. Include mental health as one of the agenda during the meetings (NIMHANS, 2020).

7.1.5 Have a crisis intervention plan

7.1.5a Allow staff members to vent in case of infection/death of a colleague. Create an opportunity to express their guilt, anxiety, or distress.

7.1.5b Encourage the grieving staff members to work in different department or work centre.

7.1.5c The staff member who continue to experience distress and expresses warning signs should be referred for mental health support.

7.1.5d Quarantined staff member should be supported by immediate colleagues by keeping them in the social contact to prevent feeling of social isolation. Convey information to prevent any guilt feeling of understaffing issues due to their absence and fear that they would have infected their colleagues and patients. Arrange online counselling for these individuals.

7.1.5e Educate the employees so as to prevent stigma related to the staff members returning to work, post quarantine/recovery from COVID-19/recovery in family members.

7.1.6 Train Health Care Workers to handle difficult situations

7.1.6a Equip health care workers to handle psychosocial issues of children with disabilities and their family members.

7.1.6b Provide training on handling angry and distressed persons – Keep safe distance, maintain composure, talk in non-confronting manner, use “I” statements, suggest discussing later in a calm and quite situation and seek help if require.

7.1.6c Equip them to handle grief – Acknowledging feelings, allowing expression of emotions, providing practical solutions and support, refer for mental health interventions if required.

7.1.6d Training on psychological first aid (WHO, 2020). Refer annexure 2.

7.1.7 Minimize psychological injury

Psychological injury can occur as a result of trauma. This includes emotional detachment, mental and physical exhaustion, loss of appetite, insomnia and self-harming behaviours.

7.1.7a Promote psychological well-being. Refer annexure 2.

7.1.7b Help them manage their emotions. Refer annexure 3.

7.1.7c Encourage resilience building. Refer annexure 3.

7.1.7d Motivate employees to involve in breathing exercises and mindfulness practices during work time. Refer annexure 4.

7.1.7e Encourage healthy coping strategies

7.2

7.2.1 Online consultation

7.2.1a Selfcare to be followed during online consultation

- Do eye, neck, hand and breathing exercise every 30 minutes
- Take a break after 45 minutes of headphone usage
- Follow a roster to provide online consultation. If a single professional is working, schedule a day free of online consultation
- Provide online consultation only during the scheduled time
- Follow eating and sleeping routine
- No screen time at least 30-40 minutes before sleep time

7.2.2 Ethical practice

7.2.2a Treat patient with respect, compassion, and dignity

7.2.2b Evaluate whether the patient require a consultation in the clinical setting

7.2.2c Communicate your opinion to the caregivers of the child with disability and take a mutual decision

7.2.2d Explain the risk and benefit of offline vs online consultation

7.2.2e Explain the confidentiality issues related to online consultation

7.2.2f Video or audio recording of the online consultation should not be done without getting informed written consent from the client and family members

7.2.2g Evaluate the risk of digital addiction in the service seekers before initiating online sessions. Stop online consultation briefly if this activity leads to the over usage of gadgets in the patient. E.g. A child with autism may start using the phone excessively followed by the online consultation.

7.2.2h Ensure the presence of the adult during the online consultation for a child.

7.3 Individual/ Organization responsibilities for well-being of health care providers

7.3.1 For infection prevention

7.3.1a A nodal officer (infection control officer) is identified by each DEIC to address all matters related to Healthcare Associated Infections (HAIs). If the DEIC is part of a large hospital, a liaison person should be identified at DEIC to link with the nodal officer identified at hospital level

7.3.1b Healthcare providers working in DEIC shall use PPEs appropriate to their risk profile as per guidelines issued by the Ministry of Health and Family Welfare (MoHFW) (https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdfhttps://www.mohfw.gov.in/pdf/UpdatedAdditionalguidelinesonrationaluseofPersonalProtectiveEquipmentsettingapproachforHealthfunctionariesworkinginnonCOVID19areas.pdf)

7.3.1c All healthcare workers have undergone training on

- Infection prevention and control (IPC);
- Use, putting on, taking off and disposal of personal protective equipment (PPE);
- Self-assessment, symptom reporting, and staying home when ill

7.3.1d A system of periodic technical updates on COVID-19 for all health care providers.

7.3.1e Provision of adequate hand washing facilities, hand sanitizers and regular sanitisation of clinics

7.3.1f Adequate availability of PPE supplies

7.3.1g Appropriate security measures as needed for personal safety

7.3.1h Provisions have been made for prompt reporting of breach of PPE by the health care providers and timely support and follow-up in these cases

7.3.1i A support system and sickness absence policy for health care providers who require quarantine

7.3.1j Provisions for curative and rehabilitative services for health care providers infected with COVID-19 following exposure in the workplace

7.3.1k Use a buddy system to ensure there is no breach in infection prevention control practices

7.3.1l Organisations should identify tasks which may be done from home. Provision for work from home/ work in low risk settings for staff above 60 years of age/ pregnant or lactating mothers and those with severe co-morbidities.

7.3.2 For wellbeing

7.3.2a Appropriate working hours with breaks

7.3.2b Encourage active lifestyle

7.3.2c Spaces to rest and socialise

7.3.2d Use a buddy system1 between care providers to help reduce isolation and support during period of quarantine or sickness

7.3.3 Support staff on quarantine or sickness absence leave or who are returning to work

7.3.3a Develop and implement an effective policy for work from home, sickness leaves and return to work

7.3.3b Maintain meaningful communication with those on quarantine or absence leave (agree frequency of contact) and keep them in the loop about important developments.

7.3.3c Have flexibility and create workplace adjustments, wherever required

7.3.3d Ensure a smooth return to work, including setting up a meeting on their return to work, or as soon as reasonably practicable thereafter to agree an individualised plan for return.

7.4 Health workers should do the following:

7.4.1 For infection prevention

7.4.1a Participate in all COVID-19 related training and other occupational safety and health training

7.4.1b Ensure that all preventive measures like frequent washing of hands/use of alcohol-based hand sanitizer, respiratory etiquettes (using tissue/handkerchief while coughing or sneezing), etc. are followed at all times

7.4.1c Use appropriate PPE at all times while on duty

7.4.1d Put on, use, take off, and dispose of PPE properly

7.4.1e Use protocols for patient care to avoid exposing others to health and safety risks

7.4.1f Any breach in PPE and exposure is immediately informed to the nodal officer/HoD of the department

7.4.1g Swiftly follow established public health reporting procedures for suspected and confirmed cases wherever required

7.4.1h Provide or reinforce accurate Infection Prevention and Control and public health information to the attendees of health care setting

7.4.1i Self-monitor for signs of illness and self-isolate and report illness to managers, if it occurs

7.4.1j Health care providers must follow social distancing and masking to prevent transmission to/acquiring infection from other health care providers or community members who may be positive

7.4.1k Staff above 60 years of age/ pregnant or lactating mothers and immuno-compromised healthcare workers shall inform their medical condition to the hospital authorities for them to get posted only in low risk settings.

Annex – I

Online Screening tool – Track and Act is one of the suggested online free Apps (Validated tool) to screen children from 4 months to 5 years, considering the correction for prematurity. This App screens children in 4 domains, namely, Social, Communication, Cognition and Motor development, and generates score in individual domain as well as the overall score.

By analyzing these scores, the facilitator can give an indication towards type of developmental problem. For example, if deficiency is found in social and communication domains, it may indicate the possibility of Autism. Low scores over all the domains may indicate global delay and low scores in motor domain may indicate motor delay/CP. This initial screening can help facilitator proceed towards right assessments. This is available in Hindi, Kannada, Tamil and English.

Detailed Assessment – This is to evaluate each child in each of the developmental domains. It will help identify functional level of the child and their deficiencies, from where the therapy goals can be set.

The areas to be assessed are gross motor, fine motor, receptive language, expressive language, play, imitation and cognitive skills. Experts observe that all the different areas of development are interlinked. For example, if one area like imitation falls back, it prevents development in language and play domains as well. Therefore, an effective assessment needs to cover all the listed domains. Subsequently, therapy should address all deficient areas (Source: Dr Nandini Mundkur, June 2020).

Individual Action Plan with Set Goals: Based on the deficiencies recognized during the assessment of the child, an individualized action plan needs to be formulated. This plan should comprise of set goals to work towards.

Parent Training: Parents play an important role in online therapy. For therapy to be effective, parents need to be trained. In India majority of the parents are authoritarian. Such an approach during therapy can hamper the intended impact of the therapy. Hence Training to parents is of utmost importance.

Monitoring and follow-up: This is required for couple of reasons.

a) One is to check the attitude and efficacy of the parents in delivering therapy to their child. Another important component is to monitor parents for their own mental health issues and provide counselling. It is likely that parents are under a lot of stress and are nervous about achievement of goals with their children. For effective therapy, parents can also be given counselling to deal with their own anxieties or depression.

b) The second reason for monitoring is to check timelines of goals being achieved. If the goals are not being achieved consistently, assessment needs to be done to identify the barriers for non-achievement.

Behavioral assessment: It is common to encounter behavioral challenges among children with developmental delays. Thus, behavioral assessment is strongly recommended. Behavioural questionnaire link is provided in the resources list below.

Resources:

- Track & Act- Free available App on line: This is available in Hindi, Kannada, Tamil and English.
  https://www.youtube.com/watch?v=yQ4oJkdloNQ
- Behavior Assessment Questionnaire link:
  https://docs.google.com/forms/d/e/1FAIpQLScOIpPNUxND5oy7yyyV37Jm_sHIPNPaMztVLg2Y7IRSeC53bw/viewform
- TOTS GUIDE LINK: www.totsguide.com
- Youtube links:
  https://www.youtube.com/watch?v=MT3duX5jK7s
- SCoPE Assessment
  https://www.moho.uic.edu/productDetails.aspx?aid=9#:~:text=The%20SCOPE%20is%20an%20occupation,evaluation%20of%20most%20MOHO%20concepts.
- Nayi Disha https://www.nayi-disha.org/
- CDC's Milestone Tracker App: https://www.cdc.gov/ncbddd/actearly/milestones-app.html

Annex – II

Examples of currently operational digital platforms in India today.

1. Practo (2008) – Appointment booking, consultation, medicines delivery, storage of health records, insurance through mobile application and website.
   www.practo.com

2. Lybrate(2013)- Allows patients to ask questions for free and consultation based on payment basis, provides feedback on healthcare experts.
   www.lybrate.com

3. Medlife (2014)- address all the health needs with their online consultations, medicine delivery, lab test, timely medicine and check-up remainder and health record storage services. Doctors are available 24/7.
   www.medlife.com

4. Portea (2013)- provides home healthcare services that include primary care, chronic disease management, physiotherapy and counseling. They provide various services including doctors, nurses, and physiotherapists for home visits.
   www.portea.com

5. DocEngage(2013)- Audio & Video Call, Online Appointment, ePrescriptions, Self-Assessments, Health tips. Family Doctor facility.
   www.docengage.in

6. MFine- Online doctor consultation (Chat, Video & Audio), Health Checkups at home, medicine delivery (Same day), Timely medicine remainder, online Assessments.
   www.mfine.in

7. Apollo 24x7- Online Consultation, Medicine delivery, Online Appointments for lab tests. (ONLY for APOLLO HOSPITALS)
   https://play.google.com/store/apps/details?id=com.apollo.android&hl=en_US
8. Netmeds- Online Consultation, Medicine delivery, Online Appointments for lab tests, timely reminder, Access to health information.

   https://www.netmeds.com/

Telepshychiatry

1. YourDost- Online counselling and psychological support platform
   https://yourdost.com/

2. The Inner Hour- The Inner Hour is an online consultation solution for patients with psychological problems. Patients can seek 1-on-1 consultations with therapists, ask questions to other patients, stay in touch with their personal therapist.
   https://www.theinnerhour.com/

3. Aurum- Stress and Anxiety Management, Counselling, Self- Educating Modules
   https://play.google.com/store/apps/details?id=com.aurum&hl=en_US

4. TickTalkTo- Counselling and Therapy
   https://ticktalkto.com/

Screening form for COVID-19

FERNANDEZ FOUNDATION

SCREENING FORM FOR COVID-19

Patient's name: ___________________________________ Date: ___________

Occupation: ___________________ Age/sex: _________ Contact no. ___________

Address: ____

1. Have you recently travelled abroad or to any other place? ☐ Yes ☐ No

   ____

2. Have you been in contact with any friend/family member/colleague who has recently travelled abroad or other to some other state? ☐ Yes ☐ No

   ____

3. Do you have fever/cough/breathlessness/diarrhoea/throat pain/headache/ fatigue/ loss of smell//loss of taste? ☐ Yes ☐ No

   ____

4. Have you been hospitalized for any of these symptoms in the last one month? ☐ Yes ☐ No

   ____

5. Have you undergone the COVID-19 screening test in the recent past? If yes, please state whether it was positive or negative. ☐ Yes ☐ No

   ____

Some general guidelines which could be shared to the parents (Ref: SOP_Triage)

(ICMR)

Mobility and accessibility

1. Please ensure that the health service is made accessible for all types of impairments by following principles of universal design, even in a makeshift health care center.

2. Please ensure that signboards/makeshift signposts are in place for people to read and access in the local language too. For persons with visual impairment, instructions maybe given as soon as they enter the healthcare canter if Braille instructions are not available.

3. Please ensure that extra precautions for personal hygiene and assistance are provided.

4. Please ensure that sanitizers are provided for aids and appliances, especially for prosthetists.

5. Please ensure that continuum of care, from diagnosis/hospital to rehabilitation/home, is provided for people with disabilities too.

6. Please ensure that Persons with Disabilities have easy and ready access to insurance coverage and government health scheme

Individual coping strategies:

1. Adopt healthy coping strategies: Play games involving brain teasers, use of cognitive-analytical abilities, solve puzzles, write something, or learn something new- cooking, art, music.

2. Keep yourself busy with things that interest you.

3. Take good care of yourself
   - Eat regular healthy meals
   - Sleep and wake up at regular times every day
   - Exercise regularly, try yoga and meditation.
   - Do not isolate yourself, stay in the company of others at home
   - Do something you like and enjoy, every day
   - Try to find humour in day to day happenings

4. Support others: be at peace yourself, and support your family. This too shall pass!

5. Stay positive and accept things that you cannot change.

6. Do not use tobacco, alcohol and other drugs or medications to withdraw from reality. Their use will isolate you further and sometimes, make you more susceptible to illness because of increased risk-taking.

7. Keep in touch with the news but do not be glued to the TV as some news may be worrying and alarming to you.

Managing conflicts at home:

1. Behave as politely and considerately with your family, as you would with outsiders.

2. Be calm. Remember everyone is in an equally difficult situation!

3. Say sorry if you have made a mistake.

4. Do not shout or argue or get into physical fights

Communication:

a. Keep talking and sharing your cares and concerns. Oftentimes, solutions are found when you talk.

b. Also share positive things- a joke, a spiritual message, a positive story.

c. Never be rude.

Dealing with stigma:

a. Do not discriminate. Share positive messages rather than discriminating against anyone due to physical or mental disability, or due to COVID-19.

b. Be careful and maintain a physical distance but not emotional distance. Talk, communicate, and play.

c. Even during quarantine, supportive assistance, physical, and communication accessibility must be ensured by guiding health care workers and family members to continue to safely support PWDs.

d. Use only reliable sources of information; do not believe rumors, social media feeds, etc.

How can we care for them?

Prepare a schedule, mimicking their previous schedule, by consulting their teachers, a professional, or according to the needs of the child or adolescent.

Ensure that the activities are learning-based and engage them in the process. Break down the activities into small parts, if needed.

Appreciate/reward any achievement to encourage them to continue with the schedule.

Select activities according to their abilities.

Ensure their basic hygiene. Prepare a pictorial chart or use step-wise instructions in educating them about handwashing practices. Help them to wash their hands and their objects, if needed.

Help them to understand the gravity of the situation and the reason for changes in their daily routine. If they find it difficult to understand, use stories or videos to explain the situation.

Enable them to express themselves in case they are feeling distressed. Children and adolescent's express psychological difficulties differently. Keep a check on how they are feeling.

Incorporate existing objects at their residence in the everyday practices to avoid infection from any new object.

Engage them in physical activities, if possible. Ensure that they maintain distance from others and are wearing covered clothes and masks. A significant reminder to their caregivers would be to understand that children observe those around them and attempt to mimic their behaviours. Adolescents, on the other hand, usually want to manage their problems on their own. This wide age range may behave in varying manners but are mostly able to observe their caregivers and the sudden modification to their routine will be challenging for them.

Role of caregivers:

1. Caregivers must follow social distancing norms and other safety measures such as hand washing and the use of masks if coming outside the home.

2. Identify relevant organizations in your community that you can access if you need help.

3. Know the telephone number of relevant healthcare services and helplines should you have questions or require urgent medical assistance.

4. The caregiver should ensure that assistive products if used, are disinfected frequently; these include wheelchairs, walking canes, walkers, transfer boards, white canes, or any other product that is frequently handled and used in public spaces.

5. Network with disability organizations, including advocacy bodies and disability service providers to get public health information and any social support if required.

6. Join a local or online support group/self-help group. A support group can share the information and connect with people who are going through similar experiences. A support group may help combat the isolation and fear you may experience as a caregiver.

7. Caregivers should take care of their families, but they need not disregard their wellbeing and happiness. Caregivers should engage in activities for their wellbeing and relaxation, such as listening to music or reading a book, or even some physical activities or indoor recreations.

8. Caregivers should provide daily therapy services and medicine as per the guidance of physicians and therapists.

9. Caregivers should seek assistance from a social organization or other health providers to train themselves as a skilled caregiver, building their capacity on specific training in therapy, equipment handling, lay counselling, and ongoing communication required to support the PWDs during this pandemic.

10. Caregivers must constantly monitor the health of the PWDs and keep them informed and connect them to the hospitals if they notice any symptom that needs attention.

11. Caregivers should be especially careful and vigilant if they are moving in and out of the hospitals and communities to provide safe and healthy care to the PWDs. 12. Risk assessments of PWDs: Caregivers should know the history of the PWD like general health details – BP, Diabetes, or any other diseases and mental health status, using routine drugs and better to make daily activities chart and follow up. 13. Staying connected with others: Caretakers need to care for their health before taking care of others so they can do their job properly. Staying in contact with friends and family is vital to looking after one's mental health.

Role of government in supporting caregivers

1) People with disabilities and their caregivers to be provided with free PPE (masks, gloves, and sanitizers). It should be delivered to their homes along with ration. 2) Create a helpline/designate an officer for separate issuance and renewal of curfew passes, access to food, social security, and other aspects. 3) Issue an advisory to police to treat caregivers the same as other health workers and provide all the needed support as they are providing essential services to people with disabilities. 4) Announce the Caregiver allowance as mandated in the Rights of Persons with Disabilities Act 2016 Section 24(3)i 5) Create a system to facilitate the transportation of caregivers. Instruct State Commissioners for Persons with Disabilities to collaborate with Ola/Uber to provide free transport to caregivers during the lockdown period. 6) Instruct the Health Ministry to ensure that testing centres and quarantine zones sanctioned by the government are to be accessible for Persons with Disabilities as per the norms mentioned in the RPWD Act of 2016. 7) Train health workers and medical professionals in testing and treating Persons with Disabilities and their caregivers without compromising their dignity and rights as per Section 8 of the Rights of Persons with Disabilities Act, 2016. 8) The Resident Welfare Associations/Community should be sensitized about the need of PWDs to allow entry of maid, caregiver, and other support providers to their residence after following due sanitizing procedure.

Precautions for the caregivers

1) Avoid close contact with people who are sick. Avoid touching your eyes, nose, and mouth with unwashed hands. Wash your hands often with soap and water for at least 20 seconds. If soap and water are unavailable, use an alcohol-based hand sanitizer that contains at least 60% alcohol.

2) Ensure you have sufficient backup caregivers in case you cannot support; either you get sick or you need to take care of an unwell family member. You will still need assistance, so make sure you have someone who can provide it. You may need to identify a caregiver from your family, relative, or neighbor. 3) If you are not able to get assistance from your family, ensure that you can get

assistance from a paid attendant within your community if possible. 4) Have at least a week of non-perishable food in your home at any given time (if possible have two weeks' supply) and identify people who can assist with shopping. 5) Stock up on other important supplies (medicines, nutrition supplements, baby food and cleaning materials) 6) Identify a way to make sure you can get your medications on time. This may mean having friends or family assist you or using a pharmacy that offers prescription delivery through call or online. 7) Wash your hands and use hand sanitizer when you arrive at home from outside and each time before touching or feeding or caring for the person with a disability. 8) Regularly clean, sanitize, and disinfect the surfaces that are touched in your home to prevent the spread of infection. 9) Use disinfecting wipes on items that are frequently touched. These include your telephone, doorknobs, your refrigerator handle, your wheelchair controls, lifting device controls, and remote controls. Make this convenient by having wipes near the items that should be regularly cleaned. 10) Take extra steps to avoid possibly infecting by wearing a mask if someone like a member of your household becomes sick. They should be extra vigilant about not touching their face or yours. 11) Caregivers should cover their cough or sneeze with a tissue, then throw the tissue in the trash. For a person with a disability, it may be difficult for him/her to cover a cough or sneeze, so encourage them to wear a mask. It is important to use a mask correctly. 12) If someone in your household becomes sick, take steps to avoid infecting other people. If possible, have them stay in a separate room of your home to get well. Regularly clean, sanitize, and disinfect shared spaces, particularly the living room, kitchen, dining, and bathroom to avoid spreading the infection. 13) Wheelchair parts such as a headrest, armrests, side guards, back of the wheelchair, push handles, footrest, seat, and wheel propeller should be disinfected anytime a new person comes in contact with the chair, or when the wheelchair return to your home. The same applies to assistive and adaptive devices commonly used by people with disabilities. 14) If the person with a disability becomes sick, seek medical care immediately.

Health care facilities for PWDs shall follow all the standard guidelines for COVID-19 cases.

1. Ensure priority testing of PWDs presenting symptoms.
2. Customizable masks should be provided to all PWDs and families for the protection.
3. Accessible barrier-free washing areas for frequent handwashing shall be made available to the PWDs.
4. Designated accessible entry and exit could be provided for PWD at hospitals. The accessible indoor and outdoor facility shall be sanitized regularly and technology (infrared or UV) may be used to sanitize the hospital areas earmarked for PWDs.
5. Separate accessible parking areas and counters, waiting for areas in hospitals could be created.
6. All other services should be provided with due care of social distancing. Their assistive devices like wheelchairs and mobility aids should also be sanitized and they should have constant access to the wiping towels or other forms of disposable wipes.
7. Designated help desks and interpreters should be available at hospitals to guide a person with visual impairment and speech and hearing impairments. Also, educate the PWDs caregiver about general precautionary measures.
8. All information about COVID-19 services offered and precautions to be taken should be available in the simple and local language in accessible formats; i.e. in Braille and audible tapes for persons with visual impairment, video-graphic material with subtitles and sign language interpretation for persons with hearing impairment and through accessible web sites.
9. Sign language interpreters who work in emergency and health settings should be given the same health and safety protection as other health care workers dealing with COVID-19.
10. HCWs should routinely enquire and provide treatment if necessary, for pre-existing medical and mental illness, past treatment history, family history of mental illness, and coping skills and strategies.

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11. Caregivers of PWDs should be allowed to reach them by being exempted from restrictions during a lockdown or providing passes in a simplified manner on priority.

12. Consider establishing opening hours giving priority to PWDs and their assistants during hospitalization.

13. Deliver telehealth for people with disabilities – provide telephone consultations, text messaging and video conferencing for the delivery of healthcare and psychosocial support for people with disabilities. This may be for their general health, and include rehabilitation needs and, where appropriate, COVID-19 related needs.

14. Hospitals should prohibit the denial of treatment based on disability and repeal provisions that prevent access to treatment based on disability, level of support needs, quality of life assessments or any other form of medical bias against PWDs, including within guidelines for allocation of scarce resources (such as ventilators or access to intensive care).

15. Identify and remove barriers to treatment including ensuring accessible environments (hospitals, testing and quarantine facilities), as well as the availability and dissemination of health information and communications in accessible modes and formats.

16. Ensure the continued supply and access to medicines or supportive medical aids and equipment for PWDs during the pandemic.

17. The hospital management could conduct training and awareness-raising of health workers to prevent discrimination based on prejudice and bias against Persons with Disabilities.

18. Hospitals can closely consult with and actively involve Persons with Disabilities and their representative organizations (NGOs, Community based organizations, Disabled people organization) in framing a rights-based response to the pandemic that is inclusive of, and responsive to, PWDs in all their diversity.

Checklist for Hospitals

To support hospital preparedness for the management of COVID-19, the following domains could be taken into consideration:

1. Establishment of a core team and key internal and external contact points.
2. Human, material and facility capacity.
3. Communication and data protection.
4. Hand hygiene, personal protective equipment (PPE), and waste management.
5. Triage, first contact, and prioritization.
6. Patient placement, moving of the patients in the facility, visitor access, and accessibility facilities.
7. Environmental cleaning.