



COVID-19 Needs Finding

Preliminary Report-1 | April 1, 2020

YosAid Health Innovation Foundation is a non-profit dedicated to patient and caregiver education and works to improve patient outcomes through better family engagement and education through the Care Companion Program (CCP). YosAid Innovation Foundation is an associate partner of Noora Health in India. Noora Health is a non-profit, born out of Stanford University and incubated at Y Combinator, that empowers families of patients with high-impact medical skills making them an integral part of healthcare delivery.

*This brief report is an early update on an ongoing needs finding that YosAid and its partner organizations are conducting in India. We conducted surveys with **866 community members and 25+ healthcare workers across India** from March 23-31, 2020. This is an initial analysis of how COVID-19 is being understood and responded to by community members and healthcare workers, with an aim to understand how to adapt COVID-19 support to low and middle income country contexts. We received ethical clearance for this data collection from the ACE Independent Ethics Committee.*

We've bolded key insights throughout the report. If you have questions please reach out to us at covid19@noorahealth.org or covid19@yosaid.org.

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SUMMARY OF KEY FINDINGS

Communities

- **Risk Perceptions:** Most people did not think they were at risk of COVID-19. Low COVID-19 risk perceptions are dependent largely on individual based protective measures (e.g. I am doing everything recommended, so I won't get COVID). In the qualitative interviews, a few mentioned the importance in the belief of god/faith, and a low number of confirmed cases in their area to explain low chances of getting COVID-19. Rather than governmental and community based infrastructure and practices, individuals' actions and inactions seem to drive perceptions for whether they could get COVID-19. This can have implications for stigma of people with confirmed COVID-19.
- **Preventive Behaviors:** Handwashing was by far the highest reported behavior across states, followed by wearing masks, avoiding crowds, and avoiding going out of homes (varied percentages across states). Qualitative participants did note challenges to social distancing and the availability of water for handwashing, but understood the value of these key behaviors for their own safety, and were still able and willing to follow these behaviors. It is important to design for those who will need to overcome barriers to these preventive behaviors. Of note, very few participants across both the qualitative and quantitative interviews mentioned they were not touching one's face, cleaning surfaces more frequently, or covering their mouth and nose when coughing or sneezing.
- **Sources of information:** Across all states, participants' sources of information included television(i.e. news channels) the most, followed by whatsapp, print/newspaper, and families

(varying percentages across states). Qualitative participants cited issues with fake news, and multiple, conflicting messages across sources of information.

- When asked if people can get infected by consuming chicken, eggs, or other meat, 55% said yes and 45% said no.
- All participants reported they would either call the government helpline or visit a hospital if they had symptoms.

Health Care Workers

- **Hospital preparedness:** District hospitals have created isolation wards, restricted the number of caregivers accompanying patients to the hospital, and increased supply of personal protective equipment, in addition to efforts focused on crowd control and social distancing. However, limitation of caregivers allowed with patients has not been followed well and there is an insufficient availability of personal protective equipment. Channels are being explored independently in a few hospitals, to communicate these changes to the patients (e.g. a radio system between inside and outside the hospital, additional helplines).
- **Communication with patients:** Respondents reported that they are communicating information around COVID-19 signs and symptom and key preventive behaviors (handwashing and social distancing) with patients, and have been getting limited questions (mostly on how it spreads), and a few myths (intake of alcohol can cure/prevent COVID-19, or that COVID-19 will be less prevalent as temperatures rise).
- **Preventive Behaviors:** For preventive measures for their own families, respondents focused on handwashing, restricting entry of people in homes, or even extensive measures such as setting up a temporary bath area outside the house which they use after returning from hospital shifts.
- **Change in patient flow:** The majority of hospitals are allowing only emergency cases in hospitals or limiting outpatient clinic/ward hours.
- **Support:** On being asked if any support is needed on communicating the importance of handwashing to patients or others, healthcare workers pointed out the requirement of print material and pointing out the need for additional training for themselves and patients.

METHODOLOGY

Communities

We reached out to family members from our ongoing neonatal evaluation in Punjab, Madhya Pradesh, Maharashtra and Karnataka. We administered a 20 minute survey over the phone to a majority of the participants, and to a smaller subset, a 30 minute qualitative semi-structured interview to understand current COVID-19 knowledge, risk perception, knowledge or preventive behaviors. Many of the survey questions were multiple choice (except the yes/no questions), hence the proportions described below may not add up to 100%. We recruited participants through a convenience based sampling strategy and called these individuals from March 23-31, 2020. Participants were consented for answering questions on this survey according to best practices. Of note is the Government of India's announcement for a 21-day lockdown beginning Tuesday 24, 2020.

Healthcare Workers

We called health workers across different healthcare facilities in Punjab, Karnataka, and Madhya Pradesh to understand how district hospital facilities plan to prepare for COVID-19, on the supply and use of personal protective equipment, shifts in patient load, challenges, and potential areas of support required. We spoke with individuals who otherwise support and implement the Care Companion Program (CCP), which is a patient education program providing families with the education and skill on key preventive behaviors which will reduce health complications and hospital readmissions.

We conducted two waves of calls with staff nurses (from Maternal Child Health and General wards) and Reproductive, Maternal, Neonatal and Child Health counsellors in general inpatient and postnatal care wards. The first set of calls were made to all 22 districts to understand the hospital situation, outpatient department (OPD) status, and feedback from staff on the ground. The second wave of calls were made to 1 counselor, 3 staff nurses, and a 1 doctor with a semi-structured interview guide. These calls were conducted from March 23-31, 2020.

SECTION 1: COMMUNITIES

This report consists of data compiled through calls with 846 families previously enrolled in our Caregiver Training programs with the survey tool, and 19 with the semi-structured interview guide, across Punjab (PB), Maharashtra (MH), Karnataka (KA), and Madhya Pradesh (MP). We called mothers or other family members from our ongoing neonatal studies; these families had a newborn in their home, and had given birth at district hospitals. For this formative research, we spoke with mothers, fathers, or any other caregiver in a household. These individuals reside in Tier 1, Tier 2 cities, and smaller cities.¹

We added demographic information after the survey was deployed, so the sample size (n) for these responses is a smaller subgroup than the total (n= 846) families we called. Among 412 participants, 46% were mothers, and 54% were other family members. Out of these participants, 12 % reported no education; 17% at least primary education (5th standard); 34% at least secondary education (10th standard); 18% at least 12th grade/Pre-university course ; 14% graduation (college level); and 4% post graduation education. Among 413 participants, 39% were homemakers; 16% self employed/small business ; 15% were daily laborers; 14% had a private sector job; 2% had a public sector job; 9% other; and 5% were unemployed. More than half of these families are below poverty line beneficiaries.²

¹ Tier 1 includes cities with more than 1,000,000 in population; Tier 2 between 500,000-999,999 in population; Reserve Bank of India—Notifications. (n.d.). Retrieved April 2, 2020, from <https://www.rbi.org.in/Scripts/NotificationUser.aspx?Id=9817#an4>

² Individuals with below poverty line cards are eligible for specific government assistance and aid.

Total interviews done - state wise

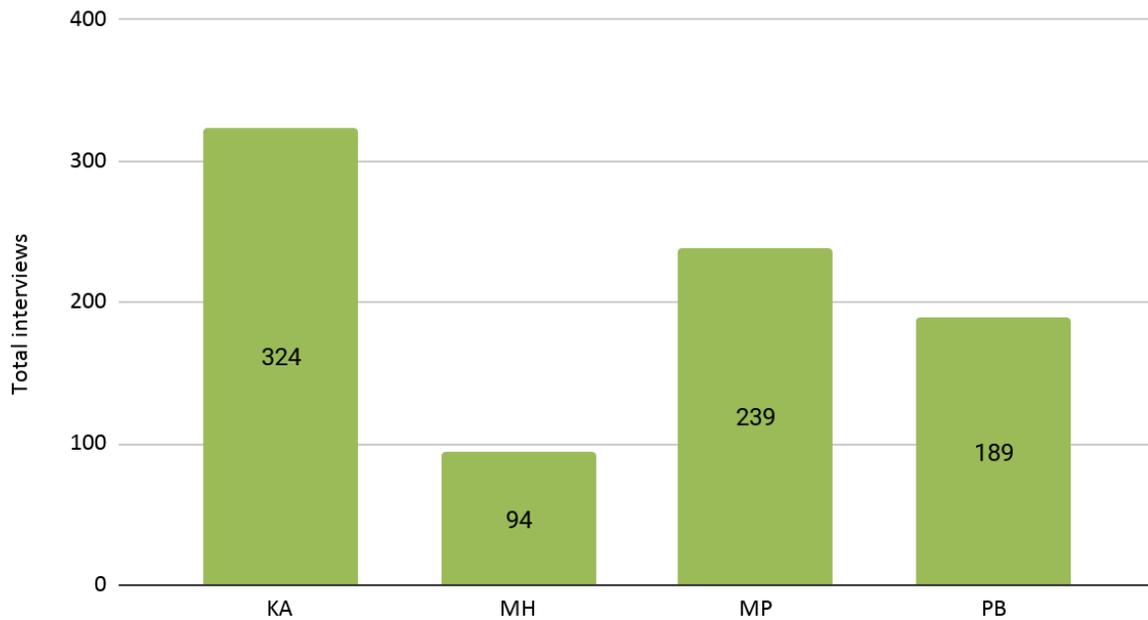


Figure 1: Interviews done by state

An additional 20 individuals participated in the qualitative semi-structured interviews in Punjab (3), Maharashtra (1), Karnataka (12), and Madhya Pradesh (4).

99% of all participants in the survey knew about COVID-19. From the qualitative research, respondents' knowledge of COVID-19 ranged from knowing very little (2 people in Punjab), to knowing detailed information regarding state level case loads (1 person in Madhya Pradesh). Most people knew about symptoms, key preventive behaviors (e.g. hand washing, staying at home) (Karnataka, Maharashtra, Madhya Pradesh, Punjab).

1.1 Risk Perception

Do you think, you or your family is at risk of infection? (N= 846)

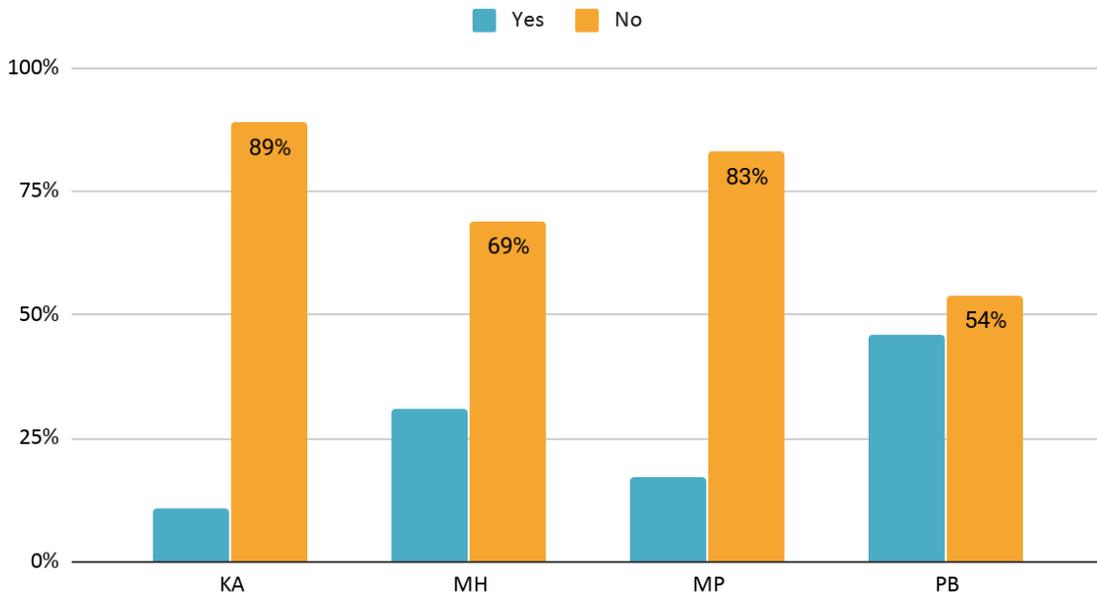


Figure 2: Reported risk perceptions by state.

Top reasons around negative risk perception on covid19 infection (N = 648)

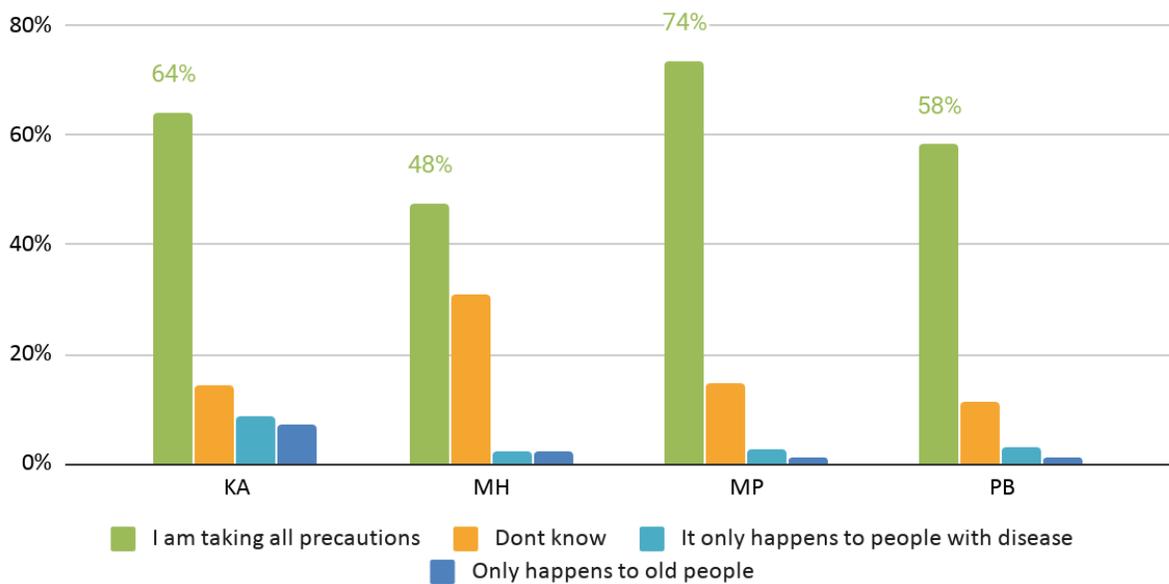


Figure 3: Reasons why people thought they were at low COVID-19 risk.

Qualitative research findings support quantitative data reporting of general low risk perception. All but **three** participants interviewed did **not** think they were at risk of getting COVID-19. As to why they believed they were not at risk, most mentioned it was because they were following recommended preventive behaviors, that there were zero to low confirmed COVID-19 cases in their locality, and that they felt no symptoms/ were healthy. As of April 1, there were 325 confirmed cases in Maharashtra, 105 in Karnataka, 86 in Madhya Pradesh, and 46 in Punjab.³ Three (2 from PB, 1 from KA) individuals cited the fact that they pray to god, which they deemed protective.

“No, we don't think [we would get COVID-19] so because we believe in god.” (Punjab)

“No , I don't think [I will get it] so, because me and my family are not going out at all, even if some goes for needed things, we are making sure to wash hands, legs soon after coming, and also ensure wearing masks during outdoors.” (Karnataka)

“No we are safe, everything is good in our area. There are no positive cases. There is a village 35 Kms from here named [name of village],where we heard that there is a man who came from Bihar he has corona. But he was found negative.” (Madhya Pradesh)

From the survey, for respondents who said they were at risk, the following reported why so (n=198):

Someone in their neighborhood had it	17%
They had traveled abroad	8%
COVID-19 could happen to anybody	21%
Only elderly people get COVID-19	4%
People with pre-existing diseases get COVID-19	5%
They may have it, even though they are taking all precautions	15%
Don't know why they are at risk	15%

Table 1: Reasons why people thought they were at high COVID-19 risk.

In the qualitative interviews, for the three individuals who reported they were at risk of getting COVID-19, all were from Karnataka, and the presence of confirmed cases, the invisible nature of the disease and that anyone is susceptible, and risk of going out.

When asked who would be at risk of getting COVID, similarly, it was attributed to people who weren't following the recommended rules and going out during lockdown, going to crowded areas, and generally not following precautions. **This hints at potential stigma for those who do get COVID-19 as those who didn't follow rules. These responses also indicate that someone getting COVID-19 may**

³ COVID-19 Tracker / India. (n.d.). Retrieved April 1, 2020, from <https://www.covid19india.org>

not necessarily be a result of others inaction but one’s own choices. One individual from Madhya Pradesh went so far as to characterize people who don’t follow precautions as “enemy of the country”:

“They are enemies of the country. They will not stay at home, and will stroll around with 10 other people and they are enemies of the country...those who are not following they should be punished. There should be a penalty of Rs. 10,000 for such people. If one offender will be punished then the other will stay at home out of fear of penalty.” (Madhya Pradesh)

Other people who could be at risk were individuals who were traveling from outside countries, those with low immunity (due to young or old age or illness condition). Two respondents, one in Karnataka and Punjab, did not know who might be at higher risk of getting COVID-19.

These responses indicate that **risk perceptions are dependent largely on individual based measures, and religious beliefs rather than governmental and community based infrastructure and practices.**

1.2 Prevention Strategies

Prevention - What are some of the things you are doing to prevent infection? (N = 846)

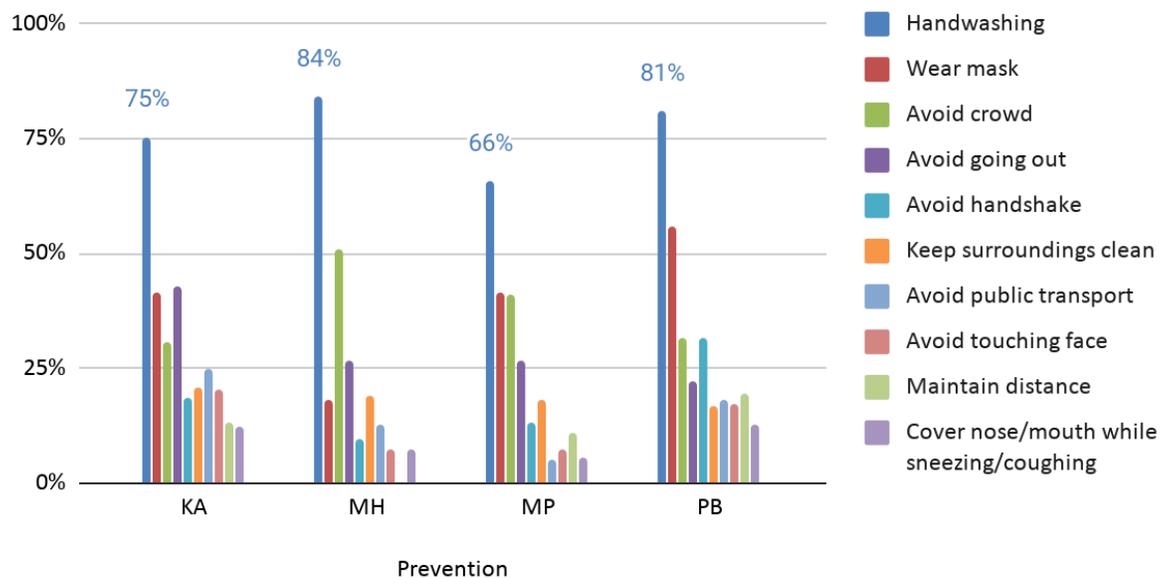


Figure 4: Prevention behaviors practiced by respondents.

Other, lesser mentioned prevention strategies included maintaining hygiene in the surrounding (19%); washing vegetables/fruits before consuming (7%); avoiding consumption of chicken/eggs / other meat (7%); and taking homeopathic pills (15); eating garlic (<1%).

When asked to **recall** prevention strategies, qualitative participants most commonly mentioned prevention included **hand washing**, covering one's face with a mask or cloth especially outside the home, and **social distancing** (includes **staying at home, avoiding physical contact with outsiders, avoiding crowds**; 3 individuals from Madhya Pradesh mentioned **social distancing of at least 1 meter** from another person). Fewer mentioned wearing gloves, drinking hot water, washing fruits and vegetables with water, and **not touching one's face**, cooking food thoroughly, and taking malaria prophylactic drugs. One person in Punjab was not aware of any preventive measures.

In terms of what people were **practicing**, for those who knew about preventive measures for COVID-19, most were washing hands and practicing social distancing. Behavioral motivations to practice these behaviors were understanding that they could safely protect themselves from COVID-19 by doing so. Other behavioral motivations included fear from the rapid increase in confirmed cases, specifically from participants in Karnataka.

“Yes, if the Prime Minister is saying all these things then it must be important. We have no cure for this virus. Precautionary measures are the only solution we have. Countries like Italy and China are facing so many problems despite having better medical facilities. In comparison India is at 102th place in WHO ranking of healthcare. We are more populous than them so it is more problematic for us.” (Madhya Pradesh)

“Yes, it's very important to take action, this is the matter of life and day by day death rates are increasing, its spreading from country to country and increasing the number of people getting affected, also spreading from state to state, and because of carelessness and negligence many people are getting affected.” (Karnataka)

Handwashing:

Overall, all but one individual knew about hand washing as a key preventive behavior for COVID-19. Most everyone was practicing handwashing, though they didn't mention nor did we probe the frequency and times that they did. Participants mentioned their own safety from COVID-19 as a behavioral motivation to wash their hands, viewing handwashing as mandatory. Additionally, one individual cited the newborn in their home as a key reason for adoption of handwashing.

“It is easy when you have to do it. Now we are getting used to it as we have a baby in our house.” (Maharashtra)

“It's easy only because it's recommended for our own safety. So it's easy to follow when it comes to our safety.” (Karnataka)

All but two participants reported no challenges with access to water, and no one reported challenges with access to soap. One participant from Punjab and Karnataka mentioned challenges due to the fact that fresh water supply was only available for 15 minutes per day, household work and poor facilities, respectively. Water tanks, water pumps, municipal supply of water, 24 hour water availability via tap or borewell were mentioned as sources of water. Several participants mentioned

that they only get water once in every two or three days. If there were challenges (e.g. water only comes once a day), participants were able to manage, plan, and store water as described by a participant below:

“We get water supply (municipal supply water) on alternative days. Challenges arise when the water does not come even on alternative days but we store enough water for our use during the time of supply.” (Madhya Pradesh)

Despite little to no current challenges with water, however, individuals from Karnataka and Madhya Pradesh cited that upcoming summer months would affect their current water supply. The following respondent from Madhya Pradesh describes how much more difficult procuring water will be during the summer:

“At present there is no problem during this month of year there is sufficient water. But from next month when the temperature will rise we have to arrange water from one kilometer from here by cycles, tricycles etc. During summer there is scarcity of water. At present we have borewell but during summer it dries and we do not get water from it. The underground water in our area is salty. The area on the other side of the bridge (on the river) is sweet (potable). Therefore during summers the whole village goes there for water. We use 2 jerry cans (15 Ltrs) each for transporting water in 2 to 3 rounds which is sufficient for the whole day.” (Madhya Pradesh)

These findings indicate that even if there are barriers to water access, they aren’t identified as barriers because the value and importance of handwashing to prevent illness is clear to them.

Social Distancing:

When asked about social distancing, all respondents from Karnataka, Madhya Pradesh, and Maharashtra knew about it, while none of the respondents from Punjab knew about it. People stayed at home, kept their children from going outside, avoided crowded areas, avoided touching other people (e.g. namaste vs. handshakes), and stayed at least 1 meter away from others. **Similar to handwashing, for those aware, respondents did not report that it was difficult to practice social distancing given that they understood its importance as a preventive measure.**

“These measures are very important. Because, if one person gets infected then he will spread the infection to everyone who comes in his contact. If we’ll stay protected then everyone will stay protected. If we will not take precaution then the whole country will get destroyed. If I get an infection, I’ll come in contact with 10 people and then these 10 will infect 1000 and it will go on. There is no medicine for corona and there is no treatment for this disease. Therefore we have taken precautions. The Prime Minister is also giving advice with regard to protecting us so we have to follow it.” (Madhya Pradesh)

One mother from Karnataka mentioned that her status as a recently delivered mother was part of why she was not allowed to go out. Additionally, one respondent from Karnataka, who is a shopkeeper,

“allows the customers to shop only with mask and hand gloves and also maintains 3 feet distance from them.”

One respondent from Karnataka mentioned challenges practicing social distancing in their home given there are a total of 15 household members. Another participant from Karnataka mentioned generally difficulty with social distancing, but understood there is no other alternative.

Other behaviors:

One person mentioned closing their store(Madhya Pradesh); another making homemade hand sanitizer from aloe vera, neem leaves, and alcohol (Madhya Pradesh); one mentioned avoiding cold drinks; and one recommended drinking a boiled mixture of garlic , clove, ginger and pepper in water for an hour, every day (Karnataka). **Of note, no one mentioned they were not touching one’s face, cleaning surfaces more frequently, or covering their mouth and nose when coughing or sneezing**

Masks:

When asked who should wear masks for prevention, 70% said everyone , 19% person with symptoms only, 10% were not sure who should wear masks, 7% Health care provider, 6% Other, 5% Care-giver of patient; and 2% masks are unable to prevent infection (respondents could provide more than one answer for this question). From the qualitative interviews, although people mentioned one should wear masks as key preventive behaviors, many did not because they were not going outside.

Misconceptions:

When asked if people can get infected by consuming chicken, eggs or meat, 55% said yes and 45% said no. This was not a commonly cited detail of COVID-19 or preventive behaviors among qualitative research participants; one qualitative participant mentioned eating chicken as a risk factor for COVID-19.

1.3 Knowledge of symptoms

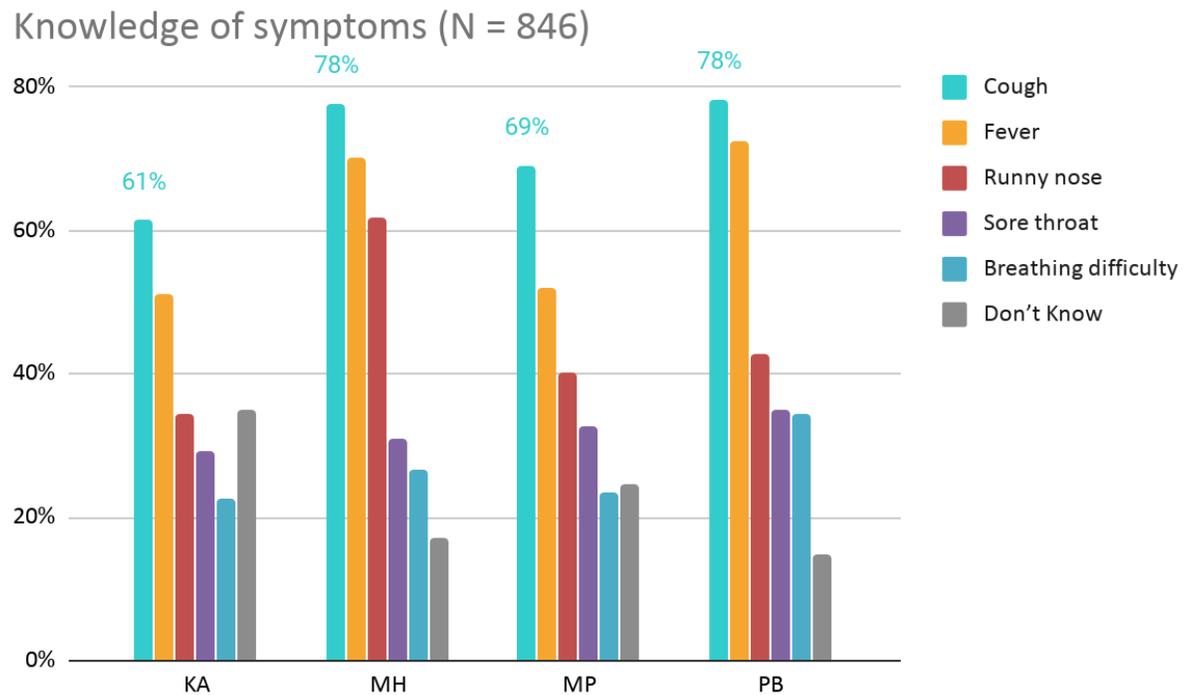


Figure 5: Knowledge of symptoms most commonly reported

Qualitative respondents' knowledge of COVID-19 ranged from knowing very little (2 people in Punjab), to knowing very detailed information including case load within their state (Madhya Pradesh), with most people knowing about symptoms, key preventive behaviors (e.g. hand washing, staying at home).

The most commonly discussed attribute of covid-19 was that it's a virus transmitted person to person through sneezing and coughing. A few participants from Karnataka mentioned touch. Most individuals identified that COVID-19 symptoms were cough, fever, cold, sneezing, pneumonia, shortness of breath, runny nose, and stomach pain. Six people across MP(2), PB(1) and KA (3) did not know what the symptoms were for COVID.

1.4 Sources of information

Source of Information (N= 846)

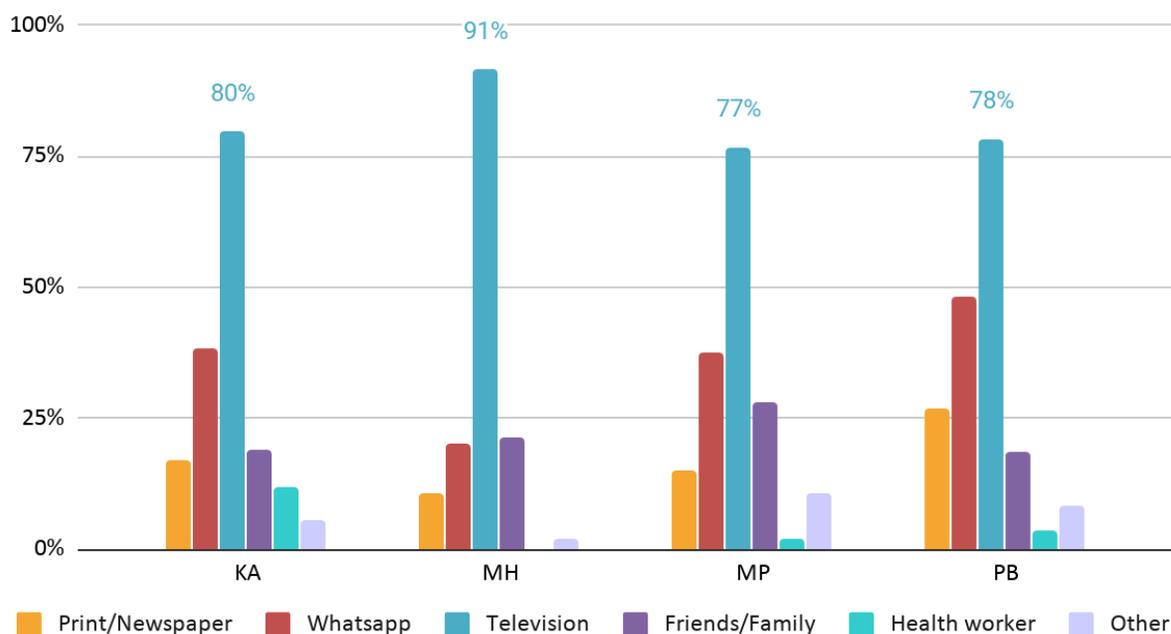


Figure 6: Source of information.

Qualitative participants relied on television (or “the news), whatsapp, social media, doctors, police, government authorities, youtube, panchayat, and health workers (e.g. ASHAs) as sources of information. For some individuals, TV was better than whatsapp and more trustworthy and believable due to the spread of fake news. However, a few individuals did continue to use whatsapp, with one individual from Punjab who reported that whatsapp was his main source of information. Messages from these sources were often reinforced and shared within families. One participant learned the importance of social distancing and handwashing from her husband (Madhya Pradesh). One respondent from Karnataka did mention challenges and difficulties in deciphering information given that there were multiple sources and elements mentioned. People did not cite information from their neighbors, given that they were practicing social distancing and not leaving their homes.

1.5 Health seeking behavior

Health seeking behaviour (N=846)

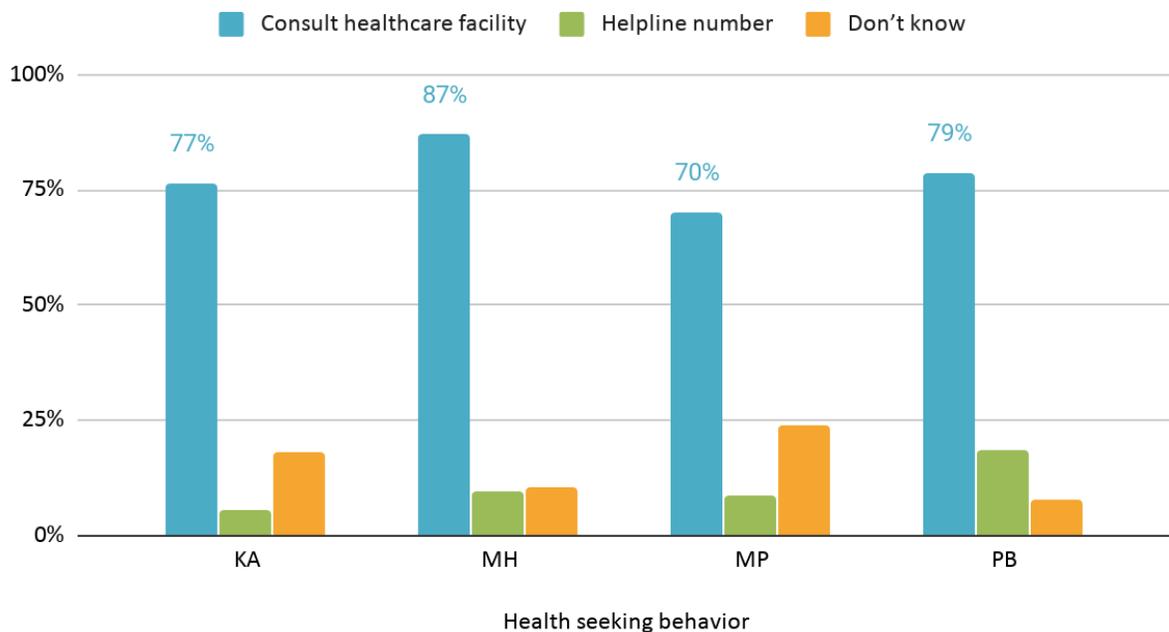


Figure 7: Health Seeking behavior if there were symptoms.

All but one mentioned that if they have COVID-19, they would go to the hospital to get a test, with a few mentioning they would call a helpline number. Two participants in Karnataka mentioned they would “keep him/ her separately and ask that person stay home to prevent spreading of infection” to maintain social distancing.

1.6 Other Behaviors

Information demand - What information would you like to hear more? (N=846)

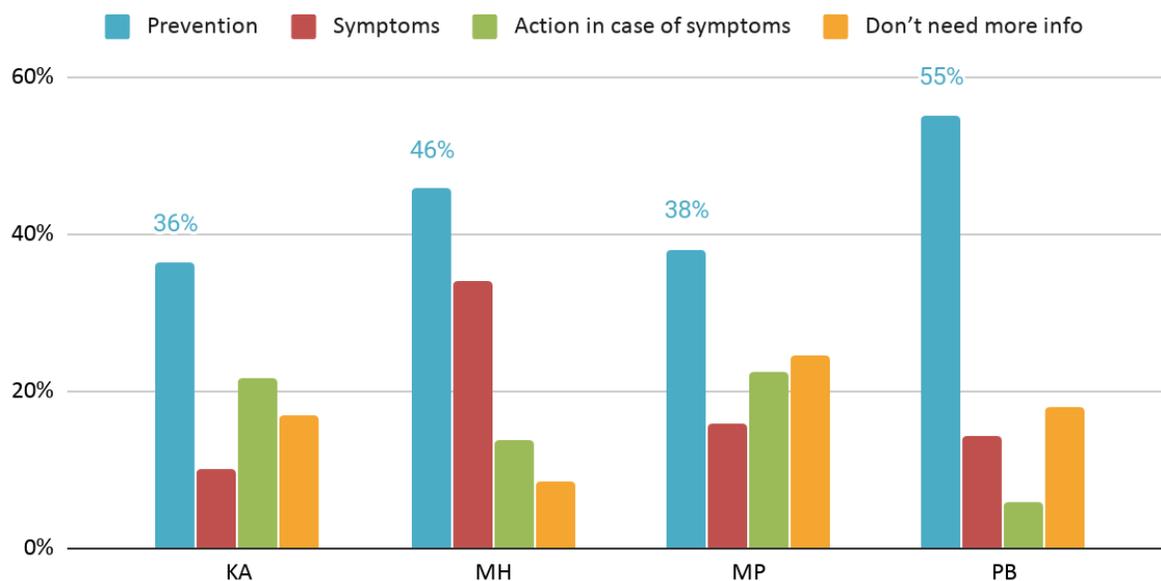


Figure 8: Additional information participants wanted to hear.

Other types of information qualitative participants wanted to know from the qualitative interviews included knowing when uncertainty of the pandemic would end. One person from Madhya Pradesh also mentioned feeling bored at home. In general, people reported anxiety and fear over both the rapid spread of COVID-19, the first time experiencing a pandemic of this scale, and experiencing lockdown for prolonged periods of time. It's well captured in the following quote:

“When it is going to end?” (Karnataka)

News of a COVID-19 cure or vaccine would make people feel calmer. Two people from Madhya Pradesh also mentioned concern for others in their community. One respondent cites others and his own challenges daily wagers and lack of policy supporting these individuals:

“Yes ma'am there are worries, there is tension regarding it. People are not able to go outside. Daily wagers like rickshaw pullers are unable to earn enough money to survive. Where they will go, they will die due to hunger rather than corona. I saw the news of a man in Delhi whose rickshaw got stolen and his three daughters died due to starvation as no one gave them food, while that man went out in search of his rickshaw. We are poor people after the government's announcement (of lockdown) we are unable to go to our fields. We are all labourers and farmers here.” (Madhya Pradesh)

1.7 Limitations

There are several limitations to the community based needs finding work. First, surveyors call participants from government district hospitals, given that is where we initially recruited participants, which may bias the responses of participants toward more socially desirable answers. Secondly, we used a convenience based sampling method⁴ for both the quantitative and qualitative interviews, hence what is reported here should not be viewed as representative. Instead, it should be viewed as a formative exploration of risk perceptions, prevention knowledge, and behaviors for COVID-19.

SECTION 2 - HEALTHCARE WORKERS

2.1 Hospital Preparedness

Currently hospitals are preparing to battle this pandemic through establishing Isolation wards and limiting OPD services, following government guidelines. Limited routine procedures are being performed, with only emergency procedures being carried out. Due to the creation of isolation wards hospitals are no longer admitting general patients. Hospitals are maintaining social distancing in wards and OPDs of at least 1 meter between people. Most hospitals have limited the number of caregivers that can accompany patients to the hospital.

Most staff were aware of how the hospital has prepared for COVID-19, such as creation of separate wards for patients, increasing the availability of masks and sanitizers, and reducing hospital load by limiting or decreasing the OPD services.

“Isolation beds are ready, we are getting all requirements fulfilled”

“Patients are asked to enter one by one and not form a queue; admissions only to the emergency cases is being given; immediate lab tests are being done for patients with cold and cough”

Some gaps were still identified by staff, such as the lack of adherence to limiting the number of patient caregivers in facilities as well as an availability of PPE.

“Even after continuous warning, more than one attendee is being allowed with the patient creating unnecessary chaos in the hospital.”

“[There are] insufficient numbers of gloves.”

⁴ Convenience based sampling is a non-probability based sampling strategy based on who is readily available for participation.

2.2 Use of Personal Protective Equipment (PPE) and Other Preventive Behaviors

Staff have been provided PPE (masks, gloves, suits) but this was primarily for staff posted in isolation wards, with other staff just being provided masks. Most hospitals shared that hospitals have limited supply of PPE.

“Masks are being provided to all the nurses; counsellors are not being given gloves as they don't come in direct contact with the patients; PPE suits are given only to the staff working in the isolation wards.”

When asked about how to handle COVID-19 patients, respondents reflected that they had to wear PPE, keep the patient in isolation, elicit the symptoms of caregivers, and enquire about family members who had tested positive. One question raised was on self isolation for staff after treating positive patients, and another was on how to care for patients with COVID-19. No reported questions on how to use PPE.

“I have a doubt here that after treating a suspected COVID-19 case we (staff) have to self-quarantine.”

For preventive measures for their own families, staff focussed on handwashing, restricting the entry of people into their homes, with one staff pointing out that they have made special arrangements by having a temporary bath area outside the house which they use after coming back from hospital shifts. All the staff were aware of what needed to be done for the care of COVID-19 patients in terms of keeping them in isolation, away from other patients, getting relatives tested too, and sanitising the ward.

“Temporary bathing area has been shifted outside the house in the verandah; does not enter inside without taking a shower after returning from the hospital; wash, sanitize and dry the clothes outside house itself; sanitize her hands before meeting her kids and cooking or eating.”

2.3 Handwashing

Staff from all the hospitals replied that they have facilities for handwashing, including a supply of clean water Most staff are strictly following handwashing protocols, as they are motivated by the responsibility of being exemplars in their role as health care workers. However, there is some uncertainty about handwashing adherence by certain staff members, specifically the cleaning staff working in the hospitals.

“As I know staff nurses are strictly following & washing their hands, but not sure other health workers doing the same as in our hospital some of the Group-Ds didn't understand the horrible situation, when we ask them then only they wash their hands.”

2.4 Shift of Patient Load in Hospitals

District hospital services are operational, but general footfall has reduced due to the lockdown. **The majority of hospitals are allowing only emergency cases** and are trying to limit attendants with patients, though there are limited means of communicating this to people coming to the hospitals.

“The guards outside are directing patients to not enter the hospital if there's nothing serious.”

“Yes now it's changed like emergency patients are only allowed to come to hospital.”

“We are telling them when they come to hospital and instructing them to inform others of their respective villages/areas.”

A few communication channels are being explored independently in a few hospitals, to communicate these changes to the patients.

“We have a radio system to give messages to the hospital patients (inside and outside the hospital).”

“ASHA Workers and clerical worker helpline numbers were created for sending this message.”

2.5 Communication with patients

Respondents reported that they are communicating information around COVID-19 signs and symptom and key preventive behaviors (handwashing and social distancing) with patients, and have been getting limited questions (mostly on how it spreads), and a few myths (like people think that intake of alcohol can cure/prevent COVID-19, or that COVID-19 will go as soon as the temperature rises).

Counsellors promote COVID-19 awareness through their interaction with patients. Respondents did not mention any stigma that they or patients have experienced or mentioned.

“[We are] just telling them to wear masks, wash hands, and maintain social distancing.”

“If someone is home isolated then how should they behave with their relative and what they should do at home.”

“How does it happen? Is this airborne?”

2.6 Challenges & Support

On being asked if any support is needed on communicating the importance of handwashing to patients or others, they pointed out the requirement of print material for this, with staff suggesting a need for training on this for clarity. Additionally, respondents mentioned that it was

important to take advantage of the short period of time patients are in hospital to provide regular COVID-19 information.

“Probably its important to tell patients about COVID-19 on a regular basis. We have one problem in hospital, patients get discharged in some days. If we had told them about Corona, then new patients will also need to know about COVID-19, we can increase CCP Session and teach them about COVID -19 through sessions.”

When asked about the support required, a few staff members expressed interest in attending training and receiving print material on COVID-19 for them and patients.

“A short training on necessary things about corona might help.”

“A qualitative training on Covid-19 [will be helpful] to fight strongly.”

A few of them are also concerned about the fake news being circulated, and mark that as a critical challenge.

“So much fake news by WhatsApp and other social media.”

Acknowledgements

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Healthcare Worker Interviews: Mahesh A M, Dr. Pragati Gurjar, Dr. Juhi Jain, Dr. Abhimanyu Kotwal, Nagesha M, Shailendra Tomar.