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COVID-19 care in India: the course to self-reliance



The public health response to COVID-19 in India has been highly centralised, resulting in a homogenous strategy applied across a sixth of the world's population. India was placed in a nationwide lockdown on March 24, 2020, with restrictions being relaxed in three phases since June. In May 2020, the prime minister called upon the Indian people to be self-reliant. We discuss here opportunities to modify several aspects of the medical response to echo this sentiment.

Until April 27, 2020, national guidelines required that all symptomatic patients and families be transferred to health-care facilities and isolated away from their homes, and entire neighbourhoods be declared containment zones.¹ This strategy overwhelmed the health-care system in India's most populous cities, including Mumbai and Delhi, and precluded access for non-COVID care.² The resultant fear and stigmatisation has resulted in delays in seeking timely care, and violations of privacy.

There was an initial rush to build new COVID-19 hospitals and secure ventilators. The government feared that by not doing this they would be criticised, given the low number of intensive care unit beds per capita. However, intensive care entails not just equipment, but systems in critical care and trained personnel, of which India has few.³

Despite ample scientific evidence against the efficacy of hydroxychloroquine, health departments and physicians continued to promote its use both prophylactically and therapeutically.⁴ State agencies have undertaken population-wide distribution of unproven homeopathic and Ayurvedic medicines and herbal tea mixes (ukalo), claiming they boost immunity and prevent quarantined individuals from getting infected.⁵ Practitioners are also prescribing various other medications, including the anti-parasitic drug ivermectin.

The attention on wonder drugs and claims about imminent vaccine availability continue to distract from gaps in testing, contact tracing, and safe work environments. For months, physicians were barred from testing asymptomatic patients. Although India's daily test count has grown exponentially, it remains low, at around 0.35 per 1000 people, as of Aug 5, 2020.⁶ To date, publicly shared data are not disaggregated enough

to shed light on local incidence, or on the demographic determinants that might explain the low reported infection fatality rate.

Anecdotes and personal testimony should be an impetus for rigorous trials, not a license to promote unproven interventions. A flood of articles, models, and mobile device applications (apps) driven by technocrats and consulting companies has resulted in a high noise-to-signal ratio globally. Policy makers must resist the temptation of quick action, and instead rely on those trained to interpret scientific evidence.

Most people with COVID-19 can be cared for at home, and there is no justification for institutionalising those with mild or no symptoms. Where isolation is essential but impossible, dignified quarantine facilities could be constructed in the community, as was done in the densely populated slums of Dharavi in Mumbai, in the absence of which, mandatory use of facial coverings (which could be inexpensively provided), would also play a substantial mitigating role.⁷ India's general practitioners and community health workers, can effectively monitor a patient's vital signs at home via in-person visits or telemedicine, distribute and encourage the use of masks and soap for handwashing, advise self-pronation, and, when possible, use adjuncts like pulse oximeters.⁸ Providing oxygen therapy (and pronation) in lower tiers of care could avert the need for subsequent ventilation in many patients and help reduce the pressure on hospital bed capacity.⁹ Some patients might benefit from steroids, and the small minority of people who clinically deteriorate will need intensive care.¹⁰ To meet this demand, existing technicians and nurses must be upskilled and general practitioners recruited to learn the basics of intensive care on the job. Liberal use of antivirals should be discouraged, as their benefit is marginal and limited to severe cases, and is cost prohibitive.

There is first-hand evidence to show how the Indian people have risen to the occasion in helping older neighbours quarantine, sharing chores, and stepping in to feed and assist the millions of migrants stranded by the lockdown. The directive for self-reliance must leverage India's societal fabric and collective sense of purpose to empower communities to say where

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they would like to quarantine and isolate. Local jurisdictions should be provided with more data, as disaster responses are most effective when locally contextualised. Community-centred guidelines for people to self-organise and self-care must be vigorously disseminated. Health agencies should work with civil society organisations to regain trust. Women’s empowerment groups in Kerala, for example, were marshalled to map where older people live to ensure they had access to medicine and food while self-quarantining—an acceptable, workable, and scalable solution in the Indian context. Symptomatic patients must be treated at home to the extent possible, and in-patient protocols must only use evidence-based interventions; most patients might only require oxygen and pronation.

In summary, what is needed is a plethora of low-tech solutions (especially facial coverings), adherence to science, and societal participation in caring for vulnerable people. There is not always an app for that. But there are the people of India.

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