Note: this document has been excerpted for the purposes of the CommunityFirst COVID19 Roadmap.

Please read the full document here:

https://www.who.int/publications-detail/community-based-health-care-including-outreach-and-campaigns-in-the-context-of-the-covid-19-pandemic

Adapting key health system functions in the pandemic context

This section addresses select health system functions for which strategic adaptations are needed to ensure a robust COVID-19 response and safe ongoing delivery of essential services at the community level.

Community health workforce

Adapting roles and responsibilities for the community health workforce in the context of the COVID-19 pandemic can include developing new approaches to existing activities and reassigning existing workers or recruiting additional workers (*15*). In the setting of such changes, it is important to avoid burnout, attrition, lapses in service delivery, reductions in quality and increases in infection risk. Since the availability of referral services may be limited in the context of increasing demands on the health system, all health workers should be prepared to take on additional responsibilities related to the initial management of key life-threatening syndromes (*16*). Where the COVID-19 context necessitates workload modifications, reassignment or recruitment, care should be taken to adequately resource, train, equip and supervise all health workers, leveraging digital solutions if available. Timely remuneration and reasonable working conditions will promote the retention of the community health workforce during the COVID-19 response and beyond.

To ensure the occupational safety and health of the community health workforce, all health staff should be provided with adequate personal protective equipment (PPE) and trained in its use and safe disposal.

Work in the COVID-19 context may result in stigmatization (*17*), and health workers may need mental health and psychosocial support, and particular consideration should be given to gender issues (*18*). Older workers and those with high-risk conditions should be assigned to duties that do not put them at additional risk.

KEY ACTIONS:

- ☐ **Ensure that the community health workforce is included in workforce assessments associated with the COVID-19 response**. Create or leverage existing databases of workers with different skills to fill critical gaps; ensure these are updated regularly. Identify qualified workers, including unemployed and retired workers, who could be part of a surge cohort (ensuring protections as above).
- ☐ **Clearly define roles for the community health workforce in the context of the COVID-19 response** and involve that workforce in planning and decision-making.
- ☐ **Ensure that the community health workforce and other critical personnel** (for example, those who are part of the supply chain) are classified as essential and exempted from movement restrictions.
- ☐ **Recognize and remunerate the community health workforce supporting the COVID-19 response** with payments and non-performance-based incentives; coordinate remuneration with partners and stakeholders.
- ☐ **Quantify training needs and invest in rapid, remote training** on new COVID-19 roles and tasks and adaptations to existing activities. Leverage digital solutions to modify training modalities, including e-health learning platforms.
- ☐ **Modify supportive supervision and communication modalities** as needed (including by using digital solutions) to ensure the timely dissemination of information and access to clinical decision support to reinforce newly acquired skills while strengthening referral linkages among the community health workforce, facilities and district health management teams.
- ☐ **Ensure that health workers have sufficient phone credit** or are compensated for the credit they use to engage with clients, access information, seek advice from supervisors, send data and receive payments using mobile phones.
- ☐ **Ensure the safety and health of all health workers** by providing PPE appropriate to the tasks performed, protecting against violence and harassment and offering psychosocial support.

Supply chain

In the pandemic context, with its associated impacts on care-seeking and access, there may be an increased reliance on primary care services and the community health workforce and increased utilization of medicines and supplies at the community level. Strengthening supply chains, anticipating interruptions and preparing mitigation strategies are critical to maintaining the availability of essential medicines and supplies (*15*). Strategies should address (a) commonly used supplies, (b) any medicines or other necessary products that are at risk for constraint due to increased demand and (c) supply and distribution mechanisms that reduce the number of visits to health facilities to replenish supplies.

Where stock is available in the country, allocating at least 1 month of essential supplies at the community level, assuming safe, secure storage is possible, may help to reduce disruptions due to transportation delays. If supplies are sufficient and if storage conditions allow, larger quantities can be dispensed. When supplies are constrained, more frequent deliveries may be needed, and it will be important to have a plan to minimize exposure at health facilities. Options may include establishing secure pick-up locations with timed appointments or secure drop-off zones where access is restricted to necessary personnel. For inventory management, additional flexibility may be required and, where feasible, electronic systems should be used.

Similarly, to mitigate the transmission risk, if medicines cannot be delivered to homes, each pick-up location should include physical barriers, such as plastic screens, to protect patients and staff. If possible, hand sanitizer or handwashing stations should be available at all pick-up locations for clients to use. To the extent possible, people should pick up products at windows or counters at the perimeter of the facility, and queue-management measures, such as distancing and advance scheduling, should be used. Adapted and expedited procedures may be required in certain areas to pre-position supplies, and special considerations apply to urban and periurban areas, informal settlements and other densely populated settings where there may be widespread community transmission.

Information about stocks and safe storage capacity at the national and subnational levels should inform these strategic choices, and when needed, rapid assessments should be conducted electronically or by phone. Where possible, resources should be designated specifically for use by the community health workforce to ensure continuity of care for people with acute or chronic conditions.

KEY ACTIONS:

- ☐ **Develop supply and distribution strategies** for medicines and other health commodities that may be in short supply or are likely to be in high demand, taking into account safety and security.
- ☐ **Adapt replenishment procedures to avoid community shortages**, limiting facility encounters through multimonth dispensing, if supplies permit
- ☐ **As supply levels allow, consider pre-positioning** a buffer supply of at least a 1 month (and ideally longer) of essential resources for community-level service delivery. Designate resources specifically for use by the community health workforce, and anticipate increased resource needs.
- ☐ **Coordinate the assessment, ordering and distribution of essential medicines, supplies (including PPE) and equipment** with partners and community stakeholders.
- ☐ **Ensure that pharmacies, health posts and other relevant public and private community-based entities are included in capacity assessments** for the production and distribution of essential resources.
- ☐ **Ensure that community-based pathways for medicine stock and distribution are included** in electronic systems for order management, assessments and planning, if possible.
- ☐ **For those making or accepting deliveries and when dispensing medicine or supplies, avoid excessive contact inside a health facility**; for patients with chronic conditions, schedule medicine pick up via text (SMS) message or phone and maintain distance between patients while they wait.
- ☐ **Consider using reverse logistics to reposition supplies** based on the transmission scenario and feasibility in the local context.

Health information systems

Community data are needed to monitor and maintain essential health services and to inform public health actions that can slow and stop COVID-19 transmission. As diagnostic technologies become widely available, surveillance strategies will change.

In settings where the community health workforce depends on paper forms[2] to collect data, alternative solutions should be explored that do not require the workforce to appear in person to submit data to a health facility.

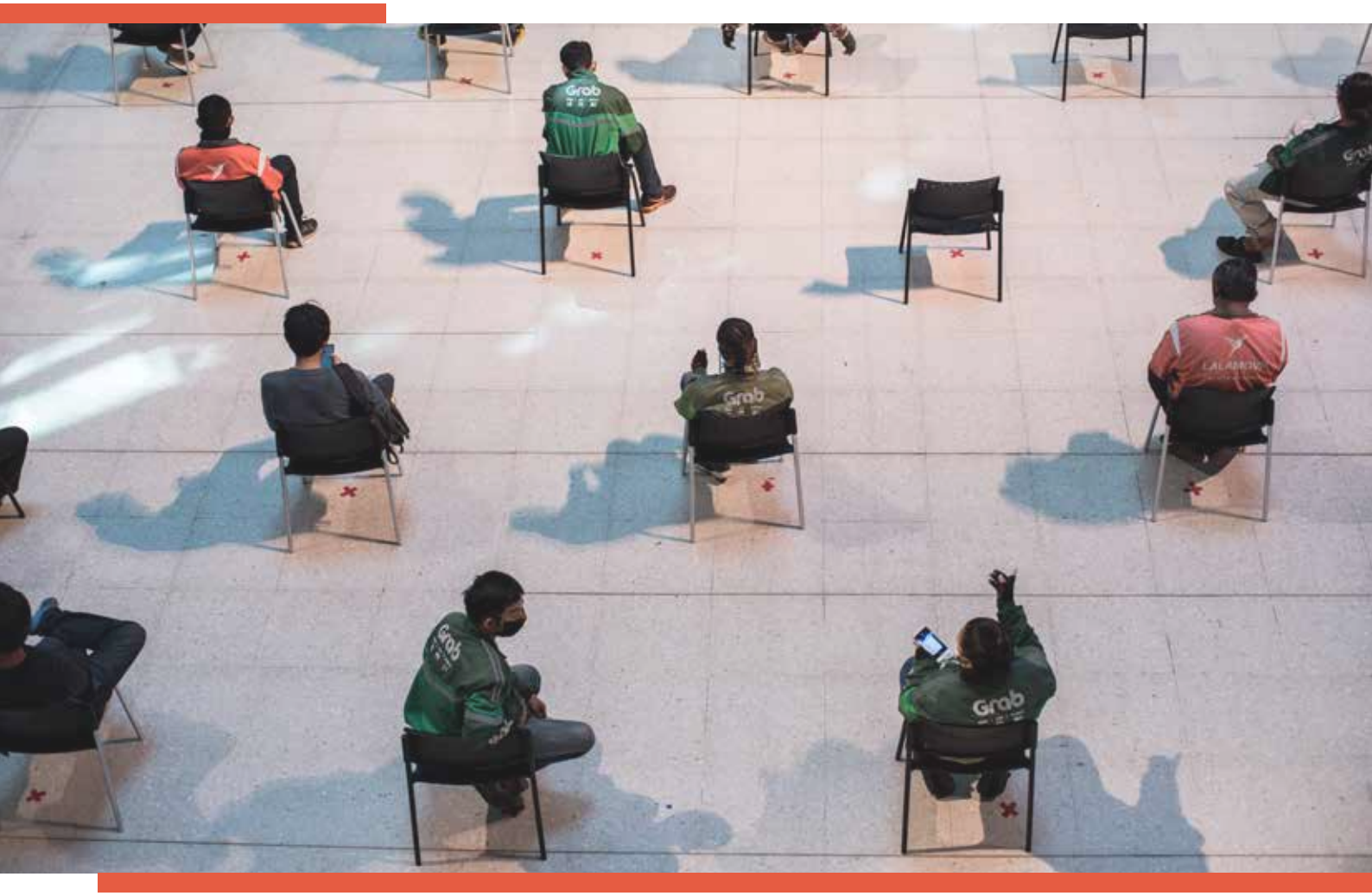
2 Ideally, data would be integrated within existing health information systems, but for the COVID-19 pandemic there may be a need for parallel COVID-19-specific information channels, since it takes time to integrate new indicators into existing systems.

If a mobile network is available, data could be called in to supervisors or facilities, or photos could be submitted to capture monthly reports. In situations in which technology cannot be leveraged, the workforce should be involved in creating a process for aggregating data at the community level and identifying appropriate pathways to ensure that data reach the health facility. The usual accountability mechanisms that increase contact, such as requiring confirmatory signatures, should be suspended. The timeliness and quality of the reporting of community data will likely decline during the pandemic, and programmes should consider prioritizing a limited set of indicators that is based on existing community data.

KEY ACTIONS:

- ☐ **Strengthen community-based surveillance for COVID-19** to identify early warnings and ensure early case identification and immediate action, according to national guidance (*19*). Invest in adapted approaches in hotspots to mitigate transmission.
- ☐ **Incorporate data collected by the community health workforce** into the health information management system (*15*). Use data to produce dashboards to inform transmission scenarios, and identify COVID-19 hotspots and disruptions in logistics and service delivery.
- ☐ **Collect and monitor data on COVID-19 infections and deaths in the community health workforce** that are disaggregated by gender, age and tasks performed.
- ☐ **Use community data to monitor the utilization of essential health services** for COVID-19 infections and for other priority health conditions (for example, measles) in order to mitigate outbreaks, especially if services are postponed or care-seeking declines (*15*).
- ☐ **Engage the community health workforce in establishing a community alert system**, and use context-appropriate technology, if feasible.
- ☐ **Leverage existing investments in digital platforms**[3] for data collection, real-time monitoring and for obtaining feedback from the community (*20*).
- ☐ **In the absence of community meetings, establish a remote digital mechanism to ensure two-way feedback** for data and for interpreting surveillance information. Support communities in using their data for decision-making, collecting community feedback (for example, questions and information about beliefs, rumours and concerns) and acting on data to inform changes in services and community engagement actions.
- ☐ **Ensure the community health workforce has sufficient access to data collection tools (whether paper or digital, as relevant)**, including disease surveillance and death notification forms and registers, providing at least 1 month of buffer supply and anticipating a surge in cases. Where possible, adapt existing register forms.

3 Such digital platforms include, for example, SMS text messaging, UNICEF's RapidPro, IntraHealth's mHero, Dimagi's CommCare, U-Report, and community health toolkit coronavirus alert applications.



Infection prevention and control

In order to keep health workers and communities safe, initial screening and appropriate IPC measures should be incorporated into all community-based health care activities (*21*). Adherence to the use of standard precautions for all patients at all times should be strengthened, particularly regarding hand hygiene, surface and environmental cleaning and disinfection, and the appropriate use of PPE. Which additional IPC measures are needed will depend on the local COVID-19 transmission scenario and the type of contact required by the activity. Physical distancing should be implemented as much as possible.

Logistics planning, budgeting and supply-chain and waste management for PPE and hand hygiene supplies should address the needs of the community-based health workforce (*22*). Potential shortages in PPE must be addressed proactively, and clear guidance must be provided on how to adapt essential activities and services in the absence of PPE.

In the setting of the COVID-19 pandemic, the following standard IPC precautions should be strengthened during all health care encounters.

- Hand hygiene: Using WHO's 5 moments approach, always clean hands before and after direct patient contact, after the risk of exposure to body fluids and after interactions with the environment (for example, after touching surfaces) (*23*). Hand hygiene includes cleansing hands either with an alcohol-based hand rub (if hands are not visibly dirty) or with soap and water and drying them with a single-use or clean towel, if available.

- Use of gloves: Gloves are required only if direct contact with blood or other body fluids is expected, including secretions or excretions, mucous membranes or broken skin (for example, while performing a rapid diagnostic test [RDT] for malaria or during certain antenatal and postnatal examinations).
- Equipment and surfaces: Equipment and surfaces should be cleaned with water and soap or a detergent, followed by a disinfectant; safe waste management protocols must be followed.
- Medical masks: Whether medical masks should be used depends on the task performed (for example, if splashes are expected) and the context and transmission scenario (Table 1).

Furthermore, the community health workforce should ensure that patients and workforce members adhere to respiratory hygiene, and when sneezing or coughing cover their nose and mouth with a tissue or bent elbow, and then dispose of the tissue safely in a bin (ideally, one with a lid).

Screening for COVID-19 infection

Screening for COVID-19 should be done in all settings where it is indicated by the transmission scenario or local policy, or both, as part of every health care encounter (*24*). Screening for COVID-19 involves evaluating risk using a set of questions, and **PPE is not required for screening if a physical distance of at least 1 m can be maintained**. Where this distance cannot be ensured, health workers should wear a medical mask and eye protection.

Screening should include assessments of:

- COVID-19 exposure risk (that is, contact with a suspected or confirmed COVID-19 case or other people with COVID-like symptoms in the household, personal travel to or contact with travellers from an area with known cases);
- symptoms as described in COVID-19 case definitions for adults and children.

For people whose screening is negative, the health care visit can continue. No mask is required if a distance of at least 1 m can be maintained and there is no direct contact.

People whose screening is positive are considered suspected COVID-19 cases, and the local system for isolation and management, must be activated according to national protocols. WHO recommends that all people with suspected or confirmed COVID-19 infection should be isolated and cared for in a health care facility or dedicated community isolation facility. Where isolation in a facility is not feasible, people with no symptoms (that is, those who are asymptomatic or presymptomatic) or mild symptoms can be managed at home, as long as there is strict adherence to IPC measures and precautions and advice is given about when to seek care (*9*). This situation might apply, for example, when it is not feasible to separate young children from their caregivers.

Note that a positive result on screening does not necessarily preclude delivering care, as long as it can be done safely. When a patient is suspected to have COVID-19 infection, health care workers should only deliver care that allows them to maintain a distance of at least 1 m or they should use the IPC precautions and protections required according to the standards for specific activities in the setting of a positive screening (Table 1, Interaction with a person with suspected or confirmed COVID-19).

Additional infection prevention and control precautions

This section discusses the use of additional IPC precautions when a health care worker is in contact with people with suspected or confirmed COVID-19 and when essential services are delivered in settings where there is widespread community transmission.

In addition to using standard precautions for all patients, contact and droplet precautions should be used when care is provided to a person with suspected or confirmed COVID-19. Contact and droplet precautions include the use of a medical mask, gown, gloves and eye protection. These precautions should be taken by the community health workforce and any other individuals, including family members, involved in supporting a

person with suspected or confirmed COVID-19. In the context of widespread community transmission, some additional precautions, such as wearing a medical mask, may also be considered when community health workers provide essential routine services. In addition, the community health workforce together with other community actors have key roles to play in ensuring that basic IPC measures are implemented and in advising and supporting community members during quarantine and home care.

Table 1 gives examples of the precautions to be taken and the PPE required in the community health setting in the context of widespread community transmission of COVID-19. It is important to note that beyond these examples, standard precautions should be used at all times and for all patients.

Table 1. Examples of health care activities and appropriate infection prevention and control precautions in the context of community transmission of COVID-19

Activity	Type of precautions and personal protective equipment
Home visit (for example, for antenatal or postnatal care, or care for a person with tuberculosis, HIV or another chronic condition)	• If feasible, conduct home visits outside in a well-ventilated space and keep a distance of at least 1 m. • Perform hand hygiene frequently and while providing care, according to WHO's recommendations on the 5 moments for hand hygiene. • Wear gloves only if exposure is expected to blood, body fluids, secretions, excretions, mucous membranes or broken skin. • Consider wearing a medical mask when in direct contact or when a distance of at least 1 m cannot be maintained.
Outreach activities and campaigns	When no direct contact is involved (for example, during the distribution of insecticide-treated nets) • Maintain distance of at least 1 m. • No screening required. • No PPE required. • Perform hand hygiene frequently. When direct contact is involved (for example, delivering vaccinations) • Perform hand hygiene between each patient. • Consider wearing a medical mask.
Community case management of acute illness in children	• Perform hand hygiene according to WHO's recommendations on the 5 moments for hand hygiene. • PPE needs depend on the outcome of screening. • If the patient is not suspected to have COVID-19: wear a medical mask and gloves for a malaria rapid diagnostic test, as per standard protocol. • If the patient is suspected to have COVID-19: wear full PPE (medical mask, eye protection, gloves, gown). – If full PPE is not available, use the modified distance community case management protocol, which maintains distance and does not involve direct contact.
Any activity involving direct physical contact with a person with suspected or confirmed COVID-19	• Perform hand hygiene according to WHO's recommendations on the 5 moments for hand hygiene. • Wear a medical mask. • Wear a gown. • Wear gloves. • Wear eye protection.
Any activity not involving physical contact (including entering the room of a person with suspected or confirmed COVID-19, but not providing direct care)	• Perform hand hygiene according to the WHO recommendations on the 5 moments for hand hygiene. • Wear a medical mask. • Maintain distance of at least 1 m. • When possible, conduct interviews outdoors, with the patient also wearing a medical mask, if tolerated.

PPE: personal protective equipment.

KEY ACTIONS:

- ☐ **Develop and disseminate standard operating procedures for IPC** that include the community health workforce and are informed by the transmission scenario and local guidance and protocols.
- ☐ **Define IPC precautions depending on the activity or service being delivered, and include information about who requires PPE and what type is required** to inform quantification and distribution and to ensure continued availability and the rational use of supplies.
- ☐ **Ensure that the community health workforce is included in the national policy on the use of PPE**.
- ☐ **Ensure adequate access to and supplies for hand hygiene and the disinfection of equipment and the environment**.
- ☐ **Designate a district-level health care officer trained in IPC** to be in charge of supervising IPC activities at primary care facilities and in the community.
- ☐ **Incorporate screening for COVID-19** into the essential services provided by the community health workforce as per local guidance and protocols.
- ☐ **Ensure thorough training for all users of standard and additional (transmission-based) IPC precautions, including how to properly wear, remove, use and dispose of PPE**, and consider how to limit direct contact between health care providers and patients and how to deliver health services using physical distancing where possible, especially in areas with widespread community transmission.