Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic

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

Maintaining essential health services and strengthening the COVID-19 response

National and subnational contexts

Different areas, even within the same country, may require different approaches to designating essential services and to engaging the community health workforce in maintaining these services and responding directly to the COVID-19 pandemic. Decision-makers must balance the benefits of different activities with the risks they pose for transmission of the virus to health workers or from health workers to others. The local disease burden, the COVID-19 transmission pattern and the baseline capacity for service delivery at the community and facility levels will impact the risk–benefit analysis for any given activity, and communities' distinct care-seeking patterns should also inform adaptations.

In settings where high-burden endemic diseases have signs and symptoms overlapping with the COVID-19 case definition (such as those of malaria), public health messaging will need to be adapted to ensure that people do not delay seeking care for potentially life-threatening illnesses. In addition, where, how and from whom communities seek health care may vary significantly by context. Private sector providers and NGOs, including faith-based organizations, are important stakeholders and key service providers in some communities. Rapid assessments at the national and subnational levels should guide strategic choices about policy and protocol changes and response action, taking into account that pre-exisiting gaps in health services delivery and system functions may be exacerbated during the outbreak. When they are well-informed and coordinated, adaptations made in the pandemic context have the potential to strengthen both facility-based primary care and its integration with the community-based platform into the early recovery period and beyond.

Community-based delivery of essential health services

To meet ongoing population health needs and mitigate the negative impacts of the COVID-19 outbreak, nationally agreed primary care programmes need to ensure capacity for preventing morbidity and mortality through the community-based delivery of essential services (4), including:

- preventing communicable disease through delivery of vaccines, chemoprevention, vector control and treatment;
- avoiding acute exacerbations and treatment failures by maintaining established treatment regimens for people living with chronic conditions;
- taking specific measures to protect vulnerable populations, including pregnant and lactating women, young children and older adults;
- managing emergency conditions that require time-sensitive intervention and maintaining functioning referral systems.

National and subnational processes for identifying essential services, coordinating with COVID-19 response planning and optimizing the health care workforce and service delivery should incorporate relevant community-based activities and include consultation with relevant community health workforce representatives.

Populations across the life course

There are distinct considerations for people at different stages in the life course with regard to the risks associated with COVID-19 infection, overall health service priorities and the implications of public health measures and other social changes associated with the pandemic. Specific considerations examined by stage of the life course are addressed in a dedicated section in Part 2.

Outreach and campaign-based prevention services

Community-based prevention activities include outreach services (an extension of facility-based primary care services used to reach the underserved), campaigns (supplementary activities to routine services used to achieve high population coverage) and outbreak responses (used to curb an emerging health threat). While these activities are life-saving, they may also increase the risk of COVID-19 transmission within communities and between health workers and communities. The decision to continue, modify or postpone these activities should take into account the impact on COVID-19 transmission, the speed of disease resurgence and the consequences of withholding the intervention. For example, if insecticide-treated net (ITN) distribution campaigns are discontinued in areas where malaria is highly endemic, there will likely be a near-term increase in cases and deaths; the COVID-19 transmission risks associated with ITN distribution can be minimized by switching from group distribution to door-to-door delivery and then leaving ITNs at the door to a house. If ITNs are to be delivered at sites such as health facilities, large gatherings should be avoided, and all physical distancing measures should be applied. Activities that rely on large-scale gatherings, such as mass vaccination campaigns, will need to be suspended where COVID-19 transmission is established, although oral vaccines delivered in monodose vials, such as for cholera and polio, could be safely self-administered or administered by a caregiver during a home visit while a health worker monitors from 1 m away. However, outbreaks of vaccine-preventable diseases (VPDs) create immediate health needs and require a risk–benefit assessment on an event-by-event basis (see Part 2).

Maintaining therapies for chronic disease

While face-to-face routine monitoring visits for people with a stable chronic disease can likely be temporarily suspended, ensuring the continuity of treatment regimens through alternative provision methods is essential to mitigate the risk of life-threatening acute exacerbations, such as diabetic crisis, heart attack, psychosis or the emergence or re-emergence of clinical symptoms and treatment resistance in the case of chronic infectious diseases such as tuberculosis (TB) or HIV infection (see Part 2). Replenishment procedures should be adapted

to avoid medicine and supply shortages and to allow people to obtain needed resources without undue risk to themselves or others. Where supply levels permit, consider dispensing multiple months of treatment for patients with chronic conditions (see Part 2).

Time-sensitive conditions and community-based acute care

Most acute and emergency care services will need to continue throughout the COVID-19 pandemic because of their highly time-sensitive nature and potential to avert death and disability across all phases of the life course. Ensuring that the community health workforce is trained and equipped to address acute conditions is critical, as restrictions on movement, recommendations to limit in-person encounters in facilities and fears about the safety of facility-based care will increasingly shift acute care to the community setting. The community-based health workforce is likely to face expanding numbers of acutely ill patients, including people with respiratory compromise from COVID-19 and those with other emergency conditions indirectly related to the pandemic context: interruptions in therapies for chronic conditions contribute to acute exacerbations (such as severe asthma or heart attacks), while decreased access and delayed care-seeking result in later and more severe presentations (such as sepsis that has evolved from a localized infection or shock in the setting of injury or pregnancy-related bleeding).

Simple, inexpensive and effective first aid and acute care can be safely administered by individual community members and community health workers with appropriate training, including those organized into community-based first aid responder (CFAR) programmes. Such programmes use rota systems and people trained in first aid who can be called on 24 hours per day to attend the scene of acute illness or injury to deliver basic care. In many settings, these programmes overlap with and complement other case-management programmes, and they may also be linked to volunteer ambulance services, such as those run by Red Cross and Red Crescent Societies. In many settings, in addition to providing care onsite, CFARs accompany patients to ensure their safe transport to facility-based care.

Ensuring early recognition, rapid treatment and timely referral for acute conditions maximizes the impact of subsequent interventions and often mitigates the need for them. Robust community-based acute and emergency care can help avoid excess morbidity and mortality during and after the COVID-19 pandemic, facilitating a return to comprehensive service delivery and thus building a more resilient system.

KEY ACTIONS:

- [ ] **Review community health service interventions and delivery channels and identify essential services and delivery channels that need to be maintained,** linking these processes with national or subnational planning.
- [ ] **Define nonessential services that can be interrupted or postponed and identify triggers** for their phased resumption and catch-up strategies that can be used during early recovery.
- [ ] **Modify community-level service delivery to avoid large gatherings of people**.
- [ ] **Update registers of vulnerable households** (for example, those with pregnant or lactating women, newborns or older people; or people living with disabilities (5), or chronic conditions), and monitor such households to ensure continuity of care and establish social safety nets.
- [ ] **Adapt diagnosis and treatment protocols** and train and equip the community health workforce to screen for COVID-19 symptoms, recognize danger signs and appropriately activate notification and referral pathways.
- [ ] **Create a roster of community members trained in first aid and acute care**, and strengthen or create an organized CFAR system with 24-hour coverage that can be activated by mobile phone.
- [ ] **Monitor the utilization of essential health services in the community by liaising regularly with the community health workforce**.

Strengthen the COVID-19 response in the community

The community health workforce can be leveraged to strengthen the COVID-19 response because they are trusted members of the community with important links to the facilities, leaders and organizations that are key contributors to an effective response.

KEY ACTIONS:

- ☐ **Ensure that community-based activities are incorporated into national response plans**, and engage networks of community service providers (including NGOs, private health providers and volunteers) to support response efforts in a coordinated manner.
- ☐ **Identify context-relevant ways** for the community health workforce to contribute to the COVID-19 response; these might include screening, making referrals, providing support for home care, staffing community-based isolation centres, and engaging in surveillance, contact tracing, risk communication and community engagement (see Part 2).
- ☐ **Establish protocols** for community-based COVID-19 screening using standard case definitions (6), recognizing danger signs and making appropriate referrals. Prepare home-to-hospital protocols and adapt community-level referral and counter-referral protocols for suspected cases of COVID-19.

Community Engagement and Communication

As outlined in the Astana 2018 document, systematic engagement and communication with individuals and communities are essential to maintain trust in the capacity of the health system to provide safe, high-quality essential services and to ensure appropriate care-seeking behaviour and adherence to public health advice (*7*).[1] Communication and engagement strategies for COVID-19 should include all dimensions of community-based health care and aim to facilitate optimal care-seeking, health behaviours and home care practices. Communities will rely on local health facilities, and trusted community actors, including local media, for information. It is important to ensure that they have up-to-date, accurate and contextualized information in the local language.

Communication should focus on building trust, reducing fear, strengthening collaboration and promoting the uptake of public health measures and essential services.

Key topics for communication include:

- **COVID-19 transmission, public health actions to reduce the risk of transmission and risk factors associated with severe illness** (*8*). Consider developing hotlines, implementing question and answer (Q & A) sessions and leveraging digital platforms where available to dispel harmful myths, curb the spread of misinformation, reduce stigma associated with COVID-19 and support the reintegration of recovered COVID-19 patients into the community;
- **continued care-seeking for essential services**, how care can be sought safely and any changes in service delivery settings or points of care;
- **self-care and family care practices in the home**, which should be provided to all members of the household to address their health needs and avoid reinforcing traditional gender roles;
- **home care** for people with mild to moderate COVID-19 symptoms, according to national guidance (9); share information about who to contact and where to seek care in case the patient has danger signs;

1 In this document, communication and community engagement encompass social and behaviour-change communication strategies, as well as health promotion, health education, community mobilization and community engagement. This section complements guidance already published as *Risk communication and community engagement (RCCE) action plan guidance: COVID-19 preparedness and response (7).*

- **the role of the community health workforce as trusted actors** in protecting the community;
- **mental health and psychosocial well-being**, addressing the increased risks of domestic violence against women (*10*), children, adolescents, persons with disabilities and older people, and providing information about accessible services. Community resources may help to identify trusted family, friends and neighbours who can keep in touch with and support persons subjected to violence.

The community health workforce and broader community support will become increasingly important in the COVID-19 context as stay-at-home measures have been reported to decrease care-seeking for essential services and to increase violence, the use of alcohol and other substances, addictive behaviours and stress-related conditions.

KEY ACTIONS:

- ☐ **Engage stakeholders and the community in designing and implementing communication plans, strategies and materials**. Include vulnerable populations (*11*), such as women, children, adolescents, older people, people with disabilities (*5*) and people living with HIV.
- ☐ **Engage with community stakeholders to identify and address barriers to access** caused by stay-at-home policies, the suspension of public transport, concerns about infection and other factors.
- ☐ **Engage women's, parents', and adolescent and youth groups** to ensure there is effective, targeted peer outreach.
- ☐ **Coordinate with and provide resources for community governance committees** so they can offer strategic guidance for the delivery of community-based health services, act as a conduit for community feedback and contribute to oversight of the community health workforce (*12*).
- ☐ **Establish or reinforce existing mechanisms for communities to hold health authorities accountable, including those in the private sector**, to ensure the equitable allocation of resources and to improve the responsiveness and quality of service delivery (*13*).
- ☐ **Avoid community-level mobilization approaches that entail large gatherings of people**.
- ☐ **Use existing digital platforms** for teleconsultations and to disseminate information and alerts to communities. Identify **inclusive delivery mechanisms** for people with disabilities.
- ☐ **Leverage trusted community resources, such as primary care facilities, local authorities, influencers and religious leaders** (*14*), to promote the dissemination of helpful information, including about safe worship and burial practices, the need to avoid gathering, to prevent and reduce fear and stigma, and to provide reassurance to people in their communities.

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.