

 **International**

**A Frontline Guide for Local Decision-Makers  
in Low- and Middle-Income Countries**

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## COVID-19: A Frontline Guide for Local Decision-Makers in Low- and Middle-Income Countries

The COVID-19 pandemic is disrupting daily life in communities around the world. This guide provides an initial strategic framework to reduce the impact of the outbreak in the near term, tailored to the needs and constraints of local leaders in low- and middle-income countries. The guide and checklists were developed by a team of deeply experienced experts and former public health officials, in consultation with officials in governments and NGOs operating around the world. Our focus has been on providing information for both slowing and suppressing the spread of the virus, and also on supporting community needs in settings where long-term lockdowns may not be viable.

This guide is informed by existing guidance from international public health authorities, research findings, and lessons observed from countries that have been battling COVID-19 since January 2020. **It is intended to complement, but not in any federal and local public health and other authorities.**

### Overview for the Guide

This guide is intended to inform and assist leaders and public officials at any sub-national level with strategy and decision-making on COVID-19 response. It is NOT a prescriptive set of instructions; rather it provides a framework and advice on how to tailor principles of outbreak control strategy, disaster management, and evolving knowledge on COVID-19 dynamics to different local conditions.

**Given that this virus currently has no proven vaccines or treatments, the most important way to limit COVID-19 mortality in the near to medium term is to slow and reduce transmission – resulting in fewer cases, improving health outcomes for those who do become sick, and preventing disruption to routine healthcare.** However, the tactics for doing this must be tailored to the risk and capacities of every country, and may look different in high-income and low-income environments. Some pillars of response strategy in developed countries may be less feasible in low-income settings – notably prolonged “lockdowns” that greatly limit human mobility and access to labor; widespread testing; and sophisticated clinical case management. However, even where it may be difficult to reduce transmission to zero, it will be possible to significantly slow it through robust application of traditional public health measures. Some low-income settings may choose to abbreviate, adapt, or avoid the “lockdown” phase used in other countries and pivot to robust contact tracing paired with sustainable physical distancing measures and efforts to provide additional protection to high risk groups.

Measures to slow the spread of COVID-19 are vitally important, even in countries where containment may be unrealistic. COVID-19 cases requiring medical intervention are *in addition* to the existing healthcare demand, and experience from China, Italy, Brazil, the United Kingdom and the United States shows that unchecked spread of the virus has the potential to rapidly and abruptly overwhelm local health systems and disrupt routine care. While the world’s understanding of COVID-19 is still evolving, it is clear that the disease is many times more dangerous than seasonal flu (which has a fatality rate of approximately 0.1%). Recorded case fatality rates in various countries have ranged from more than 10% (Italy, United Kingdom, Spain) to low single digits (China, US, Germany). South Korea, which has extensive testing, has recorded a case fatality rate of approximately 2%, or 20 times as high as seasonal flu. It is important to note that these case fatality rates may be an overestimation if mild or asymptomatic cases are not part of the calculation due to low testing rates – and that high case fatality rates may themselves be an indicator of widespread transmission undetected by the existing testing infrastructure.

**During the early phase of a local community’s COVID-19 outbreak, all elements of an initial response strategy should connect to the overarching goal of limiting deaths by reducing overall transmission.** Especially in environments where healthcare access and the capacity of the existing healthcare infrastructure is limited, it is vital to reduce overall number of cases in order to minimize the number of severe cases and to ultimately reduce the number of fatalities. Delayed actions to reduce transmission allow the disease to spread widely, generating a sudden surge in critically ill cases, eroding care quality, and worsening fatality rates. The difference between these scenarios may be as little as days or weeks.

Once transmission rates have been reduced and the burden on the healthcare system has declined, it will eventually become possible to consider incrementally relaxing the range of distancing measures put in place to limit transmission.

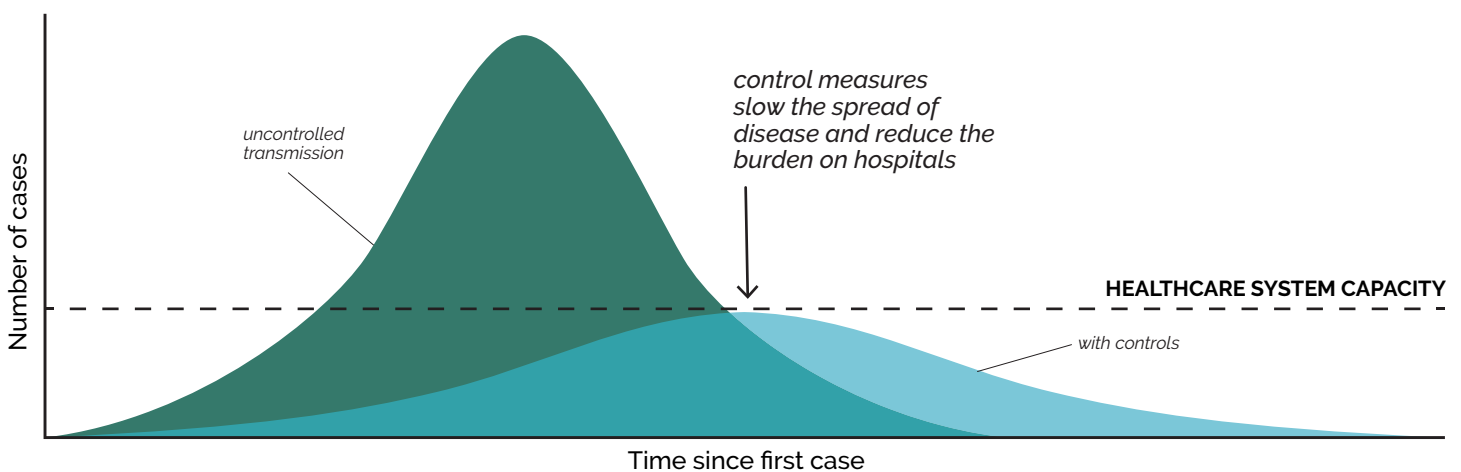


Figure 1. A conceptual overview of the impact of applied control measures in reducing the rate of spread of COVID-19, and how they can, hypothetically, limit the burden on the health system.

## Phases of COVID-19 in a Community

**Given the existence of widespread community transmission throughout the globe, all local leaders should be preparing with the expectation that they could face large-scale community transmission.** Undetected community transmission can rapidly evolve into an overwhelming outbreak. Given limitations in testing and surveillance, information will be imperfect or incomplete and it may not always be possible to assess the state of the outbreak in real time. Local leaders may need to make decisions about social distancing or other non-pharmaceutical interventions using imperfect data. Outbreaks are not always linear -- apparent declines in transmission are reversible, and a community may experience multiple waves of cases.

If increased transmission occurs, drastic measures may be required to contain it. These measures must be calibrated to the specific risks and capacities of the country or community. The "lockdown" approaches applied to halt explosive transmission in wealthy countries may not be replicable in developing countries, where the populations over the age of 65 are smaller, where public health and disease surveillance initiatives

often rely on in-person community outreach, and where there is less ability to cushion the economic and food security shocks a lockdown imposes. Developing countries may instead pursue sustainable mitigation: scalable measures to slow transmission such as physical distancing measures and large-scale contact tracing, linked to supportive quarantine and isolation of cases and identified contacts.

While many graphics show only a single rise and fall of caseload, it is likely that there will be multiple stages of an outbreak with multiple curves, particularly in the mitigation and suppression phase following the initial surge in cases. Absent sufficient testing, effective contact tracing, and available hospital capacity, an initial plateauing or decline in cases is not sufficient basis for relaxing physical distancing or other containment measures. Communities with declining cases may suddenly see an increase due to a variety of factors including, but not limited to, an increase in testing or a change in reporting requirements, a premature relaxation of control measures, and/or importation of new cases.



## Key Objectives for Addressing COVID-19 at the Community Level

The guide below provides local leaders with key questions to ask, answer, and track as they initiate COVID-19 preparedness and response in lower-resource settings.



### KEY OBJECTIVE #1 Calibrate COVID-19 strategy to local needs, risks, and capacities

The costs and benefits of different response tactics will vary from country to country. Community response tactics must be adapted to the specific risks, vulnerabilities, and capacities that exist locally. Tactics suited to a dense urban environment may not apply in a rural setting; tactics that work in a wealthy country with a strong social welfare system may not work in a developing country with a large informal economy. In any setting, the priority is for local leaders to assess their existing capacity and develop a local response strategy that adapts the measures outlined below – operational coordination, slowing transmission, protecting high risk populations, protecting the health system, communicating effectively – to their own particular context. Identifying the most critical priorities will also help local leaders form the partnerships with non-governmental organizations, national leaders, and the private sector that are necessary to bolster existing capacities and to enable a more robust response.



### KEY OBJECTIVE #2 Activate an Emergency Operations Center (EOC) and establish a whole-of-community incident management structure

Controlling a pandemic outbreak is a multi-disciplinary and whole-of-society endeavor, and the leadership and management structure must reflect that. Community leaders should utilize an incident management system to provide empowered operational coordination. Decision making ability should be as devolved as practicable to allow for fast action while balancing reporting and accountability. This is especially important for transmission control in contexts where delays in data reporting at the national level make responsive top-down guidance unfeasible. Activating an Emergency Operations Center as an enabling component of an effective incident management system is a best practice used in previous large-scale outbreaks like Ebola. The EOC should host an incident management structure representative of the community. A whole-of-community EOC can improve and streamline communication, planning, decision-making, and operational coordination across a wide range of community leaders and stakeholders, including communication and alignment with higher-level (such as the regional or national level) EOC processes and decision cycles. The EOC should also have liaisons to, or representatives from, other levels of government, humanitarian and development partners, public health officials, civil society, religious leaders, the business community, academia, and others.

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### KEY OBJECTIVE #3

#### Expand risk communication and community engagement

Risk communications promote the real-time exchange of information, advice and opinions among relevant experts and communities facing risks to their health, social, and/or economic well-being. The effectiveness of a national response to any major public health event depends heavily on the ability of national and sub-national leaders to communicate with all stakeholders throughout the cycle of an outbreak. Public officials have an obligation to accurately and transparently relay risk information, even (or perhaps especially) when it is alarming. Community trust can make or break an outbreak response, because the effectiveness of physical distancing and other interventions hinges on community compliance, and public trust may be undermined when messages do not align with local practices, capabilities, and beliefs. Risk communication should follow best practices to mobilize informed action rather than inducing panic. Identifying and partnering with community representatives from trusted non-governmental organizations, faith-based groups, and other informal structures is critical to building and maintaining the trust of the community; ideally these stakeholders should be represented in EOC coordination and planning. In rural and other settings where public health messaging typically relies on in-person outreach by community health workers, radio and loudspeaker messages might be considered while adhering to physical distancing. These materials should be translated into all relevant languages to ensure that outreach efforts are not inadvertently missing some communities. Utilization of existing community health workers from other programs may be especially helpful in hard-to-reach settings.

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### KEY OBJECTIVE #4

#### Understand the real-time spread of COVID-19 in the community

A pandemic control strategy is grounded in understanding ongoing transmission risk in the community. This requires continuous disease surveillance, diagnostic testing, and reporting systems that ensure up-to-date information on local spread is available to inform strategy-setting and daily tactical decision-making. While scaling up and sustaining local access to centralized testing resources is an important strategy when feasible, this may be difficult where limited access to healthcare, laboratory facilities, and supplies may prevent widespread testing without targeted capacity building. To understand transmission in the absence of widespread testing, communities can establish or enhance syndromic surveillance (for acute respiratory and influenza-like illness), integrated surveillance systems (by introducing COVID-19 surveillance into existing programs for polio, tuberculosis, or malaria), and other dynamic surveillance tools to gauge disease activity within the community, including community leaders and trusted personnel who can be trained as contact tracers. In the absence of widespread testing or confirmed case counts, countries may want to consider other types of data – such as the percent of tests that return positive for COVID-19, cause-of-death indicators, infections among healthcare workers, and excess mortality – to inform operational decisions. In settings where sample transport, internet connectivity, and data aggregation may impact case reporting, these delays (in addition to the incubation period) should be accounted for when assessing “real-time” transmission.



 5**KEY OBJECTIVE #5****Slow and reduce transmission**

Slowing and limiting transmission within a community is central to reducing the near-term human cost of the outbreak and ensuring that healthcare facilities will be able to continue to provide lifesaving and life sustaining care as well as routine medical services. Decisions on measures to slow and reduce transmission should be developed based on the amount of protection they provide and the severity of the secondary disruptions they may impose. Large-scale contact tracing should be a priority in all settings, as identification and isolation of infected contacts offers the best enduring protection against spread of the virus. Widespread wearing of non-medical cloth masks in public settings is likely to reduce transmission from pre-symptomatic individuals as well as symptomatic individuals who cannot physically distance themselves. Cotton masks may be an accessible control measure even in very low-resource settings. If they can be maintained, strategically placed handwashing or sanitizing stations, such as at market entrances and exits, may also help to slow transmission. Highly disruptive lockdown measures may be merited – for a limited period – if communities have the capacity to mitigate the accompanying economic disruption and can use the lockdown to buy time to reinforce preparedness measures. Countries whose demographics skew younger and which lack the ability to mitigate disruption to livelihoods and basic public services may be able to limit their reliance on lockdown tactics.

 6**KEY OBJECTIVE #6****Protect vulnerable groups**

COVID-19 poses extreme risks to older individuals and those with complicating health conditions. Vulnerable groups can also include people living in high-risk settings such as informal settlements and those working in the informal economy without social protections, or those who otherwise live or work in close quarters in factories, dormitories, and similar settings. Groups experiencing widespread food insecurity, malnutrition, and large health burdens from other infectious diseases such as HIV and TB may also be at higher risk of severe illness from COVID-19, although this requires more study. To reduce risks to these groups, community leaders should monitor and engage with specific locations where high-risk populations are concentrated; assess hygiene infrastructure, community practices and leadership, and communication practices; develop local strategies and guidance for group isolation and delivery of health services; and extend basic services (e.g. handwashing stations, masks, cash transfer/mobile money) where possible.

 7**KEY OBJECTIVE #7****Reinforce and expand health system surge capacity to sustain healthcare operations and avoid high mortality**

The mortality risk posed by COVID-19 can grow substantially if a healthcare system becomes overwhelmed and regular services cannot be provided or are prevented by strict lockdown conditions. Especially in contexts where transmissible diseases pose a significant health burden, disrupting non-COVID-19 health services – such as maternal and child health, immunizations, and management of noncommunicable diseases – could threaten as many lives as COVID-19 does or more, so urgent action should be taken to minimize disruption to routine healthcare. Measures to prevent transmission in health facilities – such as enhanced triage, improved sanitation and infection prevention and control, and segregation of COVID-19 and non-COVID-19 health services – may all be helpful strategies. Safe and dignified management of the deceased will also be an important consideration if the virus spreads on a large scale. Healthcare facilities should also assess current supply availability and project future needs, forming partnerships with the private sector to strengthen the supply chain.

 8**KEY OBJECTIVE #8****Mitigate economic and social consequences of the COVID-19 pandemic**

Pandemic outbreaks can cause enormous social and economic disruption. These disruptions are damaging in their own right, but can be particularly problematic if they create economic disincentives to cooperation with physical distancing measures. These disruptions will not fall equally across all sectors of society. Analysis of gender dynamics, informal economies, and social and political marginalization will be critical to ensure that economic mitigation measures, where available, are targeted toward those most in need. Mitigating these disruptions can help to reduce the human cost of the outbreak, beyond the immediate toll of the disease itself. Leaders should also pay careful attention to the impact that both the outbreak itself, and the measures to control it, may have on vulnerable populations.



## INDICATORS OF PROGRESS



### 1 Criteria to consider prior to relaxing physical distancing orders within the community.

- |  |     |    |
|--|-----|----|
| a. Are surveillance measures in place to enable robust early identification of future increases in transmission?                                       | yes | no |
| b. Are most new cases coming from among identified contacts?   | yes | no |
| c. Among tests conducted, is the percentage of positive test results declining?  | yes | no |
| d. Are hospitals and health centers able to treat all patients without resorting to crisis standards of care?  | yes | no |
| e. Have hospitals, health centers, and community health worker networks developed sufficient surge capacity to deal with future spikes in case counts? | yes | no |
| f. If a-e are in place, have daily case counts declined for at least 14 consecutive days (at least one incubation period)?                             | yes | no |



### 2 Activation of an emergency operations center (EOC) or similar incident management structure to manage local response efforts.

- |   |     |    |
|---|-----|----|
| a. Is there a clearly designated and empowered incident manager?  | yes | no |
| b. Are there clearly designated organizational units in the EOC aligned with principal operational priorities (e.g., testing, hospital capacity, crisis communication, protection of vulnerable populations, etc.)? | yes | no |



### 2 EOC staff and key leaders understand principles and practice of the Incident Management System (IMS) structure.

- |  |     |    |
|--|-----|----|
| a. Have they received recent training?   | yes | no |
| b. Does community leadership have an accurate understanding of the level of COVID-19 transmission?                                       | yes | no |
| c. Does the general public in the community have an accurate understanding of the status of COVID-19 transmission through daily updates? | yes | no |

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INDICATORS OF PROGRESS (CONTINUED)

- |          |  |            |           |
|----------|--|------------|-----------|
| <b>3</b> | <b>Implementation of</b>   |            |           |
|          | a) an operational crisis communication strategy, including scheduled updates and clear lines of communication with critical local and national stakeholders; and | <i>yes</i> | <i>no</i> |
|          | b) a public risk communication strategy including regular, real-time updates for public receipt.   | <i>yes</i> | <i>no</i> |

- |          |   |            |           |
|----------|---|------------|-----------|
| <b>4</b> | <b>COVID-19 testing and disease surveillance throughout the community.</b>  |            |           |
|          | a. Have clinical personnel at all levels been trained on COVID-19 symptoms, protocols, and reporting procedures?  | <i>yes</i> | <i>no</i> |
|          | b. Is COVID-19 testing available at sub-national or local-level facilities?   | <i>yes</i> | <i>no</i> |
|          | i. If sufficient testing is not available, have contextually relevant proxy indicators for COVID-19 disease surveillance been identified?   | <i>yes</i> | <i>no</i> |
|          | ii. Is access to testing available beyond major urban centers? If not, have other surveillance strategies been initiated in places where access to testing is limited? What percentage of the population is captured by testing capacities? | <i>yes</i> | <i>no</i> |
|          | c. Are specimen referral and sample transport mechanisms in place?  | <i>yes</i> | <i>no</i> |
|          | d. Are syndromic (symptom-based) surveillance efforts to report suspected cases in place?   | <i>yes</i> | <i>no</i> |
|          | e. Is the existing pipeline of testing supplies sufficient to sustain an adequate level of testing?   | <i>yes</i> | <i>no</i> |
|          | f. Are testing and surveillance systems linked to contact tracing?  | <i>yes</i> | <i>no</i> |

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**INDICATORS OF PROGRESS (CONTINUED)**

**5**

**Sustainable measures to slow and reduce transmission.**

- a. Is there sufficient contact tracing capacity to trace 90% of contacts of all identified and suspect cases? yes no
- b. Is there a clear policy for isolating identified and suspect cases, and quarantining their close contacts? yes no
  - i. Have special facilities been established to enable supported and safe quarantine and isolation outside of homes? yes no
- c. Are non-lockdown physical distancing measures in place (bans on large gatherings, mask-wearing regulations, occupancy limits in businesses and on buses, work-from-home, distancing measures required in public places, etc.)? yes no
- d. If considering “lockdown” measures, is the community capable of sustaining them and managing the impact on food security and economic livelihoods for at least 6 weeks? Are there clear metrics for determining when the lockdown can be safely lifted? Who would make that decision? yes no
- e. If considering lockdown measures, how will authorities use the lockdown period to significantly enhance preparedness and safely lift the lockdown? yes no

**5**

**Infection, prevention, and control practices have been implemented to prevent disruptions in critical services, including:**

- a. Food supply and distribution? yes no
- b. Health system? yes no
- c. Water distribution? yes no
- d. Waste management? yes no
- e. Electricity? yes no

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**INDICATORS OF PROGRESS (CONTINUED)**



**Institute protective measures for vulnerable populations as much as possible.**

- |    |  |            |           |
|----|--|------------|-----------|
| a. | Has a comprehensive list of vulnerable populations been compiled?  | <i>yes</i> | <i>no</i> |
| b. | Do high-risk locations (slums, prisons, densely packed apartment buildings or migrant worker dormitories, refugee or IDP camps, or other locations where physical distancing is difficult) have sufficient access to hygiene and sanitation, masks, and other infection prevention measures? | <i>yes</i> | <i>no</i> |
| c. | Have all gaps identified in high-risk locations been assessed and addressed? If identified gaps cannot be addressed due to resource constraints, have they been flagged as potential risk factors?   | <i>yes</i> | <i>no</i> |
| d. | Are there strategies, such as low-cost partitions or supported isolation facilities, to protect high risk individuals (including the elderly or people with health complications) who are living in households?  | <i>yes</i> | <i>no</i> |

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**INDICATORS OF PROGRESS (CONTINUED)**

<b>7</b>	<b>Availability of acute care treatment capacity in the community.</b>		
	a. Are the healthcare facilities in the community able to meet current and projected demand for patient care capacity?	<i>yes</i>	<i>no</i>
	b. Do healthcare workers have the appropriate training and supplies to prevent nosocomial transmission?	<i>yes</i>	<i>no</i>
	c. Can approximate anticipated bed and supply needs be projected over the next two weeks?	<i>yes</i>	<i>no</i>
	d. Are measures being implemented to expand critical care/intensive care unit capacity?	<i>yes</i>	<i>no</i>
	e. Where possible, has surge production or purchasing been initiated for oxygen supply systems (concentrators, splitters, consumables, pulse oximeters, etc.) and are trained biomedical technicians available at points of use?	<i>yes</i>	<i>no</i>
	f. Are local health care facilities able to separate intake for patients with COVID-19 or acute respiratory infection (ARI) from those needing other types of care?	<i>yes</i>	<i>no</i>
	g. Have user fees for health services been waived for COVID-19 treatment?	<i>yes</i>	<i>no</i>

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<b>7</b>	<b>Supply of personal protective equipment (PPE) available for health systems. Essential PPE supplies are defined and PPE reuse strategies and procedures are defined, available to all users, and implementable.</b>	<i>yes</i>	<i>no</i>
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 1**KEY OBJECTIVE #1****Calibrate COVID-19 strategy to local needs, risks, and capacities**

The costs and benefits of different response tactics will vary from country to country. Community response tactics must be adapted to the specific risks, vulnerabilities, and capacities that exist locally. Tactics suited to a dense urban environment may not apply in a rural setting; tactics that work in a wealthy country with a strong social welfare system may not work in a developing country with a large informal economy. In any setting, the priority is for local leaders to assess their existing capacity and develop a local response strategy that adapts the measures outlined below – operational coordination, slowing transmission, protecting high risk populations, protecting the health system, communicating effectively – to their own particular context. Identifying the most critical priorities will also help local leaders form the partnerships with non-governmental organizations, national leaders, and the private sector that are necessary to bolster existing capacities and to enable a more robust response.

**PRIORITY ACTIONS**

- **Conduct a community-level needs assessment using available data**
- **Identify high-risk sectors of the community and consider all populations and needs within**
- **Determine the capacity of government and nongovernmental entities operating within the population**
- **Evaluate the cost/benefit of possible containment measures and the economic and social disruption they may cause**
- **Develop an Action Plan (while considering the other objectives of this guide) and implement**

**Operational Requirements**

1. Have community leaders developed an action group or task force to conduct a needs assessment for the COVID-19 response? (Resources available [here](#) and [here](#))
  - a. Are there existing needs assessments that can be adapted for this exercise?

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**KEY OBJECTIVE #1 (CONTINUED)**

*Calibrate COVID-19 strategy to local needs, risks, and capacities*

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**Operational Requirements (continued)**

- b. Does the task force engage relevant stakeholders (first responders, healthcare facility managers, business managers, informal community leaders, religious leaders, etc.) to understand the range of needs within the community?
  - c. How does this plan feed into the national action plan? What is the two-way chain of communication between community and national leaders?
- 
2. Has the community developed a prioritized action plan covering:
- a. Community capacities and needs?
  - b. Potential partnerships to fill critical needs? (Resources available [here](#))
  - c. Needs of vulnerable or at-risk populations?
  - d. Secondary or tertiary impacts of physical distancing measures, such as access to food and reductions in income?
  - e. Resource needs for emergency operations?
- 
3. Have community leaders assessed the following before pursuing lockdowns or closures? Consider that without access to most of these community members will need to make frequent trips into the community to survive regardless of orders. (Resource available [here](#))
- a. How long can households maintain their livelihoods and food supplies under a lockdown, particularly if their livelihoods are dependent on day labor or informal economic activity?
  - b. Are there available means to offset the economic damage of a sustained lockdown order?
  - c. What proportion of the population is high-risk for severe COVID-19 health impacts, and how does this compare to the proportion of the population that could face life-threatening economic and food security impacts?
  - d. Do people have access to safe drinking water in the home?

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**KEY OBJECTIVE #1 (CONTINUED)**

*Calibrate COVID-19 strategy to local needs, risks, and capacities*

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**Operational Requirements (continued)**

- e. Is there adequate sanitation in the home?
  - f. Do homes have a reliable source of energy?
  - g. Is there access to information or communications technology in homes?
- 
4. Are humanitarian and development partners engaged in supporting locally-led efforts?
- a. Are NGOs or UN partners active in the area, and do they have programs relevant to the COVID-19 response?
  - b. Are NGOs or UN partners able to maintain normal operations under physical distancing conditions? For what services (food distribution, etc.) might exceptions to distancing regulations be provided?
  - c. Are aid organizations coordinating their efforts with local authorities?
  - d. Are aid organizations reflecting local priorities in their own programs and fundraising?
- 
5. What is the current capacity for local financing of the response effort? (Resource available [here](#))
- a. Is there a clear understanding of what resources will be available from outside sources (central government, aid organizations, etc.)?
  - b. Is there a strategy to coordinate and advocate with the government, aid groups, and donors for additional resources?
  - c. Is there a projection of the budget required for the community-level response, based on the risk assessment?
- 
6. Is there a data dashboard or other method to track implementation of the Action Plan? Can the task force assess if their plan is making an impact? (Resources available [here](#) and [here](#))
- a. What indicators will be used for situation and needs monitoring?

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**KEY OBJECTIVE #1 (CONTINUED)**

*Calibrate COVID-19 strategy to local needs, risks, and capacities*

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**Operational Requirements (continued)**

- b. Has the task force identified likely “blind spots” in data, and developed plans for decision-making in data-scarce conditions?
- 

**Resources**

[Public Health and Social Measures for COVID-19 Preparedness and Response in Low Capacity and Humanitarian Settings. \(IASC\)](#)

[Guide: Undertaking Needs Assessments \(Australian Workforce Council\)](#)

[Participant Workbook, Community Needs Assessment \(U.S. CDC\)](#)

[Global Humanitarian Response Plan COVID-19 \(United Nations Coordinated Appeal\) – Particularly the Monitoring Framework on pages 32 – 34](#)

[Critical Preparedness, Readiness, and Response Actions for COVID-19 \(WHO\)](#)

[COVID-19 Emergency Response – Local Government Finance \(UN CDF\)](#)

[Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study \(Lancet\)](#)



## KEY OBJECTIVE #2

### Activate an Emergency Operations Center and establish a whole-of-community incident management structure

Controlling a pandemic outbreak is a multi-disciplinary and whole-of-society endeavor, and the leadership and management structure must reflect that. Community leaders should utilize an incident management system to provide empowered operational coordination. Decision making ability should be as devolved as practicable to allow for fast action while balancing reporting and accountability. This is especially important for transmission control in contexts where delays in data reporting at the national level make responsive top-down guidance unfeasible. Activating an Emergency Operations Center as an enabling component of an effective incident management system is a best practice used in previous large-scale outbreaks like Ebola. The EOC should host an incident management structure representative of the community. A whole-of-community EOC can improve and streamline communication, planning, decision-making, and operational coordination across a wide range of community leaders and stakeholders, including communication and alignment with higher-level (such as the regional or national level) EOC processes and decision cycles. The EOC should also have liaisons to, or representatives from, other levels of government, humanitarian and development partners, public health officials, civil society, religious leaders, the business community, academia, and others.

#### PRIORITY ACTIONS

- **Activate or establish local coordinating body (Emergency Operations Center or similar structure) to coordinate the local response and link to higher-level coordination**
- **Designate an empowered Incident Manager**
- **Organize functional units/teams around major operational priorities**
- **Establish liaisons with key government partners local, regional and national stakeholders**

#### Operational Requirements

1. Does a **crisis response structure** already exist in the community? Is it formal or informal?
  - a. Is there an incident management system (IMS) in place with clear lines of authority? Or a comparable existing body that could be used for this purpose? (Resources available [here](#), [here](#) and [here](#))

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**KEY OBJECTIVE #2 (CONTINUED)**

*Activate an Emergency Operations Center and establish a whole-of-community incident management structure*

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**Operational Requirements (continued)**

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2. Is there a **crisis manager** responsible for operations of the EOC or coordination structure? Does the crisis manager have clearly identified decision-making authorities?
  - a. Are there clearly defined roles and responsibilities for all staff? Are lines of communication among staff clearly defined?
  - b. Is the coordination structure divided into working groups that can focus on specific areas of need? Operations? Communications? Data and reporting? Logistics? Finances?
  - c. How will the IMS be affected if personnel are diagnosed with or exhibiting symptoms of COVID? Can the IMS work virtually if needed? Are there plans and infrastructure in for these circumstances?

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3. Is there a dashboard with key performance indicators and is it updated regularly?

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4. Does the IMS have liaison and information-sharing links with:
  - a. Existing national response structures and emergency operations center?
  - b. Local or international partners providing care or supporting operations in the area?
  - c. Other sectors of the local community (private sector, UN clusters, civil society, marginalized communities)?
  - d. Local clinicians and laboratories for gathering of case information?

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5. Is there an existing infectious disease response plan developed? If this plan is at the national level, can local operations integrate accordingly?
  - a. Is the local plan based on a recent risk assessment of the community? Does it incorporate local resources and needs to execute an effective response (based on a needs assessment)? What parts of the community are most at risk?
  - b. Are there personnel in the community who have experience in emergency response? Are they available to work? Can they rapidly train others?

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**KEY OBJECTIVE #2 (CONTINUED)**

*Activate an Emergency Operations Center and establish a whole-of-community incident management structure*

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**Operational Requirements (continued)**

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6. Is there a way to dedicate space to a physical emergency operations center (EOC)? Can ICM operations be facilitated through the EOC to ensure comprehensive operations? (Resources available [here](#), [here](#) and [here](#))
    - a. Is the space utilized able to support operations? Are infrastructure and information systems appropriate?
    - b. Is there space for all relevant working groups and partners involved in the ICS?
    - c. Are there technologies in the facility that would help with operations, case tracking, and other areas of operations?
- 

**Resources**

[Framework for a Public Health Emergency Operations Centre \(WHO\)](#)

[Handbook for Developing a Public Health Emergency Operations Centre \(WHO\)](#)

[Containment of Ebola and Polio in Low-Resource Settings Using Principles and Practices of Emergency Operations Centers in Public Health. \(Journal of Public Health Management Practices\)](#)

[Useful Links and Publications \(WHO\)](#)



## KEY OBJECTIVE #3

### Expand risk communication and community engagement

Risk communications promote the real-time exchange of information, advice and opinions among relevant experts and communities facing risks to their health, social, and/or economic well-being. The effectiveness of a national response to any major public health event depends heavily on the ability of national and sub-national leaders to communicate with all stakeholders throughout the cycle of an outbreak. Public officials have an obligation to accurately and transparently relay risk information, even (or perhaps especially) when it is alarming. Community trust can make or break an outbreak response, because the effectiveness of physical distancing and other interventions hinges on community compliance, and public trust may be undermined when messages do not align with local practices, capabilities, and beliefs. Risk communication should follow best practices to mobilize informed action rather than inducing panic. Identifying and partnering with community representatives from trusted non-governmental organizations, faith-based groups, and other informal structures is critical to building and maintaining the trust of the community; ideally these stakeholders should be represented in EOC coordination and planning. In rural and other settings where public health messaging typically relies on in-person outreach by community health workers, radio and loudspeaker messages might be considered while adhering to physical distancing. These materials should be translated into all relevant languages to ensure that outreach efforts are not inadvertently missing some communities. Utilization of existing community health workers from other programs may be especially helpful in hard-to-reach settings.

#### PRIORITY ACTIONS

- **Establish regular information sharing in collaboration with the community in local languages and dialects**
- **Ensure that community-engagement is a two-way process that promotes messaging for safe community behaviors while also channeling community input back into response strategy and decision-making**
- **Build trust between local leadership, business, religious, and other civil society members to effectively inform communities through the co-creation, review, and dissemination of credible materials and campaigns.**
- **Develop messaging and guidance in light of community centered needs**

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**KEY OBJECTIVE #3 (CONTINUED)**

*Expand risk communication and community engagement*

**Operational Requirements**

1. Is there a routine process for consistently communicating with and updating the community? (Resources available [here](#) and [here](#))
  - a. Have the most effective visual and written communication methods been identified?
  - b. Is information available in all relevant languages or dialects?
  - c. Which populations are communications least likely to reach?
  - d. Is there an effective way to dispel disinformation or misinformation?
  - e. Is community leadership, or consistent and trusted representatives, regularly and effectively communicating with various sectors of society, government and non-governmental organizations (policy, education, etc.)?

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2. In all phases of an outbreak, is leadership able to: (Resource available [here](#))
  - a. Encourage community members to adopt protective behaviors appropriate to the outbreak phase?
  - b. Manage expectations and communicate uncertainties?
  - c. Provide information and guidance in collaboration with community members?
  - d. Maintain trust by listening to the population and modifying plans for risk communications depending on people's perceptions and questions?
  - e. Empower and foster resilience in individuals, groups, and communities?

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3. Is community feedback being regularly sought and integrated into response strategy and decision-making? (Resources [here](#) and [here](#))
  - a. Direct engagement with focus groups and key informants
  - b. Opinion polling or survey tools

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4. Are community engagement efforts specifically reaching peripheral or marginalized populations? Are there established and tailored messages and mechanisms for communicating with affected or at-risk populations?

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**KEY OBJECTIVE #3 (CONTINUED)**

*Expand risk communication and community engagement*

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**Additional Considerations**

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5. Have credible and trusted spokespeople been identified and assigned to relay important, fact-based messages to the different groups within the community? Are these spokespeople connected to local leaders and empowered to effectively communicate? (Resource available [here](#))

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6. Are messaging efforts taking mental and psychosocial considerations into account? (Resource available [here](#))

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7. Do messaging efforts work to minimize and mitigate social stigma? (Resource available [here](#))

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8. Are informational materials accessible for all populations in the community, in the most common languages? Are pictorial materials available in areas where literacy rates are low?

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9. Is there a strategy in place for monitoring and addressing people's perceptions, beliefs, and sources of misinformation or disinformation? How does local messaging link to national guidance and outreach?

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**Resources**

[Risk Communication and Community Engagement \(WHO\)](#)

[COVID-19 risk communication package for healthcare facilities \(WHO\)](#)

[COVID-19 Global Communication Network \(Johns Hopkins University\)](#)

[World Health Organization guide for preventing and addressing social stigma associated with COVID-19 \(WHO\)](#)

[Best Practices in Public Health Risk and Crisis Communication](#)

[Risk Communication Training \(TEPHINET\)](#)

[Qualities of an Effective Spokesperson \(US CDC\)](#)

 4**KEY OBJECTIVE #4****Understand the real-time spread of COVID-19 in the community**

A pandemic control strategy is grounded in understanding ongoing transmission risk in the community. This requires continuous disease surveillance, diagnostic testing, and reporting systems that ensure up-to-date information on local spread is available to inform strategy-setting and daily tactical decision-making. While scaling up and sustaining local access to centralized testing resources is an important strategy when feasible, this may be difficult where limited access to healthcare, laboratory facilities, and supplies may prevent widespread testing without targeted capacity building. To understand transmission in the absence of widespread testing, communities can establish or enhance syndromic surveillance (for acute respiratory and influenza-like illness), integrated surveillance systems (by introducing COVID-19 surveillance into existing programs for polio, tuberculosis, or malaria), and other dynamic surveillance tools to gauge disease activity within the community, including community leaders and trusted personnel who can be trained as contact tracers. In the absence of widespread testing or confirmed case counts, countries may want to consider other types of data – such as the percent of tests that return positive for COVID-19, cause-of-death indicators, infections among healthcare workers, and excess mortality – to inform operational decisions. In settings where sample transport, internet connectivity, and data aggregation may impact case reporting, these delays (in addition to the incubation period) should be accounted for when assessing “real-time” transmission.

**PRIORITY ACTIONS**

- **Assess existing diagnostic testing capacity and identify alternate resources**
- **Analyze data from influenza-like-illness (ILI), Severe Acute Respiratory Illnesses (SARI), or other community-based surveillance systems to identify suspected cases**
- **Link any testing and surveillance data to EOC or established reporting structure**
- **Conduct and document formal risk assessment based on current level and trajectory of COVID-19 or ILI/SARI spread in the community**

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**KEY OBJECTIVE #4 (CONTINUED)**

*Understand the real-time spread of COVID-19 in the community*

**Operational Requirements**

1. Does the EOC/IMS have an accurate real-time picture of the trajectory of the outbreak within the community for each of the following: (Resources [here](#) and [here](#))
  - a. Daily suspected (or confirmed) case counts?
  - b. Proportion of new cases from beyond known contacts of existing cases (this is a proxy for degree of community spread)?
  - c. New cases in high-risk settings?
  - d. Total active cases being managed in the health system?
  - e. Number of people in isolation or quarantine?
  - f. Lag time between case onset and receipt of information by EOC?
2. Has a comprehensive surveillance system been implemented to monitor new cases in the community? (Resources [here](#) and [here](#))
  - a. Are health care providers analyzing syndromic data on Influenza-Like Illnesses, Severe Acute Respiratory Illnesses, and/or new indicators to identify suspected cases of COVID-19? How do these indicators account for other high-incidence febrile illnesses?
  - b. Are presumptive positive cases identified through syndromic surveillance linked to contact tracing programs?
  - c. Have standardized reporting forms and databases been established and distributed specifically for COVID-19 surveillance, including for suspect cases and syndromic surveillance?
3. How much demand for testing can be met with current resources? (Resources [here](#) and [here](#))
  - a. Are sufficient test kits available?
  - b. Are health providers able to test all whom they think need diagnosis?
  - c. Is there a reporting structure to ensure medical providers are rapidly notified of results and have a clear plan to communicate to patients?

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**KEY OBJECTIVE #4 (CONTINUED)**

*Understand the real-time spread of COVID-19 in the community*

**Operational Requirements (continued)**

4. **Where testing is insufficient**, has a strategy been developed to prioritize use of existing testing capacity (ex. by testing health care workers, transit workers, settings with high-risk or vulnerable populations, or validating syndromic surveillance indicators)?
5. Are there mechanisms for transporting patient samples to laboratories capable of testing for COVID-19?
  - a. Where can specimen referral systems and shipment reliability be reinforced?
  - b. If transport capacity is likely to remain limited, can it be expanded to a handful of indicator sites (specific clinics or hospitals, displacement camps, secondary urban centers, etc.) outside of the primary urban center?
6. Are community health workers conducting active surveillance in non-clinical settings?

**Additional Considerations**

7. Is data disaggregated by vulnerable population status?
  - a. Sex?
  - b. Age?
  - c. Healthcare worker status?
  - d. Underlying condition status?
8. What financial barriers for patients (clinic fees, additional testing fees, presence of public/private health facilities) might depress reporting?

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**KEY OBJECTIVE #4 (CONTINUED)**

*Understand the real-time spread of COVID-19 in the community*

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**Resources**

[World Health Organization Surveillance Technical Guidance](#)  
(note: includes a template for epi line listings)

[Introduction to Public Health Surveillance \(U.S. CDC\)](#)

[Integration of Private Sector Laboratories in National COVID-19 Response \(Nigeria CDC\)](#)

[Public Health and Social Measures for COVID-19 Preparedness and Response in Low Capacity and Humanitarian Settings. \(IASC\) – particularly p 15-16 on developing a local testing prioritization strategy](#)

[Principles of Epidemiology in Public Health Practice, Third Edition an Introduction to Applied Epidemiology and Biostatistics. Lesson 6: Investigating an Outbreak \(U.S. CDC\)](#)

[World Health Organization Global COVID-19 Clinical Characterization Case Record Form and new data platform for anonymized COVID-19 clinical data \(WHO\) Note: cities do not need to enroll, but this resource includes a checklist of key COVID-19 epi considerations](#)

[Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission \(U.S. CDC\)](#)

[Use of Verbal Autopsy and Social Autopsy in Humanitarian Crises \(BMJ Global Health\)](#)

[Fever Screening \(IN-Q-TEL\)](#)

[Reporting a PUI or Confirmed Case \(U.S. CDC\)](#)

 5**KEY OBJECTIVE #5****Slow and reduce transmission**

Slowing and limiting transmission within a community is central to reducing the near-term human cost of the outbreak and ensuring that healthcare facilities will be able to continue to provide lifesaving and life sustaining care as well as routine medical services. Decisions on measures to slow and reduce transmission should be developed based on the amount of protection they provide and the severity of the secondary disruptions they may impose. Large-scale contact tracing should be a priority in all settings, as identification and isolation of infected contacts offers the best enduring protection against spread of the virus. Widespread wearing of non-medical cloth masks in public settings is likely to reduce transmission from pre-symptomatic individuals as well as symptomatic individuals who cannot physically distance themselves. Cotton masks may be an accessible control measure even in very low-resource settings. If they can be maintained, strategically placed handwashing or sanitizing stations, such as at market entrances and exits, may also help to slow transmission. Highly disruptive lockdown measures may be merited – for a limited period – if communities have the capacity to mitigate the accompanying economic disruption and can use the lockdown to buy time to reinforce preparedness measures. Countries whose demographics skew younger and which lack the ability to mitigate disruption to livelihoods and basic public services may be able to limit their reliance on lockdown tactics.

**PRIORITY ACTIONS**

- **Outline a physical distancing strategy appropriate to the risks and realities of the local community. Assess the net costs and benefits of large-scale lockdowns or other drastic measures.**
- **If the disruptive impact of a lockdown would outweigh the protective public health benefit, shift to other more sustainable distancing measures.**
- **Recruit, train, and scale up a contact tracing workforce capable of rapidly identifying and isolating contacts of positive cases**
- **Reorient Community Health Worker networks to educate the population on COVID-19 protection**
- **Establish mechanisms for supportive quarantine to minimize livelihood disruptions for quarantined households**

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**KEY OBJECTIVE #5 (CONTINUED)***Slow and reduce transmission***PRIORITY ACTIONS (CONTINUED)**

- **Implement a policy for isolating identified and suspect cases, and quarantining their close contacts, and establish special facilities to enable supported and safe isolation outside of homes**
- **Clearly outline local physical distancing guidelines to the community, implement, and maintain them**
- **Establish criteria for essential and non-essential activities**
- **Assess and mitigate secondary impact of physical distancing measures**
- **Plan for future reintegration efforts and what will be needed to bring the community back to normal**

**Operational Requirements**

1. What non-lockdown measures could be applied to slow transmission through physical distancing or behavior change? Depending on the community, have leaders considered implementing the following distancing measures: (Resource available [here](#))
  - a. Canceling mass gatherings?
  - b. Adaptation of public spaces such as markets to minimize close and prolonged contact between people?
  - c. Telework or remote work where feasible?
  - d. School closures and other similar measures?
  - e. Public transportation closures and/or workplace closures?
  - f. Public health quarantine of asymptomatic contacts and isolation of ill individuals?

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**KEY OBJECTIVE #5 (CONTINUED)***Slow and reduce transmission***Operational Requirements (continued)**

- 
2. Have community leaders encouraged the public to adhere to individual- and household-level best practices including: (Resources [here](#) and [here](#))
    - a. Proper hand washing? This is particularly critical in health care facilities. Ideal materials for communities and homes include water/soap or alcohol-based hand rub, ash or mud, and water alone.
    - b. Avoiding close contact?
    - c. Staying home if sick?
    - d. Covering coughs and sneezes?
    - e. Wearing face coverings in public?
    - f. Cleaning and disinfecting?
    - g. Keeping water supplies safe? Boiling supplies? Filtration?
    - h. Proper waste disposal and sanitation? This includes fecal matter, as well as health care waste (tissues and other materials included)

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  3. Does the community have defined thresholds for when to impose or lift measures for physical distancing, including stay-at-home orders, non-essential business and school closures, and curfews? (Resources available [here](#), [here](#), [here](#), [here](#), [here](#), and [here](#))
    - a. Is it early enough in the outbreak to introduce quarantine procedures effectively? Is the setting appropriate and can adequate food, water, and hygiene provisions be made for the quarantine period?
    - b. Has the community established guidance criteria or official limitations on gatherings consistent with current public health guidance (e.g. no gatherings of 10 or more)?
    - c. Is there a way to ensure triage, early recognition, and source control of all cases?
    - d. Should schools be closed to prevent spread?
- 

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**KEY OBJECTIVE #5 (CONTINUED)***Slow and reduce transmission***Operational Requirements (continued)**

- 
4. Have contact tracers been recruited or redirected from other programs?
    - a. Are contact tracers distributed appropriately relative to caseload?
    - b. Are systems in place for clear communication between contact tracers, clinical care providers, and any community isolation facilities?

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  5. Is the community able to manage the bodies of patients who have died from or are suspected to have died from COVID-19? (Resource available [here](#))

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  6. Before considering how to re-open society or adjusting public health and social measures following lockdowns or extended closures, consider the following: (Resource available [here](#))
    - a. Is COVID-19 transmission controlled?
    - b. Are sufficient public health workforce and health system capacities in place?
    - c. Are outbreak risks in high-vulnerability settings minimized?
    - d. Are preventive measures established in workplaces?
    - e. Is testing capacity sufficient to detect new transmission clusters?
    - f. Is the risk of exporting and importing cases from communities with high risks of transmission managed?
    - g. Are communities fully engaged?
- 

**Additional Considerations**

- 
7. Is there a policy on when and how to use masks in the community? (Resource available [here](#))
    - a. Outside of medical usage, consider the purpose, risk of exposure, vulnerability of a population, setting in which the population lives, feasibility, and type of mask utilized.

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**KEY OBJECTIVE #5 (CONTINUED)***Slow and reduce transmission***Additional Considerations (continued)**

- 
8. Is there a plan to incentivize interventions that can slow community spread of disease?
- 
9. Is there a process in place for addressing noncompliance (e.g., fines, criminal charges, etc.)?
- 
10. Is there a way for community leaders to be in contact with organizations in the community, particularly those that may host large gatherings? Do these organizations or sectors have relevant guidance and information? (Resources available [here](#), [here](#), [here](#))
    - a. Religious organizations?
    - b. Sporting events?
    - c. Political rallies, or other events where large numbers of people may gather?
- 
11. Is the community able to locally produce sanitizing hand rubs to help prevent spread? (Resource available [here](#))
- 
12. Are family members or care givers able to care for COVID-19 patients with mild symptoms at home if a health care facility is unavailable? Do they have the knowledge and resources to do so? (Resource available [here](#))
- 
13. Are essential services able to be maintained? If not, are continuity plans in place? (Resource available [here](#))
    - a. Adapt and implement existing plans to COVID-19 when possible.
    - b. Work with partners to identify and support continuation of critical functions (i.e., water and sanitation; fuel and energy; food; telecommunications/internet; finance; law and order; education; and transportation), necessary resources, and essential workforce.
- 

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**KEY OBJECTIVE #5 (CONTINUED)***Slow and reduce transmission***Resources**

[Non-Pharmaceutical Interventions \(NPIs\): Actions to Limit the Spread of the Pandemic in Your Municipality \(PAHO\)](#)

[Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza \(WHO\)](#)

[Guidance for School Settings \(U.S. CDC\)](#)

[Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19 \(WHO\)](#)

[CDC guidance on COVID-19 and mass gatherings \(US CDC\)](#)

 6**KEY OBJECTIVE #6****Protect high-risk groups and vulnerable communities**

COVID-19 poses extreme risks to older individuals and those with complicating health conditions. Vulnerable groups can also include people living in high-risk settings such as informal settlements and those working in the informal economy without social protections, or those who otherwise live or work in close quarters in factories, dormitories, and similar settings. Groups experiencing widespread food insecurity, malnutrition, and large health burdens from other infectious diseases such as HIV and TB may also be at higher risk of severe illness from COVID-19, although this requires more study. To reduce risks to these groups, community leaders should monitor and engage with specific locations where high-risk populations are concentrated; assess hygiene infrastructure, community practices and leadership, and communication practices; develop local strategies and guidance for group isolation and delivery of health services; and extend basic services (e.g. handwashing stations, masks, cash transfer/mobile money) where possible.

**PRIORITY ACTIONS**

- **Establish a comprehensive list of vulnerable communities and the places where they are concentrated (e.g. displacement camps, worker dormitories, temporary settlements, slums, crowded urban centers, prisons)**
- **Assess available WASH (water, sanitation and hygiene) facilities, infection prevention and hygiene practices and supply needs**
- **Address identified areas of insufficiency (e.g. PPE, contact tracers, healthcare workers and their training, infection control practices)**
- **Establish guidance to minimize exposures for vulnerable communities e.g. mask-wearing, physical distancing**
- **Focus on particular on needs of marginalized populations, including refugees or internally displaced populations and detainees**

**Operational Requirements**

1. Has a comprehensive list been compiled of high-risk and vulnerable populations and sites where they are concentrated? Including:
  - a. Populations living or working in sustained close quarters?
  - b. Clusters of elderly individuals?

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**KEY OBJECTIVE #6 (CONTINUED)**

*Protect high-risk groups and vulnerable communities*

**Operational Requirements (continued)**

- c. People living with HIV/AIDS? People with TB?
  - d. Food insecure or malnourished populations?
  - e. Populations with little to no access to regular healthcare?
  - f. Prisons? (Resource available [here](#))
  - g. Refugee and displaced persons camps?
  - h. Slums and other informal settlements?
- 
2. Have assessments considered the specific needs of women and girls within vulnerable populations and high-risk settings?
- 
3. Have community settings with high-risk and vulnerable populations been assessed for effective infection prevention and hygiene practices?
- a. Do the communities have sufficient WASH and hygiene facilities and capacity to maintain them?
  - b. Can supplemental hygiene kits, NFI kits, and cloth masks be provided?  
Can supplemental WASH stations be established and maintained?
- 
4. Have high-risk settings and vulnerable communities received guidance and site-visits to ensure compliance with policies for infection prevention?
- 
5. Are Community Health Workers mobilized to provide support to vulnerable populations?
- 
6. Has visitor access been restricted to settings with high-risk and vulnerable groups?
- 

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**KEY OBJECTIVE #6 (CONTINUED)**

*Protect high-risk groups and vulnerable communities*

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**Resources**

[World Health Organization protocol for assessment of potential risk factors for COVID-19 infection among health care workers in a health care setting \(WHO\)](#)

[Recommendations for Adjusting Food Distribution SOPs in the Context of the COVID-19 Outbreak. \(WFP\)](#)

[COVID-19 and Ending Violence Against Women and Girls \(UN Women\) – Especially p6-7 for example initiatives and specific actions](#)

[Strategic Considerations for Mitigating the Impact of COVID-19 on Key-Population-Focused HIV Programs \(FHI 360\)](#)

[Preparedness, prevention and control of COVID-19 in prisons and other places of detention \(WHO\)](#)

[Coronavirus disease \(COVID-19\) Technical Guidance: Humanitarian operations, camps and other fragile settings \(WHO\)](#)

[Mental health and psychosocial considerations during the COVID-19 outbreak \(WHO\)](#)

 7**KEY OBJECTIVE #7****Reinforce and expand health system surge capacity to sustain healthcare operations and avoid excess mortality**

The mortality risk posed by COVID-19 can grow substantially if a healthcare system becomes overwhelmed and regular services cannot be provided or are prevented by strict lockdown conditions. Especially in contexts where transmissible diseases pose a significant health burden, disrupting non-COVID-19 health services – such as maternal and child health, immunizations, and management of noncommunicable diseases – could threaten as many lives as COVID-19 does or more, so urgent action should be taken to minimize disruption to routine healthcare. Measures to prevent transmission in health facilities – such as enhanced triage, improved sanitation and infection prevention and control, and segregation of COVID-19 and non-COVID-19 health services – may all be helpful strategies. Safe and dignified management of the deceased will also be an important consideration if the virus spreads on a large scale. Healthcare facilities should also assess current supply availability and project future needs, forming partnerships with the private sector to strengthen the supply chain.

**PRIORITY ACTIONS**

- **Bolster or reassign healthcare workforce to manage increased demand**
- **Implement strategy to maintain other critical health services such as maternal and child health and immunizations**
- **Initiate plans to separate screening and intake of potential COVID-19 cases from general health care intake**
- **Assess availability of critical supplies and project needs across the healthcare system**
- **Assess and address gaps in infection prevention and control in health facilities**
- **Track exposure and infections of health workers and assess impact on system capacity**
- **Reinforce oxygen supply systems**
- **Implement strategies for safe management of the deceased**

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**KEY OBJECTIVE #7 (CONTINUED)**

*Reinforce and expand health system surge capacity to sustain healthcare operations and avoid excess mortality*

**Operational Requirements**

1. Has the healthcare community assessed its current workforce capacity and identified methods for filling COVID-19 response needs?
  - a. Has the community identified opportunities for training of additional staff, leveraging academic communities, community healthcare workers assigned to other portfolios (i.e. polio, HIV/AIDS), and out-of-scope practitioners (i.e. pharmacists, dentists, etc.)?
2. Have healthcare user fees been waived for COVID-related medical care?
3. Has the healthcare community developed a strategy for balancing the COVID-19 response with the need to continue to provide essential health services? (Resource available [here](#))
4. Has the health system established a way to track infections among health workers, including contact tracers? Is this information included in capacity projections and updated regularly?
5. Are priority diagnostic tests available for healthcare workers?
6. Do healthcare facilities have clear lines of communication to local contact tracers? Can they initiate contact tracing for presumptive positive patients within 24 hours?
7. Can healthcare facilities establish separate entrances, waiting areas, or bed sites for patients arriving with respiratory complaints? Have they instituted policies about mask-wearing for all patients?
8. Is there any government coordination of access to commodities (i.e. PPE) for both public and private health sectors?
9. Are health facilities able to meet basic infection prevention and control (IPC) standards for COVID? (Resource available [here](#))
  - a. Is sufficient PPE available and can future needs be projected?

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**KEY OBJECTIVE #7 (CONTINUED)**

*Reinforce and expand health system surge capacity to sustain healthcare operations and avoid excess mortality*

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**Operational Requirements (continued)**

- b. Have staff been trained on proper PPE practices, including donning and doffing?
  - c. Are health facilities able to meet essential hygiene and sanitation standards?
  - d. Are health facilities using environmental and engineering controls (patient flow, intake procedures, facility layout and spacing) to reduce the risk of infection?
- 
10. Are there ways to surge capacity for oxygen supply systems, including oxygen concentrators, oxygen splitters, consumables, and pulse oximeters? Are trained biomedical technicians available to proactively service outmoded equipment?
- 
11. Do all those who attend to deceased persons with confirmed or suspected COVID-19 have the guidance and resources to safely and respectfully manage dead bodies? (Resource available [here](#))  
Have hospitals and health centers established relationships with funeral homes, crematoria, etc. to manage anticipated surge in deaths?
- 

**Additional Considerations**

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12. Have response protocols been established and implemented for suspect cases and persons under investigation? (Resource available [here](#))
- a. Do response protocols include steps toward release from isolation or quarantine?
- 
13. Are health facilities receiving timely feedback about COVID-19 test results?
- 
14. Are health facilities receiving up-to-date information about test availability, testing protocols, and syndromic diagnostic guidelines?
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**KEY OBJECTIVE #7 (CONTINUED)**

*Reinforce and expand health system surge capacity to sustain healthcare operations and avoid excess mortality*

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**Resources**

[Infection prevention and control during health care when COVID-19 is suspected \(WHO\)](#)

[Infection prevention and control for the safe management of a dead body in the context of COVID-19 \(WHO\)](#)

[COVID-19 Operational guidance for maintaining essential health services during an outbreak \(WHO\)](#)

[Alliance PPE Supplier Spreadsheet](#)

[Surgical N95 Whitelist of Trusted Suppliers \(US CDC\)](#)

[KN95 Supplier Whitelist \(US FDA\)](#)

[Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\) or Persons Under Investigation for COVID-19 in Healthcare Settings \(US CDC\)](#)

[Strategies for Optimizing the Supply of N95 Respirators \(US CDC\)](#)

[World Health Organization Training for Infection Prevention and Control \(IPC\) for Novel Coronavirus \(COVID-19\) \(WHO\)](#)

[Crisis Standards of Care \(US HHS\)](#)

 8**KEY OBJECTIVE 8****Mitigate economic and social consequences of the COVID-19 pandemic**

Pandemic outbreaks can cause enormous social and economic disruption. These disruptions are damaging in their own right, but can be particularly problematic if they create economic disincentives to cooperation with physical distancing measures. These disruptions will not fall equally across all sectors of society. Analysis of gender dynamics, informal economies, and social and political marginalization will be critical to ensure that economic mitigation measures, where available, are targeted toward those most in need. Mitigating these disruptions can help to reduce the human cost of the outbreak, beyond the immediate toll of the disease itself. Leaders should also pay careful attention to the impact that both the outbreak itself, and the measures to control it, may have on vulnerable populations.

**PRIORITY ACTIONS**

- **Establish mechanisms to assess and address impacts of the pandemic on vulnerable populations (e.g. food insecure families and communities)**
- **Identify any disproportionate impacts on marginalized communities and develop a strategy for proactively mitigating potential unrest**
- **Assess and mitigate impact of physical distancing measures on the local economy, including informal economy, and key workforce sectors (health care, public services, etc.)**
- **If aid organizations are active in the community, engage them toward targeting assistance toward those most at risk of negative impacts related to any lockdown or required distancing measures**
- **Identify and work to mitigate economic disincentives to physical distancing measures**

**Operational Requirements**

1. Have the specific impacts of the pandemic on vulnerable and politically marginal populations been assessed?
2. Are there plans in place to mitigate the challenges of physical distancing, quarantine, and/or isolation on at-risk populations? Is the community able to provide the necessary resources (e.g., food, immunizations, other necessities) to highly vulnerable populations? (Resource available [here](#))

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**KEY OBJECTIVE #8 (CONTINUED)**

*Mitigate economic and social consequences of the COVID-19 pandemic*

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**Operational Requirements (continued)**

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3. Are economic support measures available – including through the national government, safety net programs, or aid groups – to cushion the wider economic impact of the pandemic, and are these tools included in local coordination systems?

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4. Are there mechanisms in place to support neighborhood food distribution and door-to-door service provision?
  - a. Are community maps accurate and updated?
  - b. Are there designated sub-sections for door-to-door distribution across the community?

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**Resources**

[Responding to COVID-19 in Africa: Using Data to Find A Balance \(Prevent Epidemics\)](#)

[Updates on Ongoing Research on the Impact of COVID-19 in Crisis-Affected Countries \(REACH Initiative\) – includes country-level survey data on secondary impacts](#)

[Considerations Relating to Social Distancing Measures in Response to COVID-19 \(European CDC\)](#)