



## **Coronavirus Disease (COVID-19) Pandemic Response** **Quick Reference Guidance for National Societies**

National Societies' and volunteers' roles will change through the progression of the COVID-19 pandemic in their respective countries/communities, based on which public health, clinical and health systems activities are likely to be most impactful. National Societies must work with their public authorities so that both governments and NS understand their respective mandates and the roles the NS is technically and organisationally able to take on. NS must be prepared to change their operations over time to continue in their auxiliary role; as the outbreak progresses, the gaps and needs for effective outbreak response measures may change. Below are some evidence-informed health activities that National Societies can support. These activities may be complemented by other auxiliary roles particular to each National Society's context. Throughout, it is important that National Societies identify their high-risk activities and plan to adapt them to ensure they maintain lifesaving humanitarian services throughout the epidemic.

There are three broad approaches to epidemic response. First, an elimination strategy aims to eliminate human-to-human transmission. This approach requires intensive and sustained interventions, with a focus on identifying, isolating, and treating all cases, and identifying all contacts or people at risk of exposure. These public health measures need to be maintained until the virus is eliminated, while maintaining high levels of surveillance and quarantine for new arrivals to prevent and rapidly identify reintroduction. Reintroduction of cases requires rapid and effective interventions around the case, including contact tracing, quarantine and isolation, and testing. As such, these rapid response capacities must be maintained. Second, suppression strategies aim to maintain very low levels of transmission of the virus but not eliminate it completely from the population. In this case, the above measures need to be sustained indefinitely, including during the roll out of vaccines, as these become available. While maintained, they can have significant social and economic impacts, and require a significant scale-up of health systems capacity. Finally, a mitigation approach seeks to prevent the most significant impacts of the pandemic by protecting the vulnerable (e.g. the elderly and those with underlying diseases), without broadly coordinated public health responses meeting the needs of the broader population. The disruption to health, social and economic systems is likely to be profound. Mitigation strategies are expected to result in significant death and health system impacts. The 'mitigated' epidemic can still be expected to overwhelm the health system with many times more cases than can be properly cared for, resulting in many avoidable deaths, including among people not considered highly vulnerable.

There is now some evidence of the outcomes of countries' strategic choices for pandemic responses. High income nations have largely opted for a suppression strategy, with the goal of flattening the epidemic curve, but without expecting to end community transmission. In contrast, New Zealand successfully switched from a mitigation to an elimination strategy, starting with a stringent countrywide lockdown in late March 2020, lasting 7 weeks. Importantly, the government supported businesses and supplemented the incomes of employees who lost their jobs or whose jobs were threatened. In June, the government declared the national epidemic over. Currently, New Zealand is in the post-elimination stage and vaccine planning has started. International travellers are kept in government-managed quarantine or isolation for 14 days after arrival, not to compromise the country's elimination status. However, future outbreaks cannot be ruled out arising from failures

of border-control and quarantine or isolation policies<sup>1</sup>. Other countries following an elimination strategy include China, Taiwan, and Australia, and have had markedly lower COVID-19 mortality than those in Europe and North America pursuing mitigation and suppression. Furthermore, the effect on gross domestic product (GDP), based on International Monetary Fund projections for all of 2020, was more favourable for countries with elimination than for those with suppression strategies<sup>2</sup>.

At the national and local level, the WHO has divided the COVID-19 outbreak into four distinct phases:

1. No cases (ongoing preparedness)
2. Sporadic cases
3. Clusters of cases over time or in different areas of the country (clusters)
4. Larger-scale outbreaks with local transmission (community transmission)

National Societies can support critical public health, clinical, and health systems activities during each phase, and support vulnerable communities by helping to mitigate the impact the outbreak has on health, social and economic systems. National Societies may need to approach and engage with the Ministry of Health and other actors proactively and repeatedly, identifying the ways in which the pandemic response locally and nationally requires auxiliary support to reduce death, illness, and suffering.

**Community transmission:** Slow large-scale outbreak by helping to reduce transmission of the virus. Support public confidence in the health system and epidemic response, support implementation of outbreak response measures, and carry out effective community engagement, risk communication, behaviour change and hygiene promotion approaches. Support clinical and prehospital care for COVID-19 cases where appropriate. Support access to and availability of existing essential health services for the broader population. Tasks shift and support community-level access to essential health and care services to ease the burden on the health system and to reduce indirect morbidity and mortality. Support the most vulnerable communities affected by the health, social and economic impacts of the outbreak and measures to suppress it.

#### *Community-based actions to reduce transmission and respond to the epidemic*

- Intensify risk communication and community engagement, with focus on strengthening community-led solutions to prevent and control the outbreak (closely linking to health and PSS approaches);
- Motivate acceptance and adherence to community-based protection and home care for COVID-19 and other diseases (based on MOH guidance);
- Provide psychosocial support to reduce the mental health and social wellbeing impacts of the pandemic;
- Support broad access to and availability of testing, contact tracing, surveillance, and COVID-19 immunization activities;
- Cash and/or livelihood support to facilitate quarantine and isolation for low-income cases and contacts;

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<sup>1</sup> Baker, M. G. et al. 2020. Successful elimination of COVID-19 in New Zealand. *The New England Journal of Medicine*, 383:e56. DOI: 10.1056/NEJMc2025203

<sup>2</sup> Baker, M. G., Wilson, N. and Blakely, T. 2020. Elimination could be the optimal response strategy for COVID-19 and other emerging pandemic diseases. *BMJ*, 2020: 371. <http://dx.doi.org/10.1136/bmj.m4907>

- Community health programming (detection and referral, health education and hygiene promotion, support for homebased care as context and mandate dictate), scaled and adapted for medium- to long-term COVID-19 response;
- Inform community and religious leaders and family members about behaviour changes needed to bury people who have died of COVID-19 and reduce the risk of transmission at funerals and other rituals.
- Continually identify systems gaps and weak points in public health response as systems become overloaded, and work with MOH and others to identify ways the NS can support.

*Clinical actions to support outbreak response*

- Clinical, paramedical or homecare service provision to provide specific COVID-19 treatment as per mandated role and where the NS has the capacity to do so in a safe and ethical manner, always ensuring a do-no-harm approach
- Support caregiving to those ill with COVID-19 (clinical, paramedical, as context and mandate dictate), and reduce risk of healthcare worker infection and nosocomial transmission in health facilities.

*Actions to support health systems and mitigate social and economic impact on the most vulnerable*

- Task shift to increase the reach of or access to non-COVID health services;
- Further scale-up of non-COVID related clinical, paramedical, or homecare service provision to supplement health system in cases where capacity is exceeded and where NS has technical capacity to safely support
- Infection prevention and control and other health-system interventions to improve care or access to care
- Cash and/or livelihoods support to address immediate needs/restore income of vulnerable households in communities affected by the pandemic and/or measures taken to contain it
- Promote social cohesion and a culture of non-violence, particularly in communities facing the heaviest burdens

**Sporadic cases or clusters:** Prevent large-scale epidemic with targeted health actions to suppress transmission of the virus when cases are sporadic or clusters have been detected. Support public confidence in the health system and outbreak response measures, and carry out effective community engagement, risk communication, behaviour change and hygiene promotion approaches. Support clinical and prehospital care for COVID-19 cases and maintain access to existing essential health services for the broader population. Support the most vulnerable communities affected by the health, social and economic impacts of the outbreak and measures to suppress it.

*Community-based actions for outbreak prevention and response*

- Risk communication, community engagement, and health promotion, including promoting acceptance of public health measures, social cohesion, and communicating about available services
- Targeted community health, PSS, and WASH programming adapted as "surge" response

- Testing, contact tracing, quarantine and isolation support, and other services in support of government activities to prevent transmission, carried out rapidly and at-scale in order to rapidly contain clusters and prevent community transmission
- Activate community-based surveillance where such systems are in place, and include “cough and difficulty breathing” (or locally appropriate community definition) as a health risk, and “cluster of unusual illnesses or deaths”
- Improve community-level prevention, detection of serious cases, and referral through existing community-based health and surveillance activities in the immediate area experiencing transmission
- Psychosocial support to affected populations, including responders
- Emergency social services for quarantined or movement-restricted communities affected by localized response to the cluster of cases

#### *Clinical actions to support outbreak response*

- Clinical, paramedical or homecare service provision to provide specific COVID-19 treatment as per mandate and in line with pre-existing clinical capacity, always ensuring a do-no-harm approach
- Ongoing refresher training for healthcare workers on clinical and IPC protocols

#### *Actions to support health systems and mitigate social and economic impact on the most vulnerable*

- Cash and/or livelihoods support to address immediate needs/restore income of vulnerable households in communities affected by the outbreak or containment efforts
- Support health system and social services (e.g. scale up services required, direct service provision as appropriate)
- Provide psychosocial support to reduce the mental health and social wellbeing impacts of the outbreak
- Support immediate needs/livelihoods, social services, and health services for general/affected population.
- Maintain or increase existing non-COVID clinical, paramedical or homecare service provision to supplement health system in cases where capacity is stretched

**Preparedness (no cases):** Support authorities and at-risk communities to prepare to respond to first cases (detect, isolate, and treat, trace contacts, quarantine contacts/new arrivals and isolate cases, as appropriate); promote effective behaviour change and hygiene practices, engage communities and address misinformation and rumours; adapt community and clinical programming to be ready to effectively respond and limit risks to personnel; assess NS auxiliary roles and institutional capacities for public health and clinical responses.

#### *Institutional readiness and coordination*

- Establish institutional readiness (business continuity planning; identification of programming changes needed for appropriate outbreak response; institutional linkages to Ministry of Health, Emergency Operations Centres, WHO country offices, Humanitarian Country Teams, and other relevant stakeholders and partners)
- Identify auxiliary role of NS and prepare for designated outbreak response activities (e.g. support to quarantine, contact tracing, point of entry screening)

### *Community-based actions to support health*

- Identify/access most vulnerable communities and systems; knowledge, attitudes and practices of at-risk populations related to COVID-19; barriers to adapting behaviours/preventing transmission
- Enhance NS staff and volunteer capacity to prepare and respond to epidemics and enable community-led planning and action (e.g. community-based health and wash activities, adaptation of existing community-facing programming)
- Risk communication, community engagement, and health promotion, in coordination with key stakeholders

### *Prepare for public health epidemic response actions*

- Determine with local and national health authorities the needs and gaps in epidemic response capacity, particularly risk communication and community engagement, contact tracing, testing, surveillance, and support to people in quarantine or isolation
- Agree with health authorities the roles the NS and volunteers will play in the event cases are detected
- Train and prepare for rapid activation of the NS's agreed epidemic control roles

### *Prepare for clinical actions*

- Assess overall clinical capacity of the health system to respond; clearly identify and define the role of the NS in clinical service provision, including level of care (primary vs prehospital vs tertiary, community vs inpatient) to be provided and ability to increase or adapt to increased demand.
- Preposition appropriate PPE for healthcare activities, adapt facilities to allow for isolation activities and correct patient flow, identify clinical referral pathways, train clinical staff on latest COVID-19 clinical guidelines and on IPC policies.

**Note on PPE:** As per WHO recommendations, contact and droplet precautions must be applied during care for patients with suspected, probable and confirmed COVID-19. Importantly, it is not recommended to reuse PPE or to use gloves in settings where they are not needed. Depending on the type, masks can be used to protect healthy persons or to prevent onward transmission. Medical masks are necessary for anyone suspected or confirmed of having COVID-19 or awaiting viral laboratory tests, when in the presence of others. Guidance on the rational use of PPE, including both clinical and community activities, as well as guidance on mask use in the context of COVID-19, are available on the Health Help Desk.

## **CONSIDERATIONS FOR SCALING-UP RED CROSS RED CRESCENT CLINICAL RESPONSE**

In addition to the above actions, some National Societies with existing clinical or paramedical services may be asked to adapt or scale-up these services, either to specifically support COVID-19 patients, or to improve access or health service availability for the general population experiencing the system-wide impacts of the pandemic. National Societies with existing capacity and previous experience delivering clinical and paramedical services are encouraged to consider the following:

**Things to consider BEFORE scaling up any clinical services:**

- Is this activity being formally requested by National authorities?
- Does this activity fit within the mandate of my NS?
- Is there potential that engaging in this activity may cause harm to patients, staff, or the NS reputation?
- Do we have adequate HR capacity (or the realistic ability to scale up appropriately)? If dealing specifically with COVID19 patients, this capacity must include specialist physicians, high-acuity nurses, clinical support staff, facility management experts, IPC experts, HR management, etc.
- Do we have adequate PPE to carry out the activities? If yes, do we have adequate quantities? If no, how will we source?
- Do we need international support, including global surge human resources or Emergency Response Units, to carry out the planned activities? If yes, strongly reconsider as due to the global nature and scale of this emergency, these resources will most likely not be available for international deployment.

**NS with existing capacity and mandate in hospital-level clinical care pre-COVID should consider:**

*Support to health systems for all or vulnerable populations*

- Scale up hospital care (excluding COVID patients) to support the overall system and reduce the burden on facilities/systems caring for COVID patients
- Scale up primary health care activities (including NCD care, MNCH services including non-complicated deliveries)

*Support to clinical care for COVID-19 patients*

- Scale up hospital care to include COVID patients IF this capacity exists and the NS is mandated to do so by MoH
- Support home care and quarantine activities (for mild to moderate COVID patients) where mandated by MoH

**NS with existing capacity and mandate in primary health care (including outpatient clinical care) should consider:**

*Support to health systems for all or vulnerable populations*

- Scale up primary health care activities (including NCD care, MNCH services including non-complicated deliveries and other primary care services)

*Support to clinical care for COVID-19 patients*

- Support home care and quarantine activities (for mild to moderate COVID patients) where mandated by MoH

**NS with existing capacity and mandate in prehospital care should consider:**

- Scale up and adapt prehospital services as mandated by MoH

**National Societies without existing capacity or mandate in clinical care** and National Societies without any current health mandate or capacities should instead focus on building community and public health and WASH capacity, carrying out effective RCCE activities, and supporting the most vulnerable communities as outlined in the different phases of COVID-19 response above. These interventions that will likewise have a significant impact on both outbreak response and overall humanitarian impact of the pandemic, without the high risk involved with clinical care.