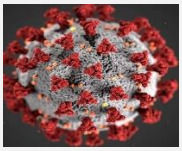
Guideline

for

Integrated Community Case Management

on

COVID-19 RESPONSE



For Village Clinic Trained - Health Surveillance Assistants

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Integrated Community Case Management (ICCM) IN COVID-19 CONTEXT

Background

COVID-19 is a disease caused by a novel coronavirus, SARS-CoV2, which requires precautionary measures.

As trusted members of the community, Health Surveillance Assistants (HSAs) have an important role to play ensuring equitable access and providing lifesaving treatments for the major causes of illness and death in children, namely **malaria, pneumonia, diarrhea, childhood Tuberculosis (TB)** and **acute malnutrition.**
In the context of the current pandemic, HSAs are called upon to provide other valuable services at community level to reduce and stop transmission of COVID-19 including;

- Surveillance and contact tracing
- Referral of presumed COVID-19 cases (following national protocols)
- Provision of key messages to communities and families regarding care seeking
- Infection prevention and control measures
- Provision of advice on home management of COVID-19.

This document provides guidance for community case management of childhood illnesses and conditions with the aim of:

a) Protecting HSAs
b) Maintaining the community's trust in the health system
c) Ensuring uninterrupted continuation of the provision of essential life-saving services for children through iCCM, given that malaria, pneumonia, childhood TB and diarrhea, as well as under-nutrition, will continue to be the leading causes of death among children under five but, in certain settings, COVID-19 might be an important differential diagnosis.

COVID-19 in Children

The symptoms of COVID-19 are unspecific and overlap with symptoms of common childhood illnesses such as malaria, pneumonia, childhood TB and diarrhoea.

COVID-19 symptoms

Symptoms of mild disease include unspecific signs of upper respiratory tract infection, including fever, general tiredness, general body pains, cough, sore throat, runny nose, and sneezing. Some cases may have no fever, or have only digestive symptoms such as nausea, vomiting, abdominal pain and diarrhea.

Children with moderate disease present with pneumonia, frequent fever and cough, mostly dry cough, followed by productive cough, some may have wheezing, but no obvious signs of low oxygen such as shortness of breath. Respiratory symptoms may be accompanied by gastrointestinal symptoms such as diarrhea.

Note**:** Progression to severe disease with hypoxemia (low oxygen in the blood) may happen within the course of one week.

Infection prevention and control (IPC)

COVID-19 is transmitted among people including children through close contact and droplets (those that are asymptomatic and have mild disease can still spread the disease). Preventive and mitigation measures are therefore key to ensure the health and wellbeing of HSAs and the community.
It is therefore important to follow recommended best practices in the prevention and control of COVID-19

Basic principles for Infection Prevention and Control (IPC) by HSAs include:

● Adherence to infection prevention and control (IPC) measures established by authorities and guided by local epidemiology and transmission.

● HSAs should communicate Infection Prevention and Control measures to community members to reduce fear and stigmatization

● Avoid any catchment area activity that attracts crowds. Adapt community based services to ensure spatial distancing among clients (minimum 2 m)

● If HSAs conduct household visits or provide services in their own houses, it is advisable that HSAs identify a well-ventilated location outdoors for the consultation instead of entering the houses.

In case of a lockdown, HSAs are among the essential health service providers that will access community members.

● **Before**, **during** and **after** each **Village Clinic consultation**, the HSAs should practice frequent and appropriate handwashing with soap and clean water or use of hand sanitizer if available.

● Sanitization of surfaces and equipment (thermometers, respiratory timers, MUAC tape) with alcohol or soap and water.

● **Triage** (screening of children, no direct contact): in the absence of PPE, maintain spatial distance of at least 2 meters, triage both caregiver and child for symptoms)

● **Physical examination and performance of tests** such as malaria Rapid Diagnostic Tests (RDTs) requires PPE (at a minimum gloves, ideally gloves & mask and if available a medical mask).

● In the absence of PPE, consider a **'No touch policy**' (ideally 2m distance) that focuses on history of symptoms and clinical observation of the sick child. Certain tasks routinely conducted by HSAs may be shifted to the caregiver with supervision and guidance from the HSAs to minimize direct contact with sick patients.

Note:HSAs are at increased risk of COVID-19 and therefore prevention of transmission is important.

Case Management

Malawi like any other country has been affected by COVID-19. This disease situation has been classified by World Health Organization in four categories.

1. Countries with no cases (no cases);
2. Countries with one or more cases, imported or locally acquired (sporadic cases);
3. Countries experiencing cases clusters in time, geographic location, or common exposure (clusters of cases);
4. Countries experiencing large-scale outbreaks of local transmission (community transmission).

In settings with no cases or sporadic cases

iCCM trained HSAs should continue using the existing iCCM protocols, without changes or modifications, unless containment measures such as physical distancing or lockdowns are put in place that may require low- or no-touch protocols. This is because the level of transmission is minimal.

In this category;

- HSAs, Village Health Committee members and volunteers should reinforce and support early, prompt and appropriate care seeking for sick children.
- HSAs should be conversant with key messages on COVID-19 to mitigate the spread of misinformation and stigmatization in their communities that might negatively impact care seeking, and to effectively communicate information on prevention measures.
- HSAs who are providing village clinic services in their homes should operate on a place where physical distance will be easy to enact (away from their houses). The place should be well ventilated.
- Adherence to IPC protocols is highly encouraged especially increased frequency of handwashing with soap and clean water.
- HSAs should be prepared for service delivery modifications depending on advice from the Ministry of Health.

Communities with localized clusters (e.g. urban centers or regional transportation hubs) or community transmission

In this category the level of transmission is high. Cases can be identified from catchment areas or particular geographical location**.** ICCM protocols will be slightly modified. The main principle is to maintain equitable, quality case management for childhood illness while identifying children with possible COVID-19 as much as possible, and minimizing the risk of COVID-19 transmission in the context of patient care.

In this category:

- HSAs, Village Health Committee members and volunteers should reinforce and support early, prompt and appropriate care seeking for sick children.
- During case management the HSAs should;
    - Focus on symptom history and observation with physical distancing (at least 2 m)
    - Reduce touching patients and consider no-touch policies only if PPE is not available
- In the case of "no-touch guidance" the HSA should engage the caregiver in the assessment of the child to maintain distance.
- Presumptive treatment e.g. for malaria without use of RDTs is a **last resort** option when the safety of patients and HSAs cannot be assured. Children with signs and symptoms of severe disease continue to require referral, some for presumed severe COVID-19 to isolation units.
- The HSA should ensure that the child is protected from any type of stigma.
- HSAs should refer any presumed COVID-19 patient.
- Follow up of children is encouraged as per standard protocol.
- HSAs who are providing village clinic services in their homes should operate on a place where physical distancing will be easy to enact (away from their houses). The place should be well ventilated.

Large-scale outbreaks of COVID-19 local transmission (community transmission)

In this category there is wide spread transmission of the infection in a particular country**.** ICCM protocols will be modified. The modification includes revised flow of assessment, observation and actions taking into account the need for COVID-19 risk assessment, IPC including no-touch measures.

Disease-specific considerations:

Management of Fever/Malaria

- Fever is a symptom of COVID-19, in some cases combined with cough.
- Confirming malaria infection with a diagnostic test does not rule out that the patient could also be suffering from COVID-19; similarly, having presumed or confirmed COVID-19 does not mean that the individual does not also have malaria infection
- Malaria management protocols should be maintained as long as possible including the continued use of rapid diagnostic tests (RDTs) for malaria by HSAs (gloves are required in standard protocols due to handling of blood products; in situations of increased risk of COVID-19 transmission, add a face-mask for protection (see WHO recommendations on grade, level of

face-mask recommended). Presumptive treatment e.g. for malaria without use of RDTs is a **last resort** option when the safety of patients and HSAs cannot be assured.

- Pre-referral treatment with rectal artesunate (RA) using gloves for severe malaria is still recommended as part of iCCM modalities in areas where it is being administered. In the absence of PPE, the mother should be guided through providing the RA.

- In the event of a '**No-Touch Policy,**' HSAs should classify suspected malaria cases based on a history of fever, and provide presumptive treatment of malaria with the appropriate antimalarial treatment. If NO response to LA treatment within 48hrs, malaria as the cause of fever should be excluded. This strengthens the likelihood of other febrile illnesses, including Covid19 and/or any other problem. Therefore, active follow-up of fever cases will be required, and if symptoms have not resolved by 48 hours and the child shows danger signs, referral to the nearest health facility for further investigation is required.

Symptoms of COVID-19 are non-specific and similar to illnesses addressed in standard HSAs iCCM training manuals.

Management of respiratory illness/pneumonia/childhood TB

- Any child presenting with cough might have COVID-19, pneumonia, childhood TB and/or acute respiratory infection.
- HSA should continue to classify and treat suspected pneumonia as per iCCM protocol based on fast breathing.
- When counting breaths, ensure that there is visibility and ask the caregiver to lift the child's clothing. **NOTE:** 2-meter **distance** should be maintained if no PPE available.
- Children with chest indrawings should receive urgent referral to the nearest health facility.

  Any child contact to a TB patient should always be referred to the nearest health facility.

Management of diarrhea

- Children with diarrhea and vomiting, especially in combination with respiratory symptoms, might have COVID-19.
- HSAs should continue to provide oral rehydration therapy (ORS) and zinc to all children with a history of frequent stools, defined as three or more loose stools in the past 24 hours.

Management of acute malnutrition

- During assessment, in order to adhere to distancing guidelines and in the absence of PPE, caregivers should be actively included in the assessment and guided by the HSA to perform MUAC.
- If MUAC tapes have to be re-used, they should be sanitized after each use with alcohol or soap and water.
- HSAs should ensure follow up of malnourished children.

Sick newborn care and advice on breastfeeding in COVID-19 context

- Sick newborns under the age of 2 months should continue to be referred to the health facility for further assessment and management.
- HSAs should use the opportunity of home visits to provide important information on breastfeeding to mothers with presumed or confirmed COVID-19 (e.g. identified during risk assessment when presenting their child for CCM or during home visits)
    - Infants born to mothers with presumed, probable or confirmed COVID-19 infection, should be fed according to standard infant feeding guidelines, while applying necessary precautions for IPC.
    - Breastfeeding should be initiated within 1 hour of birth.
    - Exclusive breastfeeding should continue for 6 months with timely introduction of adequate, safe and properly fed complementary foods at age 6 months, while continuing breastfeeding up to 2 years of age or beyond.
    - As with all confirmed or presumed COVID-19 cases,
        - Symptomatic mothers who are breastfeeding or practicing skin-to-skin contact or kangaroo mother care should practice respiratory hygiene, including during feeding (for example, use of a medical mask when near a child if with respiratory symptoms), perform hand hygiene before and after contact with the child, and routinely clean and disinfect surfaces which the symptomatic mother has been in contact with.
    - Breastfeeding counselling, basic psychosocial support and practical feeding support should be provided to all pregnant women and mothers with infants and young children, whether they or their infants and young children have presumed or confirmed COVID-19.

Annex I:Assessment and treatment of sick children at community level during COVID-19 outbreak in settings with no transmission/sporadic cases.

- Consider the transmission of COVID-19 in asymptomatic cases
- Consider distancing, PPE and protocol adaptations as per national guidelines (see algorithm for settings with local transmission
- Increase adherence to IPC protocols. Perform handwashing before and after each consultation
- Provide basic messages and perform risk assessment for COVID-19

Ask to assess COVID-19 risk of child and caregiver

→ Known exposure to a confirmed or presumed COVID-19 patient?

→ Other household members or close contacts sick with fever, cough/shortness of breath, loss of sense of smell, sore throat, runny nose, diarrhoea/vomiting?

→ Recent travel to or contact with someone from an area with known COVID-19 cases?

Any question 'Yes' = Possible COVID-19

- Notify health center/Hotline
- Determine need for referral (see danger signs or follow national protocol for testing)

Follow standard CCM protocol

Ask, Look and Decide

Treat and follow up

Refer for danger signs

Provide guidance for supportive care, fever management and IPC as per national protocol.

Annex II: Assessment and treatment of sick children at community level during COVID-19 outbreak in settings with clusters or community transmission

Distancing and PPE (gloves and facemask) or no touch protocol in place

- Hold visitation outside, if possible, consider phone-based visitations/consultations
- Wash hands before and after each visitation
- Keep minimum. 2m distance from the caregiver and the child
- Low-touch: Focus on ASK and OBSERVE
- Perform Malaria RDT if PPE (gloves and face masks) available
- Advise the caregiver to perform MUAC and lift the child's clothes for assessment of breathing and provide pre-referral treatment
- Any child contact to a TB patient should always be referred.

1. Ask to assess COVID-19 risk of child and caregiver
→ Known exposure to a confirmed or presumed COVID-19 patient?
→ Other household members or close contacts sick with fever, cough/shortness of breath, loss of sense of smell, sore throat, runny nose, diarrhea/vomiting?
→ Recent travel to an area or contact with someone from an area with known COVID-19 cases?

Any question 'Yes' = Possible COVID-19
- Notify health center or hot line
- Determine need for referral (see danger signs or follow national protocol for testing)
- Provide advice on home care and infection control

2. Ask
- Fever (history of fever/hot to touch according to caregiver). If YES for how long _____days?
- Cough yes/no. if YES for how long____days
- If diarrhea: blood in stool?
- Convulsion?
- Difficulty drinking or feeding?
- Vomiting? If yes vomits everything
- Any other problem?

Danger Signs
- Infant 0-2 months of age
- Cough > 14days
- Blood in stool
- Fever >7days
- Convulsions
- Not able to drink or eat anything
- Vomits everything
- Chest in drawing
- Very sleepy or unconscious
- Red and Yellow and or oedema

If 'Yes' to any danger sign = REFER

*See treatment protocol for acute malnutrition

3. Look and decide
- If cough or difficulty breathing: count breath rate for 1 min. asking caregiver to expose the child's chest.
- If fever and malaria endemic region: perform Malaria RDT only if PPE available
- Unusually sleep/unconscious?
- Instruct caregiver to perform MUAC. Color:_____
- Swelling of both feet?

Immediately refer
- Follow standard referral protocol for children
- Refer to health facility suspected COVID-19 + danger signs
- Guide caregiver to provide pre-referral treatment as per protocol

- Fever/Malaria RDT Positive
- Fever/Malaria RDT Negative
- Fast breathing pneumonia
- Diarrhea

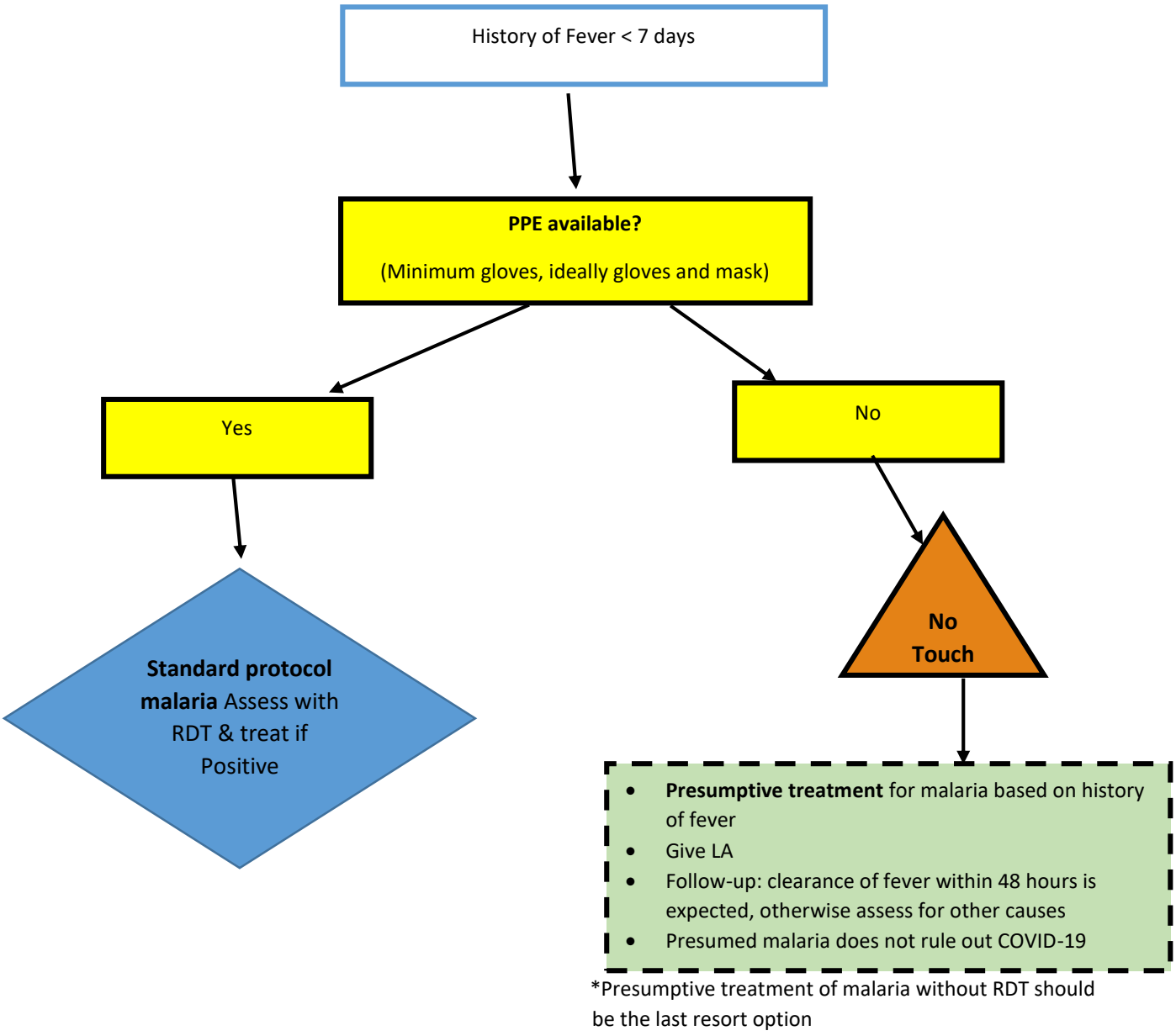
Treat according to CCM protocol

All children might have possible COVID-19
Provide guidance for supportive care, fever management and IPC as per CCM protocol

Advise the caregiver
- Take medication as advised
- Return immediately/go to health facility if danger signs develop
- Notify the HAS if other household members develop signs and symptoms of illness that might suggest COVID-19

Follow up to evaluate improvement, worsening, danger signs

Annex III: Assess and treat for malaria in a setting with cluster/community transmission



*Presumptive treatment of malaria without RDT should be the last resort option

All children with fever might have COVID-19 (including those with positive RDT)

- (Home) care and IPC According to iCCM guidelines
- Supportive care and fever management
- Follow-up: lack of improvement to ACTs within 48 hours increases the possibility of COVID-19
- **Either positive or negative RDT does not rule out COVID-19. Negative RDT=Investigate other potential causes of fever (e.g. Pneumonia and childhood TB)**
- **Presumed malaria does not rule out COVID-19**

Annex IV: Assess and treat for Pneumonia/childhood TB in a setting with clusters/community transmission

History of Cough < 14 days or difficulty in breathing

PPE available?

(Minimum gloves, ideally gloves and mask)

Yes

No

1. **Standard protocol Pneumonia:** count breaths. **Fast breathing=Treat**
2. **Standard protocol childhood TB screening**

No Touch

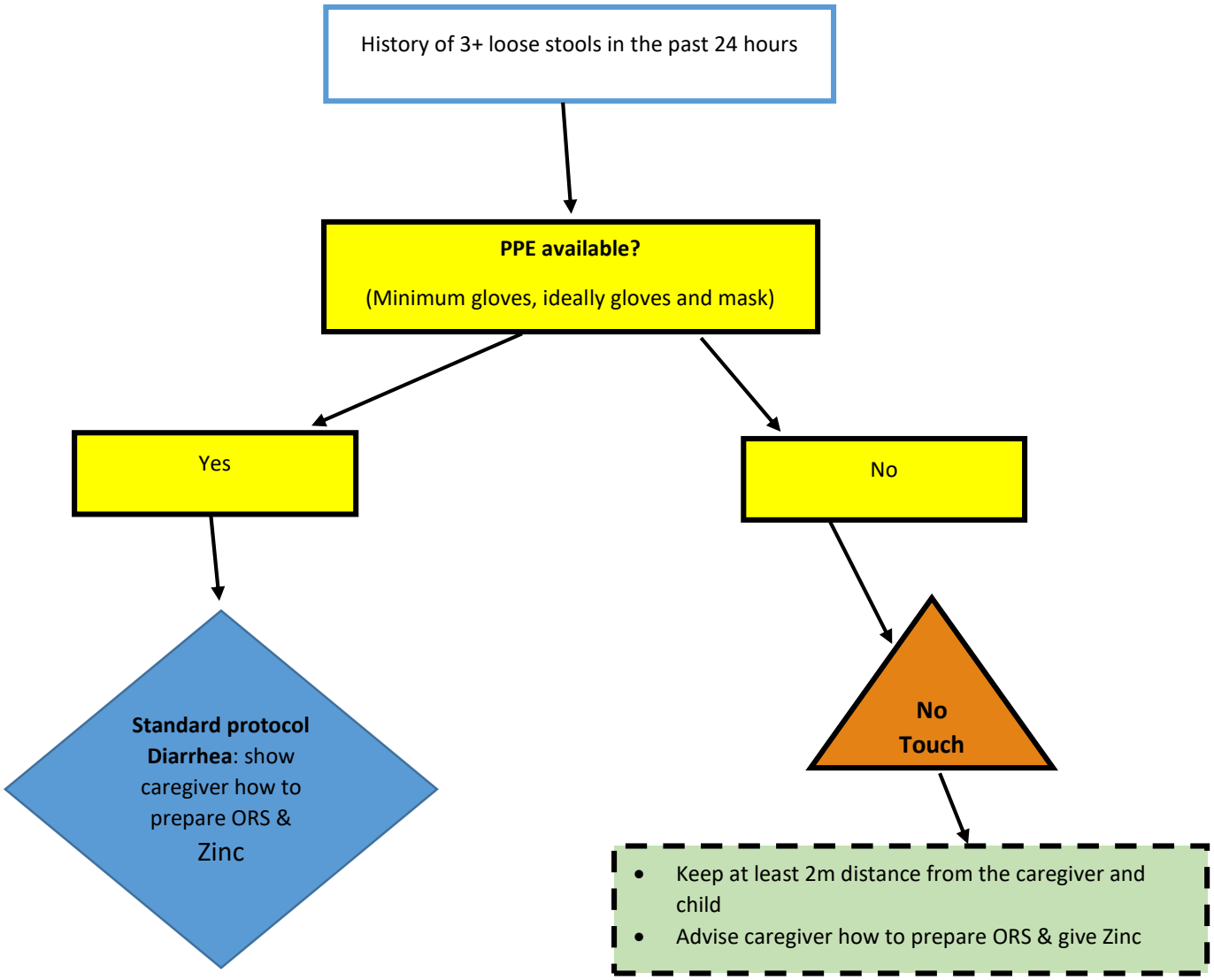
- Keep at least 2m distance from the caregiver and child
- Ask caregiver to expose child's chest, observe and count breaths from distance, with the help of the caregiver
- **Fast breathing = treat**
- **Ask caregiver about history of contact to a TB case**

*The limitations of counting breaths from a distance should be carefully considered

All children with cough with or without fever might have COVID-19

- (Home) care and IPC According to CCM guidelines
- Care seeking for danger signs
- Supportive care and fever management
- Follow-up: lack of improvement within 48 hours increases the possibility of COVID-19 or other cause

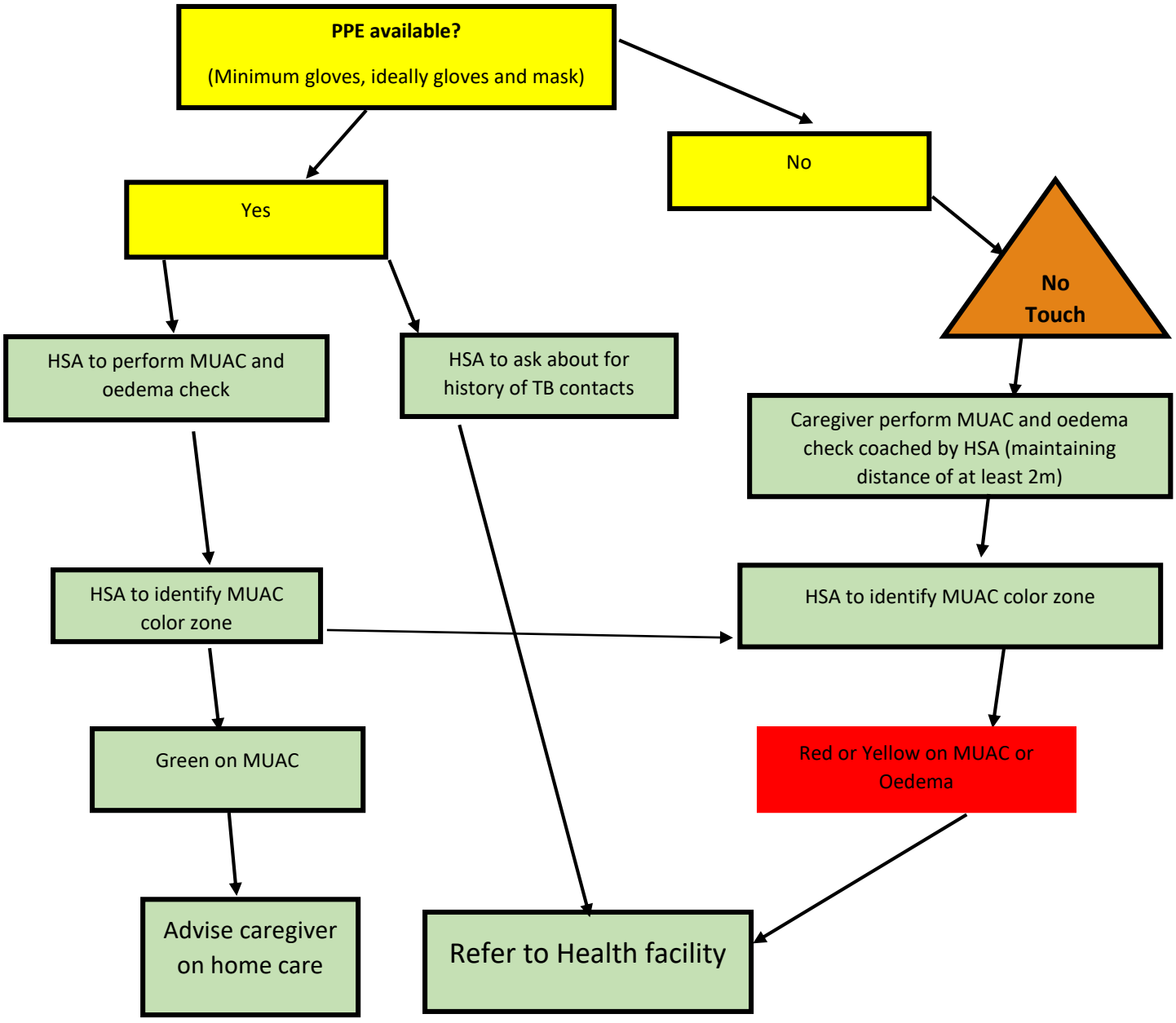
Annex V: Assess and treat for diarrhea in setting with cluster/community transmission



All children with diarrhoea and vomiting, especially in combination with fever and/or respiratory symptoms might have COVID-19

- (Home) care and IPC According to CCM guidelines
- Care seeking for danger signs
- Supportive care and fever management
- Follow-up within 3 days

Annex VI: Assess and treat for acute malnutrition in settings with cluster/community transmission



Annex VII: SOPs for EPI

ADDITIONAL IMMUNIZATION STANDARD OPERATING PROCEDURES IN THE CONTEXT OF COVID-19 PANDEMIC

APRIL, 2020

MINISTRY OF HEALTH

Expanded Programme on Immunization (EPI)

1.0 BACKGROUND

Immunization is one of the most cost-effective ways of reducing infant and childhood illnesses and deaths. This is achieved through vaccinating children against vaccine-preventable diseases like measles and polio. It is against this background that immunization services remain an essential public health service even during this COVID-19 pandemic and ought to continue undisrupted to prevent vaccine-preventable diseases (VPDs). This additional standard operating procedure handbook is designed to prevent transmission of COVID-19 to both health care workers and the public.

2.0 OBJECTIVE

To provide guidance during the immunization session and ensure prevention of transmission of Corona virus-19 among the population.

3.0 REQUIREMENTS AT AN IMMUNISATION SESSION

a) Bucket with a tap and basin
b) Aprons
c) Hand Sanitizer/hand rub
d) Gloves
e) Water
f) Chlorine
g) Masks
h) Hand Soap

4.0 PROCEDURE

a) Clients should wash hands with soap or chlorinated water on arrival at the Immunization session.
b) Outreach clinic with high turn up should be split to accommodate less than 100 clients per session (Reduce the number of villages to turn to a scheduled clinic session).
c) Maintain a social distance of 1meter between clients while sitting for health talk and when queuing for vaccination.
d) Give health talk and vaccinate the clients as soon as they arrive to avoid over-crowing.

e) Health workers must wash hands with soap or chlorinated water before the Immunization session, use hand rub between each child, wash hands with soap or chlorinated water when one feels that the hands are contaminated and after the Immunization session.
f) Health workers must always be in PPE while administering Immunizations
g) Health workers must ensure that all furniture and immunizations equipment are cleaned and disinfected thoroughly.
h) Sick children/caregivers with cough or flu-like symptoms should be isolated and managed promptly.
i) A health worker with cough or flu-like symptoms should not administer Immunization services.
j) Clients must wash hands with chlorinated water or soap after the Immunization session.
k) Health workers must ensure that all solid and liquid waste is disposed of safely in line with health care waste management guidelines.

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