

Frequently Asked Questions (FAQs): Health and Care in the COVID-19 Outbreak

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The purpose of this document is to provide guidance to IFRC and National Society staff and volunteers who are undertaking health and care activities directly related to COVID-19, or are concerned as to how COVID-19 affects their ongoing health and care programmes. The questions outlined here have been identified based on the most frequently asked questions to this date. **This document will be updated frequently as questions arise and official recommendations and guidance increase and change.**

This document includes information on:

General information and response options	2
General information on COVID-19	2
National Societies' health response to COVID-19	4
Public health measures to prevent and suppress transmission	8
Community-based surveillance (CBS)	8
Contact tracing	13
Epidemic control for volunteers (ECV)	13
Quarantine	13
Management of the dead	14
Personal protective equipment for non-clinical activities	15
PPE for community programming	15
Cloth masks	16
Water, sanitation and hygiene (WASH)	18
Clinical and prehospital care	20
Scaling National Society clinical support during COVID-19	20
Infection prevention and control (IPC) in clinical contexts	22
Clinical care for COVID-19 patients	25
Emergency medical services	27
Mental health and psychosocial support (MHPSS)	27
Maintaining essential community and clinical health services during the pandemic	29
Community based health and first aid (CBHFA)	29
Reproductive, maternal and newborn health	31

Immunisation	32
Malaria prevention	34
First Aid	35
Support for older people	38
Non communicable diseases (NCDs)	39
National Society epidemic and pandemic preparedness	39

General information and response options

General information on COVID-19

What is COVID-19?

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. Coronaviruses are a large family of viruses which may cause illness in animals or humans. In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The most recently discovered coronavirus causes COVID-19. This new virus was unknown before the outbreak was discovered in Wuhan, China, in December 2019.

What are the symptoms of COVID-19?

The most common symptoms of COVID-19 are:

- Fever
- Tiredness
- Dry cough
- Some patients may have aches and pains, nasal congestion, runny nose, sore throat or diarrhea

These symptoms are mild in 40% of cases, and begin gradually. Some people become infected but don't develop any symptoms and don't feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Older people, and those with underlying medical problems like high blood pressure, heart problems or diabetes, are more likely to develop serious illness.

How does COVID-19 spread?



People can catch COVID-19 from others who have the virus. The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth. People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets. This is why it is important to stay 2 metres (6 feet) away from a person who is sick.

How can I protect myself from COVID-19?

The most basic prevention measures in order to remain protected from COVID-19 are as follows:

1. Regularly and thoroughly clean your hands with an alcohol-based hand rub or wash them with soap and water. This will kill viruses that may be on your hands.
2. Maintain 2 metres (6 feet) distance between yourself and anyone who is coughing or sneezing.
3. Avoid touching eyes, nose and mouth, as once contaminated with the virus, hands can transfer the virus to your eyes, nose or mouth. From there, the virus can enter your body and can make you sick.
4. Cover your mouth and nose with your bent elbow or tissue when you cough or sneeze. Then dispose of the used tissue immediately.
5. Stay home if you feel unwell. If you have a fever and cough or difficulty breathing, seek medical attention in accordance with your local health authority's advice. Follow the directions of your local health authority. Calling in advance will allow your health care provider to quickly direct you to the right health or testing facility. This will also protect you and help prevent spread of viruses and other infections.
6. Regularly keep informed about the outbreak as strategies and response activities will constantly improve as new information becomes available about the disease. It is important to follow trusted and evidence-based sources such as the [World Health Organization](#) and your local health authorities for the latest guidance and updates on health information.

Why do I have to use soap when I wash my hands, and what do I do if I don't have soap?

Handwashing with soap is one of the key measures in breaking the transmission. Our hands have natural moisture and oils on them. We know germs can stay on the skin for a long time.

- *What does soap do?*

The lather from the soap attaches to dirt and natural oils on the hands. When you wash the soap off the hands with water it picks up all of the dirt and oil and germs and washes them away. Soap deactivates the germs by breaking down the outside fatty cover of the virus. When soap comes in contact with the germ it basically dissolves it hence destroying it. This is why soap is such a good effective intervention to fight against the Coronavirus disease.

- *What else is important when asking people to wash their hands with soap?*

Germs can live in the web between the fingers and in cracks of the skin so it is very important to lather the soap and wash hands for a minimum of 20 seconds ensuring each finger, thumb, palm and back of hand and wrist are washed so the germs can be destroyed.

- *Can ash or sand be used if I don't have soap?*

Ash and sand work the same way primarily through friction. We are not sure if it is as effective as soap but the friction does help remove the germs so it is better than just water alone.

- *Is alcohol based hand rub better than soap?*

Soap and water remain the recommended method to remove the germs from hands. Alcohol hand rub is another effective method but it is more expensive than soap and most likely less available to many people. For the alcohol hand rub to be effective it must have at least 60% alcohol in it.

- *Should we use chlorine to wash our hands?*

Soap and water is a highly effective way to kill the virus. If there is no access to soap or it has a very limited supply then chlorine can be considered as an option. The strength used should be 0.05%. Contact your WASH colleague to get further instructions on the preparation.

For more information: <https://resources.hygienehub.info/en/>

How can a pandemic like COVID-19 be slowed or stopped?

There are two broad approaches to epidemic response. There is not yet evidence or experience for either strategy to fully understand the long-term viability, limitations or future impacts of each. Both strategies are expected to be needed, in various formulations, for a minimum of 12-18 months.

First, a suppression 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 for as long as the virus is circulating, or until a vaccine is available. While maintained, they can have significant social and economic impacts, and require a significant scale-up of health systems capacity.

Second, a mitigation approach seeks to slow but not stop the spread of the virus, with the goal of reducing the demand on health systems and protecting the most vulnerable people (e.g. the elderly and those with underlying diseases). The disruption to health, social and economic systems over this



time period is likely to be profound. Mitigation strategies are still 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. However, this approach may be the only option in countries with limited health systems capacity.

When and how is this pandemic likely to end? What scenarios can inform decision-making?

Broadly speaking, there are three ways this pandemic could turn out from an epidemiological perspective. First, efforts to suppress viral transmission could succeed and we could see a complete interruption of human-to-human transmission, meaning that the pandemic ends and the virus is eliminated from the human population. As more and more people are infected, this scenario is unlikely. Second, epidemic control efforts may result in recurring epidemic waves, large or small, where communities or entire regions experience periods of relative normalcy interrupted by waves of more cases. Finally, we could see a continuous outbreak with low-level transmission that results in a sustained but lower-level burden on health systems. The progression of this outbreak depends on the success of suppression and control measures, and on a number of factors related to human immunity, which we don't yet know enough about to make good predictions. For the first two scenarios, it is likely that efforts to control and respond to the pandemic will last a minimum of 18 months, and potentially several years.

For scenario planning assessing the possible humanitarian impact of this pandemic, please see the [ACAPS COVID-19 scenarios](#).

National Societies' health response to COVID-19

What is the role of National Societies in addressing the direct and indirect health impacts of COVID-19?

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 the government 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 as the outbreak progresses and appropriate outbreak response measures 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 life-saving humanitarian services throughout the epidemic. National Societies can support critical public health, clinical, and health systems activities during each

phase, whether suppression or mitigation approaches are chosen, and support vulnerable communities by helping to mitigate the impact the outbreak has on health, social and economic systems.

My country or community doesn't have any reported cases. What should we do to prepare?

Support countries and at-risk communities to prepare to respond to first cases (detect, isolate, and treat, trace contacts and screen, 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

- Make sure your NS, branch or local volunteers are ready (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 the auxiliary role of your NS and prepare to carry out your designated outbreak response activities (e.g. support to quarantine, contact tracing, point of entry screening);

Community-based actions to support health

- Identify and begin to access the most vulnerable communities and systems; assess barriers to adapting behaviours and 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);
- Begin to carry out risk communication, community engagement, and health promotion, in coordination with key stakeholders;

Prepare for clinical actions

- Assess the 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 the NS' ability to increase or adapt to increased demand (see section on scaling up clinical activities).
- 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.

My country or community has sporadic cases or clusters of a few cases. How should we respond?

The goal is to prevent large-scale outbreak by helping to suppress transmission of the virus once cases 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, if clinical service provision is an area where your National Society works. 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;
- Screening, contact tracing, quarantine, and other services in support of government activities to suppress transmission;
- Activate community-based surveillance where such systems are in place, and include pneumonia as a health risk;
- 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, or related to systems failures;

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 the indirect health impact on the most vulnerable

- 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 health services for the general population to make sure that people still have access to life-saving health services;
- Maintain or increase existing non-COVID clinical, paramedical or homecare service provision to supplement health system in cases where capacity is stretched;

My country or community has many cases and community transmission of the virus. How should we respond?

The goal now is to slow large-scale outbreak by helping to suppress transmission of the virus. 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 where appropriate. Support access to and availability of existing essential health services for the broader population. Task 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 for outbreak prevention and response

- 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 outbreak
- Community health programming (detection and referral, health education and hygiene promotion, support for home-based 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 (note that “Safe and dignified burial” as for Ebola is not required).

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;

Public health measures to prevent and suppress transmission

Community-based surveillance (CBS)

What is community-based surveillance (CBS)?

CBS is the systematic detection and reporting of events of public health significance within a community by community members ([WHO 2018](#)).

CBS is often used to alert about health risks/events related to epidemic-prone diseases. With the large RCRC volunteer network in communities around the world, the RCRC movement is well placed for CBS, and providing volunteers with the tools for CBS in their communities allows for early detection of health risks and can trigger an early response in communities to stop further transmission. CBS can also be used in ongoing outbreaks to monitor transmission as the outbreak evolves to guide response activities.

When and where is CBS useful?

CBS can be useful in contexts where the existing surveillance system is not able to capture health risks/events from the community level that can lead to outbreaks. This is often due to lack of access to health care facilities, which is where surveillance systems are often based. These gaps can also be due to conflicts, emergency situations such as natural disasters, large outbreaks, lack of resources or other challenges. CBS can help fill the surveillance gap by getting information from the community level to the level necessary to trigger an early response.



Implementing CBS should be done in collaboration with the national authorities, and as an addition to complement existing surveillance systems. CBS provides information about signs and symptoms of health risks/events which can indicate disease, but it does not report on confirmed cases and can thus not replace a regular surveillance system for diseases.

How does CBS work?

The decision to implement CBS, and which health risks/events to do CBS for, is decided together with the community. The CBS volunteers, who are most often existing National Society volunteers, should also be identified by the community.

CBS can be done in different ways using different tools, but the core purpose is to give community members the opportunity to give information about health risks or events directly from their community to trigger responses when needed. This is often done by having CBS volunteers as focal points for the community members. They both report to their NS on health risks/events, while providing a community-level response to the health risks.

For CBS to be implemented it is necessary to have a mechanism in place to ensure there is a response and investigation to the reports coming from the community. The party responsible for the response can vary between contexts; e.g in most contexts the MoH is responsible for public health, surveillance activities and medical activities, but in some contexts RCRC movement can take responsibility for some of the response. In other contexts different parties may be responsible for different areas of a response.

The community-level response carried out by volunteers are based on CBHFA and ECV.

CBS reporting can be done in different ways including the use of paper forms, SMS and or mobile apps. Mobile technology has been used widely in recent years to ensure data is shared in real-time. A digital platform called Nyss, has been developed by and for the RCRC Movement. Nyss works to directly aggregate SMS reports from volunteers, as well as automatically analyse and visualise data and trigger alerts to supervisors and share appropriate data with health authorities to facilitate a response.

The RCRC CBS technical working group has identified a global list of health risks/events where CBS can add value. These are based on signs, symptoms and events which can indicate that there is a possible transmittable disease in the community. The volunteers are not medically trained and thus do not report on disease, but on the signs, symptoms and events they are trained on.

More information about how CBS works and the Nyss platform can be found on the CBS website:

<https://www.cbsrc.org>



What is the difference between CBS, contact tracing and surveys?

- CBS is systematic detection and reporting of an observed health risk/event in the community to ensure a rapid response. It is often used to be able to do immediate reporting for early warning.
- Contact tracing is identification and follow up of contacts when a confirmed case is identified
- Surveys are structured information gathering from a sample of people, often done once, or on a regular basis to obtain specific information

More about different types of surveillance/ information gathering during COVID-19, can be found [here](#).

How is personal information protected when doing CBS?

RCRC CBS is designed in such a way that personal information is not sent out from the community. The volunteers will know who they are sending the report about in order to ensure that response and help can reach the right person if necessary. However, the information they send by SMS or on paper is only which health risk/event they have seen, the sex and age group of the person. This is all the information needed to be able to determine if, and what, response is needed. All volunteers have RCRC supervisors who are the link between the community and the authorities, who support the response. It is essential to have trust within the community and agreement among community members about how CBS should be conducted in their community due to the fact that a CBS alert may require a response/ follow-up from local health authorities.

For the CBS platform Nyss, the volunteers are registered with their personal information, but they are informed about what this means and must give consent. Personal identifying information is only visible for the supervisors and the National Society staff involved in CBS. Nyss has defined password protected user access.

A description about the data protection measures in place for the CBS platform Nyss can be found in the resource page of the CBS website: <https://www.cbsrc.org/resources>

How can CBS be useful during the COVID-19 pandemic?

CBS is already being implemented as part of National Societies' response to COVID-19 in multiple locations, including using the Nyss platform in Somaliland and Senegal. In both places the health risk/event "cough and difficulty breathing" has been added, leading to reports of people with signs and symptoms matching the local community definition of this health risk. In Somaliland, one of the first cases of confirmed COVID-19 was identified through SRCS volunteers and CBS.

With the strong network of volunteers in communities around the world, RCRC has a great opportunity to inform and advise community members about necessary measures to avoid



transmission, and is well placed to transfer information quickly from the community level at an early stage of an outbreak in areas where getting this information is a challenge. As with many other health risks and events in CBS, this can lead to early detection of COVID-19 and limitation of transmission. Additional guidance on using CBS for COVID-19 can be found [here](#).

Several considerations need to be taken before implementing CBS for COVID-19. These are captured in questions below.

Can we add COVID-19 to our existing CBS program?

If you have an ongoing CBS project, it is possible to add reporting on symptoms of COVID-19. In most CBS implementations, the option to report “unusual events” or “cluster of illness or deaths” is added to allow for reporting of health risks/events that are not included in your CBS project. This means that one might be able to pick up on potential COVID-19, without even adding an extra health risk.

The National Societies who have added COVID-19 to their CBS as of today have added the health risk/event: “cough and difficulty breathing” with the suggested community definition: “fever with dry cough or difficulty breathing” from the CBS health risk/event list, as these are symptoms that align with symptoms in the [case definition for COVID-19 provided by WHO](#).

When a health risk or event is added to your CBS, it is important that the volunteers understand the signs and symptoms they are looking for, what information to give the community members, what community response actions they should do and what protection measures they need to follow. This is facilitated by adding the extra health risk/event for COVID-19 and host trainings specifically for this.

If COVID-19 is added to existing CBS projects, the volunteers need to be trained in a safe way which is in coherence with national guidelines for COVID-19. Additional suggestions can be found [here](#).

If a National Society wants to implement CBS for COVID-19, how do they move forward?

The RCRC movement has developed several tools to be able to implement CBS, including a CBS assessment tool, protocol template and training materials which are available for the Movement wide through the resource page of the CBS website: <https://www.cbsrc.org/resources> (the resource page is password protected for now while awaiting final approvals, so please ask for the password if you need access). The following tools are also available directly through the IFRC website:

- [Community-based surveillance \(CBS\) Assessment Tool](#)
- [Community-based surveillance \(CBS\) Protocol Template](#)

If you are considering using CBS for COVID-19, the following should be considered:



- Will implementing CBS add value in detecting people with signs and symptoms of COVID-19 in your context?
 - Is there a gap in the existing surveillance system?
- Is it feasible to implement?
 - Does the NS have the capacity, necessary structures and mandate?
 - Is there sufficient funding to cover the training and implementation of CBS in your context (suggested considerations are shared in the [CBS Assessment tool](#))?
 - Is the NS engaged with the MoH and does the MoH support the use of CBS to compliment their structures?
 - Will the community members approve?
 - Is it possible for the volunteers to be trained and conduct CBS activities without being put at risk?

We advise everyone who considers implementing CBS to conduct a needs and feasibility assessment prior to planning implementation. The [CBS assessment tool](#) (also found in the resource page mentioned above) gives guidance on how to conduct this assessment and what to consider. For additional support you can also reach out to cbs@ifrc.org

See more info regarding decision making around CBS for COVID-19 [here](#).

In the future it will be possible to request the Nyss platform from the CBS website (<https://www.cbsrc.org/>). If you want to request to use the Nyss platform for the COVID-19 response now, please send an email to nyss@redcross.no

How should CBS volunteers do their volunteer work during the COVID-19 outbreak?

CBS volunteers are a part of the community they volunteer in. The way in which RCRC CBS is designed, volunteers should act as focal points in their community for community members to give information about health risks/events that need to be reported. They are not tasked to conduct house-to-house visits. CBS volunteers are trained to follow-up on health risks by talking to the person reporting signs or symptoms, or asking follow-up questions to the person who reported the health risk/event. CBS volunteers are trained in first aid, community responses and key messaging (such as coughing etiquette, handwashing and physical distancing), but are not trained or tasked to examine a person or animal for which the health risk was reported.

It is recommended that volunteers keep a 1-2 meter distance from community members during discussions and no physical contact should take place. If possible, discussions about someone showing health risks should take place outside, through a window or in an open space and between a healthy member of the family/ community member and volunteer rather than the ill person themselves



If CBS is conducted by CHVs who have been trained to provide additional medical support they should follow any additional PPE measures that pertain to those activities and government requirements.

For COVID-19, the CBS volunteers should follow the guidelines of their national authorities and national societies for protection and to avoid transmission. The volunteers should receive information about how to do this for themselves and how to inform the community members. In the times of COVID-19, the volunteers should report the health risk/event in their community and give guidance if this can be done in a safe way and according to national authorities regulations.

For more advice regarding how to work in the communities, see the CBHFA chapter.

More information about CBS for COVID-19, can also be found [here](#).

Contact tracing

Coming soon - please see resources folder for available [guidance](#), and submit questions to be answered here.

Epidemic control for volunteers (ECV)

Coming soon - please see resources folder for available guidance, and submit questions to be answered here.

Quarantine

Coming soon - please see resources folder for available guidance, and submit questions to be answered here.

Management of the dead

My National Society has experience with Safe and Dignified Burials from Ebola outbreaks. Do people who have died of COVID-19 need the same procedures for special burials as people who have died of Ebola or Marburg?

The Red Cross Red Crescent has extensive experience supporting safe management of the dead in infectious disease outbreaks. This includes both safe and dignified burials (SDB)—the name given to the procedures and approaches specifically designed to prevent transmission of viral haemorrhagic fevers—and other approaches to safely manage the dead during outbreaks of cholera and other diseases. These are both in addition to, and separate from, general management of the dead (MotD or DBM) procedures for disasters, conflict, or other mass casualty events. The use of Ebola SDB



procedures and approaches for COVID-19 response would be inappropriate and unnecessary to prevent the spread of the pandemic. The [WHO technical guidance](#) lays out the necessary precautions and personal protective equipment (PPE) required for autopsy and burial-related activities when COVID-19 is suspected.

For Red Cross Red Crescent National Societies typically involved in safe and dignified burials, MotD or other activities supporting burial of the dead at the community level, the section on “Burial by family members or for deaths at home” in the WHO guidance may be useful in determining whether NS staff or volunteers have a role to play in supporting community burials for suspected COVID-19 cases. Following the Ebola SDB procedures for COVID-19 is intrusive and unnecessary, and may undermine trust between communities and RCRC volunteers and local branches and lead to increased risks for volunteers and staff. For a brief explanation of the difference between the two, [see this document](#).

In places where mortuary services are not standard or universally available, National Societies may be called upon to support families and community leaders to safely prepare bodies of suspected COVID-19 cases for burial. These activities are much more limited in scope and scale than SDB programming, and further practical guidance is being developed.

Are there special considerations when taking care of deceased (management of the dead), who has suspected or confirmed COVID-19 in a clinical setting?

As per current evidence, COVID-19 transmits via droplets, fomites and close contact. Dead bodies are generally not considered infectious, except for the lungs of the patient, if handled improperly during an autopsy.

Though the safety and well-being of everyone who tends to bodies should be the priority. It is important that standard precautions are respected at all times.

- Use appropriate PPE according to the level of interaction with the body, including a gown and gloves. If there is a risk of splashes from the body fluids or secretions, personnel should use facial protection, including the use of face shield or goggles and a medical mask.
- Prepare the body and ensure that body fluid leaking from orifices are contained.
- There is no need for disinfection of the body or usage of body bags unless it is for other reasons (e.g. excess bodily leakage).
- No specific considerations with transport needed.
- In case of an autopsy: staff involved should be minimized and the autopsy performed with proper PPE, as well as in a properly ventilated room.
- Thorough environmental cleaning of the areas (and instruments, if an autopsy is performed) should be performed.

Cultural and local customs should be respected as much as possible. Possibility for the loved one to view the body with instructions not to touch or kiss the body and to use standard precautions such as hand washing should be made available.

WHO recommendations for management of the dead in the context of COVID-19 can be [found here](#).

Personal protective equipment for non-clinical activities

PPE for community programming

What personal protective equipment do volunteers and staff need to carry out public health, WASH and other non-clinical activities?

- Personal protective equipment (PPE) may be useful for managing risks that can not be managed in other ways. However, the focus should be on the following first:
 - Reducing non-essential activities that could increase the risk of transmission of COVID-19
 - Establishing safe systems of work first, such as using remote methods of working, physical distancing (keeping at least 2m/6ft apart from other people), or using physical barriers (such as plastic screening between volunteers and service users).
- Where the risk needs to be managed at the personal level (which is much more susceptible to human-error that risks self-contamination and contamination of others) then PPE may be appropriate.
- Your national government may have issued specific advice on PPE and this advice should be adhered to. Otherwise, the following should be considered:
 - **PPE guidance for IFRC and National Societies can be found [here](#), see “Personal Protective Equipment (PPE) supplies for COVID-19 - specifications and users” which is regularly updated and includes WASH and public health activities.**
 - There may be a shortage of supply of masks, aprons and goggles, and the priority for these items should be the availability for healthcare workers who may be undertaking high-risk activities.
 - In some contexts, PPE such as masks can exacerbate anxiousness and create distance between volunteers/staff and communities
 - Masks may be considered where it is not possible to stay 2m/6ft away from other people.
 - Reusable gowns may be considered where it is not possible to stay 2m/6ft away or where clothes can not be changed out of and laundered after completing the activity
 - Gloves may only be appropriate if it is not possible to undertake regular hand-washing or use hand sanitiser frequently. Gloves should be changed between seeing different vulnerable people to minimise the risk of gloves transmitting COVID-19 between people. Gloves may give a false sense of security and reduce the frequency of handwashing.
- PPE training must be undertaken with staff and volunteers to ensure PPE is used properly and effectively, and they do not contaminate themselves or the PPE (in terms of gloves if used) when using the PPE and how to care for the PPE and spot failures and degradation of the PPE.

- It will be important to be conscious of what other humanitarian agencies and government are doing with regards to PPE in the area you are working in and trying to match PPE levels wherever possible and appropriate, such that staff and volunteers are not made unnecessarily anxious if they perceive they are not adequately protected or protecting others.

Cloth masks

Does IFRC recommend the use of cloth face masks?

The IFRC follows WHO guidance about the use of medical masks and respirators for healthcare workers and patients, and advocates for evidence-based interventions to end and mitigate public health emergencies. Where authorities or culture mandate the use of face masks, approaches advocating the use of cloth masks must both seek to prevent harm from inadequate masks and help to maintain the stock of medical PPE for the appropriate users. In epidemic or pandemic period such as Covid-19, wearing a cloth mask that covers the mouth, nose and chin may contribute to reducing the spread of the virus from infected individuals and therefore may protect others from getting infected. Any person who is in contact with an infected person, with or without visible symptoms, may be exposed to respiratory droplets containing viral particles. Use of cloth face masks may reduce the amount of virus-containing droplets produced by an infected person, thereby decreasing risk of transmission to others. There is no evidence that cloth masks reduce the risk for individuals exposed to infected respiratory droplets. The largest impact of a cloth mask policy is expected to come from replacing the generalised use of medical equipment with the use of cloth face masks in a way that does not cause harm. It is important to re-emphasise the adjunct public health measures that have shown to reduce spread of the virus such as hand hygiene and physical distancing (where possible).

This approach to cloth masks has three goals:

1. Reduce the negative impact of widespread use of medical masks on the availability of PPE for frontline health workers, by replacing medical equipment with reusable cloth face masks for members of the general public for whom WHO guidance does not recommend the use of medical masks;
2. Facilitate the correct use of reusable cloth masks meeting minimum standards, where opportunities for social distancing, respiratory etiquette, and handwashing are limited; this may limit infected people's ability to project respiratory droplets infected with the virus onto surfaces or people who have not been exposed;
3. The correct use of cloth masks may help to reduce face touching, which could help to reduce individual risk.

[Guidance on cloth masks can be found here.](#)

Who should use a cloth face mask, and what do they need to know?

Individuals without respiratory symptoms living in areas with active transmission where the use of a cloth mask has been advised should:

- Avoid as much as possible groups of people (e.g. gatherings, shopping, crowds, public transportation);
 - Implement social distancing of at least 1-2 metres from others when outside of their own households;
 - Stop shaking hands, social kissing and hugging, including at funerals
 - Wash hands frequently, using soap and water or an alcohol-based hand rub
 - Refrain from touching mouth, nose or eyes
 - Follow instructions below to wear, remove, wash and dispose of the cloth face mask
- Individuals with respiratory symptoms, in addition to the above measures, are advised to wear a medical/surgical mask, according to WHO standards and follow advice from local authorities.

How to use a reusable cloth face mask:

- After washing hands, place a clean and dry mask carefully on the face, ensuring it covers the mouth, nose and chin. Tie it securely to minimize any gap between the skin and the mask.
- Avoid touching the mask while wearing it.
- To remove the mask, do not touch the front part of the mask but untie it from behind.
- Before and after removal or whenever touching the mask, wash hands with soap and water or an alcohol-based hand rub.
- Replace the mask with a clean dry mask as soon as it becomes damp, or at least once a day, or more often for prolonged use.
- Use a dedicated storage bag to keep your used mask (see specifications).
- Wash and then dispose of damaged masks immediately.
- As early as possible after the mask is removed, wash the mask and the protective bag with hot water and soap and dry it completely before using it again.
- Do not discard or leave the mask out without washing it or closing it into a protective bag.
- Wash masks in hot soapy water (at least 60 degrees Celsius)
- Dry cloth masks in the sun or in a dryer until they are completely dry. Damp masks may increase the risk of infection.
- Expected lifespan of a reusable cloth mask is two months with daily washing.
- If planning to provide masks, count at least 3 masks per person per day.

Are all cloth face masks equally protective? Can I make my own cloth mask?

Not all cloth masks are equal, and poor quality cloth masks could actually be dangerous. The IFRC has minimum standards for face masks, including instructions and a pattern if you want to make them at home. These instructions are available [at the end of the cloth mask guidance](#).

Water, sanitation and hygiene (WASH)

What should a National Society do about household visits related to WASH activities?

Only essential household visits should be undertaken, these may include as examples, hygiene kit distributions (where items should be left outside the door and a waiver may be needed relating to donor requirements as appropriate), active case finding and referrals. Where possible do not enter the home, try to meet outside and maintain 2m/6ft distance or discuss through the door, for example. If essential to enter the house for privacy or/and dignity or because of a person with a disability, for example, do not touch surfaces, maintain 2m/6ft distance. If 2m/6ft distance can not be maintained wear appropriate PPE.

What should National Societies do about Hygiene Promotion which they normally undertake through community events, small group events or household visits?

- Avoid undertaking events which encourage or cause service users to travel or come within 2m/6ft of other people (outside of their household).
- Consider remote messaging if possible such as through social media (youtube, TikTok, Facebook etc.), radio, and giving online interviews to TV stations. Different skill-sets related to staff and volunteers may be required to undertake these tasks. There may be differences in messaging that needs to be considered for rural and urban communities and also with different groups. Please look at IEC material available [here](#).

What WASH activities can a National Society consider related to COVID-19 preparedness and response?

- Establishment and maintenance of handwashing stations at entrances to public buildings, transport hubs and other high traffic areas in alignment with WHO guidelines on universal access to hand hygiene.
- Hygiene promotion, including the use of social media, to encourage behaviour change to reduce the risk of COVID-19 transmission.
- IPC, surface disinfection and solid waste management in health facilities, communities and households.
- Distribution of hygiene kits.

NSs should also stop all non-essential activities that would cause service users to travel or come within 2m/6ft of other people (outside of their household).

Should National Societies support chlorine spraying surfaces in outside public spaces if requested by the government?

- The value of chlorine spraying outside locations is very limited and the potential to harm (especially soil, watercourses, plants and animals) is significant.
- Avoid engaging in this activity where possible
- Promote messaging on avoiding touching public space surfaces unnecessarily or where not possible (hand railings on steps or handles on doors, for example) hand washing
- Also, see [IFRC WASH Technical Note on Spray Disinfection](#).

Should National Societies support chlorine spraying surfaces in public enclosed spaces when requested by the government?

- It will be more appropriate to wipe key contact surfaces such as handrails and door handles with commercially available cleaning and disinfection solutions. Public enclosed spaces may not dry quickly if chlorine sprayed and this may present a slip risk. Chlorine spraying may also cause damage to some surfaces and is an irritant.
- Chlorine spraying should only be considered as a last resort, and where staff and volunteers have a good understanding and experience of undertaking chlorine spraying activities. Such that chlorine solutions can be made appropriately and checked before use.
- Also see [IFRC WASH Technical Note on Spray Disinfection](#).

What cleaning and disinfection agents should be used in non-medical enclosed space cleaning and disinfection?

- The Government of Canada provides advice [here](#) in-relation to public-spaces, and this describes using commercially available products which combine cleaning and disinfection for non-medical public spaces.
- The Government of the UK gives advice [here](#) in-relation to cleaning household spaces where a person suspected of having COVID-19 has stayed.
- Where the WASH team has experience of chlorine disinfection and where bleach is readily available and the team has experience of making chlorine solutions the following resources from ICRC on [WatSanMissionAssistant](#) may be [useful](#).

Should National Society WASH teams look to play a role in Infection Prevention Control (IPC)?

- During the Ebola response and other responses IPC was led by Health teams. WASH should support Health in any way possible but look for Health to take the lead and provide guidance to WASH on how best to support and to set up procedures to undertake these activities.
- Activities could include setting up handwashing stations amongst other activities requested by Health.

For Handwashing should we be providing chlorinated water in handwashing facilities?

- No, soap and normal water is fine. There is evidence that Chlorinated water is effective but the stability and correct dosage of the chlorine solution would be an issue. Chlorine solutions degrade in UV, and are also an irritant.

- There should be hygiene promotion (instruction posters for example) showing how to wash hands thoroughly and for at least 20 seconds with soap and lots of hand rubbing. IFRC community IEC material can be found [here](#).
- Alcohol based hand sanitiser can be promoted where it is available, affordable and where normal handwashing is not possible.

For Faecal Sludge Management activities (from desludging to treatment) do additional protection measures need to be put in place to manage the risk from this virus?

- Review normal control measures to ensure minimum pathogen transmission risk but it would be expected that the normal control measures will already be adequate for this virus. The main update may be to ensure that staff and volunteers do not get within 2m/6ft of contact with other people who may generate airborne droplets during the activities, and that desludging activities for example fluidising of thick faecal sludge, do not generate airborne droplets.

Clinical and prehospital care

Scaling National Society clinical support during COVID-19

The health system in my country or community is struggling to cope with the number of cases. What should my National Society consider before scaling up clinical services?

Before increasing the scale or scope of the clinical activities provided by your National Society, consider the following questions:

- Is this activity being formally requested by national or local health 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 COVID-19 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.



My National Society has existing capacity and mandate in hospital-level clinical care before the COVID-19 outbreak. How should we scale up?

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 isolation activities (for mild to moderate COVID patients) where mandated by MoH

My National Society has existing capacity and mandate in primary and outpatient clinical care before the COVID-19 outbreak. How should we scale up?

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

My National Society has existing capacity and mandate in prehospital care (e.g. ambulances) before the COVID-19 outbreak. How should we scale up?

- Scale up and adapt prehospital services as mandated by MoH

My National Society has never previously provided clinical or prehospital care. How should we scale up to support the health system?

National Societies *without* existing capacity or mandate in clinical care and National Societies without any current health mandate or capacities are not recommended to become involved in direct clinical care provision, and should instead focus on building community health and WASH capacity, carrying out effective RCCE activities, and supporting the most vulnerable communities. 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.

National Societies without previous clinical experience who are asked to support hospitals may consider (in collaboration with local authorities) establishing tented or semi-permanent structures adjacent to existing health facilities, to support with registration of patients, food provision, PSS or other non-clinical services that serve to reduce the burden on clinical care providers. These activities will allow existing health facilities and healthcare workers to dedicate their time to providing direct clinical care.

Infection prevention and control (IPC) in clinical contexts

Note: Some countries and contexts have specific guidance for IPC in clinical settings for COVID-19. It is important to follow the recommendations of local health authorities for the latest guidance and updates.

What IPC measures should be prioritized during the COVID-19 outbreak?

IPC minimum requirements should be put in place at both national and local level, and to progress to the full achievement of all requirements of the IPC core components according to local priorities. IPC strategies to prevent or limit transmission of COVID-19 in healthcare settings include the following:

- Ensuring triage, early recognition, and source control (isolating patients with suspected COVID-19);
- Applying standard precautions for all patients;
- Implementing empiric additional precautions (droplet and contact and, whenever applicable airborne precautions) for suspected cases of COVID-19;
- Implementing administrative controls;
- Using environmental and engineering controls.

More information on WHO IPC minimum standards and tools can be found at: -

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

What cleaning and disinfection agents should be used in healthcare facilities?

- CDC has guidance related to Best-Practices related to [Environmental Cleaning in Healthcare Facilities: in Resource-Limited Settings](#).
- Environmental cleaning in healthcare facilities or homes housing patients with suspected or confirmed 2019-nCoV infection should use disinfectants that are active against enveloped viruses, such as 2019-nCoV and other coronaviruses. There are many disinfectants, including commonly used hospital disinfectants, that are active against enveloped viruses. WHO guidance on cleaning and disinfection practices can be found [here](#) and currently recommends the use of:
 - 70% Ethyl alcohol to disinfect reusable dedicated equipment (e.g., thermometers) between uses

- Sodium hypochlorite at 0.5% (equivalent 5000ppm) for disinfection of frequently touched surfaces in homes or healthcare facilities

More information on IPC can be found here:

- [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125)
- <https://www.who.int/publications-detail/operational-considerations-for-case-management-of-covid-19-in-health-facility-and-community>

What type of PPE is needed when taking care of suspected or confirmed COVID-19 patients?

The protection of our frontline (health) workers is paramount and of utmost importance. Protecting yourself and your colleagues is much more than just about the PPE, and standard precautions and other instructions need to be adhered to, to ensure minimizing the transmission risk. PPE is also an important part of protection from the infection, when working closely with suspect or confirmed COVID-19 cases, but ONLY if you work according to instructions, and respect the donning and doffing procedures.

Based on current evidence, the COVID-19 virus is transmitted between people through close contact and droplets. Airborne transmission may occur during aerosol-generating procedures and support treatments (e.g. tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy); thus, WHO recommends airborne precautions for these procedures.

Current WHO recommendations of PPE when caring for COVID-19 patients are:

- The type of PPE used when caring for COVID-19 patients will vary according to the setting and type of personnel and activity.
- Health care workers involved in the direct care of patients should use the following PPE: gowns, gloves, medical mask, and eye protection (goggles or face shield).
- Specifically, for aerosol-generating procedures (e.g. tracheal intubation, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy) health care workers should use respirators (i.e. N95 or FFP2 standard or equivalent), eye protection, gloves and gowns; aprons should also be used if gowns are not fluid resistant.
- Please see, for detailed information on recommended PPE in accordance to setting, personnel and type of activity:
- [Personal Protective Equipment \(PPE\) supplies for COVID-19 - specifications and users \(25/3/20\)](#)
- [IFRC guidance on the generalised use of cloth face masks during the COVID-19 pandemic \(8 Apr 2020\)](#)



- [Rational use of personal protective equipment for coronavirus disease \(COVID-19\) and considerations during severe shortages:](#)

For more information please visit:

- [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125)
- <https://www.who.int/publications-detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>

What type of PPE is needed when performing NP or OP swaps from suspect COVID-19 patients?

Health care workers collecting nasopharyngeal (NP) and oropharyngeal (OP) swab specimens from suspected or confirmed COVID-19 patients should be well-trained on the procedure and should wear a clean, non-sterile, long-sleeve gown, a medical mask, eye protection (i.e., goggles or face shield), and gloves. The procedure should be conducted in a separate isolation room, and during NP specimen collection health care workers should request the patients to cover their mouth with a medical mask or tissue. Although the collection of NP and OP swabs have the potential to induce fits of coughing from the patient undergoing the procedure, there is no currently available evidence that cough generated via NP/OP specimen collection leads to increased risk of COVID-19 transmission via aerosols.

<https://www.who.int/news-room/q-a-detail/q-a-on-infection-prevention-and-control-for-health-care-workers-caring-for-patients-with-suspected-or-confirmed-2019-ncov>

Can disposable medical masks be reused?

No. Disposable medical face masks are intended for single-use only. After use, they should be removed using appropriate techniques (i.e. do not touch the front, remove by pulling the elastic ear straps or laces from behind) and disposed of immediately in an infectious waste bin with a lid, followed by hand hygiene.

If hand sanitizers are not available in the clinic/hospital, what should be done?

Handwashing with soap and (clean) water is the most effective way of getting rid of germs. Handwashing points should be set up (if not already) in all the rooms and areas in the clinic.

There are also local ways to make hand rub, see attached WHO guidance:

https://www.who.int/gpsc/5may/Guide_to_Local_Production.pdf

How do we clean soiled linen and laundry from COVID-19 patients?

All individuals dealing with soiled bedding, towels and clothes from patients with COVID-19 should:

1. Wear appropriate personal protective equipment, which includes heavy-duty gloves, mask, eye protection (face shield/goggles), long-sleeved gown, apron (if the gown is not fluid-resistant), boots or closed shoes before touching any soiled linen.
2. Never carry soiled linen against the body; place soiled linen in a clearly labelled, leak-proof container (e.g. bag, bucket)
3. If there is any solid excrement on the linen, such as faeces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container. If the latrine is not in the same room as the patient, place soiled excrement in a covered bucket to dispose of in the toilet or latrine;
4. Wash and disinfect linen: washing by machine with warm water (60-90°C) and laundry detergent is recommended for cleaning and disinfection of linens. If machine washing is not possible, linen can be soaked in hot water and soap in a large drum, using a stick to stir, avoiding splashing. If hot water not available, soak linen in 0.05% chlorine for approximately 30 minutes. Finally, rinse with clean water and let linen dry fully in the sunlight.

For more information please visit:

- <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control>

WHO online training on IPC can be found here: <https://openwho.org/courses/COVID-19-IPC-EN>

Clinical care for COVID-19 patients

What is the treatment for COVID-19?

There is no specific treatment for COVID-19. However, many of the symptoms caused by this virus can be treated and therefore treatment should be based on the symptoms of the patient. Moreover, supportive care for infected persons can be highly effective.

My National Society is involved in clinical care for COVID-19 patients. What clinical guidelines should we be following?



National Societies involved in clinical care should consult with their Ministry of Health regarding which clinical guidelines should be followed locally. WHO has produced several clinical guidance documents that may be helpful in your healthcare facility:

- [Clinical management of severe acute respiratory infection when COVID-19 is suspected](#)
- [Clinical care of severe acute respiratory infections – Tool kit](#)

Are antibiotics effective in preventing or treating the COVID-19?

No. Antibiotics do not work against viruses, they only work on bacterial infections. COVID-19 is caused by a virus, so antibiotics do not work. Antibiotics should not be used as a means of prevention or treatment of COVID-19. They should only be used as directed by a physician to treat a bacterial infection.

Are there any medicines or therapies that can prevent or cure COVID-19?

While some western, traditional or home remedies may provide comfort and alleviate symptoms of COVID-19, there is no evidence that current medicine can prevent or cure the disease. WHO does not recommend self-medication with any medicines, including antibiotics, as a prevention or cure for COVID-19. However, there are several ongoing clinical trials that include both western and traditional medicines. WHO will continue to provide updated information as soon as clinical findings are available.

My National Society has been asked to provide clinical services for COVID-19. How do we set up a treatment centre?

Providing clinical services for COVID-19 patients is a complex task that requires advanced resources, expertise, personnel, and equipment. Every context is different and care must be integrated into existing systems. WHO has published a practical manual to set up and manage a [SARI treatment centre](#) and a SARI screening facility in healthcare facilities that may be helpful.

What are the main steps to consider for effective triage during COVID-19?

Clinical triage includes a system for assessing all patients at admission, allowing for early recognition of possible COVID-19 and immediate isolation of patients with suspected disease in an area separate from other patients (source control).

To minimize transmission risk at the healthcare setting for healthcare personnel, as well as for other patients (and relatives), well-equipped triage, with trained staff and with a clear flow is essential.

- All health staff should be well trained and have a high level of clinical suspicion and understanding of COVID-19.
- Protocols must be adapted to local context and must take into consideration the various options available.

- All staff (including non-medical staff) that will work at the triage, should have proper training on the disease and what protective measures need to be taken and when.
- A clear flow of patients should be identified:
 - If possible, a pre-triage should be implemented, where a quick screening for possible symptoms and which 'flow' the patient should take is done (this can be done for example in advance by e.g. calling, or at the healthcare facility with information for patients with symptoms directing them to the right flow, or by HCW outside the facility who is screening the patients).
 - Separate flow and areas for the suspect COVID-19 patients from other patients. (If possible, by physical barriers, such as fences, walls, separate waiting areas etc.)
 - If appropriate, institute the use of screening questionnaires according to the updated case definition.
(<https://apps.who.int/iris/bitstream/handle/10665/331506/WHO-2019-nCoV-SurveillanceGuidance-2020.6-eng.pdf>)
 - Standard precautions should be implemented everywhere, and other protective measures (e.g. appropriate level of PPE) depending on the level of interaction, as well as procedures performed.
 - Information sharing and guidance at all levels (patients, relatives as well as all staff) should be implemented, to ensure compliance of the different measures taken.

Emergency medical services

Coming soon - please see resources folder for available guidance, and submit questions to be answered here.

Mental health and psychosocial support (MHPSS)

Note: All Mental Health and Psychosocial Support related COVID-19 resources can be found [here](#) on the IFRC Reference Centre for Psychosocial Support website. Many guidelines and tools are available in different languages.

How can Psychological First Aid be provided in the context of physical distancing? What tools are available to support this?

- Psychological First Aid (PFA) can be adapted for remote delivery. Guidance from the IFRC Reference Centre for Psychosocial Support on how to provide remote PFA can be found [here](#).
- In the context of COVID-19, PFA to affected persons is usually provided online or over the phone. Exceptionally, the provision of PFA to frontline workers may take place in person.
- Where face-to-face PFA is being conducted, the IFRC Reference Centre for Psychosocial support has extensive guidance tools:

- [Psychological First Aid Guide](#)
- [PFA Module 1: Introduction](#)
- [PFA Module 2: Basic](#)
- [PFA Module 3: Children](#)

How can National Societies provide support to those who have lost family members and other loved ones to COVID-19?

- Guidance from the IFRC Reference Center for Psychosocial Support on 'Mental Health and Psychosocial Support for Staff, Volunteers and Communities in an Outbreak of Novel Coronavirus' can be found [here](#)

How are migrants impacted by COVID-19 and how can National Societies provide support to this population?

- Migrants may be more vulnerable to the health, social, and economic risks and impacts of COVID-19 than the general population and often face barriers accessing healthcare services.
- IFRC, UNICEF, and WHO guidance on preventing social stigma can be found [here](#).
- Find [here](#) the Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings (jointly developed by IFRC, IOM, UNHCR and WHO)

What targeted support can National Societies provide to children in the context of COVID-19?

- COVID-19 has multiple direct and indirect impacts on children's protection, well-being, and development.
- Guidance, including suggested messages, on how to talk to children and young people about COVID-19 from the Australian Red Cross can be found [here](#).
- Please find [here](#) IFRC key messages for governments on 'Coordinating the Protection of Children during the COVID-19 Response'
- The Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings has published a book, [My Hero is You](#), for children affected by the COVID-19 outbreak. It is intended to be read to children aged 6-11 years by a parent, caregiver, or teacher. Audio versions are also available. The book teaches children how to protect themselves and the people they love and how to manage difficult emotions they might face in this new and changing reality.

Many National Societies have country coordinators who are deployed in different areas. How can National Societies coordinate remote support for staff and volunteers?

- Guidance from the IFRC Reference Center for Psychosocial Support on 'Mental Health and Psychosocial Support for Staff, Volunteers and Communities in an Outbreak of Novel Coronavirus' can be found [here](#)

- Guidance from the IFRC Reference Center for Psychosocial Support on Supportive Supervision for volunteers providing MHPSS during COVID-19 can be found [here](#).

How can National Societies care for staff and volunteers who are in quarantine?

- Hong Kong Red Cross has developed guidance on '[Psychological Coping during a Disease Outbreak for families, friends, colleagues of those in quarantine or self-isolation](#)', outlining what to do and what not to do when providing support to those in quarantine or isolation.
- Hong Kong Red Cross has developed a '[14-day psychological wellbeing diary](#)', offering ideas for daily activities and goals in order to stay physically and mentally active and healthy in quarantine.

Maintaining essential community and clinical health services during the pandemic

Community based health and first aid (CBHFA)

CBHFA is based on behaviour-change-focused health promotion through community-based volunteers. CBHFA volunteers work in the communities where they live, work and play. They use a number of different community mobilisation activities to help community members identify the priority issues and come up with solutions that work best for the community. But in the world of COVID-19, volunteers are modifying their community approaches to ensure that they and their community members stay safe in their interactions.

How can CBHFA volunteers work while carrying out physical distancing?

Focus Group Discussions: While CBHFA volunteers use Focus Group Discussions normally, in COVID-19, traditional Focus Group Discussions should be stopped because of the risk this method poses to safe physical distancing. Some volunteers are conducting virtual focus group discussions using online tools like Skype or Zoom, while other volunteers are still using the method as designed BUT talking with a much smaller group of people (maximum four) who each sit an adequate distance apart. These discussions should ideally be held outside or in a well-ventilated area.

Household Visits: Household visits are the most effective tools that CBHFA volunteers used pre-COVID-19. With some modifications, these visits are still possible and encouraged where safe and allowed by local authorities. We advise CBHFA volunteers to regularly check in with their vulnerable community members either by phone, through the computer or if allowed, by stopping by and checking in on them through an open door or a window. Just seeing the familiar face of their volunteer can go a long way for the mental health of people struggling in self-isolation. CBHFA volunteers already know where these vulnerable people live and so are best equipped for checking in



regularly, and if necessary doing basic chores like fetching water or bringing food to the door, or reporting their health symptoms back to the local health authority.

How are CBHFA volunteers staying current with existing safety and prevention protocols?

CBHFA volunteers are a vital link between the community's needs, concerns and health status and the local health authority. Volunteers are trained to follow the guidance of their Ministry of Health and use the CBHFA approach to support the community. The Ministry of Health is the lead public health authority for all CBHFA volunteers and all CBHFA content is written in alignment with WHO guidance and protocols, but accessible and general enough to allow for adjustments to ensure that the materials aligns with government guidance.

The [CBHFA COVID-19 Module](#) is written in accordance with WHO protocols and aligned with IFRC guidance. This guidance is vast and is kept up to date as we learn more about the virus that causes COVID-19. CBHFA content should be updated regularly to keep pace with these changing protocols, procedures, guidance, and recommendations.

How are CBHFA volunteers working with vulnerable groups in this COVID-19 response?

In the COVID-19 response, volunteers seek out the community members they know to be at risk of COVID-19 transmission. The volunteers check in on them regularly to provide health messaging, provide necessary resources like water, food, psychosocial support and information. If the person doesn't feel well or reports having one or more symptoms of COVID-19, the volunteer will coach a person in the household in proper home care and share the health information with local health authorities.

If a community was not actively using CBHFA as an approach before COVID-19, can they use it now?

Sure, CBHFA is a community-based health approach and tool. It can be used at any time. National Societies wanting to incorporate CBHFA programming can talk with the IFRC regional office to see how they can get support to train volunteers and staff virtually. IFRC is working on a suite of tools and webinars to support National Societies in sustaining or starting up CBHFA programming for a more effective COVID-19 response.

What materials are available for CBHFA or community-based volunteers to teach about COVID-19 prevention and care?

- Materials on basic community based health are available at www.ifrc-ecbhfa.org
- The IFRC Learning Platform also features several e-courses on CBHFA. The CBHFA COVID-19 Module is available at this [link](#). The content is being updated regularly.

Do volunteers need to wear masks when they work in the community?

CBHFA volunteers are asked to check with their Ministry of Health guidance as well as their National Society regulations around when to use masks. While the IFRC provides guidance, CBHFA volunteers should work in alignment with their National Society guidance. In the absence of national level guidance, we advise volunteers to NOT wear medical masks when they are interacting with the community, in light of the global shortage of medical PPE. However, cloth masks can be worn to limit the chance that a volunteer accidentally spreads the virus while asymptomatic or presymptomatic. Guidance on the [use of cloth masks is available here](#). The only exception is that volunteers interacting with sick people or caring for a sick person should wear a mask, gloves and use the guidance in proper wearing, removal and disposal of the PPE - please see home care guidance [here](#).

Reproductive, maternal and newborn health

What sexual and reproductive health services should be provided during the COVID-19 pandemic?

- Experience in past epidemics has shown that lack of access to essential health services resulted in more deaths than those caused by the epidemic itself. It is important to ensure that essential reproductive, maternal and newborn health services be maintained during the pandemic using appropriate infection prevention and control precautions. This includes intrapartum care for all births, emergency obstetric and newborn care, post-abortion care, safe abortion care to the full extent of the law, contraception, clinical care for rape survivors, and prevention and treatment for HIV and other sexually-transmitted infections.
- For antenatal care (ANC), prioritize routine visits for women in the third trimester and those with high-risk pregnancies (including hypertension and diabetes). Women with obstetric complications need to have access to care 24/7.
- Postnatal care is critical for reducing preventable mortality and should be maintained – focus on first week postnatal visits for women and newborns, including breastfeeding support.
- Health workers should be prepared to care for those subjected to intimate partner violence, as violence is likely to increase during epidemics due to stress, increased confinement and exposure to perpetrators and reduced access to basic needs.

Are pregnant women at higher risk from COVID-19?

While at this point data is limited, there is currently no evidence that pregnant women are at a higher risk of severe illness than the general population. However pregnant women have been known to experience greater difficulty with other respiratory infections and conditions such as influenza and asthma. It is important that pregnant women take precautions to protect themselves against COVID-19 and report possible symptoms to their healthcare provider.

Can COVID-19 be passed from a woman to her unborn baby?

There is currently no evidence that a woman with COVID-19 can pass the virus to her fetus during pregnancy or childbirth. To date, the virus has not been found in amniotic fluid or breast milk. Intrapartum care of women with suspected or confirmed COVID-19 needs to ensure isolation of the patient from other patients. Appropriate personal protective equipment (PPE) must be used by relevant health staff including mask, goggles, gloves, and gown/apron.

Can COVID-19 be passed through breastfeeding?

- The COVID-19 virus has not, to date, been detected in the breastmilk of any mother with confirmed/suspected COVID-19. It appears unlikely, therefore, that COVID-19 would be transmitted through breastfeeding or by giving breastmilk that has been expressed by a mother who is confirmed/suspected to have COVID-19. Researchers continue to test breast milk from mothers with confirmed/ suspected COVID-19.
- Further, newborns and infants are at low risk of COVID-19 infection. Among the few cases of confirmed COVID-19 infection in young children, most have experienced only mild or asymptomatic illness.
- Breastfeeding women with COVID-19 should practice respiratory hygiene during breastfeeding and wear a mask where available. Wash hands before and after touching the baby and routinely clean and disinfect surfaces.

Following delivery, should a baby still be immediately placed skin-to-skin and breastfed if the mother is confirmed/suspected to have COVID-19?

- Yes. Immediate and continued skin-to-skin care, including kangaroo mother care, improves thermoregulation of newborns and several other physiological outcomes, and is associated with reduced neonatal mortality. Placing the newborn close to the mother also enables early initiation of breastfeeding which also reduces neonatal mortality.
- The numerous benefits of skin-to-skin contact and breastfeeding substantially outweigh the potential risks of transmission and illness associated with COVID-19.

What are the hygiene recommendations for a breastfeeding mother confirmed/suspected to have COVID-19?

If a mother is confirmed/suspected to have COVID-19 she should:

- Wash hands frequently with soap and water or use alcohol-based hand rub, especially before touching the baby
- Wear a medical mask while feeding. However, if the mother does not have a facemask, breastfeeding can still be continued. When wearing a facemask it is important to:
 - Replace masks as soon as they become damp
 - Dispose of masks immediately

- Not re-use a mask
- Not touch the front of the mask but untie it from behind
- Sneeze or cough into a tissue, immediately dispose of it and use alcohol-based hand rub or wash hands again with soap and clean water
- Regularly clean and disinfect surfaces

If a mother with confirmed/suspected COVID-19 is expressing her milk for her baby, are there extra measures needed when handling the breast milk pump, milk storage containers or feeding utensils?

Even when COVID-19 is not a consideration, breast milk pumps, milk storage containers and feeding utensils need to be appropriately cleaned after every use.

- Wash the pump/containers after every use with liquid soap, e.g. dishwashing liquid and warm water. Rinse after with hot water for 10-15 seconds.
- Some breast pumps parts can be put in the top rack of a dishwasher (if available). Check the instruction manual before doing this.

If a mother with confirmed/suspected COVID-19 is not able to breastfeed or to express breastmilk, can wet-nursing be recommended?

Wet-nursing may be an option depending on acceptability to mothers/families, national guidelines, cultural acceptability, availability of wet-nurses and services to support mothers/wet-nurses.

In settings where HIV is prevalent, prospective wet-nurses should undergo HIV counselling and rapid testing, according to national guidelines, where available. In the absence of testing, if feasible undertake HIV risk assessment. If HIV risk assessment/counselling is not possible, facilitate and support wet-nursing. Provide counselling on avoiding HIV infection during breastfeeding. Prioritise wet-nurses for the youngest infants.

If a mother confirmed/suspected to have COVID-19 was unable to breastfeed because she was too ill or because of another illness, when can she start to breastfeed again?

A mother can start to breastfeed when she feels well enough to do so. There is no fixed time interval to wait after confirmed/suspected COVID-19. There is no evidence that breastfeeding changes the clinical course of COVID-19 in a mother. She should be supported in her general health and nutrition to ensure full recovery. She should also be supported to initiate breastfeeding or relactate.

If a mother is confirmed/suspected to have COVID-19, is infant formula milk safer for infants?

No. There are always risks associated with giving infant formula milk to newborns and infants in all settings. The risks associated with giving infant formula milk are increased whenever home and community conditions are compromised e.g. reduced access to health services if a baby becomes

unwell / reduced access to clean water / access to supplies of infant formula milk are difficult or not guaranteed, not affordable and not sustainable. The numerous benefits of breastfeeding substantially outweigh the potential risks of transmission and illness associated with the COVID-19 virus.

Is it advisable for a mother with confirmed/suspected COVID-19 who is breastfeeding, to give a ‘top-up’ with infant formula milk?

No. If a mother is confirmed/suspected to have COVID-19 and is breastfeeding, there is no need to provide a ‘top-up’ with infant formula milk. Giving a ‘top-up’ will reduce the amount of milk produced by a mother. Mothers who breastfeed should be counselled and supported to optimise positioning and attachment to ensure adequate milk production. Mothers should be counselled about responsive feeding and perceived milk insufficiency and how to respond to their infants’ hunger and feeding cues to increase the frequency of breastfeeding.

Is it alright for health facilities to accept free supplies of formula milk for infants of mothers with confirmed/suspected COVID-19?

No. Donations of infant formula milks should not be sought or accepted. If needed, supplies should be purchased based on assessed need. Donated formula milk is commonly of variable quality, of the wrong type, supplied disproportionate to need, labelled in the wrong language, not accompanied by an essential package of care, distributed indiscriminately, not targeted to those who need it, is not sustained, and takes excessive time and resources to reduce risks.

For more information on breastfeeding in the context of COVID-19, including a helpful decision tree, please see [here](#) for guidance from WHO.

Further detailed information is available from [WHO](#), the [Inter-Agency Working Group on Reproductive Health in Crises](#), and the [Safe Delivery App](#).

Immunisation

Should National Societies urge children to be vaccinated during the COVID-19 pandemic?

The IFRC, UNICEF and World Health Organization recommend that routine immunization services should be maintained to prevent vaccine preventable diseases. However, as always, National Societies should ultimately follow the guidance of each country’s Ministry of Health.

What can National Societies do if the Ministry of Health is recommending that routine immunisation services be halted during the COVID-19 pandemic?

The National Society can advocate with the government to maintain immunization services and can share the WHO and UNICEF recommendations to maintain routine immunization during COVID-19

(guidance document to be shared soon). Maintaining immunisation services will help prevent outbreaks of epidemic prone vaccine preventable diseases, such as measles, and will help protect older adults and individuals with high-risk conditions, such as respiratory diseases from pneumococcus and influenza, both of which can cause pneumonia. The approach to immunisation services should be based on local physical distancing policies and infection prevention and control measures. The immunisation visit also provides an opportunity to share information on behaviours to reduce the risk of transmission of COVID-19.

What information can National Societies share with communities and mothers or caregivers about the importance of immunization during the COVID-19 pandemic?

National Societies can help inform communities that immunisation of children is taking place and can explain the importance of vaccinating children to protect them from outbreak prone (and life-threatening diseases) such as measles, diphtheria, pertussis, and meningococcus. During the immunisation session, mothers/caregivers should follow local guidance on physical distancing while in the waiting area.

What can National Societies do to help protect children during an outbreak of a vaccine preventable disease, such as measles?

Outbreaks of vaccine preventable diseases, such as measles, may occur, especially in countries that have delayed a vaccination campaign and/or have temporarily suspended routine immunisation services. National Societies can engage local authorities and community leaders among high-risk population groups with low vaccination coverage to discuss the situation and identify barriers to immunization. These discussions should maintain physical distancing and should include only a limited number of individuals, considering local guidance on the size of meetings. National Societies can then work with government authorities to overcome the identified barriers and share information with these communities on actions taken. In the long run, listening to the community and taking actions based on the community's concern is likely to improve routine immunisation coverage. In supporting these activities, National Societies should carefully consider the safety of staff and volunteers, and may request the use of cloth face masks and may rely on younger staff and volunteers who do not have underlying health conditions.

Should National Societies continue community-based surveillance activities, including those for vaccine preventable diseases?

Community-based surveillance for polio and other health risks can be maintained during the COVID-19 pandemic. In some settings, community-based surveillance for neonatal tetanus can be conducted remotely. If this is possible, then this surveillance should be continued. Persons conducting community-based surveillance should not undertake any in-person investigations or community/group sensitizations unless asked to do so by the local health authorities, and should follow the guidance on CBS in COVID-19, available on this website..



Will receiving a vaccine cause a COVID-19 infection or make it worse?

Vaccination does not cause COVID-19 infection and there is no evidence that COVID-19 illness can be made worse by receiving a vaccine. However, individuals who have COVID-19 symptoms such as fever and cough should not be taken to a vaccination session at this time. Rather, a healthcare provider should be consulted who can give advice on the next steps related to the illness.

Malaria prevention

Alliance for Malaria Prevention guidance on insecticide-treated net (ITN) distribution during the COVID-19 pandemic can be found on the AMP website under the following link:
<https://allianceformalariaprevention.com/about/amp-guidelines-and-statements/>

How can countries integrate ITN distribution with COVID-19 response without harming either programme?

In light of the COVID-19 pandemic, many National Malaria Control/Elimination Programmes are reviewing their strategies and operating procedures for their Insecticide-Treated Nets (ITNs) mass distribution. One of the issues to be considered by countries is whether to integrate COVID-19 messages in mass campaign messaging. The [AMP guidance on Social and Behavior Change \(SBC\) activities](#) in the COVID-19 context sets out the advantages and disadvantages of integrating COVID-19 with ITN campaign measures (co-messaging) for several groups of SBC activities.

What is the recommendation for net use for COVID-19 confirmed (or suspected) cases?

Use of ITNs should be made accessible to people affected or suspected to be a carrier of COVID-19. Information that should be disseminated needs to include the fact that anyone with symptoms of COVID-19 should be able to sleep under a bed net. Another consideration for countries ordering and/or distributing nets should be to increase the buffer stock of ITNs during the pandemic, to ensure that people infected with the virus that causes COVID-19 can sleep under a net by themselves.

What should be done with a net used by someone sick with COVID-19? What should be done with a net used by someone who died of COVID-19?

ITNs, once washed, are safe to be used again after having been used by someone affected by COVID-19 or who died from the virus. Based on current evidence, soap (or equivalent) and water are sufficient for washing ITNs that have been exposed to COVID-19. ITNs that have been used by people with COVID-19, should be washed with soap in cool water. Never use hot water or harsh detergents to wash ITNs. Always dry ITNs in the shade after they have been washed. Discard the water away from clean water sources.

Any guidance on potential integration of other campaigns, like community health programs?

As distribution strategies will have to be adapted at country level, with preference for door-to-door distribution modalities instead of fixed distribution points for instance, community channels for distribution should also be explored, in particular through existing health interventions. The last mile logistics for ITN distribution is likely to be particularly challenging, and could also benefit from such distribution channels.

Are there concerns around COVID-19 and plastic bales and packages?

The main points of exposure for COVID-19 transmission are related to the handling of the bales. Therefore, it will be important to plan and budget for the required handwashing stations, soap or hand sanitizer for warehouse managers, loaders and off loaders, conveyors (where used, and to reduce risks, conveyors should be reconsidered for ITN distribution in COVID-19 affected countries as physical distancing will be difficult to maintain) and logistics personnel at all levels. On and offloading of bales typically involve bringing workers together in groups to move bales from trucks/containers to warehouses and vice versa, so the approach may need to be revised to fewer people for loading and offloading (in line with restrictions on groups of people and being able to maintain physical distance of two metres between people), which may increase the amount of time required for the operation and should be accounted for in the timeline of activities.

Should countries prioritize those populations or geographic areas with the highest malaria burden?

The AMP guidance on ITN distribution in COVID-19 context strongly advocates for NMCP and partners involved in ITN distribution to prioritize areas with the highest malaria burden. ITN distribution should also target vulnerable groups, such hard-to-reach and marginalised people, as well as IDPs and refugees. When necessary, urban areas can be deprioritised in order to free up ITNs for rural areas, where distribution will be less likely to increase COVID-19 contamination.

First Aid

First Aid guidance for National Societies comes from the IFRC Global First Aid Reference Centre (GFARC). **For additional questions related to first aid and COVID-19, contact GFARC at first.aid@ifrc.org.** Remember, always follow your local health agency/ government rules. Medical advice changes constantly. This list of FAQs should not be considered current, complete, or exhaustive. National Societies providing clinical services should continue to monitor the WHO and respective Ministries of Health for the latest clinical and infection prevention and control guidance.

In the context of COVID-19, can National Society staff and volunteers continue to provide first aid to those in need?

- Yes, however, preventive steps must be taken to reduce the potential risk of transmission. Hand hygiene measures should be followed- where possible soap and water should be used. If unavailable, an alcohol-based hand sanitiser or disinfectant solution can be used instead. Hands should be washed hands BEFORE and AFTER providing first aid.

What can I do if I do not have access to clean water, soap, or hand sanitizer for handwashing when providing first aid?

- Washing hands with ash is an alternative when soap is not available. Rub your hands with cold ash from a clean wood fire to remove germs. Remove the ash by shaking your hands or using a clean tissue or cloth to wipe them away.

What should I do if I have symptoms of COVID-19?

- Follow your local health authorities' guidance about what to do if you suspect you may have COVID-19. Some communities test anyone with symptoms in order to isolate all cases, while others recommend that anyone with symptoms of respiratory illness stays home until after their symptoms have resolved.
- If providing home care for someone who has symptoms of COVID-19, use the [IFRC home care for coronavirus patients guidance](#).

When should I call a doctor or Emergency Medical Services due to COVID-19 symptoms?

- If the person has a mild fever or cough, they should stay at home and rest in isolation from those they live with, unless the testing policy in their country or community urges them to get tested and treated even for mild COVID-19. IFRC guidance on home care for coronavirus patients can be found [here](#).
- If the person is experiencing difficulty breathing or has a persistent temperature above 38°C (103-104 Fahrenheit), call a doctor, emergency medical services, or healthcare provider immediately.

In the context of COVID-19, what are the rules for providing cardiopulmonary resuscitation (CPR) by advanced first aiders?

- There are different CPR protocols to follow depending on if the casualty is an adult or child.
- Evidence suggests that CPR has the potential to generate aerosols
- First aid providers caring for persons with a suspected case of COVID-19 should follow the general preventive measures for reducing infection risk when caring for a person with COVID-19 . It is advisable to place a facemask over the casualties nose and mouth. It is also advisable to wear gloves and a disposable gown if possible.

- When providing CPR to adults, it should be limited to continuous chest compressions at a rate of 100 to 120 compressions per minute until the arrival of an artificial ventilation device.
- When providing CPR to children, in addition to chest compressions rescuers who are willing and trained to do so can provide rescue breaths to infants and children.

What equipment do first aiders and rescuers need to wear during advanced care in the context of COVID-19?

- Workers caring for potentially infected people should wear gloves, masks, eye protection, and gowns as part of their personal protective equipment. See the [PPE guidance](#) for further details.

How should I wash first aid and rescue equipment, clothing, and materials in the context of COVID-19?

- If possible, do not shake dirty laundry. This will minimize the possibility of dispersing virus in the air.
- If possible, wash items using the warmest appropriate water setting (40°C minimum). Dry items completely. If clothing cannot be immediately laundered, store in a sealed disposable bag for transport to a cleaning facility.

Does COVID-19 require the use of infrared thermometers?

- The use of the eardrum thermometers remains valid for all first aid activities.
- Standard hygiene measures must be applied to protect personnel during the activity and to disinfect the equipment. Infrared thermometers could be used without contact.

Can I continue to organize first aid training or awareness sessions?

- Gatherings are not recommended at this time. Many governments have put restrictions on non-essential gatherings. Follow your local authority/ government rules.
- If a first aid training must take place and is authorized to do so:
 - Trainers who are ill or vulnerable to illness should not provide trainings
 - As a part of pre-class communication, potential participants who are ill or who have underlying conditions should be told to stay home.

How should mannequins and other training equipment be handled in the context of COVID-19?

- Participants and instructors should wash their hands between each use of equipment with soap and water for at least 20 seconds. Where hand washing is not possible, use an alcohol based hand sanitizer that contains at least 60% alcohol.
- Mannequins and other training devices touched by participants should be cleaned between each use with the cleaning product routinely used for this purpose, according to the

manufacturer's directions. This may include cleaning solutions, sprays and wipes, which should be labeled as effective against viruses.

- Where possible, one mannequin per participant should be used.

In the context of COVID-19, what are the rules for teaching cardiopulmonary resuscitation (CPR)?

- When teaching how to respond to an unresponsive casualty, use a mannequin and not a volunteer participant for demonstration and practice purposes
- Participants should still practice and master the chin lift technique however, do not let participants perform rescue breaths. Emphasize the importance of rescue breaths outside of the COVID-19 pandemic situation.
- Chest compressions and public access defibrillation can be practiced
- Exceptionally, participants who have not practiced giving rescue breaths can receive their first aid certification given that they have mastered the chin lift technique and all other required skills

How should first aid teaching techniques be adapted in the context of COVID-19?

- When teaching how to respond to bleeding, students should practice the direct pressure method on themselves
- When teaching how to respond to choking, do not practice back blows. Students can practice the correct hand position for abdominal thrusts on themselves.

Support for older people

What targeted support can National Societies provide to older people in the context of COVID-19?

- All age groups are at risk of contracting COVID-19 however, older people (over age 60) are at greater risk of developing severe illness and complications as a result of infection (WHO, 2020). This may be due to the physiological changes associated with ageing and/ or underlying conditions.
- Find [here](#) the Interim guidance for Red Cross and Red Crescent staff and volunteers working with older people during COVID-19 response
- Find [here](#) the Red Cross Red Crescent key messages for older people during the COVID-19 pandemic, for adaptation by National Societies.
- In the context of physical distancing, Psychological First Aid (PFA) can be adapted for remote delivery to older adults who may be in isolation or quarantine. Guidance from the IFRC Reference Centre for Psychosocial Support on how to provide remote PFA can be found [here](#).
- Hong Kong Red Cross guidance on psychological coping during disease outbreak for elderly and people with chronic conditions can be found [here](#)



Non communicable diseases (NCDs)

How are people with non-communicable diseases (NCDs) affected by COVID-19?

- All groups are at risk of contracting COVID-19. However, those with underlying conditions and non-communicable diseases (of any age group) are more at risk of severe illness and complications associated with infection (WHO, 2020). Such underlying conditions may include cardiovascular disease, diabetes, chronic respiratory disease, and cancer.

What targeted support can be provided to people with NCDs or underlying conditions in the context of COVID-19?

- Hong Kong Red Cross guidance on psychological coping during disease outbreak for elderly and people with chronic conditions can be found [here](#)

National Society epidemic and pandemic preparedness

Coming soon