In many LMICs, community-based care, or care delivered directly in homes and communities, is the entry point to the health system, making it an essential part of achieving universal health coverage for all. Shifting to or expanding community-based services, including proactive population outreach, can help provide people with continuous and comprehensive care where it is most accessible to them. By extending care directly into homes and communities, community-based services can help reach vulnerable communities who routinely face difficulties accessing quality care, (1–5) and integrated service delivery models that offer a more comprehensive set of services at the community level are particularly useful for maintaining access to routine and essential services for patients with complex conditions. (6–8)

During the COVID-19 pandemic, a community-based approach is an essential foundation for emergency preparedness and risk management, and can also support strengthening health system resilience long after the crisis. (1,9–11) As countries balance the rising demand for care with limited resources, misinformation, and restricted movement of communities, a proactive, community-based approach can play a critical role in maintaining access to needed services to help prevent excess morbidity and mortality, as well as in risk communication and community-engagement strategies for COVID-19. (1,9–11)
Making a rapid shift to community-based service provision during the COVID-19 pandemic will be challenging no matter the context, however making this pivot may offer several opportunities for health systems strengthening beyond the COVID-19 time period. These challenges and opportunities may include:

### Challenges & Opportunities

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#### Key Opportunities:

**Safety, provider competence, and motivation**

The PHC workforce will be at the center of the pivot to community-based care, putting them at increased risk to various hazards, including pathogen exposure, long work hours, psychological distress, occupational and burnout, and/or stigma. (1,14) To protect the safety and rights of health workers and patients, health systems will need to take special care to ensure health workers are adequately supplied, trained, and motivated to deliver quality care in communities. This may entail addressing issues such as logistics planning, retraining, budgeting, and supply-chain and waste management for personal protective equipment (PPE) and hand hygiene (1,14) as well as training on COVID-specific response competencies including infection prevention and control, case investigation and management, surveillance and reporting, and risk communication. (12)

**High-quality primary health care**

Community-based care can offer an effective means to ensure continuity of needed services both during the COVID-19 pandemic and beyond. Additionally, in the long term, effective community-based services help to ensure the comprehensiveness and person-centeredness of care and provides a platform to engage communities and build their trust in PHC as the first point of contact. To achieve this potential, community-based care must be coordinated with other levels of the health system—via team-based care, robust information systems, or other means—to avoid fragmentation. (1,11,12)

Resilience of health systems: Community-based care helps to build resilience of communities during a crisis and ensure prompt, sustained access to both curative and preventive services in line with local needs. Community-based platforms that actively solicit community input and respond to local health needs provide a strong foundation for rebuilding the health system during the COVID-19 recovery phase, supporting future emergency preparedness and risk management and long-term resilience. (1,11,12)

**Equitable access**

Community-based care can help strengthen the capacity of PHC to serve as the first point of contact with the health system. However, community-based care also has the potential to widen pre-existing disparities in access and health outcomes among vulnerable or often overlooked communities, such as near-poor communities in cities and urban settings. To ensure no communities or groups get left behind, community-based services should include outreach services grounded in local data and sensitive to the determinants of health, such as tracking the health of vulnerable households via data registries, coordinating with social workers and other sectors to address financial or socioeconomic barriers to health, and conducting targeted health promotion and education activities for at-risk segments of the population. (1,10,12,13)
GOVERNANCE AND FINANCING FOR COMMUNITY-BASED PHC:

The initiation or expansion of community-based health initiatives and programs should be aligned and integrated into broader PHC policies to ensure successful implementation. When planning for community-based service delivery, policymakers and planners should adopt a whole-of-system approach, taking into consideration population health needs and health system capacities and grounding policies in local evidence. In addition, policies should take care to protect the safety and rights of community-based health workers and, where needed, promote sustainability by moving towards the formal integration of these workers in the health system. (14,16,17)

To maintain quality and safety, community-based care must be embedded within a strong quality management infrastructure—including regulatory statutes, multisectoral quality policy strategies, accreditation, community engagement, and ongoing performance evaluation. (11,17,18) In particular, key decisions will need to be made about which services can be safely provided in communities, by which types of healthcare providers, and how processes and guidelines—such as referral management or personal protective equipment policies—need to change to support provider and patient safety. (1)

The transition to community-based services in the context of COVID-19 will likely require changes to payment systems and financing for community-based services. Supportive payment systems in particular enable care teams to allocate time and resources based on community needs and ensure providers are appropriately remunerated. (1,16,17,19–21) Health financing initiatives should also focus on removing financial barriers, particularly for vulnerable populations to ensure everyone can benefit from community-based care. Learn more about priorities for health financing response to COVID-19 here.

COUNTRY-BASED PRIORITIES AND SERVICE-DELIVERY:

To be effective, community-based service delivery must be designed with the needs and preferences of the communities to be served in mind, as well as aligned with national or system-level priorities. Local priority setting and community engagement practices can be leveraged to solicit community input and ensure that decisions are grounded in the local evidence and take into consideration local disease burden, the COVID-19 transmission pattern, the baseline capacity for service delivery at the community and facility levels, and communities’ distinct care seeking patterns. This process can be facilitated by empanelment, which enables community-based care teams to understand and enumerate the needs of the communities they serve and identify patients/community members in need of home or community-based care. By ensuring that the panel of any care team is appropriately sized, empanelment also helps to ensure care teams can manage the health of all their patients without becoming overburdened. This is particularly important as health systems are overburdened during the COVID crisis and may need to prioritize community-based care for specific segments of the population. (22)

To improve emergency preparedness and response and resource mobilization, priorities should be regularly re-evaluated with input from a diverse range of community stakeholders—supported by robust community engagement platforms, measurement and evaluation systems, and information systems. (1) (6,17)
HOW CAN PHC BE LEVERAGED?

WORKFORCE ORGANIZATION AND CRITICAL INFRASTRUCTURE

Shifting to or expanding community-based services is likely to entail changes in the roles and responsibilities of the PHC workforce. This may require re-assignment, task shifting, and/or in-service training to both redistribute and capacitate the workforce to deliver services in communities. Community-based service delivery is strengthened by team-based care organization that incorporates explicit processes for bi-directional communication and data sharing across sectors and levels of the health system, and the transition to community-based service delivery is likely to be easier in health systems in which the workforce already has competencies in team-based, comprehensive PHC. During COVID-19, health systems and facilities can help to facilitate this transition to team-based care by defining team structures, roles and responsibilities grounded in team members’ competencies, and communication structures. Although team cultures take time to build and develop they are essential for strong team functioning; during the rapid transitions COVID-19 is driving, taking time to align on a common vision and purpose for teams; addressing fears, stigma, and misconceptions; and demonstrating organizational support and leadership commitment can go a long way. (21, 23–28)

Additionally, optimizing the value and impact of community-based care requires that the workforce be adequately resourced and supplied. (1,14,17,19,29) To support the transition, health systems should ensure community-based care teams have access to needed drugs and supplies through strengthening supply chains, anticipating interruptions, and preparing mitigation strategies. (1,17,19) This could require changes to/extension of supply chains to get essential, time-sensitive supplies such as personal protective equipment to the community level perhaps while bypassing facilities or other links in the chain that might be shut down/inoperational.

Finally, during the COVID-19 pandemic, all essential workers are faced with greater burden and stress, and therefore maintaining workforce motivation must be a top priority. Doing so will above all require ensuring that health workers feel safe and respected.(30–32) Additional means of ensuring motivation may focus on maintaining intrinsic motivation—for example, recognizing the achievements of staff and providing positive feedback—and/or on extrinsic motivation, for example via the provision of monetary or other incentives.(33,34)

PROACTIVE INFORMATION MANAGEMENT:

Community-based services offer a critical source of information and data for surveillance and response efforts, including through the collection and use of local data that enables community-based providers to detect, diagnose, and manage conditions at the community level and subsequent notification of emergency response systems.(1,12,35) Such efforts can strengthen the immediate response to COVID-19 as well as improve surveillance and preparedness in the future.

Continuous feedback loops and ideally, interoperable, information systems are necessary to ensure that information collected at the community level informs action and improves routine service delivery activities. The information generated from surveillance and response efforts at the community level, including lessons learned from response to COVID-19, should be integrated into the broader surveillance system for continuous strengthening of the health system. (12,35) In the absence of such systems, reconfiguring existing community disease surveillance systems for COVID-19 metrics (for example, adding respiratory symptoms to malaria screening activities) and implementing protocols and procedures for provider communication and coordination will be critical to ensure closed feedback loops for effective surveillance and referrals. (36-38)
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