World Health Organization
REGIONAL OFFICE FOR Africa

COVID-19 RESPONSE

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR AFRICA SUPPORTS THE COVID-19 RESPONSE

East and Southern Africa Region Joint Interim Guidance on Continuity of Essential Health and Nutrition Services during the COVID-19 Pandemic

May 2020

AFRICA CDC
Centres for Disease Control and Prevention
Safeguarding Africa's Health

World Health Organization

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1. Introduction

On 31 December 2019, the Government of China alerted the World Health Organization (WHO) about a cluster of patients with pneumonia of unknown cause in Wuhan City, Hubei Province, which they identified on 7 January 2020 as the SARS-CoV-2 virus. The disease was initially named the novel coronavirus (nCoV 2019). On 30 January 2020, WHO declared a Public Health Emergency of International Concern (PHEIC) because of evident human-to-human transmission. The disease was formally named COVID -19 on 11 February 2020. Following evidence of extensive transmission in all regions, WHO declared the COVID-19 a pandemic on 11 March 2020. As of 28 April 2020, the disease has spread to 213 countries of all countries, areas and territories (approximately 84 per cent). The latest COVID-19 updates for countries in Africa may be accessed here: Africa CDC and WHO/AFRO.

The COVID-19 pandemic is putting increasing pressure on health systems across the world, including in Africa. East and Southern African health systems that are already weak and/or overstretched can easily be overwhelmed by the increasing number of COVID-19 cases. When health systems are overwhelmed, both direct mortality from the outbreak and indirect mortality from vaccine-preventable and other treatable conditions may increase dramatically as a result of reduced access to health services due to control measures such as lockdowns, other movement restrictions, and the impact of fear and stigma. Even in countries with low numbers of cases, programme reports already indicate a decline in access to and utilization of health care services.

Analyses from the 2014-2015 Ebola Virus Disease (EVD) outbreak suggest that the number of deaths caused by disruption of essential maternal and newborn care health services, measles, malaria, HIV/AIDS, and tuberculosis attributable to health system failures exceeded deaths from EVD (Parpia et al, 2016 and Jones et al, 2016).

A Johns Hopkins University study (Roberton et al, 2020) on early estimates of the indirect effects of the coronavirus disease pandemic on maternal and child mortality in low- and middle-income countries found that reductions in coverage of around 15 per cent for 6 months would result in 253,500 additional child deaths among children under five years of age and 12,190 additional maternal deaths, while reductions of around 45 per

cent for 6 months would result in 1,157,000 additional child deaths among children under five and 56,700 additional maternal deaths. This would represent a 9·8 to 44·7 per cent increase in under-five child deaths per month, and an 8·3 to 38·6 per cent increase in maternal deaths.

Additionally, a UNFPA study (2020) highlighted projections that 44 million women in 114 low- and middle-income countries will not be able to access contraceptives if lockdown and COVID-19 restrictions continue and there will be an additional 15 million cases of gender-based violence for every 3 months that a lockdown continues.

With a relatively limited COVID-19 caseload in Africa, health systems may have the capacity to maintain essential service delivery in addition to COVID-19 response, although some staff have been repurposed to support the response. However, increasing caseloads could result in diversion of many health workforce to response, facility overload, reduction in the workforce due to infection or fear of infection among other reasons. Additionally, COVID-19 containment and mitigation measures (mainly physical distance and lockdown) are also a major factor in reducing access and utilization of health services.

Countries will need to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain delivery of essential health and nutrition services, mitigating the risk of system collapse. When essential services come under threat due to competing demands, simplified purpose-designed governance mechanisms and protocols can mitigate outright system failure. Establishing effective patient flow including screening, triage, and targeted referral of COVID-19 cases and patients with other conditions is essential at all levels.

2. Purpose/Justification

Given the rapidly evolving trends of COVID-19 in Africa, it is important that health systems capacity is strengthened to ensure continued delivery of essential health and nutrition services. This document, which is building on recent WHO and UNICEF guidance, with technical inputs from UNFPA, Africa CDC, US CDC and VSO, aims at helping countries to address some of the observed and anticipated challenges in ensuring continuity of essential services by:

- Identifying context relevant essential services for countries to consider
- Optimizing service delivery settings and platforms
- Proposing ways to rapidly enhance and re-distribute health workforce capacity to meet demands arising from direct COVID-19 response while ensuring continuity of essential services, reducing the risk of transmission and ensuring the safety of health workers and all people
- Promoting ways to ensure uninterrupted supply and distribution of essential health and nutrition commodities

- The document will be useful as guidance for National COVID-19 taskforces and Ministries of Health in general, to prevent/mitigate and address health and nutrition service delivery bottlenecks during the COVID-19 pandemic. Specifically, the document:
- Positions continuity of essential health and nutrition services as a core element of country-specific COVID-19 preparedness and response plans and strategies.
- Proposes prioritizing the designation of a focal point and coordination mechanism for continuity of essential services with in the COVID-19 national taskforce to operationalize and monitor this work.
- Is both a guide and a training resource for continuity of essential services for operational level health care workers and managers in public and private facilities, at both national and sub national levels of the health care system.
- The document provides overarching guidance for continuity of essential health and nutrition services. Links to detailed guidance documents are included for reference purposes.

3. Context relevant essential services

A system's ability to maintain delivery of essential health and nutrition services and referral pathways will depend on existing capacity, burden of disease, the COVID-19 transmission context (classified by WHO as no cases, sporadic cases, clusters of cases, or community transmission), as well as the progression of the outbreak during the community transmission stage (pre-peak, peak and post-peak). Regardless of the stage of transmission, there needs to be a deliberate effort to ensure continuity of essential health services, which will contribute to the following:

- Population trust in the capacity of the health system to safely meet essential needs while mitigating infection risk. This is key in ensuring

appropriate care-seeking behaviour and adherence to public health advice. A key priority will be addressing pre-existing barriers to uptake of services for example stigma towards marginalized and vulnerable groups, and myths and misconceptions about COVID-19 among both clients and providers.

- Protection of the health workforce through adequate guidance and availability of supplies and measures for infection prevention and control to enable them to deliver care without fear of infection and without transmitting COVID-19 to those they are caring for.
- Task-shifting options and community engagement for interventions that can be delivered at community and household level in view of increased demands on health care providers and facilities.

A well-organized and prepared health system will therefore have the capacity to maintain equitable access to essential services throughout an emergency (COVID-19 and/or public health emergencies), limiting both direct and indirect impacts on mortality. **Table 1** highlights the critical and essential health and nutrition services countries in the east and southern Africa region should consider and why.

Table 1: Context-relevant essential services

Essential service(s)	Risk(s)	Recommendations by scenario
Maternal and newborn health services includes antenatal care, labour and delivery, postpartum and neonatal care, PMTCT and HIV testing services	• Increase in maternal and neonatal mortality, morbidity and still births. • Risk of increased poor quality of care along the pregnancy continuum and especially care around the time of birth. • Job action/strikes by health workers for various reasons (including lack of PPE) reduce access to already limited skilled birth attendance. • Reduction in the proportion of women who deliver in health facilities	**For all scenarios** • Prioritize maternal and newborn health (MNH) as an essential service within the COVID-19 response. • Identify all pregnant women and girls who meet the COVID-19 case definition OR have been in contact with a confirmed case OR have travelled from an area with community spread, triage and manage appropriately as per case management guidelines. • Consider identifying dedicated rooms or areas at treatment centres for delivery and monitoring of COVID-19 infected or suspected pregnant women and girls, and their newborns. Assign dedicated staff to these functions and ensure that they have the appropriate PPE available at all times. • Ensure communities know where to access functional EmONC and BEmNOC services as well as readiness of lower level facilities to provide the services. • Ensure continuity of sick and small newborn care services including Kangaroo Mother Care and early initiation of breastfeeding.

Essential service(s)	Risk(s)	Recommendations by scenario
		• Infant HIV testing and follow up of mother-infant pair • Strengthen linkages with COVID-19 treatment centers and referral mechanisms for pregnant women at risk of complications and those requiring specialized care. Access detailed guidance on continuity of MNH services at the following LINK.
Child health services including preventive and curative services	• Disruption of essential child health services risks a rapid resurgence and significant mortality from communicable diseases such as malaria, pneumonia and diarrhea; as well as other vaccine preventable diseases such as measles. • Possibility of misdiagnosis and mismanagement because the symptoms of COVID-19 (fever, cough and sometimes vomiting/diarrhea) are non-specific and similar to those of common childhood illnesses including malaria, pneumonia caused by other viruses or bacteria. • Co-infections with other childhood illnesses and COVID-19 can occur • Cancellation of immunization campaigns and outbreak response activities • Stock outs of vaccines due to containment measures that limit supply and focus on COVID-19 response. • Outbreaks of vaccine preventable diseases in areas with suboptimal coverage prior to COVID-19	**Sporadic Cases** Primary facility in-and outpatient units, and community-based platforms should be strengthened to continue to provide accessible and timely essential health services, with adaptations based on local protocols for hand hygiene, respiratory etiquette, physical distancing, screening, IPC etc. To facilitate a timely and efficient response: • Always assess for and appropriately manage other causes of illness in children that screen positive for COVID-19 and suspected cases. • Ensure COVID-19 facilities are equipped to provide nurturing care to children in isolation/quarantine. • Rapid training of health facility and community-based workers (with an emphasis on iCCM and IMCI distance protocols, IPC, RCCE) • Re-organization of paediatric in and outpatient departments allowing for screening, triaging and isolation facilities • Pre-positioning of essential supplies and commodities including IPC supplies Essential services include: • Prevention of communicable diseases through vaccination, vitamin A supplementation, deworming, vector control and chemoprevention. • Monitoring risk of vaccine preventable disease outbreak. There is need to carry out a risk-benefit analysis to inform implementation of reactive vaccination campaigns for disease outbreaks. • Management of severe childhood conditions at health facilities • Prevent acute exacerbations of chronic conditions, including HIV, by ensuring continued access to

Essential service(s)	Risk(s)	Recommendations by scenario
		medications and care • Community-based interventions: community case management (CCM) particularly for malaria, pneumonia, diarrhea taking into consideration appropriate protection of the CCM providers. The providers should be adequately trained on IPC measures to ensure their safety. • Adhere to standard iCCM and IMCI protocols with enhanced IPC measures unless there are national containment measures such as physical distancing or lockdowns in place
		Cluster of cases and community transmission In areas with clusters of cases, adapt national iCCM and IMCI protocols with the inclusion of screening, strict IPC measures including PPE, and the following basic considerations: • Maintain distance of at least 1 m (except for when performing malaria RDT, measure mid-upper arm circumference (MUAC). • Use personal protective equipment appropriate to the screening status of the child. If PPE is unavailable, distance CCM should be implemented • Community-level visits should be held outside or in a well-ventilated space, and gatherings of people avoided. • Screen all children for COVID-19, if protocols for screening at community level have been activated. Screening should be conducted for both the caregiver and child; includes inquiring about symptoms, and possible exposure to COVID-19 in the household and beyond. • Implement standard precautions for IPC: hand hygiene using the WHO 'five moments', routine cleaning and disinfection of material and surfaces, and respiratory etiquette. • Carry out risk-benefit analysis to inform implementation of reactive vaccination campaigns for disease outbreaks. During the community transmission scenario: • When screening of all symptomatic people has been implemented at the onset of all health care encounters, adapt case management protocols to allow for triage, adjustment of patient pathways and PPE requirements.

Essential service(s)	Risk(s)	Recommendations by scenario
		• Health facilities and community health workers should continue to provide care and treatment for common childhood illnesses. Further details on tailoring malaria interventions in the COVID-19 response can be found HERE.
Sexual and Reproductive health services including family planning, STI prevention and management, cervical cancer prevention and control, prevention of unintended pregnancies and unsafe termination of pregnancy, adolescent reproductive health services	• Continuing contraceptive services users may experience lack of access to contraceptives • Reduced ability to access contraceptive services by adolescents could increase teenage pregnancy rates. • Shortage of supplies for preventive and curative services for HIV/AIDS, TB, STIs, abortion/post-abortion care, and gender-based violence; menstrual hygiene management and lack of access to ARVs, Pre and Post-Exposure Prophylaxis (PrEP/PEP). • Access to Youth friendly services may be limited. Most disproportionately affected will be youth with disability, as well as excluded or other stigmatized groups. • Limited access to Cervical cancer screening and treatment services as countries focus on emergency operations	**For all scenarios** • Promote integrated SRH service delivery – a client coming for contraceptives should receive all other SRH services e.g. STI screening/ cervical cancer screening as appropriate. • Ensure the inclusion of contraceptive services as an essential health service in COVID-19 response planning. Resources for planning FP services may be accessed here: LINK • Ensure contraceptives supply chains are maintained for addressing the needs of all clients including adolescents/young people. – Liaise with logistics technical working group to ensure movement of commodities to subnational level, prioritizing condoms for their dual functions. Consider using other existing cross border mechanisms which will facilitate movement of commodities and reduce the possibility of stockouts[1]. – Consider using nontraditional distribution channels where feasible for contraceptive services (information and methods) through other outlets such as pharmacies, drug shops, online platforms and other outlets. This can be with or without prescription depending on national guidelines • Promote task sharing for SRH services with lower cadres including CHWs; e.g. community-based distribution of contraceptives based on the local guidelines on movements. Access guidance at this LINK . • Continue to ensure that SRHR services are age- and gender sensitive, accessible, affordable and available to all including adolescents, through delivery in existing health facilities or digital, mobile, remote or outreach services.

[1] SADC has activated a Cross Border Transport Operations across the Region as part of COVID-19 response. It is meant to facilitate and ease transportation of essential goods and services within the region.

Essential service(s)	Risk(s)	Recommendations by scenario
		• Facilitate self -care for SRH interventions including for contraceptives-condoms, self-injectable contraception, vaginal rings, fertility awareness-based methods (including lactational amenorrhea), and non-prescription emergency contraception to reduce unintended pregnancy; HIV self-testing; and where legal self-management of medical abortion etc. • A same-visit approach for undertaking both screening for cervical cancer and treatment of screen positive cases should be enabled. In the absence of HPV testing, screening should use the most efficient method such as VIA. • Comprehensive sexuality education: To the extent possible, CSE should be included in digital strategies by the education sector to reach learners at home
Gender Based Violence (GBV) including referral pathways for multi-sectoral services (health linked to police, justice, protection); resourcing existing shelters and identifying additional ones as needed; remote case management; strengthening/scale up of hotlines and outreach services and clinical management of rape survivors	• Spikes in GBV, especially domestic violence (physical, mental, emotional) • Access to youth friendly services may be limited. Most disproportionately affected will be youth with disability, and youth from excluded or stigmatized groups. • Increase in unintended pregnancies and unsafe termination of pregnancy. • Support centers and clinical services for rape survivors may be inaccessible.	• Ensure availably of medical and other services for women experiencing physical and or sexual violence. Access detailed guidance on GBV case management here: LINK • Ensure availability of services for clinical management of rape survivors • Where the law and protocol permit, improved availability of post abortion care and safe abortion care services • Whenever One Stop Centers (or similar) are available/operational in health care facilities ensure continued functionality, triage and provide appropriate PPE. • Ensure that all essential health and nutrition services have and display an up to date list of GBV and child protection services and key messages for communities. • Continue to ensure that SRHR services are age- and gender sensitive, accessible, affordable and available to all including adolescents, through delivery in existing health facilities or digital, mobile, remote or outreach services.
Emergency services including trauma and other critical care services	• Emergency units in the region commonly manage a combination of severe infectious and non-communicable disease conditions including trauma.	**All scenarios** • Ensure continued 24/7 services at Emergency units with adequate human resource; keeping separate the emergency units for other conditions from those for suspected COVID-19 cases at the health facilities designated as COVID-19 treatment centers.

Essential service(s)	Risk(s)	Recommendations by scenario
	• The risk of limited availability of health care workers due to diversion to COVID-19 emergencies and fear of infection due to lack of PPE is high during this time. Prioritization of supplies, health facility space and referral facilities (ambulances) for COVID-19 could also lead to poor outcomes among this group.	• Ensure acuity-based triage at all sites providing acute care. • Repurpose other units within health facilities for COVID-19 to free existing emergency rooms to continue attending to other emergencies. • Ensure adequate PPE supplies for all Emergency Units • Separation of ambulances for COVID-19 from those for other emergencies where possible and adherence to Infection Prevention and Control Measures. • Ensure continuity of auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services • Create a roster of community members trained in first aid and acute care and strengthen or create an organized Community First Aid Responders (CFAR) system with 24-hour coverage that can be activated by mobile phone.
Management of chronic diseases	• HIV is a predominant immune-suppressing condition in all age groups in the ESA region, with particular impact on children, adolescents and pregnant women. • Individuals with HIV and other chronic conditions including diabetes, hypertension, heart disease, and sickle cell disease may experience challenges accessing facilities for routine reviews/ procedures/ medicine refills during COVID-19 pandemic resulting in non-adherence to treatment regimen and related complications e.g. HIV drug resistance, uncontrolled diabetes and hypertension, and premature deaths. • The patients with chronic conditions may delay seeking treatment due to fear of infection at the health facilities and may therefore present late to the facility or hospital with severe symptoms. • Patients with underlying conditions like diabetes,	**All scenarios** • HCWs should screen for chronic disease based on history, age and local trends in COVID-19 positive patients and document as needed. • Consider and document HIV history/status in suspected COVID-19 cases. This includes assessing exposure during pregnancy and breastfeeding. • Consider compulsory history taking, counselling and testing of HIV status for all positive cases to rule out chronic illness, complement the right treatment regime for patients with already compromised immune systems. Ensure access to treatment initiation for those who test positive. • Ensure continuity of health care services for management of chronic conditions e.g. diabetic or cardiac clinics, sickle cell disease clinics, HIV clinics, etc. at health facilities. • Ensure continuity of treatment for people who are on Anti-Retroviral Therapy (ART), including shifting to multi-month refills. It is critical to consider adequacy of ARV supplies when making this shift. Where feasible and in line with national guidelines, consider delivery of medications through CHWs. • Ensure adequate stock and distribution of medicines and other supplies for the management of chronic disease conditions and their complications, including

Essential service(s)	Risk(s)	Recommendations by scenario
	obesity, hypertension and heart disease are at increased risk of severe COVID-19 disease.	ART and anti-TB treatment[2]. • Advocate for movement permits for people with chronic conditions that may require regular or emergency access to health facilities for review, re-fill of medications, and treatment e.g. renal dialysis, and emergency treatment e.g. patients with stroke, heart attack, sickle cell crises • Dialysis and cancer treatment services – countries to ensure uninterrupted availability of dialysis and cancer treatment services. Health Department may issue directives to the district administration allowing easy movement of these patients to access care. • Ensure implementation of social behavior change communication campaigns on integrated age appropriate HIV and COVID-19 prevention messaging including comprehensive sexuality education for out of school youth to minimize the risk of increased HIV rates.
Nutrition services	Key nutrition risks in the context of COVID-19 include • Deteriorating infant and young child feeding practices due to reduced household food access, access to health services, and deteriorating caring practices with a risk of possible increase in levels of acute malnutrition • Disruption in access and availability of quality treatment services for wasted children (Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) • Disruption of the preventive services- Vitamin A supplementation (VAS), Infant and Young Child Feeding counselling, Iron and Folic Acid Supplementation (IFAS), maternal nutrition counseling and support etc. • A general deterioration in	**Sporadic Cases** • Identify essential supplies for core nutrition services and include them in the COVID-19 response plans • Maintain counseling/BCC on breastfeeding and age appropriate IYCF with an increased emphasis on protecting and promoting breastfeeding using different communication channels • Provide treatment for severe and moderate acute malnutrition (<5 yrs), however if severe access and staffing restrictions apply, prioritize severely wasted children <2 years. • Simplify wasting treatment approaches such as enhanced engagement of community health workers in the identification and treatment of wasted children, provision of take-home ration for longer periods (e.g. a 3 weeks ration in place of 1 week) and reduced frequency of follow up for uncomplicated cases. • Simplify screening e.g. use of MUAC only and involve the CHV/CHW and caregivers more and promote mother MUAC. • Ensure supplementation of Iron and Folic Acid (IFA) for pregnant mothers, also consider multiple micronutrient supplementation (MMS in food insecure areas), promote Vitamin A Supplementation (VAS) for children using health facility and community

[2] SADC has activated Pooled Procurement Services for pharmaceuticals and medical supplies is being implemented to provide sustainable availability and access to affordable and effective essential medicine and health commodities, and Member States have been encouraged to utilise this facility for the procurement of the needed supplies for prevention, treatment and control of COVID-19 and any other epidemics.

Essential service(s)	Risk(s)	Recommendations by scenario
	household food security due to disrupted livelihoods and pre-existing threats such as drought and locusts	level delivery platforms where feasible as part of the essential MNCH services. For details on essential nutrition services, follow this LINK. **Cluster of cases and community transmission** • Maintain delivery of essential maternal nutrition interventions which includes breastfeeding and appropriate complementary feeding counseling, MUAC screening, micronutrient supplements, and deworming prophylaxis while implementing infection prevention and control procedures to reduce the risk of COVID-19 transmission • Suspend all surveys, assessments, mass Mid-Upper Arm Circumference (MUAC) screening and integrated phase classification (IPC) analyses that involve gatherings and extensive contacts in the population. • Provide treatment for moderately and severely wasted children. Whenever possible, deliver all treatment for uncomplicated wasting in the community optimizing existing community-based platforms using a limited/no touch simplified treatment approach.
Services for migrants, mobile populations and other vulnerable populations that may not be routinely covered through public health services	• Migrants are exposed to many of the same vulnerabilities as other citizens, and often to a greater extent either due to structural barriers, including legal status, or other deterrents including attitudes of healthcare workers, linguistic-cultural barriers, or fear of deportation. • Narratives around disease importation by migrants can be stigmatizing. This can limit their access to health services due to fear or stigma. • Migrants may be stranded without medicines for chronic conditions during lockdown and other mobility restrictions	**All scenarios** • Include migrants, mobile and other vulnerable populations including the disabled, adolescents and young people in the plans for provision of basic healthcare services, for acute and chronic conditions, as well as COVID-19 response. • Stigma can be countered in routine health care settings and efforts made to ensure essential health services remain available to migrants and their families. Strategies to ensure essential health services are provided to migrant and mobile populations may include: • Using migrant networks and influencers/leaders • Engaging with already existing adolescents and youth networks also as a way to amplify risk communication efforts. • Reviewing legal or service provision directives to ensure services are available for all regardless of legal status; • Providing health promotion and service information in all relevant languages representing local populations.

Cross cutting actions for all essential services

- **Risk communication**: Engage communities and provide communication on COVID-19 prevention, early treatment seeking, evidence-based self-care interventions (in line with local practice) and disseminate messaging on timely access to essential maternal, newborn and child health services. Ensure that myths and misinformation are promptly addressed and corrected.
- **Supply**: Preposition essential medicines, services, commodities and equipment so that stockouts do not jeopardize the continuity of essential services. Ensure security, proper storage and timely distribution of drugs and lifesaving commodities for essential MNCH, community health, nutrition and HIV services.
- **Data**: Enhance data collection (HMIS / DHIS2 and other appropriate tools) for monitoring essential health and nutrition status as well as documenting and sharing lessons and best practices.
- **Infection prevention and control**: Orient health care workers on screening and triaging for COVID-19, IPC including appropriate PPE use, isolation, organization of services and any changes that may take place. In affected areas, consider alternative approaches to face to face care including limiting contact with the health facility; reviewing discharge protocols especially in overcrowded health facilities. In clusters of cases or community transmission scenarios, adopt safe service delivery modalities for essential services including "low" or "no" distance touch protocols (such as telehealth) and presumptive treatment protocols taken as a last resort in high transmission and absence of PPE. Avoid activities that attract crowds, even seasonal malaria chemoprevention campaigns should be conducted in a manner in which
- **Protecting human resources for health**: Engage professional associations (midwives, nurses, doctors) and the private sector to ensure sufficient workforce to avail services. Roles and responsibilities of these organizations should be reflected in the broader plan. Put in place innovative service delivery mechanisms and consider task shifting/ sharing with lower level facilities and lower cadres including community MNH. Establish mechanisms for staff retention and motivation in the essential services[3]. Prioritize the provision of mental health and psychosocial support for communities and health care workers, through multi- dimensional approaches such as digital solutions, outreach of services and other remote means. Include adolescents, migrants, mobile and other vulnerable populations in the plans for provision of essential healthcare services, for acute and chronic conditions, SRHR, as well as COVID-19 response.

4. Service delivery settings and platforms

Essential service delivery will need to continue both at community and facility levels, and these need to be optimized for sustained service delivery. Some facilities may be repurposed for COVID-19 case management resulting in task shifting to lower level facilities or the community. Typology of countries and sub-national COVID-19 disease levels will guide the selection and adaptation of actions.

[3] In Ghana, all health workers were given income tax holiday for 3 months, subject to review. All frontline workers providing COVID-19 specific services will be given additional 50% of their current basic salary per month. The MoH is in discussion with relevant groups to agree on the list/categories of staff to be considered in this group.

4.1 Health facilities for continued service delivery

In accordance with the guidance from the seventh pillar of WHO Operational Planning Guidelines to Support country preparedness and response, health care facilities should prepare for large increases in the number of suspected cases of COVID-19. Additionally, plans for business continuity and provision of other essential healthcare services should be reviewed and updated as necessary. Special considerations and programmes should be implemented for vulnerable populations including elderly, patients with chronic diseases, pregnant and lactating women, adolescents, young people and children. Large increases in the number of COVID-19 cases can over-stretch and over-whelm the already weak health systems thereby disrupting essential health services. It is therefore critical for the health facilities to plan on how to optimize delivery of essential services and prevent disruption as much as possible. Table 2 below highlights some action points for countries to consider to optimizing service delivery at the health facility level.

Table 2: Key Actions for Optimization of Delivery Essential Health Services at Health Facility Level

Essential health services	Key Actions for Continuity of the Services for vulnerable population at health facility level
General considerations	• To avoid overburdening of higher-level health facilities that may be designated for COVID -19 case management, redirect certain visits such as ANC and postnatal follow-up visits, well child/adolescent visits to lower level health services where possible (e.g. home visits) and disseminate this information to communities • Limit the number of persons (staff and patients) that can be in the MNH service area at any one time to enable minimum physical distance of at least 1 meter. This includes in the waiting room. • Perform regular cleaning and disinfection of all service areas. Frequency of cleaning should be increased with the appropriate cleaning supplies. • Set in place stations for hand washing at each entry point into the facility, at various points before triage, at entrances to toilets and in each patient care area. Waste bins should also be placed at each triage station and in the waiting and patient care areas. A staff should be designated to check and refill the water and soap. • Strengthen IPC measures to mitigate health care worker (HCW) and Healthcare Associated infections (HAIs); this includes identification of IPC focal points, COVID-19 IPC training, ensuring availability of key documents at all levels of care (SOPs, communication materials, job aids – visual alerts for screening), visitors' policy, and IPC supplies. • Explore virtual trainings, e-learning opportunities, mentorship and supportive supervision opportunities for health care providers on RMNCAH+N services and COVID-19

	management in the context of these services. • Expand phone based and other digital approaches to appointment tracking and follow up.
MNH	• Keep in place a referral system and protocol to ensure that pregnant adolescent girls and women with complications reach the level where they can get appropriate care. This is over and above referral systems for COVID positives. Refer to the joint regional guidance on continuity of essential MNH services through LINK
Child Health	**IMNCI:** • Integrate well child clinics with immunization as long as possible, consider shifting to community-based services if facilities get overburdened and community-level capacity exists • Strengthen Emergency Triage Assessment and Treatment (ETAT) and establish triage at service delivery entry points for sick children, including emergency units for severe childhood illnesses. In areas with active clusters or during community transmission all children should be screened for COVID-19 given the overlap of symptoms with common childhood illnesses but considering exposure history. • Screening of all children, no direct contact required: maintain distance of at least 1 m, no PPE required. Isolate children identified as COVID-19 suspects during screening while ensuring other causes of illness are assessed for/excluded or treated; triage both caregiver and child for symptoms. • Ensure 24/7 designated team for management of severe childhood illnesses • Maintain spacious paediatric OPD and in-patient facilities whilst adhering to strict IPC measures (hand and cough hygiene, surface and equipment disinfection) • Ensure availability of appropriate PPE in the case of direct contact with children (Physical examination and performance of tests such as malaria Rapid Diagnostic Test) • Ensure health workers providing care for children in isolation wards/facilities are trained in management of COVID-19 as well as management of other childhood illnesses, and understand the importance of nurturing care • Strengthen community case management of non-severe childhood illnesses; and provide appropriate PPEs and training for the CCM providers.
	Immunization • As immunization services continue (except for preventive campaigns), pay attention to the following IPC measures, especially while COVID-19 is a risk: Services delivery points should be equipped with necessary supplies for IPC, including proper handling of injection waste; local innovations could be applied such as having the immunization sessions outside the facility where safety measures are easily applied. Parents should maintain hand hygiene, respiratory etiquette and physical distancing during the immunization sessions. • To sustain community demand for vaccination services during this period, a tailored communication strategy should be implemented to provide accurate health information, address community concerns, enhance community linkages • In case of temporary interruption of immunization services (national/local guidance on transmission prevention including social distancing), HF should have plans for catch-up as

	soon as possible, intensification of services and demand generation should be a priority, sustaining trust in vaccination and health services will be important • Integrate Vitamin A supplementation with plans for delivery of vaccination and health services
	Nutrition • Maintain facilities for inpatient and outpatient management of acute malnutrition to prevent increased SAM-related mortality • Prepare key messages on IYCF-E using the Global and regional guidance and question and answer document by WHO on benefits of breastfeeding. • Using digital technology, provide counseling to protect and promote breastfeeding, safe and adequate complementary feeds from local foods for children 6-24 months and continuation of breastfeeding • Continue to distribute iron and folic acid supplements to pregnant women, through MNCH services • Continue Vitamin A supplementation to children in coordination with immunization services • Conduct screening for wasting and bilateral pitting edema in conjunction with essential child health services in the context of COVID-19. • Provide care for wasted children according to the national protocols, wearing appropriate PPEs, both in outpatient and inpatient programs. For in patent care follow the standard IPC protocols and keep the beds 2M apart to minimize exposure • If available, optimize use of digital technology to share data and information on nutrition according to the indicators in the national IMAM guideline
Adolescent and young people services	• In the context of COVID-19, with the disruption of schools, essential health services and community-level centers, find ways to continue to provide affordable, essential, age appropriate and nonjudgmental sexual, reproductive and other health information (including HIV), support and services safely to adolescents and young people. • When dealing with adolescents and young people, nonjudgmental, age appropriate and gender sensitive messaging and positive communication is critical so that relevant information is transferred without creating fear/panic. • Maintain/Institute measures that ensure health facilities continue to remain adolescent and youth friendly using existing guidelines/protocols for all services. • Where possible, to avoid over-burdening of health facilities, deliver adolescent and youth friendly services using appropriate community delivery mechanisms for example - Delivery of 'remote' health outreach/consultation services, telehealth, home visiting by health workers or peer supporters, that avoid mass gatherings. Expand use of selfcare, where available. • Consider the use of community engagement activities to deliver adolescent and youth targeted sexual, reproductive and other health messaging that is appropriate and safe in the context of COVID-19 for example - Use of community radio (broadcasts, phone-ins, dramas), mobile technology, social media, on–line portals, telephone or 'on-line' helplines, working with youth networks to use digital space that they are already present in, use of public address messaging targeting adolescents and young people.

	• Ensure that all health service provision addresses the specific challenges faced by, and needs of, the most vulnerable and excluded adolescents and young people e.g. Disabled adolescents and youth, those living with HIV, migrants, homeless and displaced adolescents and youth, those engaged in sex work, adolescents and youth engaged in substance abuse, and incarcerated adolescents and youth. • Ensure that measures are in place to prevent, protect and mitigate the consequences of all forms of sexual and gender-based violence against adolescents and youth - especially girls and young women. • Consider how best to address the psychosocial support and mental health needs of adolescents and young people during periods of lock-down and social isolation in relation to the increased health, economic and/or social risks they may face. • Ensure the engagement of youth networks and young leaders to amplify risk communication efforts. For detail on adolescent and young people services refer to LINK
Services for Older persons	• Older people have a higher risk of symptomatic COVID-19 infection, severe disease and death. To protect them, ensure the continued management of existing medical conditions, interventions for prevention of COVID-19 including provide IEC on handwashing, respiratory hygiene and social distancing; prevention of elder abuse, maintenance of functional ability, emotional support and social protection. In addition, ensure maintenance of supply chains for medications and needed supplies and put in place community-based referral systems in case of emergencies. • Collaborate with social services to map persons over 60 years at the lowest administration unit. Include details of any chronic conditions and disabilities that require follow up or medication. • Create public awareness and educate community members using existing platforms including mass media, and faith-based, community and traditional leaders on the integrated care of older persons in the community as well as awareness raising to mitigate their exposure to COVID-19. • Advocate for the inclusion of services to older persons within the essential services list in COVID response including (mental health and psychosocial services and access to social services and other entitlements like pension, insurance, food) and allow passage for older persons seeking essential services in cases of curfew or lockdown. • As with people with chronic conditions, refills for medication for older persons should be provided for at least 3 months to reduce exposure at health facilities and movements during lockdown. • Establish linkages with police and law enforcement agencies for protection of older persons against all forms of elder abuse and to facilitate reporting of such incidence. • Working with communities and families promote development of emergency preparedness plans by households with older persons including encouraging them to write their will in-case of any adverse events. • Care for elderly, disabled and palliative care patients – List of patients/ individuals who need extended support to be maintained at the PHC level for regular follow up. CHWs to undertake two visits per month to such households during the period of the outbreak, to assess for onset of complications and to monitor treatment adherence. More details on services for the elderly can be found at this LINK.

Chronic diseases management	• Minimize unnecessary interaction of people with chronic diseases (HIV, TB, diabetes, hypertension) with health facility settings to reduce possible exposure to COVID-19. • Explore options for virtual consultations and reviews and mobile clinics • Keep relevant clinics for care of chronic disease patients open daily with the minimal staffing to run them; where possible arrange for these clinics at lower health facilities to avoid overburdening the big health facilities that may also be COVID-19 treatment centers. • Patients on treatment for chronic diseases, both communicable and noncommunicable, would be provided up to six months medicine supplies (or as deemed feasible by the country) at a time as prescribed by medical officers. The medicines may be delivered at home through frontline workers/volunteers during the period of the lockdown/restricted movement, provided patients are stable. • Dialysis and Cancer Treatment services – countries to ensure uninterrupted availability of dialysis and cancer treatment services. Health Department may issue directives to the district administration allowing easy movement of these patients to access care.
Emergency & Trauma and critical care related services	• Countries need to ensure that not all ambulances and other vehicles for referral of patients are diverted to COVID-19 response. There should be dedicated/designated ambulance in every district for management of emergencies pertaining to cardiac / trauma / burn / medical and surgical emergencies etc. • Emergency Services (medical, surgical and trauma) and critical care services including Intensive Care Unit (ICU); Special Newborn Care Unit; BEmONC/ CEmONC; Burn wards and Blood transfusion services to be maintained with adequate HR and equipment as per protocols • Services to survivors of gender-based violence should be ensured as per protocols. Information about support services under the gender and social welfare department, NGOs, One stop crisis centres and helplines should be provided to the survivor. • Dedicated staff and physical space for handling patients presenting with SARI need to be in place.

4.2 Infection Prevention and Control at health facility level

Given the risk of health facilities amplifying COVID-19 infection and exposing all people seeking care for other illnesses to COVID-19, it is critical that all health facilities step up infection prevention and control provisions practices and implement administrative and engineering controls to prevent transmission of SARS-CoV-2

- Triage, using appropriate IPC measures, should be implemented at all facility entry points using a screening form for COVID-19. Adequate and sufficient PPE should be available at all triage stations. For health workers who can maintain at least 1-meter distance from patients entering the triage station, no PPE is required. When physical distance is not feasible **AND** there is **NO** patient contact, use medical mask and gloves, followed by hand hygiene; when physical distance is not feasible **AND** there **IS** patient contact, use medical mask, gown, gloves, and googles,

- At each triage station, hand hygiene stations should be clearly placed for patients to clean their hands upon entry into the triage area or healthcare facility. Additionally, tissues and rubbish bins with biohazard bags should also be available to use and discard used tissues in respectively, if patients cough or sneeze. Hand hygiene should be performed after coughing and sneezing.
- In waiting areas of healthcare facilities, visual aids on physical distancing, respiratory etiquette and hand hygiene should be placed. Additionally, hand hygiene stations should be available. A staff member should be designated to check and refill the supplies (water and soap or hand sanitizers) of hand hygiene stations.
- Every health facility should have a trained IPC focal point to train fellow health workers in IPC and monitor adherence to IPC principles and requirements. The IPC focal point should work closely with facility administration to ensure proper IPC policies are being developed and/or effectively implemented.
- IPC and WASH assessment tool to be used periodically to assess compliance to IPC practices; where gaps are noted an improvement plan should be developed and implemented.
- During the COVID-19 pandemic period, health facilities should order for more IPC supplies than usual. Ensure availability of PPEs for use by clinical teams for assessment and management of COVID-19 suspected cases.
- A cleaning and disinfection schedule should be developed and implemented accordingly. If additional staff are required to ensure the cleaning and disinfection schedule is sustained, additional human resources may need to be recruited. All surfaces that patient come into contact with should be routinely cleaned and disinfected. For example, at a triage station, if a patient is sitting in a chair while being screening, that chair should be disinfected after each patient visit. Waste handlers should use appropriate PPE while cleaning.
- Disinfection agents of 70% or greater ethanol concentrations or 0.5% chlorine (as prepared with water) should be used to wipe down surfaces and medical equipment. Where chlorine is used, because of its corrosive nature, it should be cleaned off with soap and water after a contact time of 10 minutes.
- All waste produced in the healthcare facility should be properly segregated in color coded bins at point of generation, transported and disposed of as appropriate

- Sharps, once used, should be placed in a designated sharps box or container.
- Set in place stations for hand washing and temperature monitoring at each entry point into the facility, at various points before triage.
- Monitor health workers regularly for COVID-19 infections; any health workers exposed to COVID-19 should not be in direct contact with patients until infection is ruled out. Ensure that infections in health workers are monitored and reported as per guidance on health care acquired infections.

4.3 Optimizing community platforms

Community platforms, in particular community health workers and other members of the community health workforce, are critical for supporting continued service delivery and can be leveraged to extend COVID-19 preparedness and response. In every community, there are local actors, relationships and processes that intersect with the health sector and are central to delivering high-quality, people-centered health care and to building health system resilience. Relevant actors include local authorities, faith leaders, and non-governmental organizations (NGOs) and community groups, such as women's, scouting and youth groups. As trusted members of the community, the community health workforce usually has strong ties with these groups.

Key actions

- Ensure that community-based activities are incorporated into national response plans
- Ensure coordinated actions to sustaining community level service delivery including the engagement of non-governmental organizations, civil society, youth and women networks and the private sector.
- Establish protocols for community-based COVID-19 screening (using standardized national case definitions), recognition of danger signs, and targeted referral as needed.
- Ensure sustained communication with key messaging on continuity of service delivery at community level and on referral networks.

- Utilize mobile platforms to enhance community-based service delivery including for rapid training of CHWs, monitoring access to and utilization of community-based services, support service delivery (telehealth) and supportive supervision.
- Optimize services as the context allows e.g. providing supplementation, medications, contraceptives and prophylaxis (e.g. condoms) that can be used at home for longer duration, home visits for ANC/PNC, etc.
- Pay special attention to the needs of children, adolescents and elderly people, and other people living with disabilities, migrants, displaced and key populations. Expand mandate of CHV through collaboration with peer educators working as volunteers under the guidance and supervision of CSO or NGO programs.
- Coordinate delivery of nutrition and HIV services and support together with maternal and child essential health interventions (Immunization; iCCM, ANC etc.) as a way of optimizing service delivery.
- Ensure that community health workers receive training on safe and ethical referral of GBV; Psychological First Aid and have information about available GBV, child protection services and access to Post-Exposure Prophylaxis (PEP).
- Create a roster of community members trained in first aid and acute care and strengthen or create an organized CFAR system with 24-hour coverage that can be activated by mobile phone.

4.3.1 Community level service delivery modalities

The following basic precautions should be applied for all community level service delivery modalities:

- Avoid all group gatherings
- Keep distance of at least 1m, avoid direct contact
- Perform frequent hand hygiene according to the WHO ‘My five moments’. Additionally, observe respiratory etiquette and if advised, wear mask or cover nose and mouth while waiting for services.

Table 3 below shows some proposed modalities of community level service delivery in the different COVID-19 pandemic scenarios. Each country, based on the pandemic stage, should identify the feasible and most appropriate modalities for delivering essential health services at community level.

Table 3: Community level service delivery modalities by scenario

Service Delivery Modalities	COVID-19 Scenarios			
	No cases	**Sporadic cases**	**Clusters of cases**	**Community Spread**
Outreach activities / campaigns	Apply basic precautions approaches	No campaigns that entail large gatherings Suspend mass screening	No campaigns that entail large gatherings Suspend mass screening and advocate for family MUAC	No campaigns that entail large gatherings Suspend mass screening and advocate for family MUAC
Household visits	Conduct household visits as per national protocol including basic precautions	Conduct household visits as per national protocol including basic precautions	• Screen for COVID-19 according to national protocol • Conduct home-visits outside in a well-ventilated space and keep a distance of at least 1m • Use a medical mask if direct or close contact is necessary, full PPE for suspect/ confirmed COVID-19 cases • Use gloves if exposure to blood, body fluids, mucous membranes or non-intact skin is expected and change gloves after each interaction	• Screen for COVID-19 according to national protocol • Conduct home-visits outside in a well-ventilated space and keep a distance of at least 1m • Use a medical mask if direct or close contact is necessary, full PPE for suspect/confirmed COVID-19 cases • Use gloves if exposure to blood, body fluids, mucous membranes or non-intact skin is expected, and change gloves after each interaction
Community Case Management	Conduct CCM ensuring basic IPC measures are in place and reinforced	Conduct CCM ensuring IPC measures are in place	• Adopt protocols depending on screening guidance, ensure availability of PPE. • Distance protocols with presumptive treatment only in children identified as COVID-19 suspects. • If no PPE available low touch protocols	• In severe shortage of PPE, adopt no touch protocols when doing CCM in COVID-19 suspects prior to activating local protocol for COVID-19 • CHWs should follow the adapted protocols on IPC measures, use of PPE (WHO, 2020) with support from the caregiver when interacting with a sick child, and only when counting respiratory rate, reading MUAC, and other observations for assessing sick children maintaining distance of at least 1m.

4.3.2 Community-based Human resources for health

In order to ensure continuity of essential community services, its necessary to classify Community Health Workers or volunteers (CHWs or CHVs) as essential health workers. If restrictions on population movement are implemented including lockdown, shelter-in-place and/or curfew directives, CHWs/CHVs should be excluded from such restrictions in order to continue providing essential community-based health services.

Table 4: Human resources

Human resources - capacity building, remuneration, motivation
CHWs and other community cadres engaged in response should be targeted for training on IPC to enhance their capacity to deliver services without increasing the risk of transmission of COVID-19. Since a significant proportion of them may not have access to online resources, these trainings should be targeted at times of supplies collections, supervision of field activities and joint training whilst observing social distancing and existing regulations. Compensation for CHWs should be maintained and not scrapped in light of COVID-19 movement restrictions since they will continue to play a significant role in delivery of health services, including potentially contact tracing for the control of COVID-19. Pre-COVID-19 benefits and entitlements should be maintained. CHWs should be motivated through recognition, priority in social protection programmes and access to movement waivers to collect supplies and follow up of patients.

5. Supply chain

The need to redirect supplies to the treatment of patients with COVID-19, compounded by general supply chain disruptions due to containment measures such as lockdowns and the effects of the outbreak on other sectors, is likely to lead to stock outs of drugs and supplies such as vaccines, contraceptives, lifesaving drugs, emergency medications, medications for chronic disease etc. Medical supplies priority lists should be developed (or adapted from existing lists), and plan for stock piling/front loading adequate amounts to last for few months. Suppliers and pharmacies (public and private) can be networked to allow dynamic inventory assessment and coordinated re-distribution. It is recommended for countries to look into available regional pooled procurement services for pharmaceuticals and medical supplies to ensure availability of stocks.

Some key actions are as follows:

- The National Logistic Management Information System (LMIS) and National Essential Medicine Systems should be regularly updated and monitored to ensure that there are no stock outs and availability of essential medicines, essential diagnostics services and functional medical devices should be ensured.
- Adequate funds may be made available, even over and above the stipulated untied funds to effectively respond to emerging needs
- Provinces/districts/counties should make provision for additional free essential medicines and diagnostics in facilities with a higher caseload.

6. Rights, Roles and Responsibilities of Health workers

Most countries in the ESA region have existing health workforce challenges, including shortages, maldistribution, and misalignment between population health needs and health worker competencies. COVID-19 will further complicate this. Table 5 lists proposed critical support measures for this phase. Many of these actions should be adopted by countries as a good practice.

Table 5: Key interventions/strategies for health workers

Key Interventions/ strategy	Actions
Ensure rights and responsibilities of health workers	• Provide information, instruction and training on occupational safety and health, including; refresher training on IPC use, putting on, taking off and disposal of PPE. • Provide adequate IPC and PPE supplies in sufficient quantity for all healthcare or other staff but especially for those caring for suspected or confirmed COVID-19 patients, such that workers do not incur expenses for occupational safety and health requirements. • Provide a blame-free environment for workers to report on incidents, such as exposures to blood or bodily fluids from the respiratory system or to cases of violence, and to adopt measures for immediate follow-up, including support to victims • Strengthen measures for protection of occupational health, safety, and security of health workers – prevention of violence, addressing fatigue, and access to health care and psychosocial support. • Honour the right to compensation, rehabilitation and curative services if infected with COVID-19 following exposure in the workplace. This would be considered occupational exposure and resulting illness would be considered an occupational disease • Provide access to mental health and counselling resources; and enable co-operation between management and workers and/or their representatives • Identify domestic support measures (e.g. travel, childcare, care of ill or disabled family members) that could enhance staff flexibility for shift work.
Train, repurpose and mobilize the health workforce according to priority services	• Map health worker requirements (including critical tasks and time requirements) for the WHO transmission scenarios. • Consider the following sources for temporary health workforce surge capacity and essential health care services, including public health services: – part-time staff to expand hours and full-time staff to work remunerated overtime; – staff from non-affected areas and health workers available for temporary re-assignment in line with the agreed roadmap for essential health care services; – utilizing registration and certification records to identify qualified candidates and recruit additional health workers, including licensed retirees and medical trainees for appropriate supervised roles and – mobilizing non-governmental and private sector health workforce capacity.

	• Initiate web-based rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control during pregnancy and delivery • Integrate dedicated learning opportunities within training lessons plans in delivering services to vulnerable populations such as adolescents and young people, people living with HIV, migrants, sex workers etc. • Provide training on clinical management of rape; safe and ethical referral of GBV (using the GBV Pocket Guide, IASC GBV Guidelines, GBV AoR guidance) and Psychological First Aid. For detail refer to UNFPA guidance on Area of responsibility (AoR) Research Query on GBV Case Management and the COVID-19 Pandemic[8]; IASC GBV Guidelines key recommendations to reduce risks of GBV for all sectors. • Work with GBV coordination mechanisms in country to receive and widely disseminate up to date list of available services and referral pathways for survivors of GBV. • Ensure all health workforce in community and health facility services are provided with COVID-19 training (online, or in designated community training facilities). • Ensure that all health workforce is trained and up to date in basic life support according to WHO Basic Emergency Care. • Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management responsibilities and essential infection prevention and control. • Mobilize adequate supportive supervision structures and capacity to reinforce and support rapidly-acquired knowledge and skills. • Consider simple high-impact clinical interventions for which rapid up-skilling would facilitate safe task sharing and expansion of scope of practice for the entire health workforce, for example, including pharmacists, nurses, nursing assistants, social workers, physiotherapists, psychotherapists, CHWs, dentists, community health work etc.
Maintain ongoing communications with health workers	• Establish or reinforce communication platforms so that a workforce notification system is in place to regularly and frequently inform the health workforce of changes in demands, service delivery arrangements, referral pathways, training opportunities, etc.). • Work with professional associations and others to maximize communication 'reach'.
Provide mental health and psychosocial supports for health workers	• Establish a dedicated hotline or other mechanism for psychological support of health care workers. • Review work schedules and ensure distributed workload to the extent possible • Monitor health workers for illness, stress and burn-out and consider introducing psychological first aid training for volunteers and community members to support staff in high stress areas, using digital and other platforms. • Consider financial support and expansion of sick leave arrangements to support reporting of symptoms by health workers.

	• Consider childcare and other care support options for health workers, for example, when schools close due to spatial/social distancing measures or caring commitments for older relatives.

7. Monitoring

Monitoring of continuity of essential services is critical for documenting and tracking disruptions, identifying bottlenecks in access to services and addressing them. A framework for monitoring continuity of essential health services and/or disruptions is under development and will be released shortly.

Acknowledgements

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List of Acronyms and Abbreviations

BEmNOC	Basic emergency newborn and obstetric care
CFAR	Community First Aid Responders'
EmONC	Emergency Obstetric and Newborn Care
EVD	Ebola Virus Disease
FP	Family planning
GBV	Gender Based Violence
ICCM	Integrated Community Case Management *of Malaria, Pneumonia and diarrhoea*
IFAS	Iron and Folic Acid Supplementation
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IYCF	Infant and Young Child Feeding
LMIS	Logistic Management Information System
MAM	Moderate Acute Malnutrition
MNH	Maternal and Newborn
MUAC	Mid Upper Arm Circumference
PHEIC	Public Health Emergency of International Concern
PMTCT	Prevention of mother to child transmission of HIV
PPE	Personal Protective Equipment
PrEP/PEP	Pre and Post-Exposure Prophylaxis
SAM	Severe Acute Malnutrition
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
VAS	Vitamin A Supplementation

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