Interim guidance on delivery of essential health services during the COVID-19 response

Updated 27 June 2020

BACKGROUND

During the COVID-19 pandemic much of the focus of health services will shift towards preparing for, mitigating, or managing a local outbreak. It is critical at this time however, to ensure that some essential health services are maintained, albeit in a modified form. This will be critical to avoid increases in other communicable diseases, rising mortality from treatable conditions, and longer-term health impacts for the country. This guidance document provides a summary of the key essential health services for the Pacific Island Countries and Areas and is intended to assist Ministries of Health and their partners with strategic planning and coordinated action to maintain essential health service delivery.

This guidance document has been developed by members of the Pacific Joint Incident Management Team's Health Service Delivery Cell. This Cell includes members from SPC, UNICEF, UNFPA and WHO. It draws on global guidance and intends to provide a summary of key points for Ministries to consider. Additional more detailed advisory notes on some specific areas of essential health services will be developed by the Cell.

The Cell can provide further reference documents, respond to queries, and provide support to countries in their consideration of maintaining essential health services.

Purpose and Intended Audience

This document is intended to assist with national planning processes for the continuation of critical essential health services during COVID-19 pandemic. Directors of Public Health, Directors of Clinical Services, Directors of Nursing and Service Leads will find it helpful for planning purposes

Essential service areas	Considerations during pandemics	Service delivery setting & platforms	Human resources and essential medications, equipment, and supplies	Additional materials
1. Prevention and management of communicable diseases				
Vaccination	Routine immunization services should be maintained, through fixed and outreach sites, if COVID-19 response measures allow. Consider adjusting immunization schedule (countries starting primary series at two months) for the primary series of three doses of poliomyelitis, diphtheria, pertussis, tetanus; haemophilus influenzae B; pneumococcal, and Hepatitis B vaccines, starting the first dose as early as six weeks of age, and the subsequent doses given with an interval of at least four weeks between doses. Countries administering the second dose beyond the second year of life, may consider adjusting the second dose schedule to 15–18 months of age. This ensures early protection of the individual and slows the	Ensure that the facility used for provision of immunizations adheres to guidance on hygiene and safe distancing. Alternative health or other facilities away from usual facilities may be considered. Modify session timings and/or location to reduce overcrowding and limit duration in healthy facility.	Ensure availability of vaccines and supplies (syringes, safety boxes etc.) for the routine immunization programme at all levels by stock tracking. Vaccine availability at the national level should be ensured for at least three months, and at the sub-national level for at least one to three months. Appropriate storage at all levels is critical. The cold chain must be maintained. Only trained immunization nurses should be providing immunizations.	Guiding principles for immunization during COVID-19 pandemic are available from: https://apps.who.int/iris/bitstream/handle/10665/331590/WHO-2019-nCoV-immunization_services-2020.1-eng.pdf

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	accumulation of a cohort of susceptible young children. If immunization services are interrupted, conduct intensified immunization services at the earliest opportunity to close population immunity gaps.			
TB	It is critical to maintain essential TB services, including diagnostics, to ensure that the burden of TB does not increase in a country. All infection prevention and control (IPC) measures should continue to be strengthened to reduce transmission of TB.	Diagnostic services should continue to function with consideration of alternative mechanisms for sputum collection and transport, to limit hospital visits. Patient-centred ambulatory home-based care should be strongly preferred over hospital treatment for TB patients (unless serious conditions require hospitalization), to reduce opportunities for transmission.	Adequate stocks of TB medicines (one to two months' supply) should be provided to all patients, to ensure treatment completion without requiring additional visits to healthcare facility. Following-up treatment adherence can be done by phone to reduce the need for contact. Prophylaxis and preventive treatments should be continued.	WHO information about considerations for TB care and COVID-19 is available from: https://www.who.int/tb/COVID_19considerations_tuberculosis_services.pdf

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Leprosy	It is recommended that active case-finding during COVID-19 be suspended but all other patient care should continue. Provide patients with adequate information to promptly identify leprosy reactions and advise re how to contact healthcare worker. All patients should be advised to follow general guidance about hygiene and distancing.	Clinic visitations should be reduced as much as possible. Instead, use telephone-based follow-up to ensure continued compliance with treatment.	Provide multi-drug therapy supplies to patients for 2-3 months to reduce the need for clinic attendance.	WHO, International Federation of Anti-Leprosy Associations (ILEP), and Global Partnership for Zero Leprosy (GPZL) advice about leprosy and COVID-19 is available from: https://www.leprosy-information.org/media/945/download
Other NTDs	Continue critical diagnostic and treatment services as delays can be fatal or lead to profound disability Maintain facility-based care for any wound management		As supply chains may be disrupted ensure sufficient critical supplies in country.	
Surveillance for other disease outbreaks	All routine surveillance should continue, including syndromic surveillance, event-based surveillance, laboratory surveillance, vaccine-preventable disease surveillance, and National Notifiable Disease Surveillance Systems.	Maintain routine systems.	Sufficient laboratory consumables are required. Consider potential extended delivery times due to transport limitations.	

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	Any alerts and unusual disease patterns should be investigated. Reports should be produced routinely and disseminated adequately to enable a rapid response.			
HIV/STIs and hepatitis	People-centred HIV services must continue for people living with (PLHIV), and at risk of HIV. This includes ensuring the availability of condoms, pre-exposure prophylaxis, treatment, and HIV/STI testing. Consider options to reduce need for patient encounters at facilities, including through remote consultations and the provision of multi-month dispensing of HIV medications. Confidentiality for those with HIV must be maintained Ensure continued access to testing for HIV, hepatitis and STIs.	Provide multi-month dispensing (3 to 6 months' supply) for PLHIV who are clinically stable on antiretroviral therapy (ART) in line with national guidance. This will reduce the frequency of visits to the health facility, optimize treatment continuity and reduce loss to follow-up. Ensure clients are advised where treatment/support is available. Establish telehealth modalities for counselling to increase compliance with treatment	Ensure sufficient stocks of antiretrovirals, including across the country in case of local transportation restrictions. For TB coinfected clients ensure they have an adequate supply of TB treatment to complete the course. For clients receiving TB preventive therapy, prescribe enough medicines to complete the course.	Frequently asked questions and answers on COVID-19, HIV and antiretrovirals is available from: https://www.who.int/news-room/q-a-detail/q-a-on-covid-19-hiv-and-antiretrovirals

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		Adapt pre-test and post counselling to virtual sessions.		
2. Reproductive health care services				
Family planning (FP)	Continue to provide FP services while utilising options to reduce visits to facilities. Ensure public is informed of sexual and reproductive health (SRH) services and risk reduction options, including those which are adolescent-friendly. All service provision should carefully consider infection risks.	Conduct FP service provision, preferably in dedicated clinics or in separate rooms in the healthcare facility, taking care to follow social distancing and hygiene requirements. Utilise mass media, appropriate to target audiences and cultures to provide targeted messages to vulnerable populations. Service provision adjustments could include virtual/remote consultation, one-stop clinic appointments that include post-partum FP and infant immunization, multi-month provision of	Adequate stocks of FP consumables (pills and condoms etc.) should be provided to all patients to ensure uninterrupted supply, reducing the need to visit clinics to collect medicines. Technologies should be made available to support virtual/remote consultations, including use of social media/digital/broadcast platforms for dissemination of health messages. Ensuring sufficient stocks of all FP supplies are available at all facilities. Ensure that menstrual hygiene products are included in lists of priority health products to mitigate supply disruption and provide information about alternative, reusable menstrual health products	Existing WHO guidelines on self-care interventions for health (SRH) – not COVID-19 specific – are available from: https://www.who.int/reproductivehealth/publications/self-care-interventions/en/

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		medications, reducing frequency of check-ups.		
Antenatal care services (ANC)	ANC services should continue as essential services, with adjustments to respond to pandemic situation. Maintain eight antenatal contacts with consideration for the following modifications for low-risk clients: minimum of four face-to-face contacts complemented by virtual follow-up appointments between these face-to-face encounters. Individualized plans for women requiring more frequent review may be necessary e.g. pregnant women who are assessed as high risk, including women with comorbidities, who are underweight or overweight, adolescent girls, women at risk of common maternal mental health conditions, or other vulnerable groups.	Home visits should consider provision of integrated services. e.g. Well-baby checks. Reorganize ANC services and/or client flow, as needed, to reduce wait times and contacts with other patients, ensure safe distancing, improving efficiency of service delivery, and satisfaction among clients and providers. Aim to reduce contact with health facilities by ensuring all appointments and investigations are provided within a single visit, involving as few staff as possible. Women with mild COVID-19 symptoms should be encouraged to remain at home (self-isolating) in	Adequate stocks (2- 3 months' supply) of prophylactic medicines (iron, folate, calcium, prophylaxis treatment for malaria, deworming etc.) should be provided to all patients to take home to ensure no interruption and reduce the need to visit clinics. Tetanus toxoid vaccine to be provided when home visits are undertaken. Ensure stock of minimum equipment and supplies, including, adult scale, BP machine, measuring tape, fetal stethoscope/hand held doppler, adult stethoscope, thermometer, point of care tests (for haemoglobin, syphilis, urine dipstick, glucose test), vaginal specula of different sizes, cold box (for storage of drugs and vaccines), and standard personal protective equipment (PPE) for care providers. Technologies should be made available to support virtual/remote consultations including use of social media/digital/broadcast platforms	General guidance – not COVID-19 specific – WHO recommendations on antenatal care for a positive pregnancy experience is available from: https://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf?sequence=1

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	Prioritise risk assessments for conditions or situations with higher risk e.g. adolescent girls. Support for development of birth preparedness and complication readiness plans should be done which take into account changes to services. Any home visits or outreach should carefully consider COVID-19 risks and necessary precautions.	early (latent phase) labour as per standard practice. Where feasible, use digital platforms for counselling and screening, including for danger signs.	for dissemination of health messages.	
Childbirth	All women should deliver in the presence of a skilled birth attendant. Risks for mothers and newborns from unattended childbirth outweigh potential risks from COVID-19 transmission at health facilities. Continue to promote breastfeeding to all new mothers. Ensure birth companions (if allowed) are appropriately screened for COVID-19 infection.	Conduct labour and delivery, if possible, in a dedicated labour room within the healthcare facility. Maternity staff safety must also be maintained by following IPC and PPE guidelines.	Ensure there are sufficient supplies of relevant equipment: delivery kit, fetal stethoscope/handheld doppler, reflex hammer, adult stethoscope, speculums (Sim, cuscos), manual vacuum extractor/forceps, blank partograph, sterile gloves, infant scale, towels etc. Maintain adequate supply of drugs including oxytocin/misoprostol, antihypertensive drugs, magnesium sulphate, calcium gluconate,	General guidance – not COVID-19 specific – Intrapartum care for a positive childbirth experience, available from: https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/ General guidance – not COVID-19 specific – Managing complications in pregnancy and

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	Continue to promote skin-to-skin contact and initiation of and early and exclusive breastfeeding to all new mothers. A caesarean section should be performed based solely on obstetric indications, independent of the COVID-19 transmission scenario and the COVID-19 status of the mother		antibiotics, analgesia, and local anaesthetic.	childbirth: A guide for midwives and doctors https://apps.who.int/iris/bitstream/handle/10665/255760/9789241565493-eng.pdf?sequence=1
Postnatal care services	Continue to provide postnatal care services with three contacts, on day one, day three, and day seven including PNC contact within the first 24 hours after birth in the case of a home birth. Consider offering long-acting reversible contraception in the immediate postpartum period. Ensure that complication readiness plans are adapted to take into account changes to services.	Prioritise face-to-face visiting for women with known psycho-social vulnerabilities, operative birth, premature/low birthweight baby, and other complexities. Home visits may be preferable to community clinic visits to comply with social distancing. Maternity staff safety must also be maintained	Adequate (at least 3 months' supply) stocks of prophylactic medicines (iron and folate) should be provided to all patients reduce the need to visit clinics. Ensure adequate supplies for point of care tests for haemoglobin for all those delivering postnatal care.	General guidance (not COVID-19 specific) on postnatal care of the mother and neonate, is available from: https://apps.who.int/iris/bitstream/handle/10665/97603/9789241506649_eng.pdf?sequence=1

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		by following IPC and PPE guidelines. Where in-person visits are necessary, provide all relevant care in a single visit. Where feasible, use digital health platforms for counselling and screening, including for danger signs.		
Adolescent health	Consider waiving restrictions (if these exist) that impede vulnerable young people to access SRH, HIV, and STIs services like very young adolescents due to age restrictions and requirements for parental or spousal consent; young people with disabilities, young people from sexual minorities groups, young people in commercial sex work, and young people living with HIV/AIDs. Inform male and female adolescents where and how to get support and care in case of intimate partner violence or	Establish telehealth mechanisms for individual counselling of adolescents that adhere to the principles of confidentiality and non-coercive decision-making. If available, engage community groups and youth networks to extend the provision of SRH and HIV information and services Establish helplines and safe spaces, if possible	Ensure that menstrual hygiene products are included in lists of priority health products to mitigate supply disruption and provide information about alternative, reusable menstrual health products Increase access to condoms and lubricants for safer sexual practices by using different outlets. Use telephone hotlines for reporting and/or seeking advice. Use social media/digital/broadcast platforms for dissemination of health messages.	WHO guidelines and compiled recommendations on adolescent health: https://www.who.int/maternal_child_adolescent/guidelines/adolescent/en/ Adolescents and young people & coronavirus cisease (COVID-19): https://www.unfpa.org/resources/adolescents-and-young-people-

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	sexual violence as well as need for mental health and psycho-social support. Use the media, if possible.	and disseminate information on availability of these services.	Advise health workers about the heightened risk to adolescents of intimate partner violence and sexual violence; and the need to provide support and care discreetly and to ensure confidentiality.	coronavirus-disease-covid-19
3. Child health services				
Postnatal care of the healthy neonate	Provide the minimum recommended number of contacts, which is three for healthy neonates; at day one, day three, and day seven. Follow normal postnatal care protocols. Provide guidance to mothers suspected or confirmed with COVID-19 on how to safely care for neonate. Verify capacity before discharge.	Conduct postnatal care visits for healthy neonates at the PHC facility if possible and align postnatal care visits for mothers to reduce the number of contacts. Home visits may be preferable to comply with social distancing. Use remote consultations, when possible, for mothers, to provide breastfeeding support, specialised post-natal advice, early parenting advice, and other guidance.	Health care workers (HCW) should follow COVID-19 IPC protocols if the caregiver is displaying respiratory symptoms. HCWs trained to identify sick neonates by directly assessing for danger signs during home visits.	Adaptations can be made from routine guidelines on care of the neonate, available from: https://apps.who.int/iris/bitstream/handle/10665/259269/WHO-MCA-17.07-eng.pdf?sequence=1

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Postnatal care of the sick neonate	Aim to minimise movement of commonly used equipment for neonatal resuscitation and stabilisation. Enhance droplet/contact precautions if neonate remains in hospital. Limit number of caregivers providing support. Avoid nasal or oral suction for babies born spontaneously breathing. Consider early discharge with follow-up for stable preterm or LBW newborns. Refer the follow-up visit after discharge to a primary health care (PHC) facility to reduce contact with high traffic hospitals. Continue with normal postnatal contacts as for a healthy neonate.	All infant resuscitation and/or assessment should occur in the location where the infant is born – AVOID TRANSFER. If transfer is necessary, neonates should be transferred in a closed incubator if on respiratory support. Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present	Health Care Workers (HCWs) should follow COVID-19 IPC protocols, if the caregiver is displaying respiratory symptoms. Ensure neonatal staff at the hospital are trained to address complications and minimise contacts. All equipment coming out of the isolation room should be cleaned as per COVID-19 cleaning policy.	Adaptations can be made from routine guidelines on care of the neonate, available from: https://apps.who.int/iris/bitstream/handle/10665/259269/WHO-MCA-17.07-eng.pdf?sequence=1
Nutrition: Infant and young child feeding (IYCF)	Mothers with suspected or confirmed COVID-19 should be advised to follow necessary	Integrate IYCF counselling into home visits for post-natal care and ensure the	Ensure HCWs are trained on IYCF counselling.	UNICEF Briefs on infant and young child feeding available from:

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	respiratory hygiene and hand hygiene during feeding, and to follow usual infant feeding guidelines. Mothers should still be encouraged to breastfeed, while ensuring good hygiene practices. If a mother with COVID-19 is severely or, if other health complications, prevent her from breastfeeding her infant, she should be supported to express milk, and safely provide breastmilk to the infant. Intensify promotion of safe hygiene behaviours for new mothers and family. Governments and partners should not accept or seek donations of breastmilk substitutes, unhealthy foods, complementary foods, and feeding equipment. Information on healthy feeding options for infants and young children in the context of COVID-	HCWs are trained accordingly.	Use digital, broadcast and social media platforms, to provide accurate health messages to support parental decision-making.	https://www.ennonline.net/COVID-19iycfbrief Q&A breastfeeding and COVID-19 http://www.who.int/news-room/q-a-detail/q-a-on-covid-19-and-breastfeeding

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	19, lockdowns and financial barriers may be needed.			
Nutrition: Detection and management of acute malnutrition, and micronutrient supplementation	Consider programmatic modifications for detection and treatment of severe acute malnutrition (SAM). For example, reduce the frequency of follow-up visits to once per month for children with uncomplicated severe or moderate wasting, or increase the take-home ration of Ready-to-Use-Foods (RUFs) and other nutrition commodities. Maintain frequency of micronutrient supplementation. Emphasize strong hygiene measures for all those caring for infants under six months.	Reduce participation in visits to primary caregiver only. Deliver treatment for uncomplicated wasting in the community via PHC using a limited/no touch simplified treatment approach. Increase physical space to at least two metres between beds in stabilization centres. Limit contact with multiple HCWs and follow strict cleaning protocols.	Ensure adequate supply of vitamin A, Albendazole, Iron-Folic Acid (IFA), zinc, F 75, F 100, Resomal, Ready-to-Use Therapeutic Food (RUTF). Ensure availability of Middle Upper Arm Circumference (MUAC) tapes at PHC facilities. Train mothers and caregivers on how to detect SAM. Train HCWs on how to manage SAM using COVID-19 modified protocols.	UNICEF Briefs on management of child wasting available from: https://drive.google.com/file/d/1FX5CuTtrf0CNiAjqnL6a_k7sLwi_-5ct/view
Management of the sick child: Pneumonia and diarrhoea	Refer symptomatic cases for COVID-19 investigations. Raise awareness among caregivers in identifying the danger signs for pneumonia, and when to seek medical attention.	Conduct consultations for suspected pneumonia cases in a separated well-ventilated room ensuring spacing between the child and the HCWs.	Consider technology/digital solutions for communication between HCWs and patients instead of in-person visits.	Adaptations made from the local Integrated management of childhood illness guidelines.

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	Treat all suspected pneumonia cases following standard treatment guidelines. In the absence of PPE, consider a 'No touch policy' that focuses on history of symptoms and clinical observation. Raise awareness among caregivers in identifying dehydration, and when to seek medical attention. Consider increasing the capacity of mothers and caregivers on initiating home treatment early for diarrhoea.	Consider home visits. Identify a well-ventilated location outdoors for the consultation, maintain distance, and wear PPE, if available. Use radios, TV, and social media platforms to educate the mothers and caregivers on how to identify early signs of common illness.	Physical examination and tests for pneumonia requires appropriate PPE. HCWs should be trained and equipped with key messages on COVID-19 to mitigate the spread of misinformation in their communities, and to effectively communicate information on prevention measures.	
Sick child chronic care visits (chronic conditions and developmental disabilities)	Consider limiting frequency of face-to-face visits for stable patients.	Consider using virtual consultations for some assessments and reviews.	Provide medicines and other supplies for longer periods than usual.	
Well child care Including growth and developmental monitoring	Consider postponing routine well child visits, for short periods only. Integrate into every contact all possible checks/actions e.g.	Consider using digital solutions for key messages and resources.		

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	immunisations, screening, counselling .			
Rheumatic heart disease	Prioritize ensuring continuity of secondary prevention, treatment with benzathine penicillin.	Consider relocating service delivery away from those delivering COVID-19 care.	Ensure benzathine penicillin and associated supplies are adequate and appropriately prepositioned in the country to ensure continuity of access.	
4. Management of chronic diseases				
Noncommunicable disease, particularly diabetes, hypertension, heart disease, chronic respiratory disease	Support ongoing management for those diagnosed with NCDs including provision of medications and supplies, condition monitoring, and health advice. Make efforts to reduce provider encounters while ensuring NCD management is not compromised. Create self-management plans and support self-monitoring of disease if appropriate backed up by HCW using alternative delivery mechanisms if needed. Utilise pulmonary function tests with extreme caution as they may aerosolize coronavirus. Only	Decentralize routine NCD services to peripheral health facilities away from COVID-19 centres and ensure that COVID-19 screening of patients is in place at facility entrance. Limit number of patients per day by increasing clinic days, spacing of appointments, and providing prescription for medical refills for several months. Patient encounters may be further reduced through:	Stock adequate medicines in country to ensure that multiple months of medication can be provided to patients. Stock should also be decentralized in case of domestic transport restrictions. • Implement a monitoring system including central guidance on adhering to national protocols. • Ensure appropriate equipment and supplies are available in decentralized locations.	General guidance on NCDs and COVID-19 available from: https://www.who.int/who-documents-detail/covid-19-and-ncds

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	undertake is critical impact on patient care. Increase patient education to include differentiating COVID-19 from usual cough or symptoms. Emphasise importance of early detection of IHD and stroke.	• Virtual clinics or telephone/remote medical consultation, and request for prescription refills. • Offering medication pick-up sites away from COVID centres, or home delivery of NCD medicines. Further steps to consider in difficult circumstances (such as when cases of COVID-19 increase significantly and stretch health system considerably). • Expand prescribing rights of trained non-physician HCWs, consistent with national treatment protocols. • Mobilize trained community partners/private agencies for routine monitoring services such as blood	Oversight and training of non-physician HCWs would be needed. Oversight and training of community partners would be needed. This might be done remotely.	

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		pressure and blood glucose measurements, foot inspection, and wound care.		
Mental health conditions	Prioritise face-to-face care for people who are at high risk to hurt themselves or others (e.g. imminent risk of suicide) or present with severe mental health conditions. Consider home visits for this population. Raise awareness and provide key contact details (e.g. telephone numbers of mental health team, protection services, mental health or suicide hotlines) to people who may have mental health needs.	Virtual consultations can be used when possible for assessment, consultation, follow-up reviews, psychological treatments (if function not severely impaired) and for group psychosocial care. Direct initial care for mild depression to self-help resources.	Introduce use of longer prescription periods through either expanded take-home practices or delivery. Consider confidential medication drop-offs for those who require medication to reduce the need to visit facilities.	IASC (2020) *Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes During COVID-19 Pandemic*: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/operational
Cancer screening, diagnosis and treatment, including palliative care	Consider temporarily suspending open facility screening and consider relocating to venues away from high risk areas. Increase campaigns to encourage individuals with potential symptoms of cancer to seek consultation.	Maintain communication with those scheduled for screening and offer later appointments. Utilise virtual consultations to follow-up on any diagnostic results. Consider alternative sites (e.g. private practices, NGOs, patient residences)	Need for cytotoxic agents, opioids and ancillary cancer medications should be predicted and appropriate supplies positioned at safe facility for treatment of patients. Optimal storage conditions should be given close attention. Staff providing oncology or palliative care services should pay extra attention to their own health and	

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	Prioritise timely initiation of cancer treatment for cancers in which delays impact outcomes. Chemotherapy and palliative care will need to be maintained while considering compromised immune system in most cancer patients.	for this treatment provision away from facilities that manage COVID-19 patients. If this is not possible, then ensure separate rooms, entrances and exits. Some patient treatment schedules may need to be reviewed to reduce risk of COVID-19 exposure at immune-compromised periods.	minimising risk to patients. These staff should be dedicated to oncology alone and confirmed to be COVID-19 negative if possible.	
Renal dialysis	Dialysis services must be maintained while taking efforts to minimise exposure of patients to COVID-19. Explore potential of decreasing frequency of haemodialysis from three to two times a week in patients who can tolerate such a regimen.	Ensure careful COVID-19 screening of all patients arriving for dialysis treatment. Ensure strict hygiene measures in dialysis facilities and careful sterilization of all contact areas several times a day. If possible, ensure separate entrance away from general entrance for patients arriving for dialysis.	Staff covering dialysis services should pay extra attention to health, and not work if any possible COVID-19 symptoms or contacts.	

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5. Hospital services				
Emergency surgery	Postpone all non-essential or elective surgery, including invasive and diagnostic procedures such as routine endoscopy and radiology performed in theatres. Maintain emergency surgery capability and capacity. If possible, all emergency surgery patients should be screened (and tested) for COVID-19 so that they can be housed in appropriate wards to minimise transmission.	Where feasible, identify specific operating theatres or designated facilities, for patients who may have been exposed to COVID-19. Implement rigorous infection control measures.	Ensure adequate supplies of consumables and PPE for surgery and predict future demands.	
Emergency department	Consider creating parallel systems to separate presentations with symptoms for COVID-19, from those with other clinical presentations, or utilise rigorous screening before entry to facility. Hospital admissions should be limited to patients requiring essential or life-saving treatment. As a general principle, all patients should be considered as potentially infectious. Some will present with atypical symptoms.	If feasible, screen all patients prior to entry to facility. Any patients with respiratory symptoms should be diverted to a specific high-risk zone, separate from other patients.	Emergency department staff managing patients with respiratory symptoms, or those which could be COVID-19, should always wear appropriate PPE. Plan to mobilize staff from other departments at peak periods to deliver nursing care under the supervision of emergency trained nurses.	

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Auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services.	Auxiliary services should be scaled down and focus only on supporting COVID-19 response and providing essential, life-saving services.	Where possible, establish a separate location for laboratory testing and imaging of COVID-19 cases.	Where possible, appoint designated staff members to conduct diagnostic tests only for COVID-19 patients.	
Dental services	All non-urgent dental treatment should be postponed. Health authorities should make arrangements to deal with specific dental emergencies (e.g. acute infections, trauma) using enhanced IPC.	Where possible, establish a separate location for laboratory testing and imaging of COVID-19 cases.		
6. Other Essential Health Services				
Rehabilitation and physio services	Modify rehab services as appropriate and consider options for some remote consultations. Avoid any group-based rehab and/or physio services. Convert to individual services as appropriate.	Telehealth or online options may be suitable in some cases.		
Gender Based Violence (GBV)	Key GBV services must be maintained and integrated within other services, this includes:	Services must be available at all health service delivery points	Adaptation of referral for survivors of GBV to enable access to online and remote support	General guidance resources – not COVID-19 specific –

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	• Screening/checks of all women in contact with health services for GBV. • Sexual assault examination (continue as per protocol in country). Healthcare workers should be sensitised to heightened risks of domestic violence during national restrictions for COVID-19.	Some services including referral and MHPSS support may be provided through online or telehealth options Ensure information about any changes to service delivery are well publicised		Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines, available from: https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf?sequence=1 Clinical care for sexual assault survivors, available from: https://gbvresponders.org/response/clinical-care-sexual-assault-survivors/
Child protection	Key services must be maintained to identify and support victims of child abuse. Children of parents who are quarantined or hospitalized will need to be supported.	Services should be available in line with usual processes, but with special consideration for quarantined or isolated carers.		General guidance – not COVID-19 specific – from International Rescue Committee GBV Responders' Network: Caring for child survivors, available from:

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				https://gbvresponders.org/response/caring-child-survivors/
Support for people living with a disability	Support for this group should be maintained, however considerations should be given to reducing non-critical appointments. Consideration should be given to upskilling family member to provide some simple aspects of physio care at home.	Where possible services should be delivered in the community, away from health care services. Strict infection control measures will be needed. Information provided should be accessible for those with vision or hearing impairments.	If appropriate provide 2-3 months of medication	

Overarching issues

While maintaining essential health services, many considerations will cut across diseases, health issues, and support services during a pandemic.

Infection prevention and control

- Careful infection prevention and control measures must be rigorously applied across all the above essential health services. This is CRITICAL.
- This includes efforts to protect staff, clean facilities, and ensure appropriate availability of all associated consumables at all locations where treatment services will be provided.
- Clear separation of COVID-19 and non-COVID-19 treatment is critical.
- Further critical guidance on infection control has been developed for the PICs.

Medicines, laboratory supplies, and consumables:

- There are global supply issues for many non-COVID supplies due to border restrictions, factory closures, and supply line breakdowns. As such, countries need to plan for procurement and consider alternative sources for these (with focus on delivery dates).
- Within country travel restrictions need to be considered in ensuring all facilities have sufficient supplies.
- To reduce health facility use, provision of several months of routine medications, instead of requiring monthly visits, should be considered. This needs to be included in procurement planning.

Facilities

- Efforts to separate COVID-19 care and non-COVID-19 care is needed. This may be by facility (some facilities being only for COVID-19 care) or by area within facility.
- Use of non-health facilities in some communities may be of relevance to maintain non-COVID-19 care.
- Rigorous attention to hygiene, cleaning, and spacing is needed.

Staffing

- Health staff must be appropriately protected during their work, including through use of appropriate PPE.
- Health staff should be encouraged and supported to report in sick if they have any symptoms, no matter how mild, consistent with COVID-19.
- Staff dedicated to taking care of, or screening for COVID-19, should ideally be different from those delivering the essential health services.
- Counselling and support should be provided to health staff, in consideration of the considerable burden and demand they are facing, and the stress they are under due to dealing with distressed and bereaved family members.
- Efforts to increase available human resources should consider mobilizing student nurses and retired staff to take on specific supervised roles. Ministries may also consider collaboration with civil society groups or use of volunteers to fill specific demands which do not require clinical skills. However, support and training must be provided.

Remote consultations/telemedicine

- To reduce travel needs for patients and to assist with reducing use of clinics and hospitals, Ministries may consider providing some services through telephone or other communication medium, subject to their capacity. Such use needs careful consideration of risks (particularly around patient confidentiality) and what can effectively be done remotely.
- Strong communication with remote consultation facilities is needed.

Resources/funding

- It will be critical to ensure sufficient resources are allocated to enable the continuation of key essential health services.
- It is recommended that support for essential health services be incorporated into COVID-19 national plans. This can include the additional funding requirements for modifications to the current approach for essential health services in response to COVID-19.

Health information and patient information

- If services are relocated from usual facilities, it will be important to ensure that patient records are still accessible and that routine recording of information into the health information system is not compromised. This may require some relocation of records, forms, and equipment to alternative facilities.
- If services are deferred due to COVID-19 response it would be beneficial to track these e.g. deferred overseas treatment, elective surgery. If services are modified in format/delivery method it would also be important to monitor any additional costs associated with this e.g. travel, triage screening at entry to clinic, and remote consultations with patients.

Other considerations

Many PICs rely on overseas referrals and/or visiting medical teams for providing some health services such as heart surgery, cancer treatment, and specialised operations. These are likely to be severely disrupted in pandemic situations such as COVID-19. It is important that countries consider all options that may be available at this time, consider what alternatives may be feasible, and options for local management.

Overseas referrals

- Hospitals which usually receive referrals may be unable to accommodate these cases due to insufficient capacity or COVID-19 restrictions.
- Countries where patients are usually sent may have entry restrictions and may not be willing to take any inbound medical evacuation flights.
- Receiving country may require proof of patient being free of COVID-19 or may implement a quarantine period where care may not be available.
- Even if patient does make it overseas for treatment, they may not be able to return.
- There may not be enough transport for the patient both international and domestic and there may be restrictions on medical/family escorts or services required in transport.

- Can patient be stabilised locally to delay need for treatment? Consider remote support of their care planning.

Visiting medical team

- With travel restrictions these are unlikely to be occurring.
- For services usually provided, there may be scope for remote support for local teams to assess and patients.

Additional resource

https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

This document has been developed in accordance with global guidance and contextualized to the Pacific context by the members of the Essential Health Services Cell from the COVID-19 Pacific Joint Incident Management Team

Pacific Community
Communauté du Pacifique
UNFPA
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for every child
World Health Organization
Representative Office for the South Pacific