Supporting the Continuity of Health and Nutrition Services in the context of a COVID-19 in Refugee Settings – Interim Guidance V2

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The 2014–2015 Ebola outbreak was catastrophic in West Africa but the indirect impact of increasing the mortality rates of other conditions was also substantial. The increased number of deaths caused by malaria, HIV/AIDS, and tuberculosis attributable to health system failures exceeded deaths from Ebola[1].

With a relatively limited COVID-19 caseload, health systems may have the capacity to maintain routine service delivery in addition to managing COVID-19 cases. When caseloads are high, and/or health workers are directly affected, strategic adaptations are required to ensure that increasingly limited resources provide maximum benefit for the refugees and surrounding host population. The following are key considerations for UNHCR operations on prioritized health care services in the event of a COVID-19 outbreak. These are based on WHO Guidance for Maintaining Essential Health Services and UNHCR guidance for operations and where relevant operation or site level outbreak preparedness and response plans.

Services	Planning for reduced services or significantly scaled back services
General	i. Repurpose the health system and redistribute health workforce capacities including through task sharing for COVID-19 care and regularly evaluate the impact. ii. Ensure continuity of context-relevant essential health services (examples listed below). iii. Develop a consultative and collaborative mechanism to establish non-urgent care priorities. iv. Limit the number of provider encounters due to increased demand and decreased staff. v. Basic infection prevention measures (hand hygiene, respiratory etiquette, social distancing) should be promoted universally. vi. Use mobile technology, radio, other mass communication channels and community platforms informing communities on: a. which clinics are open and what services are available, including availability of drugs. b. alternative sites for collection of drugs. vii. Community outreach mechanisms should follow necessary infection prevention protocols viii. Use of digital health technologies can be intensified to support patients and programmes through improved communication, counselling, care, and information management, among other benefits. ix. Establish or reinforce screening and triage protocols at all points of first access to the health system, including primary health care centres, clinics, and hospital emergency units. x. It is important to separate people accessing routine services from suspect and confirmed COVID-19 cases. xi. Specific facilities may need to be designated for the care of patients affected by COVID-19 and/or establish targeted referral and counter-referral criteria and processes to keep the system from becoming overwhelmed. xii. Establish system for regularly reporting inventory and stockouts and for coordination of re-distribution of supplies.
Primary Health Care	Expand capacity for screening, isolation and triage, including with designated physical areas, sufficient spacing and flow of persons to reduce unnecessary contact and appropriate security. The following services should be continued ideally in a separate location to facility offering COVID-19 care if possible: i. Expanded programme on immunization including possibility of home delivery of immunization services. ii. Screening for acute malnutrition in children under five (see nutrition). iii. Outpatients department (OPD) for non-respiratory related symptoms separate to those with respiratory symptoms. OPD services may need to be scaled back to acute and urgent presentations only iv. Oral rehydration “corners” in separate facilities.

	v. Diagnosis and treatment for acute febrile illness, including malaria vi. Where community case management for childhood illnesses programs are available, ensure the community health workers have adequate stocks of necessary medications and supplies including PPE and are trained in infection prevention and control. vii. Wound care including dressings.
Immunization Activities	i. Where health system capacity is intact and essential health services are operational, fixed site immunization services and vaccine preventable disease (VPD) surveillance should be executed while maintaining physical distancing measures and appropriate infection control precautions, equipped with the necessary supplies for those precautions. ii. The appropriateness of alternative strategies (e.g. outreach or mobile services) must be assessed in the local context and should be adapted to ensure the safety of the health workers and community. iii. Where the provision of limited services is feasible, immunization of vulnerable populations at increased risk of morbidity and mortality due to VPDs should be prioritized for vaccination against outbreak-prone diseases such as measles, polio, diphtheria and yellow fever. iv. It is advised to temporarily suspend the conduct of mass vaccination campaigns due to the increased risk of promoting community transmission. v. Under circumstances of a VPD outbreak, the decision to conduct outbreak response mass vaccination campaigns will require a risk-benefit assessment on a case-by-case basis and must factor in the health system's capacity to effectively conduct a safe and high-quality mass campaign in the context of the COVID-19 pandemic. See Guiding principles for immunization activities during COVID-19 pandemic.
Sexual and Reproductive Health	It is important to ensure that essential health services and operations continue to address the sexual and reproductive health (SRH) and rights of people living in humanitarian and fragile settings. • First and foremost, **all emergency sexual and reproductive health services must remain available**. This includes intrapartum care for all deliveries, emergency obstetric and newborn care, post-abortion care, clinical care for rape survivors, and HIV prevention measures. Risks of adverse outcomes from medical complications outweigh the potential risks of COVID-19 transmission at health facilities. • **Comprehensive sexual and reproductive health services should be maintained as long as the system is not overstretched with COVID-19 case management.** This includes all antenatal care, postnatal care, essential newborn care, breastfeeding support, family planning and contraception services, cervical cancer screening, clinical management of HIV and sexually transmitted infections. These services should stay available to all who need them, including adolescents, for as long as possible. Reductions or modification in routine services should only be considered to: • ensure support to the epidemic response and COVID-19 case management and/or • to avert undue exposure to risk of contracting the virus in a health facility during an outbreak and/or when community transmission has been confirmed. Messages on when, where and why services have changed must be communicated to the communities affected, and every effort made to provide alternative access to services as soon as possible. **CONTINUATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES** The Interagency Field Manual for Reproductive Health in Humanitarian Settings provides guidance for provision of the Minimum Initial Service Package for Sexual and Reproductive Health in the initial phases of an emergency response, and support for comprehensive sexual and reproductive health services in established and protracted humanitarian responses. **This guidance assumes basic or comprehensive sexual and reproductive health**

	services are in place and is designed to assist stakeholders faced with difficult decisions on when and how to scale-back or modify services as part of COVID-19 mitigation and response measures. **Essential emergency services (minimum requirements):** i. **Intrapartum care** ○ Access to **skilled birth attendance** and **emergency obstetric and newborn care** for all births is among the most essential services and needs to be ensured for all women and girls in need and for their newborns. Care for the mother-newborn dyad should extend to 24-hours post-delivery. ○ Women with high risk conditions or warning signs of complications during pregnancy (e.g. bleeding, preterm labor) need to have access to skilled care 24/7. Ensure access to treatment and medication for all pregnant women with chronic conditions in need of continuous treatment, particularly access to antiretrovirals as well as medications for hypertension and diabetes. ○ Assess women presenting for intrapartum care and adjust personal protective equipment and infection prevention and control measures accordingly. Ensure facilities have supplies and protocols to ensure appropriate isolation of pregnant women and mothers/newborns who have confirmed COVID-19 and/or develop suggestive symptoms. ○ Caesarean surgeries should only be performed when medically indicated. Routine caesarean section of COVID-19 positive women is NOT recommended. ○ Continue to promote **early and exclusive breastfeeding** and **skin-to-skin contact.** In cases of suspected or confirmed COVID-19 infections, do not separate mother and newborn unless one or both are critically ill. *(*see *Infection prevention & control)*. ○ **Develop/adapt protocols for the management of COVID-19 in pregnancy** including labor and birth in line with national protocols. In the absence of obstetric complications or risk factors consideration could be given to advising women to stay at home for early labor if limitation of contacts is feasible (complete self-isolation is not advised for women in labour). ○ For more specific guidance on management of pregnant and postpartum women with severe acute respiratory infection (SARI) in relation to COVID-19, consult the following documents: ▪ **WHO** Clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected ▪ RCOG covid19-pregnancy-guidance.pdf ○ Intrapartum care of women with suspected or confirmed COVID-19 needs to ensure (1) isolation of the patient from other patients and (2) PPE (mask, goggles, gloves, gown/apron) for relevant health staff; the number of staff in contact with the woman should be reduced to a minimum ensuring capacity to deal with both maternal and potential neonatal complications. ○ The benefits of **breastfeeding, early and uninterrupted skin-to-skin contact, prolonged kangaroo mother care**, and enabling mothers and infants to remain together in the same room throughout the day and night outweighs the potential risks of COVID 19 transmission. The following precautions should be taken for **mothers with suspected or confirmed COVID-19** infection: ▪ wear a mask when holding a child ▪ wash hands before and after contact with her child ▪ clean/disinfect surfaces she has been in contact with ○ If a mother is **too ill to breastfeed**, she should be encouraged and supported to express milk that can be given to the child by cup or spoon. ii. **Post-abortion complications** are considered obstetric emergencies and access to care needs to be maintained 24/7. iii. **Clinical care for rape survivors** is an emergency health service and access to care needs to be maintained 24/7.

iv. **Standard precautions and HIV prevention measures,** including safe and rational use of blood transfusion and provision of antiretrovirals to continue treatment for people who were enrolled in an anti-retroviral therapy program prior to the emergency, including women who were enrolled in programs to prevent vertical transmission. Provide post-exposure prophylaxis to survivors of sexual violence as appropriate and for occupational exposure.

Consideration regarding other comprehensive services:

i. **Antenatal care**
   - Consider reducing routine **antenatal care (ANC)** visits to the minimum required and advise women with low-risk pregnancies to postpone clinic visits during early pregnancy for a few weeks. Women with ANC complications need to have access to care 24/7.
   - Priority should be given to routine visits in the 3rd trimester and high-risk pregnancies, consider shifting to community-based care
   - Consider redistribution of facility-level staff to provide ANC in the community where feasible. *Note:* Community-based intrapartum care is not recommended, with the exception of settings where skilled birth attendants are linked to facilities but working at community level, authorized and fully equipped to attend home births.

ii. **Postnatal care (PNC)** is critical for reducing preventable mortality and should be maintained.
   - If restrictions need to be made, focus on first 24 hours and then within the first week post-natal visits for women and newborns, including breastfeeding support
   - Where a community health care system exists, community health workers following appropriate infection prevention and control measures can support basic antenatal and postnatal care and home visits for the newborn at the patient's homes.

iii. Access to **contraceptives** needs to be maintained.
   - Continue to offer a range of long-acting reversible and short-acting contraceptive methods at service delivery points.
   - If restrictions need to be made, focus on providing continuity of contraceptive coverage, optimize access through community-based systems, shift to self-management when possible, provide supply for several months if possible.
   - Continue to offer a range of post pregnancy contraceptives.
   - Where feasible consider telephone consultations and follow-up.

v. **Intimate partner violence** is likely to increase in all emergencies including outbreaks due to stress, increased confinement and exposure to perpetrators and reduced access to basic needs, anyone who discloses such violence or comes to the attention of health workers for medical treatment related to violence, should be at minimum be offered first-line support

vi. **Information, education and communication**
   - Ensure clear, consistent public health messaging.
   - Reaffirm that medical complications outweigh the potential risk of transmission at health facilities. Community members should continue to seek and receive care during delivery, and for all emergencies resulting from other conditions, trauma, or violence.
   - Encourage understanding that any potential modifications of routine services are for the community's benefit:
     - to ensure support to the epidemic response and
     - to avert undue exposure to risk of contracting the virus in a health facility during an epidemic outbreak.
   - Ensure that women, girls and SRH service providers are provided evidence-based information on keeping themselves and their families healthy. Where possible distribute simple health education materials with key messages such as handwashing. Also consider pictorial versions for illiterate women and community health workers.

	vii. **Infection prevention and control precautions** apply for health staff, patients and accompanying family members. See guidance here: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control. ○ The design and provision of temporary facilities should consider the needs of mothers and newborns including adequate space for breastfeeding, kangaroo mother care, and management of sick newborns. ○ Every effort should be made to minimize overcrowding of maternity wards to reduce the risk of healthcare-associated infections.
HIV	i. Ensure continued access to ART, anti-TB drugs and cotrimoxazole; in facilities which have closed, make them available in alternative sites. ii. Provide longer refills of ARV supply (3-6 months depending upon stocks) and distribute through mobile clinics and at community level when possible. iii. Prioritize all pregnant, breastfeeding women and infants who are known to be HIV positive or whose mother is HIV positive for eMTCT services. iv. a) Distribute condoms; b) ensure safe blood transfusion services continue in all designated health facilities and c) provide post-exposure prophylaxis (PEP) for both occupational and non-occupational exposure. v. Utilize existing community platforms to facilitate ART distribution. Platforms that could assist in ART distribution and also help trace defaulters include a) community health workers b) people living with HIV (PLHIV networks) community-based women's organizations and d) mobile teams (that do not interfere with the COVID-19 response efforts). vi. HIV testing should be reserved for clinically indicated cases and, when safe and according to standard infection control procedures. vii. Any other form of HIV testing and outreach services including community awareness and other behaviour change communication activities should be delayed until the situation stabilizes. This would help avoid unnecessary movement of healthy individuals into the health system and concern for lack of personal protective equipment (PPE) in voluntary testing settings.
Services for Vulnerable Groups	**Key populations** (Sex workers, injecting drug users, men who have sex with men) are at heightened vulnerability and risk and every effort should be made to continue these services. i. Continue essential preventive services: ○ Community based condom and lubricant distribution ○ Pre-exposure Prophylaxis (PrEP) for those already on PrEP ○ STI testing and treatment ○ Oral substitution therapy and needle syringe programming ○ Support to peer educators and community-based organizations ○ Drop in centres may need to be scaled back ○ Telephone follow-up is preferred over in-person contacts
Tuberculosis Services	i. People-centred delivery of TB prevention, diagnosis, treatment and care services should be ensured in tandem with the COVID-19 response. ii. Patient-centred outpatient and community-based care is strongly preferred over hospital treatment for TB patients (unless serious conditions are requiring hospitalisation) to reduce opportunities for transmission. iii. Both COVID-19 and TB tests should be made available for individuals with respiratory symptoms, which may be similar for the two diseases. iv. TB laboratory networks as well as specimen transportation mechanisms could also be used for COVID-19 diagnosis and surveillance. v. Provision and continuation of anti-tuberculosis treatment, must be ensured for all TB patients, including those with confirmed COVID-19 infection, those isolation and those in quarantine. vi. Consider longer supplies of medication for those in the continuation phase.

	vii. Use community health networks, home visits by health providers ad telephone consultations to follow-up. viii. Preventive TB treatment e.g. with isoniazid for PLHIV and children under five years who are contacts of known pulmonary TB cases should continue in line with national guidelines. See Continuity of TB services during COVID-19
Malaria	UNHCR guidance remains the same. Early diagnosis and treatment are critical to prevent a mild case of malaria from progressing to severe illness or death. Countries **should not scale back** efforts to detect and treat malaria. i. Encourage countries not to suspend the planning for or implementation of vector control activities, including ITN and IRS campaigns. o These services must be delivered using best practices to protect health workers and communities from COVID-19 infection. o Modifications to distribution strategies may be necessary to minimize exposure. The Alliance for Malaria Prevention (AMP) has provided guidance (here) for national malaria control programmes on the distribution of ITNs during COVID-19. ii. For the implementation of IRS campaigns, UNHCR advises the following for IRS deployment teams: o increase the number of hand washing stations and soap at all operation sites; o reinforce morning health checks for all team members, adding temperature checks where feasible; o wear PPE including N-95 masks before entering operation sites; o and frequently wipe down any touched surfaces (door handles, vehicle railings, etc.). iii. Delivery of intermittent preventive treatment in pregnancy (IPTp), seasonal malaria chemoprevention (SMC), and intermittent preventive treatment in infants should be maintained. iv. There may be a case for special measures in the context of COVID-19 such as temporary return to presumptive malaria treatment or the use of mass drug administration (MDA). o These measures should only be adopted after careful consideration of 2 key aims: lowering malaria-related mortality and keeping health workers safe. i. WHO is exploring concrete proposals for when to activate such measures; guidance will be published in due course.
Non-communicable Disease	i. Urgently provide two to three months' supply of medicines (depending on stocks) for persons who are stable and well controlled. ii. Plan for home monitoring e.g. blood glucose levels, home monitoring of blood pressure. iii. Follow up in clinic or community settings for unstable or newly diagnosed patients only. iv. Home visits for patients with limited mobility or multiple chronic conditions. v. Reduced frequency of follow up visits for stable patients (3 to 6 months depending on the conditions). vi. Telephone consultations if possible, for stable patients and prescription renewals or continuations to be collected by well family members or community health worker.
Mental Health	i. Limit facility-based consultations to those who really must be seen by a health worker such as people with newly developed severe symptoms and people with chronic severe mental health conditions who are (at high risk of) relapsing. In camp settings consider home visits by health worker instead of clinic visits. ii. For other known cases: reschedule in-person appointments and replace where possible with telephone consultations. iii. Delivery of psychological interventions should be changed from face-to-face to remote methods, and barriers to accessing such methods (e.g. lack of Wi-Fi /phone credit) should be addressed. iv. Ensure medication supply (two to three months) for people with chronic mental health conditions such as bipolar disorder, psychosis, epilepsy and moderate-severe depression.

	v. Consider using community health work force for special situations such as delivering essential medication at home or emergency check-ups. Volunteers need to be trained in principles of physical distancing and infection prevention. vi. Beyond clinical care, depression, anxiety and other symptoms of stress in the community may be addressed in a number of ways, including: (a) accurate, consistent, understandable and empathic risk communication about COVID-19, (b) population messages on positive coping, (c) activities that enhance social connectedness and (d) remote psychological interventions (eg through digital health approaches) that teach people how to self-manage these symptoms. For more details see: IASC Reference Group MHPSS (2020, forthcoming): Continuation of Comprehensive and Clinical MHPSS Care in Humanitarian Settings during the Covid-19 Pandemic.
Nutrition Services	i. **Treatment** ○ Ensure continued access to RUTF and essential medicines for children with SAM, if facilities have closed, make them available in alternative sites or home-based distribution. ○ If necessary reduced frequency of follow-up for stabilised SAM children could be considered (every 2 weeks instead of every week). ○ Maintain treatment for inpatient SAM with complications ensuring separation from COVID-19 inpatient care and the health care provider following the COVID-19 IPC to prevent cross-infection. ○ Adapt the treatment of MAM children according to the context, if facilities have closed, make them available in alternative sites, if necessary reduced frequency of follow-up for MAM children could be considered (every month for example), or if it is impossible to continue MAM treatment services ensure that MAM children (even if out of the age range) for blanket feeding are included in this programme. ii. **Prevention** ○ In times where health facilities are likely to be overwhelmed and the risk of infection is heightened, it is more important than ever to prevent malnutrition and to provide children and pregnant and lactating women with good quality diets. Any increase in cases of malnutrition will put added burden on overstretched health care systems and poor-quality diets weaken the immune system. ○ Where possible continue blanket feeding programmes, (high nutrient density foods are important especially in times of reduced health care and risk of infection) but consider reducing the frequency of follow-up and/or delivering the follow-up in batches to avoid too many children at one time. ○ Continue and scale up messaging on the importance of breastfeeding and quality infant and young child feeding during this time (use mobile technology, radio, other mass communication channels and community platforms to inform the community if necessary, to reduce risk). ○ Continue to screen children for malnutrition who are treated at health centres, reduce mass screening activities at health centres and try to work with CHWs or mothers to continue to screen for malnutrition at the community level (Mother MUAC for example). ○ Ensure the distribution or alternative sites and the staff follow the guideline and hygiene protocol. See Management of Child Wasting in the Context of COVID and IYCF Programming in the context of COVID-19
Disability Services	i. Follow up in clinic or community settings only for urgent problems (such as breakdown of assistive devices, people with severe pain or people for whom physiotherapy is essential). ii. Reduced frequency of follow up visits (3 to 6 months depending on the condition). iii. Develop and distribute leaflets with information on physical therapy exercises that can be practiced independently or with minimum support and promote use of telephone consultations and check-ups.

Inpatient Care	i. Maintain only essential non COVID-19 related inpatient care if already available, ensuring separation from COVID-19 inpatient care. For example, severe diarrhoea and vomiting needing IV rehydration, IV antibiotics for non COVID-19 related infections, treatment of complicated malaria, management of severe pain.
Surveillance and Health Information System	i. Ensure continued uninterrupted reporting of mortality/deaths at the health facility and community level ii. Continue morbidity reporting especially for acute health condition and disease of outbreak potential/public health concern. iii. If the system is completely overwhelmed, use the Basic Indicator Report as a guide for reporting (only mortality, morbidity (acute health conditions), deliveries, clinical management of rape as a minimum, cases of severe acute malnutrition, and proportions of children screened found to be acutely malnourished as a minimum). iv. Focus on completing COVID-19 related surveillance reports, line lists, community data, etc.
Referral for Secondary and Tertiary Care	i. Decide when to temporarily stop elective referrals if, COVID-19 cases are in the nearby host community, national systems will not manage cases, or an outbreak is occurring and there is reduced capacity to manage non-emergency care. ii. Continue emergency referrals only based on an assessment of which services are still being offered at referral facilities. Monitor the referral facility capacity and policy and adapt referral SOPs accordingly. iii. As soon as possible restart time sensitive referrals such as treatment for cancer with a good prognosis.
Essential Medicines and Supplies	i. A COVID-19 response is likely to deplete existing stocks of some items and it is essential to maintain sufficient supplies of essential medicines and supplies. In addition, there are global disruptions to medicines and supplies supply chains. ii. Order contingency stock as part of preparedness for COVID-19 response based on the size of population served (specifically for COVID-19 care). iii. Assess existing stock levels and orders in the pipeline; quantities and expected delivery time to anticipate any shortages. iv. Monitor consumption accurately and place new orders accordingly.