National Health Mission
SDA Complex, Kasumpti, Shimla-9
Himachal Pradesh
Dated: Shimla-171009, the

MISSION DIRECTOR (NHM)

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New Shimla-9 (H.P.)
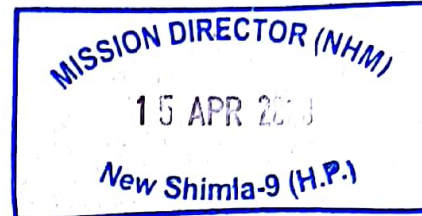
To

All the Chief Medical Officers
In Himachal Pradesh

Subject:-   Regarding essential health services during COVID-19 outbreak.

Sir/Madam,

Please find enclosed herewith D.O. Note received from Ms. Preeti Sudan, Secretary (Health), Ministry of Health & Family Welfare, Government of India regarding enabling delivery of essential health services during the COVID-19 outbreak for further necessary action.
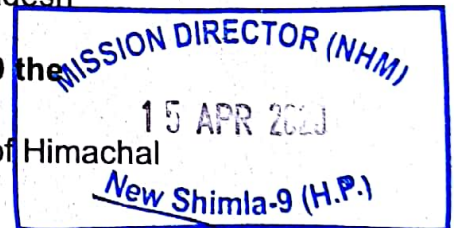
15/4/20
Special Secretary (Health)
Cum-Mission Director, NHM
Himachal Pradesh

Endst. No. As above   **Dated Shimla-9 the**

Copy for information and necessary action to:

MISSION DIRECTOR (NHM)

1 5 APR 2...

New Shimla-9 (H.P.)

1. The Additional Chief Secretary (Health) to the Government of Himachal Pradesh.
2. All the Deputy Commissioners, Himachal Pradesh
3. The Director Health Services, Himachal Pradesh
4. All State Programme Officers, NHM

15/4/20
Special Secretary (Health)
Cum-Mission Director, NHM
Himachal Pradesh

Enabling Delivery of Essential Health Services during the COVID 19 Outbreak: Guidance note

Background

The COVID 19 outbreak has placed unprecedented demands on our health system,   Our health facilities and workforce are currently inundated by a plethora of activities related to controlling the pandemic. In doing so, there is a risk that essential health services which communities expect from the health system, would be compromised.   It is likely that health seeking may be deferred because of social/physical distancing requirements or community reluctance owing to perceptions that health facilities may be infected. *Focusing* on COVID 19 related activities, and *continuing* to provide essential services, is important not only to maintain people's trust in the health system to deliver essential health services[1], but also to minimize an increase in morbidity and mortality from other health conditions. Analyses from the 2014-2015 Ebola outbreak suggests that the increased number of deaths caused by measles, malaria, HIV/AIDS and tuberculosis attributable to health system failures exceeded deaths from Ebola[2].   Particular attention needs to be paid to the delivery of essential health care for specific population sub-groups, while ensuring the safety of health workers.

Essential services for all areas include maternal, new born and child health, prevention and management of communicable diseases, treatment for chronic diseases to avoid complications, and addressing emergencies. Non-Covid services such as health promotion activities, IEC campaigns, meetings of the Village Health Sanitation and Nutrition Committees/Mahila Arogya Samitis, community based screening for chronic conditions, other screening programmes, etc. could be deferred and undertaken after lockdown/restrictions are lifted. These services could be considered as **desirable**.

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[1] https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak ; 25th Mar. 2020 (World Health Organization)

[2] Elston, J. W. T., Cartwright, C., Ndumbi, P., & Wright, J. (2017). The health impact of the 2014–15 Ebola outbreak. Public Health, 143, 60-70.
Parpia, A. S., Ndeffo-Mbah, M. L., Wenzel, N. S., & Galvani, A. P. (2016). Effects of response to 2014–2015 Ebola outbreak on deaths from malaria, HIV/AIDS, and tuberculosis, West Africa. Emerging infectious diseases, 22(3), 433.

This note is intended to guide states to deliver essential health services for the duration of the COVID 19 outbreak[3]. The structure of the document is as follows: Section 1 elucidates a set of basic principles categorized by health systems elements, and Section 2: provides guidance on the essential services with details annexed. For some services, detailed guidance notes have been issued to states from the GOI/MOHFW separately and those have been referenced in this document. (Annexure 1). States may refer to these documents as needed.

Section 1: Health system approach to essential services

1. Reorganization of service delivery

1.1 Facility Mapping and Planning

➢ States would undertake mapping of all existing heath facilities (city/ district/ block-wise) in the public and not for profit and private sectors.

➢ Identify and designate facilities or separate block within existing facilities to provide COVID -19 related services (Fever clinics, COVID Care Centre (CCC) Dedicated COVID Health Centre (DCHC) and Dedicated COVID Hospital (DCH)) as per guidance issued for appropriate management of suspect/confirmed cases of COVID-19.

➢ Remaining facilities/ blocks of facilities will continue to provide essential non COVID-19 services. States could also involve not-for profit/private sector in the provision of non COVID essential services, particularly for secondary and tertiary care, where public sector capacity needs to be supplemented. Utilization of not-for profit/private sector facilities would be based on number and spread of COVID 19 positive cases in the area. States could develop a phased engagement with the not for profit and private sector if existing public health facilities are converted into fever clinic/ CCC/ DCHC and there is a shortfall in government health facilities. States already have **PMJAY empanelled hospitals**. It should be ensured that they function to provide normal essential medical services.

➢ Dedicated first level 24*7 hospital emergency units, may be set up in suitable CHCs/ SDHs to provide non COVID acute care, including provision of emergency obstetric services.

➢ Mobile Medical Units could be utilized for delivery of services, especially follow up care for RMNCAH, chronic communicable and non-communicable diseases duly following physical
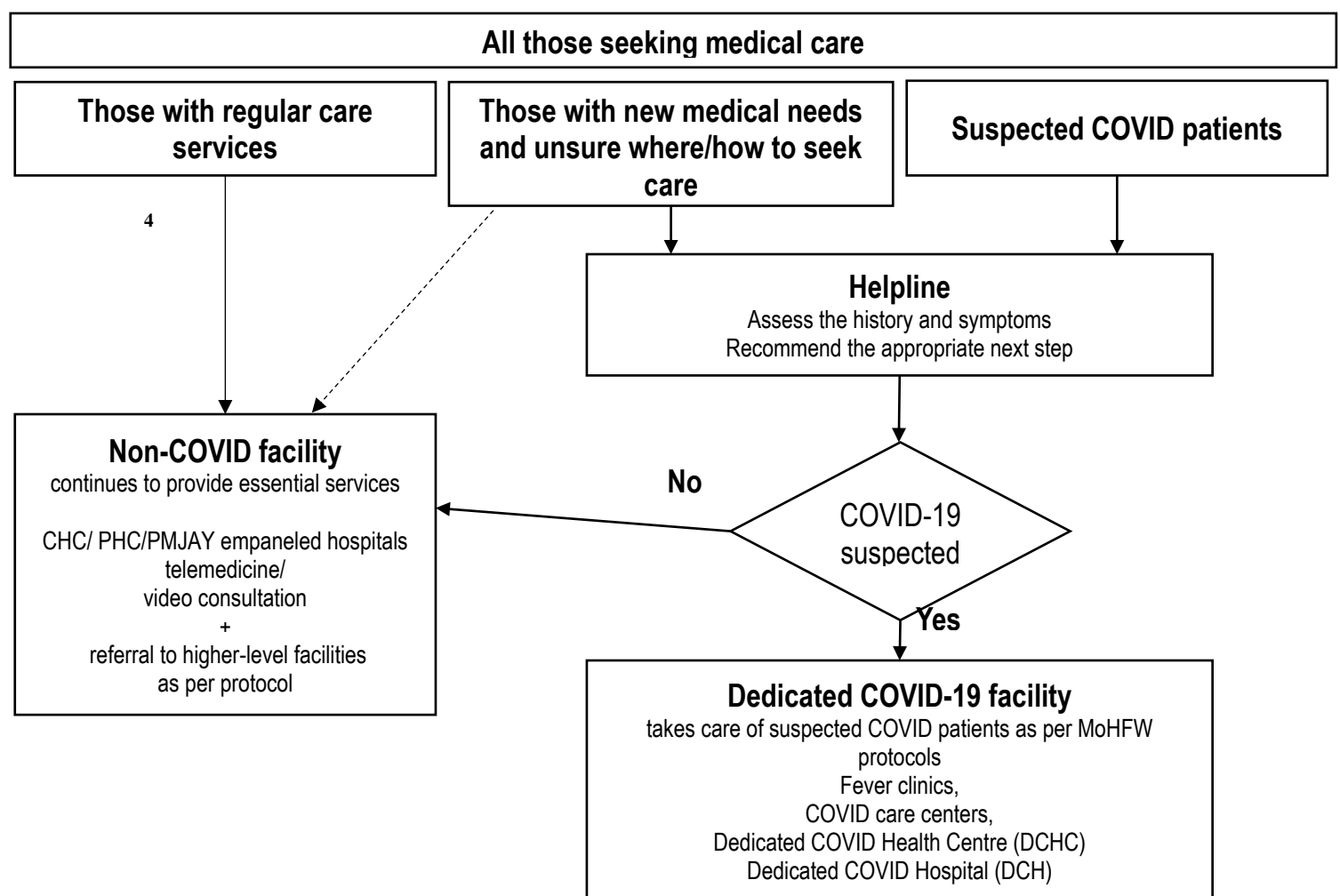
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[3] Local orders issued under respective states' epidemic act will take precedence over any guidelines issued under this guidance document.

distance norms and appropriate protection measures for the health workforce after the lockdown.

1.2 Delivery of essential services maintaining physical distancing

1.2.1 Telehealth-

Suspected COVID patients and other patients requiring ambulatory care, should be encouraged to utilise tele-platforms to determine the need to visit a health facility/ hospital/ fever centre. (as depicted in Figure 1). This will avoid overcrowding of hospitals and prevent transmission of SARS-CoV-2 virus during travel or in health facilities. Other mechanisms to minimize patient provider encounters, include self-monitoring through App, use of helpline, web-applications, video-calls, tele-medicine etc.

All those seeking medical care

Those with regular care services	Those with new medical needs and unsure where/how to seek care	Suspected COVID patients

4

Helpline
Assess the history and symptoms
Recommend the appropriate next step

Non-COVID facility
continues to provide essential services

CHC/ PHC/PMJAY empaneled hospitals
telemedicine/
video consultation
+
referral to higher-level facilities
as per protocol

No

COVID-19 suspected

Yes

Dedicated COVID-19 facility
takes care of suspected COVID patients as per MoHFW protocols
Fever clinics,
COVID care centers,
Dedicated COVID Health Centre (DCHC)
Dedicated COVID Hospital (DCH)

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4 States must use/expand existing helplines such as 104 and others.

This can be enabled through following options –

➢ Patients needing services for minor ailments would be encouraged to contact the MPW (M or F) via telephone, who would assess the situation and enable tele-consultation with a Medical Officer.

➢ All SHC/PHCs, including HWCs particularly in affected areas may be linked with a Telemedicine Hub via telephone/ video call to facilitate consultation between the patient and the provider, which will be guided by Telemedicine Guidelines

➢ Private-for-profit and not-for-profit providers can also be engaged to provide these services particularly where a tele-medicine hub in government facilities does not exist. In such cases, the MoHFW Telemedicine guidelines on prescription generation will apply. Such providers should prescribe generic medicines.

The investigations and medicines prescribed (particularly from within the EML and EDL of the state) should be provided free of cost to all the patients seeking government facilitated care.

1.2.2 Alternate models for outreach services

➢ Services that are traditionally delivered through outreach such as immunization, antenatal care, screening for common NCDs/communicable diseases etc. would need to be re-organized during the period of lockdown/restriction. Where feasible, those due for any of these services, would be asked to come to peripheral facilities (SHCs/ PHCs/UPHCs, including HWCs/ Urban Health Posts) on particular dates/times, decided at local levels and informed telephonically or through ASHAs. This can be done by allocating fixed day services for each village / ward area, ensuring adherence to physical distancing and other IP protocols.

➢ More number of immunization sessions/VHNDs/UHNDs/screening sessions could be organized at the village/ward level after the lockdown. ASHAs must create awareness in the community about change in schedule and mobilize beneficiaries in small batches of 4-5 per session to avoid crowding and ensure physical distancing norms.

➢ To undertake such multiple sessions, retired nurses, ANMs, LHVs could be engaged at local level through additional funding provided through NHM.

1.2.3   Home Visits

➢ Home-visits by ASHAs should be optimized to provide follow up care to all beneficiaries in a particular household/hamlet/mohalla during one visit and avoid making repetitive visits to the same house/mohalla. This may include beneficiaries like high risk pregnant women or new-born, elderly and disabled individuals etc.

➢ Primary healthcare team at SHC, including HWC must be encouraged to follow up with the specific sub-population groups such as- Pregnant women with EDD in current month, all High-risk pregnant (HRP) women, Newborns, Children due for immunization, Children with SAM (severe or acute malnourishment), patients on treatment for TB, leprosy, HIV and viral hepatitis, patients with hypertension, diabetes, COPD, mental health, etc, patients undergoing planned procedures (dialysis, cancer treatment and scheduled blood transfusions, etc.)

➢ In case of any complications, SHC team should first contact the PHC – MO via phone or the tele-medicine or helpline, as appropriate and seek guidance about referring the patient. ***States should ensure that the communication costs paid to FLW continue to be paid.***

➢ During home visits, ASHAs should be alert to the possibility of increased gender based violence and inform MO and support the victim to access appropriate health and social services.

1.3 Triaging

Despite encouraging patients with COVID like symptoms to use channels of telehealth, may individuals are likely to show up at those facilities providing non COVID essential services to seek care. Triaging is thus important in all facilities.   At SHC and PHC including HWC, referral would be through helplines to higher level facilities. Entry point screening during triaging would help minimize contact between probable COVID and non COVID cases. If possible temporary structures outside the building could be set up to facilitate triaging.

1. All the healthcare facilities to establish triaging mechanisms for beneficiaries/patients visiting the facility.

2. All frontline health workers should be trained in protocols for COVID screening, isolation and triage to be followed for anyone arriving with acute onset of cough, fever and breathlessness within last 14 days. States to be aware that protocols are

evolving and therefore to use the most updated provided on websites of MoHFW/ICMR/ NCDC

3. All service providers at peripheral facilities and frontline workers need to be vigilant and to report rise in cases of not only severe acute respiratory infections (SARIs), including pneumonia and influenza-like illnesses (ILIs) but also all fever cases, including dengue, TB, malaria, JE, etc.

4. MOHFW Guidelines for fever clinics also suggest that these be established at CHC/UCHC tor helplines to which patients could be referred form peripheral facilities.

5. All frontline health care workers in these facilities to be trained in IPC and provided appropriate PPE for their protection as per the guidance. The PPE could be prioritised in areas/ clusters where suspected COVID patients are likely to report.

2. Human Resources-

2.1 HR deployment and capacity building

Challenges of shortage, skewed distribution, and misalignment between health worker competencies and current/ likely population health needs are likely to be faced, in meeting the surge needs for COVID 19. Re-assignment of staff to treat COVID-19 patients and loss of staff who may be quarantined or infected is likely to pose further challenges. These predictable challenges could be offset through a combination of strategies. Guidance issued by MoHFW provides several strategies to augment health workforce availability. Some key strategies include:

- Expedite filling up existing vacancies
- Redeploy staff from non-affected areas and facilities;
- Utilize fit retirees for non-COVID services roles;
- Mobilise resources from Military, Railways, PSUs, ESIC etc.
- Hire/ requisition non-governmental, and private sector health workforce capacity, Suitable draft orders may be kept ready for temporary engagement, without creating any long term liability. Such hiring/ requisitioning can be beyond the sanctioned regular/ contractual strength

- Web portal can be created for empanelling Human Resources to provide essential non COVID-19 related services. These can include – Junior Residents, MD residents, Retired professionals and private providers etc.

- Where appropriate, consider establishing pathways for accelerated training of medical, nursing, and other key trainee groups, and ensuring supportive supervision;

- Identify high-impact clinical interventions for which rapid training would facilitate safe task sharing,

- Utilize web-based platforms to provide key trainings (e.g., on management of time-sensitive conditions and common undifferentiated presentations in frontline care),

- Utilise AYUSH doctors in delivery of non COVID essential services.

- Train and repurpose government and other workers from non-health sectors to support functions in health facilities (administration, maintenance, catering/ diets, logistics etc.)

- Increase home-based service support by appropriately trained, remunerated and supplied community health workers/ COVID volunteers

- The Empowered Group on human resources set up at the national level has also worked out various cadres of personnel and volunteers across sectors and departments that can also be involved in not only COVID related work but also for ensuring maintenance of other essential medical services. The respective roles of these cadres have also been mapped and a portal with data base of such cadres has been created. This data base and mapping will also be shared with the States to help them mobilise these cadres and volunteers for ensuring essential medical services are continued. Training programmes for these cadres and volunteers have also been worked out and are available on the iGoT platform.

2.2 Ensuring staff safety and security measures:

➤ All health care workers including frontline workers are to be trained in standard protocols for Infection Prevention Control and should adhere to advisories for infection prevention, personal protection and physical distancing norms, for facility level care, outreach visits or home-based care. Adequate and appropriate personal protective

equipment (masks, gloves and other equipment) should be provided to health workers so that they can adhere to the advisories and protect themselves at all facilities. This should also apply to health care workers in those private and not-for profit sector facilities that have been requisitioned/ mobilised to provide services.

➢ Handwashing corners should be available and functional at all facilities.

➢ Dedicated helplines including existing helplines for providing psycho-social support for health care workers may be created by using suitable professionals including psychiatry department residents.

➢ Timely payment should be ensured for ASHAs, and service providers including those requisitioned from outside of government sector.

➢ If necessary, additional incentives (financial and non-financial – e.g. accommodation particularly for those mobilised from other areas, certificate of appreciation) could be considered.

➢ Transport and stay arrangements during lockdown period/restrictions should be facilitated.

3. Ensuring supplies of medicines and diagnostics

➢ The DVDMS, BMMP portals and similar portals should be regularly updated and monitored to ensure that there are no stock outs and essential medicines, and essential diagnostics services and functional medical devices are available.

➢ Adequate funds may be made available, even over and above the stipulated untied funds to effectively respond to the needs and provide free essential medicines and diagnostics in case of higher caseload.

➢ States may consider approving the rates of medicines and equipment that have been discovered by neighbouring states following due process. The GOI will facilitate uploading the price lists of different medicines and formulations at the website to facilitate procurements at best possible rates.

➢ Patients on treatment for chronic diseases, both communicable and non-communicable, would be provided upto three months medicine supplies at a time as prescribed by medical officers. The medicines may be delivered at home through frontline workers/volunteers during the period of the restricted movement, provided

patients are stable. Patients may be advised to contact MPW/CHO where available or PHC-MO in case of any complications.

- In order to ensure uninterrupted supply of medicines, consumables and rapid diagnostic kits, alternate models may be explored. One option could be hiring of local youth by the district / block nodal officers as runners to pick up medicines from district drug ware-houses, CHCs or PHCs (as per the local context) and supply them to SHCs/ASHAs. The movement of such individuals during the period of restricted movement should be facilitated through ID cards and appropriate intimation to local authorities so that their movement between facilities is not hampered. Appropriate protective equipment (masks etc.) may be provided to runners.

4. Programme Management

- The state should establish dedicated teams within each state and each district to ensure the continuity of essential services and COVID 19 preparedness and response. These teams will assess and monitor the delivery of essential services, identify gaps and potential needs to re-organise the referral pathways. The teams should work in close coordination with other teams engaged for COVID -19 preparedness and response for planning and optimal use of existing resources to ensure that COVID -19 related response and essential services (non COVID -19) services are effectively delivered. The teams would jointly work on reallocation of HR and reorganization of service delivery.

5. Finance

- Ensure that facilities have sufficient funding to continue the provision of essential services. Additional funds in the form of increased allocation of untied funds based on facility caseloads can be provided. Managers of public facilities should receive greater authority to use funds, balancing the increased flexibility with transparent reporting requirements.
- The additional funds made available should be utilised to operationalise the above guidance involving strengthening of the health systems and providing financial

protection to the patients particularly for the essential services and COVID related testing, treatment and management.

➢ Ensure that existing entitlements related to essential health services as defined in this note are provided free of cost to those seeking care in public health facilities. Beneficiaries should be fully aware of their entitlements, so that they do not delay the process of seeking care for fear of financial hardship.

6. Accountability

6.1 Grievance redressal mechanisms for denial of entitlements for essential non-COVID and COVID-19-related services should be functional through existing channels in states with appropriate sensitization of callers.

6.2 Routine disease surveillance, service delivery monitoring and reporting according to SHC/PHC requirements should continue uninterrupted to maintain accountability and continuously inform policy, local planning ,and decision-making.

Section 2: Essential Non-COVID services:

All states should identify essential services that will be prioritized in their efforts to maintain continuity of service delivery. High-priority services include:

• Essential prevention for communicable diseases, particularly vaccination;

• Services related to reproductive health, including care during pregnancy and childbirth;

• Care of vulnerable populations, such as young infants and older adults;

• Provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions;

• Continuity of critical inpatient therapies;

• Management of emergency health conditions and common acute presentations that require time-sensitive intervention;

• Auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services

The suggestive list of high priority essential services is listed below.

All PHC-MOs should ensure that frontline workers of SHC/HWC maintain lists of key sub-population groups in need of essential services, such as: pregnant women, recently delivered, infants and children under five, those on treatment for chronic diseases, requiring treatment for dialysis, cancer, blood transfusions, and other special needs. She/He should monitor regular follow up by ASHA/ANM/CHO of all such categories and ensure essential services as appropriate during the period of the lockdown/restriction.

I. *Reproductive, Maternal, New Born, Child and Adolescent Health services*

1.Ante natal services

a. *Routine Antenatal Care services*

> Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and Village Health, Sanitation and Nutrition Day (VHSND) activities, which involve large gathering of beneficiaries could be suspended in view of restricted movements and the need for physical distancing.

> However, ANC services to be provided on walk in basis as per standard protocols at the SHC level following physical distancing norms.

> Ensure availability of TD/ IFA/ Calcium during ANC period.

b. *High-risk pregnancy (HRP) tracking and follow up*

> ANMs and ASHAs to list and follow up HRPs to ensure early detection of complications, referral and follow up.

> ANCs during the last trimester should be prioritized. Telephonic contact to be made by ASHAs / ANMs to HRPs during last trimester to ascertain status and home based follow up to be provided if necessary. (ASHAs / ANMs to follow all precautions while visiting the household).

1. Intrapartum Services

- *Ensuring safe institutional delivery-*

- Maintain due list of all pregnant women with Expected Date of Delivery (EDD) up to next three months (last trimester) at SHC level for active follow up. The district nodal officer should follow up with all peripheral centres to ensure that such lists are maintained.

- Ensure availability of Misoprostol and disposable delivery kits for clean deliveries at home with ASHAs if needed but encourage appropriate referral as per MoHFW guidelines for institutional delivery.

- Each pregnant woman to be linked with the appropriate health facility for delivery (as per antenatal status and doctor's advice) by the ANM / CHO or PHC MO.

- All districts should identify and communicate to peripheral facilities a list of functional and staffed CeMONC centres where HRP and women who develop complications are to be shifted.

- Availability of dedicated ambulances for COVID and non-COVID patients must be ensured at the district/ block level. Non-COVID patients must be transferred in non-COVID ambulances only.

- Ensure a BEmONC/CEmONC provider at appropriate facilities (Non-FRU and FRU respectively) by redeployment if necessary.

- All Blood banks/Blood Storage Units need to be kept functional.

2. Postpartum and new-born care

- Ensure availability of IFA and calcium tablets during PNC period.

- In case of home deliveries, immediate visits to be made by ANM or CHO (where available) to assess the health of the woman and new-born. Facilitate timely referral in case of any complication using the dedicated non-COVID ambulances (102/Janani Express).

3. Family Planning Services and Safe Abortion services

- Contraceptives (Condoms/ Oral Contraceptive Pills MALA/Chhaya, Injectable Contraceptive Antara /Emergency Contraceptives) to be provided to eligible couples / others needing them through all Public Health Facilities, including ASHA/SHC and PHC for easier access.

- Information about delayed availability of IUCDs and sterilization services until routine services resume should be displayed at all health facilities. Beneficiaries must be

counselled for adoption of and provided with temporary methods of other contraception methods like Condoms / OCP/ injectable etc. in the interim period.

➢ Medical and surgical abortion services to be ensured at appropriate facility level, with appropriate infection prevention measures including counselling for post abortion care and provision of contraception.

4. **Child Health**

   a. *Immunization services (including for pregnant women)*

   ➢ Birth doses for institutional deliveries to continue uninterrupted as these beneficiaries are already in the health facilities.

   ➢ Immunization services are to be provided at facilities wherever feasible, for walk-in beneficiaries.

   ➢ Every opportunity is to be utilized for vaccinating beneficiaries if they have already reported for at facilities. Subsequent vaccination could be provided at SHC or additional outreach sessions.

   ➢ Where essential services are operational and restrictions allow, fixed site vaccination and VPD surveillance should be implemented while maintaining physical distancing measures and appropriate infection control precautions.

   ➢ Delivery of immunization services though outreach must be assessed in local context and should be undertaken only if safety of health workers and community is not compromised.

   ➢ Catch-up vaccination should be conducted as soon as the restriction is eased. This will require tracking and follow-up with individuals who missed vaccinations.

   ➢ Mass vaccinations should not be undertaken until restriction in lifted.

   b. *New-born care and childhood illness management*

   ➢ Home-based new-born care visits are to be continued as per schedule by ASHAs. However, ASHAs to follow all precautions in case home visit is required to examine new-borns. Adequate and appropriate COVID protective equipment should be provided to ASHAs to protect themselves and to prevent infecting others. Breast feeding practices to be promoted with early initiation of breast feeding and Kangaroo Mother Care as per MAA/KMC guidelines.

   ➢ Admission to SNCU and NBSU to be continued as per existing guidelines.

- Instead of undertaking visits for Home Based Young Child Care, during the period of the lockdown/restriction, ASHAs may contact the family telephonically to assess health status of the child, especially for cough, cold, fever, breathlessness and diarrhoea. In case of any complication in new-born or young child, ASHAs to consult PHC MO for appropriate referral and management advice.
- In case of any childhood illnesses, ASHA/ANM should consult with PHC MO telephonically for appropriate referral and management advice
- Ensure adequate supply of ORS, Cotrimoxazole, Gentamycin, and Amoxicillin at the SHC, including HWCs.
- In case of suspected COVID-19 infection in children refer to nearest COVID-19 management facility and arrange for referral transport.

c. Management of SAM children

- During period of restriction, new admissions may be allowed only in Nutritional Rehabilitation Centres (NRC), where adequate supervisory and medical staff are available. SAM children with medical complications to be referred to nearby health facility (PHC/CHC) for medical management. For secondary care, the PHC/CHC – Medical Officer may refer the sick SAM children to the DH/Medical college.
- Previously admitted children who are stable and entered rehabilitation phase may be discharged early with appropriate feeding advice, and provided oral antibiotics, supplements except Potassium Chloride (Potklor) and Magnesium.
- For children who cannot be discharged, appropriate infection protocols to be maintained.
- List of SAM children (discharged from NRC) to be shared with Anganwadi centres for prioritizing home-based delivery of Take Home Ration.
- Follow up to be done telephonically and only children with medical complications to be called for physical follow up.

d. Adolescent health:

- Three months' supply of weekly iron folic acid supplementation tablets may be dispensed by ASHAs /AWWs for community distribution to adolescent boys and girls.

II. Communicable Diseases

1. Vector Borne Diseases

➢ Activities such as distribution of Insecticide Treated Nets (ITN) and indoor residual spraying (IRS) in targeted areas should be resumed after the lockdown. IRS teams should ensure supply of sanitizers/soap and water at all operations sites, enable health checks for all team members, and use personal protective equipment.

➢ Care should be taken to watch for admissions in dengue cases and other vector borne diseases undertake antilarval and anti-fogging measure after the lockdown.

2. Tuberculosis

➢ List of all TB patients to be maintained at the PHC/ SHC level.

➢ Delivery of DOTS to TB patients to be ensured, closer to the community, with minimum or no travel – can be done through ASHAs/ ANM/ volunteers

➢ Routine screening for presumptive TB cases to continue at primary level facilities with diagnostic services to be provided uninterrupted at designated facilities as per advisories issued by National Tuberculosis Elimination Programme.

3. Leprosy

➢ Ensure that all Leprosy patients are provided through FLWs, including ASHAs with uninterrupted drug supplies, to ensure continuity of treatment.

4. Viral Hepatitis:

➢ For patients on antiviral treatment for hepatitis at Model Treatment Centres and Treatment Centres to dispense medicines for 3 months during the period of restrictions.

➢ A list of patients undergoing treatment for Hepatitis C to be submitted to the district administration so that patients/attendants can collect the medicines during the time restrictions are in place or duration of the outbreak. States could alternatively make medicines available to the patients, through ASHAs, MPHWs, volunteers or courier/ postal services.

5. HIV

- The National AIDS Control Programme (NACP) has already issued a guidance note for frontline service providers and programme managers engaged in HIV/AIDS response, reinforcing adherence to national guidelines on infection prevention and control

- ART centres are to be provided with sanitizers, masks and other protection Equipment for PLHIV and healthcare staff. Until the lockdown has been lifted, all large events have been deferred.

- States to ensure uninterrupted supply of Anti-retroviral drugs to PLHIV, through decentralized drug dispensation, online counseling, telemedicine guidance, information, education and communication (IEC) material through social media apps, etc.

- Three month long multi-month dispensation could be provided through Anti-retroviral treatment (ART) center, Link ART center and facility-integrated ART center.

- States to enable peer educators (PEs) and out-reach workers (ORWs) under NACP to provide multi-week (2-3 week) dispensation of commodities such as condom, needle and syringe, etc. to HRGs during the period of lockdown/restrictions.

- Strategies like community dispensation of commodities (through Care and Support Centers, home delivery through out-reach workers, volunteers, PLHIV networks) and family dispensation, could also be allowed.

- In case of all PLHIV coming to ART centers, triage of symptomatic PLHIV (with fever/cough/shortness of breath/other respiratory symptoms) should be done be prioritized while maintaining appropriate physical distancing and other protective measures.

- For patients stuck in other states/districts due to lockdown, the ART centres closest to place of stay could be authorised to dispense ARV drugs, to ensure uninterrupted treatment.

III.   *Non-Communicable Diseases*

1. *Hypertension, Diabetes and other NCDs like COPDs-* All known/ diagnosed patients of Hypertension, Diabetes and COPD to receive regular supply of medicines for upto three months through ASHAs or SHCs on prescription.

2. *Dialysis and Cancer Treatment services* – 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.

3. In case of patients, who cannot afford private vehicles, RBSK vehicles can be used for facilitating transport of patients. This can be coordinated by the PHC team, who can prepare list of such patients and work with District hospitals to organize appointments via telephone for next two months.

4. *Care for elderly/ disabled and palliative care patients* – List of patients/ individuals who need extended support to be maintained at the SHC level for regular follow up. ANMs or CHOs 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. ASHAs to maintain telephonic contact with these patients and their families.

5. *Blood disorders*
   a. Services for patients with blood disorders- thalassemia, sickle cell diseases, and haemophilia need to be ensured.
   b. Blood transfusion needs to take place at regular intervals and iron chelation should be continued, with ferritin level and CBC being checked at that time only. The requisite units required for transfusion must be communicated to the blood bank in advance (preferably three days), and availability of blood verified.
   c. Request for scheduled patient transfusions should be sent early, to avoid long waiting periods. Thalassemia and sickle cell disease patients could enter their requirement of blood in e-raktkosh, specifying a particular blood unit and particular hospital blood bank.
   d. So far as possible, two or more (depending upon the load) government health facilities, should be designated for blood disorder patients to receive services. These facilities should

not be COVID 19 dedicated hospitals, given the immune suppressed status of these patients.

e. Patients requiring blood transfusion or (Anti haemophilic factor) infusion should be advised to also carry their identity cards and the hospital approval, outpatient cards to facilitate easy movement. The hospitals are requested to issues passes for these patients as well.

IV. **Emergency and Critical care Services**

1. Dedicated 108 / ALS ambulance in every district for management of emergencies pertaining to cardiac / trauma / burn / medical and surgical emergencies etc.

2. Emergency (medical, surgical and trauma) and critical care services including ICU/ HDU; SNCU/ NBSU; BEmONC/CEmONC; Burn wards and Blood transfusion services – Regular functioning to be maintained with adequate HR and equipment as per protocols and availability of resources at the facility.

3. Services to victims of sexual and physical violence should be ensured as per protocols. Information about support services under social welfare departments, NGOs, One stop crisis centres and helplines should be provided to the victim for long term support.

Annexure 1:

1. Guidance document on appropriate management of suspect/confirmed cases of COVID-19, EMR Division, Director general of Health Services, MOHFW; accessed from https://www.mohfw.gov.in/pdf/FinalGuidanceonMangaementofCovidcasesversion2.pdf

2. Role of Frontline workers in Prevention and Management of CORONA Virus https://www.mohfw.gov.in/pdf/PreventionandManagementofCOVID19FLWEnglish.pdf

3. SOP for reallocation of residents/ PG students and nursing students as part of hospital management of COVID, MoHFW accessed from https://www.mohfw.gov.in/pdf/COVID19SOPfordoctorsandnurses.pdf

4. Telemedicine Practice Guidelines, MoHFW, accessed from https://www.mohfw.gov.in/pdf/Telemedicine.pdf

5. Revised Strategy of COVID19 testing in India (Version 3, dated 20/03/2020), Department of Health Research, ICMR, accessed from https://www.mohfw.gov.in/pdf/ICMRrevisedtestingstrategyforCOVID.pdf

6. Guidelines for rational use of Personal Protective Equipment, Directorate General of Health Services, MoHFW, 24th March 2019; accessed from https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdf

7. Advisory issued by Ministry of Rural Development to the State Rural Livelihood Missions on actions to be taken to address the COVID-19 outbreak , accessed from https://www.mohfw.gov.in/pdf/advisoryMORD.pdf

8. National Guidance to Blood Transfusion Services In India in light of COVID 19, MOHFW, accessed from https://www.mohfw.gov.in/pdf/NBTCGUIDANCEFORCOVID19.pdf

9. DO letter from DDG(TB) on TB related services under NTEP during countrywide lockdown due to Covid19, Central TB Division, MoHFW; accessed from https://tbcindia.gov.in/WriteReadData/26032020DONTEPAdvisory.pdf

10. Guidelines for states regarding administration of Anti TB drugs to the patient during COVID outbreak, Central TB Division, MoHFW; accessed from https://tbcindia.gov.in/WriteReadData/765980432COVIDOutbreakLetterToStates.pdf\