Emerging good practices and lessons learnt to maintain essential health services during the COVID-19 pandemic

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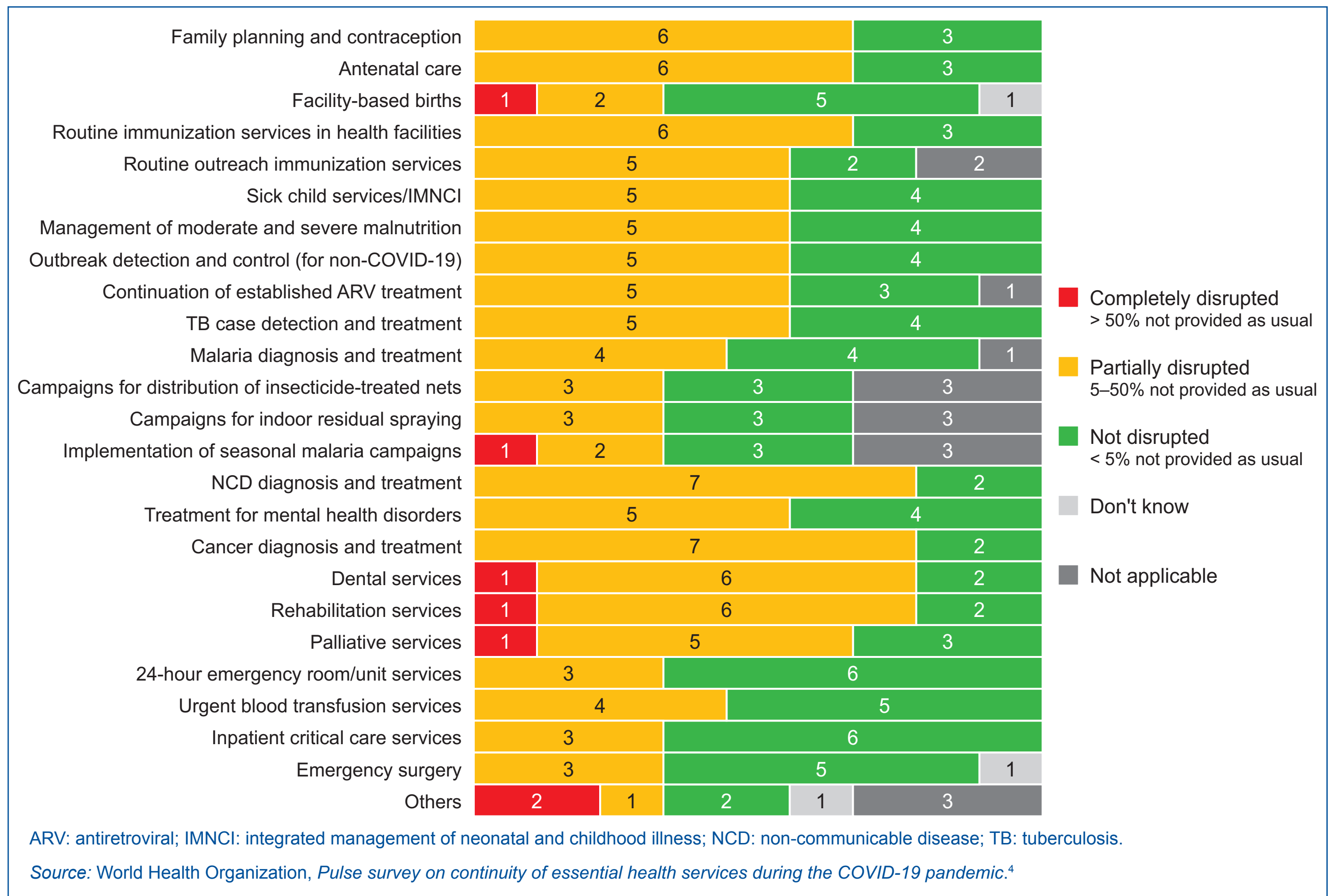
Double burden of the pandemic and disruption of essential health services

Disruption of essential health services during the course of the coronavirus disease 2019 (COVID-19) pandemic has had a significant negative impact on our health systems.[1] As a proactive measure to provide Member States with practical policy options to reorganize and maintain access to safe and quality essential health services, the World Health Organization (WHO) published *Operational guidance for maintaining essential health services during an outbreak* in March 2020, with an update in June.[2,3]

The survey "Rapid assessment of continuity of essential health services during the COVID-19 pandemic" (Pulse survey) revealed that disruption to core health services between March and June 2020 was reported in the 105 countries that responded.[4] The results of the survey showed that globally, including within the South-East Asia Region, all types of services were affected, including but not limited to essential services for communicable diseases, non-communicable diseases, reproductive health, maternal, newborn, child and adolescent health, mental health, nutritional services and emergency services (Fig. 1).

Fig. 1. Situation of essential health services in the South-East Asia Region – number of countries at different levels of disruption, March–June 2020



ARV: antiretroviral; IMNCI: integrated management of neonatal and childhood illness; NCD: non-communicable disease; TB: tuberculosis.

Source: World Health Organization, *Pulse survey on continuity of essential health services during the COVID-19 pandemic*.[4]

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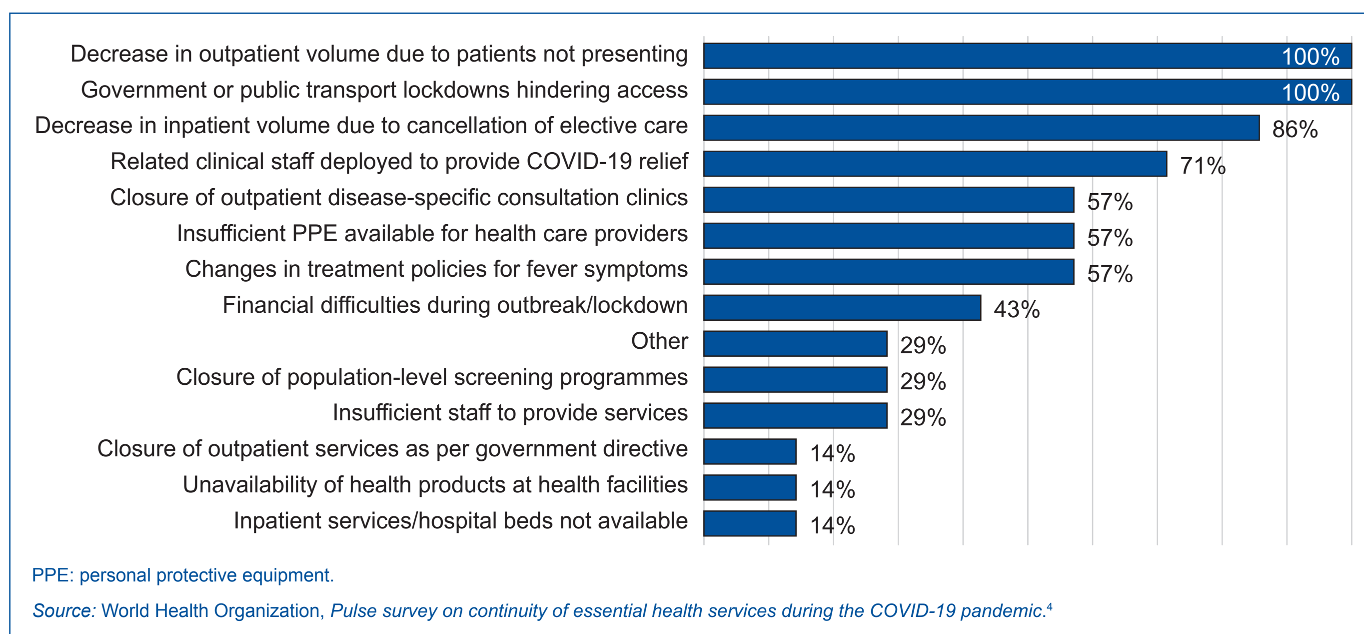
The most frequently reported types of disruption in the South-East Asia Region were experienced on both the demand side – public reluctance to utilize health services during the pandemic and lockdowns hindering access – and the supply side – cancellations of elective care and repurposing (task shifting) of the health workforce to COVID-19 response (Fig. 2).

The Pulse survey along with regional consultations also revealed how countries adapted to the changing needs imposed by the pandemic and service disruption (Fig. 3). Creative design changes in service delivery models emerged in countries as they struggled to tackle both the pandemic and the continuity of essential health services. Member States in the South-East Asia Region urgently requested the sharing of lessons learnt and best practices. Through our routine communications with ministries of health, WHO country offices and other partners in the region and beyond, we synthesized the following five key areas of learning.

Best practices were centred on primary health care principles

First, service disruption was minimized or mitigated in countries where service delivery was decentralized and patient centred. For example, provision of services such as follow-up examinations or injections was decentralized to primary levels of service delivery or provided through other means such as telemedicine. Another example was provision of access to

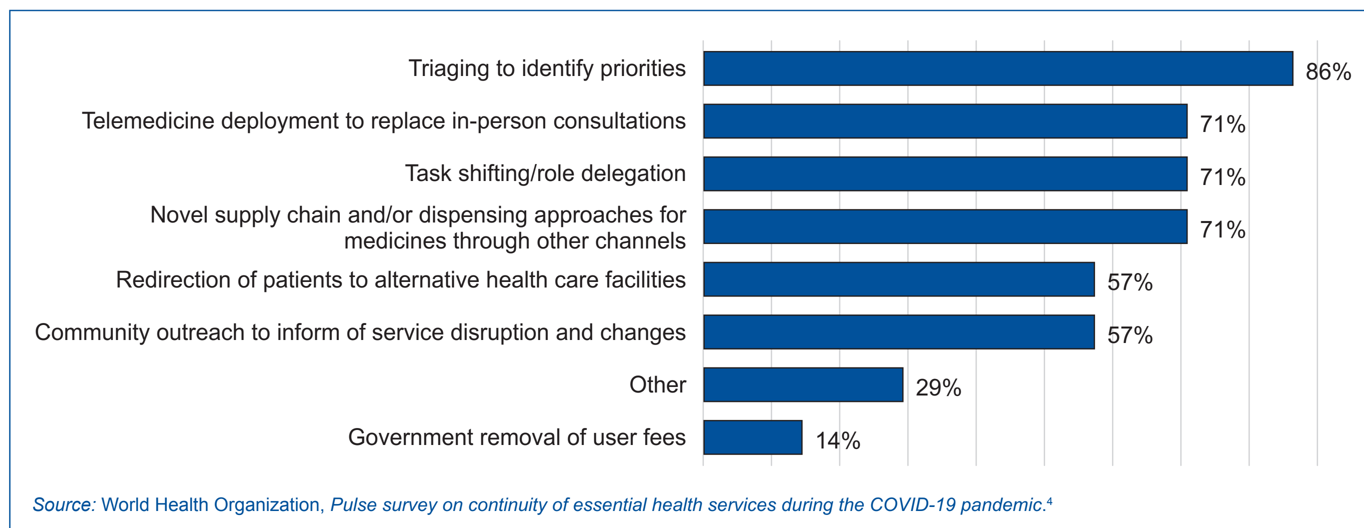
Fig. 2. Main causes of disruption of essential health services in the South-East Asia Region (*n* = 7 countries)



PPE: personal protective equipment.

Source: World Health Organization, *Pulse survey on continuity of essential health services during the COVID-19 pandemic.*[4]

Fig. 3. Approaches to overcoming disruption in the South-East Asia Region (*n* = 7 countries)



Source: World Health Organization, *Pulse survey on continuity of essential health services during the COVID-19 pandemic.*[4]

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medicines using community health workers, postal services or courier services to deliver medicines directly to patients' homes, and provision of repeat prescriptions. In conjunction, on the supply side the stock thresholds were recalibrated at every level, to minimize disruption.

Second, community engagement, through the support of community health workers and volunteers, was key in addressing misinformation about the pandemic and ensuring continuity of health services. In addition, educational messages were tailored to local contexts, and sites of care were shifted into open and less crowded areas.

Third, acknowledgement and proper protection of health workers, including training on infection prevention and control and sufficient provision of personal protective equipment, was a prerequisite for maintaining the morale of the health workforce. Patient safety starts with health workers' safety.

Fourth, good governance mattered in the public and private health sector, as well as other sectors. A whole-of-nation approach across sectors enabled some countries to draw on established mechanisms to adapt and respond with flexibility to the wide-ranging consequences of a pandemic lockdown. In some cases, decentralization provided the decision space for local authorities to make appropriate policy decisions in line with the local contexts, drawing on timely monitoring of service utilization. The combined social capital gains from responsive governance and a committed health workforce during the crisis can also contribute to increased community trust in health service provision. Many countries reported that lack of trust was a major disrupter.

Fifth, there was less disruption when countries employed integrative systemwide approaches that moved away from silos of surveillance and health service delivery for COVID-19. For example, continuity of essential services was improved when pandemic contact tracers were aware of routine surveillance needs such as assessing people for skin lesions associated with leprosy, or hypertensive follow-ups. Another example was the strengthening of pandemic surveillance when screening for COVID-19 was incorporated into routine assessments of all suspected tuberculosis or malaria cases.

Window of opportunity to build back better

The pandemic is a sharp reminder of how easily overwhelmed our health systems can become during public health emergencies. We have also witnessed during the pandemic that health systems built on a foundation of primary health care (PHC) are resilient and adapt in the face of enormous internal and external pressure. With the imminent global roll-out of COVID-19 vaccines, health systems will continue to experience significant pressure vis-à-vis health workforce capacity, resource allocation and strategic communication to address vaccine hesitancy, among other issues. Countries are not starting from scratch. We must revitalize and build on the existing PHC systems.

The lessons learnt and best practices emerging during this pandemic are indicative of the pivotal role of PHC in the continuity of essential services, improved equity and increased health security.[5] These have been captured as practical ways forward in the PHC operational framework[6] drafted jointly by WHO and the United Nations Children's Fund (UNICEF). The framework proposes 14 levers for countries to consider in strengthening PHC-centred health systems towards universal health coverage and the health-related Sustainable Development Goals. We should not miss this window of opportunity to learn from the wide range of emerging best practices in countries, encourage more and more innovations, sustain and accelerate our investments in PHC, and build back better, differently and more prepared.[7]

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