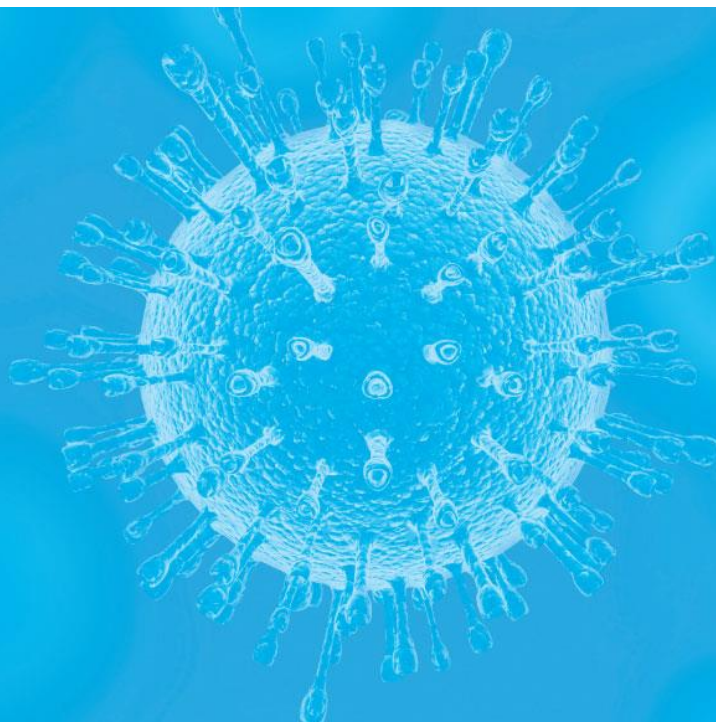

Impact of Covid-19 on SRMNCAH Services, Regional Strategies, Solutions and Innovations: A comprehensive report

Joint WHO-UNICEF-UNFPA Initiative for SRMNCAH Programme Officers from the ministries of health and UN partners

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Impact of Covid-19 On SRMNCAH Services, Regional Strategies, Solutions and Innovations: A Comprehensive Report

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Executive Summary

Introduction

COVID-19 had seriously impacted political, societal and health systems in many countries of the WHO South-East Asia (SEA) Region. The pandemic and actions taken to address it have adversely affected the provision and use of essential health services, especially for the vulnerable populations of women, newborns, children and adolescents.

Rapid assessment of the situation of SRMNCAH services and key findings

A rapid survey of the situation of delivery of essential SRMNCAH (sexual, reproductive, maternal, newborn, child and adolescent health) services during March-April 2020 and national plans to continue these services was conducted in the countries of the WHO-South East Asia Region. For this an assessment tool was prepared by the WHO Regional Office for South-East Asia (SEARO), the UNICEF Regional Offices for South Asia (ROSA) and East Asia and the Pacific (EAPRO), and the UNFPA Asia-Pacific Regional Office (APRO). This joint mapping exercise documented the impact of the COVID-19 pandemic on SRMNCAH services. National plans to continue SRMNCAH services. Key findings are provided in the Tables in the annexure.

National plans to continue SRMNCAH services

Since disruptions in service delivery could lead to additional maternal, newborn and child deaths and stillbirths (as indicated by evidence from a few countries); the Regional Offices of WHO, UNICEF and UNFPA developed documents in April and early May 2020 to provide strategic and operational guidance to governments and partners concerned. The mapping revealed that countries had prepared and implemented national plans for continuing essential SRMNCAH services. After the mapping exercise, the countries were provided the opportunity through webinars organized to share experiences and for cross-learning. The following presents a summary of the key features reported by the countries.

All countries had prepared national plans and prioritized SRMNCAH services for continuation during the COVID-19 pandemic and lockdown periods. They had adopted innovative strategies to protect and deliver services during lockdown and in containment zones.

Summary of findings on service disruption

- Essential services for SRMNCAH were interrupted to a varying extent in the countries in SEAR.
- Resources (financial and human) were diverted from SRMNCAH programmes to manage the COVID-19 outbreak in some countries.
- All countries prepared guidelines for managing COVID-19-positive women and newborns based on the WHO guidelines.
- Several countries modified the design of some SRMNCAH services during the pandemic and lockdown periods like using appointments, rescheduled visits, teleconsultations etc.
- Health work force were trained in COVID-19 related knowledge and skills, many used digital platforms
- Some countries experienced shortage of PPE supplies and stockouts of essential SRMNCAH commodities.
- All countries prioritized SRMNCAH services as essential services and prepared national plans for continuing these services during the pandemic and lockdown periods, using the global and regional guidelines.
- In only some countries SRMNCAH focal points in MOH were included in the national technical working group on pandemic.
- All countries reported good partnership in support of managing the pandemic.

What had worked? Lessons learnt

Countries of the SEA Region shared lessons on what worked well and the challenges that they have faced. The key takeaways are: SRMNCAH had been included as part of the country preparedness and response plans for COVID-19. Mapping for partners involved in response to RMNCAH services in the context of COVID-19 was undertaken. Incentives were given to frontline workers help maintain services; online training on IPC, MNCAH services have been conducted and strong collaboration between the government and partner organizations helped in the continuity of services. Health workforce surge plans were used like redeploying staff from non-affected areas and health facilities, utilizing physically fit retirees for non-COVID-19 service roles, and hiring non-governmental and private sector health workforce. Tele-medicine options were used to minimise physical contacts. Supply-side logistics for essential commodities including personal protective equipment were strengthened quickly.

Overview

During the early phase of the Sustainable Development Goals (SDG) the SEA Region had been making significant progress in the reduction of maternal, newborn and child mortality that had been initiated during the Millennium Development Goals (MDG) era. Between 1990 and 2018 the Region had reported a 72% decline in under-five mortality and 62% decline in neonatal mortality. At the same time maternal mortality had decreased by 57% between 2010 and 2017 in the SEA Region. At this rate the Region is likely to reach the 2030 targets of under-five mortality and newborn mortality.

The COVID-19 pandemic had put forth a series of challenges to this progressive gain in the Region and the consequent disruption of services may led to an additional maternal, neonatal and child mortality. If this happens over prolonged duration, the Region may no longer be able to be on track to achieve the 2030 SDG targets. WHO and partners are working with Member States to prevent such a situation.

The COVID-19 pandemic had seriously impacted political, societal and health systems in many countries in the South-East Asia Region. While the impact of the COVID-19 pandemic and measures such as lockdowns are clearly visible on economic activities, social restrictions and the care of people infected with COVID-19, their indirect effects on the demand and provision of essential health services, especially for the vulnerable populations of women, newborns, children and adolescents, are less conspicuous.

By the end of Aril 2020, the total global number of COVID-19 cases surpassed 3 million mark (WHO Situation Report 101 dated 30 Apr 2020) The first COVID-19 case was reported in Thailand on 26 Jan 2020.Through February and March new cases of COVID-19 rose steadily in in SEA Region Member countries reaching above 54,000 by end of April 2020. By March-April 2020 (the reference period on this assessment) several countries implemented severe lockdowns to stop the transmission of the virus that completely restricted the movement of people.

Since the beginning of the pandemic, WHO has been working with partners in conducting needs assessments, mobilizing essential supplies, and producing multiple technical guidelines on various aspects of the pandemic. WHO produced the global operational planning guidelines to help countries maintain essential health services during the COVID-19 pandemic; and reorganize and ensure access to high-quality essential health services for all. The WHO Regional Office for South-East Asia (WHO-SEARO) in collaboration with the regional offices of UNICEF (UNICEF-ROSA and UNICEF-EAPRO) and UNFPA (UNFPA-APRO) released the regional strategic guidelines *Continuing essential Sexual Reproductive, Maternal, Neonatal, Child and Adolescent Health services during COVID-19 pandemic* in mid-April 2020 that provided broad principles. Soon after in May 2020, more practical guidance *Continuing essential Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health services during COVID-19 pandemic Operational guidance for South and South-East Asia and Pacific Regions - Practical Considerations* was released. Countries in the Region have used these guidelines to prepare their national plans for continuing essential SRMNCAH services that

would help avert additional preventable mortality and morbidity among women, newborns, children and adolescents for this purpose.

A national-level assessment was undertaken to determine the impact of the COVID-19 pandemic on SRMNCAH services in the countries of the SEA Region. This rapid assessment was undertaken jointly by WHO-SEARO, UNICEF-ROSA, UNICEF-EAPRO and UNFPA-APRO for the reference period of March−April 2020 when countries had applied lockdown measures to control the outbreak. This section provides a summary of this mapping exercise.

Rapid assessment of the delivery of essential SRMNCAH services during the pandemic: Key Findings

WHO-SEARO, UNICEF Regional Offices for South Asia (ROSA) and East Asia and Pacific (EAPRO), and UNFPA Asia-Pacific Regional Office (APRO) jointly prepared the assessment tool for rapid mapping of the situation with selected SRMNCAH services, health system challenges and country plans to continue essential SRMNCAH services.

The purpose was to understand the status of SRMNCAH services, use the information to advocate for the implementation of appropriate mitigating measures to continue essential SRMNCAH services in the countries, and going forward to consider monitoring the country situation periodically to guide calibrated corrective actions during the pandemic and address its aftermath.

The assessment tool was designed to capture the national-level information on the extent of disruption of selected SRMNCAH services during March−April 2020, the effect on health system functions and the country plans for continuing these services. WHO-SEARO requested the WHO country offices in the Region to consult their ministries of health (MoH) for obtaining the required information in collaboration with country office staff of UNICEF and UNFPA. The survey for the assessment was undertaken from the middle of May till the end of June 2020.

Impact on SRMNCAH services during the pandemic

Specific information was sought on any reduction in antenatal care in health facilities, institutional deliveries and newborn admissions in hospitals during March−April 2020 in comparison with the figures during the corresponding period in 2019.

Antenatal care (ANC) in health facilities

Of the 10 respondent countries, Bangladesh, India, Maldives, Myanmar and Nepal reported a reduction in ANC services in hospitals during March−April 2020 compared with the same period in 2019; while there was no change in ANC in Indonesia and Sri Lanka. Bangladesh had reported a 41% decrease as per the monthly reports from DHIS2 system. Myanmar had reported a 6% decrease in March and 3.5% decrease in April compared with last year. In Nepal, ANC (1 visit) reduced by 45.5% and ANC (4 visits) reduced by 52% against the last year. India was under a total national lockdown from 23 March to 1 June 2020 due to which routine ANC utilization was disrupted due to movement restrictions. However, ANC services were

provided on a walk-in basis as per standard protocols released by MoHFW[1] up to the sub-health centre level following physical distancing norms. Bhutan, the Democratic People's Republic (DPR) of Korea, Indonesia and Timor-Leste have reported no disruption in ANC in hospitals.

Institutional deliveries

Bangladesh, Myanmar and Nepal have reported a reduction in institutional deliveries. Bangladesh had reported 31% reduction during April–May 2020 compared with the same period in 2019, based on DHIS2 data; while Myanmar reported only a marginal decrease in March 2020 – 37.3% compared with 38.2% in March 2019 – and then recovered in April 2020. In Nepal, there had been a reduction in institutional deliveries in March-April 2020 by 58.7% compared with the same period last year. In India, a state survey reported decrease in institutional deliveries in government hospitals during March–April 2020 that began to increase by May 2020. Five countries – Bhutan, DPR Korea, Indonesia, Sri Lanka and Timor-Leste) – did not report any reduction. No information is available from Maldives yet.

Newborn admissions in hospitals

Bangladesh, India and Maldives have reported a reduction in the number of admissions in the newborn units, whereas Bhutan, DPR Korea, Sri Lanka and Timor-Leste did not report any such reduction. Information from Indonesia, Myanmar and Nepal was not available.

Increased maternal, newborn and child mortality

The assessment included information on additional deaths that may have been observed in the countries during the pandemic in the reference period of March–April 2020. Definitive information on an increase in maternal, newborn and child mortality among persons not infected by COVID-19 was not available. Nevertheless, any significant spurt in mortality was not reported by the countries for the period of March-April 2020 compared with the same period in 2019. Only countries like Sri Lanka, Maldives and Myanmar that have good information system like maternal death surveillance and response (MDSR) system and HMIS reported just a few additional maternal deaths and stillbirths.

Impact on SRMNCAH related health system during the pandemic

Budgets for SRMNCAH

In three countries (namely, Bhutan, Maldives and Indonesia) SRMNCAH-specific funds were diverted to the COVID-19 response. Sri Lanka had diverted some donor funds to support the COVID-19 response, but government funds continued to support routine RMNCAH work. Finances for SRMNCAH were not affected in DPR Korea, India, Nepal and Timor-Leste. In Indonesia a budget reallocation from the Directorate of Family Health for more than 9 billion Indonesian Rupee. Nepal and Timor-Leste have provided additional financial support to the

SRMNCAH services during the pandemic. A total of US$ 343 695 had been provided for reproductive health services during the pandemic from various donor agencies in Nepal.

Designation of COVID-19 hospitals

Several countries identified health facilities and hospitals as COVID-19 hospitals and identified isolation areas for COVID-19 positive cases in other hospitals. In Bhutan, the National Referral Hospital, regional referral hospitals and district hospitals have been designated to manage COVID-19-positive cases. These dedicated facilities undertake the care of deliveries and have labour room, operation theatre (OT) and blood bank facilities. In India too there are COVID-19-designated hospitals to manage positive cases. These hospitals take care of deliveries of women who have tested positive for COVID-19. In Maldives, two tertiary public hospitals have been identified in the Capital city as specific for availability of SRMNCAH services (non-COVID-19 hospitals). COVID-19-positive women are managed in the isolation facilities and in designated COVID-19 hospitals.

SRMNCAH workforce

SRMNCAH workforce had been diverted to COVID-19-related work in six countries: Bangladesh, Bhutan, Indonesia, Maldives, Myanmar and Nepal; while DPR Korea and Timor-Leste have not diverted SRMNCAH staff at the time of reporting. In Indonesia, some staff are sharing COVID-19 duty and some adolescent programmes staff have been diverted to COVID-19-related work.

India, Maldives, Myanmar, Nepal and Sri Lanka have reported absenteeism from work due to COVID-19 issues. Myanmar and Nepal have reported workers being infected with COVID-19 while working at health facilities.

Maldives had reported that the SRMNCAH workforce, including specialists, doctors, nurses, laboratory staff, administrative and support staff, have been diverted to COVID-19 surveillance and response. Several clinical staff are engaged in the national Emergency Operation Centre. About 55% of the health workforce are available to ensure continuity of care.

Training of RMNCAH workers

Trainings in infection prevention and control (IPC) and the use of PPE have been carried out in all respondent countries. In Maldives, 188 health workers across sectors have been trained in the use of PPE. Bangladesh had trained over 1500 doctors, nurses, midwives, cleaners and support staff, supported by UNICEF; and 250 health-care providers (nurses and midwives) have been trained by UNFPA. In Timor-Leste had also provided training on the safe and effective management of pregnant women in the context of the Covid-19 pandemic. MoH with the support of partners (including UNFPA, WHO, John Snow International, USAID and UNICEF) have contextualized these guidelines. Training on screening and management of COVID-19 cases had been carried out in six countries: Bhutan, DPR Korea, India, Indonesia, Myanmar, Nepal and Sri Lanka.

All countries had used digital platforms for training except Timor-Leste. Nepal had used "Open WHO" training modules. DPR Korea had used its telemedicine network. In India training programmes are available on the integrated government online training platform (iGOT). Certification is also provided to the trainees (*https://diksha.gov.in/igot/*).

Essential supplies for RMNCAH

Essential lists of medicines and supplies for SRMNCAH during the reference period have been identified by Bhutan, DPR Korea, India, Nepal and Sri Lanka. The availability of essential supplies is being monitored in all countries. Stockouts were reported by Maldives, Nepal and Sri Lanka. PPEs were in short supply in Sri Lanka.

In Nepal, as per the findings from the rapid assessment of maternal-newborn health and sexual reproductive health services in the COVID-19 situation, conducted by UNFPA, all health facilities reported the availability of different types of health services providers. Less than half (44.5%) of the health facilities reported health service providers having faced challenges attending the facilities during the lockdowns. PPEs were in short supply: only a small fraction (7% to 26%) of health facilities had enough supply of PPEs, whereas the majority faced a shortage of this item.

The Ministry of Health and Population (MoHP) of Nepal had designated various hospitals for treatment of COVID-19. Most of the COVID-19-designated hospitals (level 2 and 3) were comprehensive obstetric care service delivery sites and had labour room and OT facilities. However, blood bank facilities were not available in all designated sites.

Health information systems

All countries had prepared a mechanism for a specific monitoring of the continuity of SRMNCAH services during the pandemic, except for Bangladesh, Myanmar and Timor-Leste, which were using the routine monitoring system. The frequency of monitoring SRMNCAH services during the pandemic was reported to be monthly to quarterly in India, quarterly in Indonesia and weekly in Nepal and Sri Lanka.

Bangladesh and Maldives have reported a decrease in health management information system (HMIS) data reporting compared with last year, whereas Bhutan, DPR Korea, Myanmar and Timor-Leste have reported no change in this.

Maternal and perinatal death surveillance is being continued in six countries (DPR Korea, Indonesia, Myanmar, Nepal, Sri Lanka and Timor-Leste) but not in four (Bangladesh, Bhutan and Maldives).

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Summary of findings on service disruption

- Essential services for SRMNCAH were interrupted to a varying extent in the countries.
- All countries prepared national plans for continuing SRMNCAH services and have used the global and regional guidelines.
- Resources (financial and human) were diverted from SRMNCAH programmes to manage the COVID-19 outbreak in some countries.
- Countries prioritized SRMNCAH services as essential services in their national plans to continue during the pandemic and lockdown periods.
- All countries prepared guidelines for managing COVID-19-positive women and newborns and have used WHO guidelines Several countries modified the design of certain SRMNCAH services during the pandemic and lockdown periods and used appointments, rescheduled visits, teleconsultations etc.
- Health work force (including SRMNCAH staff) were trained in COVID-19 related knowledge and skills.
- Some countries experienced shortage of PPE supplies and stockouts of essential SRMNCAH commodities.
- In only some countries SRMNCAH focal points in MOH were included in the national technical working group on pandemic.
- All countries reported good partnership in support of managing the pandemic.

National plans to continue SRMNCAH services during the pandemic

Member countries are quite aware that any disruptions in service delivery could lead to additional maternal, newborn and child deaths and stillbirths, as indicated in the initial modelling reports published recently. To support the preparation of national plans for continuing essential RMNCAH services, the WHO headquarters guidelines for continuing essential health services and regional guidance (developed by WHO-SEARO and the regional offices of UNICEF and UNFPA) on continuing SRMNCAH services during the pandemic were disseminated by the middle of April 2020.

This rapid assessment of SRMNCAH services included a section on finding out the country plans to continue the essential SRMNCAH services. The countries were requested to report if they had planned to continue essential SRMNCAH services at the community level, primary care level and referral level (secondary and tertiary care), or had modified or stopped these services on account of the pandemic. Provided below is a summary of the responses from the respondent countries. This section provides a brief description of the country plans as reported in the assessment exercise.

Antenatal care

During the pandemic and lockdown all countries have introduced modifications in the delivery of ANC. In Bangladesh, community ANC is being continued while the ANC services at the facility level (primary, secondary and tertiary) have been modified inasmuch that visiting hours were restricted. Nepal adopted the teleconsultation mechanism for ANC at all levels where possible. India suspended outreach ANC services and provided teleconsultation to high-risk cases of pregnancy along with emergency transport services in containment zones; walk-in ANC is also provided along with infection prevention and control at health facilities. In other areas where the outbreak was not significant ANC had been continued as usual.

Indonesia offered ANC in the community through teleconsultation and restricted ANC in hospitals to one visit each in the first trimester and third trimester by appointment, while during the second trimester ANC was provided through one teleconsultation. Women are advised to seek hospital care in case of emergency with prior appointment.

Sri Lanka is continuing routine ANC services in the community except in lockdown areas (where only teleconsultations and emergencies were handled); ANC at the primary care facility level is available for new registrations, high-risk and third trimester pregnant women; and ANC for all women is available at the secondary and tertiary care level.

Intranatal care

Institutional deliveries and comprehensive emergency obstetric and newborn care (CEmONC) services including blood bank, and services for institutional deliveries and emergency obstetric care have been prioritized and are being continued in all countries as before.

Home deliveries with skilled birth attendance

Five countries – Bangladesh, Bhutan, Nepal, Myanmar and Timor-Leste – are continuing home deliveries as before the pandemic but with some modifications, such as ready availability of misoprostol and disposable delivery kits for home deliveries wherever necessary and the arrangement of non-COVID-19 ambulance transport for this purpose.

Essential newborn care at birth, rooming in, skin-skin care and breastfeeding

These evidence-based practices continued in all respondent countries except Bhutan and Indonesia. These two countries have discontinued skin-skin care, rooming-in and breastfeeding for COVID-19-positive women.

Postnatal care for mother and newborn (especially visits in the first week of life)

Postnatal care services are being continued as before in six countries, namely Bhutan, DPR Korea, Indonesia, Myanmar, Nepal and Timor-Leste. Home visits for postnatal care for mothers and newborns is being continued in six countries – Bangladesh, Bhutan, India, Myanmar, Nepal and Timor-Leste – as before; others had suspended such home visits and replaced them with teleconsultation and similar facilities.

Facility-based newborn care

Facility based newborn care is being continued in all countries as earlier. However, family-participatory care had been suspended in India in the containment zones.

Care of under-five children with illness such as diarrhoea, pneumonia and severe acute malnutrition

The routine services for under-five children are being continued in all countries at all levels (community, primary and referral level facilities) of care.

Routine immunization for under-five children

All countries have planned to continue routine immunization services as earlier. Some modifications during the pandemic and lockdown period have been reported: Myanmar and Sri Lanka had temporarily suspended/withheld routine immunization (except BCG during the assessment period). However, the backlog was cleared by April–May 2020. Indonesia and India had also modified services.

Nutrition counselling, growth monitoring of under-five children

These services are being continued in six countries: Bangladesh, Bhutan, India, Myanmar, Nepal and Timor-Leste. In DPR Korea at they were continued at the facility level. Indonesia is continuing services with some modifications. Thailand reported that improperly measured children's weight and height could result in them suffering from malnutrition. Therefore, village health volunteers continuously measured children's weight and height while maintaining IPC.

Adolescent health services including SRH

Adolescent health had not received priority by countries except DPR Korea, Myanmar, Nepal, and Timor-Leste where services are planned to continue as before. In Sri Lanka SRH services were identified as a priority and family planning services are being provided for adolescents. In India, adolescent-friendly health-care facilities (AFHCs) were largely disrupted.

Family planning services and methods

Family planning services are being continued as per the earlier routine schedules in seven countries (namely Bangladesh, Bhutan, DPR Korea, Myanmar, Sri Lanka and Timor-Leste) at all levels of care. In DPR Korea family planning is continued at the facility level. India had suspended community-level services in containment zones and reduced the number of clients to be attended per session. Indonesia had introduced multiple changes.

Comprehensive abortion care

Services for abortion and post-abortion care are being continued as earlier in Bangladesh and Nepal at all levels; and in Bhutan, DPR Korea, India, Myanmar and Timor-Leste at the facility level.

PMTCT and HIV services

These services are being continued as earlier in Bangladesh, Bhutan, Myanmar and Nepal at all levels; in DPR Korea and Timor-Leste at the facility level. Sri Lanka had continued these at all levels but with limited services. Indonesia is continuing these services at the facility level, though with some modifications. In India, services on triple elimination for mothers and babies are continued, except for babies born to mothers who are positive for HBsAg for whom the birth dose of hepatitis B is postponed in COVID-19- positive cases with serious clinical signs. No information is available from Maldives.

Management of survivors of domestic and gender-based violence

Only Bhutan, India and Myanmar have planned to continue these services; Nepal had modified community-level services and Timor-Leste is providing these services only at the secondary and tertiary care level. Bangladesh had completely stopped these services at this time, and Sri Lanka had limited the availability of field care but sustained institution-based care for victims. In India, "one stop centres (OSCs)" are continuing to provide services to women survivors of

Strategies and innovations used for continuing SRMNCAH services

WHO-SEARO along with the UNICEF and UNFPA regional offices organized a virtual meeting with national programme officers for SRMNCAH in the ministries of health and country teams of WHO, UNICEF and UNFPA, and the focal points from the country offices from all 10 participating countries to disseminate results and get their feedback. The results from the rapid assessment were presented and mitigation strategies that were recommended for the region and globally were shared.

MoH representatives from the Member States shared their reflections about the pandemic, impact on SRMNCAH services, and actions being taken to ensure continuity of these essential services. There was consensus that the pandemic had challenged the health systems and presented additional problems related to managing COVID-19-positive cases and maintain routine yet essential services. In the process of protecting essential health services, countries observed that the development of national action plan was important. Recruitment of human resources to supplement gaps and incentives given to frontline workers helped to maintain services. Online training on IPC helps maintain the MNCAH services and training in management of COVID-19 positive cases was undertaken quickly. National response mechanisms for addressing the pandemic were activated and collaboration between the government and partner organizations was established.

All countries appreciated the importance of situation analysis of SMNCAH services in the initial phase of lockdowns for addressing the pandemic and support provided to national systems to meet the challenges. Updates and cross-learning among countries occurred during the country webinars convened by WHO-SEARO. This section presents the actions and experiences reported by countries.

Bangladesh

National Guidelines on MNCH&FP Services had been developed in the context of COVID-19 and IPC training (online and face-to-face) had been provided to all frontline service providers. Virtual orientation had been provided on MNCH guideline for all mid-level managers. Action plans (short/medium/long-term) were prepared and executed. A triage system in all health facilities to ensure services for both COVID-19 and non-COVID-19 patients was established. Low performing districts have been identified for taking rapid actions. District-level clinics continued to be functional and community clinics are continuously providing basic SRMNACH services. Field hospitals (established in high-prevalence areas such as Dhaka, Narayanganj and Ghazipur) also provided services during the pandemic.

Telemedicine services were established soon after COVID-19-positive cases were detected, and health workers also checked on clients and looked after patients. Additional human resources (doctors, nurses, midwives and laboratory technicians) were recruited. Adequate supply of PPE for all health workers was ensured and online training on COVID-19 and MNCAH services was imparted. The Government offered equivalent of two months' basic salary to all frontline health service providers as one-time incentive and a relief of 1–5 million Bangladesh Taka in case of death. Bangladesh maintains case records through the DHIS-2 platform.

Mass media appeals were made to the public through print and electronic media and national hotline (16263 and 333) was introduced as follow-up services for ANC, PNC and IMCI. Pregnant women were encouraged to come and receive services irrespective of whether they are COVID-19-positive or not. After April 2020, services have started picking up the momentum. Immunization and family planning services gained back significant coverage by June 2020.

Cooperation between the government from district to sub-district levels and stakeholders and institutions was strengthened and real-time monitoring of MNCAH service data facilitated central level actions.

Bhutan

Bhutan continued essential primary health care services including RMNCH service delivery through an integrated approach, as before the pandemic. Prevention of infections among health workers was addressed through the operational guidelines of MCH services. Health workers were oriented to deal with COVID-19 in mothers and children. Continued medical education and capacity development of health-care providers was provided online. Private sector funding to support government mobilization of PPEs was mobilized to supplement existing stock.

Some services (e.g. ANC, essential newborn care and family planning services) were modified in lockdown areas and restored soon after the lockdown was revoked.

Health desks were instituted to oversee delivery of services under the National COVID-19 Task Force. Contingency plans to ensure the provision of essential health-care services and micro-plans for health facilities were activated.

Operational guidelines for the continuity of SRMCAH were created at two levels. At the health systems level, guidelines/standard operating procedures (SOPs) were prepared to facilitate

the implementation of contingency plans and policies. Efficient functioning of health systems was boosted by the implementation of stewardship and good governance, human resources for health allocations, finance allocation, and the provision of information, supplies and services. Capacity development of the health-care providers was undertaken. Delivery of essential goods and services was facilitated.

Social mobilization and community empowerment activities were undertaken by the government including awareness-generation campaigns on essential health-care services and emergency services during lockdown. The public were reassured on infection prevention and control measures at the facilities.

DPR Korea

ANC services continued at the primary and referral levels. Institutional deliveries, CeMONC services, including the operation of the blood bank, continued. Essential newborn care at birth, rooming in, skin-skin care and breastfeeding continued at the primary and referral levels; postnatal care for mother and newborn (especially visits in the first week of life) continued at primary and referral levels. Family planning services and methods continued at all three levels. Comprehensive abortion care was provided at two levels. Home-based newborn care was provided only in cases of home delivery. Facility-based newborn care continued. Care of under-five children with illness and severe acute malnutrition continued. Routine immunization for children under the age of five continued. Nutrition counselling and growth monitoring of under-five children continued at the primary and referral levels.

The country was able to continue most of the SRMNCAH services as earlier, including SRH services. Emergency referral transport for women, newborns, children and adolescents continued at all three levels. PMTCT and HIV services continued at all three levels. Management of survivors of domestic and gender-based violence continued at the community level with community-based support services and a multisector task force. This service was also continued at the primary and referral levels.

India

The Government of India had mandated that "under no circumstances should there be a denial of essential services" to women, newborns and children. Two guidelines were developed, namely, "Enabling delivery of essential health services during the COVID-19 outbreak" (14 April 2020), and "Guidelines on provision of RMNCAH+N services during and post-COVID-19 pandemic" (24 May 2020). Critical services for women, children and adolescents were provided irrespective of their COVID-19 status.

Most of the SRMNCAH services were prioritized as essential except for some modifications applied to field-based services, especially those in the areas of containment of the outbreak. Critical services for women, children and adolescents were provided irrespective of their COVID-19 status. The walk-in ANC was provided at health facilities with IPC precautions and the outreach ANC services were replaced by teleconsultation for high-risk cases of pregnancies. Birth companions were not allowed in containment zones and the home visits for newborn care were replaced by teleconsultation or through integrated home visits in the

containment zones. Adolescent health services including SRH at the community level were provided through teleconsultation. Service provision was modified for the management of survivors of domestic and gender-based violence at the community, primary and referral levels. Provisions were made to continue the family planning services and community-based contraceptive distribution was clubbed with outreach sessions for COVID-19 activities. Family planning commodities have been distributed in quarantine centres and migrant camps in all states.

Mapping of patient-care centres was done. ICUs, ventilators and oxygen support were augmented. Private hospitals were designated; referral centres, dedicated COVID-19 health centres and COVID-19 care centres were identified. Dedicated COVID-19 health centres (DCH) were equipped with beds that had assured oxygen support. A dedicated basic life support ambulance equipped with oxygen support was also provided. Makeshift facilities were set up in hostels, hotels, schools and stadiums that were equipped with beds and assured oxygen support. At the supply level, actions such as integration of RCH commodities as part of the essential medicines list.

Community outreach sessions were modified, and a staggered approach had been adopted for visits to health-care facilities. Community-based contraceptive distribution was clubbed with COVID-19 prevention activities using integrated field visits. Mass media and digital platforms have been utilized for awareness generation. Modified outreach actions are being planned as per the guidelines. COVID-19 information provision is being twinned with awareness about SRMNCAH. Short video messages (such as on World Population Day) have been produced and messages have been printed on masks for public distribution.

Several digital platforms were adopted during the pandemic. Best practices have been uploaded for public information and sectoral cross-learning on the National Health Innovation Portal (NHInP). *E-Sanjeevani* is an online OPD as well as a web-based national, teleconsultation service. Telemedicine services (practitioner to practitioner consultation) were available in 150 000 health and wellness centres (HWCs). Aarogya Setu an online app that predicts hotspots. The Integrated Government Online Training (i-GOT) delivers training not only for the Ministry of Health and Family Welfare (MoHFW) personnel but also for those across the government system.

India adopted several human resource strategies such as expediting the filling up of existing vacancies, redeploying staff from non-affected areas and facilities, utilizing fit retirees for non-COVID services and roles, mobilizing resources from several health agencies, Railways and public sector undertakings, hiring nongovernmental and private sector health workforce, ensuring temporary engagement beyond the sanctioned regular/contractual strength and empanelling human resources to provide essential non-COVID-19 related services. Insurance cover for healthcare workers have been offered and payments to families announced in the unfortunate event of death of a healthcare worker in line of duty.

Additional funds were provided to the states under the “India COVID-19 emergency response” and “Health systems preparedness package”. Funds were also released to the states under the health systems strengthening pool.

Indonesia

Most of the primary health centres (P*uskesmas*) continued to provide health-care services as before the COVID-19 outbreak. ANC services were shifted to the online mode. Pregnancy and childbirth services were modified. Classes for pregnant women, called "Mother classes" were postponed or conducted online. Reading of the MCH Handbook and visits at the first sign of danger were advised. institutional deliveries, Suspect, probable and confirmed cases of COVID-19 in pregnant women were sent to COVID-19-designated hospitals for delivery. Newborn care for babies born to mothers with suspected and confirmed COVID-19 infection in mothers was modified as rooming-in, skin-skin care and breastfeeding were not allowed.

While PNC-first visit was conducted within a health facility, PNC visit 2, 3, 4 were done through home visits or remote contact. Family planning services and methods were modified. IMCI and COVID-19 protocols were combined with triage protocols. Separate waiting rooms and medical examination rooms were provided. Additionally, implementation of physical distancing, IPC and use of PPE were implemented.

Routine immunization for children under the age of five at the community level were provided through outreach services called "Posyandu" (Outreach Integrated Service Post). Growth and development were monitored by the family using the MCH Handbook and through *Posyandu*. Services were scheduled based on appointments and implemented with IPC norms. Adolescent health services including SRH services shifted to the virtual meeting/tele-counselling mode.

PMTCT and HIV services for triple elimination for mothers and babies were still given. However, babies born to HBsAg positive mothers with confirmed COVID-19 infection vaccination of hepatitis B birth dose to the baby was postponed. For the management of survivors of domestic and gender-based violence, visits were by prior appointment only at the primary level and referral levels.

Adaptation and modification of service delivery including digital platforms, monitoring and taking necessary action have been good practices. Community knowledge and awareness of mother-and-child healthcare was undertaken including availability of COVID-19-designated hospitals that were ready to provide maternal and childcare.

Maldives

Most of the services were protected from disruption during the pandemic and continued as before. The preparations included digitization of MCH records to further harmonize real-time monitoring of service data, and monitoring of stocks of PPE and essential drugs through the Central Medical Supply of the Ministry of Health. Outreach programmes have been conducted for ensuring timely ultrasound scan and ANC consultations for clients from the islands. Family planning commodities were distributed to all health facilities and outreach services continued. Online refresher training was offered to health professionals in relevant SRMNCH areas. Teleconsultations have been carried out in Maldives.

Health workers have been trained on the use of PPE. Online training sessions for facilitating service management among personnel working in the atolls/regions have been implemented.

Community-level actions undertaken included awareness generation through "leaders and peers" to reduce fear and combat misinformation about the pandemic. Campaigns promoting care-seeking behaviour were also implemented and community members who required services monitored.

Maldives also benefited from local donor support towards health workers and patients, and from gifts of PPE, hand sanitizers and disinfectants. Handwashing facilities were provided in public places, markets, bus stops, banks, malls, parks and public buildings.

Myanmar

The Ministry of Health and Sports started implementing public health interventions based on the International Health Regulations (IHR) 2005 in January 2020. COVID-19 management protocols were established with Yangon as the epicentre. Fever clinics were opened and person under investigation (PUI) cases were tracked. Robust door-to-door contact tracing measures were undertaken. A Central COVID Committee was formed and chaired by the State Counsellor. Budgets were allocated from ministries other than that of Health and Sports. A Logistics Management Information System for PPEs and other equipment for COVID-19 was started in April 2020 with the help of WHO and UNFPA and other partners. All medical personnel and volunteers have been trained in the use of PPE and other preventive measures. There was mild disruption in contraceptive services, but these were resumed with the implementation of COVID-19 SOPs and guidelines formulated by the Ministry of Health and Sports. A booking system for immunization services was introduced at tertiary hospitals. Elective surgeries were postponed at tertiary and secondary hospitals and the focus shifted to emergency RMNCAH services.

Myanmar adopted a health systems approach:

- In terms of human resources for health (HRH): targeted deployment of HRH for the three COVID-19 designated hospitals and centre. HRH skilled in taking care of critically ill patients, emergency intensive care doctors, ICU nurses, anesthetists, laboratory technicians and ward support staff and volunteers.
- Supplies and equipment for COVID-19 response: fast track procurement, quantification, specification, distribution through functional eLMIS.
- Mobilization of resources through UN country team and development partners for technical and laboratory support, drugs, equipment and expertise.
- Special flights and transportation of laboratory specimens at the beginning, and laboratory capacity built rapidly for COVID-19 testing.
- At some places, midwives were deployed to check temperature and vital signs for returnees at cross-border points. Task shifting of public health supervisors and volunteers was undertaken for the COVID-19 response.

Nepal

The RH Sub-cluster was formally activated on 5 March 2020 (weekly meetings were conducted) and the interim MoHP circular for continuation of COVID-19 and essential non-COVID-19 services was issued in mid-April. SRMNCAH is included in the Country Preparedness

and Response Plan for COVID-19. Interim guidance for SRMNCH services during the COVID-19 pandemic as developed by the MoHP was approved and rolled out. Regional guidelines on the continuity of SRMNCAH services have also been used. These guidelines cover all services for women, newborns, children and adolescents, including gender-based violence.

In the process of ensuring service continuity, Nepal realized that an alternate service delivery modality needs to be adopted/promoted, and that additional logistics and human resources are required to bring services to a normal level. Furthermore, capacity-building and additional mentoring support are needed for health workers to function.

Home deliveries with skilled birth attendant services were modified (misoprostol, clean delivery kit and chlorhexidine were provided for women in the eighth month of pregnancy if they were unable to come to a health facility for delivery). ANC services continued in the teleconsultation mode at the community, primary and referral levels. Postnatal care for the mother and newborn (especially visits in the first week of life) were provided through teleconsultation. The management of survivors of domestic and gender-based violence continued via a hotline at the community level. All other services were provided as before.

The country established helplines to guide target populations to access RMNCAH services. Teleconsultation practices were promoted to continue remote services in ANC and PNC. Visiting service-providers were mobilized for providing long acting contraceptives.

Communication materials, such as flyers, public service announcements (PSA) on the radio and television, and frequently asked questions (FAQs) on reproductive health, were developed and adapted to the context of COVID-19.

The measles-rubella vaccination campaign continued. The rotavirus vaccine was launched during the pandemic, despite challenges, and a campaign on vitamin A was implemented.

Health workforce and infrastructure ere reorganised, alternative capacity-building approaches were adopted, and referral mechanisms and transportation facilities were strengthened. Continuous monitoring and assessment were used for evidence-based planning and response. A coordinated and harmonized response was crucial to ensure population coverage, equity and impact.

Sri Lanka

The country had developed many guidelines, such as the Preparedness and Response Plan, rational use of PPE, hospital preparedness, and Stakeholder Engagement Plan (SEP). RMNCAH services were optimized by providing care for COVID-19-positive patients (via designated hospitals/units, ICU care, COVID-19 management guidelines, etc.); care for those in quarantine and in lockdown areas, providing routine care for those with limited accessibility to services (maternity kits, specialized regional care) and providing care in the “new normal” phase (including high-risk approach in antenatal care, growth monitoring and immunization services, PPE and protective measures; implementation of national technical guidelines and reorganization of clinic services).

ANC services were continued in all areas except the areas under lockdown. Home deliveries with skilled birth attendants were performed by trained persons only during an emergency and by adhering to IPC norms. PNC for mother and newborn (especially visits in the first week of life) at the community and primary level continued with IPC measures and a reduction in the number of visits. At the referral level, PNC services continued to be provided with IPC measures for high-risk groups with an appointment system in place. Care of under-five children with illnesses such as diarrhoea, pneumonia and severe acute malnutrition at the primary care level was continued with IPC measures and reduction in the number of visits. Adolescent health services including SRH continued in a limited way. Emergency referral transport for women, newborns, children and adolescents were provided through a government-funded ambulance service. Some innovations to cope with the "new normal" included developing guidelines on youth centres/universities, preparation to open schools, gender-based violence (GBV) care centres, and COVID-19 guidelines for preschool settings.

Supplies for infection prevention, equipment and supplies for EmONC care and supplies to protect personal hygiene were mobilized. Staff were re-located to provide specialized care in designated hospitals. Staff were also trained on use of PPE, supportive services; and transportation and facilities were provided. Measures such as relocation of staff for specialized MNCH care in designated hospitals and safeguards to strengthen health workforce protection were put in place.

The country used mass communication (including a social media campaign) and roped in the mass media to create awareness about MNCH. Digital platforms were used for consultation and treatment, and resources mobilized to cope with the pandemic situation.

Overall support from the Ministry of Health, continuous communication with provincial, district and field health teams, technical guidance from professional bodies and relevant focal points, a resilient public health infrastructure and acceptance of alternate modes of service delivery were also responsible for uninterrupted service provision during the pandemic.

Thailand

Thailand had not participated in rapid assessment as there was minimum disruption in services during the pandemic and that, too, was also controlled effectively in a short time. In the Regional webinar they presented some highlights of actions they undertook to protect essential SRMNCAH services, including development of service guidelines on SRMNCAH in an emergency; use of online/telecommunication technology for counselling services; continuous training for health service providers on SRMNCAH. Thailand documented the impact of COVID-19 on "children in early childhood". The health system and supply-side impacts that facilitate uninterrupted service provision during the pandemic include cooperation among public health officers at the central, provincial and local levels on MCH and family planning and birth control services at the community level through village health volunteers.

A cadre of village health volunteers visits families, provides information and referrals, and monitors the risk of COVID-19. They also facilitate and send public health information from the community to the public health officers. The ministry of health developed "Early Moment Matters" for access on mobile phones and created a *Maternal and Child Handbook*. An online

platform called "Save Mom" (http://savemom.anamai.moph.go.th/login) was created and a *Handbook of Dental Health Knowledge for Pregnant Women and Children in Early Childhood* was developed.

Timor-Leste

All SRMNCAH services were provided at all levels. Family planning services and methods, routine immunization for under-five children, and nutrition counselling and growth monitoring of under-five children were continued at the community level through community (SISCa) and mobile clinics. MoH developed specific clinical protocols and guidelines for ANC, intrapartum and immediate postpartum care, establishment of a separate maternity isolation ward at the maternity clinic and family planning commodities to all health facilities (for distribution through outreach services).

Country preparations and responses to the pandemic included strengthening of the health system, isolation rooms, laboratory facilities, PPE distribution as well as encouraging preventive measures., and reactivation of RMNCH working group. Rehabilitation and construction of new WASH facilities was undertaken. All outreach and community-based health services that had stopped were reinstated in early July 2020.

Recommendations from the mid-year meetings to review impact of COVID-19 on the disruption of routine RMNCH services during the pandemic have been implemented.

Monitoring plans for SRMNCAH services

During the experience-sharing webinars, countries reported their methods of monitoring SRMNCAH services, as outlined below.

Bangladesh

The country had used the existing DHIS-2 system to monitor the delivery of SRMNCAH services. Monitoring indicators of SRMNCAH services (derived from the existing DHIS2) included:

i. Women who received antenatal care (ANC1 & ANC4).
ii. Births conducted in health facilities (women who delivered in health facilities).
iii. Caesarean sections performed at health facilities.
iv. Mothers and newborns provided with postnatal care within 24 hours of birth.
v. Women who received contraceptives in the community and health facilities.
vi. Women managed for GBV in the community and health facilities.
vii. Teleconsultation with pregnant mothers.
viii. Maternal deaths in health facilities.
ix. Stillbirths in health facilities.
x. Neonatal deaths in health facilities.

xi. Stock of MNCH episodes of essential commodities.

xii. Newborns admitted at special newborn care units.

xiii. Under-five children treated at IMCI clinics.

xiv. Vaccine dropout monitoring: BCG-Penta 3, Penta 1, Penta 3, Penta 3–MR.

Bhutan

The focal persons from each facility had been identified to monitor service utilization (including MCH), develop indicators, provide oversight and report to the Ministry of Health. It was also incumbent upon them to notify events immediately as they occur, as per the guidelines.

India

The entire COVID-19 response was coordinated by the Prime Minister of India who provided monitoring and oversight for a strategic multilevel response. There is continuous engagement with chief ministers and state health ministers and monitoring by the Group of Ministers (GoM). The Health Ministry's review meetings are held periodically and advisories on the pandemic have been issued to the states since 17 January 2020. The integrated response is coordinated by the Committee of Secretaries (CoS). Joint monitoring group meetings are held to review the situation and there are regular interactions between the state governments and the Government of India. State-level online reviews for RMNCAH+N services (with specific SRMNCAH indicators) have been implemented. The virtual meetings and videoconferencing provide a platform for the monitoring and cross-learning and facilitates the improvement of service delivery in all states.

Indonesia

Routine system was used for quarterly monitoring of SRMNCAH services during the pandemic including ANC 4 visits, institutional deliveries and neonatal visits; whereas monitoring of adolescent services is every month. The use of the SISRUTE referral system and the "*Pulih* COVID-19" dashboard had helped clients utilize services as well as monitor the functioning and utilization of these services.

Nepal

Weekly monitoring of essential RMNCAH services for their availability and utilization is being done using selected indicators like, number of deliveries per day, availability of transport services/ambulance, availability of "Aama" incentive scheme, availability of isolation wards, stock status of commodities for FP/RH/MH and review of maternal deaths at the community level and in facilities.

Two rounds of rapid assessment for the situation of MNH and SRH service readiness and functionality have been conducted. Maternal death monitoring is included in the weekly services monitoring plan. Detailed information of the identified maternal deaths were collected using MDSR forms and reviewed at the national level.

Sri Lanka

Sri Lanka utilizes routine HMIS for monitoring SRMNCAH services during the pandemic.

Thailand

The country is developing a simple reporting and data management system for SRMNCAH services that will be user-friendly for use at the local level. Service guidelines on SRMNCAH in an emergency are being drafted and continuous training for SRMNCAH health providers is being conducted.

Timor-Leste

A simple reporting format using existing HMIS indicators had been developed for monitoring the key SRMNCAH indicators to monitor access, quality of care and health system disruptions during the COVID-19 pandemic. This format is to be filled monthly by the District Public Health Office at the municipal level and sent to the national programme officer. This exercise is led by the HMIS/M and E Section of the MoH. Additionally, review meetings will be focused on quantifying the impact of COVID-19 on access, quality of care and health system deficiencies.

What worked in protecting essential services - Lessons learnt

Common national and sub-national actions that worked towards continuing SRMNCAH services, as reported by the countries include:

- Establishing a purpose-designed governance and coordination (establish TAG/ participation with RMNCAH staff) and mechanisms to complement response protocols.
- Prioritizing SRMNCAH services in the national plans as essential services during the pandemic.
- Optimize service delivery settings and platforms, including alternative locations and models like rescheduling visits and appointments, community services, targeted outreach, and teleconsultations.
- Establishing effective patient flow at all levels, including screening, triage, isolation of suspected and confirmed patients, and targeted referral.
- Rapidly re-distribute health workforce capacity, including by re-assignment and task-sharing and remote training.
- Strengthening communication strategies to support the appropriate use of essential services and for maintaining population trust to safely meet population needs and control infection risk at health facilities.
- Strengthen the monitoring of essential health services.

Support required by countries

During the rapid assessment countries were asked about what support they required in preventing service disruptions. In view of the difficulties faced in continuing SRMNCAH services, some countries had specific asks. Bangladesh and Bhutan requested support for online training and guidelines to establish hands-on training in pandemic conditions. Sri Lanka

requested support to develop a training cascade from national to the grassroots levels and the creation of digital platforms and blended training methods and support from donor agencies. Bhutan asked for support in capacity-building of programme managers in the context of pandemics.

Bangladesh requested support for the development of social and behaviour change communication materials for awareness generation. Bhutan asked for online platforms for training, information dissemination and data collection, and help in developing guidelines for the adaptation and implementation of services during the pandemic

Indonesia asked for technical support to update MCH training and monitoring tools onto digital platforms such as blended training, telemedicine and teleconsultation. In terms of research, the country asked for assistance in studies/data analysis on SRMNCAH services affected by the pandemic and the adaptation of the global guidelines for the capacity-building of health providers. Sri Lanka also asked for help in the adaptation of guidelines and for both logistic and research support.

Annexure

Table 1: Impact of the pandemic on SRMNCAH (March–April 2020)

Item	Bangladesh	Bhutan	DPR Korea	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Timor-Leste
Disruption of SRMNCAH services										
Reduction in ANC in health facilities	Yes 41%	No	No	Yes	No	Yes	Yes 6%	Yes 45%	Not known	No
Reduction in Institutional deliveries	Yes 31%	No	No	No	No	No Info	Yes 1%	Yes 58%	No	No
Reduction in newborn admissions in newborn units	Yes	No	No	Yes	No info	Yes	No info	Not known	No	No
Indirect deaths (COVID-19-negative cases): additional deaths reported										
Maternal deaths	No	No	No	No info	No info	No	No info	No	Yes	No
Stillbirths	No	No	No	No info	No info	Yes	Yes	No info	Yes	No
Neonatal deaths	No	No	No	No info	No info	No	No	No info	Yes	No
Child deaths	Not known	No	No	No info	No info	No	Yes	No info	No info	No

Table 2: Impact on health systems (March–April 2020)

Item	Bangladesh	Bhutan	DPR Korea	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Timor-Leste
Finances for SRMNCAH										
SRMNCAH specific funds diverted to COVID-19 response	No info	Yes	No	No	Yes	No info	No	No	Yes	No
Additional financial support provided for SRMNCAH services	No info	No	No	Yes	Yes	No	No	No	Yes	Yes
SRMNCAH health workforce										
SRMNCAH workforce diverted to the COVID-19 work	Yes	Yes	No	No	Yes	Yes	Yes,	Yes	No	No
SRMNCAH workers reported to be infected with COVID at work	No info	No	No	Yes	No info	NO	No	Yes	7 inclu-ding 1 from RMNCH	No
SRMNCAH workers have been absent from work because of COVID-19 related issues	No info	No	No	Yes	No info	Yes	Yes	Yes	Yes	No
Training of health-care workers										
Training on IPC and PPE use	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Training on screening and management of COVID-19positive cases	No info	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	NO
Digital platform used for trainings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Essential supplies for SRMNCAH										

Essential list of medicines and supplies for SRMNCAH during the pandemic identified	No	No	Yes	Yes	No	No	No	No	Yes	No
Availability of essential supplies being monitored	No info	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Stockouts in the past two months – drugs or supplies affected	No info	No	No info	No	No	Yes	Yes	Yes	Yes	No
Monitoring of SRMNCAH services during the pandemic										
Monitoring continuity of SRMNCAH services during the pandemic exists	No	Yes	Yes	Yes	Yes	No info	No	Yes	Yes	No
Frequency of monitoring	N/A	No info	Daily	Monthly	Quarterly	No info	N/A	Weekly	Weekly	N/A
Indicators used	N/A	Routine	Routine	HMIS	No info	No info	N/A	Yes	Routine	N/A
HMIS/DHIS2 and birth and death registration reporting had decreased	Yes	No	No	No info	No info	Yes	No	No info	No Info	No
MDSR/ MPDSR continued	No	No	Yes	No info	Yes	No	Yes	Yes	Yes	Yes
Standard case recording form used for COVID-19-positive mothers and newborns	No	No	No	Planned	No	No	No	No	No	No

Table 3: National plans, guidelines and partnership for continuing SRMNCAH services

Item	Bangladesh	Bhutan	DPR Korea	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Timor-Leste
Essential services continuity plan										
National essential services continuity plan on SRMNCAH services **available**	Yes	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	Yes
Regional Guidelines for continuity of SRMNCAH services used	Yes	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	Yes
Covers **all services** for women, newborns, children and adolescents, including gender-based violence	Yes	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	Yes
Guidelines and protocols for managing COVID-19-positive pregnant women, newborns and children										
National guidelines prepared on management of COVID-19-positive cases	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Used global and regional guidelines	Yes	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	Yes
Protocols prepared for triaging, screening, testing and isolation	Yes	Yes	Yes	Yes	Yes	No info	Yes	Yes	Yes	Yes
Guidance prepared for health workers use of PPE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Enough PPE available for	Yes	Yes	No	Yes	No	Yes	No	No	No	Yes

SRMNCAH workers										
Identification of hospitals/health facilities for COVID-19-positive cases										
Hospitals designated to manage COVID-19-positive cases	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Care of deliveries (labour room, OT, blood bank facilities) in COVID-19-designated hospitals	No info	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Are COVID-19-positive women and children also managed in non-COVID-19 hospitals	No	No	No	Yes	No	No	Yes	Yes	No	Yes
Pandemic emergency response: SRMNCAH focal point										
SRMNCAH focal point (Ministry of Health) is included in the national COVID-19 Task Force/Steering Committee	No	No	Yes	Yes	Yes	No	No	Yes	No	Yes
Partnership										
Formal mechanism for collaboration among WHO, UNICEF, UNFPA (H6) and other partners to support the government	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 4: Ministry of Health officials who participated in the rapid assessment of SRMNCAH services (March-April 2020)

Bangladesh		
	Programme Manager, Maternal Health Programme	Dr Md Azizul Alim
	Programme Manager, NNHP & IMCI	Dr Muhammad Shariful Islam
Bhutan		
	RH Programme Managers	Mr Pema Lehtro, Ms Tashi Tshomo, Ms Karma Tenzin
DPR Korea		
	Vice-Director, prevention and treatment department	Dr Ri Ok Hyang
Indonesia		
	Head of Maternal and Neonatal Health Sub-directorate	Dr Nida Rohmawati
	Head of Neonatal Health Unit	Dr Rima Damayanti
	Head of under-five and pre-school age health Sub-directorate	Dr Ni Made Diah
	Head of child survival unit	Dr Ario Baskoro
	Head of out of school adolescent health unit	Dr Weni
	Head of Reproductive Health Sub-directorate	Dr Lovely Daisy
Maldives		
	Public Health Programme Manager, Reproductive Health Section, Health Protection Agency	Ms Saina Ali
Myanmar		
	Asst Director, MRH Division, MoHS (focal person)	Dr May Zin Soe
	Director, MRH Division, MoHS (supervised the process)	Dr Myint Moh Soe
Nepal		
	Director, Family Welfare Division, Directorate of Health Services	Dr Bhim Singh Tinkari
	Section Chief, MNH Section, Family Welfare Division	Dr Punya Poudel
	Section Chief (FP and RH) Family Welfare Division	Ms. Kabita Aryal
Sri Lanka		
	Director, Maternal-Child Health	Dr Chithramalee de Silva
	Chief Community Physician-M&E	Dr Kaushalya Kasturiarachchi
	Chief Community Physician-Planning:	Dr Hemali Jayakody
Timor-Leste		
	Head of Maternal and Child Health Department	Ms Augusta Amaral