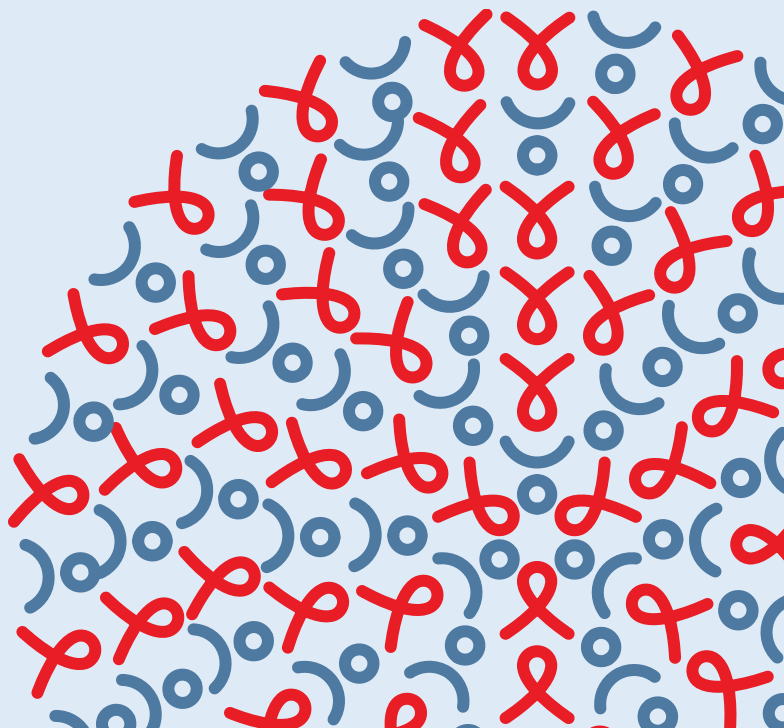


MEETING TARGETS AND MAINTAINING
EPIDEMIC CONTROL (EPIC) PROJECT

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Strategic Considerations for Mitigating the Impact of COVID-19 on Key- Population-Focused HIV Programs

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EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobe Group.

Strategic Considerations for Mitigating the Impact of COVID-19 on Key-Population-Focused HIV Programs

Introduction

COVID-19 is a serious and rapidly evolving global pandemic with more than 4 million confirmed cases and 290,000 deaths.¹ While about 97–99% of individuals infected with coronavirus recover,² a high proportion of cases requires hospitalization, and people over 65 and those with some underlying medical conditions experience higher mortality. As the virus spreads, the COVID-19 pandemic has the potential to quickly overwhelm health systems. While cases are currently concentrated in Europe, East Asia, and the Americas, the COVID-19 pandemic now spans 183 countries. The potential impact in countries in the Caribbean, Africa, and Southern Asia, which may have lower-capacity health systems and large vulnerable populations, is still unknown. Appropriate precautions and mitigation strategies must be developed and implemented across all public and private health and other sectors to prevent potentially devastating outcomes.

As COVID-19 disrupts health systems and affects human health globally, it is crucial to protect those most impacted by COVID-19, sustain gains made to address other infectious diseases, and maintain people's access to life-saving health services. Critical priorities during the COVID-19 pandemic include ensuring continuity of treatment and support for viral suppression among people living with HIV (PLHIV), continuing to identify undiagnosed individuals and ensure their prompt enrollment on treatment, and helping those who are at risk of HIV acquisition remain HIV negative. This resource offers strategies to reduce the impact of COVID-19 on key population program beneficiaries and staff while safely maintaining access to HIV testing, prevention, care, and treatment services.

Key Populations and COVID-19

Members of key populations (KPs)—including sex workers, men who have sex with men (MSM), people who inject drugs, and transgender people—are particularly vulnerable to COVID-19. People in prisons and other closed settings are also considered a key population by the United Nations, but the unique issues related to HIV service delivery and COVID-19 in these settings are not addressed in this document. Several factors that elevate KPs' risk of HIV acquisition may also place them at higher risk of acquiring coronavirus, such as high mobility and close physical contact with others through social and sexual practices. KP individuals living with HIV who are not on antiretroviral therapy (ART) and not virally suppressed may have a compromised immune system, which may place them at higher risk of coronavirus acquisition and COVID-19 morbidity and mortality. Furthermore, emerging evidence shows that groups already experiencing a disproportionate burden of poverty and marginalization are more affected by severe COVID-19 complications, in part because of a greater concentration of underlying health conditions.

¹ JHU (2020, May 12) JHU Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at John Hopkins University. [Link](#).

² Based on 1-3% COVID-19 mortality. NY Times (2020, March 19). Coronavirus death rate in Wuhan is lower than previously thought, study finds. [Link](#).

Stigma and discrimination experienced by KP members in health care settings limit access to and uptake of HIV services and will also likely affect their access to COVID-19 care and other health services. Moreover, concerns about potential exposure to COVID-19 in health facilities may lead to interruptions in treatment and other essential services for KP members living with HIV. For KP individuals who are HIV-negative, the COVID pandemic may reduce their access to pre-exposure prophylaxis (PrEP) and other prevention services such as condoms, lubricants, and other sexual health and family planning commodities. Stigma and discrimination may also mean KP individuals are more likely to be targeted by law enforcement under public health and order laws, for example, for breaching restrictions or exposing others to COVID-19. They may be particularly vulnerable if their circumstances mean they cannot shelter in place (e.g., they have been ostracized by family) or due to discriminatory targeting by police. There are already [reports](#) of sex workers; lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities; and people who use drugs being targeted, harassed, and arrested, putting them in further danger of acquiring HIV.

At the same time, the lives of KP members and KP program implementers are likely to become significantly more difficult because of measures to prevent the spread of COVID-19. Directives to stock up on staples and avoid movement are difficult, if not impossible, for individuals who live day-to-day as many members of KPs do. Access to information is difficult for individuals and communities who may not have consistent internet or other trustworthy news sources, leading to further misinformation, confusion, and panic. Health care costs associated with COVID-related care may also deter KP individuals from seeking care and taking measures to protect their own health and that of their communities. Maintaining access to food, shelter, and other essential goods may become more difficult for KP members because many do not have access to social safety nets and public distribution systems available to residents in the general population.

Crises such as pandemics also lead to increases in violence within relationships; this situation is likely to be exacerbated by forced physical distancing and shelter-in-place measures and by economic distress caused by widescale job losses that will harm the most vulnerable first. Individuals forced to live with abusive families or to hide their sexual orientation or gender identity in order to have access to shelter, all while dealing with increased social isolation, may also experience increased anxiety and depression. Additionally, physical distancing measures to prevent the spread of coronavirus may affect the livelihood and safety of sex workers; many will have fewer clients, increasing the risk of homelessness and the need to accept riskier clients. The closing of bars and other hot spots may also cause sex workers to move from a more protected environment to street-based activities, and in settings with strict lockdown measures, they may be at increased risk of arrest. Finally, bans such as those that limit access to alcohol and tobacco products may support healthier populations who are less susceptible to severe complications, but they can harm individuals who use tobacco and alcohol to cope—especially those for whom tobacco use is part of a harm reduction strategy. The supply of street drugs will also be affected by the COVID-19 pandemic. That can mean that people who use drugs, and their families, will be left to weather withdrawal symptoms in an already highly tense and contained environment.

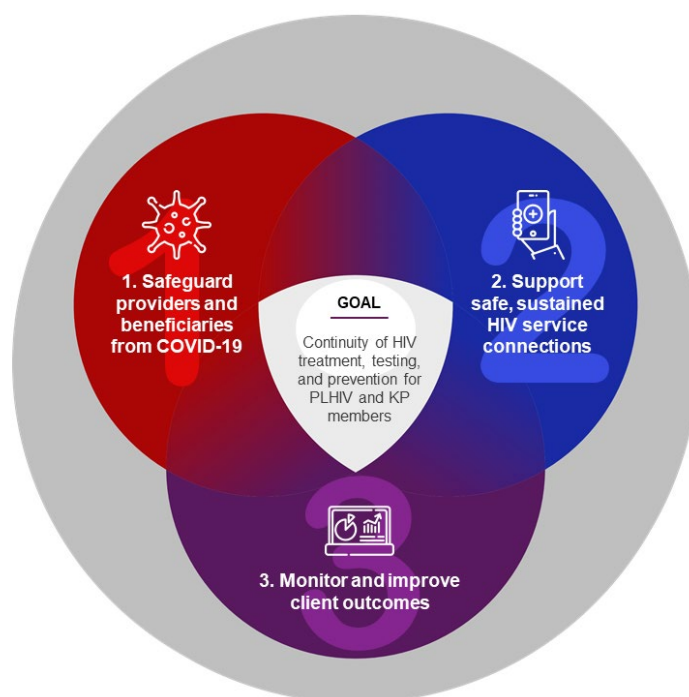
Program implementers, especially those moving through the community, may face unique risks, such as accusations of spreading COVID-19. Indeed, several KP peers have already been

arrested after such accusations involved local law enforcement authorities. They also face increased mental health strain as they themselves lose access to previous coping methods that involved in-person support while attempting to support others in their communities dealing with even less access to necessary services, goods (including food), and shelter. HIV program staff, such as health facility staff and community-based cadres providing outreach services, are also at heightened risk of COVID-19 because of their proximity to program beneficiaries and other patients—a risk that they may not fully understand or for which they do not know how they will be supported if they do contract COVID-19. In many locations, HIV program staff and peer service providers are unable to deliver services due to strict lockdown measures, effectively bringing some KP-focused HIV programs to a standstill.

HIV programs, and in particular those that cater to KPs, must put measures in place to help mitigate the impact of the COVID-19 pandemic on access to HIV prevention, care, and treatment services while simultaneously promoting the safety of staff and program beneficiaries. These measures must be grounded in a human-rights-based approach, and KP communities must be engaged and empowered to participate in all aspects of the response.

Strategy

This strategy is intended to support KP-focused HIV programs mitigate the impact of COVID-19. Developed for KP-focused HIV programs implemented or supported by FHI 360 in the Caribbean, Asia, and Africa, it may be used and adapted more broadly. Mitigation strategies refer to efforts to reduce exposure to and impact of COVID-19 on HIV program beneficiaries and staff and safely maintain HIV services within KP-focused HIV programs. Not included herein are strategies for responding to COVID-19 directly. This is a living document that will be updated frequently to reflect the rapidly changing context of COVID-19 and its impact on KP members, staff, and programs.



The considerations and approaches listed as part of this strategy aim to support the continuation of HIV services for PLHIV and KPs through:

1. Safeguarding providers and beneficiaries from COVID-19
2. Supporting safe, sustained connections to HIV services and commodities
3. Monitoring and improving client outcomes

1. Safeguard providers and beneficiaries from COVID-19

HIV programs can support continuation of HIV prevention, care, and treatment services during the COVID-19 pandemic by supporting the health of program staff, providers, and beneficiaries through preventing COVID-19 infection, supporting links to COVID-19-related screening and care, and addressing the holistic well-being of providers and beneficiaries.

1.1. Prevent COVID-19 infection among program staff and beneficiaries

- 1.1.1. Train all staff on COVID-19 transmission, symptoms, prevention methods, and implications for PLHIV; e.g., clients on ART versus clients not on ART, clients with viral load (VL) suppression versus those who are not suppressed, PLHIV with comorbidities, tuberculosis (TB) and hepatitis coinfecting clients, people with substance use problems, sex workers, MSM, the elderly, etc.
- 1.1.2. Develop or adapt social and behavior change materials to support adoption of COVID-19 prevention behaviors and use of relevant personal protective equipment (PPE) for staff and beneficiaries. Guidance on specific messaging considerations for key populations, PLHIV, and community and health staff is available [here](#).
- 1.1.3. Ensure adequate supply of soap and water for handwashing, alcohol-based hand sanitizer, face masks, thermometers, and other PPE at facility and community levels (such as tissues or cloth masks to cover faces if disposable face masks are in short supply).
- 1.1.4. Review, revise, or create flexible staff/facility strategic operating procedures (SOPs) to integrate COVID-19 prevention practices into HIV programming. These include frequent handwashing; cough hygiene (coughing into the crook of the elbow rather than the hand, or into a tissue and disposing of it immediately and safely); enhanced infection control measures for clinical and laboratory staff when collecting sputum samples for TB or other causes of pneumonia; regular/daily health checks of staff (e.g., taking temperature); avoiding crowded areas and social gatherings; developing procedures for staff exhibiting COVID-19 symptoms (e.g., testing locations, quarantine, designated staff to report results and status, and no-work policy for staff who test positive for COVID-19 or are ill); making accommodations for staff who feel uncomfortable performing assigned tasks due to COVID-19 risk, especially in the absence of PPE and where staff care for elderly or have a compromised immune system; and cross-training staff and task-shifting to fill gaps caused by absent staff.
- 1.1.5. Provide reliable information on COVID-19 to program beneficiaries that reiterates HIV core messages and is adapted to their realities.
 - Offer real-time accurate information that clearly explains what COVID-19 is, discusses individual prevention measures tailored to KP members' lives, clarifies the rationale for social distancing and other societal prevention measures, and explains possible consequences of infection. Directly address misperceptions and myths about COVID-19, especially those related to individuals living with HIV (e.g., dispel the myth that ART prevents COVID-19 infection and remind clients that ART should not be shared with peers).
 - Support activities that increase KP members' access to information, such as airtime for peer educators so they can provide education via mobile platforms.

- Reiterate messages such as the importance of adhering to ART or PrEP and other treatment for chronic conditions, such as opioid substitution therapy, in the context of COVID-19 (e.g., that having a stronger immune system will help individuals have less severe complications if they acquire COVID-19).
- Create alternative spaces, including on virtual platforms that safeguard privacy, where community members brainstorm together and discuss harm reduction strategies that minimize COVID-19 exposure while taking into account that many suggested prevention strategies can result in other harms (e.g., loss of food or shelter due to an inability to engage in sex work).

1.2. Support links to COVID-19-related screening and care among beneficiaries and staff

- 1.2.1. List nearby COVID-19 testing locations/options and isolation facilities, including those known to be KP-friendly places; include online resources and hotlines for COVID-19 information.
- 1.2.2. Ensure access to free or affordable COVID-19 screening, testing, and care.
- 1.2.3. Develop a protocol for how to respond to beneficiaries if they themselves, or their recent contacts, experience COVID-19 symptoms or test positive. (Refer to World Health Organization or local guidelines.) Beneficiaries being tested for COVID-19 should also be tested for HIV if their status is unknown. There is overlap between symptoms of COVID-19 and TB, so beneficiaries presenting with cough and fever, especially people known to be living with HIV, should also be screened for TB, with special precautions taken while collecting and handling sputum specimens.
- 1.2.4. Support pre-screening of HIV program clients for COVID-19 symptoms online or at the community level, including screening of contact/exposure to confirmed/suspected COVID-19 cases. Exposed individuals should be advised and supported, if need be, to self-quarantine for 14 days. If they are ART clients, they should be advised to avoid ART clinics until cleared of possible COVID-19 infection. They should be advised not to stop ART and, if necessary, to have an unexposed friend or family member collect their medicines. Adapt national tools and standards for COVID-19 screening and integrate into program communication channels (such as on the Online Reservation App) to refer clients to appropriate COVID-19 care resources/sites and away from ART facilities to protect ART staff and other ART clients.
- 1.2.5. Establish procedures to track all program beneficiaries who have COVID-19 and who may be admitted to hospital or quarantined at home in order to ensure that PLHIV with COVID-19 maintain access to ART. Also develop procedures for ART distribution at facility and community levels in alignment with infection prevention and control measures.

1.3. Address broader needs of KP members that may be exacerbated by COVID-19

- 1.3.1. Directly respond to the increase in poor mental health outcomes that arise from COVID-19 fears and social isolation.
 - Create or build on infrastructure for KP members to support one another, such as buddy systems.
 - Help KP members stay connected, including through organizing online or phone-based activities that are informative and allow for social connection.
 - Increase the mental health support available to beneficiaries through online and virtual platforms.
 - Help KP members identify positive and negative coping mechanisms.
- 1.3.2. Train health care workers on the increased risk of intimate partner violence and other forms of violence that beneficiaries may face during the pandemic and on how to document and respond appropriately to disclosures of violence.
- 1.3.3. Have health care workers continue to identify cases of violence, especially in required program approaches such as PrEP services and index testing, and help individuals who have not disclosed their HIV status or PrEP use to their partners to safely and discreetly take their medication during lockdown or shelter-in-place orders.
- 1.3.4. Provide appropriate support to beneficiaries who disclose violence (including online or phone-based first-line support). This includes enough phone/internet credit so that implementers can provide virtual psychosocial and safety planning services.
- 1.3.5. Consider asking case managers who normally provide support only to PLHIV to also track the services received by individuals who report violence, regardless of their HIV status. At a minimum, this should be done for those who are initiating PrEP.
- 1.3.6. Maintain an updated list of gender-based violence response services and make that list available to all workers. Check violence response services routinely to avoid referral to services that have been halted in light of COVID-19. For example, routinely check the functionality of hotlines and the availability of services such as post-exposure prophylaxis and emergency contraception in emergency departments before referring individuals to those services.
- 1.3.7. Engage counselors and social workers to provide mental health services, including through virtual platforms.
- 1.3.8. Provide referrals for KP-friendly legal support to beneficiaries who are victims of discriminatory targeting by police or other state actors, and support efforts to aggregate incidents and share them with duty bearers to promote accountability.
- 1.3.9. Support ongoing access to harm reduction for people who inject drugs, including access to needles and syringes and opioid substitution therapy for opioid dependence. Consider making needles and syringes available through new channels, such as pharmacies, and ensure access to safety disposal bins where needles are dispensed.

- 1.3.10. Advocate for inclusive COVID-19 support services—such as food provision to those who cannot work due to lockdowns—that are also accessible to KP members (e.g., minimize barriers related to requirements related to identification or official notice of unemployment). Keep updated lists of the services available and help individuals navigate access to these services (including food, safe housing, and child support services).
- 1.3.11. Provide guidance and tips to KP members who are deciding whether and how to engage in online programming as more activities shift to this medium. Help them decide how much information they can safely provide about themselves in online settings (e.g., what can be said in a chat with an outreach worker versus in a closed Facebook group).
- 1.3.12. Integrate into staff training, guidance, SOPs, and job aids the importance of nonstigmatizing care for anyone with COVID-19, related symptoms, or for other reasons such as stigma related to KP or HIV status. For example, refer to people affected by COVID-19 as “people who have COVID-19,” “people who are being treated for COVID-19,” or “people who are recovering from COVID-19.” Do not refer to them as “cases,” “victims,” “infected,” or other stigmatizing language that defines a person’s identity by COVID-19.
- 1.3.13. Sensitize COVID-19 health care workers on issues of stigma, discrimination, and unconscious bias against KP individuals and PLHIV and the need to provide care to these groups in a nonstigmatizing, nondiscriminatory manner.
- 1.3.14. Given the disproportionate harmful impact that restrictions to protect public health may have on KP members, advocate that they are proportionate, necessary, evidence-based, and reviewable by a court.

SUPPORTING CSO RESPONSE PLANS

Community service organizations (CSOs) are central to the HIV response globally, and the safety and health of their staff are paramount in the context of COVID-19. CSOs should be supported to consider how to respond when staff are at particular risk for COVID-19 or if they have become infected.

Considerations include:

- Establishing strong links to testing and care for staff with COVID-19 for rapid recovery
- Naming contact people to communicate with staff with COVID-19 and provide updates
- Immediate testing of potentially exposed coworkers (and others)
- Immediate communication of service disruptions due to COVID-19 to staff and beneficiaries
- Legal support provided to outreach workers and program beneficiaries if they are arrested or have other legal support needs
- Facility sanitation process
- Quarantine and work-from-home procedures for noninfected staff

1.4. Consider KP program implementer safety holistically

- 1.4.1. Work with National AIDS Control programs, ministries of health, local authorities, and other relevant parties to ensure that community-based activities are understood as pro-health and not as increasing the spread of COVID-19.
- 1.4.2. Share written permissions with peers and others doing outreach that can be presented to law enforcement and others as needed. If commodity amounts change to compensate for fewer outreach activities, provide written authorization to those delivering goods such as condoms, methadone, or ART.
- 1.4.3. Explain the evolving situation and its potential risks to outreach and other workers and describe their rights as implementers (such as the organization's commitment to provide a lawyer if workers are arrested during outreach or support that will be provided if the worker is exposed to COVID-19). Help individual workers assess their own risks (for example, due to underlying health conditions or ill relatives at home) and decide together on the level of risk workers will be asked to take on.
- 1.4.4. Consider having outreach workers share information on COVID-19 with the community beyond KPs (for example, pass out sanitizer and information on COVID-19 symptoms during outreach). This will help ensure that hard-to-reach communities receive frequent updates and up-to-date information and bolster the image of the program and its implementers, which may also improve their safety.
- 1.4.5. Recognizing that the COVID-19 pandemic and associated prevention efforts create an environment in which KP-led or KP-serving organizations may experience additional security threats, encourage local partners who have not already done so to use existing [checklists](#) to self-assess security measures already in place and identify and address any priority gaps.
- 1.4.6. Provide physical distancing and infection prevention and control guidance to all project staff and front-line staff. Ensure compliance to self-isolation and other guidance in case of exposure to other people with COVID-19 or related symptoms. Provide special guidance to project staff and front-line workers who are living with HIV.
- 1.4.7. Make mental health support available to front-line workers and project staff and encourage the use of these services, including by making mental health check-ins systematic (such as during regularly scheduled supervision). Support workers new to implementing online programs: review appropriate data management procedures, provide safety tips for working from home, and share any local laws or policies that dictate what can be said online about COVID-19. This is especially important in contexts where statements about government responses to COVID-19 can result in legal action.

2. Support safe, sustained HIV service connections

HIV programs can support safe and sustained HIV service connections by integrating physical distancing measures in line with local and national efforts. This includes connecting with clients virtually and offering convenient long-term dispensing, pick-up, and delivery options for HIV commodities, services, and medications.

2.1. Prepare programs for physical distancing

- 2.1.1. Collect or verify contact information for beneficiaries on a voluntary basis and, with permission, contact them via the medium shared (phone number, email address, and/or preferred social media). This data should be collected using a form that does not disclose KP or HIV status to help maintain confidentiality.
- 2.1.2. Tell beneficiaries and staff how information shared using online and phone-based services will be kept confidential and provide guidance on the types of information they can safely share in different online spaces.
- 2.1.3. Prepare community outreach staff (including case managers, peer educators, and navigators) to work from home or remotely; give them access to devices (such as tablets/phones) and airtime and/or mobile data plans to stay connected with their CSO, program support team, and beneficiaries in their cohort.
- 2.1.4. Prepare clinics and clinic staff to manage increased patient volume and screening. Appointment booking systems (e.g., the Online Reservation App - ORA) can help clinics manage client flow by forward triaging clients before they arrive at the clinic. Clinic staff should also use HIV risk assessments to prioritize HIV testing efforts and use COVID-19 screening to link clients to providers who offer COVID-19-related services.
- 2.1.5. Help clinics procure and use devices (tablets and smartphones) and mobile data plans to offer telemedicine services, such as providing routine counseling and pre-appointment COVID-19 screening virtually. In some settings, approval of the relevant government body is required for these measures to be put in place.
- 2.1.6. Share regular updates with beneficiaries on any policies that affect clinic operations or outreach strategies, using contact lists of outreach staff.

2.2. Continue delivery of HIV outreach services

- 2.2.1. If any physical peer outreach is still possible and advisable, reduce physical contact and large gatherings. For example, reduce frequency of outreaches, limit maximum number of participants, or increase the number of service delivery points to avoid overcrowding, and where possible, consider prioritizing clients at high risk of COVID-19 to receive virtual case management and to remain at home. Minimize touching by delivering pre-packaged prevention materials (e.g., place condoms and lubricants in paper bags and leave them at a central location for easy access).
- 2.2.2. Explore the use of [social network outreach](#) to maintain contact with beneficiaries online and reduce or end physical or hot-spot-based outreach. Leverage commonly used channels such as phone calls, SMS, and WhatsApp and other social media apps for audiences with better internet connectivity. This may require co-training outreach staff with remote experts and local skilled community members, developing

guidance and tools for safe and confidential outreach, and providing new mobile devices and airtime to conduct online outreach.

- 2.2.3. Develop new social media channels or boost existing platforms to disseminate HIV program messages, including those related to COVID-19.
- 2.2.4. Use hotlines, e-referral, or online booking platforms (e.g., [Online Reservation App](#)) to virtually link clients to HIV services, including to facility-based services and connections to ARVs, PrEP, HIV self-testing, and condoms and lubricants as relevant. Virtual referrals help avoid the need to meet clients in person. Modify clinic intake forms to record referral source instead of collecting paper referrals.
- 2.2.5. Use virtual support groups and communication channels for beneficiaries to report experiences of violence, stigma, discrimination, and economic distress to staff who are trained to respond to such disclosures. Use encrypted platforms for communication and explain to participants the risks and rules for maintaining privacy and security.
- 2.2.6. Support ongoing access to condoms, lubricants, needles and syringes, and other sexual health and family planning commodities. Adapt distribution and supply systems to ensure an uninterrupted supply of prevention commodities at community distribution points, including by providing multimonh dispensing to allow for less frequent pickups (where stock allows).

2.3. Continue delivery of HIV testing services

- 2.3.1. Expand options for HIV testing services that will reduce clinic walk-ins and physical contact, such as HIV self-testing, facility pick-up, peer delivered, at-home testing, home delivery, and testing at private labs.
- 2.3.2. Consider home blood collection for relevant testing services.
- 2.3.3. Expand the use of social network strategies, such as the enhanced peer outreach approach, for creating demand for HIV testing, noting that online social networks may expand during physical distancing.

VIRTUAL CONNECTING WHILE PHYSICAL DISTANCING

Going Online is a framework and set of approaches for HIV programs to conduct outreach and service delivery through online and mobile platforms.

Support continuation of HIV services during the COVID-19 pandemic with these approaches:

- Maintain contact with beneficiaries and reach new audiences with social network outreach.
- Support PLHIV through virtual case management.
- Screen and consult with patients virtually using telemedicine to reduce unnecessary clinic visits.
- Manage outreach, referrals, clinic reporting, and case management with electronic data systems (using the [Online Reservation App](#)).

Learn more:
fhi360.org/goingonline

- 2.3.4. Ensure the continued capacity to perform confirmatory HIV testing for clients screened in the community and provide immediate access to ART to those diagnosed HIV positive.

2.4. Continue delivery of ART, PrEP, and HIV care services

- 2.4.1. Advise clients with influenza-like illness/COVID-19 symptoms not to come to the ART clinic. If appropriate, they can be referred for COVID screening or send a relative to pick up medications.
- 2.4.2. Where possible, ART clinic staff should not be assigned to direct COVID patient care in order to avoid exposure, infection, and possible quarantine of the entire ART clinic staff.
- 2.4.3. Clinics should rapidly scale up multimonth dispensing (MMD) of ART, PrEP, and other comorbidity medications for clients, including TB preventive therapy, anti-TB drugs, and cotrimoxazole (CPT). For ART, consider establishing 3- and 6-month MMD options immediately if stocks allow, so clients do not come to the clinic during possible peak COVID-19 transmission periods. Where stocks are limited, consider a priority list of clients who should be offered MMD. Programs should work with the relevant logistics and supply chain management agencies to ensure adequate stock for all necessary medications.
- 2.4.4. Consider differentiated service delivery through community initiation and refill of ART and PrEP. Clients who are currently on ART or PrEP should be offered MMD, and follow-up for side effects should be conducted virtually using phones, SMS, etc. All clients on PrEP should also continue to receive adherence support at the community level as well as from service providers using virtual platforms.
- 2.4.5. Advocate for and support revision of government policy to permit MMD for more clients on ART and PrEP, including relaxing the criteria for eligibility for MMD.

MAINTAINING ACCESS TO ART FOR PEOPLE LIVING WITH HIV

Ensuring continued access to ART for people living with HIV is critically important for maintaining gains in global HIV response during the COVID-19 pandemic. Priority actions for programs include:

- Support fast-tracked and emergency policies for full implementation of 3- and 6-month MMD of ART as recommended by [UNAIDS](#) to allow clients to maintain ART adherence while health facilities are overwhelmed by COVID-19 cases and when lockdowns and social distancing limit ART refills. This may require revising forecasts and placing advance orders for ARVs.
- Train case management and peer navigator teams to support clients with uptake of MMD of ART.
- Adequately supply case management and peer navigator teams with tools and devices to maintain contact with all beneficiaries living with HIV to provide virtual check-ins and support their continued access to ART.

- 2.4.6. Update training and communications with health facility staff, peer navigators, and counselors on the importance of immediate linkage to ART for clients newly diagnosed HIV-positive.
- 2.4.7. Establish alternate ART distribution plans with clear SOPs if clinics and drop-in-centers (DICs) are unable to function because staff are sick or quarantined. Examples include decentralized community distribution, pharmacies, private clinics, and home delivery (if acceptable to beneficiaries and can avoid stigma). Programs may also consider leveraging treatment support groups where one member can collect the multimonth supplies for several beneficiaries. Processes for referral to new distribution sites should be tested ahead of time. The handling of confidential medical records, ARV stocks, proper recording keeping, and communication with potential confused or distraught clients will require careful planning.
- 2.4.8. Create a directory of ART facilities available for clients in case they are unable to access ART at preferred DICs (e.g., health centers, other DICs, or clinics within the areas supported by the DIC). A plan for shifting ARV stocks, records, and communication with ART patients is essential. When a facility's operations are reduced or stopped, communicate this immediately to affected beneficiaries.
- 2.4.9. Help peer navigators/case managers continue supporting HIV-positive KP individuals while enhancing their safety and protection from COVID-19 through use of phone-based support, virtual case management software, and online platforms (such as the Online Reservation App).
- 2.4.10. Operationalize other adherence support measures such as the use of text messaging, online case management, etc.
- 2.4.11. Consider delaying routine VL testing until the capacity of laboratory services normalizes (but continue to provide ongoing support for adherence). Certain groups of PLHIV should be prioritized for VL testing during this time. They include those who develop opportunistic infections, those with suspected treatment failure after enhanced adherence support, those who are yet to be virally suppressed, and pregnant women.
- 2.4.12. Consider systems for VL sample collection at the community level such as the use of dry blood spot, home collection, and testing at private facilities/laboratories.
- 2.4.13. Prioritize VL testing for unstable clients, especially those who were recently initiated on ART but eligible for VL testing, and those with adherence challenges.

2.5. Promote access to essential wrap-around services

- 2.5.1. Since TB and COVID-19 may have overlapping symptoms, programs should consider screening and testing for both infections, especially in settings with high prevalence of TB. Depending on the outcome of the screening, clients should be linked to appropriate facilities for further diagnostic work-up and management. Community, clinic, and laboratory staff should take extra infection control precautions while collecting and handling sputum from those who may have COVID-19.
- 2.5.2. PLHIV who have TB should be promptly initiated on TB treatment and, if not already on ART, should be commenced on ART as soon as possible.

- 2.5.3. People newly diagnosed with HIV who have no symptoms of TB should be given a course of TB preventive treatment, which is proven to reduce TB incidence and mortality among people living with HIV. If possible and if there are no adherence issues, such clients should be considered for multi-month dispensing of TB preventive therapy.
- 2.5.4. All PLHIV already on TB treatment should continue to access their treatment and should avoid exposure to COVID-19 both in the community and facilities. Such patients should be considered for MMD of anti-TB medications. As much as possible, try to avoid face-to-face support (usually a part of directly observed therapy) by leveraging virtual support systems.
- 2.5.5. As much as possible during the COVID-19 pandemic, help female program beneficiaries who do not wish to become pregnant access family planning services. Provide MMD of oral contraceptive pills and condoms for clients who choose those methods. For clients who use or desire a long-acting contraceptive method, provide them with an updated list of facilities where they can access that service.
- 2.5.6. Help transgender program beneficiaries limit disruptions to gender-affirming treatments, including hormone replacement therapy.
- 2.5.7. For programs that cater to people who inject drugs, consider offering extra supplies for beneficiaries in case of service closures; the supplies include syringes, naloxone, and harm reduction equipment for safer smoking, snorting, and injecting drug use.

MAINTAINING ACCESS TO HARM REDUCTION SERVICES FOR PEOPLE DEPENDENT ON OPIOIDS

Ensuring continued access to harm reduction for people who inject drugs and opioid substitution therapy for people dependent on opioids is critically important for maintaining gains in global HIV response during the COVID-19 pandemic. Priority actions for programs include:

- Support fast-tracked and emergency policies for implementing take-home dosages of methadone or buprenorphine for clinically stable beneficiaries while health facilities are overwhelmed by COVID-19 cases and when lockdowns and social distancing limit daily supervised dispensing.
- Support provision of sufficient prevention commodities, including needles and syringes and naloxone to prevent HIV infections and fatal opioid overdose.
- Train case management and peer navigator teams to support clients with uptake of take-home opioid substitution therapy medications.
- Adequately supply case management and peer navigator teams with tools and devices to maintain contact with patients and support their continued access to opioid substitution therapy.

- 2.5.8. For opioid substitution therapy programs that cater to people dependent on opioids with maintenance methadone or buprenorphine, support more flexible dispensing modalities such as take-home dosages to reduce the burden on health care services. Develop mechanisms to monitor overdosing and diversion of opioid substitution therapy.
- 2.5.9. Advocate for and support revision of government policy to permit take-home dosages of methadone or buprenorphine for more clients on opioid substitution therapy, including relaxing the criteria for eligibility

3. Monitor to ensure continuity of services and improve client outcomes

Country programs will need to adjust their monitoring and evaluation (M&E) systems to allow for continued monitoring of HIV service delivery and to monitor the impact of COVID-19 on HIV programs and beneficiaries.

3.1. Prepare strategic information systems for physical distancing

- 3.1.1. Ensure that all sites and outreach workers have adequate supplies of the relevant data collection tools.
- 3.1.2. Consider scaling up the use of online and virtual data collection and reporting tools for outreach and clinical staff such as eCascade, the DHIS2 tracker tool, and the [Online Reservation App \(ORA\)](#).

3.2. Use strategic information systems to monitor the impact of COVID-19 on programs and beneficiaries

- 3.2.1. Depending on the services that are affected, a small set of indicators that can quickly demonstrate changes in service availability, uptake, and outcome among KPs should be tracked. This could be done using the standard indicators or additional ones that are able to quickly detect changes in the health of the project, the staff, or individual beneficiaries. For PEPFAR-supported implementing partners, potential indicators that can be used for this purpose include: KP_PREV, TS_TST, TST_SELF, HTS_TST_POS, TX_NEW, and PrEP_NEW. For non-PEPFAR-supported countries, indicators from the [UNAIDS Global AIDS Monitoring \(GAM\) 2020](#) can be used, including indicators 3.4 to 3.10, 3.13, 3.15 to 3.19.
- 3.2.2. Use the weekly data collected for high frequency reporting to track trends on service uptake.
- 3.2.3. Track key local changes such as new policies that affect implementation (e.g., those affecting movement of implementers or the number of people who can be gathered for any event, such as a training) or the interruption of services, including closure of facilities as a result of COVID-19.
- 3.2.4. Use security incident logs to capture issues faced by implementers during outreach or at facilities.
- 3.2.5. Update tools used to record incidents of violence against beneficiaries to explicitly include COVID-19 related abuses.

- 3.2.6. Ask CSOs about challenges faced by their staff on a weekly basis and use these data for immediate decision-making (e.g., the need for more laptops as all staff begin to work from home).
- 3.2.7. Where community monitoring systems exist, advise clients to use those mechanisms to provide feedback on services and report stockouts of medicines, service disruptions, and other access issues.
- 3.2.8. Exchange knowledge with other implementers and countries; share information about effective mitigation solutions and lessons learned from implementation experience, resources, and technical expertise.

The considerations set forth in this document are intended to guide immediate measures that programs can put in place to mitigate the impact of the COVID-19 pandemic on key-population-focused services, staff, and beneficiaries. As the pandemic evolves, so will the needs of HIV programs and the people they serve. This guidance will be updated over time to support the safe, sustained delivery of HIV services in the context of the COVID-19 pandemic.

Additional resources

1. AVAC (2020). COVID-19 resources for Advocates. <https://www.avac.org/covid-19-resources-advocates>
2. CDC (2020). Stress and Coping: <https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html>
3. CDC (2020). Coronavirus (COVID-19): <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
4. Higher Ground Harm Reduction, Reynolds Health Strategies, Harm Reduction Coalition, and Vital Strategies (2020). COVID-19 Guidance for People Who Use Drugs and Harm Reduction Programs: <https://harmreduction.org/miscellaneous/covid-19-guidance-for-people-who-use-drugs-and-harm-reduction-programs/>
5. IAS (2020). COVID-19 DSD Resources: <http://www.differentiatedcare.org/Resources/Resource-Library/COVID-19-DSD-resources>
6. IDSA and HIVMA (2020). COVID-19: Special Considerations for People with HIV: <https://www.idsociety.org/globalassets/covid-19-special-considerations>
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7. ITPC (2020). Personal and Community Guidance—Coronavirus Disease (COVID-19): <http://itpcglobal.org/resource/personal-and-community-guidance-coronavirus-disease-covid-19/>
8. MPACT (2020, March 20). 10 tips for LGBT advocates worldwide. <https://mpactglobal.org/covid-19-10-tips-for-lgbti-advocates-worldwide/>
9. UNAIDS (2020). What people living with HIV need to know about HIV and COVID-19.: <https://www.unaids.org/en/covid19> https://saafrica.org/new/wp-content/uploads/2020/03/hiv-and-covid19_infographic_A3_en.pdf
10. UNAIDS (2020). Rights in the time of COVID-19. Lessons from HIV for an effective, community-led response.: https://www.unaids.org/sites/default/files/media_asset/human-rights-and-covid-19_en.pdf
11. UNAIDS (2019). Global AIDS Monitoring 2020.; https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
12. UNODC (2020). COVID-19 HIV prevention, treatment, care and support for people who use drugs. https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Infographics_1.pdf
13. WHO (2020). Country & Technical Guidance - Coronavirus disease (COVID-19) <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>
14. WHO (2020). Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected. [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125)
15. WHO (2020). Preparedness, prevention and control of COVID-19 in prisons and other places of detention. <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2020/3/preventing-covid-19-outbreak-in-prisons-a-challenging-but-essential-task-for-authorities>.
16. WHO (2020). Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19). https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf
17. WHO (2020). Mental health and psychosocial considerations during the COVID-19 outbreak. https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_10
18. WHO (2020). Information Note Tuberculosis and COVID-19. https://www.who.int/tb/COVID_19considerations_tuberculosis_services.pdf
19. WHO (2020). Coping with stress during the 2019-nCoV outbreak. https://www.who.int/docs/default-source/coronaviruse/coping-with-stress.pdf?sfvrsn=9845bc3a_2