PEPFAR Technical Guidance in Context of COVID-19 Pandemic

In January 2020, a novel coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), was identified as the causative agent of an outbreak of viral pneumonia centered in Wuhan, Hubei, China. The disease caused by this virus is called coronavirus disease 2019 (COVID-19). The disease is now widespread, and every country in the world has reported cases. https://who.sprinklr.com/. Many PEPFAR countries are experiencing third and fourth waves of disease, vaccine roll-out has been slow, colleagues have been personally affected, and PEPFAR programs and beneficiaries are being impacted. In this context PEPFAR programs need to adapt to the local situation. The priority remains program continuity for both prevention and treatment services and the provision of services in a way that is safe for both providers and recipients of services and our guidance reflects that priority.

PEPFAR continues to leverage its investments in USG personnel, implementing partners, and health infrastructure, including labs, health facilities, and supply chains as well as human resources for health for HIV and, as possible, for health security needs. PEPFAR has specifically and continually strengthened more than 3,000 laboratories, 28 national reference laboratories, 70,000 health care facilities, and over 290,000 health care workers – the vast majority in Sub-Saharan Africa. Partner countries have leveraged these robust health care delivery, data, diagnostic, surveillance, and pandemic response systems and capacities to swiftly and effectively prevent, detect, and respond to various other outbreaks, such as Ebola, avian flu, cholera, and COVID-19, while advancing HIV efforts. COVID-19 is the latest challenge, but PEPFAR investments ensure that pandemic preparedness capacities are resilient, responsive, and enduring for countries to sustain epidemic control of HIV.

Widespread disturbances of international travel and shortages of medical supplies have led to challenges in the provision of medical care. In the areas hardest hit, medical facilities have been overwhelmed by large numbers of COVID-19 patients. Stay-at-home orders and staff illness provide additional challenges. Throughout the COVID-19 pandemic, PEPFAR has remained committed to continuing essential HIV prevention and treatment services, while maintaining a safe healthcare environment for clients and staff. In order to meet our commitment to uninterrupted care and treatment for PLHIV and the prevention of deaths among PLHIV due to HIV associated co-morbidities, PEPFAR has been committed to adapting HIV services, so that PLHIV have the best possible outcomes within the context of stretched healthcare systems.

Nearly two years into this pandemic, we still have much to learn but we also have a several tools available to prevent COVID-19 transmission, severe COVID-19 disease and death. Many government, commercial, health and social activities have resumed.   PEPFAR recognizes the dynamic and unpredictable nature of the COVID-19 pandemic; ongoing case-by-case and context-specific assessments will be essential to determine when activities should be resumed, modified or even paused again. Context-specific factors that may be used to help decision making include case rates, lockdowns, school closures and USG mission status. Safety of staff and clients should be paramount in all planning by USG country teams and their partners. Some COVID-19 spurred innovations in HIV service delivery were client-centered, effective and resource-efficient; such innovative approaches should be incorporated into routine programming. We know that COVID-19 caused deferral of HIV testing, treatment and prevention services, and so HIV services will not only need to be resumed, adapted and accelerated in order to make up for that deferred care and get back on the robust path to epidemic control.

The evidence on the impact of COVID-19 amongst PLHIV is emerging. A growing body of evidence suggests that PLHIV are at risk for severe COVID-19 and death.   We will continue to monitor the science and will communicate important advances. HIV virological suppression is a critical intervention that improves the health of all PLHIV, and PEPFAR is committed to ensuring that PLHIV have uninterrupted care.

Technical guidance is provided here for a variety of PEPFAR issues and will be updated routinely as the situation evolves.

Contents

1. Guiding principles for the provision of services in PEPFAR-supported countries during COVID- 19 Pandemic

- ***Protect the gains in the HIV response:***
- Continuity of treatment and prevention services for PLHIV and those at risk for HIV is the foundational principle guiding PEPFAR programs during the COVID-19 pandemic. Several strategies are available and detailed in this document. Chief among them is separating drug delivery from clinical care and expanding the use of multi-month dispensing and decentralized delivery of medication. The COVID-19 pandemic has highlighted the need to focus attention on site safety. COP 21 guidance emphasizes the importance of and the need for robust implementation of infection prevention and control (IPC) at PEPFAR supported health facilities.   All PEPFAR programs should incorporate the implementation and monitoring of IPC interventions (i.e., administrative, environmental and personal protection) as an integral component of quality HIV care services at all PEPFAR supported facilities.   All implementing partners should have dedicated resources to this activity and should incorporate them into their routine QI/QA processes.
- The safety of PEPFAR-supported staff must be assured. Programs have learned how to provide client services safely and should be able to access recommended PPE more readily. If client services cannot be adapted to be performed safely, they should not be performed and the SGAC Chair/PPM should be informed.
- Continue leveraging the country health systems and infrastructure supported by PEPFAR to strengthen country COVID-19 response. PEPFAR has been proactively leveraging its platform to support HIV while also addressing COVID-19 screening, diagnostics, infection, and vaccine readiness and administration in the best interest of HIV clients and beneficiaries.
- Extending flexibility to the PEPFAR country teams within PEPFAR's mandates and authorities to the extent possible to take into account COVID-19--related needs, in the context of seeking to achieve the best possible HIV outcomes.

- ***Reduce risk of transmission of COVID-19 among clients served by PEPFAR and PEPFAR-supported staff:***
  - All PEPFAR programs are under Chief of Mission authority; therefore, country teams and implementing partners should follow Embassy Front Office direction on all programming that requires personnel movement.

  - In the setting of community transmission of COVID-19, particularly during escalations of transmission, minimizing patient contact with health facilities reduces risk to recipients of care and reduces the burden on these facilities.

  - Community programming should support social distancing and the use of alternative methods of communication to maintain contact and provide support to enrollees. These methods include virtual and digital platforms such as calls, SMS, social media, WhatsApp. Plans should be in place to adapt programming should service be disrupted. Most community programming that requires in-person contact can be safely resumed.

o   Group-based activities should follow local guidelines for large gatherings. In-person group-based activities may need to be adapted to assure safety of the participants but should be safely resumed as soon as possible.

● *In consultation with host governments, PEPFAR Operating Units (OUs) have flexibility to determine how best to continue to serve clients with HIV prevention and treatment services in areas affected by COVID-19 using the FAQs as a guide.*

2.   Today's Updates

• *Information on vaccine safety p.7-8*

• *Updated information about IPC p 51-52*

• *Updated links on vaccine safety pp 60-62*

• *Highlighting link for CSO field observations and feedback on this guidance – see* https://www.surveymonkey.com/r/V7RJW59

3.   Role of PEPFAR Coordination

What is the role of PEPFAR Coordination Offices in the larger USG COVID response?

PEPFAR Coordination Offices have stepped up to serve our broader U.S. interests during the COVID-19 disruption and we commend them for exceptional efforts under very trying circumstances. PEPFAR Coordination Offices should remain acutely focused on coordination of the PEPFAR program; this is the congressional appropriation for which PCOs are held accountable, and S/GAC depends on the oversight by the PEPFAR Coordination Office during this time. Beyond any Chief of Mission directive, involvement in the larger USG COVID response should be based on and limited to the intersection of HIV, HIV/TB and COVID-19. PEPFAR Coordination Offices should stay abreast of the ways in which PEPFAR program investments are being leveraged for the larger USG COVID-19 response and potential adaptations necessary to implement the PEPFAR program safely in an environment of COVID-19.

4.   Basic information about COVID-19

How is COVID-19 spread and what can people do to protect themselves and others in community and other non-healthcare settings?

The best way to prevent illness due to COVID-19 is to avoid being exposed to the virus, to get vaccinated and to encourage those in your household and community to also get vaccinated if eligible.

The virus spreads mainly from person-to-person and especially between individuals who are in close contact (within 1-2 meters) from infected respiratory droplets produced when an infected person coughs, sneezes or talks. COVID-19 may be spread by people who are not showing symptoms.

Personal Protective Behavior refers to taking personal responsibility for one's own behavior and not endangering anyone else. Separation from other people, respiratory hygiene,(e.g., sneezing/coughing into disposable tissue or elbow, hand hygiene (see links under hand hygiene), close fitting face coverings which

cover the nose and mouth, and avoiding large gatherings are all critical interventions each person can take to prevent the spread of COVID-19.

In the health care setting health care workers should wear a medical mask continuously, from the beginning of their shift to the end. This is called **universal masking**. All visitors and clients of the facility should wear face coverings as described above. This is called **universal source control** and is of critical importance in reducing the spread of COVID-19.

Are people with HIV at greater risk for severe COVID-19?

An increasing body of evidence indicates that individuals with HIV who acquire SARS-CoV-2 infection are at greater risk for severe COVID-19. A July 2021 WHO report suggests that HIV is an independent risk factor for severe or critical illness at hospital admission and in-hospital mortality. It remains less clear how much of this higher risk is due to comorbidities, HIV-related immunosuppression, and other HIV-related factors (e.g. socioeconomic), Individuals with advanced HIV disease appear to be at greater risk for severe SARS CoV-2 (see here). Individuals with HIV and severe COVID-19 may be at greater risk for death[1] Well established risk factors for severe COVID-19 include older age, obesity, diabetes and hypertension. It is as yet unknown whether treatment of these comorbidities mitigates risk for severe COVID-19. Both the WHO and US CDC have identified PLHIV as a group at higher risk for severe COVID-19 and vaccine receipt is recommended. See here and here.

Can people with HIV receive the COVID-19 vaccine?

Yes. All persons with HIV must be offered SARS-CoV-2 vaccines when they become available, regardless of CD4 count or viral load level. Safety and efficacy data are emerging for the current licensed vaccines; PLHIV do not appear to be at increased risk for vaccine related adverse events. A protective, robust, and durable immune response in PLHIV has been documented for the ChAdOx1 nCoV-19 (AZD1222) manufactured by Astra-Zeneca, mRNA-1273 (Moderna) and Pfizer/BioNTech BNT162b2 vaccines. See here, and here. Information for recipients of care may be found here.

More information can be found here and here.

Is there a new coronavirus circulating?

Viruses commonly mutate over time, which can change some of their characteristics-for both good and bad. Since December 2020, several independent variants that appear to spread more quickly and easily than other strains (i.e., more transmissible) have been reported. These variants were originally detected in samples from the United Kingdom (Alpha formerly called B.1.1.7), South Africa (Beta, formerly called B.1.351), Brazil (Gamma formerly called P.1) and India (Delta formerly called B.1.617). Most recently the Omicron variant has been identified by South African scientists, named a variant of concern by the WHO and is rapidly spreading. Twenty-two African countries have reported this variant. Omicron appears to be significantly more infectious than previous strains and has the potential to cause significant disruptions in health care systems. Early experience, however, is reassuring about Omicron's virulence and clinical course.

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[1] Patient care and clinical outcomes for patients with COVID-19 infection admitted to African high-care or intensive care units (ACCCOS): a multicentre, prospective, observational cohort study. Lancet. 2021;397(10288):1885-94. doi:10.1016/s0140-6736(21)00441-4.

Vaccine efficacy against variants is different across each of the vaccines and these data continue to emerge. All of the available vaccines provide protection against severe disease and death including against the Omicron variant. The US FDA and the National Institutes of Health are collaborating to study the performance of rapid tests to detect the Omicron variant (see here). These tests hold significant promise and the effort to evaluate and implement them is supported by the Africa CDC and the African Society for Laboratory Medicine. More information can be found here and here.

Maximizing vaccine coverage remains the best way to prevent the emergence of new variants and attention to personal protective behaviors remains critical to mitigating the spread of SARS-CoV2, including these variants and any variants that may arise in the future. It will be important to continue monitoring for new information about these and other variants, including potential impact of variants on transmissibility, reinfection risk, virulence (i.e., greater ability to cause severe illness), performance of diagnostic tests and vaccine efficacy.

More information can be found from UNAIDS here and from CDC here and from WHO here.

What about therapeutics for individuals with COVID-19?

The US Food and Drug Administration (FDA) has recently granted Emergency Use Authorization for two oral antivirals for the treatment of COVID. Paxlovid (nirmatrelvir/ritonavir) and molnupiravir can be given to non-hospitalized, COVID-confirmed, and high-risk patients to reduce the risk of hospitalization and death. Both Merck (molnupirivir) and Pfizer (Paxlovid) have initiated voluntary licenses with the Medicine Patent Pool, and in the case of Merck, bilateral licenses with Indian generic companies. These agreements could make generic products available for low- and middle-income countries in the next 6-9 months.

5. COVID-19 vaccine guidance

PEPFAR is moving with urgency to support country efforts to administer COVID-19 vaccine doses by strategically utilizing existing PEPFAR-supported health system capabilities. A cable was issued 8/10/21 (21 STATE 82870 "PEPFAR Guidance for Support of COVID-19 Vaccine Administration") to USG PEPFAR teams providing broad guidance on how this might occur. Further details are provided here in the COVID-19 technical guidance.

How can PEPFAR programs best support COVID vaccination efforts?

Efforts to improve vaccine uptake may be supported by PEPFAR funding to help ensure continuity of services for PEPFAR programs and beneficiaries and PEPFAR service delivery platforms. Vaccine support should follow country guidance for vaccine eligibility and priority populations while including PLHIV and other PEPFAR clients and beneficiaries. Existing PEPFAR-supported infrastructure and health systems (e.g. supply chain management, health information systems, and human resources) should be leveraged to support countries in COVID-19 vaccination, planning and administration. PEPFAR partners are also encouraged to leverage opportunities to improve vaccine demand at the time of provision of other services. As an important part of demand creation, staff and client safety, and to enhance vaccine confidence, PEPFAR supported staff are encouraged to get vaccinated.

PEPFAR will NOT be providing additional funding or resources to partners for vaccine-related efforts. PEPFAR support of vaccine administration should not compromise HIV services, and partners are expected

to fully meet their HIV program targets within their approved COP budget. PEPFAR-supported COVID vaccination efforts must explicitly complement national vaccine plans and follow national COVID-19 vaccine policy for eligibility and prioritization.

PEPFAR funds can NOT be used to: 1) establish new, vaccine-specific activities that are outside the usual HIV program; 2) purchase or procure COVID-19 vaccines; 3) hire new staff or health workers and; 4) establish new PEPFAR-supported sites or work outside of existing PEPFAR-supported sites.

Please see several examples below of vaccination activities that ARE allowed and encouraged under PEPFAR. These are illustrative examples, and thus should not be construed to be exhaustive.

- PEPFAR-supported nurses and data clerks may help coordinate logistics and participate in a national vaccine campaign at the health facility (or at a community site within the catchment area) where they normally provide HIV care and treatment services. Beneficiaries of this national vaccine campaign should include PLHIV and other HIV at-risk clients that the health facility normally serves. However, these PEPFAR-supported nurses and other staff must ensure their HIV program clients continue to receive all expected HIV services and assistance; participation in a vaccine campaign is not a valid reason for delay or decrease in provision of HIV services.

- PEPFAR-supported staff may contribute to vaccine administration efforts to all types of patients during the workday, as long as there is no adverse impact on delivery of HIV services. This is particularly applicable in situations where PEPFAR supports staff for additional HIV services in a site where other (often MoH) staff provide HIV and non-HIV services. This is also an example of how synergies can be gained through the PEPFAR platform and how vaccination can be integrated into other HIV prevention or treatment service delivery.

- Understanding the tremendous amount of human resources needed for vaccination, PEPFAR-supported staff may directly administer vaccine shots, within existing PEPFAR-supported locations.

- PEPFAR-supported supply chain systems may be utilized to provide technical assistance, management, storage, and distribution (but not purchase) of vaccines and ancillary supplies (e.g. diluents, syringes).

- PEPFAR partners who normally support health information systems for HIV programs may provide technical assistance in establishing electronic platforms for tracking vaccination coverage. However, they may not hire new staff that will be primarily devoted to developing data systems and tracking vaccine uptake, and full support to HIV programs must be maintained.

- COVID-19 vaccine information may be incorporated into any IEC materials or messaging intended for PLHIV or PEPFAR beneficiaries. For example, as part of normal outreach activities to key populations, partners may address fears and misconception of vaccines.

What other resources are available to help with COVID-19 vaccine demand creation?

We have compiled a list of resources that may be helpful at the end of this document.

What is PEPFAR's guidance on safe delivery of COVID-19 vaccines?

- There are a number of resources available to ensure the safe delivery of vaccines. The WHO has an online vaccine training course (Welcome - WHO Vaccine Safety Basics (vaccine-safety-training.org). Adverse events are rare with the current vaccines, but specific guidance on the management of

anaphylaxis and monitoring for vaccine adverse events is included at the end of this document in section 23.

- The WHO has provided guidance on IPC for COVID-19 vaccine delivery. Aide-memoire: Infection prevention and control (IPC) principles and procedures for COVID-19 vaccination activities (who.int) In brief, standard precautions with the addition of COVID-19 adaptions including mask use should be followed. A clean, hygienic and well-ventilated environment with appropriate waste management and adequate spaces that facilitate best IPC practices are required. Hand Hygiene should be performed between each client, before putting on and removing PPE and between each vaccine administration.   The use of gloves does not obviate the need to perform hand hygiene. The application of alcohol based hand rubs on gloved hands is strongly discouraged.

- The use of safety-engineered injection devices is preferred. If these are not available, sterile single-use syringes and needles may be used.

- If multidose vials are used, a sterile needle should be used every time the septum is pierced.

6.   Human Resources for Health (HRH)

Can PEPFAR funds be used to pay for COVID testing for PEPFAR staff (HRH) to ensure continuity of HIV services?

PEPFAR IPs may use funds from their PEPFAR program management budgets to pay for COVID-19 testing, test kits and testing supplies for the purpose of providing COVID testing for PEPFAR-supported IP staff (HRH) as necessary to ensure safe, uninterrupted delivery of HIV services.

The use of PEPFAR funds for this purpose would be subject to the usual agreement conditions including, OU Agency lead and AOs/COs or project officer approval. IPs should follow local policies, guidelines, and SOPs for when such testing is indicated.

Can PEPFAR-supported health workers support vaccination campaigns?

Yes, per guidance/cable issued in summer 2021. PEPFAR-supported health workers are permitted to support vaccination campaigns, including (but not limited to) administering vaccinations, supporting demand generation, or supporting vaccine supply chain logistics. Demand generation and attending to supply chain logistics are strengths in PEPFAR's HIV prevention and treatment programs. Now, using ARPA funds these tools have demonstrated effectiveness for COVID-19 prevention. PEPFAR-supported vaccination efforts should not compromise the delivery of services to our HIV clients. For more information on this, please see Section 5: COVID-19 Vaccine Guidance.

How should PEPFAR partners approach staffing for resuming services?

Over the past several months, PEPFAR programs have rapidly modified their staffing and service delivery models to maintain essential HIV treatment and prevention services and support the local COVID response as possible. PEPFAR has continued to deliver essential HIV services through reconfigured health provider teams, advanced task-sharing for essential HIV services, and repurposed or redeployed staff. PEPFAR-supported staff have been able to meet clients' needs despite challenges including health worker absenteeism due to quarantine, COVID infection and/or overall social disruption.

Countries may move through various states of opening and shutdowns, depending on the pandemic's path. PEPFAR programs will need to remain flexible in their management of the health workforce, with the safety of health workers and clients remaining the highest priority.

 PEPFAR programs should resume treatment and prevention activities if they can be performed in compliance with national government and health authority guidance, and safely, with appropriate social distancing and other modes of protection to minimize transmission of COVID-19.   If services can be performed PEPFAR programs should remain committed to supporting the safety of PEPFAR-supported HCWs. Programs should procure sufficient health worker supplies, including PPE, performing HIV services delivery safely. PEPFAR-funded staff hired through the MOH will be required to follow government policies for resuming work and PEPFAR programs should support such staff to do their work safely. PEPFAR-supported cadres should continue to follow host government guidance on conducting home visits while using strategies to limit levels of in-person interactions in order to continue to minimize risk of COVID-19 transmission. To the extent possible, PEPFAR programs should continue the use of community-based services and telehealth to minimize risks to HCWs.

As the response to the COVID-19 pandemic continues, PEPFAR programs should continue to stay abreast of health worker challenges and constraints and continue to track changes made to HCW staffing. PEPFAR programs should have contingency staffing plans in place to support rapid adjustments in case of additional lockdown scenarios, staff shortages due to staff illnesses, or increases in local COVID case rates.

As services reopen, what are the recommended actions if there are any additional diagnosed cases of COVID-19 among health workers?

As detailed above, COVID-19 vaccination should be encouraged in PEPFAR supported staff. PEPFAR programs should make all efforts to protect community- and facility-based HCWs in the provision of services to clients. This should include implementing procedures in facilities to minimize risk to health workers in patient care areas and staff areas.

Universal source control with face coverings for all, and either universal or targeted continuous medical **continuous medical masking** for health care workers (depending on the transmission scenario), and hand hygiene (see section 20) are critical interventions to prevent the spread of COVID-19 in healthcare settings. These measures have been documented to prevent transmission of COVID-19 to health care workers[2].

What is the difference between isolation and quarantine?

Isolation refers to the practice of separating people who have disease until they are no longer infectious. Quarantine refers to separating people who have been exposed to an illness so that they do not spread the disease.

What is an exposure in the health care setting?

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[2] Wang X, Ferro EG, Zhou G, Hashimoto D, Bhatt DL. Association Between Universal Masking in a Health Care System and SARS-CoV-2 Positivity Among Health Care Workers. JAMA: the journal of the American Medical Association. 2020.

With respect to workplace exposures, the CDC defines exposure in the health care setting as cumulative duration of 15-minutes over a 24-hour period with an infected individual without appropriate PPE or source control (see here).

National guidelines should be followed for the management of health workers who were confirmed to be exposed to COVID-19.

When should isolation end for HCW who test positive for COVID-19?

Both the WHO and the CDC have recommended time-based criteria for terminating isolation in individuals who test positive for COVID-19. Time based criteria are also recommended for health care workers who have COVID-19, but testing may shorten the period of isolation. Note that RT-PCR for SARS CoV-2 may remain positive after the period of infectiousness is over. Those with severe COVID-19 illness and those who are immunocompromised require exclusion from the workplace for longer (see here).   The WHO has developed detailed guidance on management of HCW infection. Of note, they recommend that asymptomatic health care workers with a positive test may return to work 10 days after their last positive test.

Clinic closures pose a risk to clients and in most cases, an isolated case of COVID-19 should not prompt clinic closure. Clinic closures may be warranted if there is a cluster of cases, especially if associated with a breach of infection prevention and control procedures may warrant clinic closure. Staff absenteeism because of illness or quarantine due to high-risk exposure may also require suspending services until there are sufficient staff to provide safe and effective care.   Please see FAQ (How do we prepare for clinic closures or disruption of services related to COVID-19?) for suggestions on how to ensure continuity of care should clinical services be suspended. Guidance on disinfection can be found in the IPC section (here) and the associated links.

What should the role of PEPFAR programs be in ensuring testing of exposed or symptomatic PEPFAR-supported health care workers for COVID-19?

COVID-19 testing for HCWs exposed to COVID-19 or with symptoms concerning for COVID-19 can be an important tool in detecting and preventing transmission of COVID-19 in healthcare settings.

Local and national guidelines should be followed for COVID-19 testing, contact tracing and quarantine. PEPFAR programs can facilitate development and dissemination of guidelines that provide specific policies on the use of COVID-19 testing in symptomatic and exposed health care workers that are consistent with published guidance. Where testing is limited, and where there is community transmission the WHO recommends prioritizing HCW.

If such policies exist but are not being properly implemented at PEPFAR-supported facilities country teams should discuss with host governments and inform country chairs. This is an evolving area, and the following documents may be helpful from CDC and WHO.

What training should be provided to PEPFAR HCW to continue to respond to HIV in the context of COVID-19?

PEPFAR-supported HCWs should receive regular refresher training in Infection Prevention and Control (IPC) to protect themselves and PLHIV patients from COVID-19, TB and other infections. While delivering HIV services, all HCWs should be equipped to provide COVID-19 risk communications to at-risk populations and PLHIV. As appropriate to their HIV service delivery role, HCWs should be trained to screen PLHIV and their

household members for COVID-19 & TB and refer based on national guidelines. HCW should be provided with up-to-date in-country COVID-19 guidance and case referral information (hotlines, facilities, etc.)

During the COVID-19 pandemic, most training for HCWs and other PEPFAR providers, including prevention and OVC implementers, should be provided virtually using online platforms or printed job aids. In the rare exception that an OU would like to hold an in-person training during the pandemic, they should have a strong justification for why the training could not be done virtually. In the setting of escalating community COVID-19 spread, all in-person trainings should be paused. Country teams and implementing agencies should be fully aware of planned training events and involved in decision making on whether and how to most safely proceed. A landscape assessment is currently underway and country and activity-specific guidance, recommendations, and SOPs will be shared, as available, to assist country teams in their considerations.

WHO is regularly updating available COVID-19 training [here](#).

What actions - beyond provision and use of PPE - should be taken to safeguard PEPFAR HCW?

PEPFAR programs should continue to follow host country and WHO guidance on minimizing HCW risk of contracting or spreading COVID-19. Identify opportunities to support HCWs to do their jobs in different, safer ways. PEPFAR programs should report all continued concerns regarding HCW staff safety and movement in communities to PEPFAR country staff.

- During continued or new lockdowns, support HCW safety within the communities they serve by securing authorization from local authorities for continued work, and work with local governments and civil society to raise awareness in the community, in particular for lay workers such as community health workers or social workers. Consider introducing a uniform, badge, or other marker to aid law enforcement/community in readily identifying CHWs on official duties and provide CHWs with documentation of their role and authorization to continue work.
- In areas with higher COVID-19 transmission, support HCW staff to use transportation methods that reduce risk of exposure while traveling to and from work, and when delivering services in the community (i.e. refrain from public transport). Consider introducing a transport stipend or arranging transport.
- Be aware and sensitive that HCWs may have underlying conditions that may affect their outcomes if they contract COVID-19, consider offering opportunities for staff to safely and discreetly transition to roles away from direct service delivery if they are concerned, maintaining privacy and dignity.
- Provide clear guidance to HCWs on OU national policies and applicable international policies that provide for workplace rights for safety, self-quarantine, and time off for caregiving of sick family members.
- Continue to support reduced in-person contact for routine administrative tasks, such as using digital payment mechanisms to ensure continuity of salary and stipend payments.
- Ensure that HCW staff are kept abreast of relevant technical updates on COVID-19.
- The role of community health workers has expanded during the COVID-19 response and has been widely leveraged to support COVID-19 services. It is critical to safeguard and support these workers, including though adequate remuneration.

How can the wellness and mental health of the health workforce be protected in a prolonged COVID-19 environment?

Working in a prolonged COVID-19 response environment can negatively impact the wellness and mental health of PEPFAR supported staff. PEPFAR programs should continue to focus on building PEPFAR supported health workers' resilience to reduce the risk of burnout and preempt longer term mental health effects. Ensuring a safe working environment is vital for supporting physical and mental health. Partners should conduct routine wellness checks on the health workers they support to determine their emotional and physical well-being and ability to maintain responsive services. Health workers should be taught skills to increase resilience, such as taking short breaks to calm anxiety, establishing work routines/rituals, and taking time for self-care and for grieving the loss of family members and colleagues and friends. Health workers should be given adequate time between shifts to recuperate. Partners should work to ensure that staff have access to mental health services and encourage staff to utilize the support. Further resources may be found from [WHO](#), [UNAIDS,](#) [NIMH](#) and [IASC](#).

Should PEPFAR-supported healthcare worker (HCW) staffing continue to be reconfigured to maintain essential HIV services?

Early in the pandemic, a number of PEPFAR HCW clinical staff were repurposed in response to staffing shortages or because PEPFAR staff's regular services were paused or delayed. As services resume, PEPFAR-supported HCWs should continue to deliver the essential HIV services using service delivery teams that may be rapidly and regularly reconfigured in response to changes in staffing requirements. Consideration should include health worker needs, the impact of service disruptions from lockdowns, patient demands for more flexible and virtual services, and community fears and concerns. PEPFAR programs should plan for additional health worker staffing needs and continued care model provider team reconfiguration, such as modified roles that may include integrated HIV and COVID-19 services (e.g., COVID-19 screening of PLHIV and vaccine administration when warranted). Staff should continue to be prepared for task-sharing of essential services where allowed and should work with MOH and policy makers to allow emergency task-shifting where formal task-shifting policies are not in place. PEPFAR staff whose regular services continue to be paused or delayed (e.g., VMMC, roving technical assistance) should continue to be repurposed and redeployed to support essential HIV clinical services (e.g., treatment services). Rapid training may be required to refresh or build capacity in new roles. Every effort should be made to retain the health workforce that PEPFAR supports, including repurposing into new roles to support HIV services for the duration of the pandemic and redesigning how services are delivered to make it safe for PEPFAR-supported HCW staff to continue.

How should the use of digital applications for virtual/telehealth services continue?

PEPFAR programs have rapidly adopted use of technology to provide virtual services since the onset of the COVID-19 response. As services reopen, PEPFAR partners should continue to plan for reconfigured service delivery with use of virtual services to provide HIV services safely for the duration of the pandemic. Health workers should continue to be supported with the tools, airtime and data required, as well as training and scripts to use the technologies effectively and protect confidentiality and privacy. PEPFAR programs have also applied digital applications to provide technical assistance such as supportive supervision and clinical mentorship to providers across facilities. Continued use of these technologies in lieu of site visits, even when no longer driven by COVID-19 disruption, is encouraged where these approaches have been effective

and well received by clients, especially in hard-to-reach areas.   Expanded use of technologies can promote better provider performance, productivity and collaboration to support client-centered care.

How can client confidentiality and privacy be safeguarded with the increasing use of digital applications for virtual/telehealth services?

As programs continue to increase their use of technology for virtual/remote patient contact, they should ensure use of standard processes to safeguard the confidentiality and privacy of clients. Key considerations for standard operating procedures include:

- Ensure virtual technology use is consistent with National Guidelines
- Develop standard operating procedures (SOPs) for the HCW's environment at the time of the conversation in order to ensure client privacy.
- Confirm with clients their individual preferences (in advance, when possible) on receiving calls, receiving voicemails, and receiving SMS messages.
- Develop SOPs for what content can be left in voicemails/sent via SMS to clients.
- Verify identity and receive client permission before discussing any health information.
- Before initiating a voice call, always confirm whether the client is in a safe in safe/comfortable environments to discuss their health care before initiating a conversation about sensitive health issues.
- Verify identity and receive client permission before discussing any health information.
- Develop guidelines for the HCW's environment at the time of the conversation in order to ensure client privacy.
- Develop guidelines regarding management of audio/video content (e.g. advising HCWs not to record/capture any content and developing safe channels for sharing client information).
- Develop guidelines for what content can be left in voicemails/sent via SMS to clients.

Is the provision of health worker hazard pay allowable?

PEPFAR's stance is that if services cannot be provided safely, they should not be provided. PEPFAR does not support providing hazard pay to PEPFAR supported health workers, unless a government mandate requires hazard pay for all at-risk health workers, including those supported by donors, or where such pay is contractually or otherwise legally required. In such an instance, PEPFAR OUs should consult with the relevant Agency Headquarters and their Chairs to determine a way forward, considering: the current compensation of PEPFAR health workers (those whose regular compensation is higher than the sum of the government pay scale plus hazard payment will not be eligible for additional compensation), the timeline for introduction and suspension of hazard pay, and the types of health workers/roles that are eligible for payment. Under no circumstance should PEPFAR-supported workers who are not directly delivering services receive a hazard pay allowance.

Community meetings and trainings

What community trainings and programming can be done in the setting of COVID-19?

Increases in COVID-19 transmission in several countries have created a need for clearer guidance to steer ongoing community, group-based training and program implementation activities. Community in this case includes all non-medical or health facility training and activities outside of health facilities.

For the purpose of this guidance, a group is defined as two or more people from different households. Community, group-based training includes trainings of individuals who will deliver the program to the end user (i.e., training of trainers, facilitators, implementers, teachers, mentors). Community program implementation includes bringing together peers and others (e.g. mentors) to deliver a curriculum, intervention, or similar activity.

There are 2 critical objectives that need to be balanced that align with the general principles outlined in the introduction:

- Minimizing the risk of COVID-19 during PEPFAR-supported community activities; and
- Ensuring that the core of community programming moves forward as much as safely possible.

Final decisions about training and program activities should be made on a case-by-case manner by considering these recommendations as well as the country's local government policies and U.S. Embassy protocols. Decisions should be made in collaboration with OU implementing agency leadership, MoH, and implementing partners. Please refer to the program-area-specific sections of this guidance (e.g. DREAMS, OVC, etc.) for additional information on approval required for virtual training and program implementation.   The OU should follow the most conservative guidance.

In general, training should be conducted virtually whenever possible. It may be that resources can be allocated for the purchase or use of affordable hardware (e.g., laptops, tablets, and/or smart phones), phone and/or internet credit, and data packages (e.g., Wi-Fi and hotspots) to enable trainees or beneficiaries to participate remotely. Programs should work with AORs/CORs, project officers or other relevant agency budget leads to determine if there are resources available and with Chairs/PPMs to see if an OPU is required.

The following are requirements for in-person training and program implementation. Programmers should know that the situation is dynamic; maximum flexibility is required, and mitigation plans should be in place, should there be a local change in the COVID-19 transmission dynamics.

- IPs should designate a focal person to oversee infection prevention and control measures, for any in-person activities (see Infection Prevention and Control section of this guidance [here](#)).
- Group size should always fall within local guidance. IPs should consider whether group sizes can be reduced even further depending on venues, available equipment, and other relevant factors.
- Social distancing of at least 2 meters (or local definition) throughout all activities
- Consistent use of face coverings by all participants and facilitators at all times, except when actively eating or drinking
- Routine daily symptom and exposure screening should be conducted.
- No singing or shouting is permitted.
- No sharing of laptops or other equipment is permitted.
- Hand sanitizer and/or hand washing facilities must be available.
- Regular cleaning and disinfecting measures must be undertaken.

- If communal meals and/or tea are served, participants must maintain appropriate distance and may not share utensils; meals should be packed or served individually.
- Transport of participants to and from the in-person activities should be considered and arrangements should be made to keep participants as safe as possible (see here).
- Programs should try to avoid lodging participants.
- Programs should try to be conducted outdoors or ensure maximal ventilation with open doors and windows as feasible.
- Gather contact information of everyone involved and create a response plan in case of COVID-19 exposure

Are there specific recommendations for community-based training of trainers (e.g., program facilitators, instructors, implementers, providers)?

These trainings commonly involve a group of people who meet for multiple hours in the same room across multiple days or even weeks*. This type of event could carry serious risk of transmission among participants and, therefore, the threshold for considering such an activity during COVID-19 should be very high. The table below outlines requirements and considerations as OUs make decisions about training of trainers during COVID-19.

Situational Assessment	Requirements	Considerations
OU or SNU/Locality prohibiting non-essential gatherings and travel due to COVID-19	• If fully virtual is not possible, postpone activity.	• If IPs must postpone critical in-person trainings because of COVID-19, they should promptly notify PEPFAR country and HQ teams (through their ISMEs and agency budget leads if necessary) so that program achievement impacts can be anticipated and tracked. • IPs/OUs should NOT request exceptions or special permission from public health authorities in order to conduct in-person training
OU or SNU/Locality permitting travel and gatherings with specific restrictions	• If at all possible, activity should be fully virtual. • If fully virtual is not possible, activity may be in-person and outdoors. • If virtual or outdoor training are not options, programs may consider an in-person indoor training in a well-ventilated space	• Is this a critical training that must take place now, or can it be postponed? (e.g. new programming that can't begin without the training and there is no current programming in place) • If the training cannot be fully virtual or outdoors, what is the justification for this? • Can group size be reduced to maximize safe social distancing? (e.g., if a group of 20 usually meets,

	(i.e., open air building, or doors and windows open). ● If in-person (outdoors or indoors), must follow all COVID-19 safety precautions and public health guidance.	can this be split into smaller groups?). If so, teams should consider the need for additional staffing or less frequent meetings. ● Can group lodging be avoided? ● If IPs must postpone critical in-person trainings because of COVID-19, they should promptly notify PEPFAR country and HQ teams (through their ISMEs and agency budget leads if necessary) so that program achievement impacts can be anticipated and tracked ● IPs/OUs should NOT request exceptions or special permission from public health authorities in order to conduct in-person training

What about community-based program implementation for beneficiaries?

This often involves a small group of people who meet weekly and for a short period of time (1-2 hours). This type of programming is often the center of our community work, and therefore, should be continued if allowable by local restrictions and the IP is able to meet the requirements laid out on the next page.

Situational Assessment	Requirements	Considerations
OU or SNU/Locality prohibiting non-essential gatherings and travel due to COVID-19	● If activity is amenable to virtual delivery, then it should be conducted fully virtual. ● Delivery to beneficiaries within a household (e.g. OVC home visits) that must take place, should be conducted outdoors with COVID-19 safety measures and assuring confidentiality. ● Group activities that must take place in person should be deferred. ● If in-person, must follow all COVID-19 safety precautions and public health guidance.	● The decision to implement virtually should follow specific program guidance (e.g., DREAMS and OVC are not permitted to deliver skills-based curricula in a fully virtual format; see the DREAMS section of this guidance) ● If IPs must postpone critical in-person services because of COVID-19, they should promptly notify PEPFAR country and HQ teams (through their ISMEs and agency budget leads if necessary) so that program achievement impacts can be anticipated and tracked ● IPs/OUs should NOT request exceptions or special permission from public health authorities in order to conduct in-person training

OU or SNU/Locality permitting travel and gatherings with specific restrictions	● If activity is amenable to virtual delivery, then it should be conducted fully virtual. ● If fully virtual is not possible, activity may be in-person outdoors. ● If virtual or outdoor delivery are not options, programs may consider implementing in-person and indoors in a well-ventilated space (i.e., open air building, or doors and windows open). ● If in-person (outdoors or indoors), must follow all COVID-19 safety precautions and public health guidance.	● The decision to implement virtually should follow specific program guidance (e.g., DREAMS and OVC are not permitted to deliver skills-based curricula in a fully virtual format) ● Can group size be reduced to maximize safe social distancing? (e.g., if a group of 20 usually meets, can this be split into smaller groups?). If so, teams should consider the need for additional staffing or less frequent meetings.

7.   HIV Treatment

What is most important for PEPFAR teams to implement at this time?

Key principles for the PEPFAR response to COVID include high quality clinical care, continuity of ART therapy and accelerated decongestion of health facilities to minimize transmission of COVID-19 and protect PLHIV. Separation of clinical services and drug delivery will allow individuals to have the supplies they need for treatment and provides streamlined access care when appropriate and necessary. The critical intervention for all programs and individuals is to accelerate and complete scale-up of 3-6 multi-month dispensing (MMD) of ART and decentralized distribution for all PLHIV including PBFW and children. Most programs have adopted this intervention and are providing MMD to their clients. If there are any barriers to MMD (such as sufficient ARV availability or stringent viral load suppression requirements) implementation, programs should alert their S/GAC Chair and PPM and USAID immediately for advice and assistance and should immediately quantify the increased ARV needs to scale up MMD. USAID is working with PSM to consider the additional quantities that may be required beyond the amount budgeted in COPs; and additional PEPFAR funding to roll out MMD at a broader scale will need to be considered by S/GAC before additional TLD is procured to support a rapid implementation of MMD.

How will clinical services for PLHIV be affected?

Guidance for continuation of essential medical service may be found [here](#). Ensuring and maintaining HIV viral load suppression should be considered an essential medical service for PLHIV. Please see laboratory section for suggested prioritization of viral load testing. Routine viral load monitoring in stable patients may be delayed based on local circumstances.

Can clients initiating ART receive multi-month dispensing?

PEPFAR recommends that ALL PLHIV who are starting ART receive at least 3 but preferably 6 months of drugs. Phone or electronic follow-up may be helpful to assess and support adherence and to assess and manage side effects. Evidence from cohort studies indicate that <5% of clients initiating ART will require a change in ARV regimen in the first 6 months of treatment. Two forms of contact, as recommended in the COP 21 guidance, should be obtained for all PLHIV, especially in ART initiators. Data from AFRICOS support the notion that 3 MMD is associated with viral load suppression.

Can ART initiation in newly HIV diagnosed be delayed in those who are also either suspected or confirmed to have COVID 19?

No. COVID-19 should not delay ART initiation.

How do we prepare for clinic closures or disruption of services related to COVID-19?

To prepare clinics for potential closure due to COVID-19 pandemic, the following steps should be taken aligning with local context and guidance:

- Develop a complete client list with contact details.

- Make the client list available to key clinic staff.

- Ensure databases are backed up and encrypted.

- Secure paper patient records, where applicable.

- Contact clients and provide instructions for medical emergencies and medication refills.

    o Post these instructions for medical emergencies and medication refills at the clinic and as an outgoing message for the clinic telephone.

    o Coordinate with MOH public address announcements providing guidance on what to do for medical emergencies, medication refills, and medical hotlines for advice and assistance during clinic closures.

- Ensure that facility and community partners are aware of clinic closure. If possible, continue to provide virtual support to OVC and other vulnerable clients.

What about clients coming to clinic who usually receive their medication elsewhere?

These clients, regardless of their citizenship or immigration status, should be provided medication. Please note that they should not be counted as TX_NEW.

What should I do about individuals who are on our books but have not accessed meds in in the last 3 to 6 months?

Every effort should be made now to trace individuals who have been lost to follow-up and provide them with the package of care and treatment that they require before COVID-19 disruptions worsen. This is a core principle of COP 21 and section 6.1.2 of the COP 21 guidance contains tools for tracking and tracing which may be adapted for use in the current environment. The HRH section of this document provides additional considerations for ensuring home visits are safe.

What about individuals who are returning to care after having been out of care for a year or more?

These individuals should have a CD4 performed to assess eligibility for the advanced disease package of care. If clinically unwell, these individuals should at least receive cotrimoxazole as well as prompt initiation of ART. If a CD4 cannot be performed, consideration should be given to providing the individual with cotrimoxazole until a CD4 count can be obtained. If TB screen is negative, TPT may be provided if appropriate. Please see updated recommendations on individuals with advanced disease.

What if PEPFAR's recommendations for adapting HIV services in the context of COVID-19 do not align with local policy?

PEPFAR operates in partnership with the host government, and under Chief of Mission authority. PEPFAR country teams are urged to work promptly and closely with national governments to effect changes in policy that will allow uninterrupted essential HIV services to children, adolescents, pregnant and breastfeeding women, and adults while minimizing potential exposures to COVID-19.

Can clients still be counted as "TX_CURR" they are getting ARVs delivered but only having phone (or other virtual) contact with program staff instead of clinic visits?

Programs can continue to count clients on ART towards TX_CURR if the client is not more than 28 days from when, based on the last delivery, their ARVs would be expected to run out. Programs should continue to be available to serve clients on ART, but the interaction does not have to include in-person contact. Please see MER guide for definitions of TX_CURR and TX_ML.

How can the impact of COVID-19 be minimized for PLHIV supported by PEPFAR?

The critical intervention for all programs and individuals is to accelerate and complete scale-up of 3 to 6-month dispensing of ART and decentralized distribution.

What changes should be considered for adjusting the model of service provisions for PLHIV?

- The overarching goal is to minimize exposure to COVID-19 at healthcare facilities and reduce the burden on these facilities.

- Health facilities should optimize clinic spaces in order to minimize potential exposure to COVID-19. Individuals with proven or suspected COVID-19 should be separated from where care is provided to other clients.

- Open windows and well-ventilated waiting spaces are recommended where applicable. Waiting areas outside may also be helpful.

- Through phone calls or SMS, facilities staff should proactively communicate with HIV clients using positive messaging about the need to stay healthy.

- Clients should preferentially receive their drug supplies outside of the health facility. These options may be used for dispensing ARV for any duration (for 1 month, 3 month or 6-month pick-ups), PrEP, HIV self-tests and other medicines already being supplied for chronic conditions (including drugs for hypertension, diabetes, etc.). Decentralized distribution approaches include:
    - Home deliveries: through peer-run groups OR private delivery mechanisms that maximize social distancing and respect client's privacy.

- o Community or private pharmacies: with scheduled pick-up times to maximize social distancing.
- o Pop-up pharmacy: that provide additional infrastructure in remote areas outside hospital or clinic settings with pick-up windows that are configured to ensure social distancing.
- o Automated lockers: provide additional infrastructure outside hospital or clinic settings for drug pick-ups.
- o Community pickup: through community structures such as schools, churches/FBOs, post offices or KP-focused sites

- Where countries are moving towards limiting movement, due to COVID-19, countries will need to work with law enforcement, national militaries, and other officials to:

  - o Ensure importation and transport of health commodities is not interrupted
  - o Designate health commodity logistics, warehousing, and distribution (e.g. last mile delivery) operations - including private sector providers - as exempted activity and related personnel as essential personnel
  - o Ensure that decentralized distribution approaches are permitted

- If OUs have significant movement restriction and/or high absenteeism amongst HCW, alternatives to face-to-face care provision should be considered, including the use of phone consultations.

Given the priority on reducing non-essential visits to health facilities to limit COVID-19 exposure among PLHIV coupled with known adherence challenges among Adolescent and Youth living with HIV (A/YLHIV), what are the recommendations for peer support groups and mentoring for A/YLHIV?

To the extent possible, and in line with host country guidelines, please ensure that peer support groups, one-on-one peer support, and treatment literacy activities are maintained virtually and ideally at the same frequency that they would normally meet. Adherence group meetings and one-on-one peer support can convene over the phone, SMS, through WhatsApp, or through other social media platforms that adolescents find acceptable, accessible, and can protect confidentiality. One-on-one virtual check-ins should be conducted for appointments and ART/MMD pick-up scheduling.

If staff/resources are limited, the highest risk A/YLHIV should be prioritized, including those with high viral load, newly initiated on ART, that are pregnant and breastfeeding, at risk for treatment disruption (running out of ARVs at home), and those with mental health or psychosocial challenges. Adolescents without personal phones can consent for their caregivers to be engaged and are encouraged to identify an accessible phone when possible. To the extent possible, incorporate COVID-19 prevention messaging per host country MOH guidelines and resources into the adherence group meetings and one-on-one check-ins.

Please ensure that youth peer leaders and facilitators have adequate resources, including airtime and/or data, to continue performing these functions. ([See here](#)).

Children may have stressful reactions to COVID-19. How can they be supported?

Children may respond to difficult/unsettling situations in different ways: clinging to caregivers, feeling anxious, withdrawing, feeling angry or agitated, having nightmares, bedwetting, frequent mood-changes, etc. Children usually feel relieved if they are able to express and communicate their disturbing feelings in a

safe and supportive environment. With assistance, children can find positive ways to express disturbing feelings. Children need adults' love and often more dedicated attention during difficult times. Children often take their emotional cues from the important adults in their lives, so how adults respond to the crisis is very important.

Techniques that can be used:

- Keep regular routines and schedules as much as possible or help create new ones in a new environment

- Provide facts about what is going on and give clear child-friendly information about how to reduce risk of infection and stay safe in words they can understand

- Demonstrate to children how they can keep themselves safe (e.g., show them effective handwashing).

- Provide information about what has happened or could happen in a reassuring, honest and age-appropriate way

- Support adults/caregivers with activities for children during home isolation/quarantine.

One-page tips for parents that cover topics like managing stress, and talking about COVID-19 can be found at "[Parenting in the Time of COVID-19](#)".

What changes in the clinic flow should be made to protect patients and HCW?

Waiting rooms can be a source of transmission for respiratory illness. Despite measures to maximally reduce the number of PLHIV coming for in-person facility visits, some visits will be necessary.

Consider staggering clinical appointments to avoid crowding and streamlining clinic flow so PLHIV do not interact with multiple HCW (e.g. avoiding multiple points of contact between PLHIV and HCW).

Optimizing space to reduce close contact may be helpful. HIV patients should be seen in clinics that are dedicated spaces for HIV treatment services.

What is the role of ARVs in the treatment of COVID-19?

There is no evidence that ARV drugs have any activity or role in treating COVID-19 infections ARVs including Lopinavir/r[3] and, more recently, tenofovir disoproxil fumarate (TDF)[4] have been studied for potential role in treatment of COVID-19 but there is no *evidence supporting efficacy. Accurate messaging to prevent diversion of ARVs should be provided.*

How can the most vulnerable patients be protected?

Older age and presence of uncontrolled comorbidities such as obesity, hypertension, diabetes and heart disease pose a higher risk for COVID-19 morbidity and mortality. All efforts should be made to streamline

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[3] Cao B, Wang Y, Wen D, Liu W, Wang J, Fan G et al. A Trial of Lopinavir–Ritonavir in Adults Hospitalized with Severe Covid-19. 2020. doi:10.1056/NEJMoa2001282.

[4] del Amo J, Polo R, Moreno S, Díaz A, Martínez E, Arribas JR et al. Incidence and Severity of COVID-19 in HIV-Positive Persons Receiving Antiretroviral Therapy. Annals of internal medicine. 2020. doi:10.7326/M20-3689.

health services and prioritize vaccination for older individuals living with HIV (>age 50), PLHIV with advanced disease, and those with co-morbidities. Programs should be sensitive to the medication needs of these individuals, seek methods to reduce the number of times these individuals require visiting health care facilities.

Some of the older clients are struggling with COVID-19. How do we best help them?

Age is one of the key drivers of COVID-19 mortality and morbidity. Medical needs of older adults living with HIV need to be met and may include other comorbidities for which they require uninterrupted access to their medications.

Older adults may have more difficulty with quarantine especially if they are sheltered or alone. As with all clients, emotional support can be provided through informal networks (families) and mental health professionals. Simple facts about what is going on and clear information about how to reduce risk of infection that can be understood easily by people with and without cognitive impairment are key to improved mental health. Information in clear language with large font from multiple trusted sources (family, health care providers, media) with frequent repetition may be necessary.

Use of online platforms and messaging apps may not be the preferred method of communication for this group. Personal contact may be needed.

PLHIV with advanced HIV disease

Should evaluation of newly diagnosed clients for advanced disease continue during the COVID-19 pandemic?

Yes. Extant activities for the evaluation and management of advanced disease in clients newly diagnosed during the COVID-19 pandemic should continue. PEPFAR's recommendations for the diagnosis and treatment of individuals with advanced HIV disease can be found in the COP21 guidance. If COVID19 disrupts timely availability of CD4 testing (to assess for advanced disease), in addition to prompt initiation of ART, consideration should be given to providing cotrimoxazole to all newly diagnosed clients until CD4 testing can be performed.

Should individuals with advanced disease stay away from health care facilities?

Individuals with advanced disease represent a subset of PLHIV who require more intensive care, and careful consideration should be given to whether they should be seen in person. In many instances the benefits of being seen in person outweigh the risks of COVID-19 acquisition in health care facilities. A phone consultation with a mid-level or advanced level practitioner may be helpful in monitoring this group of individuals and may lessen the need for in-person evaluations.

When should individuals with advanced disease be evaluated in person?

Concerning symptoms include, but are not limited to fever, persistent cough, shortness of breath, intractable headache and inability to walk unaided. For children other concerning signs and symptoms include fever, lethargy, convulsions, poor oral intake, and persistent vomiting or diarrhea. Note: all CLHIV under age 5 years who are NOT taking ART are classified as having advanced disease.

Should PLHIV with advanced disease be given MMD?

Absolutely. Medication delivery should be separated from clinical care. Extra effort should be taken to ensure that these fragile patients have sufficient medications to avoid unnecessary trips to the health facility. In addition, they should be provided with all of the other medicines that they may need, such as cotrimoxazole and TPT.

Should PLHIV with advanced disease be vaccinated against COVID-19?

Absolutely. These individuals should be prioritized for vaccine receipt as recommended by the WHO. These individuals may also be recommended for extended primary series, depending on local guidance.

Pediatric Issues

How will the COVID-19 epidemic affect children living with HIV or HIV/TB?

Children can become infected and severely ill with COVID-19/SARS-CoV2; however, they appear to be at lower risk for severe COVID-19 disease when compared to adults. (See here). Multisystem Inflammatory Syndrome in Children (MIS-C) is a rare condition temporally associated with current or recent infection with SARS-CoV2 among children requiring immediate intervention. (See https://www.cdc.gov/mis-c/). Most reported cases have occurred in high transmission communities. No common risk factors have yet been determined but the majority of children diagnosed with MIS-C were previously healthy.

There are few data on the impact of COVID-19 on children with HIV or TB or those co-infected with both diseases. However, children and especially children with HIV are at very high risk for mortality and morbidity from TB which can present with symptoms similar to COVID-19. Therefore, it is critical that routine programs be maintained for screening and testing for TB among children and adolescents, especially those with HIV, and among child household contacts (<5 years of age) of individuals with TB. Children assessed for SARS-CoV2 should be concurrently assessed for TB and HIV, if appropriate, with IPC precautions taken as recommended in current guidelines. If negative for TB (through screening or full diagnostic evaluation), C/ALHIV and child household contacts of individuals with TB/HIV should be initiated on TPT with MMD.

OVC programs can help support C/ALHIV and their caregivers during COVID-19 by offering community-based services. Clinical and OVC programs can work together to leverage their strengths to best support C/ALHIV's retention and adherence during COVID-19 and support their households. See the OVC Section for more information.

Our host country requires documented virological failure before optimizing a pediatric or adolescent ART regimen. What should we do if routine VL monitoring has been impacted by COVID-19 (i.e., unreliable sample transport, lengthened turnaround time due to competing needs with SARS-CoV-2 testing, etc.)?

Please see HIV Treatment FAQ "*What if PEPFAR's recommendations for adapting HIV services in the context of COVID- 19 do not align with local policy?"* In addition, WHO recommends that viral load monitoring should not be a rate limiting step to optimizing ART. CLHIV who weigh < 20 kg should be transitioned to a pediatric DTG based regimen. C/ALHIV who weigh 30+kg can be transitioned to TLD.

What are the recommendations for pediatric MMD in the setting of COVID-19?

Programs should make every effort to supply children and adolescents living with HIV (CLHIV/ALHIV) initiating and refilling ART with a 3-month supply of ARVs for those who weigh < 20 kg and a 6-month supply

for those who weigh 20+ kg. The caregiver should be allowed to pick up the child's medication without bringing the child, unless the child needs a clinical visit. For children requiring Cotrimoxazole, a 3-6-month supply should be provided at the same time as ARV pickup. For children starting a new medication, administration of the first dose should be demonstrated and administered in clinic, particularly LPV/r-based formulations (liquids, pellets, granules, and 100/25mg tablets). Phone or electronic follow-up for pediatric clients (within 3-4 weeks) should be emphasized and include assessment of medication dosing and administration.

HIV-exposed infants should be given the greatest quantity of infant prophylaxis, both ART and cotrimoxazole as possible to last until the next immunization or EID testing appointment.

In the face of COVID-19 disruptions to PEPFAR-supported treatment programs, what is PEPFAR's guidance for children who are receiving EFV based regimens?

CLHIV who are already 20kg and receiving EFV should immediately transition to a DTG-based regimen. CLHIV who are <20kg and stable on EFV with virologic suppression can continue to receive EFV temporarily (during program disruption by COVID-19) but should be transitioned to DTG 10mg once feasible

Food Insecurity and Nutritional Status

What is the potential impact of COVID-19 on food security and nutritional status of PLHIV and OVC households?

- There is ongoing concern about food shortages and the world food program and other international organizations are monitoring impacts. The situation is fluid and there is concern that a prolonged pandemic and the associated mitigation measures will profoundly increase the risks to food and economic insecurity, particularly among individuals with pre-existing vulnerabilities, including those with HIV.

- Food insecurity and poor nutritional status are recognized threats to successful ART therapy and are also associated with a range of poor outcomes for children and pregnant/breastfeeding women regardless of HIV status. ART clients previously considered stable may face rapid onset of food insecurity in the current context.

- Food insecurity is also an acknowledged driver of HIV risk behaviors, particularly among key populations selling sex, and may limit consistent condom and lubricant use, as well as uptake and adherence among PrEP and ART clients. Moreover, key populations are less likely to be eligible for food and other social protection assistance that may be available to the general population from traditional structures, government schemes, and donor-funded programs.

How should programs deal with food insecurity?

Recent SitReps all point to rapidly deteriorating food security in the Southern and Eastern Africa region due to COVID-19 restrictions, including widespread unemployment, reduced cross-border remittances, and food price spikes.

- Country teams should closely monitor the evolving situation (and planned local response) through in-country food/nutrition clusters and global situation reports from WFP, FEWS NET, and FAO.

- USG country teams should coordinate closely with USG supplemental food assistance planned for the COVID-19 response, led by USAID's Bureau for Resilience and Food Security (RFS), to determine planned coverage, eligibility criteria, and resources available for priority PEPFAR beneficiaries. This supplemental assistance should be the primary mode of support, where available, for PEPFAR beneficiaries experiencing acute food insecurity related to COVID-19.

- If usual international or bilateral food assistance is unavailable in a PEPFAR supported area and given documented needs, OU's may work with their respective Chairs and PPMs to develop proposals using limited amounts of PEPFAR funding for nutrition assistance. All proposals will need to be cleared by S/GAC executive management.

- For more information about USAID's RFS programs for specific countries please contact USAID's program office in country.

What mitigation measures should be put into place for PLHIV and OVC households experiencing food insecurity as a result of the COVID-19 pandemic?

- IPs should continue food and nutritional assistance activities previously authorized under COP19.

- IPs should integrate food security and nutritional assessments into routine beneficiary follow-ups (virtual or in-person) to identify and prioritize beneficiaries requiring immediate support (highest priority are ART clients at risk of treatment disruption). IPs should clearly document any trends in deteriorating food security or nutritional status among their beneficiaries to inform country-level planning and coordination.

8.   HIV Testing Services

Should all people being evaluated for COVID-19 also be tested for HIV?

It is unknown whether patients with HIV are at increased risk for acquiring COVID-19. There is overlap in COVID-19 symptoms with TB (see TB-HIV FAQ guidance) and other respiratory infections, which may be more common in PLHIV.

We recommend application of the usual criteria for determining eligibility for HIV testing when patients with unknown HIV status present with symptoms consistent with COVID-19.

How will HIV testing activities be affected?

See guiding principles. All efforts should be made to support community social distancing and reduce contact of well persons with health care settings. Plans should be in place to adapt programming should service be disrupted. We acknowledge that everyone who needs an HIV test may not get tested and target achievement may be impacted by COVID-19.

Potential issues/responses include:

- Adapting HTS programming to government directives or policies on social distancing.

- Maximizing use of self-testing outside of the clinic setting (including providing self-tests through decentralized distribution approaches such as: peer home delivery, private or community pharmacies, etc.)

- Prioritizing clinical-based HTS for those most in need:

    o Testing in ANC

    o Diagnostic testing for individuals presenting (or admitted) to facilities with illness suspicious for HIV infection (Diagnostic testing)

    o Individuals with TB, STIs, malnutrition

    o Early infant diagnosis (EID) detection

    o Partner/index/family testing may be offered for individuals presenting at facilities (passive testing),

    o Testing in KP programs if ongoing and not facility based.

- HRH (including lay counselors/testers) may be impacted, reducing capacity from those affected by COVID-19

- HTS should not take place where routine adequate PPE is not available, (e.g. gloves) and where there is not adequate ventilation and appropriate waste disposal.

- For RTK implications, please see Supply Chain/Commodities section

COVID-19 transmission is continuing in our community; how should we proceed with HIV testing?

Community case finding strategies may need to be modified in these circumstances and programs should consider the following factors as they make program adaptations:

- Safety of community staff in performing case finding activities
- Adequate levels of PPE
- Ability to conduct program monitoring to ensure program adaptions are effective
- Mitigating fear/stigma related to Covid-19 to ensure safety of health workers in the community

Program adaptations should be clearly articulated and effective in reaching the target populations.   When possible, programs may continue to leverage successful COVID-19 adaptations, such as the targeted expansion of HIV self-testing (see below,). With HIVST expansion and other adaptations, it is important to continue to support and track linkage to treatment to assess effectiveness of program adaptations.

If the program determines that it is unsafe or ineffective to perform certain case finding strategies within the community, the strategy may be modified and active testing in community settings may be limited. COP 21 implementation funds should not be diverted to less effective testing strategies. We accept that this may mean that the original testing target (and consequently, original treatment targets) for COP20 may not be met.   Whenever possible, pauses in testing should be avoided as case finding when associated with linkage and viral suppression is a life-saving strategy.

Accordingly, we expect that some portion of planned funding for such activities related to scalable costs (e.g. travel, test kits, related commodities) would not be outlayed at the end of COP20; we expect that funds for non-scalable costs like salaries would continue to be disbursed. If possible, staff may be shifted to support other activities as described in the HRH section on reconfiguration of staffing (p.9). OUs should work closely with their Chairs and PPMs in implementing programmatic adaptations.

Can community testing for HIV continue?

Programs should adapt provision of active index testing services (also referred to as provider assisted notification) and community-based HIV testing accordingly to ensure the safety and security of testing staff and other health personnel. In some settings, it may be appropriate to continue to distribute HIV self-testing kits for KP, DREAMS, OVC, and partner testing. Any changes to guidance should be reviewed with the Chair/PPM and be in accordance with Chief of Mission directives.

Can active index testing for HIV, facility or community-based, continue?

Programs should adapt provision of active index testing services (also referred to as assisted partner notification) accordingly to ensure the safety and security of testing and other health personnel. Newly diagnosed individuals should be counseled on the importance of partner testing. Client-referral should be offered as an approach for index testing. However, in the context of COVID-19, programs are encouraged to distribute HIV self-testing (HIVST) kits to index clients so that partners can screen themselves prior to coming to the facility. This will ensure that only partners who are most likely to have HIV will come to the facility for confirmatory HIV testing (see FAQ about role of HIV self-testing). National policies may limit the feasibility of active index testing and country teams should review guidance with the Chair/PPM.

What is the role of HIV Self-testing in the context of COVID-19 planning?

To alleviate congestion at the facility level and reduce the need for in-person testing services, countries may consider accelerating their plans for scaling HIV self-testing distribution for those with increased risk of HIV infection. Programs may need to develop alternate workflows to ensure that patients can receive for confirmatory testing. Please discuss with your Chair/PPM to ensure there is adequate supply of HIV self-testing kits. Please see the FAQ on testing in children for additional guidance on the role of HIV self-testing in the context of COVID-19 for children.

If we are expanding HIV self-testing in the setting of COVID-19, do we need to adjust our IPs' HIV self-testing targets?

Targets should not be adjusted prospectively to expand HIV self-testing in the setting of COVID-19. This should be discussed with Chairs and PPMs.

Some IPs are participating in COVID-19 contact tracing activities. Can they incorporate HIV testing/case finding into their activities as long as they are able to do so safely?

Yes, HIV and TB testing/case finding (including TB symptom screening) can be incorporated into COVID-19 contact tracing with agreement from the team. Use of HIVST through oral screening is encouraged. Please see guidance related to HIVST for adults and for children/adolescents.

How should partners and field staff approach HTS for children and adolescents during the COVID-19 response?

Per previous guidance, we recommend maximizing use of self-testing outside of the clinic setting and prioritizing clinical-based HTS for those children most in need

HIV Oral Screening in Children

WHO Prequalification Department approved the use of OraQuick oral HIV testing kits for use in children 2-11 years of age in November 2019. To promote HIV screening in children during the COVID-19 response, PEPFAR Programs, in collaboration with Ministries of Health, may consider providing parents with HIV

(index clients) with oral screening kits to screen their biological children >2 years of age for HIV at home. This temporary adaptation is intended to mitigate the effects of COVID-19 on identifying children with HIV before disease progression. Children with a positive oral HIV screening require prompt confirmatory HIV testing and, if infection is confirmed, immediate ART initiation.

HIV Recency Testing

Should recency testing be resumed as COVID-19 restrictions are lifted?

Recency testing continues to be an important part of PEPFAR programming which will inform targeted and effective community HIV prevention interventions. Due to restrictions in group gatherings and travel associated with COVID-19 and pauses in non-essential clinical services, trainings and site visits for activation, monitoring, and quality assurance activities for recency testing have previously been postponed, scaled-back, or transitioned to virtual formats. While recency testing may add time to the provider-client interaction and overall clinic visit and does not affect the overall clinical care of individual patients, there may be benefits to resuming the program to inform targeted and effective community HIV prevention interventions. As COVID-19 restrictions are lifted and routine HIV testing resumes, it is recommended that each country, in collaboration with MoH, consider starting or resuming recency testing as soon as infection control protocols and adequate supplies of PPE are in place to protect both clients and health care workers during the extended provider-client interactions and counselling sessions. Countries restarting recency surveillance activities after significant pause (>3 months) due to COVID-19 restrictions should consider refresher trainings and re-assessment of testing competency through QC specimen panels for staff conducting recency testing. In settings with SARS-CoV-2 transmission, trainings will need to be adapted to be consistent with local transmission prevention regulations. This will likely include appropriate personal protective equipment (PPE), smaller class size, social distancing, symptom screening, and virtual training, if [appropriate](#).

9.   TB Services

How can we distinguish COVID-19 from tuberculosis (TB) in PLHIV?

TB and COVID-19 symptoms may overlap, and patients may be co-infected.

Programs should continue to screen, test, and think TB in high prevalence areas and consider testing for both TB and COVID-19 in PLHIV, especially in people presenting with fever and cough.

How will COVID-19 affect contact tracing for TB among PLHIV?

TB contact investigations are administered by the TB Programs not through PEPFAR. However, if normal TB contact investigations for PLHIV are suspended, PEPFAR programs may consider coordinating with local TB programs to identify contacts and reiterate the importance of informing health care workers of their contact status should they present to a health facility for symptoms. If PEPFAR programs are supporting TB contact investigations for TB/HIV clients, they should make every effort to maximize their use of mobile and virtual platforms for conducting contact investigations.

Community-based testing and active TB case finding strategies among PLHIV should follow local guidance on movement restriction and social distance measures to preserve the safety of healthcare workers and should be consistent with the national programs' continuity of operations in setting of COVID-19. If mobile

and virtual platforms cannot be used and it is not safe for HCWs to conduct contact investigation in the community, programs may need to defer these activities.

How can we ensure continuity of services for TB-treatment in the context of COVID-19 disruptions?

- PLHIV on TB treatment, including CLHIV, should continue their TB and HIV treatment and avoid potential exposures to COVID-19 at health facilities.

  o Patients should be provided the full or remaining course of their drugs for TB at the next scheduled visit or sooner, if possible.

  o Where possible, we recommend adhering to the usual schedule of evaluations for PLHIV with TB substituting telephonic consultations for in-person evaluations.

  o Specimen collection should adhere to national guidelines. Individuals should be provided with materials and instructions for sample self-collection in an outdoor or well-ventilated space.

  o Telephone or digital consultation during the intensive phase of TB treatment is critical and should focus on screening for signs of deterioration that would warrant a visit to a healthcare facility and on counseling regarding medication adherence.

  o Provision of refills should be adapted to align with MMD for ART.

  o For PLHIV undergoing treatment for active TB, a clinical visit may be warranted based on the clinical course at the end of the intensive phase of therapy.

- TB screening algorithms should incorporate COVID-19 evaluation pathways. PLHIV screened for COVID-19 should be screened for TB. PLHIV screened for TB should be screened for COVID-19.

- Routinely assess PLHIV for TB & COVID-19 symptoms, even if they are being seen in the community. Ensure that CHWs have a clear protocol for referring and linking PLHIV to further assessment and testing, if appropriate.

- Further guidance may be found [here and](#) [here.](#)

How will COVID-19 epidemic affect HIV testing of individuals with presumptive TB?

All patients with suspected or confirmed TB should continue to receive HIV testing. Please refer to testing guidance for strategies and guidance for HIV testing in the setting of COVID-19. Those who test positive for HIV, should be linked to ART.

How do we manage people with TB newly diagnosed with HIV in context of COVID-19 epidemic?

ART is usually started after TB therapy is underway. Consideration may be given to dispensing ART at the same time as the initial TB therapy with clear instructions, and close follow-up on when to start ART and for clinical follow-up to detect potential adverse events (e.g., IRIS-related symptoms). ART visits should be aligned with TB visits.

How will the COVID-19 epidemic affect TB testing of PLHIV with presumptive TB?

Any patient presenting with suspected COVID-19, should also be tested for TB and HIV. All PLHIV should be screened for both TB and COVID-19 symptoms at every visit, and if screen-positive for either or both diseases, appropriate specimen(s) should be collected for molecular diagnostic testing according to local

policies and guidance. Note that presence of a positive COVID-19 test does not eliminate the need for TB testing, which should proceed according to current country and PEPFAR guidance.

COVID-19 testing should take place according to local guidance and should be conducted concurrently with TB testing. PLHIV who screen positive for TB and/or COVID19 should be sent directly for testing, bypassing HIV outpatient clinic areas. Whenever possible, programs should facilitate the provision of safe, accessible, and free services to patients reporting TB and COVID-19 symptoms and conduct testing for PLHIV. Programs should encourage the use of innovative digital platforms to encourage PLHIV to self-report symptoms using phone, SMS, email or other digital applications.

Can we distinguish between COVID-19 and TB symptoms among PLHIV?

There is overlap between TB and COVID-19 symptoms. PLHIV who present with fever, cough, shortness of breath or difficulty breathing should be referred for concurrent testing for both TB and COVID-19 based on national guidelines. Countries should follow WHO guidance on laboratory testing for COVID-19 found **here** and [here](#).

Appropriate specimens should be collected for both TB and COVID-19 according to specimen types found **here** and biosafety guidelines. If only sputum samples are available for collection, facilities should have clear guidelines in place for the prioritization of testing if the person is only able to produce one specimen to be tested for either TB or COVID-19. If COVID-19 testing is prioritized, then arrangements must be made to collect another specimen for TB testing. Specimens should be initially processed and transported according to national TB biosafety guidelines for TB and interim laboratory biosafety guidance related to COVID-19 found **here**. Existing TB/HIV specimen transportation mechanisms should be used to transport COVID-19 specimens for diagnosis and surveillance.

As described in the laboratory guidance, SOPs for prioritizing specimens using of the GenXpert should be followed.

What about TB/HIV patients who become unwell at home?

TB-HIV patients who become unwell at home, should first contact the health facility or community health worker by telephone, SMS or WhatsApp to determine whether it is necessary to come into the facility and COVID-19 symptom screening should be performed. If an in-person visit is necessary, ensure understanding of procedures on arrival which should include screening for COVID-19 symptoms and COVID-19 isolation where appropriate.

How will the COVID-19 epidemic affect people undergoing directly observed therapy (DOT)?

Individuals providing DOT should follow local guidance on social distance measures and restrictions on movement. The benefits of DOT must be balanced against the potential unintended exposure of healthcare workers. Telephone and/or video-assisted visits can help ensure adherence while abiding by social distance measures.

What infection control precautions should healthcare workers caring for TB-HIV patients take in the setting of COVID-19?

Please see Section [21](#) for infection control guidance.

Addressing the triple risk of stigma, discrimination and social isolation for patients with TB, HIV, and COVID-19

Stigma, discrimination, and social isolation are relevant for COVID-19, TB, and HIV. Programs should use lessons learned and ongoing efforts to reduce stigma for HIV and TB to also address and reduce the potential impacts of stigma and discrimination against patients with COVID-19.

What should be done with TPT programs?

Tuberculosis preventive therapy (TPT) remains a core HIV service and countries should continue their scale- up.

- TPT: Sites should have sufficient quantity of isoniazid (INH) and B6 or 3HP:

    o   To dispense multi-month supplies that allow PLHIV and CLHIV already having started a TPT course to complete it without returning to the health facility

    o   To cover 6 months isoniazid preventive treatment (IPT) for volumes of PLHIV and CLHIV projected to initiate TPT

    o   Provision of refills should be adapted to align with MMD for ART

Programs should ensure that systems are in place for side effect and adverse event monitoring whether via telephone, SMS, or electronically. Differentiated service delivery models, if in place, may be utilized for community distribution and adherence support as long as they adhere to infection control, social distancing policies, and guidance within the country/district.

10. Integrated Women's Health

What changes for integrated women's health services are needed for women living with HIV (WLHV) during the COVID-19 response?

During the COVID-19 pandemic, voluntary family planning (FP) services and reproductive health (RH) care continue to be an essential service for women of reproductive age, per country guidance. Principles of voluntarism and informed choice guide USG health service efforts.

HIV services which are integrated with contraceptive services should be optimized and streamlined to avoid unnecessary patient visits to health facilities and to efficiently use client and provider time when clinic visits are necessary.

PEPFAR funds cannot be used to procure contraceptives except condoms; however, multi-month provision of oral contraceptive pills (OCPs) and condoms should be provided to clients who choose to use/continue use one of those methods; where allowed by policy, emergency contraceptive pills (ECPs) can also be provided to women in need of this method

- Through coordination with other programs that procure contraceptives, voluntary long-acting and reversible contraceptives (LARCs) and permanent methods (PMs)should be offered and available to clients; Sites should develop and disseminate a schedule of service provision to ensure that clients have continued access during periods of limited facility operations/provider availability; for women who wish to discontinue implants or IUDs, removal services should be offered when possible or referred for removal to an appropriate facility that can provide the service;

- ▪ Fertility awareness methods of contraception may be helpful because they do not require commodities, resupply, or continued contact with health care, but women must be informed of expected efficacy of all methods to allow informed choice;

- ▪ Client-centered FP education and counseling should proactively address possible side effect concerns related to hormonal contraceptive use to help minimize need for revisits;

- ▪ Client FP revisits should be coordinated with other individual and family follow-up services to streamline and/or integrate revisit appointments.

How will programs ensure an adequate supply of FP commodities are available for WLHIV in PEPFAR integrated programming during COVID-19?

Although PEPFAR funds cannot be used to procure contraceptives, they are made available to PEPFAR supported programs through coordination and collaboration with national FP programs and through USAID and other donor-funded FP activities. Due to ongoing and newly emerging challenges with global contraceptive supply chains, it is possible that some countries may experience problems with procuring certain contraceptives. Country teams are advised to keep in close contact with their national contraceptive coordination team to get updates and report contraceptive supply problems. Contraceptives are to be included in the list of essential drugs that are allowed entry into countries while shipments are restricted. Integrating FP and HIV supply chain management and distribution may also help ensure that contraceptives are available for HIV affected populations.

ANC attendance is down during COVID-19 due to social distancing guidelines and fear. Are there other ways we can make sure pregnant and breastfeeding women (PBFW) are reached for testing and treatment services?

HIV self-testing may be used as a testing strategy for PBFW. HVST can be utilized for initial or retesting points depending on the country-context. Women who screen positive should be fast-tracked for confirmatory testing and care and treatment services. Tests can be delivered by community health workers, mentor-mother groups, or other appropriate ways of reaching women at risk. Virtual follow-up after self-test distribution should be used with all precautions followed if home visits are needed. Other guidance on HVST can be found within that section of the FAQs as well as COP guidance documents.

How will cervical cancer screening services be affected?

Cervical cancer screening for WLHIV should be considered an essential service and every effort should be made to conduct these screenings within routine same-day and same-site ART clinical service visits. Cervical cancer screenings conducted outside of same-day and same-site ART clinical service visits should be limited to decrease exposure to health centers. Planned cervical cancer screenings may also be held in community spaces in countries who have reduced routine ART clinic visits through the use of MMD, with appropriate use of PPE and social distancing measures in place. Women undergoing evaluation and treatment for high grade lesions should continue with their recommended medical management with scheduling considerations to decrease exposures described above. Where HPV testing is available, consideration should be given to offer HPV testing (either patient or provider collected) as the first level of screening with VIA reserved for those with a positive HPV test. Lastly, effective and timely treatment of precancerous lesions is essential to prevent progression to cervical cancer; as a result, where feasible,

country teams should explore options for treatment catch-up strategies, such as LEEP camps and similar service delivery models in accordance with national safety protocols for COVID-19.

11. Maternal Child Health (MCH)

How will maternal and child health (MCH) services change within the context of COVID-19?

Please defer to local government regulations for specific guidance on clinic operations. When MCH clinics are operational, please encourage or enable HIV testing for pregnant/breastfeeding women (PBFW) and treatment services for women living with HIV (WLHIV) and their HIV-exposed infants to be included within essential services, including prioritizing maternal HIV testing and treatment and early infant diagnosis. PBFW on treatment should receive MMD (see HIV Treatment FAQ) with refill tracked to a scheduled ANC visit. Consider options to limit or reduce time spent in clinical settings, such as providing services in community settings, bundling services, or providing them in separate mother and baby fast track areas. Consider home delivery of ARV prophylaxis for HIV exposed-infants when MCH and PMTCT clinics are not operational.

Should the frequency of ANC visits be adjusted, given the current COVID-19 context?

Women should follow local and national guidelines for ANC testing.

- Regular retesting for HIV is still encouraged if feasible, especially in high burden areas, at the already-scheduled visits and at delivery;
- Women should be encouraged to leave children and other family members at home during their clinic visits. While at the clinic, all consideration should be made to allow patients to wait in uncrowded areas for their visits and to streamline visits by integration with other essential services;
- Consider operational adjustments to improve flow of patients through the clinic and to reduce amount of time spent in clinical settings;
- Consider dispersing some services to community settings when possible.

Are you tracking ANC attendance to protect against increases in MTCT rates?

Country teams are following local Ministry of Health guidance as it pertains to ANC service delivery and monitoring mechanisms. Although not a global policy, some teams and countries are trying to proactively reach women who have missed ANC visits to offer HIV testing and infant prophylaxis as needed or requested.

Should we continue offering PrEP to PBFW during this time?

Absolutely. PrEP is a critical HIV prevention tool. Consider multi-month dispensing of PrEP. Additional discussion of PrEP in PBFW considerations below, HIV Prevention- PrEP.

If safety concerns related to COVID-19 result in WLHIV giving birth outside facilities, should they be offered newborn prophylaxis to take home in case they deliver at home/in a community setting?

Yes, this can be supported through PEPFAR programming.

- Consider providing infant ARVs with dosing instructions to women who will not be able to return to the facility for delivery. Please ensure that women are offered the correct regimens and dosages pursuant to local guidelines and provide supply for as long as necessary. The weight of

the unborn infant will need to be estimated by the provider in order to determine the correct dosing. It may be useful to estimate if the baby will be small, medium, or large to determine which weight band to use.

- In some countries, mother-baby packs have been used to package ARVs for mother-infant pairs together. Clinic staff can actively follow up with WLHIV by phone to check in on accurate dosing. Retention and adherence support can also be reinforced by phone through community cadres, such as M2M, Mentor Mothers and/or OVC community caseworkers.

- If a woman has been given drugs to keep at home for newborn prophylaxis and she comes to a facility for delivery, she should bring the drugs with her for her newborn.

Should EID continue during the COVID-19 pandemic?

Yes, EID is an essential service. There is high mortality associated with untreated HIV among infants. HIV-exposed infants should continue to receive an EID test and clinical assessment as close to the recommended algorithm timing as possible. Routine immunizations are also an essential life-saving health service for infants, and EID testing and EPI schedules are commonly aligned. Fears of COVID-19 may make women reluctant to attend postnatal visits with their infants, threatening scheduled EID testing and immunizations.

Consider options for timing and location that allow for social distancing such as reducing wait times and crowded waiting rooms through scheduling and staggering appointments, streamlining clinic flow so that patients do not interact with multiple clinic providers, and providing EID and immunizations during the same health facility visit or in community settings if possible.

Consider creating an area for postpartum/well-baby checkups that is near to but separated from the health care facility to reduce contact/exposure for PBFW and their infants. Every effort should be taken to minimize stigma by integrating HIV services for HIV-exposed infants and mothers with postpartum/well-child services including immunizations. If mobile testing or point of care services are available at the community level, please consider expanding those options.

Women are not returning with their infants for follow up visits or HIV testing. Most mass immunization campaigns have been suspended. How can we improve services for PBFW during the COVID-19 pandemic?

Retention and adherence support to pregnant and breastfeeding women is still crucial to prevent MTCT. Consider expanding phone/SMS support to mothers and infants through existing support mechanisms (e.g. community health workers, peer navigators, M2M, mentor mothers) to align with ANC, PNC, and FP clinical touchpoints, as well as identifying transport methods to bring women or infants who are high risk or in need of clinical support to the facility.

Can pregnant and breast-feeding women with HIV or at risk for HIV receive a COVID-19 vaccine?

Yes. Both pregnancy and HIV infection are conditions associated with severe COVID-19 disease. The WHO SAGE Roadmap For Prioritizing Uses Of COVID-19 Vaccines In The Context Of Limited Supply recommends that pregnant women be prioritized for COVID-19 vaccination in the tier "Groups with comorbidities or health states determined to be at significantly higher risk of severe disease or death". Compared with non-pregnant women, those infected with COVID-19 during pregnancy are at higher risk developing severe

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disease, ICU admission, mechanical ventilation, and death. COVID-19 infection in pregnancy is also associated with adverse pregnancy outcome such as preterm birth and neonatal COVID-19 infection. Although PBFW were not included in the initial vaccine clinical trials, data from animal studies and post-introduction surveillance have not shown increased risks of vaccination in pregnant compared to non-pregnant individuals. Breastfeeding women should receive COVID vaccination like any other adult and should continue breastfeeding when vaccinated.

12. HIV Prevention – General

Can implementing partners who work on HIV prevention activities continue operations during the COVID-19 pandemic?

HIV prevention activities can and should continue. The safety of staff members, volunteers and clients must be prioritized, and person-to-person interactions should be limited whenever possible – but PEPFAR is not stepping away from the life saving measures that HIV prevention services bring to people around the world. Alternate methods of communication such as phone calls, WhatsApp and text messaging services should be utilized in order to minimize individual visits, meetings or counseling sessions related to HIV prevention.

Why are we concerned about HIV acquisition rates increasing during periods of confinement/social isolation/self-quarantines?

Physical confinement measures are critical to contain the spread of COVID-19, but as these periods of confinement are extended, there is growing potential for increasing rates of sexual exposure for many people. Interpersonal violence, including sexual violence and violence against women and children may increase. Agencies need to work with IPs and Government to ensure that information about Gender Based Violence (GBV) is provided. Please see GBV specific FAQs. Sharing local contact options of responders who can address GBV related concerns may be initial options in some PEPFAR contexts.

What are some HIV prevention services that can be kept operational within the physical distancing parameters of COVID-19?

Some examples such as the following should be considered based on populations at risk and budget availability:

- As PEPFAR teams prepare supply chain forecasts early, they should ensure that condom and lubricant supplies are also increased both to account for the increase in need, and because bulk packaging/delivery will be necessary once shipments arrive (i.e. clients will no longer be able to take 1 or 2 condoms at a time during a clinic visit or from a volunteer health care worker at a community gathering); Please see the supply chain section on condoms.

- Packaging of condoms and lubricants should be made in larger than normal quantities (akin to multi-month dispensing of ARVs) so that clients can obtain necessary supplies in sufficient quantities that allow them to minimize the number of collection visits they might need to make to a collection point. Distribution points or displays should be modified in order to allow clients to pick up these products without touching or handling products for other clients (e.g. avoid bowls)

13. HIV Prevention - PrEP

Should PrEP be considered an essential prevention intervention during the COVID response?

PrEP is an essential component of PEPFAR HIV prevention programming. Strong advocacy for PrEP service delivery should continue as part of comprehensive combination prevention including risk reduction counseling (by phone), condoms, and lubricants, referrals to VMMC, DREAMS, or as outlined in country guidelines. All efforts should be made to scale up PrEP during COVID-19.

Can multiple months of PrEP be given on the first/initiation visit? What happens to the currently standard one-month check in visit?

If a client is committed to taking several months of PrEP from initiation, it should be allowed. This should be assessed and decided by the client and provider together according to the client's needs. Many clients express interest in taking PrEP but either don't start or don't follow-up at the one-month visit. Follow-up one month after starting PrEP remains important but can be conducted through other available modalities, including outside of the clinic space or by phone. This decreases facility congestion and allows better adherence to social distancing and mask guidance, but also increases accessibility of services for clients. Success with multi-month dispensing of PrEP during COVID-19 should encourage its continuation and scale-up even as COVID-19 disruptions and restrictions ease. HIV testing is required every 3 months for PrEP users

Are there innovations or programmatic solutions that implementing partners (IPs) can utilize to keep PrEP services going during COVID-19?

PEPFAR recommends moving PrEP services away from and out of facilities, using virtual options for client initiations, refills and check-ins, decentralizing dispensing of PrEP through community delivery, and moving to multi-month dispensing (MMD) as much as possible. Increasing PrEP use will have the impact of reducing new infections in vulnerable populations. We recommend using SMS for refills and pill taking reminders, for example. While these innovations are important to COVID mitigation, they should also be continued even when mitigation for COVID is no longer needed as an ongoing effective way to increase clients' access to PrEP.

Should demand creation for PrEP continue?

Demand creation based on larger social gatherings, or social mobilization, may be paused until social distancing requirements are relaxed in the specific community. However, other demand creation based on no-contact or limited-contact platforms such as radio, printed materials or virtual platforms such as videos, internet banners or podcasts should continue. With increased attention to social platforms (WhatsApp, Facebook, Instagram) to encourage community cohesion during physical isolation periods, community leaders and mentors can continue to encourage PrEP uptake safely from these settings.

Programs should actively and regularly evaluate the ability to safely resume the full spectrum of demand creation activities.

How will PrEP be affected?

If a client is committed to taking several months of PrEP, a 3-month supply of medication should be dispensed. Any interim or follow up visits to assess side effects should be done by telephone, SMS, internet, or e-mail if possible (with agreement of clients). Teams are encouraged to immediately calculate any

increase in PrEP that would be required to dispense 3 months' worth of PrEP. Even when/where social distancing requirements are relaxed in the specific community, these follow up methods can be continued where effective to increase clients' access to PrEP.

Community distribution and PrEP continuation support in small groups for PrEP may help support people and would not be a burden on the health care system. Continuation group meetings over the phone and use of SMS to send reminders is suggested as well. It is suggested that decentralized drug distribution approaches be considered for PrEP that include peer home delivery, scheduled community or private pharmacy pick-ups, or distribution through pop-up pharmacies (that dispense other products such as products for hypertension, diabetes, HIV self tests, etc.).

Decentralized approaches can be used whether dispensing a monthly or 3-month supply. Note that it is up to the provider and client to decide how many months to dispense according to the needs of the client, and this can be done at any visit, including the first. As multi-month dispensing of PrEP occurs, it will be important to notify supply chain colleagues to ensure adequate supply planning.

Can HIV self-testing be implemented as an alternate approach to monitoring PrEP clients for incident HIV infections?

During COVID-19, some settings experienced disruptions to HIV testing services and began using HIV self-tests to maintain essential services –including for quarterly HIV testing for PrEP users. WHO supports the use of HIV self-testing during COVID-19 only as an interim measure and is currently reviewing evidence on the use of HIV self-testing for PrEP initiation and continuation. Oral fluid-based HIV self-tests are usually not recommended for PrEP users due to a lower sensitivity and longer window of detection. Blood based self-tests are preferred over oral fluid self-tests if available. However, providers could consider use of self-tests when other options are not available, in situations where a PrEP client has been adherent and when the local COVID context prevents them from accessing a HIV testing with a blood sample using the approved national algorithm.

14. HIV Prevention – VMMC

VMMC services were heavily impacted by the COVID-19 pandemic. There was a significant decrease in performance in FY20Q3, during which many programs were partially or completely suspended.

By FY20Q4, most PEPFAR priority countries resumed VMMC services, although many programs continue to operate at a decreased volume due to COVID-19-related restrictions. Overall, resumption has not been uniform across and within OUs due to varying local COVID-19 situations. Innovative approaches to demand generation, client scheduling, and remote follow-up are a few ways programs have adapted to continue service provision in the context of COVID-19. The COVID-19 pandemic continues to affect VMMC performance and programs must continue to assess the local context and prioritize the safety of healthcare workers, clients, and communities when making decisions about VMMC program implementation. We commend each program's focus on safety.

What should VMMC programs consider in restarting services in the context of COVID-19?

Programs should actively and regularly evaluate their ability to safely resume and continue VMMC services. When restarting VMMC services, programs should conduct a readiness and risk assessment, and adapt

services as required to mitigate risk of COVID-19 infection. This will require careful consideration of how programs and services will be modified to align with safety recommendations. Although VMMC is an important component of the overall strategy to address the HIV epidemic, it is an elective, preventive intervention. Thus, the risks and benefits of reopening or continuing operation of a site/program must be weighed. Each program will need to adapt their approach and activities to their context and unique transmission scenario, considering both the epidemic and compliance with national standards and guidelines.

Using a phased approach in reopening (for example, initially limiting the number of locations and procedure volume at those locations) allows programs to quickly address inevitable challenges. Services at a particular site should only resume when essential risk mitigation interventions needed to comply with national standards are available at and possible for that site. The safety of participants and practitioners must be assured in PEPFAR supported programs. See guidance on infection protection and control and PPE.

Please see [here](#) for further considerations, and resources for programs to use in planning for restarting or continuing services.

Should country teams continue reporting VMMC Notifiable Adverse Events and conducting investigations?

Teams should continue reporting NAEs as they normally would. If guidance around travel/stay-at-home orders makes the investigation of NAEs impossible, please include that information in the initial notification email to VMMC_AE@state.gov. Interviews can be conducted virtually if in-person is not possible. **Investigations of any cases involving the death of a client should continue as normal to the extent possible**. Country teams should reach out to VMMC_AE@state.gov for any further guidance as needed.

Should possible or confirmed cases of COVID-19 among VMMC clients or staff be reported to PEPFAR by the site as a notifiable adverse event (AE)?

On resumption of service delivery IPs should have written procedures for identifying and triaging clients and staff with potential COVID-19 exposures or illness. Possible and confirmed cases of COVID-19 identified through VMMC site activities should be tracked and reported in accordance with national standards but should not be reported as VMMC-associated AEs to PEPFAR. Site-level information about possible and/or confirmed cases of COVID-19 among VMMC clients or staff is vital for decision making for the program (e.g., weighing the risks/benefits of resuming or re-suspending services). Because a timely and appropriate response can reduce transmission, IPs should develop plans consistent with national guidance for how to respond to potential or confirmed COVID-19 cases. Please see section 5 for further details about HCW with COVID-19.

What age considerations should be followed for VMMC once services are resumed?

VMMC eligibility includes:

1. No circumcision in boys under age 15

2. For boys under 15 presenting for VMMC, provide other age-appropriate prevention services as outlined in COP21 guidance, counsel the client/parents on additional risks identified in boys 10-14 and encourage them to return for VMMC when the boy is 15 years or older.

The only exception to this age guidance is use of the ShangRing device to circumcise boys aged 10-14 years, with prior approval from OGAC to do so. Note that in COP21 guidance, this ShangRing exception changes to ages 13 and 14 only. This must be accompanied by enhanced safety monitoring as detailed in the OGAC communication (email) sent to programs on 1 October 2020. Guidance may be found [here](#).

15. DREAMS

How are DREAMS activities being affected?

During periods of COVID-19-related restrictions and lockdowns, in-person DREAMS activities have been limited or paused, especially those that involve group in-person meetings.   This involves interventions across multiple DREAMS core package components and target populations, such as AGYW (including AGYW who belong to key populations), parents/caregivers, and community members. Because DREAMS aims to build social connections between AGYW and behavioral skills through hands-on practice, in-person delivery is a critical feature of DREAMS programming and should be prioritized for resumption as soon as safe and allowable by local guidelines.

How can we continue in-person, group-based DREAMS activities in the era of COVID-19?

All DREAMS activities that involve group gatherings (e.g., community mobilization and norms change sessions, parenting sessions, and 'safe space' sessions) should follow local guidelines for COVID-19 prevention, including those on mass/group gatherings. During escalations of community COVID-19 spread, partners may need to pause in-person group activities based on local guidelines on lockdowns, gatherings, etc. If this is the case, partners should stay engaged with AGYW based on the Continuum of Virtual DREAMS Content Delivery outlined below until activities can safely resume, per local guidelines. Please see the [HRH Section](#) on maintaining safety of health workforce in the evolving context of COVID and the [Community Meetings and Trainings](#) section for additional guidance.

While adhering to proper COVID-19 safety measures for staff, mentors, and beneficiaries, we encourage teams to be creative in providing interventions and services to AGYW. For instance, if allowed, and whenever possible, DREAMS interventions should be delivered outdoors with smaller groups of AGYW using proper COVID-19 precautions (e.g. cloth face coverings for facilitators and beneficiaries, social distancing, hand sanitizer). Please refer to the [Infection Prevention and Control](#) section of this document for additional detail. If DREAMS groups are delivered indoors, teams/partners should ensure that the room is well-ventilated and can accommodate social distancing requirements and that all staff and participants follow face-covering recommendations. If multiple groups are meeting concurrently in a shared space, whether indoors or outdoors, teams/partners should ensure enough physical space is allowed between groups to adhere to local mass gathering guidance. Larger cohorts of AGYW can be split into smaller groups.

If groups cannot gather or individuals cannot meet in person, how should DREAMS IPs stay engaged with AGYW?

Delivery of in-person DREAMS activities should be re-assessed on a frequent, regular basis to align with changing regulations and ensure they are paused and resume as safe and allowable by local guidelines However, where in-person group-based activities still need to be paused based on local regulations, a major priority is to maintain contact with DREAMS beneficiaries in the most practical and cost-effective way possible. Depending on the country and local context, this might be via SMS, phone calls, or other digital

platforms such as WhatsApp. Digital contact should be made both individually and as a group if possible. As possible, partners should report on the number and proportion of AGYW with whom they are able to maintain contact.

Contact should focus on keeping beneficiaries engaged with mentors and peers and providing referrals for time-sensitive clinical services (e.g. GBV response, FP, and PrEP). AGYW should continue to access clinical services as needed. In addition, IPs should deliver information ranging from basic check-ins to some standardized topline messages (see Figure below). **Please note that** *IPs should NOT deliver curriculum-based interventions (e.g., primary prevention of HIV and sexual violence curricula) in a fully virtual format at this time* due to concerns regarding fidelity to the evidence-base and equity due to varying internet and technology access*.* A hybrid virtual/in-person curriculum delivery model may be explored within limited parameters and contexts, and in collaboration with AGYW/OVC ISMEs and the AGYW Prevention COOP's Virtual Program Delivery Subgroup. For additional detail on content that can be delivered at each point in this continuum, see the [Virtual Delivery of Group-Based DREAMS and OVC Content during COVID-19](#) document on the DREAMS SharePoint site. OU teams considering hybrid virtual/in-person curriculum delivery should review the document and accompanying checklist to develop a proposed modification plan for AGYW COOP and S/GAC approval.

Figure: Continuum of Virtual DREAMS Content Delivery

If groups cannot gather or individuals cannot meet in person, how should DREAMS IPs train mentors and program facilitators?

Please see the Community Meetings and Trainings section for guidance about virtual training of trainers/facilitators/implementers. An interagency subgroup of the AGYW Prevention COOP is reviewing all virtual training of trainer (ToT) adaptations proposed for implementation in multiple DREAMS/OVC countries. OU-specific virtual ToT adaptations do not require COOP review, but should be reviewed by country teams and ISMEs using this checklist on the DREAMS SharePoint page.

How may COVID adaptations impact primary package completion and reporting of AGYW_PREV?

DREAMS IPs should deliver the full core package to as many AGYW as safely possible under COVID-19 travel and group restrictions. However, at this time, some AGYW who need to complete one or more curriculum-based intervention(s) in order to complete the DREAMS program may NOT be able to complete the intervention or the DREAMS primary package. They should stay enrolled in DREAMS and complete other interventions as possible until able to resume the in-person interventions. It is understood that this may impact the rate at which AGYW complete DREAMS and overall AGYW_PREV completion rates. The definition of an active DREAMS beneficiary remains as stated in the AGYW_PREV MER 2.5 reference sheet (i.e. started or completed at least one DREAMS service/intervention in the past 6 months (at Q2) or 12 months at Q$ Inactive DREAMS beneficiaries should not be counted under AGYW_PREV. If a large number of beneficiaries are inactive due to COVID-19 complications, please make note of this in the narrative as

directed in the indicator reference sheet. Country teams should identify ongoing challenges and solutions to share with AGYW ISMEs.

How should DREAMS mentors and facilitators be supported during this period?

Mentors and facilitators should have adequate phone airtime and/or data to perform the functions described above (e.g. checking in with beneficiaries, providing referrals to services). Continued support and supervision must be provided to mentors as they carry out their duties in this new implementing environment. Mentors should attempt to maintain contact with beneficiaries in their cohorts with the same frequency with which they would have met before COVID. The IP staff responsible for supervising mentors should continue to routinely engage with mentors and ensure that they have the relevant information and resources to actively link DREAMS beneficiaries to services.

16. Orphans and Vulnerable Children (OVC)

Per MER 2.6 guidance, OVC "active" beneficiaries in the OVC Comprehensive program are required to have a case plan and must receive and eligible service and be monitored at least quarterly. Due to "stay at home" restrictions imposed by host country governments during COVID-19, OVC frontline workers are, in many cases, unable to monitor children via direct contact. Can OVC continue to be counted as "active" if contact is not made in person?

Yes. Since COVID-19 restrictions are being eased in many communities, paused in-person OVC activities should be re-assessed on a frequent, regular basis to ensure they are resumed as soon as safe and allowable by local guidelines. While direct contact is preferred to observe the status of the child(ren) and family, the MER guidance states that monitoring can occur "virtually where needed." In settings of significant COVID-19 transmission, virtual contact may be the only option. This can be through phone calls, SMS, WhatsApp, or group chats. To be counted as "active" under the OVC Comprehensive program, all OVC_SERV requirements must be met, including: having a case plan that has been developed (or updated) in the last 12 months; at least quarterly monitoring; and delivery of at least one eligible OVC service (listed in MER Guidance Appendix E) in each of the previous two quarters. Documentation of any virtual contact should be recorded in the child's case plan. If beneficiaries do not meet this definition of "active," they should be counted as "exited without graduation" and an explanation provided within the OVC_SERV MER narrative.

As many OVC programs shift to providing temporary virtual support to children and families via remote case management, which services may be counted under OVC_SERV?

Any OVC service included in MER Guidance (Appendix E: Illustrative eligible services for active OVC beneficiaries) that can be delivered or facilitated via remote/virtual support, in line with host country government social distancing policies and guidelines, can be counted. For example, adaptations may include providing treatment literacy and adherence support, through routine phone, SMS, and/or WhatsApp communications and support. Remote case management can facilitate linkage to local food supplementation, hygiene supplies, social grants, and distance learning opportunities. IPs are also encouraged to incorporate COVID-19 prevention messaging per host country MOH guidelines and resources into their virtual support to households.

Please note that curriculum-based interventions that require skills building (e.g. primary prevention of HIV and sexual violence curricula) **should NOT be delivered in a fully virtual format** due to concerns about

fidelity to the evidence base and equity due to varying internet and technology access. A hybrid virtual/in-person curriculum delivery model may be explored within limited parameters and contexts, and in collaboration with AGYW/OVC ISMEs and the AGYW Prevention COOP's Virtual Program Delivery Subgroup. For additional detail on content that can be delivered at each point in this continuum, see the [Virtual Delivery of Group-Based DREAMS and OVC Content during COVID-19](#) document on the DREAMS SharePoint site.

Please see the [Community Meetings and Trainings](#) section for guidance about virtual training of trainers/facilitators/implementers. An interagency subgroup of the AGYW Prevention COOP is reviewing all virtual training of trainer adaptations proposed for implementation in multiple DREAMS/OVC countries. OU-specific virtual ToT adaptations do not require COOP review, but should be reviewed by country teams and ISMEs using [this checklist](#) on the DREAMS SharePoint page.

HIV Risk Screening in OVC

If OVC case management shifts to a phone-based or virtual approach, consider including HIV risk screening of OVC with unknown HIV status in the list of phone-based services. Implementing partners can develop a list of children who need HIV testing to ensure these children are linked to services as soon as possible. OVC staff should work with nearby facilities to facilitate completion of testing referrals. IPs and OVC staff should be aware of potential confidentiality issues due to a virtual case management approach and should mitigate these issues as possible.

OVC Enrollment in the Context of COVID-19

Should enrollment in OVC programs continue in the context of the COVID -19 epidemic?

The safety and wellbeing of OVC workers and potential beneficiaries are of the utmost importance and should be prioritized when assessing whether to continue enrollment during COVID-19. PEPFAR-supported cadres should follow host government guidance as it relates to new enrollments and avoid unnecessary interactions with potential beneficiaries in facilities, communities, and homes to reduce exposure to and spread of COVID-19. National approaches and sub-national unit operations to prevent COVID-19 transmission may vary within a given country or region. If enrollment is not allowed or feasible, programs should create a waiting list or tracking system to ensure that eligible beneficiaries who were not able to be enrolled due to COVID-19 can be rapidly enrolled when normal operations return.

If enrollments into OVC programs are feasible, which infants, children, and adolescents should be prioritized?

OVC programming should follow current COP guidance. Populations to be prioritized for enrollment include:

- Children and adolescents living with HIV (C/ALHIV)
- HEI at high risk of treatment interruption (i.e. pregnant and adolescent mothers and their infants)
- Children of adults living with HIV at risk of treatment interruption; children who have lost parents to AIDS
- Children of female sex workers (especially FSWLHIV))
- Survivors of sexual violence

If OVC enrollment is allowed/feasible, how should enrollments of priority sub-populations take place?

As previously discussed, OVC programs should explore the temporary use of telephone-based enrollment and referrals. In select cases (e.g. critically ill child/child failing treatment, child abuse), in-person referrals, enrollment, and immediate linkage to emergency services may be required (see PEPFAR FAQs regarding home visits and GBV/CP). Key steps for enrolling priority OVC sub-populations in the COVID-19 operating context include:

- Update program MOUs, SOPs, and/or referral protocols between OVC and accredited clinical, child protection/social service, and law enforcement service providers to include an option for routine telephone-based referrals to the OVC program. Referrals to OVC should include accurate telephone contact information for each child's parent/primary caregiver.

- Designate relevant OVC case workers to serve as points of contact for phone-based referrals; ensure that the service providers mentioned above have case workers' current contact information; and ensure the provision of adequate airtime for OVC case workers processing referrals via phone. Provide case workers with forms, paper records to document calls.

- Based on receiving a phone referral from a service provider, the OVC case worker contacts the child's parent/primary caregiver via phone; provides key information about the OVC program and the types of support provided; and offers OVC program enrollment to the family.

- If the parent/primary caregiver accepts OVC program enrollment, the OVC case worker proceeds to request additional child and family information via phone in order to complete the program enrollment form.

- The OVC case worker and parent/primary caregiver arrange an appropriate date and time for a follow-up call to conduct a broader assessment of the child and family in order to complete the OVC needs assessment form.

- The OVC case worker opens a new child and family OVC case file and initiates remote case management (including care plan development, relevant counseling, service linkage where feasible, and monitoring) via routine telephone checks-ins with the parent/primary caregiver.

Please see the FAQ on testing children under HIV Testing, and cadres working with children and families under HRH for further relevant information

How should PEPFAR-supported cadres work with children and families in households?

Home visits, when necessary, can still achieve important objectives. Key considerations include:

- To ensure safety and well-being of both home visitors and families, program staff should determine whether a home visit is absolutely necessary.

- Home visitors should help to ensure that all PLHIV have access to six months MMD, ideally through community-based distribution points, to maintain adequate supply of ARVs at home as well as TB medicines, TPT and other required medications

- To protect home visitors and beneficiaries, every effort should be made to use phone calls and/or text messages to communicate.

- Home visitors who are at higher risk for severe COVID-19 should consider avoiding home visits. Home visitors should NOT visit beneficiaries if the visitor has any symptoms of acute illness,

especially fever, cough, or shortness of breath, even if the symptoms are mild. Home visitors should NOT visit beneficiaries known to have a recent exposure to a person who tested positive for COVID19 or is suspected of having COVID-19.

- Many issues can be managed through counseling by phone. If unable to communicate via phone, situations that may warrant a visit include: 1) a critically ill beneficiary that urgently needs transport assistance to the clinic or hospital, 2) a child or adult exposed to physical harm, abuse or neglect requiring urgent attention, 3) CLHIV (or adult due to disability or other limitation) who cannot access ART and is in danger of treatment interruption.

- If the visit is deemed essential, ensure appropriate measures, including personal protective equipment (PPE) if available, are in place before, during, and after the visit. Both OVC staff and the client(s) must consent to a visit. Once the family is stabilized, focus should then be to assist with 6mo MMD and/or drug pick-up from a community-based distribution point to ensure adequate supply of ARVs at home.

Considerations for resuming services/reopening: Home visits may occur if they are deemed safe and in line with local guidance. However, PEPFAR programs should continue to utilize the alternative methods listed above to the degree practical and effective, to continue to minimize risk to HCWs.

Over a million children have lost one or both parents (or a custodial grandparent) due to COVID globally according to new estimates published in the Lancet how can PEPFAR respond to these children?

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01253-8/fulltext

- While the majority of COVID response efforts fall outside of PEPFAR's mandate, PEPFAR investments in child protection infrastructure over nearly two decades has enabled countries now grappling with COVID-19 to better respond to children affected by this new threat. It is also key to note that in COVID-affected communities where PEPFAR has active programs, PEPFAR is playing an incredibly important role in both preventing and responding to violence against children through both Orphans and Vulnerable Children and DREAMS platforms.

- The USG response specifically directed to children who have lost caregivers to COVID is led by the Interagency COVID Task Force and implemented by several different USG departments and agencies. It is critical to coordinate any efforts with these entities as well as with international development partners at the country level through the Child Protection Cluster.

For a better understanding of what PEPFAR can (and is currently) funding in regard to vulnerable children, as well as what could be funded through other resources (both USG and non-USG) please refer to the following document here. PEPFAR OUs are encouraged to share the linked document with their implementing partners. A joint report from USG, WHO, the World Bank and others citing the estimates of children who have lost parents and other caregivers to COVID, as well as recommendations for the response can be found here.

17. Key Populations (KP) Services During the COVID-19 Pandemic

Depending on how COVID-19 impacts your country, there may be significant interruptions in access to HIV services for key populations. This may lead to economic uncertainty, increased risk-taking behavior, further

experience of stigma and personal violence. Community outreach and traditional peer outreach approaches will likely be disrupted and will need to be adapted based on the client's needs.

What should be prioritized for Key Populations?

- Uninterrupted HIV treatment access, clinical care, and support are critical to maintaining access for key populations.
- Services should be modified and decentralized so that all KPs can continue to access treatment, PrEP and viral load testing and other care through community platforms.
- Continued coordination and collaboration among community case management teams prioritizing virtual platforms to determine appropriate and needed differentiated services for KPLHIV

What can be done to support people who inject drugs to maintain access to medication assisted treatment (MAT) given COVID-related restrictions?

- Country teams should work with IPs, partner governments, civil society and others to explore and implement take away dosing of MAT, where stable MAT clients are provided with extra doses of medication to reduce the need to attend the clinic for daily dispensing. Policy changes may be required.

Testing, Prevention and PrEP Services

- Prioritize differentiated service delivery through community initiation and refill of PrEP and delivery of HIV testing including self-testing via mobile clinics, drop-in centers (DICs), and other community platforms or alternative arrangements for pickup or delivery of services
- Ensure peer outreach workers have enough supply of commodities and/or there are also community distribution points for commodities like condoms, lubricant and self-test kits.
- **Leverage Virtual Approaches**: Use of social media, phone, SMS, and alternative methods of communication by health care and peer workers may ensure critical services are continued.

Ensure Safety of Key Populations

- Programs should track reports of barriers to service delivery
- Work with IPs and engage KP community-based organizations to provide basic communications materials including infection prevention
- Programs should ensure violence prevention mechanisms and referrals are functioning to track and link clients to needed services. PEPFAR funding cannot support the provision of housing for at-risk clients, but instead recommends referring to existing resources

Is there an update on index testing for key populations?

The evolving situation with COVID-19 may have implications for HTS implementation, monitoring and achieving HTS results, and teams are expected to operate under any COVID-19 related country guidelines as well as KP and HTS programming considerations below. However, given the progress made in recent months on ensuring HTS minimum standards through multiple processes, at this time, the previous halt on active index testing among key populations has been lifted. PEPFAR will work with country teams to ensure

that either: (1) existing data confirm that current HTS provision at sites meets minimum standards or (2) sites are brought up to standards and assessed using vetted and valid tools. PEPFAR remains committed to ensuring all sites providing index testing services do so in a manner that meets established standards. Consult your S/GAC chair or PPM if needed.

18. Gender-Based Violence (GBV) & Child Protection (CP)

What should all PEPFAR teams be aware of regarding violence during the COVID-19 pandemic?

Domestic violence has sharply increased since the COVID-19 outbreak (Godin, 2020). Violence, particularly intimate partner violence (IPV), increases risk of HIV acquisition (WHO, 2013) and can negatively impact an individual's adherence, retention, and viral suppression (Hatcher, 2015), PEPFAR programs must respond to violence to maintain achievements in retention and viral suppression during the COVID-19 outbreak.

All PEPFAR programs (both clinical & community) can respond to GBV and CP by:

1. Advocating with host governments to designate child protection and GBV responders (and their organizations and government agencies) as essential and operational during lockdowns. This also includes child helplines and other remote services.

2. Working with local governments, community partners, local organizations, and other donors to continuously update lists/directories (e.g. contact information, opening hours) of all local GBV/CP response services and national hotlines that are functional, including both clinical and non-clinical supportive services.

3. Specific considerations for clinical and community partners are noted in the following FAQs. Additional resources can be found [here](#).

If there is immediate concern for a child being exposed to physical harm, abuse or neglect that requires urgent attention, this should be reported to the appropriate accredited authorities. Please see FAQs on home visits.

How can clinical partners respond to GBV and CP issues during the COVID-19 pandemic?

1. Ensure that all staff have access to an updated list of local GBV/CP responses services and national hotlines for referrals.

2. Facilities should have printed material that provides information on functioning local GBV/CP services and national hotlines that providers can discreetly give to clients. Community partners and local organizations may already have materials available for distribution.

3. Providers should deliver age-appropriate first-line support (LIVES) to all clients who disclose violence and provide or refer clients to appropriate, functioning GBV response services.

4. Providers should help clients make a plan to stay safe at home while living in quarantine or isolation, including tips on how to safely access support. Ensuring privacy is critical (e.g., using a safety/code word if disclosing violence in proximity of the perpetrator). It is important to do no harm.

5. Providers should help clients find ways to discreetly and safely take their ARVs while in quarantine or isolation. This is important for people who have not disclosed their status or use of ART or PrEP to their partner/family.

6. Ensure PEPFAR-supported specialized GBV/CP facilities or one-stop-centers have enough phone/internet credit to provide virtual psychosocial support and safety planning services.

How can community partners respond to GBV and CP issues during the COVID-19 pandemic?

Maintain and adjust communication

- Implementing partners (IPs) should use calls, SMS, social media, and/or work with Governments to provide information about GBV/CP and COVID-19, including contact information for functioning GBV/CP response services.

- IPs with access to media such as radio, internet, or television can provide information on the risk for increased interpersonal violence during COVID-19 and resources available to those who need support.

Keep in contact with those at elevated risk for GBV or child abuse/neglect

- For participants who have disclosed experiences with violence or are potentially at higher risk for violence, staff (e.g., counselors, social workers, gender leads) may proactively reach out and discretely offer support, including developing a safety plan in the case of quarantine or social isolation and ensuring those in need know how to safely access support. Ensuring privacy is critical (e.g., using a safety/code word if disclosing violence in proximity of the perpetrator). It is important to do no harm.

- Programs that have existing relationships with individuals and families (e.g., OVC, DREAMS) should maintain communication using virtual platforms as possible. Please refer to the DREAMS FAQ on maintaining contact with AGYW.

Support frontline staff

- IPs should ensure their field staff, mentors, and community health workers have the resources (e.g., internet connection, airtime) to reach out to PEPFAR participants to provide support, safety planning, and linkage to services as necessary.

- IPs should promote self-care and prioritize safety of staff, being cognizant of potential trauma during emergency situations.

Ensure appropriate response services are in-place and known

- Ensure that all staff have access to an updated list of local GBV/CP responses services and national hotlines for referrals.

19. Civil Society Engagement

How can community and civil society organizations provide input to PEPFAR about its response to COVID-19?

PEPFAR values the perspective of community and civil society organizations at both the global and local level. Community and CSO engagement with and observations of PEPFAR programming and response to COVID 19 can help us further refine our activities. If CSOs and communities have questions, comments, or observations about how PEPFAR is adjusting in the context of COVID 19, feedback can be provided here. PEPFAR teams are encouraged to share this opportunity with local CSOs.

In addition, PEPFAR encourages OUs to engage in virtual consultations with local civil society and community organizations as teams make decisions about and adaptations to programming in the context of the COVID 19 pandemic. While it is understood that varying degrees of physical distancing measures may preclude in-person meetings in many countries, country teams are encouraged to make use of virtual technologies to convene or otherwise seek critical input from the communities and constituencies that they serve.

What does PEPFAR do with the feedback from stakeholders?

As of July 10, 2020, PEPFAR has received 58 submissions to its online COVID-19 stakeholder feedback mechanism (here). Responses were submitted by a range of civil society organizations and community-based implementing partners. Diverse topics were covered, including comments, questions, and concerns about the purchase of PPE, availability of nutritional support, HIV commodities availability, virtual program adaptations, MER target achievement, and others. Each submission is reviewed by a PEPFAR U.S. government interagency task team, drawing in additional subject matter experts as necessary, to determine which refinements are needed to PEPFAR's COVID-19 FAQ and guidance, which is updated weekly. PEPFAR continues to find these questions and feedback extremely important for understanding "on the ground" realities and will continue to review incoming submissions and make adjustments or clarifications to the guidance accordingly.

20. Faith and Community Based Organizations

How can Faith and Community leaders help with the multiplicity of challenges countries are facing due to the co-occurrence of HIV and a COVID-19 pandemic?

● Provide accurate and timely information from reliable sources about practical considerations and recommendations for religious leaders and faith communities in the context of COVID-19. See example here.

● Encourage PLHIV in and/or known to their congregations, to maintain an adequate supply of ART and to request multi-month distribution of ART.

What changes in the 'Faith and Community Initiative' activities are needed during the COVID-19 response?

In the context of COVID-19, PEPFAR-supported staff working on priority #1 of the FCI: "Engaging faith communities to reach men and children living with HIV, and to link and retain them in care", should be focused on supporting, maintaining, and extending the continuity of HIV testing and decentralized treatment services for men, youth, and children, by:

● Leveraging functioning religious structures to use weekly virtual Facebook Live/YouTube® religious services for congregations and men's, women's, and youth groups, as well as congregational WhatsApp groups, to disseminate HIV Messages of Hope, prioritizing messages that use FCI message

prototypes (SMS messages, video clips, etc.) to support ART adherence and continuity of treatment; leveraging these religious structures to integrate COVID-19 risk prevention communications for at-risk populations and PLHIV.

- Expanding engagement of Religious Leaders affected by and living with HIV, in reducing HIV-associated stigma/discrimination, to also address the harms of stigma/discrimination associated with TB and COVID-19

- Expanding client base of faith-engaged decentralized neighborhood Community Posts to increase convenient access to MMD, among index clients and contacts,

- Expanding evidence-based FCI models that promptly link highly targeted HIV self-testing to either prevention or treatment services

- PEPFAR-supported FCI staff providing psychosocial support to boost adherence should conduct home visits and in-person support in accordance with national and local COVID-19 mitigation regulations.

PEPFAR-supported staff working on priority #2 of the FCI: "Strengthening Justice for Children" will need to adjust the 4 required activities to align with local "stay at home" orders and guidance regarding mass gatherings.

- Since COVID-19 restrictions are being eased in many communities, paused in-person JfC activities should be re-assessed on a frequent, regular basis to ensure they are resumed *as soon as* safe and allowable by local guidelines. Please see the DREAMS and OVC sections of this document (Sections 13 and 14) for guidance on how to resume in-person, group-based JfC activities in the era of COVID-19. For countries in which restrictions prohibiting these activities still exist, OUs should continue to follow the guidance below:

- Country teams and IPs should continue planning for future trainings and education modules as well as who the target audience(s) will be and appropriate venues for when restrictions are lifted.

- If already part of implementation plans, efforts focused on Justice Sector systems change should continue and be finalized, with government entities using conference calls and video platforms, if available.

- Justice for Children implementing partners should review the technical guidance on Child Protection and GBV (see section 17) to ensure that they can provide appropriate assistance regarding post-violence care for survivors of violence.

- Investigation is underway to determine whether evidence-based interventions and curricula can be delivered remotely or virtually and further guidance will be issued if and when these approaches are deemed safe and appropriate.

21. Infection Prevention and Control

What measures should be implemented to reduce COVID-19 exposures in the healthcare setting?

- The basic principles of IPC and standard precautions should be applied in all health care facilities and are critical to containment of SARS CoV-2.

- Health care facility visits should be minimized when possible.

- **Universal source control measures** should be used. This refers to the use of face coverings over the mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. The WHO has recommendations about the composition of these face coverings and how to use them appropriately.

- Patients with respiratory symptoms should be provided medical masks, as opposed to face coverings, upon entry to the health care facility

- HCW should practice universal **medical masking.** In settings where widespread COVID-19 is suspected or documented, WHO recommends that all healthcare workers, including community health workers and caregivers, should wear a medical mask at all times, for any activity (care of COVID-19 or non-COVID-19 patients) and in any common area (e.g., cafeteria, staff rooms)

- As of December 2021, the WHO has updated guidance in light of the rapid spread of the Omicron variant of concern: while the recommendation remains that a respirator (FP2, FFP3, NIOSH-approved N95, or equivalent or higher-level certified respirator) or medical mask should be worn along with other PPE before contact with a patient with suspected or confirmed COVID-19. WHO guidance now also highlights that a respirator SHOULD be used in care settings where the ventilation is poor and according to healthcare worker values and preferences and on their perception of what offers the highest protection possible. , and wherever aerosol generating procedures are being performed on patients with suspected or known COVID-19. More information on medical masks a from the FDA can be found here. Other required components of PPE for healthcare workers providing care of suspected or confirmed COVID-19 include eye protection (goggles or face shield), long-sleeved gowns and medical gloves. Information about appropriate use of PPE for a wide variety of situations and healthcare personnel can be found here: Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages (who.int))All facilities should have a designated focal point to oversee and monitor infection prevention activities; this individual should be supported to provide the basic principles according to WHO guidance which include:

    o Written procedures for identifying and managing clients and staff with potential COVID- 19 exposures or illness;

    o Systematic triage to identify ill persons;

    o Strict adherence to hand hygiene and respiratory hygiene;

    o Prioritization of care of symptomatic patients;

    o When symptomatic patients are required to wait for services; ensure they are placed in a separate waiting area;

    o Appropriate supplies to allow implementation of contact and droplet precautions for all suspected COVID-19 cases. Any healthcare worker or caregiver providing care to a known or suspected COVID-19 patient either in a facility or home should wear appropriate PPE.

- o Strict protocols for routine cleaning and disinfection of medical equipment Information on cleaning and disinfection in the context of COVID-19 can be found here: Cleaning and disinfection of environmental surfaces in the context of COVID-19 (who.int) With appropriate cleaning, environmental contamination should not be a reason to close clinics.
  - o Education and training of staff regarding IC precautions for COVID-19;
  - o Ensure adequate ventilation in waiting areas and procedure/testing areas, using an "open window" policy
  - o Assurance of appropriate and safe waste disposal of PPE and other items that might have been exposed to COVID-19
  - o Contact and droplet precautions are recommended for COVID-19 protection. Airborne precautions are recommended only for staff performing aerosol generating procedures. These procedures include tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, and bronchoscopy.
  - o Guidance on cleaning and disinfection of environmental surfaces in the context of COVID-19 can be found here. With appropriate cleaning, environmental contamination should not be a reason to close clinics.

- Similarly, home care or community healthcare workers should consider using a medical mask when in direct contact with a patient (e.g. when obtaining blood for an HIV test) and social distancing measures cannot be maintained. Updated guidance that including information about disposal of potentially contaminated medical waste has been provided by the WHO in this document on page 3.

- WHO has recently released updated guidance for infection prevention in the setting of COVID-19 which is largely congruent with PEPFAR guidance (see here).

What type of PPE is required?

- The rational, appropriate, and correct use of PPE is essential to maximize the protection of healthcare staff and to help mitigate supply shortages.

- The WHO has outlined the appropriate PPE for healthcare workers based on the setting and the types of activity performed (see here and here).

- Facilities should conduct monitoring of PPE use by healthcare workers and other staff working in healthcare settings to ensure compliance with recommended practices use results to guide improvements.

Healthcare workers providing direct care to patient with respiratory symptoms:

  - ▪ Medical mask*, Gown, Gloves, Eye protection
  *N-95 Respirators and aprons should be used
  N-95 Respirators should be used if performing aerosol-generating procedures, in areas where aerosol-generating procedures are regularly performed, and in settings where ventilation is poor or cannot be properly assessed or maintained.
  - ▪ Medical mask
  - ▪ PPE according to standard precautions and risk assessment

- Healthcare workers conducting triage (NOT in direct contact with patient AND able to maintain recommended social distancing)
  - Medical mask
- Laboratory personnel handling respiratory specimens:
  - N-95 respirator if TB is suspected, medical mask otherwise, Gown, Gloves, Eye protection
- Cleaners
  - Medical mask, gown, heavy duty gloves, eye protection, boots or closed work shoes

Additionally, facilities should establish systems to monitor PPE stock, track distribution, and manage ongoing procurement

What should we do in the setting of a resurgence of cases of COVID-19?

The WHO has [WHO Information Note: COVID-19 considerations for tuberculosis (TB) care](#) on a range of action steps to be followed in the setting of a resurgence of cases of COVID-19 designed to reduce transmission of health care associated infections and to lower the risk of the health care facility amplifying the outbreak.

What measures should be implemented to ensure safety in non-clinical workplaces?

The safety of all PEPFAR supported staff including implementing partner staff, must be assured. Activities must be in compliance with national government and health authority guidance and include appropriate social distance, hand hygiene and face coverings for source control. Remote work options should be considered where feasible and appropriate ([see here](#)).

How can we perform hand hygiene during visits to clients without running water?

Alcohol based hand rubs are an effective method of hand hygiene and are an important part of the WHO "clean hands" campaign, which has been active since 2009 [(see here)](#). WHO and UNICEF are now sponsoring "Hand Hygiene for All Global Initiative" cosponsored by UNICEF [(see here).](#)

Hand hygiene is a critical intervention for the prevention of COVID-19 infection. It is also important for prevention of healthcare associated infections and combatting spread of multidrug resistant bacteria – for this reason, hand hygiene remains essential to quality healthcare delivery.

A method for local production of hand hygiene products is [here](#).

More information on personal protective equipment can be found in that section.

Cloth face coverings (or Homemade Masks)

Should IPs promote the use of non-medical (or homemade) masks as personal protective equipment (PPE) for health care personnel in PEPFAR-supported health clinics/facilities?

No. Non-medical or homemade facemasks are not considered PPE because they have unknown protective capabilities. This is consistent with both CDC guidance and WHO guidance.

Should IPs promote the informal production and use of non-medical (or homemade) masks to prevent community spread of COVID-19?

- The WHO has issued guidance on the use of masks in community settings as part of a comprehensive package of prevention and control [measures](#). The guidance emphasizes well-fitting masks and includes information about essential parameters of effective masks.

- Decisions regarding the use, promotion and informal production of cloth face coverings should align with local customs and guidance issued by national authorities in the context of COVID-19. If cloth face coverings are used, best practices should be followed about how to wear, remove, and dispose of them, and for hand hygiene after removal. IPs should always communicate that cloth face coverings used in community settings are distinctly different from PPE used in healthcare settings for the provision of clinical services.

22. Laboratory Services

How should PEPFAR supported laboratories ensure uninterrupted HIV (VL/EID) and TB testing in the midst of COVID-19?

The goal of antiretroviral therapy is virological suppression that should be determined by testing for viral load at six months after initiating ART and then yearly thereafter. Though many PEPFAR supported programs have made significant progress in achieving between 85% and 95% viral load suppression, some of these countries are below 80% viral load testing coverage. Similarly, though significant progress has been made in improving infant diagnosis, many countries have not yet reached the 90% target for EID coverage by 2 months of age and have lengthy turnaround time and poor linkage to ART (<95%). Recent efforts to bridge these gaps have been impacted by COVID-19 at the country level. Many patients did not come to the clinic for sample collection and laboratories were unable to transport samples from rural communities to the central laboratory for testing.

Supply chain challenges associated with border closures and global flight restrictions, further led to reagent stock outs and sample backlogs. The use of instruments originally procured for HIV (VL/EID) and TB testing and repurposing of some HIV molecular staff   to support COVID-19 has also impacted some programs. As such, previous guidance recommended prioritization of COVID-19, EID, TB, and VL for children, PBFW, and virally non-suppressed clients. As the COVID-19 situation improves, PEPFAR teams should work with country MOH and other stakeholders to routine and uninterrupted VL, EID and TB testing. In doing this, COVID-19 mitigation options should be deployed within the facilities that allow for social distancing. These include reduction in waiting times for sample collection, avoiding crowded waiting rooms, scheduling and staggering appointments, streamlining clinic flow so that patients for sample collection do not interact with multiple clinic providers, and reactivating safe sample transport systems. These should be implemented to ensure improved sample collection and testing. More use of DBS for sample collection outside of the facilities to avoid many patients coming to the facility for sample collection should be encouraged. The use of point of care platforms in the interim to test and deliver quick results to avoid patient or sample movement should be considered as well.

As noted, programs faced huge supply chain issues at the beginning of COVID-19 due to manufacturing gaps or delays in shipment due to air traffic and border closures, which have improved significantly in many countries. To avoid this, programs should place orders for laboratory test kits and consumables at least one month earlier than baseline to account for potential shipping delays. OUs should routinely review and

update current stock counts at national and subnational levels and forecast for additional consumable needs. In PEPFAR supported laboratories running COVID-19 and HIV-related tests on the same instrument, standard operating procedures (SOPs) should be developed in collaboration with the MOH and other stakeholders to document how concomitant testing will occur. Issues to be considered and agreed upon include consumable use, sample transport, data systems, space and time allocation, and HRH.

23. Supply Chain/Commodities

Supply Chain for ARVs

The supply chain continues to operate at a reduced capacity and delays are anticipated for the foreseeable future.

The situation in India is devastating. Most ARV orders originating in India, how will the most recent situation in India impact supply security?

Orders for abacavir/lamivudine/dolutegravir (ALD) are delayed because of a variety of reasons including absenteeism from manufacturing sites, transportation delays of API (abacavir) from China to India. We will continue to monitor the situation and provide you with updates.

Action required: Please convert existing orders for COP21 funded ARVs, particularly TLD, to firm orders so as to avoid the potential for commodity security risks, such as stock outs and increases in prices, associated with a potential pause in manufacturing.

What will USG do to mitigate risks? ? At the Annual ARV Summit, USG provided an update on the forecast to the ARV manufacturers with an outlook for the next 18 months to CY23Q2.

How will the India situation impact the introduction of pediatric dolutegravir?

Fortunately, the suppliers that manufacture pediatric dolutegravir 10 mg, also manufacture TLD. Both formulations rely on dolutegravir API and suppliers report that they have sufficient stock of dolutegravir API for three to four months. The first deliveries of pediatric dolutegravir have begun to arrive in country, with some arrive two to four months ahead of schedule.

What should be done to prevent country-level drug shortages?

Consider the following interventions:

- Substituting products/formulations where necessary.

- Ongoing supply plan and inventory data (PPM/R) review to identify and respond to urgent need

- Decentralized distribution approaches (as highlighted above) that include: Home deliveries, community or private pharmacies, pharmacy in a box and automated lockers.

- Order staggering to prevent delivery delays

- Reallocation of urgently needed orders to less impacted suppliers, as warranted and feasible

What about laboratory reagents?

Because of the demand for testing and the use of common consumables and starting materials for VL, EID, and SARS-CoV-2 molecular testing, laboratory consumables are in short supply globally and reagents are facing longer lead times. Mitigation measures have been in place to track consumption and stock on hand on a regular basis. We will continue to monitor the situation and provide relevant updates.

Supply Chain for Condoms

My country is concerned about potential condom and/or lubricant stock-outs due to COVID-19. What are our options to access PEPFAR assistance for these commodities?

While some PEPFAR programs are accustomed to using central funds to procure condoms and/or lubricants, many countries currently obtain male and female condoms and lubricants from non-PEPFAR sources for distribution within PEPFAR-supported services. Supply chain for health has been tracking the impact of COVID-19 on condoms suppliers. Currently, we do not foresee any major impacts to any current USAID orders, but longer lead times should be expected. We will continue to monitor the situation and provide relevant updates.

 We are aware that other donor sources have experienced more significant delays in production and/or shipments due to COVID-19. Early modeling on the global potential impact of COVID-19 on HIV indicates that disruptions in condom supply may lead to an increased incidence of HIV. Condom availability is an essential component of many PEPFAR prevention, testing, and treatment services and national programs should strive to make sure that in-country supplies are sufficiently available.

Based on coordination with other country actors (donors, private suppliers, etc.), country teams are highly encouraged to discuss their condom and lubricant supply status with their supply chain POCs, tabulate any anticipated gaps in condom and/or lubricant availability within PEPFAR programs, and estimate their potential budget needs. PEPFAR's GHSC-PSM program has some ability to rapidly source additional condoms and/or lubricants communicating earliest product availability dates as a stop-gap measure. If usual condom and lubricant support is unavailable in a PEPFAR supported area, OUs may work with their respective Chairs and PPMs to develop proposals for reprogramming limited amounts of PEPFAR funding for condoms and lubricants. These proposals should follow previously provided reprogramming guidance and will require approval by S/GAC.

Tracking Supply Chain Impact

How will supply chain risks for COVID-19 be tracked?

GHSC-PSM in conjunction with USAID has developed a **COVID 19 Impact Dashboard**, which will allow Mission supply chain staff to track the impact of COVID-19 on their orders. Additionally, GHSC-PSM is developing a **Market Risk Map** by commodity portfolio to assess the short-term and long-term sourcing risks and develop mitigation strategies as appropriate.

How will USAID and GHSC-PSM Mitigate Risk?

- Early Identification of Delayed and At-Risk Orders
- Bi-weekly order status reports from all suppliers with supplemental calls as needed
- Ongoing monitoring of key raw material export data

- Ongoing market assessments to identify capacity constraints

- Ongoing updates on sampling restrictions and communications with QA labs

- Exploring alternate shipment modes to reduce delays

- Coordination meetings with WHO Access to Medicines and Health Products, and the Global Fund

Personal Protective Equipment (PPE)

What about personal protective equipment?

Implementing partners may use PEPFAR COP and PEPFAR ARPA funding to procure PPE without further approvals for the protection of and use by PEPFAR supported staff or for the safe and effective continuity of PEPFAR-funded programs.

Implementing partners should ensure that facility and community-based staff providing HIV services are equipped with PPE appropriate to their job duties (e.g., HIV testing, handling of drugs, etc.), in accordance with available local guidelines for use of PPE. Partners should consider PPE requirements and needs for community health workers, home visit staff and other community staff according to national and WHO guidelines for community-based care during COVID-19.

Note: HIV testing (or other direct HCW-patient interaction for HIV services) should not take place where routine adequate PPE is not available, (e.g. gloves and masks for phlebotomy).

Requirements for PPE can be found [here](#). Information about the use of PPE for infection prevention may be found in the IPC section 21.

See additional information on respirators, surgical masks, and face masks from the US Food and Drug Administration [here](#) and [here](#), plus further resources from the CDC [here](#).

If a health care worker and client have both been vaccinated are masks still required?

Both WHO and CDC guidance have not changed for the health care setting, and thus PEPFAR continues to recommend continuous medical masking for health care workers and universal face coverings for facility visitors regardless of vaccination status. The CDC guidance is limited to the United States and not meant to address international settings and recommended precautions during international travel remain unchanged. Although CDC may provide further guidance for the non-healthcare workplace setting, this guidance will likely only be applicable within the United States. Host country guidance and local US Embassy standards of practice for maintaining a safe working environment should be maintained.

24. Operations

How will operations at PEPFAR be affected and what measures should be taken to prevent disruptions?

- Social distancing measures including quarantine have resulted in disrupted operations due to evacuations, travel restrictions and fragile communications networks outside of the larger cities. PEPFAR country teams should make all efforts to stay in communication with headquarters, and with implementing partners who may be most affected.

- Requests to utilize resources that support HIV services but also respond to COVID-19 should follow budget guidance that has been provided in a separate document. Agencies at Post must, in turn, consult with the S/GAC Chair with copy to **SGAC_M&B@state.gov** ahead of granting approval for such activities.

25. Reporting and SIMS

We are having challenges collecting data. Is there a process for relaxing some of the data requirements?

PEPFAR does want to acknowledge the need for flexibility due to the impact of COVID-19, but in order to best understand the services PEPFAR needs to provide clients who are also impacted by COVID-19, reporting must be as complete and timely as possible. If certain reporting requirements can't be met, that should be noted in the narratives in DATIM as much as possible, giving a sense of how much reporting is missing (rough estimate is fine -- a tenth of sites, half the sites, etc.). This will allow everyone reviewing the portfolio to be on the same page.

- The FY21 Q3 regular deadline for data entry is Aug 13th (import deadline Aug 6th)
- The FY21 Q3 cleaning deadline for data entry is Sept 17th (import deadline Sept 10th)
- If these deadlines are not possible, please contact us so we can discuss options. We will try and assess the situation in late August/early September. Please alert your PPM, who will alert DUIT through the DUIT Liaisons. Solutions at that point will depend on indicators involved, and whether reported results impacted are usually entered directly into DATIM or imported, but may include some form of entering Q3 results in Q4 window.
- Please be advised we can't show data that wasn't reported, and so if data entry can't happen, this may add complexities to discussion, review of progress at Q3 POART. We continue to have warnings on Panorama that this may be an issue broadly.

The original MER 2.0 v 2.5 reporting requirements should be followed for all FY2021 reporting, as much as feasible. We do recognize that the COVID-19 situation is constantly evolving and want to keep all PEPFAR and PEPFAR-supported staff as safe as possible, and in compliance with Chief of Mission directives and Host Country Government policies.

Are we expected to continue SIMS implementation and reporting?

SIMS implementation and reporting has been limited by the pandemic and expect it will continue to be affected during this time. Teams are requested to keep their S/GAC chair and PPM updated on changes in SIMS implementation status. In general SIMS assessments should not be performed where COVID-19 spread is prevalent in the community. If considering adaptations due to COVID-19, please review SIMS 4.1 Implementation Guidance (page 21-22) and contact SGAC_SIMS@state.gov during planning.

Budget Guidance

Please coordinate with your agency financial and agreement management POCs for how to address any budget implications of implementing this guidance.

Can PEPFAR Panorama help us communicate COVID impacts on our program?

In light of COVID, PEPFAR has developed the COVID MER dossier to assist USG stakeholders to more easily access and understand the impact on PEPFAR programs. The purpose of this dossier is to:

I. Better understand COVID-19 situation in PEPFAR countries

    a. View current and past trends in COVID metrics

    b. View current and past vaccine coverage

    c. Anticipate and prepare for potential challenges

II. Examine MER data in context of COVID-19

    a. Assess potential program challenges, impacts, and adaptations

    b. Provide additional context for MER performance

The dossier receives public COVID case, mortality, stringency index, mitigation data reports, vaccine doses, fully vaccinated status, and vaccine narratives from John Hopkins University, the WHO, and Our World in Data. This is imported into PEPFAR systems and is merged with MER data. Given the nature of how this data is collected and merged, the dossier is housed in PEPFAR internal USG systems and not available for public access.

Users can access the COVID MER dossier by logging into PEFPAR Analytics Workspaces (PAW): workspace.pepfar-panorama.org following the path (Project: Workspaces, Folder: COVID 19). Please note, user access is limited to PEPFAR USG colleagues with access to Panorama. If users have issues accessing this workspace, please submit a Zendesk ticket https://pepfar-panorama.zendesk.com/hc/en-us.

26. Information and Resources

Resources and Information on Implementing PEPFAR During COVID-19 Pandemic:

*   https://pepfar.sharepoint.com/:b:/r/Shared%20Documents/01.06.21%20PEPFAR%20Technical%20Guidance%20During%20COVID.pdf?csf=1&web=1&e=VABGla

World Health Organization's Mobile Learning App:

*   With content in six languages, the app delivers mobile access to a wealth of COVID-19 knowledge resources developed by WHO, including up-to-the-minute guidance, tools, training, and virtual workshops to support health workers in caring for patients infected by COVID-19 and protect themselves as they do their critical work. It is available in the Apple App Store https://apps.apple.com/us/app/who-academy/id1506019873?ls=1 and the Google Play Store https://play.google.com/store/apps/details?id=org.who.WHOA

Specimen Handling, Testing and Laboratory-related Resources

*   CDC Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html
*   WHO Guidance on Laboratory Testing of 2019-nCoV in Humans: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/laboratory-guidance

- WHO Laboratory Biosafety Guidance Related to COVID-19: https://www.who.int/publications-detail/laboratory-biosafety-guidance-related-to-coronavirus-disease-2019-(covid-19)

Information for Pediatric Healthcare Providers:

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html

Resources on GBV and Child Protection:

- Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook – WHO, 2014
    - Job aids can be found on pages 11 (how to ask about violence) and 14-32 (LIVES, including safety planning and referrals)
- Caring for women subjected to violence: A WHO curriculum for training health-care providers - WHO, 2019
- Integrating Violence Against Children Prevention and Response into HIV Service
    - Job aids can be found in the Participants Manual on pages 48-53 (LIVES) and 72 (referrals).

Training Resources:

- The Strengthening Interprofessional Education for HIV (STRIPE) program offers trainings specific to COVID-19 for HIV care providers at: https://stripe-website-dev.globalhealthapp.net/module-material/.

Food Security references:

- Food and Agricultural Organization, Q&A: COVID-19 pandemic – impact on food and agriculture, http://www.fao.org/2019-ncov/q-and-a/impact-on-food-and-agriculture/en/?fbclid=IwAR0LkDhDLGABJx6kgwXJs9R4f0CjocQVnIMEpMGFmBnV4Fo57yCAqXhnRss
- International Food Policy Research Institute, Poverty and food insecurity could grow dramatically as COVID-19 spreads, 4/16/20. https://www.ifpri.org/blog/poverty-and-food-insecurity-could-grow-dramatically-covid-19-spreads

Hand hygiene resources

- CDC hand hygiene https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html
- WHO info graphic https://www.who.int/infection-prevention/campaigns/clean-hands/WHO_HH-Community-Campaign_finalv3.pdf

COVID-19 Vaccine resources:

WHO resources:

- https://www.who.int/publications/i/item/WHO-2019-nCoV-vaccination-demand_planning-tool-2021.1
- https://www.who.int/initiatives/act-accelerator/covax/covid-19-vaccine-country-readiness-and-delivery/acceptance-and-demand
- WHO: The different types of COVID-19 vaccines: https://www.who.int/news-room/feature-stories/detail/the-race-for-a-covid-19-vaccine-explained
- WHO: The Road to COVID-19 Vaccine: https://www.youtube.com/watch?v=CrsnwQZIak8

- WHO: How do vaccines work? https://www.who.int/news-room/feature-stories/detail/how-do-vaccines-work
- Vaccine Safety: https://www.who.int/news-room/feature-stories/detail/safety-of-covid-19-vaccines
- https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-vaccines-safety

CDC Resources:

- Building Vaccine Confidence in Health Systems and Clinics – presentation on tips for immunization coordinators
- Building Confidence in COVID-19 Vaccines
    - Guidance on how to conduct a rapid community assessment to understand barriers and facilitators of vaccination
    - 12 COVID-19 Vaccination Strategies for your community
- Building Confidence in COVID-19 Vaccines Among your patients
- Talking with Patients about COVID-19 Vaccination (applying Motivational interview principles)
- Video on COVID-19 conversations that is really good.
- How to talk about COVID-19 vaccines with friends and family
- Link: Talking to Recipients about COVID-19 Vaccination | CDC (see the Education Materials for Vaccine recipients)
- COVID-19 Vaccination Toolkits | CDC
- Building Confidence in COVID-19 Vaccines – Has key strategies, resources, and a readiness checklist that can be tailored to specific populations.
- Benefits of Getting a COVID-19 Vaccine: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html
- This page on how to have conversations with parents about vaccines might be helpful: https://www.cdc.gov/vaccines/hcp/conversations/index.html

Other Resources:

- The Immunization Action Coalition has developed handouts on vaccine confidence in different languages that may be helpful.
- UNICEF: Interpersonal Communication for Immunization Training Guide for Front Line Workers
- Key messages from a rapid review on Vaccine Hesitancy and Building Confidence in COVID-19 Vaccination: https://www.socialscienceinaction.org/resources/covid-19-going-beyond-misinformation-to-build-vaccine-confidence/
- https://covidbehaviors.org/
- https://resourcecentre.savethechildren.net/
- https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/15794/SSHAP%20Rapid%20Review_Vaccine%20Hesitancy%20and%20Building%20Confidence%20in%20COVID-19%20Vaccination%20.pdf?sequence=4&isAllowed=y

Vaccine adverse event monitoring

- https://www.who.int/docs/default-aource/coronaviruse/vaccine_safety_poster_final.pdf?sfvrsn=31614713_5

Anaphylaxis management:

- https://www.who.int/teams/regulation-prequalification/regulation-and-safety/pharmacovigilance/health-professionals-info/aefi#:~:text=Effective%20spontaneous%20reporting%20of%20adverse,and%20are%20being%20safely%20administered.&text=The%20goal%20is%20that%20all,investigating%20those%20that%20are%20serious.
- https://www.un.org/sites/un2.un.org/files/coronavirus_vaccination_anaphylaxisguidelines.pdf
- https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html