



# Guide for Contingency Planning for Key Population HIV Services

during COVID-19  
and Other Emergencies

2021

# Table of Contents

Acknowledgments . . . . .	3
Introduction . . . . .	4
<b>Key Definitions</b> . . . . .	<b>5</b>
<b>Timing and Purpose of This Document</b> . . . . .	<b>6</b>
Global Background, Resources, and Literature . . . . .	8
Framework for Contingency Planning . . . . .	11
<b>How to read this Guide</b> . . . . .	<b>13</b>
Guide for Contingency Planning for Global Health Security Events and Other Emergencies . . . . .	14
<b>Essential Health Sector Interventions</b> . . . . .	<b>14</b>
HIV prevention . . . . .	14
HIV Testing & Linkage to Care . . . . .	19
HIV treatment and care . . . . .	23
Prevention and Management of Coinfections and Comorbidities . . . . .	28
General Care . . . . .	31
<b>Enabling Environment</b> . . . . .	<b>33</b>
Financing . . . . .	33
Laws, policies and practices . . . . .	33
Antidiscrimination and protective laws . . . . .	34
Addressing violence against people from key populations . . . . .	34
<b>Resilient and Sustainable Health Systems</b> . . . . .	<b>35</b>
Quick Guides to Contingency Planning . . . . .	37
Conclusion . . . . .	41
Annex 1. Country Planning Guide . . . . .	42
<b>Rapid Situation Assessment</b> . . . . .	<b>42</b>
<b>Contingency Planning Template</b> . . . . .	<b>43</b>
Annex 2. Advocacy Agenda Planning Guide . . . . .	44

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## Disclaimer

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Viewpoints presented in this Guide are solely those of the authors and may not coincide with the views of the organizations of the consortium and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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# Introduction

The global outbreak of the novel SARS-CoV-2 coronavirus has dominated global attention since the World Health Organization declared it a Public Health Emergency of International Concern on 30 January 2020, and subsequently categorized it as a pandemic on 11 March 2020. By 4 April 2020, over one million cases of COVID-19 had been recorded globally; by 30 June 2021 there had been over 181 million confirmed cases globally, with over 3.9 million deaths.

The impact of COVID-19 on the Eastern European and Central Asian (EECA) region has varied, ranging from just under 100,000 confirmed cases and 1500 deaths in Montenegro to almost 5 million confirmed cases and over 116,000 deaths in the Russian Federation by the end of June 2021. With concurrent HIV epidemics, all highly concentrated amongst key populations, all countries shared one thing in common: the need for a robust COVID-19 response threatened to derail progress made in containing HIV transmission and supporting the health and well-being of people living with HIV (PLHIV).

Even under normal circumstances, key populations – including people who use drugs (PWUD); gay, bisexual and other men who have sex with men (MSM); sex workers (SW); and transgender people – can be difficult to reach with effective programming. With the increased pressures of COVID-19 restrictions, the disruption of services across the spectrum from prevention to treatment and care is inevitable – at least without significant, thoughtful adaptation of programming. During the first, disorienting year of the COVID-19 pandemic, service providers and key populations alike rose to the challenge of rapidly adapting services to ensure as much continuity as possible. This document shares glimpses into some of those successes. Alas, the COVID-19 pandemic continues, and has exposed several serious faults in the systems designed to serve key populations. Any one of these faults – weaknesses and vulnerabilities in the system – has the potential to lead to interruptions for at least some segments of some key populations.

But there is a bright side: using the lessons that have been learned from COVID-19, many countries have already strengthened their approaches to account for the limits the current pandemic imposes, and they are now much better prepared to thoughtfully plan for future emergency responses. With careful adaptations to services conceived in advance, and able to operate within a clear framework of policy, practical guidance, and robust monitoring, countries will be better prepared to assure continuity of services while also taking advantage of more efficient and sustainable approaches.

**The following Guide to Contingency Planning for Key Population HIV Services provides a framework by which countries in EECA – or elsewhere – can examine the lessons of the COVID-19 pandemic and systematically strengthen their service delivery paradigms to ensure reliable, robust outcomes from services even under the most dire or unexpected emergency circumstances.**

## Key Definitions

### ***What is contingency planning?***

The World Health Organization defines contingency planning as “part of a cycle in which the identification and regular monitoring of risks, vulnerabilities and capacities informs the planning and implementation of measures to mitigate the risks and prepare to respond.”<sup>1</sup>

### ***What does contingency planning mean in the health sector?***

For the broader health sector, most contingency planning for COVID-19 or for similar infectious disease outbreaks of international concern (e.g. influenza pandemics) is centered on assuring adequate health system capacity and systems to respond to the emerging threat. This may typically include the reduction of focus on non-essential health services in order to devote more resources to the emergency situation.

### ***What does contingency planning mean for HIV and key population services?***

Contingency planning for HIV and key population services focuses on the optimization of existing services to assure continuity during an emergency. In contrast to general health sector contingency planning, it does not seek to reorient around an emerging crisis but rather to safeguard service continuity despite the emergency.

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<sup>1</sup> WHO (2018) Guidance for contingency planning, p4. Accessible at:  
<https://apps.who.int/iris/bitstream/handle/10665/260554/WHO-WHE-CPI-2018.13-eng.pdf?ua=1>

## Timing and Purpose of This Document

This Guide was developed in the first half of 2021, already a year into the COVID-19 pandemic and after the development of several successful vaccines to prevent COVID-19 from manifesting and spreading.

While this Guide is inspired by needs and challenges associated with the COVID-19 pandemic and designed to respond directly to the ongoing COVID-19 impacts, it also acknowledges that it may appear to be awkwardly timed – in fact, it is too late to develop “contingency plans” for the initial outbreaks of COVID-19 across EECA.

Indeed, in ideal circumstances, contingency plans are made in advance of a crisis, and enacted as needed. At the same time this Guide has three main values to be considered for EECA countries as the pandemic continues:

1. COVID-19 has been shown to develop in **outbreak waves** – with a rise in cases precipitating further, exponential rise, typically until behavior change (e.g. wearing of face coverings, restriction of movement or “lockdowns”, etc.) or a strong increase in vaccination causes cases to drop again. Even countries who have been through multiple waves up to this point, may face another wave in the coming months. Putting in place contingency plans to react to future waves still has the potential to improve continuity of service delivery for key populations.
2. At the time of publication of this Guide, **vaccine access** was still highly inequitable, with high-income countries accounting for over 80% of all COVID-19 vaccination globally. Many EECA countries do not hope to achieve herd immunity until at least the end of 2021, providing the need for COVID-19 mitigation strategies for several more months.
  - For both of these factors, the continuity of services may be of increasing importance as time progresses, and populations become weary of COVID-19 risk aversion.
3. While the challenge presented by COVID-19 for key population programming was unprecedented, it was characterized by individual elements that, combined, caused such severe disruption. During the development of this Guide, the following key **elements of disruption** were identified:



**Restriction of movement**



**Transportation changes**



**Physical contact restrictions**



**Limited access to government institutions**



**Supply chain disruptions**



**Economic distress and reduced demand for services**

While the confluence of these elements, experienced rapidly and concurrently, was unique to the COVID-19 epidemic, these individual elements can be experienced in many different emergency scenarios. Recognizing and preparing for them, individually, is good practice for safeguarding the continuity of key population programming for potential future emergency scenarios. These might include, but are in no way limited to:

- Localized natural disasters, leading to disruptions in transportation and access to health care, and potentially resulting in economic distress
- Local political or social unrest, leading to restrictions on movement and disruptions in transportation services, with the potential for disruption in access to health care and government institution, and/or economic distress, depending on severity and length
- Regional or global trade disruptions, leading to supply chain disruptions and/or economic stress
- Future pandemics, public health security events, or even local epidemics or outbreaks of infectious diseases (including potential flu or coronavirus variants, or other novel infectious agents)

Therefore, this Guide has been purposely designed to accommodate themes of disruption that may be applicable to other public health security events or emergencies. This is envisioned to provide not only a longer useful life of this document, but also to assist advocates in making the necessary changes to put in place contingency plans that will be applicable to a wide range of scenarios potentially affecting the continuity of services for key populations.

In addition to safeguarding the continuity of services, the adaptations proposed by this Guide may have one or more of the following benefits contributing to sustainability and efficiency of services:



**Lower-threshold services improve client-centered approach and reduce burden on key populations to accessing services**



**Improved sustainability through reduced cost of operation and increased efficiency**



**Building sustainable bridges between government and non-governmental actors**

# Global Background, Resources, and Literature

In 2018, prior to the outbreak of COVID-19, the World Health Organization (WHO) developed a **WHO guidance for contingency planning**, which anticipates an infectious disease outbreak similar to COVID-19 and lays out a framework for consideration for broader health system contingency planning. It advocates that each country has a system-wide health contingency plan, which monitors risks to population health, plans a response that would mitigate the impact of those risks, and prepares to respond in a way that saves lives and preserves health and well-being. This WHO guidance also calls for the development, simulation, monitoring and regular update of the national contingency plan, with clearly defined roles, responsibilities and planned actions for each partner involved. In the fifteen months this coronavirus has been categorized as a pandemic, several COVID-19-specific resources have been published to describe contingency planning for the novel pandemic. Of particular interest for this region, the European Centers for Disease Prevention and Control have also developed a disease-specific **Guidance for health system contingency planning during widespread transmission of SARS-CoV-2 with high impact on healthcare services**. This guidance focuses on preparing health systems to adequately respond to and mitigate the impact of COVID-19, specifically by protecting populations at risk of severe disease, decreasing the acute burden on healthcare services, and reducing excess mortality from COVID-19.

While these guidance documents are essential for health systems level planning, they describe broad measures to secure health system stability. In settings like the countries of EECA, where HIV is not a public health issue affecting a significant portion of the population (e.g. over 1%), such plans do not specifically include HIV services, let alone a focus on assuring service continuity for key populations. Thus, it is necessary to also consider HIV-specific guidance and experience that has been published within the COVID-19 era to guide the monitoring risks and planning of a response, specifically for HIV and for key populations.

## Risks

The **Global Fund's report on the impact of COVID-19 on HIV, TB and malaria programs** (published April 2021) outlines the risks associated with COVID-19 outbreaks more globally, describing a survey of 502 health facilities in Africa and Asia. This report describes serious impacts on care-seeking, with 85% of facilities reporting a significant decrease in patients seeking care due to fear of exposure to COVID-19, while facilities have also reduced their promotion of services and public health messaging, and in some cases reduced operating hours or scope of services provided. The result has been a reduction of HIV referrals and testing averaging between 30-40% throughout 2020. The report ultimately describes COVID-19 as “creating a perfect storm of economic, health and social crises and threatens to reverse the extraordinary gains made by the Global Fund partnership in the fight against HIV, tuberculosis (TB) and malaria and in building resilient and sustainable systems for health.”<sup>2</sup>

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<sup>2</sup> Global Fund, 2021 (p2)



A number of other resources document the specific impacts of COVID-19 on key populations and the HIV prevention, testing, care and treatment services that are tailored for them in the EECA region. Notably, these were published rapidly by community-led organizations, and typically describe the earliest and most severe impacts of COVID-19 restrictions. These include:

- An early report from the European AIDS Treatment Group on the *COVID-19 crisis' impact on PLHIV and Communities Most Affected by HIV* (published April 2020) reports early and severe disruptions in access to all non-emergency medical care among the 30 survey respondents from 21 countries (including Western Europe). While the report outlines early emerging practices in adaptive response, it also highlights the severe disruption of community-based services and the need to mitigate the impact of travel restrictions on PLHIV and others from key population communities.
- A *Rapid Situation Assessment on Quarantine Measures' Affect to LGBT Community NGOs Working in the Field of HIV Prevention* (published April 2020) by The Eurasian Coalition for Health, Rights, Gender and Sexual Diversity (ECOM) describes significant decreases in the number of NGOs providing in-person services as well as the number of clients being served, as well as reduced client access to HIV testing services in the public sphere.
- The Eurasian Harm Reduction Association's report on *Harm reduction programmes during the COVID-19 crisis in Central and Eastern Europe and Central Asia* (published May 2020), which provides a snapshot of country experiences from 22 countries during the earliest (and in many cases, most severe) restrictions related to COVID-19. It touches on the risks of service interruption and the additional hazards posed by changes in drug supplies and use patterns, and stresses the importance of collaborative partnerships between public and non-governmental service providers – ultimately leading to some positive innovations in remote harm reduction services and adaptive in-person services including take-home OST.
- The International Committee on the Rights of Sex Workers in Europe (ICRSE) and the Sex Workers' Rights Advocacy Network (SWAN)'s report on *COVID-19 crisis impact on access to health services for sex workers in Europe and Central Asia* (published June 2020), which outlines the severe economic impact of COVID-19 on sex workers through loss of livelihood and income, as well as increased risks of violence from law enforcement and inability to access social support networks due to travel restrictions. This report also documents restricted access to health services, from HIV-specific services to more general sexual and reproductive health services, and major limitations in availability of abortion care.

### ***Planning an Effective Response***

To support the planning of an effective response for key populations amidst COVID-19, in April 2020 the United States President's Emergency Plan for AIDS Relief (PEPFAR) project Meeting Targets and Maintaining Epidemic Control (EpiC) released ***Strategic Considerations for Mitigating the Impact of COVID-19 on Key Population-Focused HIV Programs*** (subsequently updated May 2020). This document outlines a three-prong strategy for safeguarding the health of service providers and beneficiaries from COVID-19, sustaining HIV service connections, and monitoring to ensure continuity of services and improve client outcomes. Its step-by-step approach provides detailed guidance for national programs and service providers to take during the immediate crisis, and should be considered a key guidance document at the service implementation level. This guidance is further complemented by a second publication from PEPFAR's EpiC: ***Ensuring uninterrupted essential HIV treatment services to clients during the COVID-19 pandemic*** (published May 2020). While the latter does not focus specifically on key populations, it outlines key elements of differentiated service delivery to be leveraged to ensure continuity of services for PLHIV during the COVID-19 pandemic, and thus should be considered integral guidance especially for key populations living with HIV.

### ***Preparing for Implementation of an Effective Response for Key Populations***

Despite the value of the documented experiences and guidance above, at the time of publication of this Guide, there has been no comprehensive, actionable guidance on advanced contingency planning for key populations' HIV programming. Such a document could guide the strategic preparation for and execution of effective, responsive programming during emergency situations, leaving HIV responses better prepared to implement the types of detailed guidance provided by PEPFAR EpiC. Therefore, this Guide sets out to provide a framework for contingency planning specifically for key population health services in EECA, and provide tools to guide countries through planning processes for COVID-19 and other crises causing similar disruptions.

# Framework for Contingency Planning

The overall purpose of contingency planning for key populations services should be threefold:

Reducing HIV transmission	Reducing HIV-related illness or mortality	Reducing exposure to COVID-19 or other additional risks
<p>While other priorities may take precedent during emergency situations, increased risk environment and risk behaviors may occur and result in increased transmission of HIV. Assuring that HIV prevention services remain accessible and utilized is key to preventing increased levels of HIV transmission.</p>	<p>In order to safeguard the gains in access to HIV treatment and viral suppression, it is critical to assure that PLHIV have uninterrupted access to antiretroviral treatment (ART) and monitoring. Other critical health services, including tuberculosis and viral hepatitis screening and treatment, should also be available to reduce the impact of coinfections.</p>	<p>Out of both the respect for the human rights of key populations, and also the public health benefit, it is critical to assure that key populations are not at increased risk for exposure to COVID-19 (or other emergency-related risks) due to their HIV-related health needs.</p>

This Guide adopts a framework that is aligned to the *WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (WHO, 2016), which outlines essential health interventions for key populations:

1. HIV prevention
2. HIV testing and linkage to care
3. HIV treatment and care
4. Prevention and Management of Coinfection and Comorbidities
5. General Care (including sexual and reproductive health, nutrition)

Across these interventions, this Guide also considers key elements of resilient and sustainable systems for health (RSSH), as outlined by the Global Fund to Fight AIDS, Tuberculosis and Malaria and identified as critical for reaching Sustainable Development Goal #3. These are described below, alongside a summary of how each can be impacted by COVID-19 or other similar emergencies.

**People-centered service delivery** becomes even more critical during an emergency like the COVID-19 pandemic, in which individuals must weigh the risks and benefits of accessing health care services against the risk of exposure to COVID-19 or other health or physical safety threats.

**Human resources** are likely to be strained by COVID-19 or similar emergencies, due to the reallocation of health personnel (especially those trained in infectious disease) to respond to COVID-19 or other health emergencies, as well as by staff illness. Breakdowns in transportation systems can also affect health personnel availability.

**Community systems** are essential in a response to COVID-19 or other health security threats in which government and potentially other private sector health systems are overwhelmed and/or prioritizing other services. At the same time, non-medical professionals and those working outside of the formal medical sector, such as outreach workers, counselors, and social workers are not always considered by regulations and laws to be formal contributors to the health sector. During these times, it becomes ever more critical that non-governmental, community-based organizations are recognized as legitimate partners in delivering services to key populations, and that staff of these organizations are afforded the same status in human resources for health. In particular, peer-led approaches may be particularly important to reaching key populations who are displaced or otherwise more difficult to reach due to disruptive elements; the role of peers in accessing harder-to-reach members of populations has been *well-documented by the Global Network of People Living with HIV (GNP+)* and others during the COVID-19 pandemic.

For the purpose of this Guide, Human Resources & Community Systems is addressed as a single, inter-related topic. This is appropriate for EECA, where a significant portion of key population services are provided by community-based actors. For users outside of the EECA region, applicability may vary and local context should be considered.

**Procurement and supply chain** can be disrupted by border closures and slow-down or halt of government services (including Customs procedures), as well as by regional or international commodity shortages.

**Data systems and use** of data play a key role in understanding the degree to which COVID-19 or another emergency is disrupting the provision of, access to, or demand for services. Without responsive data systems and the timely use of the information they produce, disruptions in service and the subsequent health consequences (e.g. increased infections, treatment resistance) can go unnoticed. While data may seem like a secondary priority during an emergency like COVID-19, it is actually more critical than ever to understanding and supporting continuity of services.

## How to read this Guide

Under each essential health intervention below, there are a variety of presentations of information to be used to guide contingency planning for continuity of key population services:

- **Stories from EECA** provide vignettes of the real experiences of key population communities and responses in EECA in 2020 and early 2021, often summarizing common challenges across countries. These provide some context for the Potential Disruptions and Potential Opportunities sections, described further below.
- **Positive Progress in EECA** provides examples of good practices and successful adaptations, either in an individual country or in several countries that took similar approaches to a discrete issue. These aim to provide positive examples that can be drawn upon as the user of this Guide develops ideas for their own contingency planning.
- **Potential Disruptions and Potential Opportunities**, by sub-element of each intervention, provide an analytical summary of the main disruptions that were observed across the region during COVID-19, framed in a generic manner that can foresee a range of different emergency types; and Potential Opportunities finds space for how to use problems to drive innovation and change and, in some cases, improved sustainability or efficiency.
- **Priorities for Continuity** provides a concise summary of the issues that must be addressed as top priorities for each essential health intervention; this summarizes information presented up to this point.
- **Preparedness Checklists** provide step-by-step actions that need to be taken at the policy, implementation and monitoring level in order to successfully achieve the items described in the Priorities for Continuity.

At the conclusion of the main section of this Guide, there is a ***Quick Guides to Contingency Planning*** which further consolidates this information, for easier digestion and use in advocacy, meeting planning, and other practical communications tasks.

# Guide for Contingency Planning for Global Health Security Events and Other Emergencies

## Essential Health Sector Interventions

### HIV prevention

#### Stories from EECA: Challenges Accessing OST Services During COVID-19

*In settings where take-home OST was not permitted, even under emergency circumstances, adherence to OST was a significant challenge for clients. In Belarus, daily presentation for OST during COVID-19 meant increased exposure to law enforcement and concerns about transmission of COVID-19 in crowded OST facilities. In Kazakhstan, the temporary closure of at least one OST site further complicated this, requiring inter-city travel even amidst a strict lockdown where such travel was not permitted.*

*Even in countries where take-home dosing was permitted for ongoing, stable clients, there were challenges in place for people wishing to enroll in OST. In Northern Macedonia and Romania, for instance, no new enrollments were permitted on OST during the state of emergency period – a significant problem at a time when drug markets were disrupted and an increased number of people were reported to be seeking treatment.*

Under HIV prevention, the WHO guidelines define six sub-elements for key populations. Potential disruption of each sub-element, caused by COVID-19 or other emergencies, are summarized below.

#### 1 Comprehensive condom and lubricant programming

*Potential disruption:* Condom and lubricant programming are typically implemented through outreach programs and at fixed, community-based sites (e.g. drop-in centers). A people-centered service model is usually at the core of this programming, due to the stigma, discrimination and criminalization faced by key populations. During COVID-19 or similar emergencies, restricted freedom of movement and transportation can make it more difficult for key populations to access stationary services. At the same time, the highly social nature of outreach and other community-based delivery methods, including drop-in centers and pop-up services (e.g. at night clubs) is at high risk of restriction during an emergency like COVID-19, where social gatherings may be strictly limited. This may create the need for adapted outreach protocols and alternative peer-delivery models.

*Potential opportunity:* The standard of a person-centered approach means that service providers are likely to be attune to client needs and accustomed to adapting strategies, such as outreach, to reach people under difficult circumstances. With advanced preparation, contingency plans for adapted condom and lubricant distribution can assure continued access to these key commodities.

## 2

## Harm reduction for people who inject drugs, including needle and syringe programs, opioid substitution therapy, other drug dependency treat, and overdose prevention

*Potential disruption:* Like condom and lubricant programming, harm reduction services are often delivered through outreach or drop-in centers. This is true for commodity distribution including needle and syringe distribution, overdose prevention, and other safer injecting materials. As noted for condoms and lubricants, increased reliance on outreach may be desirable for harm reduction programming; however, the additional criminalization of drug use and the status of needles and syringes as illegal paraphernalia in some settings can pose significant risks for increased activity by outreach workers. Disruption of drug supply chains and markets may also change injecting behaviors and needs (including requiring more frequent injection), and create additional overdose hazards.

Opioid substitution therapy (OST), on the other hand, is typically delivered through a fixed-site model, often at a government institution. While some countries regularly implement take-home dosing (typically for periods of 1-2 weeks between in-person visits), many require daily presentation to the OST clinic to receive treatment. When transportation systems are disrupted by lockdowns or other restrictions on movement, lack of public transportation can make travel costly or impossible for clients without private transportation. For those who do have private transportation, non-essential movement may be restricted, and special permitting will be needed to move freely to access treatment. In settings where law enforcement is known to harass or extort people being treated for drug dependency, additional hazards may be posed by exposure to the increased presence of law enforcement. The institution of take-home dosing can reduce these burdens and harms, though may still expose clients to the same issues once every week or two.

*Potential opportunity:* As detailed above for condom distribution programs, with careful contingency planning, the supply of needles and syringes may be adapted to work within the parameters of any emergency restrictions. A most critical practice noted during COVID-19 was the distribution of larger quantities of commodities per outreach contact, in order to reduce the number/frequency of contacts needed. Peer-exchange models can also help to expand the reach of services, where some members of populations may not be able or willing to travel to outreach spots, but peers who are mobile can aid in further distribution of commodities.

For OST, well-documented global practice supports take-home dosing of OST for clients who are stable on treatment. Countries which are already regularly using this practice may have an easier time adapting to emergency protocols that require more extended take-home dosing, and may find it more feasible to institute emergency take-home doses (potentially with other support including video observed therapy) for the minority of clients who are not eligible for take-home dosing under normal circumstances. In addition to supporting continued adherence to treatment by clients, this approach also reduces frequency of exposure to non-household contacts for both clients and health care providers – a key benefit during an infectious disease emergency such as COVID-19.

## 3

## Behavioral interventions

*Potential disruption:* Both physical contact restrictions and reduced freedom of movement pose challenges for behavioral interventions, which are often delivered in social settings or in group formats. While clients and outreach workers alike may have difficulty reaching typical gathering places, limitations on gathering sizes and reduced demand for services due to fear of infection with COVID-19 may pose additional barriers.

Additionally, during the 2020 onset of the COVID-19 pandemic, many populations experienced severe economic distress related to loss of employment. This led to housing and food insecurity, and these competing factors can significantly reduce appetite for behavioral interventions to prevent the transmission of HIV.

*Potential opportunity:* While appetite for HIV prevention behavior change may be low during emergency situations, appetite for other aid may be increased. NGOs which typically do not provide humanitarian aid may find that their clientele have overwhelming need for these services, and having contingency protocols in place for aid distribution can help organizations to link emergency commodities and services to continued behavioral intervention messaging to prevent increased HIV risk-taking. Additional efforts may be made to provide behavioral intervention relevant to the emergency context – i.e. services providers may bundle HIV behavioral interventions with both humanitarian aid and also COVID-19 behavioral interventions, including promotion of face-covering, physical distancing and hand-washing.

Delivery of behavioral interventions may also be adapted to virtual format, utilizing a range of methods from sophisticated applications and outreach on existing virtual platforms (e.g. gay dating sites) to simpler push-messaging through SMS or platforms like Telegram or WhatsApp. In these fora, combined messaging for HIV prevention and COVID-19 prevention may also be utilized to ensure that client needs for emergency information are met.

#### 4 Prevention in health care settings

*Potential disruption:* In general, access to health care settings is limited during COVID-19 and therefore the prevention of transmission of HIV within health care settings is not inherently disrupted and may even reduce in frequency. The most critical risk comes from supply chain disruptions that could impact commodities needed for blood supply screening and other infection prevention and control. Health care worker shortages also have the potential to reduce adherence to infection prevention and control protocols, although this phenomenon was not documented in EECA during the COVID-19 pandemic, and therefore is not further addressed here.

*Potential opportunity:* Extra vigilance to infection prevention and control is likely to have a natural positive impact on prevention in health care settings during a public health emergency of an infectious disease nature. During other emergencies, there are unlikely to be significant opportunities to expand this practice – underlining the need for a robust infection prevention and control system that is prioritized under all circumstances.

#### 5 ARV-related prevention

*Potential disruption:* ARV-related prevention, including pre-exposure prophylaxis (PrEP), may be challenging to access either because of disruption in community-based services, as described above; or may have a different set of challenges at health care facilities. For the purpose of this Guide, community-dispensed PrEP scenarios are addressed in this section, while facility-based PrEP dispensing is further addressed alongside HIV treatment, below.

*Potential opportunity:* While community-based dispensation of PrEP has been controversial or faced skepticism in some settings, the strong performance of NGO services providers during COVID-19, including their roll in delivery of ART to PLHIV (see further details below), provides a compelling argument to start or re-open conversations related to the roll of communities in this practice. This is likely to require regulation or policy updates, and potentially special training or staffing arrangements for NGO service providers, and therefore requires a long timeframe to be planned effectively.




#### 6 Voluntary medical male circumcision







Voluntary medical male circumcision is recommended in hyperendemic and generalized epidemics. This is not applicable to any of the countries in EECA, and therefore this sub-element is not considered further in this Guide.



Positive Progress in EECA	
Freedom to Operate Prevention Services in Montenegro	Take-home Doses for Opioid Substitution Therapy
<p>While many countries managed to operate at least some prevention services – including outreach – despite strict lockdowns, in Montenegro NGO service providers were explicitly granted permission by the Ministry of Health to continue the provision of services. This was accompanied by exemption from many of the restrictions on movement imposed on others, and ultimately by the prioritization of outreach workers for vaccination – affirming that prevention services are considered health services, and outreach workers categorized as frontline health care workers. This may be linked to the strong formal relationship between NGO service providers and the Ministry of Health, through social contracting mechanisms supported by the Global Fund grant. This explicit permission to continue service operation reduced risk for NGO staff and clients, assuring that they were not operating outside of the legal restrictions put in place to control COVID-19 transmission.</p>	<p>Seven of the surveyed countries in EECA introduced take-home dosing for opioid substitution therapy (OST) in response to the COVID-19 emergency: Bosnia and Herzegovina, Georgia, Kyrgyzstan, Moldova, Montenegro, Romania and Ukraine. One additional country, Northern Macedonia, had previously-established take-home dosing for OST clients, and maintained this practice during COVID-19. Windows for take-home doses ranged from 5 days to two weeks, and in Montenegro NGOs were permitted to deliver take-home doses of OST to clients who opted into this service. This practice represents an important step forward but comes with room for further growth and improvement: several countries had already removed or attempted to remove take-home flexibilities by the end of 2020, despite ongoing COVID-19 outbreaks.</p>

Priorities for Continuity of Prevention Services
<ol style="list-style-type: none"> <li>1. Ensure that NGO service providers are free to continue prevention operations as essential service providers, including exemptions for staff to travel during lockdown</li> <li>2. Ensure that key populations receive an adequate quantity of prevention commodities while minimizing risks of traveling to obtain them</li> <li>3. Ensure that PWUD who are on OST treatment are able to maintain adherence to treatment while minimizing the risks of traveling to receive treatment</li> <li>4. Incentivize continued access to behavioral interventions by considering and meeting emergency needs paired with HIV prevention messaging</li> </ol>

Preparedness Checklist for Continuity of Prevention Services		
Policy		
Action		Responsible
 Recognize prevention services as health services, and prevention service workers as a class of health care worker		Ministry of Health or relevant regulatory authorities
 Ensure that a functioning financing mechanism whereby government funds can contract non-governmental service providers		Ministry of Health, Ministry of Finance, and/or other relevant government bodies
 Ensure that any legal or regulatory frameworks needed to allow multi-day dispensing of OST, are in place		Ministry of Health and any other relevant regulatory authorities

Practice	
Action	Responsible
 Develop emergency protocols for the distribution of larger numbers of commodities using reduced teams, including the potential use of peer-distribution models	Prevention outreach services providers (both NGO and government, where applicable)
 Develop protocols for distribution of mutual aid and/or humanitarian aid, including how its distribution is linked to regular prevention services (both commodity distribution and behavioral interventions)	NGOs providing prevention outreach services (who do not normally provide humanitarian aid)
 Develop standard operating procedures and/or clinical guidelines to support the dispensation of take-home doses of OST for emergency circumstances (at minimum) and/or for all stable patients (preferred)	Depending on country systems, this may be central authorities responsible for developing SOPs or clinical guidelines, or may need to be done on a facility-by-facility basis
Monitoring	
Action	Responsible
 <ol style="list-style-type: none"> <li>1. Review data monitoring practices and develop agreements for more-frequent-than-usual analysis of prevention services to ensure that trends in client reach, commodity distribution, behavioral intervention delivery can be perceived over short periods in emergency situations</li> </ol>	Depending on the context: <ul style="list-style-type: none"> <li>• In countries where prevention data are compiled centrally, this should be led by the agency that is responsible for compiling data, but undertaken collaboratively with all involved stakeholders</li> <li>• In countries where prevention data are not compiled centrally, this process will need to be undertaken by all</li> </ul>
 <ol style="list-style-type: none"> <li>2. Develop a framework for surveying different populations on their access to and barriers from prevention services during emergency situations, including how clients will be reached for survey</li> </ol>	NGO service providers and/or civil society actors
 <ol style="list-style-type: none"> <li>3. Develop accountability procedures to be enacted during emergency situations, for civil society to monitor delivery of public services</li> </ol>	NGO service providers and/or civil society actors

## HIV Testing & Linkage to Care

### Stories from EECA: Challenges Accessing Testing During COVID-19

*Eight of the fourteen countries surveyed reported reductions in the number of HIV tests administered in 2020 – though it should be noted that among the countries that did not report a reduction, this was due to an absence of data and not due to confirmation that testing rates had not declined. Reductions ranged from 20.7% in Ukraine (all of 2019 to all of 2020) to 75% in Romania (first half of 2019 to first half of 2020), though most countries reported 30-40% reductions.*

*Reduced testing was also accompanied by a reduced number of positive diagnoses, confirmed in at least 6 countries. This included in Belarus, where the total number of tests performed in 2020 actually increased in comparison to 2019, but the number of positive diagnoses fell – indicating that testing was not reaching those most in need. The most dramatic declines in the number of new positives were in Romania (approximately 50%) and Kyrgyzstan (42%). Given ample evidence of increased risk-taking by key populations during the COVID-19 pandemic, accompanied by reduced reach of prevention services, it is reasonable to assume that these reductions in diagnosis reflect a serious unmet need for testing. This is particularly concerning in countries where late presentation for testing is common, such as in Tajikistan where over half of all new diagnoses have a CD4 cell count less than 350 cell/mm<sup>3</sup>; in such cases, even moderate delays in diagnosis could have severe impact on treatment outcomes.*

### 1 Facility-based HIV Testing Services

*Potential disruption:* Throughout EECA, a variety of health care facilities serve as testing locations for key populations. Most commonly, these are: infectious disease clinics (e.g. AIDS Centers); designated voluntary counseling and testing sites within primary care clinics (e.g. VCT Centers); or combined prevention and testing sites, typically at the primary care level (e.g. Trust Points). During a public health emergency, these sites and/or their staff may be diverted to respond to the immediate crisis; during an infectious disease outbreak such as COVID-19, infectious disease clinics are at especially high risk of diverting their mission to the emergency situation.

In addition, facility-based testing units may more frequently utilize laboratory-based testing, rather than rapid testing technology. During public health emergencies, laboratory services may be diverted or simply overwhelmed by novel testing and treatment needs, leaving less capacity available for HIV testing. Supply chain disruptions are also possible, especially if transport capacity, storage or budget are reprioritized for reagents or equipment to respond to the emergency.

*Potential opportunity:* Where facility-based testing access is limited, referrals to alternative testing services (including community-based testing) can provide continuity for those seeking testing.

## 2 Community-based HIV Testing Services

*Potential disruption:* In settings where community-based HIV testing is available, limits on accessibility may mirror the challenges faced for community-based prevention services: NGOs may be restricted from operating (especially on an outreach basis), may have challenges remaining fully staffed (related to transportation changes, restrictions of movement, and/or concerns about safety), and may experience reduced demand for services from clients. In an infectious disease emergency such as COVID-19, additional concerns may be present related to disease transmission.

*Potential opportunity:* At times when government health clinics are inaccessible (due to transport and freedom of movement challenges, facility diversion/closures, and/or lack of staff), the availability of community-based testing can present a more accessible alternative. Especially where outreach or mobile unit models are able to be maintained, bringing testing to clients (thus helping them avoid travel challenges) can be an effective way to assure access to testing is not interrupted.

## 3 HIV Self-testing

*Potential disruption:* At the time of publication of this Guide, HIV self-testing is not a wide-spread practice across most of EECA, and represented a small portion of the total number of HIV tests conducted. The most significant disruptions or challenges with self-testing related to interfacing with confirmatory testing and registration of confirmed positive cases, as discussed further below in Linkage to Care.

*Potential opportunity:* In many settings in EECA, self-testing has failed to gain significant traction prior to COVID-19. The sudden closure of many health care centers and limitations on outreach provided a clear rationale for a client-controlled testing model that circumvents most transportation and physical contact concerns. Building on the value of this model for emergency circumstances should help to promote self-testing as a standard option to be available for key populations at all times, in line with WHO recommendations.

## 4 Linkage to Care

*Potential disruption:* One of the most significant disruptions in linkage to care is likely to be related to lack of available health care facilities and laboratory capacity: both confirmatory testing and baseline viral load and CD4 cell testing may be inaccessible or delayed. Without careful consideration for linking newly-diagnosed PLHIV to care and initiation of treatment, there is a potential hazard of PLHIV learning their HIV status without the option to enroll in care. This is particularly concerning in settings where late diagnosis is common, and where even a few months of delay in initiation of treatment could have serious impacts on treatment success and survival.

This is true for most community-based testing as well, where preliminary positive rapid testing also relies on confirmatory laboratory testing within the public sector. Bottlenecks or other limitations within the laboratory system, as discussed above, may introduce barriers to linking to care within the public system.

*Potential opportunity:* While a test-and-treat approach has been recommended by WHO for some time now, not all countries adhere to the guidance on rapid initiation of ART. Preparation for future emergencies offers a strong incentive to streamline protocols for linkage to care and prompt initiation of treatment.

### Stories from EECA: Challenges Linking to Care During COVID-19

*While countries with community-based testing generally fared better in maintaining testing access for key populations during the COVID-19 pandemic, linkage to confirmatory testing and to care were challenged by interruptions in state health services, particularly laboratory services.*

*This was particularly starkly observed in Belarus, where initiation of ART requires not only confirmatory testing but also the results of initial viral load and CD4 cell testing. A long wait for confirmatory testing (nearly a month, even prior to COVID-19) conspired with shortages in laboratory capacity to process viral load and CD4 results, and ultimately led to a 49% drop in ART enrollment across the country. While this drop in enrollment reflects a drop in the number of new diagnoses (despite increases in the total number of tests administered), it also reflects systematic challenges in enrolling PLHIV into treatment under emergency circumstances, and necessitates an update to treatment enrollment protocols to better reflect WHO guidance.*

### Positive Progress in EECA: The Rise of Self-Testing


*While advocates have argued for the introduction of self-testing for some years now, countries in the EECA region have been slow to adopt this testing modality – despite its recommendation by WHO since 2016. The onset of the COVID-19 pandemic and the accompanying lack of testing accessibility provided additional, clear benefits to self-testing as an alternative method.*

*While Georgia continued with self-testing for key populations as previously introduced, in other countries self-testing found fertile ground amidst the new pandemic. In Ukraine, for instance, self-testing schemes utilizing vending machines were introduced in 2020 with a planning that pre-dated COVID-19. In Russia, some NGOs reported experimenting with the distribution of self-testing kits via mail – though confirmatory testing algorithms needed further refinement in order to make sure that all clients could get the follow-up they needed. Nevertheless, in all cases the pandemic provided an ample demonstration of the real benefit of clients being able to access services without a health care provider (or even lay-provider) as intermediary.*

*Still another story comes from Kyrgyzstan, where the introduction of “assisted self-testing” – whereby a social worker or outreach worker is present and instructs the client, but the client physically conducts the test procedure themselves – was devised as a makeshift method to permit the safe continuation of community-based testing. This emergency measure may pave the way for continuity of a variety of self-testing models to be introduced long-term, especially building on strong experiences from peers in Georgia, Russia and Ukraine.*

### Priorities for Continuity of Testing Services

1. Utilize outreach-based testing models as much as possible, bringing testing to those in need (through outreach workers or mobile units) and supporting clients to avoid challenges related to travel during emergencies
2. Ensure that NGO service providers are free to continue testing operations as essential service providers, including exemptions for staff to travel during lockdown
3. Ensure that self-testing, accompanied by appropriate post-test counseling and linkage to care (in line with WHO recommendations), is available and actively offered to key populations who may have need for testing but be prevented from promptly accessing testing due emergency restrictions
4. Ensure that prompt linkage to care, including initiation of ART, is available for newly-diagnosed PLHIV, even when full and timely laboratory services may not be available

Preparedness Checklist for Continuity of HIV Testing Services and Linkage to Care		
Policy		
Action		Responsible
	1. Ensure that all policy and normative documents explicitly support community-based testing, including testing by lay-providers, in line with WHO guidance	Ministry of Health
	2. Recognize HIV testing services (including those delivered at the community level) as health services, and community-based workers as a class of health care worker	Ministry of Health or relevant regulatory authorities
	3. Ensure that HIV self-testing is included in and permissible as part of the national HIV testing strategy	Ministry of Health and relevant regulatory authorities governing the use of self-testing technology
	4. Ensure that newly-diagnosed PLHIV are eligible to initiate treatment immediately, even in the absence of availability of baseline viral load and CD4 cell testing	Ministry of Health, AIDS Center, or other responsible authority in charge or ART enrollment guidelines
Practice		
Action		Responsible
	1. If not already in place, introduce community-based testing systems, with robust training and monitoring protocols in collaboration with government health authorities	AIDS Center in collaboration with NGO service providers
	2. Develop protocols and train staff on supporting self-testing and follow-up care	NGO service providers, with support from and in collaboration with AIDS Center
	3. Ensure that clinical guidelines and/or standard operating procedures are in place, as needed, to support rapid initiation of ART and follow-up for newly-diagnosed PLHIV even in the absence of a known viral load or CD4 cell count  <i>*In settings where ART initiation prior to VL and CD4 results is already permitted, protocols may only need to be revisited to adapt follow-up practices for emergency situations, incorporating telemedicine, mobile unit follow-up, or other adaptive approaches</i>	AIDS Center, with engagement from any other facility where ART is initiated
Monitoring		
Action		Responsible
	1. Review data monitoring practices and develop agreements for more-frequent-than-usual analysis of testing data (e.g. monthly, comparing with the same month of previous years) to ensure that trends can be perceived over short periods in emergency situations	Ministry of Health or AIDS Center (responsible authority for compiling testing data), in collaboration with bodies who implement or provide referrals to testing (at a minimum, AIDS Centers and NGO service providers)
	2. Develop a framework for surveying different populations on their access to and barriers from testing during emergency situations, including how clients will be reached for survey	NGO service providers and/or civil society actors
	3. Develop accountability procedures to be enacted during emergency situations, for civil society to monitor delivery of public services	NGO service providers and/or civil society actors

## HIV treatment and care

### Stories from EECA: Challenges in HIV Treatment Access During COVID-19

*Access to ART was reported as an almost-universal challenge during COVID-19, due to the conversion of many AIDS Centers or infectious disease clinics to COVID-19-only facilities, or more generally due to the restrictions on movement imposed by lockdowns. It should be clearly acknowledged that many countries found innovative solutions to assure that these challenges did not lead to interruptions (see positive cases, in case study below) – however not all countries did this in a systematic manner. While ad hoc emergency responses by NGOs were a much-needed and appropriate response in the early days of COVID-19, clear and comprehensive protocols for medication delivery, telemedicine consults, and continuity of clinical monitoring services should be developed in advance to address future emergency situations.*

*Furthermore, the extent to which these challenges had an impact on ART adherence is underpinned by a different, but related problem: lack of regular and systematic use of data to monitor trends in ART adherence and retention. The availability of some surveys of PLHIV (notably in Romania, Russia and Uzbekistan) lent critical insight to the experiences of PLHIV during this time. Such survey practices should be complemented with critical analysis of available data over short periods (e.g. monthly or quarterly) for program implementers to track trends, especially as alternative, emergency delivery protocols are developed and implemented.*

#### 1

### Antiretroviral Treatment

*Potential disruption:* Across EECA, the standard setting for delivery of ART to PLHIV is government health facilities – most often an Infectious Disease clinic or AIDS Center, with dispensing at the primary care level being less common. During any emergency situation in which transport is disrupted and/or movement is restricted, accessing these facilities for treatment may be cost prohibitive or otherwise impossible for PLHIV. A clear system of exemption would be required to allow PLHIV to travel to access treatment (noting that this is useful only for those with private means of transportation).

Additionally, during a public health emergency – particularly one of an infectious disease nature – facilities may be converted to serve as designated screening and treatment sites for emergency purposes, such as was seen with the temporary repurposing of many AIDS Centers into COVID Centers across EECA. Alternatively, services delivered through primary care or other sites that are not repurposed for the emergency may also experience staff shortages or facility closures, depending on overarching guidance from the Ministry of Health or other relevant regulatory authorities.

For settings where PrEP is prescribed and/or dispensed only by AIDS Centers, these barriers may apply to PrEP access as well; further, restriction may be more severe for key populations versus PLHIV, as the former are not permitted any exemption to travel during lockdowns on the basis of HIV status.

*Potential opportunity:* The global movement towards differentiated service delivery (DSD) has provided a range of models for increasing accessibility of ART<sup>3</sup>. Of particular importance for COVID-19 and similar emergencies, these include multi-month dispensing (MMD) and dispensing outside of the health facility setting.

MMD is the recommended standard for stable patients on ART, and where countries have not already adopted this practice, the act of emergency preparedness should provide strong incentive to do so<sup>4</sup>. While normally this approach is limited to stable patients, global guidance in response to COVID-19 recommended<sup>5</sup> that this adaptation be extended to all patients on ART during emergency situations.

The dispensation of medications outside of the clinical setting may involve delivery or community-based pick-up sites, and be supported by non-physician health care workers or non-medical community providers. Mail delivery models may also be considered, as utilized in EECA during COVID-19 – though these may be subject to reliable functioning of the postal system and therefore may not be superior to delivery or community-site pick-up.

When utilizing these differentiated dispensing methods, care should be taken to ensure that PLHIV are not without medical consultation as needed. This service can be separate from the dispensing of medication, and may utilize tele-medicine when appropriate.

## 2 Routine Treatment Monitoring

*Potential disruption:* While the importance of the continuity of ART is widely recognized and accommodations may be made to assure no interruption, treatment monitoring has experienced a different fate during the COVID-19 pandemic, and thus is addressed separately here. Drawing on the barriers to accessing treatment that are described above, access to routine treatment monitoring such as viral load testing may be impaired by restricted transportation and freedom of movement, and health care facility closures or restrictions (sometimes secondary to lack of available staff). However, treatment monitoring can face another challenge, particularly during a public health emergency such as COVID-19: the laboratory resources required to monitor treatment success may be prioritized to respond to the emergency. This is particularly true for emergencies which require the use of polymerase chain reaction (PCR) laboratory services, as these are the same technologies required for viral load monitoring.

*Potential opportunity:* The frequency of viral load monitoring may be temporarily reconsidered for patients known to be stable on treatment, allowing for prioritization of limited services to monitor newer/non-stable patients, in line with standard protocols. A clear contingency protocol specifying the period of suspension of routine testing for stable patients will aid in communication, e.g. a patient due for testing every six months may be delayed for three months up to two times, for a total of a six-month delay.

Depending on the technologies utilized for viral load testing, countries with mobile unit infrastructure may also explore the opportunity to provide point-of-care viral load testing for prolonged emergencies like the COVID-19 pandemic. This approach may need to be used in conjunction with temporary reduced frequency, as described above, in order to access enough patients equitably. For geographically larger countries, differentiated approaches may be needed in different localities, based on resource availability.

3 Continually evolving models for out-of-facility ART distribution, in line with WHO recommendations, can be found at the Differentiated Service Delivery site, which is hosted by the International AIDS Society in collaboration with WHO and UNAIDS: <https://differentiatedservicedelivery.org/Models/OutOfFacilityIndividual>

4 The World Health Organization addresses multi-month prescribing particularly as it relates to COVID-19 responses, here: <https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-hiv-and-antiretrovirals>

5 Expanded MMD is recommended as part of the PEPFAR's guidance on Ensuring Uninterrupted Essential HIV Treatment Services to Clients During The Covid-19 Pandemic, accessible at: <https://www.fhi360.org/sites/default/files/media/documents/epic-uninterrupted-hiv-treatment-covid-19.pdf>



## 3

## PMTCT

*Potential disruption:* In general, obstetric care for pregnant women was seen as an essential health service throughout the COVID-19 emergency, and therefore services remained available to those in need. However, disruptions in transportation, as well as economic distress, may make it more difficult for at-risk women to access care. While no significant disruption to PMTCT was noted across EECA during COVID-19, additional outreach efforts may be needed to assure that at-risk pregnant women are accessing the care that is available.

In the absence of serious supply chain interruptions for HIV tests or antiretroviral treatment, disruption to the availability of PMTCT should not be significantly impacted by most emergencies, assuming that general access to obstetric care is not impeded.

*Potential opportunity:* To the degree that obstetric services may become higher threshold due to transportation challenges, economic distress, or other barriers (e.g. requirement for COVID-19 testing, use of a face-covering, or other similar mitigations for future emergencies), outreach services may place special emphasis on reaching pregnant women from key populations.




### Stories from EECA: Challenges in HIV Treatment Monitoring During COVID-19

*While adaptations that allowed ART to be continued in the absence of health facility visits were undoubtedly a positive development for PLHIV, the lack of in-person care for most PLHIV led to challenges in treatment monitoring and more general consultation across the region. A survey of PLHIV in Romania, for instance, reported that only 59% of PLHIV received any regular treatment monitoring in 2020, and limited access to viral load testing in particular was also reported in Belarus, Kyrgyzstan, Northern Macedonia and Serbia. Similarly, 62% of PLHIV surveyed in Romania reported challenges in accessing their infectious disease doctor for any kind of consultation. This challenge was also noted in Kyrgyzstan – though the use of informal virtual platforms such as Telegram and WhatsApp helped some clients to access necessary medical advice in the absence of in-person consultation possibilities.*

Positive Progress in EECA	
Adaptations to Support ART Retention	Mobile Services
<p><i>Maintaining access and adherence to ART for PLHIV was an early and urgent priority defined by UNAIDS at the start of the COVID-19 pandemic, and communities of PLHIV and their service providers echoed this imperative. Significant efforts to support retention on and adherence to ART were documented in nine countries, with some limited, non-systematic effort in a tenth. Six countries (Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukraine) extended prescribing practices for 3 to 6 months of dispensing at a time; these countries also accommodated delivery of ART via mail or by mobile unit. An additional three countries (Montenegro, Northern Macedonia, and Uzbekistan) did not alter dispensation timelines, but did have NGO-led delivery systems, with NGOs in Montenegro and Northern Macedonia covering significant portions of the population of PLHIV with these services. With the support of these adaptations, countries have preliminarily reported excellent retention of PLHIV on ART throughout the COVID-19 crisis – indicating that these services should be formalized and replicated for all emergency situations.</i></p>	<p><i>While NGO-facilitated delivery of ART was quite common, the delivery of lower-threshold viral load testing and other services was relatively limited, leading to a gap between continuity of ART and continuity of viral load testing, as described in the Stories from EECA, above. However, some limited positive experience may be instructive for EECA, both for emergency circumstances and potentially for the introduction of lower-threshold services under ordinary circumstances. Among those are Kazakhstan and Georgia, where mobile units managed by AIDS Centers delivered HIV services to PLHIV, including blood collection to facilitate viral load testing without presentation to a health clinic. This model may be easily expanded in settings like Moldova, where mobile units were already used to deliver ART; Serbia, where mobile units continued to administer HIV testing; and Northern Macedonia, where a range of health services were delivered via mobile units including OB-GYN services. For countries without mobile units, the collection of blood at fixed community sites may also be considered as a possibility for emergency circumstances where health facilities are limited.</i></p>

Priorities for Continuity of Treatment Services
<ol style="list-style-type: none"> <li>1. Ensure that PLHIV are included as an at-risk or priority population during emergencies, assuring that they have exemptions from restrictions on movement, in order to access care</li> <li>2. Ensure uninterrupted access to ART for PLHIV, assuring that transportation challenges and other barriers including personal health and safety concerns (e.g. concern about infection with COVID-19 or other infectious disease health threats) do not incentivize interruption of treatment</li> <li>3. Ensure reasonable access to viral load testing and other clinical monitoring services, acknowledging that frequency may be reduced in comparison to regular standards</li> <li>4. Ensure access to medical consultation related to PLHIV, as needed, via telemedicine or other virtual models<sup>6</sup></li> </ol>

<sup>6</sup> Telemedicine practices should be in line with emerging WHO guidance, knowledge and experience on this topic. WHO Euro's work on this issue should be followed at: <https://www.euro.who.int/en/health-topics/Health-systems/digital-health/news/news/2020/9/digital-health-transforming-and-extending-the-delivery-of-health-services>

Preparedness Checklist for Continuity of Treatment and Care for PLHIV	
Policy	
Action	Responsible
 1. Ensure that national ART guidelines are in line with WHO recommendations including multi-month dispensing of medication for stable patients	Ministry of Health and/or AIDS Center, as relevant
 2. Explore, revise and/or develop any national regulatory norms needed for the delivery or distribution of medication by non-medical providers, at least under emergency circumstances	Ministry of Health, AIDS Center and/or any other relevant regulatory body
 3. Develop (or update) policies that permit and support telemedicine consults for HIV care	Ministry of Health, AIDS Center and/or any other relevant regulatory body
Practice	
Action	Responsible
 1. Train health care workers who prescribe ART on updated differentiated approaches, including MMD and other approaches to be used during emergency situations	AIDS Center
 2. Establish working agreements (e.g. Memoranda of Understanding, or other) between AIDS Centers and NGO service providers for either ongoing (for stable patients) or emergency-only (for all patients) collaboration in the delivery of ART to PLHIV; ensure that both health care workers and NGO staff are familiar with the related protocols	AIDS Center, NGO service providers
 3. Operationalize telemedicine or other virtual consultation systems or protocols, with clear training for health care providers on ethical limits and practices <sup>7</sup>	AIDS Center, other ART-dispensing health facilities (as relevant)
Monitoring	
Action	Responsible
 1. Review data monitoring practices and develop agreements for more-frequent-than-usual analysis of treatment data to perceive trends in loss-to-follow-up, reduced adherence (where adherence tracking measures are present), increased treatment failure, and other significant trends	AIDS Center
 2. Develop a framework for surveying different populations on their access to and barriers from treatment and treatment monitoring during emergency situations, including how clients will be reached for survey	NGO service providers and/or civil society actors

<sup>7</sup> The World Health Organization's emerging guidance on and analysis of digital health strategies, including telemedicine, can be accessed here: <https://www.euro.who.int/en/health-topics/Health-systems/digital-health>

## Prevention and Management of Coinfections and Comorbidities

### 1 Tuberculosis

*Potential disruption:* Screening and treatment for tuberculosis is likely to be impacted similarly to the HIV response. Depending on the degree to which HIV and TB services are integrated, TB services that are delivered through vertical systems may be even more disrupted in case of emergencies linked to respiratory illnesses, such as COVID-19, due to diversion of pulmonologists and other specialists normally engaged in TB care. In settings where services are integrated and PLHIV receive TB screening and/or treatment within the same setting as HIV care, disruptions are likely to mirror those experienced in accessing HIV care and treatment.

*Potential opportunity:* In settings where mobile units regularly deliver services to key populations, mobile screening for TB can be offered alongside other services.

For key populations or PLHIV being treated for TB (including treatment of latent TB infection), advances in video-observed therapy can support treatment in places where a directly-observed therapy (DOT) approach is required; and delivery of TB medications can utilize systems in place for delivery of ART to PLHIV.

### 2 Viral Hepatitis

*Potential disruption:* Testing and treatment for viral hepatitis is only available in a limited number of countries in the EECA region. Depending on the health systems structure and venue for such services, they may be severely impacted (e.g. if integrated or collocated with HIV and TB services in an infectious disease clinic) or may mirror the disruption seen more widely across the health system (e.g. if provided in primary care settings, and/or if considered to be a non-priority health issue during emergencies).

*Potential opportunity:* Much like screening and treatment for TB, services for viral hepatitis may be offered via mobile units where the necessary infrastructure exists, and medications may also be delivered through systems designed to support adherence to ART for PLHIV.

### 3 Mental Health

*Potential disruption:* In many countries of EECA, mental health services outside of specialized psychiatric facilities are limited. Support services adjacent to other health services, including HIV treatment and OST, may be available under normal circumstances, but may be quickly curtailed during a public health emergency that limits physical contact, or where trauma services are in high demand. This may abruptly interrupt the services that assist clients with maintaining medication adherence and other aspects of well-being.

Even where existing mental health services are not severely disrupted, emergency situations such as COVID-19 may precipitate significantly increased demand for such services, while supply of professionals to fill this need remain stagnant.

*Potential opportunity:* Telemedicine approaches are easily utilized for psychological counseling as well as psychiatric consults, since physical examination is not required. While technology access problems may still create limitations, especially among key populations, novel approaches to ensuring technology access can be paired with telemedicine systems to ensure that access to mental health support is maintained or even expanded during emergencies.

A growing body of practice with psychological first aid also provides the opportunity for community-based services during times of crisis. **WHO guidance** exists for supporting mental health during Ebola outbreaks, offering a model for how general guidance has been previously adapted, and the **Pan American Health Organization (PAHO) offers several COVID-19-specific guidance documents** on applying psychological first aid under the recent emergency conditions.

## Positive Progress in EECA

### Virtual Support Groups in Romania






While globally many mental health service providers utilized virtual platforms to maintain contact with clients, key populations everywhere are less likely to have access to appropriate technologies. In EECA, where mental health professionals are in short supply to begin with, lack of existing telemedicine policies and regulations further complicated access – all while service providers reported burgeoning mental health needs amongst their clients. While none of the countries surveyed reported a seamless solution to these challenges, one example from Romania provides an alternative to supporting client needs during difficult times. There, PLHIV support groups moved to an online platform in order to maintain connection and discuss common challenges – especially related to isolation, fears about COVID-19, and strategies for maintaining adherence to medications. While this was initially challenging and it took time for participants to adjust, ultimately the platform expanded access to individuals who would not have been able to join an in-person support group due to geography. Organizers feel that this format has helped to mobilize a more representative national movement of PLHIV, and virtual support groups will continue even after COVID-19 restrictions are fully lifted (to be complemented by in-person groups, for those who prefer).

## Priorities for Continuity of Coinfection and Comorbidity Services

*These priorities recognize that the function and continuity of the full TB response and full viral hepatitis response cannot be addressed through this Guide. Therefore, these priorities focus on what, within these responses, should be done to ensure continuity for at least key populations and PLHIV – recognizing that these should also be available equally for all people in need.*

1. Ensure that TB and viral hepatitis screening and treatment are considered essential health services for at least key populations and PLHIV, even during an emergency
2. Ensure uninterrupted access to treatment for TB and HCV for at least key populations and PLHIV, assuring that transportation challenges and other barriers including personal health and safety concerns (e.g. concern about infection with COVID-19 or other infectious disease health threats) do not incentivize interruption of treatment
3. Recognize the importance of mental health services as part of a package of support for key populations, and ensure that service accessibility is maintained and potentially expanded to meet needs during emergencies
4. Prepare non-mental health professionals to provide psychological first aid<sup>8</sup> during emergency situations
5. Prepare for and/or introduce peer-to-peer mental health support interventions, including virtual support groups and buddy systems, which can be introduced or expanded as needed during emergency situations

8 General guidance on Psychological First Aid has been developed by WHO: <https://www.who.int/publications/i/item/9789241548205>, and further COVID-19-specific resources have been developed by the Pan-American Health Organization (PAHO): <https://www.paho.org/en/mental-health-and-covid-19>

Preparedness Checklist for Continuity of Coinfection and Comorbidity Services	
Policy	
Action	Responsible
 1. Ensure that relevant key populations and PLHIV are included as at-risk groups in the national TB strategy, to facilitate continued access to services during emergencies	National TB Program, National AIDS Program/AIDS Center
 2. Ensure that relevant key populations and PLHIV are included as at-risk groups in the national viral hepatitis strategy, to facilitate continued access to services during emergencies	National Viral Hepatitis Program, National AIDS Program/AIDS Center
 3. Develop (or update, as needed) policies to permit telemedicine consultations for mental health	Ministry of Health, other relevant regulatory authorities
Practice	
Action	Responsible
 1. Develop emergency TB screening protocols for key populations, leveraging the engagement of NGO service providers with these groups	National TB Program in collaboration with AIDS Center and NGO service providers
 2. Establish working agreements (e.g. Memoranda of Understanding, or other) between AIDS Centers, NGO service providers, and other relevant dispensing bodies for the use of ART delivery mechanisms to include TB and/or hepatitis treatments for coinfecting patients	AIDS Center, NGO service providers, other relevant providers of TB and hepatitis treatment
 3. Train NGO staff on psychological first aid as a general practice, with protocols in place for urgent refreshers or updates to adapt to specific emergencies	NGO service providers, optionally (but desired) also health care providers working with key populations
 4. Develop protocols to support clients to access mental health services via telemedicine, either on an ongoing basis or at least in emergency situations, including protocols for converting drop-in center space to provide confidential counseling spaces for engaging in telemedicine	NGO service providers
Monitoring	
Action	Responsible
 1. Review data monitoring practices and develop agreements for more-frequent-than-usual analysis of treatment data to perceive trends in reduced diagnosis and treatment of coinfections and comorbidities for key populations	AIDS Center, other relevant service providers
 2. Develop a framework for surveying different populations on their access to and barriers from treatment for coinfections and mental health needs (noting that these can be distinct issues requiring distinct surveys)	NGO service providers and/or civil society actors

## General Care

1

### Nutrition

*Potential disruption:* Emergency situations, especially those that precipitate changes in transportation or ability to travel freely, or that otherwise pose physical security risks, pose a significant risk for disrupted livelihood. Where many key populations live with limited economic means under ordinary circumstances, and where many work in an informal economy and may be ineligible for state benefits, disruption of livelihood can quickly precipitate food insecurity.

*Potential opportunity:* Nutrition assistance programs are often among the most prevalent form of humanitarian aid available during emergency situations. The priority adaptation for key populations is to assure that these populations qualify for such services. In the absence of accommodation of key populations for existing nutrition support programs, civil society may also provide designated programs for key populations, through the mobilization of donor support or mutual aid.

2

### Sexual and Reproductive Health Intervention

*Potential disruption:* While obstetric care (see above under PMTCT) is generally prioritized during an emergency, other elements of sexual and reproductive health care may not be seen as urgent priorities. The screening and diagnosis of sexually-transmitted infections may be particularly impacted, especially where these services are still centralized through infectious disease clinics.

Contraceptive access may be limited during emergency situations, because of pharmacy accessibility or supply chain limitations. There can also be lack of demand due to economic distress, transportation and freedom of movement limitations, and fear of contracting infectious disease (e.g. COVID-19).

These interruptions can be particularly concerning during strict lockdowns where women may be at increased risk for intimate partner violence and sexual assault.

*Potential opportunity:* Existing outreach systems providing HIV prevention and testing services may be able to include additional sexual and reproductive health services, at least or especially under emergency circumstances. However, this must be done with careful advanced planning, assuring that staff capacity is available for expanded services, and should be done in careful coordination and cooperation with government health care services providers. Such expansion of service would require additional resources, and provides a strong case for the development of social contracting mechanisms, whereby service providers are able to be contracted through government resources to provide additional services.

### Priorities for Continuity of General Care Services

1. Support enhanced access to shelter and nutrition for key populations during emergencies, recognizing that normal support services may be curtailed
2. Ensure continuity of key sexual and reproductive health interventions for key populations, utilizing alternative outreach or mobile approaches, as needed

Preparedness Checklist for Continuity of General Care Services	
Policy	
Action	Responsible
 <p>1. Ensure that key populations and PLHIV are explicitly included for state-provided emergency nutritional support and/or other social welfare services, regardless of employment status</p>	Ministry of Social Services or relevant state agency in charge of welfare and/or emergency support services
 <p>2. Review and update, as needed, regulations that govern the involvement of non-governmental service providers in sexual and reproductive health care</p>	Ministry of Health, relevant departments/programs in charge of sexual and reproductive health services, and any other regulatory authority involved in the regulation of non-governmental service providers
Practice	
Action	Responsible
 <p>1. Develop protocols for referral of clients to state-provided nutritional support services (for both emergency and non-emergency circumstances)</p>	NGO service providers, in collaboration with state agencies in charge of nutritional and/or emergency support services
 <p>2. Define priority sexual and reproductive health services to be provided, and potential modalities of referral and/or delivery, under different emergency circumstances</p>	Ministry of Health and potentially NGO service providers
Monitoring	
Action	Responsible
 <p>1. Develop a framework and protocol for surveying different populations on their need for nutrition support and other humanitarian services during emergency situations, including how clients will be reached for survey</p> <p><i>*This may be combined with other surveying protocols recommended under other interventions</i></p>	NGO service providers
 <p>2. Develop accountability procedures to be enacted during emergency situations, for civil society to monitor delivery of public services including both nutritional support and SRH services</p> <p><i>*This may be combined with other accountability procedures recommended under other interventions</i></p>	NGO service providers and/or other civil society advocates



## Enabling Environment

Within its guidance on HIV prevention, testing, treatment and care for key populations, WHO recognizes the enabling environment as a key factor in the availability and accessibility of the essential health intervention discussed above. While this Guide will not cover a comprehensive list of enabling environment elements that need attention in order to improve or sustain key population services, the following section summarizes key elements that should be considered particularly in light of contingency planning for emergency situations.

### Financing

While most countries in the EECA region still operate with limited health budgets overall, the COVID-19 experience demonstrated that those that provide public financing for HIV services generally showed a higher degree of ownership and coordination of adaptive HIV responses during emergency measures. This was particularly true of countries where social contracting of NGO service providers is in place – even if funding is still ultimately supported by external resources from the Global Fund (e.g. Montenegro, Serbia). Such social contracting arrangements seem to have provided a bridge for government-NGO cooperation, with an established understanding that NGOs are legitimate service providers leading to increased ease in new roles such as delivery of antiretroviral medications or OST take-home doses.

Therefore, while the financing landscape is likely to be increasingly complicated by the response to and recovery from the COVID-19 pandemic in coming years, it is all the more important for advocates to continue pushing for strong domestic financing of HIV responses, targeted at key populations and involving non-governmental service providers. Lessons in the beneficial nature of NGO service providers during COVID-19-related health system overwhelm may be leveraged as evidence of why such arrangements are desirable.

### Laws, policies and practices

Throughout EECA, the laws, policies and practices that prevent key populations from accessing health services under normal circumstances are relatively well-documented. Criminalization, harassment and extortion of key populations by law enforcement are reported as significant human rights barriers in most countries. While many countries have antidiscrimination laws that should protect PLHIV, they are not always enforced in practice, and even where overt discrimination does not occur, stigma remains strong in social and many health care settings. Key populations (who are not also PLHIV) generally have no legal or policy protection against discrimination in health care settings or elsewhere.

In general, emergencies such as COVID-19 do not introduce any new challenges in terms of law, policy or practice – but they do heighten the existing challenges at a time when key populations may be increasingly vulnerable. Therefore, when advocating for changes to known harmful laws, policies, and practices, advocates should draw on the specific harms seen during the COVID-19 response, including the potential public health impact of avoiding health care services.

## Antidiscrimination and protective laws

The unprecedented lack of availability of most AIDS Centers or other designated infectious disease clinics provided a stark wake-up call: while such facilities have long been safe-havens for key populations to receive safe, responsive care, the rest of the health system remains poorly equipped to serve the needs of key populations without discrimination. This is true beyond the health system, as well: social benefits, including food and housing support, were limited in many countries to those within the formal employment sector and/or those with appropriate identification documents – leaving many people who use drugs, sex workers, and transgender people in precarious situations and unable to access benefits.

While true sensitization of health services is a much larger task that also involves broader societal shifts in thinking, the COVID-19 emergency reiterates the need for all countries to have antidiscrimination legislation in place, not only for PLHIV but also for populations at risk for HIV (e.g. key populations). Further protective laws, including those who define key populations as a priority population of public health concern, would be beneficial in assuring access to benefits as well as status to access HIV prevention and testing services even during emergencies.

## Addressing violence against people from key populations

Like harmful laws, policies and practices, violence against people from key populations was not a new phenomenon during COVID-19 – but increased exposure to law enforcement, paired with unprecedented restrictions on movement and lack of acknowledgement of key population needs (e.g. the need for exemption from lockdown to seek certain health services) placed key populations at much greater risk of exposure to violence. Opportunities for mitigating violence were also limited by reduced operation or accessibility of many organizations who may help key populations to access safer alternatives. Gender-based and intimate partner violence also increased as result of the stress and confinement of strict lockdowns, and in some settings victims of violence were not exempted from travel restrictions in order to report incidents of violence or seek safe shelter.

## Resilient and Sustainable Health Systems

Looking across all of the elements outlined by WHO in a comprehensive package of services for key populations, there are several overarching opportunities for strengthening resilient and sustainable systems for health in a way that promotes both continuity of services during emergency situations, and more broadly the sustainability of services across time.

### People-centered Services

People-centered approaches are always critical to key population responses, due largely to broader systems of marginalization and oppression that make it difficult for these groups to access traditional health services. However, during emergency circumstances, key populations are often disproportionately affected. Loss of income can rapidly create food and housing instability and increased exposure to law enforcement can pose additional hazards, as described above.

One way to accommodate this is by offering **increased options in differentiated care**, especially whereby clients/patients present for care only as frequently as needed. This approach has a strong potential to create cost-efficiency and permit resources to be better focused on individuals who require more support, while reducing the burden for those who are more able to self-manage. During a crisis situation, having such a system in place helps to quickly and efficiently transition to a lower-contact approach that is less intensive on human resources for health.

For those who are not able to self-manage care with more autonomy, the **scale-up of low-threshold approaches**, particularly ones that reduce the need for client travel by bringing services to the client are particularly desirable. While these approaches may be more costly in the short-term, they are likely to demonstrate higher cost-efficiency by retaining clients in care (thus preventing HIV infection, morbidity and mortality).

### Human Resources & Community Systems

The COVID-19 pandemic served as a strong reminder about the importance of infectious disease expertise for many health systems. Key informants from several countries cited a long-held national disinterest in investing in infectious disease specialties, and the shortage of trained staff was evident in the quick overwhelm of infectious disease clinics as well as designated AIDS Centers. While countries will now need to carefully assess their broader needs to incentivize infectious disease practice, the way in which primary care can interact with PLHIV who are stable on care should also be considered. Some countries may find it feasible to move to **treating PLHIV in a primary care setting** in consultation with or by visiting infectious disease specialists, providing greater alternatives for continuity of care in a clinical setting during emergencies when infectious disease clinics have other priorities.

Regardless of how health systems rationalize their infectious disease services, this will not have an impact on the single largest workforce in most national HIV responses: community-based prevention and testing service providers. This divide, whereby a large portion of the disease response is done by non-governmental providers, presents a unique problem in emergency circumstances. Because most prevention services are non-medical in nature and implemented through community systems, they may be viewed by authorities as non-essential social services, rather essential health services. This may prevent staff, including outreach workers, from traveling during lockdowns/restricted movement periods without exposure to clashes with law enforcement. Key population clients may face similar risks in trying to access services – which, to authorities including law enforcement, are not considered to be critical. The clear **designation of these services as essential health services**, and their providers and a class of health care worker, is critical for at least prevention and testing services, though has implications for treatment support, comorbidity screening and management, and general care support.

## Procurement & Supply Management

Emergency situations have strong potential to disrupt supply chains, especially when transportation is affected and when medications or commodities are being procured across international borders. A primary defense against critical stock-outs is a well-attuned **logistics and supply management system**, which can signal potential problems in stocks based on changing demand (e.g. if larger-than-usual levels of stock have been distributed to accommodate for the emergency). Additionally, close and regular monitoring of procurement systems can help to signal any anticipated emergencies as early as possible, allowing maximum time for reaction. For both medications and commodities, the maintenance of **buffer stocks** is critical to allow time to react to identified problems. Following the COVID-19 experience, supply chain managers may need to revisit buffer stock levels, considering the larger distribution of both commodities and some medications (e.g. ART) than under usual circumstances.

During COVID-19, and potentially during any future, similar infectious disease outbreaks, access to **personal protective equipment** was a substantial problem, especially for the community sector. Both supply chain availability and cost posed significant problems. This underlines the importance of recognition of community-based, non-governmental service providers as key partners in implementing the health response. In such emergency circumstances, community-based providers should at very least have access to pooled purchasing of such supplies alongside their government counterparts, at a rate negotiated by government procurement agencies; and may also be the beneficiaries of supplies purchased by the government, in recognition of their provision of essential health services.

## Data Systems and Use

In quickly evolving situations, such as the COVID-19 pandemic, the monitoring of changes in prevention service demand, supply and actual coverage is critical to understanding how services may need to be adapted. This requires not only collection of data, which most countries appeared to maintain, uninterrupted, throughout COVID-19, but also the critical analysis of data at junctures more frequent than under normal circumstances.

As a most basic measure, the **regular monitoring of service reach**, including commodity distribution for prevention services, should be prioritized during emergency situations, monitoring as often as weekly or at least on a quarterly basis (depending on the timeline and severity of the emergency) to perceive the need for any adapted approaches to continue reaching clients. This can and should be done at both the service delivery level (NGO or government facility level), and the national aggregate level.

Particularly in instances of reduced demand for services, service providers must understand the unique barriers in place that are preventing clients from seeking services. The COVID-19 experience showed that these can include fear of infection with COVID-19, lack of transportation options, fear of law enforcement (either because of strict curfew enforcement, or because of identity-related harassment), and prioritization of other needs including shelter, nutrition, and other physical security. Special **client/patient surveys** are an ideal way to obtain this insight, and should be considered as part of standard needs assessment practice in emergency situations.

# Quick Guides to Contingency Planning

These “quick guides” for contingency planning consolidate some of the key priorities that run across different interventions, while also briefly and succinctly highlighting the priorities that are unique to each health intervention. These quick guides are not presenting novel information; they are a tool for briefly summarizing what is presented in more detail in earlier sections of this document, and may be used by working groups or other planning committees for quick reference.

Intervention	Common Priorities	Specific Priorities
HIV Prevention	<ul style="list-style-type: none"> <li>Ensure that NGO service providers are free to continue prevention, testing and treatment support operations as essential service providers, including exemptions for staff to travel during lockdown</li> <li>Ensure that <i>at least</i> PLHIV are included as an at-risk or priority population during emergencies, assuring that they have exemptions from restrictions on movement, in order to access care</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that key populations receive an <b>adequate quantity of prevention commodities</b> while minimizing risks of traveling to obtain them</li> <li>Ensure that PWID who are on OST treatment are able to <b>maintain adherence to treatment</b> while minimizing the risks of traveling to receive treatment</li> <li>Incentivize continued access to behavioral interventions by considering and <b>meeting emergency needs paired with HIV prevention</b> messaging</li> </ul>
HIV Testing & Linkage to Care	<ul style="list-style-type: none"> <li>Ideally, ensure that all key populations are categorized as at-risk or priority populations during emergencies (on the basis of their health needs being of public health concern), assuring that they have exemptions from restrictions on movement, in order to access care</li> </ul>	<ul style="list-style-type: none"> <li>Utilize <b>outreach-based testing models</b> as much as possible, bringing testing to those in need (through outreach workers or mobile units) and supporting clients to avoid challenges related to travel during emergencies</li> <li>Ensure that <b>self-testing</b>, accompanied by appropriate post-test counseling and linkage to care (in line with WHO recommendations), is available and actively offered to key populations who may have need for testing but be prevented from promptly accessing testing due emergency restrictions.</li> <li>Ensure that <b>prompt linkage to care, including initiation of ART</b>, is available for newly-diagnosed PLHIV, even when full and timely laboratory services may not be available.</li> </ul>

Intervention	Common Priorities	Specific Priorities
HIV Treatment		<ul style="list-style-type: none"> <li>• Ensure <b>uninterrupted access to ART</b> for PLHIV, assuring that transportation challenges and other barriers including health concerns (e.g. concern about infection with COVID-19 or other infectious disease health threats) do not incentivize interruption of treatment</li> <li>• Ensure <b>reasonable access to viral load testing</b> and other clinical monitoring services, acknowledging that frequency may be reduced in comparison to regular standards</li> <li>• Ensure access to medical consultation related to PLHIV, as needed, via telemedicine or other virtual models<sup>9</sup></li> </ul>
Coinfections and Comorbidities		<ul style="list-style-type: none"> <li>• Ensure <b>uninterrupted access to treatment for TB and HCV</b> for <i>at least</i> key populations and PLHIV, assuring that transportation challenges and other barriers including health concerns (e.g. concern about infection with COVID-19 or other infectious disease health threats) do not incentivize interruption of treatment</li> <li>• Recognize the importance of <b>mental health services</b> as part of a package of support for key populations, and ensure that service accessibility is maintained and potentially expanded to meet needs during emergencies</li> <li>• Prepare non-mental health professionals to provide <b>psychological first aid</b><sup>10</sup> during emergency situations</li> <li>• Prepare for and/or introduce <b>peer-to-peer mental health support interventions</b>, including virtual support groups and buddy systems, which can be introduced or expanded as needed during emergency situations</li> </ul>
General Care		<ul style="list-style-type: none"> <li>• Support enhanced <b>access to shelter and nutrition</b> for key populations during emergencies, recognizing that normal support services may be curtailed</li> <li>• Ensure <b>continuity of key sexual and reproductive health interventions</b> for key populations, utilizing alternative outreach or mobile approaches, as needed</li> </ul>

9 Telemedicine practices should be in line with emerging WHO guidance, knowledge and experience on this topic. WHO Euro's work on this issue should be followed at: <https://www.euro.who.int/en/health-topics/Health-systems/digital-health/news/news/2020/9/digital-health-transforming-and-extending-the-delivery-of-health-services>

10 General guidance on Psychological First Aid has been developed by WHO: <https://www.who.int/publications/i/item/9789241548205>, and further COVID-19-specific resources have been developed by the Pan-American Health Organization (PAHO): <https://www.paho.org/en/mental-health-and-covid-19>

Preparedness Checklists		
Policy	Practice	Monitoring
Ensure a functioning financing mechanism allows government funds to contract non-governmental service providers for HIV and sexual and reproductive health related services	Develop emergency protocols for the distribution of larger numbers of commodities using reduced teams, including the potential use of peer-distribution models	<p>Review data monitoring practices and develop agreements for more-frequent-than-usual analysis of the following, to perceive trends over shorter periods in emergency situations:</p> <ul style="list-style-type: none"> <li>prevention services to ensure that trends in client reach, commodity distribution, behavioral intervention delivery</li> <li>testing data (e.g. monthly, comparing with the same month of previous years)</li> <li>treatment data to perceive trends in loss-to-follow-up, reduced adherence (where adherence tracking measures are present), increased treatment failure, and other significant trends</li> </ul>
Recognize prevention and testing services as health services, and community-based prevention and testing workers as a class of health care worker	If not already in place, introduce community-based testing systems, with robust training and monitoring protocols in collaboration with government health authorities	
Ensure that any legal or regulatory frameworks are in place to allow extended prescribing of OST (multi-day or multi-week take-homes) and ART (at least 3-6 month prescribing) in line with WHO guidance	Develop protocols and train staff on supporting self-testing and follow-up care	
<p>Ensure that all policy and normative documents related to testing are updated in line with WHO guidance, especially to:</p> <ul style="list-style-type: none"> <li>allow community-based testing, including testing by lay-providers</li> <li>allow HIV self-testing</li> </ul>	<p>Develop or update standard operating procedures and/or clinical guidelines to support:</p> <ul style="list-style-type: none"> <li>dispensation of take-home doses of OST for emergency circumstances (at minimum) or for all stable patients (preferred)</li> <li>rapid initiation of ART and follow-up for newly-diagnosed PLHIV even in the absence of a known VL or CD4 cell count</li> </ul>	

Policy	Practice	Monitoring
Ensure that newly-diagnosed PLHIV are eligible to initiate treatment immediately, even in the absence of availability of baseline VL and CD4 cell testing	Train health care workers who prescribe ART on updated differentiated approaches, including MMD and telemedicine approaches	<p data-bbox="1150 349 1453 763">Develop a framework for surveying different populations on their access to and barriers from the following during emergency situations, including how clients will be reached for survey and how many will be targeted as an adequate sample:</p> <ul data-bbox="1150 801 1437 1496" style="list-style-type: none"> <li data-bbox="1150 801 1406 920">● prevention services during emergency situations</li> <li data-bbox="1150 958 1433 1037">● testing during emergency situations</li> <li data-bbox="1150 1075 1437 1153">● treatment and treatment monitoring</li> <li data-bbox="1150 1191 1342 1270">● treatment for coinfections</li> <li data-bbox="1150 1308 1422 1346">● mental health needs</li> <li data-bbox="1150 1384 1433 1496">● nutrition support and other humanitarian services</li> </ul>
Explore, revise and/or develop any national regulatory norms needed for the delivery or distribution of medication (including both ART and OST) by non-medical providers, at least under emergency circumstances	Establish working agreements between AIDS Centers and NGO service providers for either ongoing or emergency-only collaboration in the delivery of ART, TB treatment and HCV treatment to PLHIV; ensure that both health care workers and NGO staff are familiar with the related protocols	
Develop (or update, as needed) policies that permit and support telemedicine consults, for at least HIV care and mental health	Develop emergency TB screening protocols for key populations, leveraging the engagement of NGO service providers	
Ensure that relevant key populations and PLHIV are included as at-risk groups in the national TB and viral hepatitis strategies, to facilitate continued access to services during emergencies	Train NGO staff on psychological first aid as a general practice, and develop protocols to support clients to access mental health support via telemedicine	
	Define priority sexual and reproductive health services to be provided, and potential modalities of referral and/or delivery, under different emergency circumstances	
Ensure that key populations and PLHIV are explicitly included for state-provided emergency nutritional support and/or other social welfare services, regardless of employment status	Develop protocols for referral of clients to state-provided nutritional support services (for both emergency and non-emergency circumstances)	
	Develop protocols for non-governmental distribution of mutual aid and/or humanitarian aid, including how its distribution is linked to regular prevention services (both commodity distribution and behavioral interventions)	



# Conclusion

While the COVID-19 pandemic and other emergencies undoubtedly pose a threat to access of and quality of services for key populations throughout the EECA region, the experience of 2020 and early 2021 show that there are significant opportunities to mitigate the impact of this threat. Outreach services can be adjusted to the new and changing realities of emergency situations, to safeguard or even expand client reach. Critical services, usually provided in health care facilities, can be shifted to a more accessible community-based setting, and partnerships between the governmental and non-governmental sector can be expanded in mutually respectful ways. New approaches and technologies for testing and treatment monitoring can expand access and streamline the use of limited health sector resources by putting more power in the hands of clients, in spaces where they are comfortable and safe. And by recognizing the need for holistic support – including coinfections and comorbidities, reproductive and sexual health, mental health and nutrition – new frameworks can be forged for integrating services and providing support through community-based actors

Moreover, the opportunities that exist can not only mitigate the threat to continuity of services posed by an emergency, but can actually be leveraged to improve the quality, efficiency and sustainability of services in emergency and non-emergency situations, alike. Progress such as formalizing and recognizing the role of community-based health service providers as a critical part of the health system for key populations; expanding the range of services that are available at a community-based or outreach level; and introducing WHO-recommended technologies like self-testing are all examples of long-overdue programming upgrades, which are now well-justified in the name of emergency preparedness.

With careful, intentional planning and commitment from the community level all the way up through the political level, contingency planning for continuity of key population services during emergencies has the power to be a significant driver of change. It is our hope that this Guide supports stakeholders in seizing the opportunity to create more accessible, equitable and sustainable systems of service for the populations who need it the most.

# Annex 1. Country Planning Guide

## Rapid Situation Assessment

In any emergency, the first step should be to conduct a rapid situation assessment of the gaps in access and the needs that exist. Over a year into the COVID-19 pandemic, the main portion of this Guide provides details on needs that have been assessed in fourteen countries in EECA. However, for any countries (in EECA, or elsewhere) that have not conducted such assessments to date, a rapid scan of the situation is advised. This exercise should look not only at current needs, but at the experience of COVID-19 as a whole, in order to inform contingency planning for future emergencies (including potentially future waves of COVID-19).

Using the table below, provide brief bullet point observations as they relate to each intervention, by RSSH element.

Intervention Being Assessed	Service Delivery	Human Resources & Community Systems	Procurement and Supply Chain Management	Data Systems and Use
HIV Prevention				
HIV Testing and Linkage to Care				
HIV Care and Treatment				
Coinfection and Comorbidities (TB, HCV, mental health)				
General Care (SRHR, nutrition)				

This exercise does not need to utilize a formal assessment, and in many cases the table below may be completed collaboratively by key stakeholders during a meeting (held virtually, as needed), or a single person responsible may conduct brief interviews with a variety of stakeholders and synthesize key findings. While a formal survey of affected populations is ideal, and data may be used and incorporated if available – however, if not such survey is available, the accounts of key stakeholders, especially those delivering services, should be considered adequate for a rapid assessment.

From this rapid assessment, priority needs should arise, to be used in the exercise on the following page.



# Annex 2. Advocacy Agenda Planning Guide

Some of the preparedness actions outlined in your national or subnational contingency plan may require advocacy to achieve. This may be particularly true for Policy actions, which may require buy-in from stakeholders who were not part of the original contingency planning process.

While it is beyond the scope of this Guide to provide detailed instruction on how to plan for and conduct advocacy, the table below may be used to help organize advocacy priorities. Further instruction on advocacy can be found in the many detailed resources produced by key population network partners. Throughout EECA, in particular, organizations including the Alliance for Public Health; the Eurasian Harm Reduction Association (EHRA); The Eurasian Coalition for Health, Rights, Gender and Sexual Diversity (ECOM); and the Eurasian Women's Network on AIDS (EWNA) have rich experience in advocacy approaches and may be able to support the mobilization of resources for advocacy efforts.

Advocacy Goal/Aim	Target	Allies	Advocacy Steps	Resource Needs
1. <i>List a single goal or aim, corresponding to one of the priorities outlined in your country's contingency planning table. You may list additional goals or aims below, as needed.</i>	<i>Describe which decision-maker needs to be targeted to achieve this aim; this may be an individual or an entity/depending.</i>	<i>List any allies who may be enlisted to support your advocacy efforts.</i>	<i>List key actions or steps that you expect to take in order to achieve your advocacy goal or aim. For complex advocacy aims that may require a detailed campaign, you may include the development of a full advocacy strategy as a first step.</i>	<i>Insert here any resource needs that will be required for you to complete the required priority steps. These may include both financial and technical support, or other resource needs.</i>
2.				
3.				
4.				
5.				

# **Guide for Contingency Planning for Key Population HIV Services during COVID-19 and Other Emergencies**

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