

Maintaining and prioritizing HIV prevention services in the time of COVID-19



Introduction

In the time of coronavirus disease (COVID-19), sex and drug use will continue, regardless of physical distancing orders and policies. People who previously met in community gathering venues such as bars and clubs may now meet in different sites, ones that are “hidden” or less accessible. This, in turn, may hinder efforts to reach them with prevention interventions, such as condoms, lubricants, and needle–syringe programmes. With the widespread loss of livelihood and fewer employment opportunities, transactional sex, sex work and sexual exploitation may increase. Anxiety about the pandemic and personal vulnerability also may lead to some disruption in community cohesion, and to changes in the social and sexual norms that influence behaviour.

During previous epidemic emergencies like Ebola, other health issues received less attention, and we learned that health service interruption can have negative impacts on health and well-being. For example, decreased access to contraception services during Ebola outbreaks led to an increase in unplanned pregnancies, and subsequently to unsafe abortions and increased morbidity and mortality for adolescent girls and young women.

Condoms, lubricants, contraceptives, sterile injecting equipment and antiretroviral medicines all remain essential to avoiding the transmission of HIV, sexually transmitted infections (STIs) and viral hepatitis, and to the prevention of unplanned pregnancies.

Preserving momentum and focus on HIV prevention

Several critical actions and temporary modifications can be considered for continued effective HIV prevention and related services.

1. Leadership and financing: Keep all major epidemics at the top of the global health agenda

Resources are scarce, but this is not the moment to shift the spotlight from any of the major epidemics of our time. COVID-19 presents a new challenge requiring new—not re-allocated—resources, renewed energy and robust, enlightened leadership. Reducing resources for HIV prevention in the face of COVID-19 will only exacerbate the current HIV prevention crisis and threaten the gains that have been achieved so far. The universal right to health demands a determined focus on funding comprehensive, integrated and sustained approaches to existing, new and—invariably—future global health challenges.

2. Support supply chain continuity for critical HIV prevention and contraception commodities

The COVID-19 response has absorbed resources, disrupted supplies and even led to reduced production of some health products (such as condoms). These types of disruptions and delays will continue for the foreseeable future.

It is therefore critical to include key HIV prevention supplies alongside HIV testing kits, antiretroviral medicines and contraceptive

supplies as part of essential commodity security plans. This includes male and female condoms, lubricants, harm reduction commodities (including methadone, buprenorphine and sterile injecting equipment) and contraceptives.

3. Assess changing HIV programme needs and consider the needs of key and other priority populations

The COVID-19 pandemic and response is rapidly evolving, and it will continue to change as countries move through different stages in their specific epidemic responses. This will require assessment of the needs of all people living with HIV, key populations and other priority populations (such as young women and their male partners) in high HIV burden settings. These groups may be affected by COVID-19, but they also may be affected more widely by the COVID-19 response measures, disruptions in HIV and other health services, loss of livelihoods and, importantly, by new aspects of discrimination.

4. Deliver prevention commodities and services safely

A range of ways to continue key HIV prevention and contraception services safely needs to be considered. These could include:

- Multimonth prescribing (MMP) and dispensing (MMD) of antiretroviral medicines in the context of COVID-19 have already been issued by the World Health Organization (WHO).¹ MMP and MMD also need to be considered for condoms, lubricants, pre-exposure prophylaxis (PrEP), harm reduction commodities (including opioid substitution therapy, or OST), take-home doses and contraceptives.
 - Delivery of condoms and harm reduction commodities through community service points that can support physical distancing, such as dispensers or other collection points.
 - Provision of condoms, contraceptives, HIV self-tests and other non-therapeutic/pharmaceutical supplies through vending machines, pharmacies and food retail outlets that remain open during the COVID-19 response, and through online ordering (also see #7, below).

- Relaxing policies that may have restricted the number of needle–syringes, condoms and/or lubricants that can be dispensed per service contact.
- Take-home doses for OST can be considered. Many countries are doing this already for periods of one week to two months, including for new patients. Given their inability to access street drugs, more people are going through withdrawal and may need treatment. Some countries are opening their OST programmes to include new patients for this reason.

- Identifying new opportunities for delivering essential prevention products. For example, as community activities are often being restricted or stopped in the first wave of the COVID-19 response, emergency support services are being developed (such as food deliveries for vulnerable households or the elderly and infirm). Linking with these community services for the delivery of condoms and other HIV prevention commodities may be possible.

5. Consider a temporary delay and repurposing of some prevention interventions

Voluntary medical male circumcision (VMMC) programmes will often need to be delayed while mass gatherings are reduced. Furthermore, clinical staff may be deployed to other services, VMMC facility space may be repurposed, and some of the personal protective equipment (PPE) used in these services may be needed for health workers providing essential services related to COVID-19. In addition, VMMC programmes have built competencies that may support the COVID-19 response in East and southern African countries: general infection prevention and control, including hand hygiene and the development of person-centered messages, and the capacity of community health workers to reach community leaders and men with vital health information. VMMC remains a proven partially protective HIV prevention intervention, and services will need to be restored after resources can be redirected or resupplied back to VMMC.

Decisions regarding the provision of PrEP services will likely be made at the local level. It is already recommended that people taking PrEP should be supplied with three months of

¹ See: Q&A on COVID-19, HIV and antiretrovirals. In: who.int [Internet]. 24 March 2020. Geneva: World Health Organization; c2020 (<https://www.who.int/news-room/q-a-detail/q-a-on-covid-19-hiv-and-antiretrovirals>, accessed 27 April 2020).

tenofovir/emtricitabine (TDF/FTC). Longer term prescriptions have not been recommended because of the need for HIV testing. However, some flexibility could be considered, including through the provision of blood-based self-tests during PrEP continuation. Recognizing that PrEP services may be disrupted, some organizations for gay men and other men who have sex with men are promoting messages such as “delay your hook-up until lockdown is lifted” and suggesting ways to enjoy sex safely online.

6. Expand access to HIV self-testing

Continued availability of HIV testing and treatment remains a priority to protect and promote the health of people living with HIV, to strengthen protection and immune resilience in the time of COVID-19, and to reduce HIV transmission. HIV self-testing is an innovative way to provide access to HIV testing safely by reducing the need for contact with others and by decreasing work load in health facilities. Many countries have self-testing programmes; these could be adapted and expanded to increase access to HIV testing with distribution of self-test kits through grocery stores, pharmacies and community sites where physical distancing can be maintained, as well as through clinical facilities. In countries that still have regulatory and policy barriers, it could be an opportune moment to advocate for HIV self-testing, a strategy that has the potential to reduce the burden on the health system. Facility-based HIV testing should also continue to be supported. Where HIV testing is routinely offered, such as in the context of antenatal care in high HIV burden settings, service delivery should continue.

7. Provide community messaging and online support

Communities have been central to the HIV response, raising awareness, providing messages and information, dispelling myths, countering misinformation, testing for HIV infection and linking those who need them to services. Community organizations and networks, including those for and by key populations, should be mobilized to provide similar support around COVID-19. Where community-led approaches can no longer be used, community engagement could be achieved through the expansion of online programmes and social media platforms.

Online support options will also be instrumental in maintaining HIV prevention services. This could include interactive platforms, virtual counselling by peers or health workers, and video-observed options for PrEP, antiretroviral therapy and OST. Online ordering of free or low-cost products such as condoms, needle-syringes or HIV self-tests could be considered in many settings. Associated services—such as violence prevention and responses and mental health support—could also be part of online prevention resources.

8. Address domestic violence

During the COVID-19 response, eventual lockdowns may take different forms, and they can lead to increases in domestic and intimate partner violence, and to increased violence outside of the home. Services for preventing and addressing domestic violence should be reinforced during the COVID-19 response, and access to PrEP, post-exposure prophylaxis (PEP) and emergency contraception should be ensured, with special measures put in place for vulnerable groups. Opportunities for providing these services online should be explored.

9. Listen to and focus on key populations who remain most affected

Sex workers, gay men and other men who have sex with men, transgender people, people who use drugs, and prisoners and other confined individuals may be affected differently by COVID-19 and the response to it than other populations, as they face additional barriers to accessing services due to stigma and discrimination.

During periods of lockdown, sex workers may lose their income, people who use drugs may find their supply of prescription and illicit drugs to be interrupted, and members of other marginalized populations may experience additional stigma. Under these conditions, health service access will be even more challenging.

It will be critical for HIV prevention to continue to support and scale up programmes for key populations, to engage with them, to listen to their concerns, and to develop community-owned and community-led solutions for maintaining access to HIV prevention services throughout the COVID-19 response period and beyond.

Physical distancing may be nearly impossible in settings where enforced confinement creates congested living conditions. In correctional systems, prisoners, prison staff and their families are at increased risk of being infected by the virus responsible for COVID-19. Countries may consider decarceration in a number of situations: where prisoners are scheduled for imminent release, for older prisoners, or for inmates who have committed minor infractions or non-lethal crimes. Mental health institutions may need to identify alternative or supplementary facilities or strategies in order to ensure physical distancing for patients and staff.

10. Apply a rights-based approach to HIV—now more than ever

Both COVID-19 and HIV prevention responses need to adhere rigorously to a rights-based approach. Complementary to this brief, UNAIDS has issued **materials** specifically addressing the needs of people living with HIV and human rights-based approaches to the HIV and COVID-19 responses.

11. Continue expanding HIV prevention: synergies with the COVID-19 response

The context of each country may provide opportunities for new synergies between COVID-19 and HIV responses. Can condoms and HIV self-tests be delivered alongside COVID-19 testing services at this time? Can information platforms be linked? Can the COVID-19 response provide new channels for communicating about HIV prevention? Preventing COVID-19, HIV and other infectious diseases jointly is a new area that will benefit from further learning.

Living with and preventing HIV in the time of COVID-19

There are differences between HIV and COVID-19, but prevention and mitigation responses are intertwined.

HIV is lifelong and not transmitted through casual contact. Therefore, movement restrictions for people with HIV are not necessary and never justified. The COVID-19 virus, however, spreads easily and has the potential to affect everyone. To mitigate the societal impact of COVID-19, temporary quarantine measures and movement restrictions between areas with and without COVID-19 infections can be useful and reduce vulnerability to the virus in all settings.

Despite this, COVID-19 mitigation measures will not affect everyone equally. Measures imposed to reduce the transmission of the COVID-19 virus will likely exacerbate vulnerabilities that define the conditions of life for marginalized people, including for key populations living with or at risk of HIV. As businesses are shuttered, commerce slows and economies teeter on the brink of collapse, the livelihoods of millions of people will be affected indefinitely. At the same time, there is a need to respect the rights and needs of vulnerable populations, especially low-income communities whose survival depends on remaining economically active.

As an urgent priority, mechanisms that mitigate the loss of earnings for workers in low- and middle-income countries are needed to ensure that the number of people vulnerable to HIV does not grow. Key populations and their families must be included in—and actively prioritized for—emergency measures such as cash subsidies, rent and utility waivers, emergency food supplies, and access to free health services and temporary shelter. By prioritizing the needs of the most marginalized populations during this new pandemic, HIV prevention will remain a priority alongside the global response to COVID-19.

This brief was prepared by the Global HIV Prevention Working Group in April 2020, and the WHO HIV team led in the elaboration of the brief.

The Global HIV Prevention Working Group includes (in alphabetical order) representation of the: African Youth and Adolescent Network on Population and Development, AIDS Vaccine Advocacy Coalition (AVAC), Bill & Melinda Gates Foundation, Frontline AIDS, Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Network of Sex Work Projects (NSWP), Institute of Tropical Medicine (Antwerp), International Planned Parenthood Federation (IPPF), Kenya National AIDS Control Council, National AIDS Council of Zimbabwe, UNAIDS, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), United States President's Emergency Plan for AIDS Relief (PEPFAR) and World Health Organization (WHO).

The Global Prevention Coalition has established a web platform for country-level governments, civil society and other partners to share their experiences and new solutions.

Please share your experiences with hivpc@unaids.org