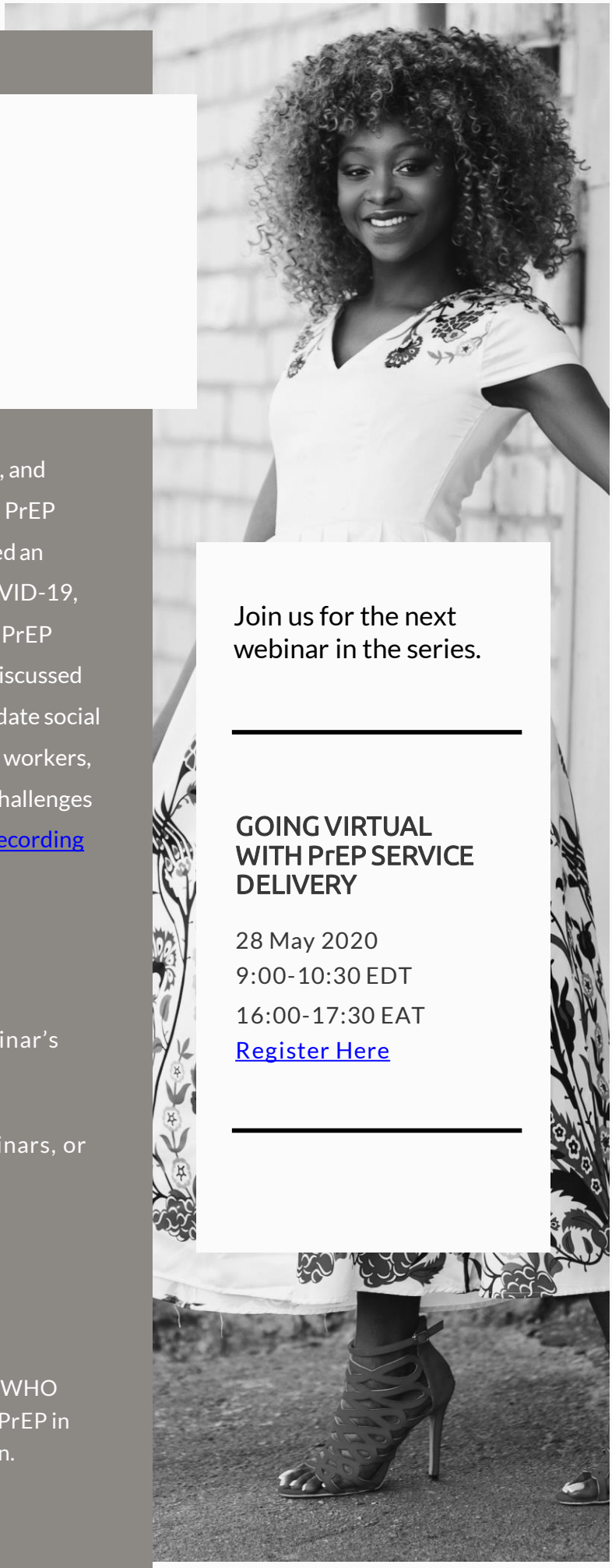
23 APRIL 2020 | WEBINAR 10

PrEP Delivery in the Context of COVID-19

PrEP Learning Network Webinar Series



Thank you to our speakers from OGAC, Wits RHI, FHI 360, and Jhpiego, as well as attendees who participated in the tenth PrEP Learning Network webinar. In this webinar, OGAC provided an overview of PEPFAR's PrEP guidance in the context of COVID-19, including key considerations for program implementation. PrEP implementers from South Africa, Botswana, and Lesotho discussed how they have adapted PrEP service delivery to accommodate social distancing, lockdowns and ensure the safety of health care workers, clients and the community. Experiences, innovations and challenges were shared. If you missed it, you can access the webinar recording here .

Top 7 Questions

Seven primary questions were raised during the webinar's Q&A; summaries are provided below. Learn more by listening to the webinar recording, accessing complementary resources, signing up for future webinars, or visiting the PrEP Virtual Learning Network page.

1. **Can HIV self-testing be used as a replacement for regular testing to support social distancing and lockdown guidance?**

   Based on the lack of experience and available evidence, WHO does not recommend HIV self-testing for people taking PrEP in its current PrEP guidelines. This is not a preferred option.

Join us for the next webinar in the series.

GOING VIRTUAL WITH PrEP SERVICE DELIVERY

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Top 7 Questions (continued)

However, given these extraordinary times, a quality assured HIV self-test can be considered for PrEP maintenance 3-monthly testing. A critical caveat, however, is that anyone testing positive would need to be confirmed with the full national algorithm due to the risk of false positive results. People should not discontinue PrEP based on an initial reactive result.

2. How should multi-month dispensing (MMD) be handled at the initiation visit, particularly given the importance of a month 1 HIV test to assess for acute HIV infection?

WHO recommends that PrEP users be given MMD. People newly initiating PrEP should return for month 1 testing and a clinic visit before getting a MMD prescription to assess intention to continue, potential adverse effects, and HIV status. WHO understands the need for flexibility in the current situation, so for motivated clients without recent potential exposure to HIV, providers could consider MMD from the point of initiation with decisions made on a case-by-case basis.

PEPFAR guidance aligns with WHO. MMD should be assessed and determined by the client and provider together, based on the client's needs. Many clients express interest in taking PrEP, but after month 1 there is a sharp drop off, which could result in unused PrEP if multiple months supply is dispensed at the initiation visit.

EpiC is following the client-centered approach by looking at risk for a particular individual to see if a month 1 follow-up visit should be done and if the client would benefit from MMD at the time of initiation. Many countries are currently conducting the first monthly visit and then considering stock levels before determining MMD prescriptions, which may be for two or three months. Other considerations include whether testing can be done at another nearby facility or whether community health workers can conduct testing at month 1. If physical distancing due to COVID-19 continues, it is expected that there will be an option for more than three months of MMD.

3. What are the guidelines around event-driven PrEP?

WHO updated their PrEP guidelines in 2019 to include the option of event-driven dosing for men who have sex with men (MSM) (link). National guidelines on event-driven PrEP vary. For example, to our knowledge, Cote d'Ivoire is the only country in sub-Saharan Africa rolling out on-demand PrEP; other countries are discussing it, but have not yet changed their guidelines.

On-demand PrEP use is safe and very effective for reducing HIV vulnerability through receptive and/or insertive anal sex between men. On-demand PrEP use is also referred to as "2+1+1" or "event-based" PrEP. The choice between daily and event-driven dosing depends primarily upon how frequently a client expects to have sex.

Top 7 Questions (continued)

PrEP can be used "on demand" only by MSM who:

(1) have sex infrequently (one day per week or less on average)

(2) can predict when sex will happen

(3) do not have chronic hepatitis B

For on-demand PrEP, the first dose (called the loading dose) of two pills should be taken between two and 24 hours prior to sex. The second dose is one pill taken 24 hours after the first dose. The third dose is one pill taken 24 hours after the second dose. If he has sex again in the next few days, one pill should be taken each day that sex continues. After the last sex act, he should take a single pill each day for two days.

On-demand use can be easier for some MSM because it involves taking fewer pills and also costs less. On the other hand, on-demand use can be more challenging to take correctly compared to daily PrEP. MSM who are interested in on-demand use should talk with a health care provider to see if they are eligible and if it may be a good fit for them. There is no evidence that on-demand PrEP use works in other populations, anyone who does not meet the specific criteria must take PrEP daily for it to be effective.

For whom is ED-PrEP appropriate?	For whom is ED-PrEP NOT appropriate?
• a man who has sex with another man: – who would find ED-PrEP more effective and convenient – who has infrequent sex (for example, sex less than 2 times per week on average) – who is able to plan for sex at least 2 hours in advance, or who can delay sex for at least 2 hours	• cisgender women or transgender women • transgender men having vaginal/frontal sex • men having vaginal or anal sex with women • people with chronic hepatitis B infection.

COVID-19 may affect which type of PrEP MSM choose based on changes in frequency of sex during the pandemic. For example, if someone is living alone and practicing social distancing, he may be having reduced frequency of sex and could switch from daily to event-driven PrEP use. Alternatively, someone may be living with a partner who was previously traveling for work regularly but is now home full time and they are having sex more frequently, so daily PrEP use may be more appropriate.

Top 7 Questions (continued)

4. How is intimate partner violence (IPV) best addressed during this time?

PEPFAR-funded PrEP programs are required to provide IPV inquiry and response to clients. Details about these requirements and how PrEP programs are implementing them was covered in the PrEP Learning Network webinar session in March: Addressing Intimate Partner Violence in PrEP Services. See this resource sheet and webinar for more information on this topic broadly, and also to find resources specifically on addressing gender-based violence risks in the context of COVID-19.

In the context of COVID-19, it is important for PrEP implementers to know that many people are at increased risk of IPV or are experiencing more frequent IPV. As a result, it is more important than ever to inquire about IPV and provide first-line support (summarized by the acronym LIVES: active listening, inquiry about immediate needs, validation of the client's experience, enhancing the person's safety, and linking the client to other support). If possible, provide new or refresher training to PrEP providers using the WHO training curriculum.

For IPV services that can no longer function (i.e., face-to-face support groups), programs should think creatively about alternatives. This might include confidential virtual spaces, bolstering helplines or working with clients on safety planning during isolation. Some programs have set up a gender-based violence reporting line for key populations (KPs). Often, KPs do not want to report to the police for fear of harassment; instead, they can report to the program and safe spaces can be arranged as needed.

HIV programs should ensure that they have a network of referral agencies established so they can refer clients experiencing IPV. If that network already exists, HIV programs should check in with agencies to see which services are still operational during COVID-19 and whether/how service delivery has been modified. For example, some services are now available via phone instead of in-person.

In PrEP programs generally, sometimes those eligible for PrEP present after recent exposure to HIV and post-exposure prophylaxis (PEP) is needed. Particularly during this time when IPV may be occurring at higher rates, consider whether clients are eligible for PEP when they present at PrEP services.

Top 7 Questions (continued)

5. **Are any of these projects using drop-in centers and how are they operating them during COVID-19? Are home visits possible at this time?**

All drop-in centers in Botswana are currently closed due to lockdown. The peer navigators are working remotely and reaching KPs virtually and directing them to services. Support groups have also been suspended and people living with HIV and PrEP clients are supported through WhatsApp groups. Similarly, Wits RHI in South Africa is not using drop-in centers at the moment but they are actively exploring ways to make off-site drop off and pick up possible for existing PrEP clients.

In Lesotho, Jhpiego has drop-in centers that are still open but with minimal traffic due to movement restrictions. Refills are being provided mostly through home visits (from vehicle windows). The providers wear medical masks when social distancing cannot be maintained. The Jhpiego team also works from outside people's homes depending on the situation and masks are used whenever the providers go inside the home to do HIV testing and any other procedure.

6. **In South Africa, what percentage of adolescent girls and young women (AGYW) clients have cellphones or access to cellphones? How is one-on-one demand creation done at the community level and at what point does the mobile clinic visit? Do you have a schedule that you follow religiously for the mobile clinic? How has ambiguity around masks been addressed?**

Nationally, in South Africa, 83% of youth are reported to have access to a smart phone. One-on-one demand creation is done through conversations the Project PrEP demand creation officers and peer navigators have with each client as they arrive at a clinic. They are commonly positioned at the clinic gate or in the vicinity of an entrance. The peer navigators also navigate them through the process, being an informed friend.

Each mobile clinic has a set roster that it follows for the lockdown period, depending on what we have established as demand in that area. Each mobile clinic will park at the premises of fixed facilities at least twice a week and offer services. However, in one of our busier sites, services are offered by the mobile every day.

There has been no indication of social media fatigue. The demand creation team that responds to queries report increasing engagements with each week post national lockdown.

Top 7 Questions (continued)

Initially, there was confusion for staff on the ground regarding when it was necessary for different cadres of staff to wear a mask (N95 vs. surgical vs. non-medical). We continuously clarified mask messaging during online training and in team weekly meetings (adapting messaging as new guidance was received from WHO and CDC). We also provided quick reference materials (job aides) to assist with addressing this confusion. Currently, none of our staff are directly involved with COVID-19 sample taking, so they do not wear N95 masks at this point.

7. **How successful is virtual outreach for sex workers? While research indicates it a viable means to reach MSM and AGYW, are you seeing success in reaching female sex workers (FSWs) as well? What about transgender clients?**

In the EpiC program in Botswana, about 9% of those reached through the virtual outreach platform are FSWs. The majority of KPs reached are MSM, likely because the team structured the strategy to reach MSM primarily and used social influencers and social media ads targeting this population. FSWs are reached through Virtual Outreach Workers, mainly by sharing links on WhatsApp and Facebook groups where the FSWs "smart sellers" solicit. EpiC has a few transgender clients book appointments, but they frequently do not make it to the physical space to access services.

In Lesotho, Jhpiego uses virtual outreach primarily for AGYW; they are not using this form of outreach for FSWs at the moment. The program relies on peer networks for FSWs and does not have experience with transgender clients.

Wits RHI's sex worker and transgender program in South Africa utilizes three virtual platforms to reach these KPs: Telerivet, Facebook, and Twitter.

Top 7 Questions (continued)

Platform/Use	Benefits	Challenges
Telerivet - a bulk SMS platform which can be used to send automated visit reminders as well as health promotion messages and event notifications to program beneficiaries. Used to remind and encourage clients to continue taking their medication, to report to the facility for PrEP and ART refills (if possible). Used to communicate critical COVID-19 messages to clients.	• Relatively cheap and efficient to send bulk messages to beneficiaries • Can personalize the message to include the beneficiary's name, so they know it targeted to them • Adherence messages have been well received, and the feedback is that it is a great mechanism to encourage adherence and disseminate information	• Sex workers change their numbers frequently so there is a need to continuously update the platform with the correct numbers • Some of the sex workers/TG share their phones with family members/friends/partners, the message can inadvertently disclose that someone is taking medication if the message is seen by others – *when we send the messages, we do not disclose what medication we are referring to or that the person is a SW or TG*
Facebook - targeted for TG communities and primarily used for health promotion and demand creation. Also used to share information, events, and relevant news (particularly the latest information related to COVID-19); share contact details for the clinic; to promote adherence, provide Viral Load literacy and market PrEP.	• It is a free service for the program • Gives an opportunity to communicate longer messages, such as busting myths around PrEP and answers some questions • Reaches a wider audience and allows for sharing • TG community is very active on Facebook and the program has received positive feedback	• Community needs to have access to Wi-Fi and some data on their phones (although there is also a free version available on mobile phones so data not always necessary) • Posts need to be published at a peak time when most people are likely to be online, if that opportunity is missed, there is a risk that the reach is very minimal
Twitter - added to increase coverage and provide a wider reach of the TG and SW community. The platform allows bi-directional communication with beneficiaries.	• Allows for faster sharing of posts and events by the project • Allows for quicker bi-directional communication with beneficiaries.	• Character limitation on twitter is 280, therefore need to communicate effectively with brevity • Due to the quicker two-way communication, the program needs to be on high alert to respond to messages, particularly negative feedback

ADDITIONAL RESOURCES

Additional resources related to COVID-19 and PrEP are below:

- Updates from the PEPFAR interagency Short-Term Task Team are released twice weekly (Wednesdays and Fridays) and are posted publicly at: www.state.gov/pepfar/coronavirus/
- South Africa National Department of Health guidance on PrEP during COVID-19
- Article on virtual pharmacies in South Africa

We hope you join us again on May 28th! Our eleventh webinar will focus on Going Virtual with PrEP Service Delivery. Visit the PrEP Virtual Learning Network for more information on previous sessions.