The United Republic of Tanzania

Ministry of Health, Community Development, Gender, Elderly and Children

National AIDS Control Programme

INTERIM GUIDANCE ON PROVISION OF HIV PREVENTION AND CARE SERVICES IN THE CONTEXT OF COVID-19 OUTBREAK IN TANZANIA

Second Edition

2020

The United Republic of Tanzania
Ministry of Health, Community Development, Gender, Elderly and Children

National AIDS Control Programme (NACP)

Interim Guidance on Provision of HIV Prevention and Care Services in the Context of COVID-19 Outbreak in Tanzania

Published in 2019

National AIDS Control Programme,
P. O. Box 784, Dodoma, Tanzania
Kilimani Area, NACP Building
Tel: +255 (0) 262060148,
E-mail:nacp@afya.go.tz
Website: www.nacp.go.tz

CONTENTS

FOREWORD

This guide outlines the updated recommendations for Health Care Workers (HCWs) and People Living with HIV and AIDS (PLHIV) attending HIV Care and Treatment Clinics in the COVID-19 context. It further, aims at maintaining standard precautions against COVID-19 as per National guide while ensuring uninterrupted services to PLHIV.

Since November 2004, the Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) through the National AIDS Control Programme (NACP) is coordinating a nationwide care and treatment programme, aimed at providing antiretroviral medicines (ARVs) to PLHIV.

In January 2020, a novel coronavirus, named Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), was identified as the causative agent of an outbreak of viral pneumonia disease named as Coronavirus disease of 2019 (COVID-19) which was reported in Wuhan, Hubei, China. Since March 11, 2020, WHO declared COVID-19 outbreak as a Pandemic. The first confirmed case of COVOD-19 was reported in Tanzania on March 17th, 2020 and community mode of transmission was declared by the end of April by the Ministry of Health, Community, Development, Gender, Elderly and Children (MoHCDGEC).

Experience from affected countries shows that the Corona Virus outbreak can cause massive disruption of services in the Health Care System including provision of HIV services to PLHIV. In light of that, the Ministry in collaboration with stakeholders developed the first edition of a guidance on provision of HIV prevention and care services in the context of COVID-19 outbreak in Tanzania in April 2020.

Since then, the pandemic has evolved, new evidences on prevention, diagnosis and management of COVID 19 have been documented and experience from the field and feedback from

implementation of the previous guidance envisaged revision of the guidance on provision of HIV prevention and care services in the context of COVID-19 outbreak in Tanzania.

Therefore, the second edition contains updated guidance on; execution of Enhanced Adherence Counseling (EAC), use of facial masks among HCWs and PLHIV attending Care and Treatment Clinics (CTC), specific recommendation for provision of pediatric and adolescent's friendly HIV services and proposed mitigation plan on HIV services continuation upon closure of facility. Moreover, this edition insists on provision of 6 Multi-Month Dispensing in Dar Es Salaam region and 3 Multi-Month Dispensing in other regions among stable clients.

The MoHCDGEC through NACP will continue to update the guidance as the evidence and experience from the field continue to evolve.

Prof. Abel Makubi
Chief Medical Officer

ACKNOWLEDGEMENT.

The guidance on provision of HIV prevention and Care services in the context of COVID-19 outbreak in Tanzania is a product of joint effort and contributions from various stakeholders. The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) appreciates and acknowledges the valuable technical assistance from stakeholders during the process of revision of this this guidance.

The MOHCDGEC would wish to specifically recognize and thank the institutions involved directly in the development of this guidance by providing members of the task force team who participated in various consultative meetings and/or provided written contributions, herewith mentioned; - UNAIDS, WHO, UNICEF, PEPFAR, PORALG, TACAIDS and CUHAS.

Dr. Leonard Subi.
Director for Preventive Services

1. INTRODUCTION/BACKGROUND

In January 2020 a novel coronavirus, SARS-CoV-2, was identified as the causative agent of an outbreak of viral pneumonia centered on Wuhan, Hubei, China. The disease caused by this virus is called COVID-19. Since March 11, 2020, WHO declared COVID-19 outbreak as a Pandemic. The disease is highly contagious, within short time has caused significant morbidity and mortality in many countries around the world. COVID-19 varies from mild to severe form depending on the presence of other comorbidities, immunity of an individual as well as diagnostic and treatment measures undertaken. The documented severity of the disease is observed among people with pre-existing medical conditions, advanced age and compromised immunity. It is important to note that persons with asymptomatic and mild disease, including children and adolescents, are likely playing a role in transmission and spread of COVID-19 in the community; therefore Health Care Providers(HCP) should maintain a high index of suspicion for COVID-19 infection in children, adolescents and monitor for progression of illness with underlying conditions.

Health systems around the world are being challenged by increasing demand for care of people with COVID-19, compounded by fear, stigma, misinformation and limitations on movement that disrupt the delivery of health care for all conditions. Maintaining population trust in the capacity of the health system to safely meet essential needs and to control infection risk in health facilities is key to ensuring appropriate care-seeking behavior and adherence to public health advice.

Recent investments in primary health care for universal health coverage provide a critical foundation for adapting to the pandemic context. A well organized and prepared health system has the capacity to maintain equitable access to high-quality essential health services throughout an emergency, limiting direct mortality and avoiding indirect mortality.

Prevention of spreading of COVID-19 helps to flatten the epidemic curve such that the number of cases remain manageable within the health system capacity. Drastic prevention measures such as physical and social distancing, disease surveillance, isolation and treatment of symptomatic cases are crucial to ensure that the epidemic curve is flattened underneath the health systems capacity.

1.1. PATHOGENESIS AND CLINICAL MANIFESTATIONS OF COVID -19

The incubation period ranges from 1 to 14 days, before symptoms develop after contracting SARS-COV 2 virus infection.

According to current evidence, COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. The COVID-19 transmission model among children has been reported to be intra-familial, (more from adults to children), or a history of exposure to epidemic areas. Vertical transmission between pregnancy, labor and delivery and or breastfeeding is unknown, but preterm delivery in COVID19 pregnant mothers has been reported. If confirmed or suspected infection in pregnant women, it is recommended to maintain a high level of surveillance during the 14–21 days after delivery.

About 80% COVID-19 infected individuals get a mild disease and recover without requiring special treatment and about 15% develop severe disease while 5% develop critical illness.

The lung is commonly affected and patients present with cough (usually non-productive), fever, tiredness, and in severe forms, respiratory distress. The main clinical features of COVID-19 reported among children are fever, dry cough and other features of pneumonia.

Complications of COVID-19 include lung fibrosis leading to respiratory failure, severe hypertension through the activation of the Renin- Angiotensin System, septicemia and multisystem organ failure.

Reports from China show that mortality rate of COVID-19 in hospitalized patients is about 28%, and 62% among critically ill patients and over 80% among those requiring mechanical ventilation. Risk factors for increased mortality include older age, presence of co-morbidities, a high SOFA (Sequential Organ Failure Assessment) score and high blood D-dimer levels. However, overall mortality among COVID19 patients is about 3%.

1.2.ASSOCIATION BETWEEN COVID-19 AND HIV

People living with HIV have higher rates of certain underlying health conditions which are exacerbated by increased age. These conditions or lowered immunity due to poorly controlled HIV infection can increase the risk for more severe illness if people with HIV get COVID-19, including people with advanced HIV Disease. (CDC Information for Clinicians on Therapeutic Options for COVID-19 Patients MARCH 21, 2020). Compared to adults, children rarely have co-morbidities such as hypertension, cardiovascular diseases and diabetes. However, children living with HIV (CLHIV) may present with history or concurrently be infected with tuberculosis which should not be overlooked. Although most cases reported among children to date have not been severe.

The limited data currently available mainly from countries with low HIV prevalence do not indicate that the disease course of COVID-19 in persons with HIV differs from that in persons without HIV. However, PLHIV who have other comorbidities (e.g., diabetes mellitus, hypertension, cardiovascular disease or lung disease) or poorly controlled HIV may be at increased risk for a more severe course of COVID-19 illness. Caution should be taken in children, despite the fact that lack of data suggests that an increased risk of severe infection has not been demonstrated in these patients. This highlights the need for uninterrupted supply of both appropriate prescribed ARVs, and opportunistic infections prophylaxis (CPT, and IPT if TB has been ruled out).

1.3 HIV AND ACQUISITION OF COVID -19

There is limited data to suggest that PLHIV have increased risk of acquiring COVID-19 infection. The risk of acquisition of COVID-19 should not be different from that of non-HIV infected individuals among PLHIV on anti-retroviral treatment (ART) with optimal suppression. However, there The transmission model among children has been reported to be intra-familial, (more from adults to children), or a history of exposure to epidemic areas. Vertical transmission between pregnancy, labor and delivery and or breastfeeding is unknown, but preterm delivery in COVID19 pregnant mothers has been reported. If confirmed or suspected infection in pregnant women, it is recommended to maintain a high level of surveillance during the 14–21 days after delivery1.sis also no evidence which has ruled out increased risk of acquisition of COVID -19 among PLHIV with advanced HIV disease, taking into account the severe immunosuppression associated with AHD. (WHO Interim guidance Maintaining essential health services: operational guidance for the COVID-19 context 1 June 2020)

2.0COVID-19 RESPONSE IN TANZANIA

Taking into consideration of approved intervention to minimize acquisition of COVID-19 infections the MOHCDGEC have released the National guide on clinical Management and infection prevention and control of novel corona virus.

2.1 COVID -19 IN THE CONTEXT OF HIV/AIDS IN TANZANIA

It is estimated that in year 2019, there was 1.6 Million people living with HIV in Tanzania. By December 2019, a total of 1.28 Million (79%) knew their HIV status and had been enrolled in ART care and treatment services, 1.27 (99%) million were already taking ART medication. The first confirmed case of COVID-19 was reported in Tanzania on March 17th, 2020 and community mode

of transmission was declared by the end of April by the Ministry of Health. Urgent and widespread measures to limit community transmission were promptly instituted. Maintenance of essential services for prevention of HIV and care for PLHIV in this context is a priority.

2.1.1 PROPOSED MEASURES IN THE PROVISION OF HIV CLINICAL CARE AND TREATMENT IN COVID -19 CONTEXT

The overarching goal will be to maintain standard precautions against COVID-19 as per national guide while ensuring uninterrupted services to PLHIV. Despite measures in place to maximally reduce the number of PLHIV coming for in-person facility visits (MMD, Outreaches etc.) some health facility visits will be necessary. Gathering in the consultation and waiting rooms can be a source of transmission of COVID – 19. Experience from affected countries shows that front line HCPs are at increased risk of being infected by SARS-CoV-2 and its of paramount importance for HCPs to protect themselves and their families from getting COVID19 in daily life and at workplace so as not compromise further the shortage of health care providers in provision of health services.

2.2.1.1. Recommendations for Health facility managers and HCPs

General Recommendations

- Protect healthcare workers through routine training and supervision on appropriate protection during service provision and availing necessary PPE.
- Optimizing care and treatment clinic (CTC) space to reduce close contact among PLHIV visiting the facility at the same time.
- Rearrange waiting and triage area to ensure physical distancing

between clients.

- Ensure standard precautions as per National Guideline of Clinical Management and Infection Prevention and Control of Novel Coronavirus.
- HCWs should wear a surgical mask all the time when they attend clients or while they are in high risk areas
- Encourage PLHVI attending care and treatment facilities to wear a mask (this can be clothing or surgical mask)
- Prioritization/triage of care for symptomatic PLHIV, those with comorbidities (e.g HTN, DM and Cardiac conditions) and elderly ones (more than 50 years).
- To enhance clinical appointments arrangements to reduce crowding.
- Emphasizing implementation of block system appointments for clients attending at the facility. The maximum number of clients per day should be determined by CTC in charge based on availability of space and service providers in a day.
- Utilization of Telephone/mobile phone or virtual visits for routine or non-urgent care and adherence counseling to replace face-to-face encounters.
- Routine laboratory tests for PLHIV including children and adolescents should continue to facilitate clinical decisions.
- Execute multitasking practices i.e. One HCP to provide multiple services (e.g. EAC, Clinical review and ART refill) at one station within the facility and optimization of fast track ART refill model.
- Provision of one-month medication and to reports any side effect to the clinician through the phone while at home for new and unstable clients.
- Enhance multi-month prescription and dispensing (6MMD and 3MMD in Dar Es Salaam and 3MMD only in other regions) for stable clients.

- Scaling up of other ART refill DSDMs such as ART refill by treatment supporter, outreach services and group refill models at facilities and community, to ensure uninterrupted supply of ART to PLHIV.
- New and Unstable Clients should receive INH for IPT and CPT dispensation aligned to ART dispensing with appropriate information on triggers for return to facility. Monitoring for potential adverse reactions should be conducted by phone or virtual visits.
- Enhanced adherence Counselling (EAC)
- All PLHIV including C/ALHIV on enhanced adherence counseling should complete their sessions according to EAC standard of care once they visit the facility.
- Mask, social distancing and strict hygiene should be observed in each physical EAC session
- Health Care Providers should also practice infection prevention control including wearing masks without fail and washing hands in between clients while serving clients.
- Establish psychosocial support for PLHIV especially for children and adolescents on coping with COVID 19 illnesses and fear related
- Provision of correct information to PLHIV clients on HIV and COVID 19 using the existing communication channels (distribution of brochures on HIV and COVID19). Facilities should provide continuous education to enhance COVID-19 awareness.
- Innovate alternative mechanisms to identify PLHIV and linking to care by scaling up testing and treatment services
- Maximizing use of self-testing outside of the clinic setting
- Prioritizing clinical-based HTS for those most in need:
  - ❒ Testing in ANC

- ❒ Diagnostic testing for individuals presenting (or admitted) to facilities with illness suspicious for HIV infection (Diagnostic testing)
- ❒ Individuals with TB, STIs, malnutrition
- ❒ Early infant diagnosis (EID) detection
- ❒ Index testing testing/exposed contacts.
- ❒ Testing in KP programs if ongoing and not facility based.

- Ensure availability of commodities including ART and condoms.
- Give advice to pregnant women and mothers living with HIV to wash hands before and after touching the baby, to keep all surfaces clean. Mothers should be supported to breastfeed safely, with good respiratory hygiene and encouraged to hold the newborn skin-to-skin, and be supported to share a room with the baby.
- Efforts should be undertaken to document and share cases of coronavirus and HIV co-infection, as well good practices.

Specific considerations for children and adolescents living with HIV

General Recommendations:

Children and adolescents' strategies on reducing the spread of COVID-19 are physical and social distancing, practicing infection prevention methods such as respiratory hygiene, hand washing with running water with soap and wearing face mask when around others and at all times when visiting facilities.

Justification:

- ✓ There is a challenge in controlling children behavior at facility. Children adherence to directives and hygiene measures is

rather difficulty (eg hand washing, and covering the mouth in coughing, and observing social distancing).

- ✓ Travel in public transport that doesn't observe social distancing and hand washing/ use of sanitizers exposes them to contamination from infected people or can be the other way round as they can contaminate surfaces by touching or coughing if not wearing masks and propagate infection to any possible immediate contact including their familiesTravel in public transport exposes them to contamination from adults or they contaminate surfaces where adults touch and propagate infection to their families.
- ✓ MostSome Children and adolescents living with HIV are living with grandparents who are vulnerable to severe SARS-COV-2 infection.

- Caregivers should be encouraged to make follow-up to the facilities via phone or SMS if they experience challenges in administration of drugs or when they need to refill a prescription. Care givers may return to the facility or visit a nearby health facility if they or their child become ill.
- Facilities should integrate pediatric and adolescent HIV services to the outreach services for those who are suffering from COVID-19 who cannot access health facilities
- Continue with HIV testing services to adolescents and children while observing COVID-19 precautions

Psychosocial support

1. Health care workers offer psychosocial support to children, adolescents living with HIV to relieve potential psychosocial issues related to fear, stress levels related to uncertainties on schooling, availability of treatment, livelihood, gender and domestic based violence related to isolation
   a. Where possible, the psychosocial support can be provided

through a mobile/digital platform.

b. Provide adolescent with contact information for the call center for more information on COVID 19 for psychosocial counselling if need be

c. Adolescents may be encouraged to establish an online platform i.e. social media for adolescents above 15 years i.e. Facebook, WhatsApp group for ALHIV who may wish to participate for the purpose of sharing information, asking questions and guidance on the situation.

Recommendation for Children 0-9

1. Continue transitioning to weight appropriate optimized regimen (LPV/r or DTG based)
2. In case LPV/r oral suspension shortage, granules should be used.
3. Where possible, Caregiver/treatment supporter should be encouraged to pick up drugs for CLHIV on subsequent visits.
4. Administration of LPV/r-based formulations (Syrup, granules, and 100/25mg tablets) should be demonstrated for first users.
5. Education to care givers should include proper handling and disposal of stools of children as they may contain SARS-COV -2.

Recommendations for Adolescents (10-19):

The National Policy promotes Adolescents friendly clinics; some facilities setting a day/hour for care and support services, that include teen clubs and playgrounds.

1. Continue transitioning adolescent living with HIV to weight appropriate optimized regimen (LPV/r or DTG based).
2. Deploy fast tracking service delivery models, and discontinue the use of playgrounds and edutainment session
3. Continue supporting virtual learning sessions where possibly otherwise organize peer education sessions in smaller groups

that allows for social distancing

4. Provide opportunity for psychosocial support remotely through mobile phone or social medial channels
5. Encourage facility led community ART refill modals for stable clients. This will reduce congestions at the CTC

What can we do to help PLHIV including Children who are COVID-19 exposed, suspects, or confirmed?

1. Should continue with ARVs as prescribed
2. Management of such person should follow the COVID-19 Standard Operating Procedures (SOPs) for Case Management and Infection, Prevention and Control
3. Care givers/treatment supporter to inform HFs for more guidance and refill modalities
4. Provide psychosocial support to PLHIV including C/ALHIV who contract COVID-19 to alleviate anxiety

2.2.1.2 Recommendations for PLHIV

Steps that people living with HIV can take to prepare in addition to what is recommended for the general population;

- ✓ Clients of HIV services who may have higher risk to COVID-19 (with underlying medical conditions (HHD, DM), poorly controlled HIV or other cause for suppressed immunity and those with advanced HIV disease.)
- Ensure there is at least a 30-day supply of other medications for the underlying diseases (e.g Respiratory diseases, HHD, DM and Cancer).
- Ensure optimal adherence to all medications prescribed to reduce vulnerability to COVID-19 acquisition.
- To have a balanced diet and physical exercise plan in order to boost immunity.

- Alert the CTC in advance by phone before presenting to the health care workers if they develop symptoms suggestive of COVID-19 (fever, cough, difficulty in breathing) so that preventive measures can be taken at the CTC to prevent COVID-19 transmission at the health facility.
- When receiving services at the clinic all PLHIV including C/ALHIV should wear face masks at all time (Clothing local masks should be encouraged for cost and reusability*) and observe social distancing.
- Minimize time spent in facilities as much as possible by use of remote communication and fast-track modalities of service provision including triage clients at higher risk and elderly.
- Adhering to respiratory and hand hygiene and cough etiquette all the time and when presenting to the CTC and ask for a face mask on arrival if having any respiratory symptoms.
- To get the right information on COVID 19 from the reliable sources. e.g MOHCDGEC.

***Note;**

- ❖ Mask is not an alternative to social distancing.
- ❖ Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- ❖ Cloth mask should be frequently washed with clean water and soap and ironed.
- ❖ Once worn, an individual should avoid touching the mask, adjustment should be done using the mask straps that go onto the ears/head. If the mask is touched accidentally, hand washing/ sanitizer should be recommended.

PROPOSED MITIGATION PLAN ON HIV SERVICES CONTINUATION UPON CLOSURE OF FACILITY

The COVID 19 pandemic has caused enormous disruption in all sectors in the world including the health sector. This is a proposed plan of action in the event that one or more health facilities stop providing HIV services.

Below are steps that should be followed when developing region-specific plan to ensure service availability in their regions.

1. R/CHMT in collaboration with regional Implementing Partners (IPs) and relevant stakeholders to identify alternative care and treatment centers or PMTCT sites that are close to the affected facility so that clients can be informed to access care and treatment services in these alternative facilities.
2. Define activities and identify roles for different stakeholders. Provide contact details for the lead in each activity (mobile number and email)
3. Prepare an action plan showing each step to ensure clients are informed and moved to other facilities for continued services. The plan should also include measures to ensure the continuation of data processing and reporting.
4. Proposed detailed plan is described in Annex 1

3.0 COORDINATION OF COVID-19 RESPONSE

Regarding coordination of COVID-19 information gathering and write up, the involvement of WHO, UNICEF, UNAIDS AND PEPFAR country office teams, CSOs from the beginning is recommended in order to avoid information gap. Also, NACP in collaboration with EOC section will use existing platforms including clinical subcommittee meetings and monthly MOHCDGEC/PEPFAR technical meetings for a collective technical and policy decision making on HIV and AIDS/COVID-19 planning and execution. The Ministry will coordinate resource mobilization and/or reprogramming

of available program funds to support COVID 19 response in collaboration with relevant stakeholders. To establish mechanisms to get feed-back from regions/facilities in case they need assistance/ clarifications from NACP/regional level on challenges they are facing while operating within COVID19 epidemic context (disruption of services and main causes).

4.0 CURRENT TREATMENT AND FUTURE TREATMENT OPTIONS

Currently there is no specific treatment for patients with COVID-19. They are being treated symptomatically based on clinical presentation and complications.

There are a number of different treatments which have been used in small studies with promising but inconclusive results. To address this challenge, WHO is now going to undertake a global trial called SOLIDARITY which will include thousands of patients in many countries. The four drugs in this trial are the most promising drugs, namely: Remdesivir, boosted Lopinavir, Chloroquine and hydroxychloroquine, and interferon –beta. Results from this trial will inform on safe and effective medication for COVID -19.

Research is also being done to find drugs which will affect the life cycle of SARS-COV2.

1. Drugs which will block the ACE2 receptor used by SARS-COV-2 virus.
2. Drugs which will block replication of SARS-COV-2 virus.
3. Drugs which will block SARS-COV-2 packaging systems.
4. Drugs that will enhance the activity of natural killer cells and hence kill the virus.

   Transfusing COVID -19 patients with blood containing neutralizing antibodies from COVID-19 recovered patients has also shown promising results.

Researches to find a COVID-19 prevention vaccine are also being

carried out in many research centers.

4.1 HIV ANTIRETROVIRALS AND SARS-COV-2 TREATMENT

Few HIV ARVs have been used as a treatment option for COVID-19 but there is, no research at present identifying any HIV medication as an effective treatment for COVID-19.

Specifically:

- Darunavir (Prezista): There are no data to suggest that darunavir-based antiretroviral therapy can effectively treat COVID-19, according to a release by the drug's U.S. manufacturer, Johnson & Johnson, on March 16.
- Lopinavir/Ritonavir (Kaletra): Lopinavir/ritonavir offers no benefit over current standard of care in the treatment of severe SARS-CoV-2 infection, according to a 199-patient study published in the New England Journal of Medicine on March 18.
- There is no evidence that DTG- and EFV-based regimen which account for >90% of all ART in SSA, have any activity or role in treating COVID-19 infections.
- Ensure client safety and WHO recommendations on COVID 19 treatment for PLHIV.

Annex 1: MEMBERS OF TASK TEAM:

SN	NAME	TITLE	INSTITUTION
1.	Prof. Samwel Kalluvya	Chair Clinical Subcommittee/ COVID-19 team	CUHAS
2.	Dr. Beatrice Mutayoba	Program Manager	NACP
3.	Dr. Anath Rwebembera	Head – HIV C&T services	NACP
4.	Dr. Magreth Kagasheki	Head – HIV C&T services	NACP
5.	Dr. Prosper Upendo	Head – HIV C&T services	NACP
6.	Ambwene Mwakalobo	Head – HIV C&T services	NACP
7.	Shoko Subira	Communication Officer	NACP
8.	Dr. Pendo Saro	HIV & AIDS Officer	TACAIDS
9.	Dr. Christine Musanyu	Medical Officer, HIV and AIDS Treatment and Care	WHO

SN	NAME	TITLE	INSTITUTION
10.	Dr. Mary Mmweteni	Pediatric HIV specialist	UNICEF
11.	John George	HIV/AIDS specialist	UNICEF
12.	Otilia Scutelniciuc	Fast Track Advisor	UNAIDS
13.	Dr. Eva Matiko	HIV & AIDS Officer	CDC
14.	Dr. Mageda Kihulya	Program Officer	PORALG
15.	Dr. Siraj Shabani	Secretary - COVID-19/HIV team	NACP
16.	Dr. Isaya Jelly	Program Officer	NACP
17.	Dr. Boniface Silvan	Program Officer	NACP
18.	Esther Ntulo	Program Officer	NACP
19	Sharon Lwezaura	Program Officer	NACP
20.	Dr. Florence Ndaturu	Program Officer	NACP
21.	Dr Mastidia Rutaihwa	Program Officer	NACP

Annex 2: Action Plan for mitigating closure of HIV care and treatment services

SN.	ACTION	RESPONSIBLE PERSON	TIMELINE	PROGRESS (as of date)
1	Clients management			
1.1	Write/ print a notice that will be placed at the entrance gate to closed facility directing clients where to access CTC services. The poster should also include mobile number which client can call to for clarification/ more information. Inform gatekeepers to provide appropriate information to clients who may have inquiries.			
1.2	Design message to be used for informing clients by phone, SMS or other medium, that care and treatment service will not be offered to their usual facility, but they can receive services at other facilities (name the alternative facilities).			
1.3	Generate a list of clients from the closed facility and order the list by appointment date. Note telephone contact as well as that of the treatment supporter.			
1.4	Call all clients from the list and document if clients have been contacted, document the site, they have selected to get HIV services (see template in Annex 2). If the client could not be reached, call their treatment supporter and inform them about the changes. If both client and treatment supporters could not be reached refer the case to tracker for follow-up.			

SN.	ACTION	RESPONSIBLE PERSON	TIMELINE	PROGRESS (as of date)
1.5	Record information of all clients called by phone (proposed template to capture name of the client, CTC #, phone number, treatment support phone number, whether reached on the phone or not, the site the client decided to use and date client attended services) (see Annex 3).			
1.6	Inform hospital administration as well as CTC in-charges at identified alternative facilities on the number of clients expected to start receiving services at their facility. The information will also include the list of clients CTC numbers; however, the facility should continue to accept unscheduled visits as they may appear.			
2	Equipment			
2.1	Update the inventory of all electronic equipment (server, desktop, laptop, tablet, smartphones, and other mobile devices) indicating where the equipment has been stored and whether the equipment has personal identifiable information (PII).			
2.2	Electronic equipment and any records containing PII should be stored under the following conditions: □ locked cabinet □ locked room □ window locks □ bars/grills for doors or windows			
3	Health Care workers			

SN.	ACTION	RESPONSIBLE PERSON	TIMELINE	PROGRESS (as of date)
3.1	Ensure all Health Care Workers and support staff in the closed facility and the destination facilities are aware of these changes.			
3.2	Inform and work with community IP where available to station community outreach point near the closed facility to provide ARV pick up to clients who may show up in need of the services.			
3.3	Identify staff who will be assigned to community outreach team (for up to 4 weeks) to work with the community IP team to provide outreach ART services near the closed facility but also direct clients to alternative facilities for necessary services.			
3.4	Facilitate relocation of staffs to alleviate additional workload at alternate facilities that clients will start getting services.			
4	Clients medical records (paper)			
4.1	Secure and lock all paper files with client information at the facility. Make sure unauthorized persons cannot reach any records with PII.			
4.2	Ensure there are measures in place to protect records from natural risks, for example: □ fire □ water damage □ animal damage (such as mice or termites)			
4.3	Secure and lock all client's information at the CTC.			
5	Electronic records (Data management)			

SN.	ACTION	RESPONSIBLE PERSON	TIMELINE	PROGRESS (as of date)
5.1	Based on number of clients the affected facility has and also based on how many alternative facilities are expected to serve the clients from affected facilities. Multiple temporary mini databases may be created and data merged through designated host database electronically. Contact NACP head of SI unit for instructions.			
5.2	Obtain permission from the hospital administration to move the database server and IT equipment and Data Officers to the identified host facility.			
5.3	Establish procedure for data entry. Design a process for handling filled client records/ temporary forms when moved between points of service provision to data entry and storage.			
5.4	If it has been decided that database will be hosted at one designated facilities, a community ART register or temporary CTC 2 card may be used to record all information for clients receiving HIV services at alternative sites then conveyed to the facility for entry to the CTC 2 database.			

SN.	ACTION	RESPONSIBLE PERSON	TIMELINE	PROGRESS (as of date)
5.5	When moving the registers, records or any other document with PII, ensure the following: • the amount and sensitivity of the information contained in any piece of correspondence remains minimal • documents are put in a sealed envelope • mail marked "confidential" should only be opened by the addressee • documents are carried in a locked case if possible • documents are carried only by authorized persons • the sender should alert the addressee of incoming packages and the addressee should promptly verify receipt			
6	**Laboratory testing**			
6.1	Contact testing lab for VL and EID and request rerouting of printed VL and EID results of clients from the closed facility.			
6.2	VL and EID results for clients from the closed facility will follow the data management process as described for HIV care and treatment services above.			
7	**ARV and TB supplies**			
7.1	In collaboration with R/CHMT, move required HIV care and treatment supplies to the alternate facilities.			
7.2	Redistribute quantities at each alternate facility based upon observed clients' attendance.			

NOTE: Upon resumption of services at original facility, clients should be informed promptly using same flow of information as during service interruption.

Annex 3: Client contact information and outcome template

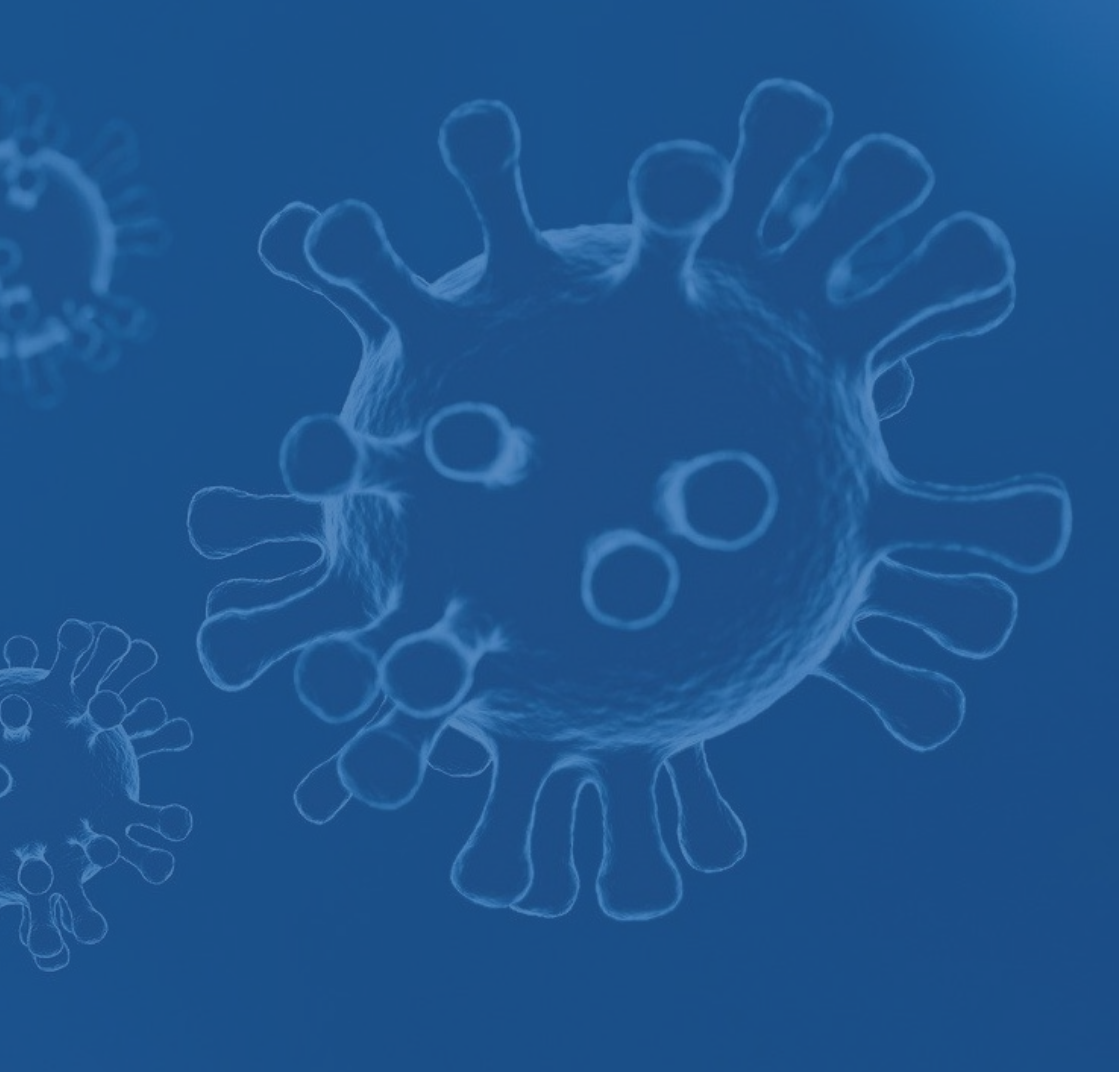
ame:

ne	Age of the client	CTC Number	Client Phone Number	Client Appointment date	Treatment Support phone number	Contacted (Yes/No)	If Yes Name of the facility client will Visit	Expected visit date	If Not Contacted, Name the tracker for follow up	Outcome of the tracker follow up *	Date client attended services	Facility and District where client attended services

come codes:
: (enter date of last visit)
to come (enter date promised)
ed to another clinic
d.
ing
)
ter date of death)

Annex 4: Early warning tool for RACCs/DACCs

Na	Mkoa	Idadi ya Vituo vya CTC	Idadi ya Vituo vya RCH(Standalone Option B+)	Idadi ya Vituo vya CTC vinavyotoa huduma hadi sasa Hivi	Idadi ya Vituo vya RCH(Standalone Option B+) vinavyotoa huduma hadi sasa	Idadi ya Siku zinazotoa huduma zimepungua?(Ndio/Hapana)	Kama jibu"Ndio" kwa swali la Mhimili wa 7. Je Ni vituo vingapi vimepunguza idadi ya Siku za kutoa huduma ya ART	Sababu ya Vituo vya ART kufungwa au kupunguza Idadi ya Siku za kutoa huduma
1	Dar es Salaam							
2	Mtwara							
3	Lindi							
4	Pwani							
5	Morogoro							
6	Iringa							
7	Njombe							
8	Mbeya							
9	Ruvuma							
10	Songwe							
11	Rukwa							
12	Katavi							
13	Dodoma							
14	Singida							
15	Tabora							
16	Simiyu							
17	Shinyanga							
18	Mwanza							
19	Geita							
20	Mara							
21	Kigoma							
22	Kagera							
23	Kilimanjaro							
24	Tanga							
25	Manyara							
26	Arusha							



Ministry of Health, Community Development,
Gender, Elderly and Children,
NATIONAL AIDS CONTROL PROGRAMME
P.O.Box 784, Dodoma

26260148 nacp@afya.go.tz www.nacp.go.tz