University of Manitoba

PROGRAM INTERVENTIONS *To Address* THE COVID-19 CRISIS

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UP-TSU

PHDA
Partners for Health and Development in Africa

Content

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The Institute of Global Public Health (IGPH), University of Manitoba mobilizes global health programs across several countries in partnership with local Non-Government Organizations. The objective of this report is to document the programme interventions implemented by IGPH and its partners, namely India Health Action Trust (IHAT) in India and Partners for Health and Development in Africa (PHDA) in Kenya in response to COVID-19 epidemic in their ongoing programs.The Report aims to assist the respective State/County in documentation and dissemination of learnings and implementation experiences for evidence based decision making.

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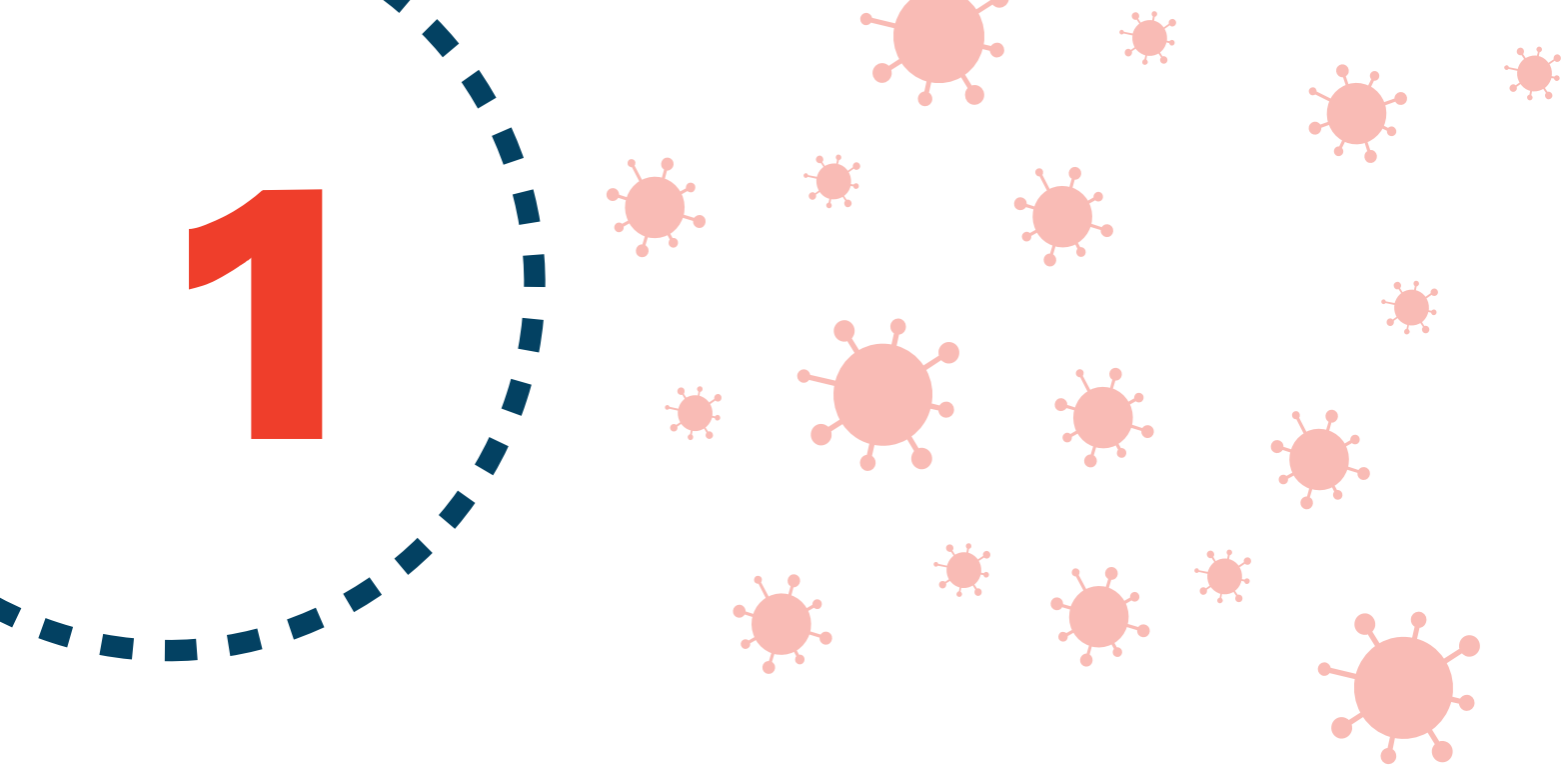


1

INTRODUCTION

A highly contagious disease,COVID-19 caused by the very recently discovered coronavirus called SARS-CoV-2 has created a worldwide pandemonium. Coronaviruses are a large family of viruses that may cause illness in animals or humans. In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

The first case of COVID-19 was reported at Wuhan city in Hubei province of China in December 2019. Since then, it has spread like wildfire across countries and continents engulfing almost the entire world. Declared a pandemic by the World Health Organization (WHO), COVID-19 has rapidly spread to more than 210 countries and territories, with approximately 4.4 million diagnosed positive and more than 295,000 individuals killed (as of 13th May 2020 (https://www.worldometers.info/coronavirus/). In addition to the health complications, the relatively high reproductive number (R0) of the virus (Zhang et al.,2020) driven in part by the infectiousness of pre-symptomatic and asymptomatic individuals, is contributing to the rapid person-to-person spread of the infection.

To counter the rapid transmission of COVID-19 in populations, Governments across the world have responded at varying speeds by introducing Public Health Interventions such as :

- International and Domestic travel restrictions accompanied by increased border controls.
- Massive scale-up of testing and contact tracing.
- Promotion of regular hand washing or sanitizing.
- Social Distancing

- Declaration of a state of emergency followed by curfews and complete lockdowns.

Unemployment rate has soared to unprecedented levels forcing non-essential businesses to shut down or limit their operations severely in many jurisdictions. To tide over this period of recession, Governments in many countries have rolled-out massive socio economic welfare programs. However, there is growing criticism that these programs are limited in scope, both in terms of eligibility and geographic coverage.

1.1 COVID-19 in India

The first case of COVID-19 infection in India was recorded in late January 2020. By middle of March 2020, there were more than 50 cases across the country. Uttar Pradesh (UP), one of the largest and most populous states in India which has 77% of its population living in rural areas, has also been affected by COVID-19. The first confirmed case in UP was reported on 5th March 2020 in Ghaziabad, followed by six positive cases in Agra. By 21st March, UP had around 30 cases and was placed at the unenviable third position among states with a maximum number of COVID-19 cases. With a literacy rate of only 67%, fragile health systems and poor availability of a functioning private health care sector, it was imperative to mobilize community-level interventions to prevent the spread of the pandemic through the community.

With a surge in the number of cases in the country, the Prime Minister announced Janta Curfew, i.e., voluntary public curfew for 14 hours (7 am-9 pm) on 22nd March 2020. Following this, the first phase of a three week nationwide lockdown was imposed on 25th March 2020, limiting movement of the entire nation and enforcing specific rules and regulations.

The nationwide lockdown which brought the entire country to an abrupt halt gradually began to witness a mass movement of people from cities to small towns and villages. It was an exodus of the nation's migrant workers to their native villages. UP constitutes a sizeable population that migrates to other states for alternate employment. During the lockdown, a majority of these migrant workers returned from Maharashtra and Delhi, states with a high number of COVID-19 cases. This incoming migrant population to UP posed a potential danger. To cope with the imminent crisis, the State Government geared itself by formulating guidelines and equipping the existing systems for community prevention and management of COVID-19 to provide necessary services to these vulnerable groups.

1.2 COVID-19 in Kenya

The COVID-19 pandemic is slowly taking hold in Africa, with numbers beginning to increase. Out of approximately 152,442 cases having tested positive for COVID-19, recoveries stand at 63,661 and deaths at 4,344 (as of 2nd June 2020). However, some mathematical models forecast more than 300,000 cases by the end of the year, while other estimates suggest over 1 million deaths in the continent (United Nations, 2020). Northern and Southern African countries are most affected, whereas the countries of Central Africa are least affected as per data shared by the Centres for Disease Control (CDC), although the prevalence may be linked to the rigorous testing in these countries [https://africacdc.org/covid-19/]. There is much speculation about how the COVID-19 pandemic will unfold in Africa. The inadequacies in health care infrastructures with a sizeable proportion of the population living in overcrowded conditions of abject poverty, especially in urban areas, pose a major public health threat. The situation is further compounded by the fact that many health care systems in Africa (and elsewhere) were inadequately prepared for COVID-19, as critical care wards and protective gear were insufficient

Figure 1: Intensive COVID-19 training conducted in HAPA Kenya offices, Mombasa

to deal with an influx of severe cases.

Kenya has proactively implemented aggressive measures recommended by the WHO to limit the expansion of COVID-19. These include rigid and abrupt stay-at-home measures enforced through curfews and lockdowns, which have disrupted the socio economic lives of many communities, especially the urban poor who reside in the informal settlements. Food insecurity is emerging as a major struggle, leading many to seek casual labour in the streets to feed their families, culminating in violent altercations, riots, and police brutality as officers go about their duties enforcing curfew and lockdown. A full lockdown is a globally accepted strategy to 'flatten the curve' of disease transmission. However, in Kenya and most African countries, a full lockdown, even in the short term, holds limited feasibility, since many Kenyans are employed in the informal sector (Corburn et al., 2020). These daily wage earners have no savings and therefore need to work on a daily basis to meet their basic needs.

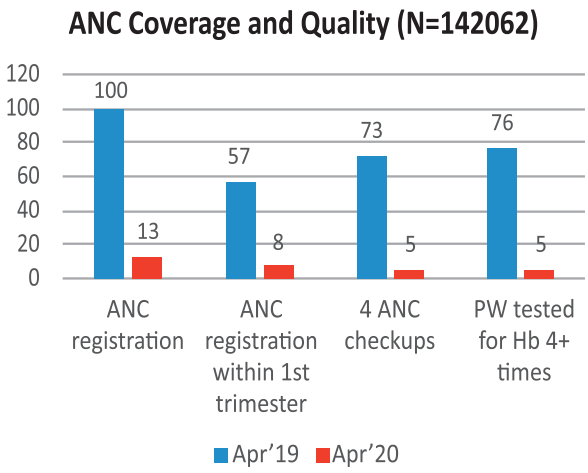
2

IMPACT OF COVID-19 ON PUBLIC HEALTH PROGRAMS

2.1 Maternal, Newborn and Child Health Programs – India

With the rising numbers of COVID-19 cases, Frontline Health Workers (FLW) like Accredited Social Health Activist (ASHA), Auxilliary Nurse Midwife (ANM) led the COVID-19 response at the community outreach level. VHNDs (Village Health and Nutrition Days), the most prominent platform for the provision of Ante Natal Care (ANC), reproductive health, nutrition, and immunization services were suspended on 24th March 2020 by the Directorate of Health and Family Welfare (DoHFW), Government of UP (GoUP), in accordance with the Govt.directive of social/physical distancing.

ANC and Routine Immunisation (RI) services declined in the month of April 2020 as compared to April 2019 in the 28 UP-TSU supported districts, as shown in figure2.



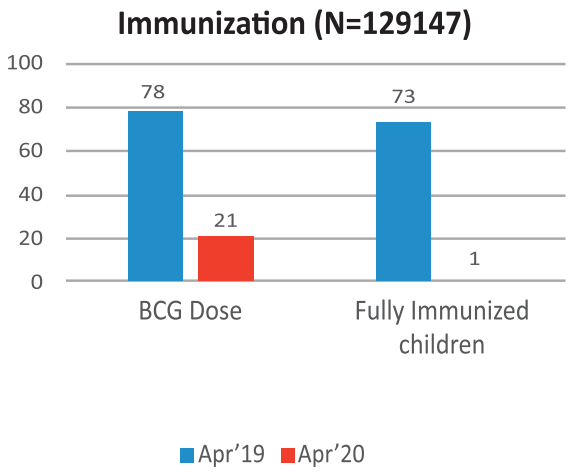


Figure 2: Comparison of ANC and Routine Immunization Services between April 2019 and April 2020
Source: Uttar Pradesh Health Management Information System[1]

As seen in **Figure 2**, ANC registrations measured against estimated pregnancies underwent a sharp decline from 100% in April 2019 to 13% in April 2020. The first-trimester registration shows a downward trend from 57% in April 2019 to 8% in April 2020. A significant drop can be seen in pregnant women receiving 4 ANC check-ups, which came down to 5% in April 2020 from 73% in April 2019.

The proportion of fully immunized children (9-11 months) measured against estimated live births came down to 1% as compared to 73% in April 2019. A considerable decline from 78% to 21% can be observed in the Bacillus Calmette–Guérin (BCG) vaccination during the same period.

The suspension of VHND services and Out Patient Departments (OPDs) at health facilities impacted the distribution of Iron Folic Acid (IFA) and iron sucrose administration. However, ASHAs continued home visits to support the pregnant women in their birth preparation plan.

> "Immunization and ANC services were largely hampered in community and facility. Many children were not immunized as per the schedule, Pregnant Women (PW) did not get ANC services and supplements such as IFA, calcium pills etc" ***-ANM Sunita from Village Shehuda, SC- Mahla, Block Jogiya, Distict Siddharthnagar***

The percentage of Institutional deliveries measured against estimated deliveries in the 28 UP-TSU supported districts remained almost constant in April 2020 as compared to April 2019 (**Figure 3**). Pregnant women, due for delivery, were rerouted from the Community Health Centres (CHCs) in their block which were converted to COVID Level 1 facilities, to other nearby delivery points. The 102 Ambulances were operational and were used by ASHAs so that the pregnant women can reach the facilities for delivery.

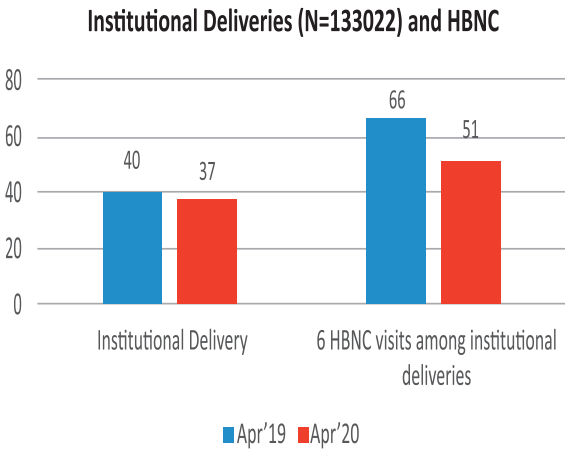


Figure 3: Comparison of Institutional Deliveries and HBNC Services between April 2019 and April 2020 in 28 districts
Source: Uttar Pradesh Health Management Information System[2]

Physical assessment of newborns and mothers stopped during the scheduled HBNC (Home Based Newborn Care) visits being conducted by ASHAs, owing to physical distancing protocols in place. Only 51% of the newborns born in

[1]Data adjusted as per reporting cycle i.e. 20 days of reporting in the month of April
[2]Data adjusted as per reporting cycle i.e. 20 days of reporting in the month of April

institutions received six home visits by ASHAs as per the HBNC protocols compared to 66% in April-19 (**Figure 3**).

> "Suspension of VHND during lockdown impacted maternal and newborn care. Pregnant women were not able to receive ANC services, ASHAs were not able to conduct Home Based Newborn Care (HBNC) visits, and there was no new pregnant women identification during lockdown. Birth planning and Counselling services were also disturbed".-***Premlata an ASHA from village Kaswa, district Shahjahanpur***

In the case of home deliveries too, the same dropped to 65% in April 2020 as compared to 86% in April 2019. The main activity affected was the weighing of newborns as it requires physical contact, subsequently affecting HBNC reporting. ASHAs now examined only visible danger signs during their visits while maintaining physical distance and followed up over the phone in certain cases. Those identified with any danger signs were referred to the facility or New Born Stabilization Units (NBSU)/Sick Newborn Care Unit (SNCU).

2.2 HIV program with Key Populations in Kenya

Key populations in Kenya include female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID) and transgender populations. In Kenya, most female and male sex workers run their businesses at night and, therefore, face the harsh realities of entertainment hotspots closures, strict curfew hours, cessation of movement, and promotion of physical distancing with fines and police violence for those who violate the new regulations—all of which have been accompanied by a general financial downturn. The stringent public health measures adopted to limit the COVID-19 pandemic in Kenya have gravely impacted sex workers', including a series of interrelated negative socio-economic and health-related issues. For other Key Populations like men who have sex with men (MSM) and people who inject drugs(PWID), COVID-19 has caused social isolation due to restrictions in travel and social distancing, anxiety and stress due to loss or fear of loss of social networks, challenges in accessing drugs, leading to an increase in violence with intimate partners and law enforcement. An existing history of HIV stigma borne by Key Populations have made matters worse for them during this time of the pandemic as they make a good scapegoat for being the carriers of the virus. Accusations of spreading and being transmitters of the epidemic are being hurled at them by their neighbours in the crowded contexts of informal settlements. In this way, COVID-19 has reinforced and deepened pre-existing stigmas that Key Populations already suffer, undermining the effectiveness of current HIV prevention and treatment programs that are crucial for improving and maintaining access to sexual health services.

Shouldering the burden of the HIV epidemic in Kenya, Key Populations with HIV are concerned that their prior conditions with its negative effects on their immune system, will make them especially vulnerable to contracting COVID-19. HIV prevention services have been more difficult to access because of the dependence upon hotspot-based outreach, which is difficult to execute with the closures, leading to an increase in HIV incidence during this crisis. Earlier, while Key Population (KP) clinics typically operate as community drop-in centers, they now run their services primarily by appointment, placing limits on the number of people permitted inside the clinic at any given time to maintain physical

distancing guidelines.

HIV prevention and treatment have been affected in relation to regular contacts, clinic visits, HIV testing and services related to treatment.

Figure 4 and **Figure 5** below show performance of one of the programme as an example.

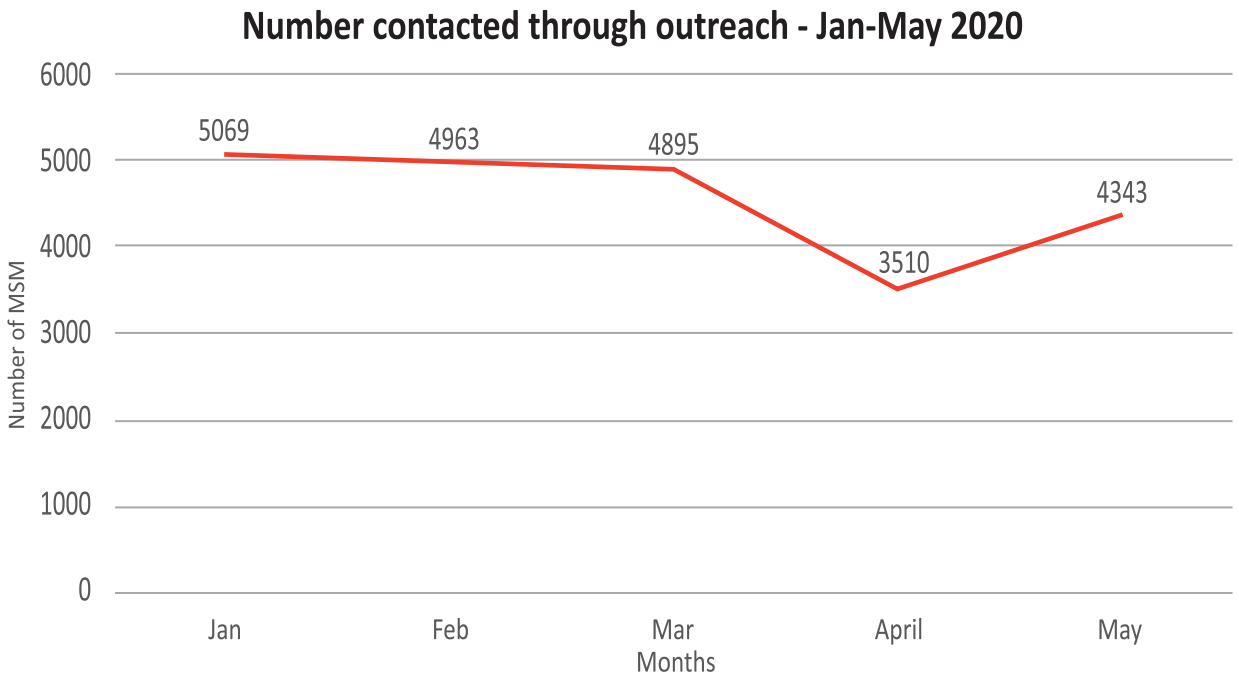


Figure 4: MSM contacted through peer outreach in the three sites (combined program data, Jan-May 2020)

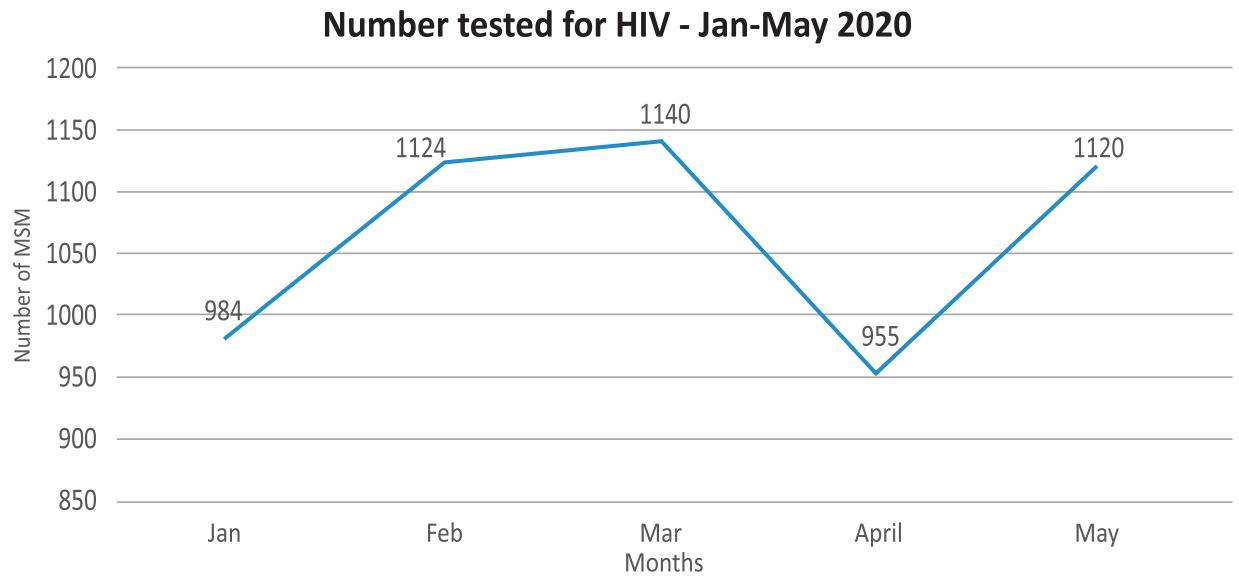
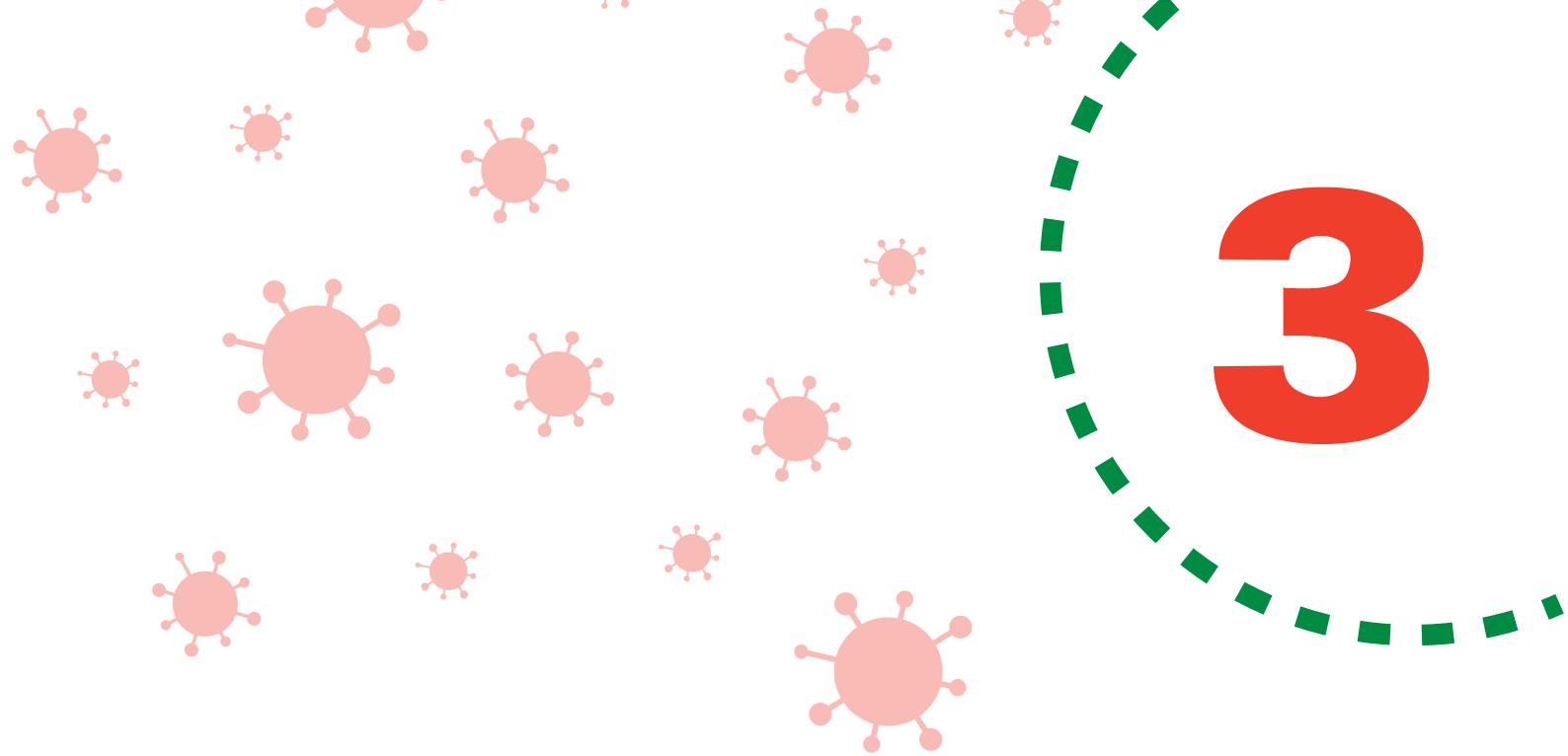


Figure 5: MSM HIV tested in the three sites (combined program data, Jan-May 2020)



3

PROGRAM RESPONSE

In India, University of Manitoba (UoM) in partnership with the India Health Action Trust (IHAT) and supported by Bill and Melinda Gates Foundation (BMGF) established the **Uttar Pradesh Technical Unit (UP-TSU)** to provide statewide techno-managerial support to the Government of Uttar Pradesh on reproductive health, maternal health, newborn health, child health, nutrition, and on strengthening of health systems.To achieve the state health and nutrition goals, several projects implemented by UP-TSU include:

- **Maternal and Newborn Health:** This project aims at improving the availability, utilization and quality of antenatal, intrapartum and postnatal care services at the community and facility levels within 28 priority districts in Uttar Pradesh
- **Family Planning:** This project focusses on improving availability of expanded basket of choice, utilization and quality of FP services and roll out of injectables and Family Planning Logisticts Management Information Systems (FPLMIS) across the state of Uttar Pradesh.
- **Health Systems Strengthening:** This project cross-cuts across all thematic areas and focusses on strengthening of health systems through improving availability of human resources and their rationalization based on Human Resource Management Information System (HRMIS), improving supply chain system, strengthening data systems and development and implementation of Information Education Communication (IEC) / Behaviour Change Communication (BCC) strategy across the state.
- **Nutrition:** This project aims to improve Integrated Child Development Services (ICDS) and health systems' capacity to deliver quality MIYCN (Maternal, Infant,

Young Child Nutrition) interventions in 28 districts of Uttar Pradesh.

- **Routine Immunization (RI) :** UP-TSU has recently expanded into routine immunization space with the aim of improving Full Immunization coverage across Uttar Pradesh through strengthening data driven decision making, enhancing state capacity in management and governance and improving RI performace in priority blocks.

In Kenya, in partnership with **Partners for Health and Development in Africa (PHDA)**, the Institute of Global Public Health (IGPH) focuses on HIV prevention and treatment among Key Populations. Several projects implemented by the Institute and its partners include:

- **Direct Service Delivery to Key Populations:** Through several clinics across Nairobi, Kenya IGPH and PHDA provide HIV prevention and treatment services to female sex workers and men who have sex with men in Nairobi.
- **Technical support to Ministry of Health:** Through the Technical Support Unit within the National AIDS and STI Control Programme (NASCOP), IGPH and PHDA supports the Key Population Program lends support to lead and manage an effective and impactful national Key Population Program
- **Implementation Research:** IGPH and PHDA also executes several implementation research projects in partnership with community-based organizations and non-governmental organizations in HIV Self Testing, HIV and Violence.

The following section highlights the response designed and implemented by IGPH within the existing interventions related to Maternal Neonatal and Child Health (MNCH) in India and HIV in Kenya.

3.1 Policy Changes

3.1.1 India

3.1.1a Guidelines on migrant tracking:

To streamline activities, UP-TSU clearly defines the roles of FLWs, supports GoUP to draft the Government orders (GO), released by the Department of Health and Family Welfare (DoHFW). The GOs define the role of respective FLWs, broadening their role to identifying, line listing, and tracking the incoming migrant workers from other countries, other Indian states, and districts.

I. **Migrant tracking phase-1:** This GO from the Principal Secretary (PS), (DoHFW) GoUP, addressed to all the District Magistrates (DMs) and Chief Medical Officers (CMOs) was circulated on 30th March 2020. Key highlights include:

   - ASHA to visit 25 to 30 households daily and line list and report people with history of travel to a different country/ state/ district or those who have had contact with migrants, to Block Community Program Manager (BCPM) while advising self-quarantine at home.
   - Provision of Paracetamol Tablets for 3 days to those with fever, cough, and referral to COVID -19 treatment facility in case of breathing difficulty.
   - COVID -19 incentives for ASHA and ASHA Sangini.

II. **Migrant tracking phase-2:** With the lifting of travel restrictions on 3rd May, the Government of India announced the commencement of migrant trains (Shramik Express) in addition to other modes of transportation. Anticipating the return of a large number of migrant workers stranded in other states of India, UP-TSU supported GoUP in the development of protocols

for screening, line-listing, testing, and home quarantine of these migrants. The GO released on 1st May 2020, prescribed screening of all migrants by district authorities upon entry into the district/ state/ block and in case of any COVID-19 like symptoms, transfer the individuals to facility quarantine for further screening and testing. If tested positive, these migrant workers would be admitted to a COVID hospital, and if the sample is found to be negative, they would be kept in facility quarantine for seven days and re-tested. If there are no symptoms after seven days, these cases would be kept under home quarantine for 14 days. Those found to be asymptomatic, would be quarantined at their homes for 21 days. The ASHA's role would be to visit the quarantined households in the village every three days and report symptoms. This GO also defined the formation of Nigrani Samiti (Village Monitoring Committee) headed by Gram Pradhan. The ASHA is a key a member of Nigrani Samiti in each village and Mohalla Nigrani Samiti for each ward of urban areas for community surveillance. Pasting of quarantine flyers outside the homes under quarantine allows easy monitoring by Nigrani Samiti.

III. **Nigrani Samiti Guidelines:** A letter addressed to all the District Magistrates was circulated by the Principal Secretary on 12th May 2020, instructing them to form Nigrani Samitis in each city and every village of their districts. This Committee will be involved in community surveillance, raising awareness, ensuring community as well as personal hygiene and sanitation is maintained and help people to avail the services provided by the Government. The Samiti would educate people on social distancing, advocate using masks and emphasize the importance of handwashing. Tracking of migrants and vulnerable groups, i.e., people above 60, pregnant women, persons with co-morbidities, and children below five years to ensure isolation of these groups in their homes while providing them with all the goods and services offered by the Government. Availability and Accessibility will be the key focus of Nigrani Samiti. Additionally, the Samiti would ensure adherence to protocol as per GO during social events and provide any information related to COVID-19 on the toll-free number.

3.1.1b Guidelines of Resumption of Reproductive on Maternal Newborn Child Health (RMNCH) Services:

To minimize the impact of COVID-19 on maternal, neonatal, and infant mortality rates, UP-TSU supported GoUP to draft a GO released on 29th April, restoring key maternal, neonatal and child health services in the community.
VHND services were restricted to districts with no COVID-19 cases and the non-containment areas of districts with less than 20 cases. Protocols regarding maintenance of appropriate physical distance (at least 1 metre), hygiene, and sanitization of the venue and equipment were also defined to ensure safe delivery of services in VHNDs. The beneficiaries were to be mobilized in hourly time slots based on their due-list by ASHAs to avoid overcrowding.
HBNC services were also resumed by ASHAs in the same districts. In areas with higher cases of COVID-19, the ASHAs were expected to follow up on the status of newborns and their mothers telephonically. To maintain physical distance and avoid exposure to newborns, ASHAs were instructed not to weigh the newborns or touch them for assessment of danger signs but record the same based on visible danger signs and from the feedback derived from the mother and other family members. This GO was followed by the release of a supplementary guideline on 4th May, allowing resumption of RMNCH services in all districts excluding containment zones.

3.1.2 Kenya

3.1.2 a Standard Operating Procedure (SOP) for dispensing of Medication-assisted Therapy through mobile vans for People who Use Drugs

The Coronavirus pandemic and its attendant containment measures like the curfew and county lockdowns have immensely affected the models of service delivery within the Medically Assisted Therapy (MAT) facilities given that the MAT clients come from far and wide, often crossing County borders to access their mandatory daily doses and other medical services offered at the MAT clinics. Consequently, the majority of People who Inject Drugs (PWID) and People who Use Drugs (PWUD) have not been able to access their treatment, leading to relapse and going back to the injecting dens or resorting to petty crimes and other criminal activities to procure food and basics for daily subsistence. NASCOP, MAT clinics, and Stakeholders came out with various modalities and strategies during this period to ensure that the MAT clients have access to the services extended to them without any hindrances. The strategies included using a mobile van to dispense methadone at various designated sites in various counties implementing MAT services. The vans would follow a defined route while adhering to the COVID-19 prevention and response directives given by the Government

In this regard, the KP-TSU under the leadership of NASCOP and in collaboration with the Partners developed standard operating procedures (SoPs) for mobile dispensing of MAT. This SoP was validated virtually in consultation with the Stakeholders and approved by the Ministry of Health for implementation.The strategies put forth for the implementation utilized a multipronged approach which included the acquisition of mobile vans for Mombasa, Nairobi and Kiambu counties with authorization for the movement of methadone and the operationalization of the vans. The Ministry of Interior Coordination and the Pharmacy and Poisons Board, Kenya authorized and supported this initiative. The introduction of mobile vans for dispensing MAT will ensure that MAT services are accessible to clients not only during a crisis situation like COVID-19 but also when this crisis is over. This will benefit around 6000 MAT clients. The underlying objective is to streamline logistics and supply chain management to ensure timely availability and accessibility of drugs and services.

MINISTRY OF HEALTH

OFFICE OF THE PRINCIPAL SECRETARY

The Chief Executive Officer
Council of Governors
Delta Plaza
NAIROBI

RECEIVED

RE: USE OF MOBILE CLINICS FOR DELIVERY OF MEDICALLY ASSISTED THERAPY (MAT) FOR DRUG USERS TO MITIGATE COVID CONTAINMENT MEASURES

Figure 6: Order from Government of Kenya approving mobile dispensing of MAT

3.1.2 b Guidance for the resumption of services

The national KP program developed guidelines for Implementing Partners to ensure the provision of services to the community. The guidance focused on outreach, clinical services, and violence prevention and support for KPs during COVID-19.

Guidance provided for Outreach:

1) Ensuring the Outreach team is safe and well informed
2) Ensuring the Outreach team is prepared to conduct virtual outreach
3) Ensuring the Key Population receive information and commodities
4) Ensuring the Key Population are referred to services

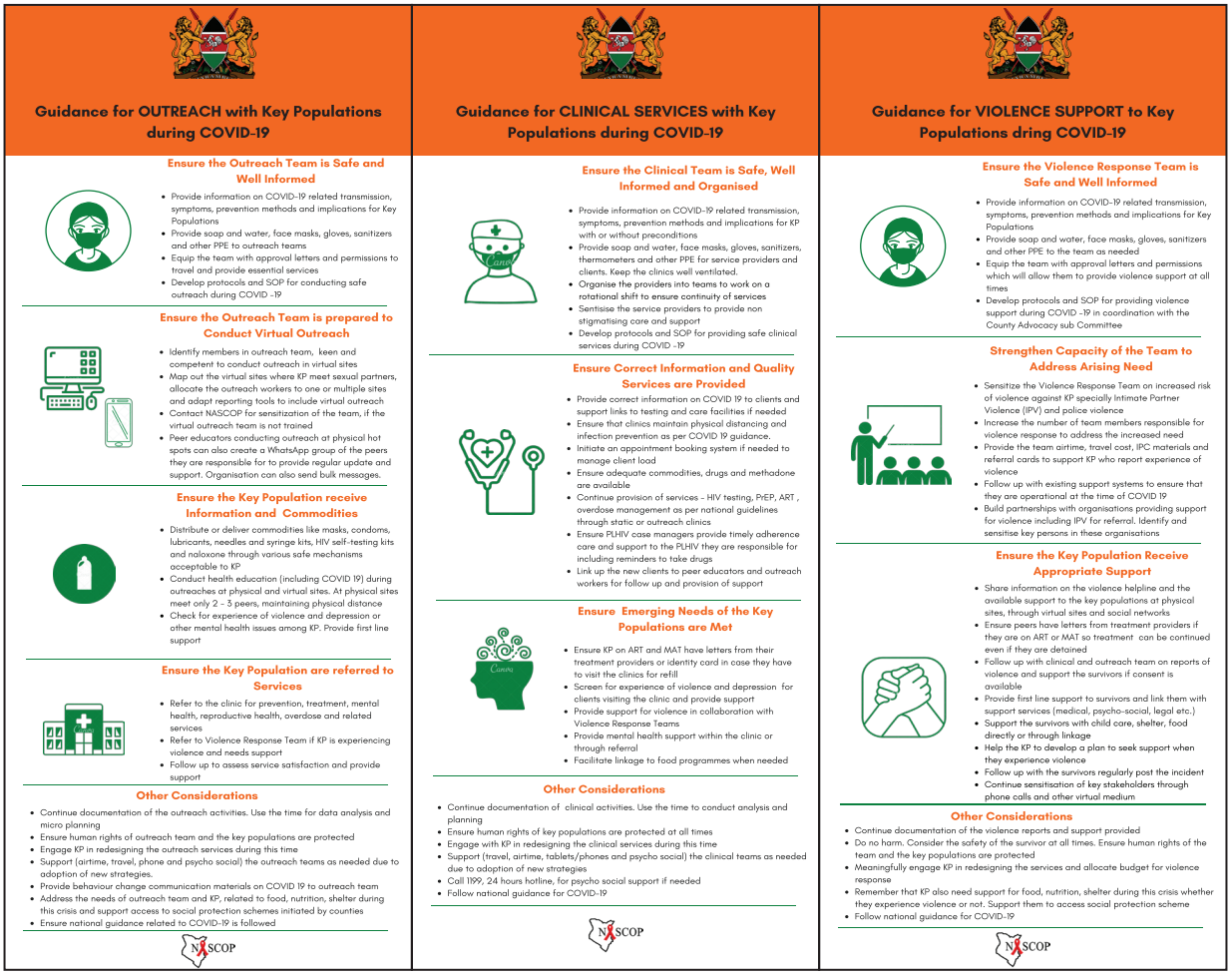
5) Other considerations- documentation of outreach services, safeguarding human rights of outreach teams, protecting key population and provision of airtime, transport, and psychosocial support.

Guidance for Clinical services during COVID-19 focused on:

1) Ensuring the clinical team is safe, well informed and organized
2) Ensuring correct information and quality services are provided
3) Ensuring the emerging needs of the Key Populations are met
4) Other considerations - documentation of clinical services, engaging the KP in redesigning clinical services for the times and supporting (travel, airtime, tablets / phones, and psychosocial) the clinical teams to adopt new strategies.

Violence support to KP during COVID-19 looked at:

1) Ensuring the violence response team is safe and well informed
2) Strengthening the capacity of the team to address arising needs
3) Ensuring the Key Population receive appropriate support
4) Other considerations - documentation of the violence reports and support provided, allocating budget for violence response, considering the safety of the survivors at all times, safeguarding the human rights of the team, and protecting the Key Population. Engaging KP in redesigning services, and supporting KP's needs for food, nutrition, shelter during the crisis irrespective of their being subjected to violence or not.



3.1.2c Conducting county KP Technical Working Group (TWG) to review progress and share experiences

In light of the present pandemic, County Governments and Partners adapted and held virtual Technical Working Group (TWG) meetings to discuss KP programs in the county. 53% (19 out of 36) of the counties implementing KP programs were able to hold virtual TWG meetings. The inclusion of vulnerable KP to the list for social protection as well as access to food baskets was agreed upon. Supporting and safeguarding outreach for KP while adhering to guidelines provided for COVID-19 were also finalized. For example, in Busia County, Partners were able to conduct outreach at the chief's camp and integrate food baskets with the services.

3.1.2d Advocacy with donors to allocate resources for COVID-19-related needs

With the current pandemic, the Government has taken measures to curb the spread of the disease and is re-programming and implementing innovative strategies to achieve continuity of services to the Key Populations. The KP TSU is supporting NASCOP in helping prioritise the key activities and documenting challenges experienced by KP programmes. This information is being used for advocacy with donors. One strategy was a virtual meeting with President's Emergency Plan for AIDS Relief (PEPFAR) and Global Fund, the prime funders of KP programmes in Kenya, to understand the measures they had put in place to ensure continuity of services. Major interventions agreed upon during the meetings included:

1. Provision of re-usable masks to Partners as well as a cohort of Peer Educators and Outreach Workers.
2. Distribution of re-usable masks every two weeks to clients along with daily methadone service.
3. Providing support to print and distribute communication materials on COVID-19 and HIV.
4. The Donors were to follow-up with their Partners regularly to ensure services were ongoing and provide support if challenges arose.
5. Support for airtime and travel of Peer Educators, Outreach Workers and Clinical Team to ensue their safety and coordinate and follow up Peers virtually.

3.2 Capacity strengthening efforts

3.2.1 India

3.2.1a National Training of Trainers:

Post completion of the National Training of Trainers, held on 27th March 2020, National Health Mission (NHM), UP conducted a meeting on 30th March 2020 to discuss the strategy to be undertaken for the orientation of FLWs and measures to be initiated for containment of COVID-19 at the community level. Thereafter, it was decided to adopt the cascade model for training of FLWs. A comprehensive training plan was developed centrally for the orientation of district and block level functionaries through virtual platforms and subsequently for frontline workers on the prevention and management of COVID-19. The Director General of Maternal Health and Family Welfare (DGoMHFW) issued a letter on the importance of training of FLWs on COVID-19 on 30th March 2020.

Different training modules were developed for ASHA, ASHA Sangini, and ANMs, explaining their roles and responsibilities. For better understanding and communication, audio and video voiceover of the modules were developed for ASHAs.

	Aspects covered by the Learning Resource Package for FLWs for prevention and management of COVID-19	Key messages delivered through these modules:
1	Information about COVID -19, its symptoms, and how it spreads.	Do's and Don'ts for the community to prevent the spread of COVID-19.
2	Who is more likely to be infected by it?	Importance of social distancing in preventing the spread of COVID-19.
3	Steps to be followed if an individual shows symptoms of COVID-19.	Steps for handwashing
4	Measures to prevent the spread of COVID-19 and the role of FLWs in restricting its spread.	Use of masks
5	Guidelines for the migrants who have returned from a different district/state/ country.	Instructions for home quarantine
6	Steps for taking care of infected people.	
7	Instructions for people under home quarantine.	

3.2.1b. State Level Training and Planning

After the first GO issued by GoUP at the end of March 2020, UP-TSU supported NHM to plan the strategy, prepare the training content and modules, activate training and rollout plans to orient the FLWs. The first step was to centrally orient the district-level officials, CMOs, DPMs, DCPMs, District Surveillance Officers, DPO, ICDS, DHEO, UNICEF district Officials and SMOs from WHO. This was subsequently followed by an orientation of the block-level officials like MOIC, CDPO, HEO, BPM, BCPM, and WHO Field Monitors via virtual Zoom Training Platform. These trained block level officials would then further train the FLWs in a group of 10-15 people, virtually or face to face while maintaining physical distancing norms.

3.2.1c. District Level Training

A two and a half hour district-level training on the role of FLWs in addressing COVID-19 was held on 31st of March 2020 through Zoom platform, using Government of India (GOI) and GoUP approved resource materials. A total of 589 participants from 75 districts comprising of district-level staff from the health department, NHM, National Urban Health Mission (NUHM), Integrated Child Development Services(ICDS) and partners like WHO, UNICEF, Piramal, United Nations Development Programme (UNDP) and UPTSU attended the training. The objective of the training was highlighted by Dr Jha, General Manager, Community Process (NHM) followed by Ms Hekali Zimoumi, Secretary, Health department who emphasised upon the role of district and sub-district teams in educating FLWs on COVID 19. Dr Vikasendu, State Surveillance Officer shared the current situation of COVID 19 and the steps to be taken for its prevention. Md. Ataur Rab, Deputy General Manager Community Process (NHM) explained the role of FLWs along with an introduction to the online FLW toolkit.

3.2.1d. Block Level Training

The training on the roles of FLWs in COVID-19 prevention and management was held centrally through Zoom on 1st and 3rd April. The District Community Process Managers (DCPM) and District Program Managers (DPM) were the Master Trainers for a total of 3462 block level functionaries, divided into two batches, including

Medical Officer In-Charge (MOICs), Health Education Officers (HEOs), Child Development Project Officers (CDPOs), Block Community Process Managers (BCPMs), Block Program Managers (BPMs), and health partners from all 75 districts of UP who participated in this training.

3.2.1e. Sub-block Level Training ASHAs and ASHA Sanginis

Trainings for 1.5 lakh ASHAs and 8000 ASHA Sanginis (supervisors) were initiated subsequently. These trainings were conducted in-person in small batches maintaining physical distance as well as through WhatsApp calls for those FLWs who owned a smartphone. Around 99% of ASHA Sanginis, 86% of ASHAs, and 87% of urban ASHAs were trained across 75 districts of UP. UP-TSU prepared Whatsapp compatible training videos on the role of FLWs and uploaded them on a weblink. An SMS with the link for the video was sent to 6624 ASHA Sanginis, 151184 ASHAs, 19288 ANMs, 807 BCPMs and 131 DCPMs. Voice messages on Do's and Don'ts, home care etc., developed for FLWs have been circulated through Whatsapp groups.

3.2.1f. Training of Auxiliary Nurse Midwives (ANMs) using various digital platforms

It is imperative to train Auxiliary Nurse Midwives (ANMs) in the appropriate identification, referral, and management of COVID-19 cases, as they are the closest available clinically trained frontline workers in the community. The majority of ANMs in the state possess a tablet and hence were trained directly through the training module shared via various digital mechanisms like Mobile Device Management (MDM) and through uploading on a weblink shared through an SMS. Whatsapp calls and Zoom calls were used extensively for ensuring maximum training coverage for ANMs in the state. The various methodologies used to train the ANMs on prevention and management of COVID-19 are detailed below:

I. Use of weblink

UP-TSU supported GoUP to develop a learning resource package and uploaded it on a weblink. This weblink was then pushed via SMS to all ANMs. 94% of ANMs accessed this link to view the training material.

II. Use of Mobile Device Management (MDM)

The GoUP learning resource material for ANMs was also uploaded through MDM (Mobile Device Management) software and pushed to ANM tablets. An SMS link for the training module was sent to the ANMs to access and download the pop-up link on their tablets.

III. Group Whatsapp and Zoom calls in 28 UP-TSU supported districts

Out of 4225 ANMs in 28 UP-TSU supported districts, 3987 were trained by district and state staff through group calls using platforms like Zoom and Whatsapp. An initial pilot over a zoom call was held centrally with all ANMs from Pilibhit district. UP-TSU staff, District Community Specialists (DCSs) and ASHA Sangini Mentors (ASMs) trained the ANMs through group calls within the rest of the HPDs (High Priority Districts).

Since physical training was not possible during the lockdown, technology was used extensively to reach out to the district, block, and sub-block level health workers. Since the ANMs in the state possess a tablet, they were trained directly through pushing of the training module via various digital mechanisms like MDM, Whatsapp calls and web links shared through SMS with the ANMs. In case of ASHA and ASHA Sanginis, a more elaborate approach was

followed which entailed cascade training through Zoom calls and WhatsApp calls as well as video modules shared with those ASHA and ASHA Sanginis who owned a smartphone.

3.2.1g. Use of Information Education Communication (IEC) materials, audio and video-based messages for knowledge dissemination

UP-TSU developed flyers on important COVID-19 related topics like home care, home quarantine, and care for the elderly which were approved by the Directorate of Medical Health, GoUP, and were shared with all DCPMs and BCPMs for further dissemination to FLWs. Audio and video messages were developed for the FLWs to clearly understand their roles and generate awareness in the community related to COVID-19. These messages were uploaded on a web link shared via SMS with all ASHAs and ASHA Sanginis. A script was developed for BCPMs to orient ASHAs regarding their role in the prevention and management of COVID-19. Apart from the establishment of quarantine centers, several district authorities also undertook initiatives like pasting of home quarantine slips in front of households with suspected cases and using stamps for those in quarantine.
UP-TSU has been constantly lending support to GoUP in working towards strengthening the knowledge and improving the skills of ASHAs/ ASHA Sanginis/FLWs by transforming the existing cluster meeting platform into a capacity building platform.

Overall Health Staff Trained in Uttar Pradesh

Details	# trained	# available
Total CHOs trained	1423	1555
Total ANMs trained	19288	23135
Total ASHAs trained	132811	155055
Total ASHA Sanginis trained	6781	6844
Total Urban ASHAs trained	5509	6341

3.2.2 Kenya

3.2.2a Capacity building of Transgender Population on Violence prevention and response

The KP TSU is supporting NASCOP to conduct virtual training related to KP programming on request from Implementing Partners. One such training focuses on prevention and response to violence against Transgender population. The participants are drawn from Jinsiangu, a Community Based Organization (CBO). Facilitators are drawn from the KP TSU, Jinsiangu, and FHI 360 who supports the training. The training is being organised using the Zoom Platform and will run for a total of 5-6 days (3 hours per day).

3.2.2b Capacity building on mental health needs

The increase in mental health disorders, including depression and anxiety, due to the restrictions imposed during lockdown, has prompted capacity building initiatives in this area. In Mombasa county, KP-TSU in collaboration with NASCOP and County Government plans to hold mental health webinars which will bring on board various Key Population Stakeholders, including the County Health Representatives to discuss mental health challenges brought forth by COVID-19.

In Mombasa, KP TSU also supported 3 HIV and AIDS People's Alliance of Kenya (HAPA-Kenya), an MSM led organization to conduct mental health sessions with Outreach Team (the Peer Educators and Outreach Workers) to ensure that the MSMs whom they might identify from the community to have symptoms of depression and anxiety, are referred to the Drop-in Service Centers (DICE) for counseling, follow up and referral.

KP-TSU also supported Mamboleo Peer Empowerment Group (MPEG), another MSM led CBO in Kiambu county to conduct an online mental health sensitization session of health caregivers in collaboration with the County Health management team to create awareness in the health care workers on issues of mental health affecting the MSM.The sensitization session conducted by a psychologist equipped the 12 participants with skills to manage clients with mental health problems in regard to screening, diagnosis, and referral.

3.3 Resumption of key maternal, newborn and routine immunization services

3.3.1 India

UP-TSU developed guidelines for high quality, well coordinated techno managerial support in coordination with Health Partners and GoUP for the resumption of critical reproductive, maternal, newborn and child health (RMNCH) services in UP. The GO, released on 29th April, 2020 allowed recontinuing of VHND services in only those districts with no COVID-19 cases (Green zone) and the blocks with non-containment areas of districts with less than 20 cases (Orange zone) while maintaining appropriate social distance, hygiene protocols and sanitization of venue and equipment. The supplementary guideline released on 4th May 2020 allowed these services in the non-containment areas of hotspot districts (red zone). As per the directives of the Government Order, the health care providers are required to follow safety protocols while providing services to the beneficiaries in VHNDs.

The Village Health, Nutrition and Sanitation Committee (VHNSC) were directed to explore other sites if the designated VHND place had been used as a quarantine center. They were also instructed to sanitize the place before resuming the services. It was ensured that every VHND site had a **handwashing corner** with water and soap availability and written instruction for handwashing for approximately 20 seconds

before entering the VHND. FLWs were advised to assign **time slot to beneficiaries on an hourly basis**, depending on the number of beneficiaries in the due list to avoid big gatherings. To follow physical distancing at each VHND site, ASHAs drew circles on the floor, maintaining a 1-meter gap between two circles. All the beneficiaries were instructed to stand/sit within the circles.

> "We always have this fear of getting infected but it is our duty and responsibility to provide need based services to pregnant women and their children as they were not able to get the required services during lockdown. We sanitize our VHND site before and after the session, sometimes we are not supported by the Gram Pradhan. Our VHND sessions which earlier used to take place at a villager's house are not allowed at present due to the fear of coronavirus infection. Because of this we are now forced to organize our VHND session in an open area. We need to call beneficiary as per their time slot which is very tiring at times but I believe it's important to avoid social gatherings for our own safety."- ***ASHA, Samaspur Village, Block Gandundwara, District Kasganj***

3.3.1a Orientation of district & field level staff on revised strategy for VHND & HBNC

To ensure that these services were operational at field level as per the GO and the health care providers are following safety protocols, a web-based platform i.e., ZOOM application, was used to orient district-level officers. The said orientation was conducted under the chairmanship of Dr. Ved Prakash (General Manager (GM), RI/VHND/CH-NHM) on 1st May 2020 along with Dr. Rajesh Jha, GM Community Process, Dr. Usha Gangwar, GM Maternal Health and Dr Alpana Sharma, GM Family Planning. Additional Chief Medical Officers (ACMOs), District Immunization Officer, DCPM, DPM and district level staff from UNICEF, WHO and UP-TSU were among the 300 participants during this training.

3.3.1b Resumption of services: Improvements in key ANC and RI indicators

With the resumption of VHNDs in May 2020 with all physical distancing and hygiene protocols in place, there has been a marked improvement in ANC and RI services that are mostly provided in VHNDs. As shown in **Figure 7**, the ANC services are back on track with ANC registration (measured against estimated pregnant women) at 98% in May-20. The proportion of pregnant women registered in 1st trimester also attained pre-COVID levels with 58% in May-20 which is an increase from 8% in April-20. Percentage of pregnant women receiving 4 ANC check-ups also shows a considerable leap from 5% in Apr-20 to 66% in May-20. This is in congruence with the pre-COVID levels (65% in May-19). The percentage of pregnant women tested for Haemoglobin (Hb) 4 or more times also increased from 5% in Apr-20 to 64% in May-20 attaining pre-COVID levels of 65% (May-19).

As shown in **Figure 8**, there has been a sharp increase in the RI services indicated by improvement in administration of BCG dose from 21% in Apr 2020 to 66% in May 2020 as well as an increase in the percentage of children aged 9-11 months receiving full immunization from 1% in Apr 2020 to 68% in May 2020. Although there has been a marked improvement in the coverage of these routine immunization services, they are yet to reach pre-COVID levels and thus need further improvement.

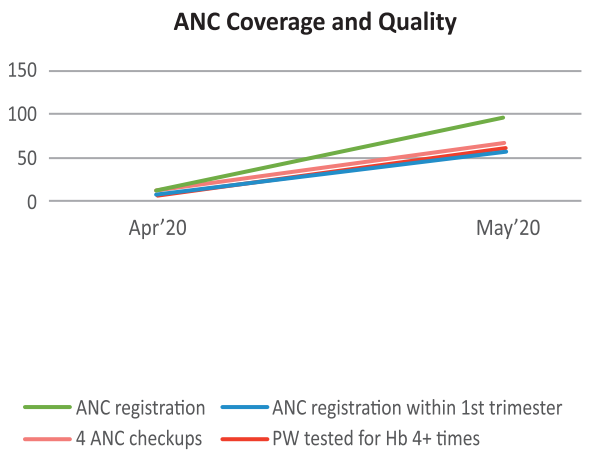


Figure 7: Resumption of ANC services (May 2020) in 28 districts of UP
Source: Uttar Pradesh Health Management Information System (N_{Apr} = 142062, N_{May} = 213093)

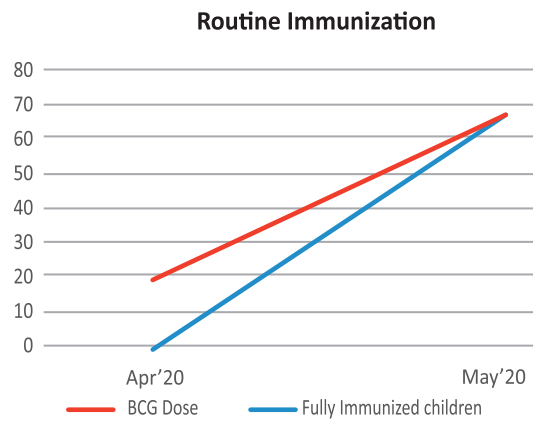


Figure 8: Resumption of routine immunization services in 28 districts of UP
Source: Uttar Pradesh Health Management Information System (N_{Apr} = 129147, N_{May} = 193721)

"Social distancing is a prime practice for prevention of COVID-19. Following social distancing in VHND makes it easy to provide services of immunization and ANC as the beneficiaries come one by one for service. No large gatherings take place during VHND sessions. Mobilization of beneficiaries are also done as per time slot and we are ensuring that every beneficiary washes their hands when they visit here. Some of the beneficiaries are currently afraid of vaccinations due to fear of COVID infection".

- ASHA Juhi Devi, Village- Mahamdapur, Block – Siswa, District – Maharajganj

3.3.1c Resumption of ANC services at VHND with safety protocols: a case study

Sushma (name changed), 23 years old, lives in Navgaw village of Robertsganj block in Sonebhadra district of UP, with her husband and in-laws. She is pregnant for the first time and is currently in the 3rd trimester of her pregnancy. She had received ANC services during the VHND held until February this year. The services included 2 TT, HB test, BP and weight measurement, and urine test. With a nationwide lockdown, VHND was not held in her village in March and April 2020. Although, the ASHA of her area did not visit her place during lockdown for ANC care, Sushma was informed by her regarding the resumption of VHND services during her visit to nearby households for other purposes. Sushma was also informed over the phone on the day of VHND (23rd May) to attend the session and was asked to carry the Mother-Child Protection (MCP) card.

Figure 9: Weight of a pregnant women being measured at VHND

Soon after commencement of the VHND session, the ANM came to know that one person was quarantined in the school i.e., the place of VHND site. Though it was not a quarantine centre, the person had been accommodated there for the last 4 days with the Pradhan's support as there was no separate room in his house to keep him in isolation. ASHA had no prior information about the case. The VHND venue was immediately shifted to a nearby house where all arrangements were made accordingly. The alternate arrangement didn't affect the mobilization of beneficiaries. Importantly, social distancing was ensured at VHND site where beneficiaries waited for their turn. All beneficiaries washed their hands and they also covered their face and mouth to protect themselves from infection. Sushma attended the VHND session and her Hb, BP, urine and her weight were measured during the session. Sushma claimed that the quality of ANC service remained the same as before. Beneficiary mobilization was well managed and she was happy to receive ANC services. Sushma said, "I know COVID-19 is an infectious disease, and maintaining distance and covering mouth will prevent me from this disease."

3.3.1d Home-based and newborn care visits

As per the GO released on 28 April, HBNC visits are to be continued as per schedule by ASHAs. However, ASHAs were advised to follow all precautions during the home visit if there is a requirement to examine newborns. In areas, with higher cases of COVID-19, ASHAs are directed to telephonically obtain the health status of newborns and their mothers.

Maintaining protocols, ASHA is undertaking HBNC visits to all newborns in her catchment area as per schedule and counselling the mothers and other members of the households on critical indicators like identification of danger signs among newborns and mothers, exclusive breastfeeding and delayed bathing of the newborn. The percentage of newborns receiving 6 HBNC visits have increased to 71% in May 2020 from 51% in April 2020. ASHAs are also intensively following up with households that have low birth weight newborns along with counselling the mother and other members of the household on Kangaroo Mother Care (KMC) practices.

3.3.1e HBNC services in the times of COVID-19, a case study

Pooja (name changed) is a 27 year old woman, residing in Shekhupur village, Block Ujhani in Budaun district, UP. She delivered her second baby at Primary Health Centre (PHC), Shekhupur on 12th May 2020. At the time of birth, the baby did not receive any birth dose vaccination although breastfeeding was initiated immediately. The baby weighed 3.9 kg at birth and was healthy. She used 102 Ambulance for transfer to the facility and opened her account to benefit Janani Shishu Suraksha Yojana (JSSY) and other incentives offered under UP/Central Government schemes. Before the lockdown, ASHA (Phoolshree) had visited her home to counsel her on ANC and birth planning.

Figure 10: Mother with a healthy newborn during ASHA household visit

Pooja had received 3 ANCs but was not able to receive her 4th ANC due to lockdown. During the lockdown, the ASHA could not visit her home for HBNC services immediately after her delivery as

she was engaged in the line listing of migrants for COVID screening. ASHA made her first HBNC visit to Pooja's home on 14th May 2020 and so far the mother and newborn have received 3 HBNC visits. During HBNC visits, ASHA was unable to perform any physical assessments such as measurement of baby weight, temperature etc. However, she took physical history and verbal information about mother and baby's health and also oriented Pooja on danger signs that can occur in mother and newborn. ASHA further counseled her to call 102 ambulance or contact them in case of any visible danger signs. Pooja is very keen to know the status of her baby's weight, temperature etc and eager to receive other services that are not taking place due to COVID effects and hopes that her newborn is immunized in the next VHND session.

3.3.2 Kenya

3.3.2a Resumption of direct services to KPs

COVID-19 has altered the pattern of how implementing partners offer services to Key Populations. The Sex Workers Outreach Program (SWOP) implemented by PHDA has 7 Drop-In Centers (DICs) in Nairobi that provides services to sex workers and men who have sex with men. SWOP is also partnering with Ministry of Health (MOH) facilities for clients that are affected by the lockdown in Nairobi and its environs, to enable continuity of services. Thermal temperature

Figure 11: Peer educator from HAPA delivering commodities to clients in a motor bike

scanners screen everyone accessing the space. Clients are attended to via appointments set up by the clinical and outreach team. Multidrug dispensing helps to further reduce crowding at the Drop in Centres. Pre Exposure Prophylaxis (PrEP), Anti Retroviral Drugs (ARV), Condoms, Lubricants, are packed and distributed to clients accordingly. Hand washing stations are set up in the centers. Use of technology has helped reduce groups coming together. Adherence Counseling is conducted via phone and Peer Educators (PE) conduct health education via SMS and platforms such as Facebook and Whatsapp. Presently Staff, Peer Educators, and Outreach Workers work in shifts on different days and are provided with masks and hand sanitizers.

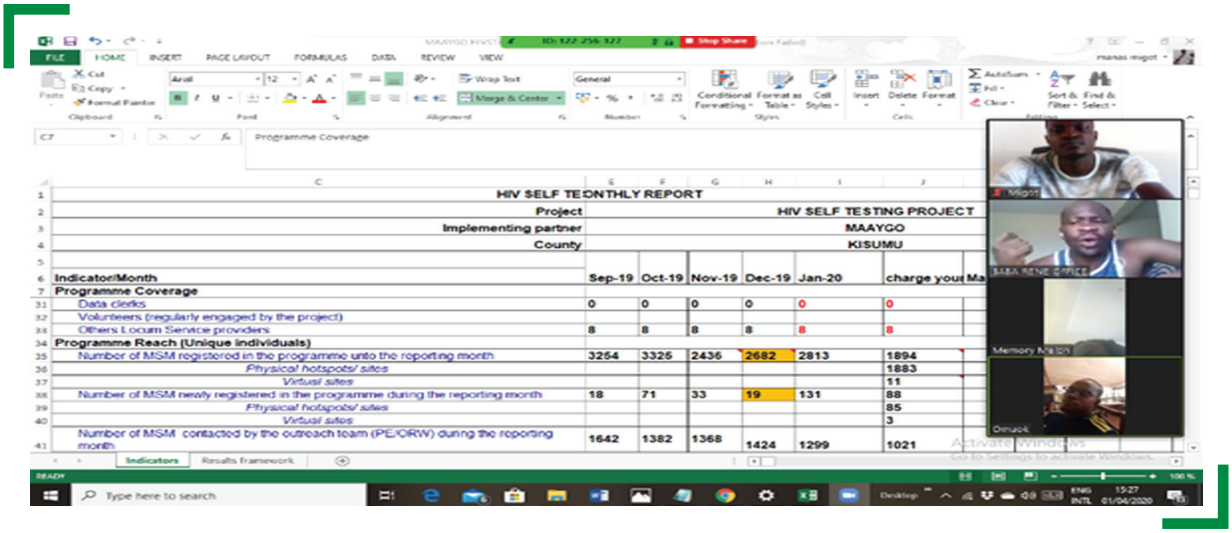


Figure 12: MAAYGO staff and outreach workers evaluating project implementation progress through a zoom call

3.3.2b Strengthening the violence response

As per the guidance of the National KP program, the KP TSU conducted an assessment of the rapid rise in violence due to the COVID-19 situation to understand the changing context and identify any gaps in capacity and services concerning response to violence. This study revealed an increase in the rate of violent incidents among the KPs, especially related to intimate partner violence. The need to improve the capacity of the Violence Prevention and Response teams to handle the reported incidences were required to be strengethed.

The KP TSU under the guidance of NASCOP proposed the following steps to strengthen and ensure that the KPs received violence support services without delay:

- Activating the county advocacy sub committees so that they can play a proactive role in relation to violence prevention and response related to KPs
- Engaging in advocacy to include Violence Response as an essential service specially during lockdown
- Developing a Violence Prevention Response (VPR) guidance for implementation by KP Implementing Partners
- Strengthening the existing VPR and referral systems and encouraging regular updates
- Integrating the KP VPR system into the national and county COVID-19 response strategies
- Establishing a robust coordination and communication strategy
- Integrating and leveraging the emergency response hotline and setting up a coordination structure to prevent and address violence amid COVID-19 in all counties

3.3.3c Resumption of HIV Self Testing services in 3 counties

A collaborative study to evaluate the incremental benefit of the community-based implementation of HIV Self Testing (HIVST) strategies on reducing the overall size of the undiagnosed MSM population and time given for prevention, treatment, and care following HIV testing, has been ongoing in the country since early 2019. The announcement of the first COVID-19 case and initiation of safety measures impacted the HIVST program's implementation, especially the delivery of HIVST kits to MSM peers. Initially, Peer Educators sensitized and mobilized their peers for HIVST through group and one-on-one sessions at physical hotspots and on virtual platforms. These mobilization activities would then be followed by distribution of HIVST kits to Peers at their places of convenience regardless of the mode of mobilization. The primary target for HIVST at the time were MSM who were non-testers and infrequent testers. Upon receiving the kits, the Peers would then reach out to the clinic for either confirmatory testing and/or other prevention commodities. Uptake of HIVST kits by the Peers and Peer Educators' performance would then be reviewed regularly to make room for improvement. Virtual platforms became favourable modes of engagement for outreach activities as well as programs' management. Demand creation for the HIVST kits was intensified online across the three sites through dating sites, Facebook, bulk messaging, and WhatsApp groups. Besides targeting peers, HIVST kits were also extended to frequent testers to maintain routine quarterly testing as recommended in the guidelines. To accommodate the changes brought in by the pandemic, the study budget was reviewed to include the purchase of PPEs for clinical and outreach teams and, in some instances a communication allowance was allowed to enhance virtual peer education and considerations for motorbike transportation to deliver kits to peers. Teams were trained on necessary safety measures to observe at the clinic and when reaching out to

peers. Clinics had to alter normal operations to adhere to the public health guidelines that have been put in place.

3.3.3d Development of Standard Operating Procedure (SOP) for outreach during COVID-19

During this pandemic, KP TSU supported organsiations to develop standard operating procedures. An example is HAPA Kenya, a MSM led Community based organization (CBO) in Mombasa county. The main purpose of the SOP is to ensure that all clients in need of the commodities such as HIV(self-test kits or condoms) can be reached and provided with commodities in a safe manner. The SOP is designed to streamline operations for condom and HIVST kits so that both the Outreach Worker or Peer Educator who is giving out the commodities and the peer that is receiving are safe. The SOP outlines procedures to be followed to ensure commodity security and client safety and satisfaction. Additionally, It provides programmatic guidance for effective delivery of commodities and services among the MSM community.

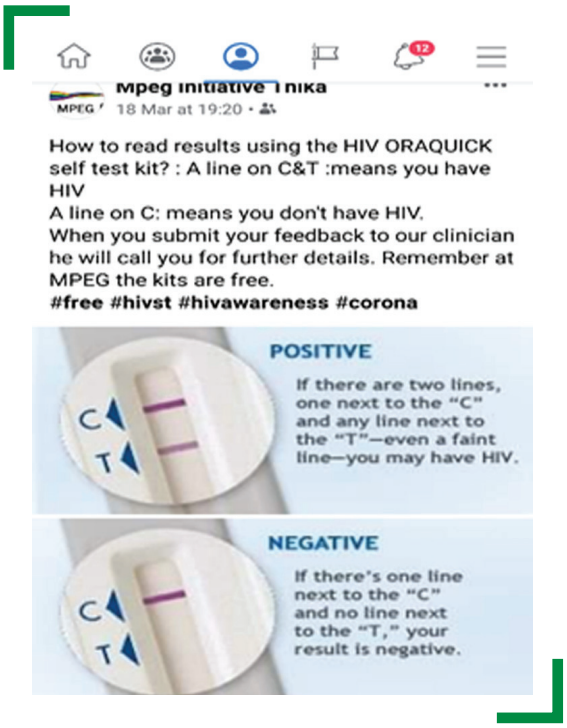


Figure 13: Social media page sensitizing on HIVST and where to get the kit

3.3.3e Development of a communication platform

Regular communication with Stakeholders has been a vital part of the response during COVID-19. The Key Population Technical Support Unit supported NASCOP to develop a communication platform through WhatsApp and Zoom to communicate with donors, implementers, and community groups. Through the WhatsApp group, the members are encouraged to stay in touch, raise their concerns and challenges. KPTSU supports NASCOP in facilitating these discussions and documenting the same. While these communication forums were initially used to share challenges, they have slowly developed into spaces to brainstorm on creative ways of providing services; advocate for the commitment of resources towards these innovations; raise resources for providing Personal Protective Equipment (PPE) for the clinic staff and clients; and celebrate successes.

3.3.3g Joint supervision with the Counties to assess the delivery of services

Key population Implementing Partners work in collaboration with both the National and County Government to ensure sustained delivery of quality services to the KPs. The role of the County Government is mainly to ensure the coordination of KP activities in the county. During this period of COVID-19, TSU officer joined Kisumu County Team and Development Partners to assess prevention measures and service delivery to Key Population around Covid-19 hot spots. This was part of TSU support supervision and quality improvement initiative conducted jointly with the county MOH teams. The supervision was scheduled in eight Key Population drop-in service centres (DICEs) in the county with a small team, including the TSU officer. It was noted that measures had been put in place by the different DICEs to ensure that guidelines set to curb the spread of COVID-19 were adhered to which included but not limited to social distancing, hand washing, clients' scheduling, wearing

Figure 14: County team together with TSU officer in one of the DICEs during supervision

masks among others. Innovative strategies were also incorporated to ensure continuity in service delivery, such as; multi-month dispensing of commodities, use of vans/motorbikes to deliver services, online mobilization, and follow-ups .

Engagements were also done with the county team's support with the various facility in charges to ensure delivery of services to KPs in the satellite facilities during COVID period. The TSU office equally supported the Partners in ensuring timely and quality reporting and entering of KP data into the Kenya Health Information System (KHIS) database as some Partners submitted late reports due to challenges experienced as a result of COVID-19.

3.4 Monitoring and documenting the response

3.4.1 India

3.4.1a Tracking of migrants

As per the GO released by GoUP for tracking migrant workers by FLWs, ASHAs have been tracking the migrant workers, their contacts, and the symptoms developed. The ASHAs share these tracking details with ASHA Sanginis and the BCPMs and DCPMs, after which the data is uploaded on a web portal hosted by UNICEF. The government uses this data regularly to keep track of symptomatic and asymptomatic individuals and take appropriate action. The list containing the names of symptomatic patients is shared with the District Surveillance Officers (DSOs) and State Surveillance Officer (SSO) on a regular basis to be further shared with Chief Medical Officers (CMOs) for an appropriate response. During the 1st phase of migrant tracking (24th March to the 3rd week of April), 11.2 lakh migrants were line-listed, 6552 of these were identified as symptomatic, and 40 were found to be positive post-testing. In the 2nd and current phase of migrant tracking, as on 22nd May, 8 lakh migrants have been registered. 747 cases of this cohort have been reported with some symptoms of COVID-19 and 56 symptomatic individuals are positive.

3.4.1b Study on COVID-19 response (proposed)

A plan to conduct a rapid data collection and an analytical study that aims at comprehending the effect of COVID-19 on citizens and service delivery for routine RMNCH services is formulated. The specific objectives of this study would be:

To document the system-level responses to the outbreak while continuing to provide routine MNCH, Nutrition, and Family Planning (FP) service to meet the community's needs.

1. To study the routine MNCH, Nutrition and Family Planning (FP) service to the community and the community response to the provision of these services at their doorsteps and address the constraints in delivering the services including the human resource and supply issues
2. To document the challenges to the health system providers due to public health concerns from the COVID-19 crisis and
3. To understand the different stakeholders'

perspectives on the experiences of the COVID-19 responses and how it can help in shaping public health strategies. This study is commissioned by the Bill and Melinda Gates Foundation and led by Sambodhi Research and Communication Pvt. Ltd. and Population Council in collaboration with UP-TSU.

3.4.2 Kenya

3.4.2a Monitoring at national and site level

As the country battles against COVID-19, the Key Populations program continues to offer services – though in a limited scale- to beneficiaries through the following innovative approaches.

- Multi-month dispensing of commodities such as ART, PrEP, condoms, and lubricants guided by individual needs
- Dissemination of HIV prevention messages through online platforms (Facebook, Twitter, dating apps etc)
- De-centralization of methadone dispensing- ferrying the commodity to localities where the community resides to bypass restricted movement and
- Appointment scheduling of visit to DICE to prevent crowding.

At site-level (specifically for HIVST and Young Key Population (YKP) study), layering of additional measures to combat the effects of COVID-19 has been explored including:

- Re-allocate budget items to purchase personal protective gears for Key Populations,
- Lobbying with social protection programs to include KPs in food distribution and
- Enforcing a shift-based system for service providers to ensure the sites remain open throughout the COVID-19 period.

Programmatic indicators for these intervention efforts are being reported both monthly (through Kenya Health Information System, a de-facto platform for health-related programs) and every quarter through excel based system reportable at DICE level. In the January-March 2020 quarter, we have observed a decline in Anti Retroviral Therapy (ART) linkage for all the three KP groups (Female sex workers, Men who have sex with men and People who Inject Drugs) in comparison to the previous quarter (Oct-Dec 2019). ART linkage stood at 73%, 80%, 60% for FSW, MSM, and PWID, respectively. A downward trend was seen from 74%, 89%, and 67% for FSW, MSM, and PWID from the previous quarter. While this might be an isolated case, the Key Populations program plans to undertake an in-depth analysis to understand the effects of COVID-19 in service uptake.

3.4.2b Publications and documentation

Very early in the pandemic, our group documented the responses related to COVID-19 in the Key Population Newsletter and NASCOP newsletter. The KP newsletter carried stories written by our team on KP services responding to the COVID-19 crisis, strengthening the violence response system at the time of COVID-19 and response of the MAT clinics to address COVID-19 related challenges to ensure clients get services every day. Our group also published a paper titled The effects of COVID-19 on the health and socio-economic security of sex workers in Nairobi, Kenya: Emerging intersections with HIV in Global Public Health on 27th May 2020. The paper is a commentary that projects the challenges Kenya faced by daily curfews and lost economic income due to COVID-19, coupled with further changes to sex work that increase potential exposure to infection, stigmatization, violence, and various health concerns. It also highlights how communities and programs have demonstrated resourcefulness in responding to this unprecedented disruption to emerge healthy when COVID-19, and the measures to contain it, subside. The publication is now uploaded in the Global Prevention Coalition website.

https://hivpreventioncoalition.unaids.org/resource/the-effects-of-covid-19-on-the-health-and-socioeconomic-security-of-sex-workers-in-nairobi-kenya-emerging-intersections-with-hiv-may-2020/


Global Public Health
An International Journal for Research, Policy and Practice

The effects of COVID-19 on the health and socio-economic security of sex workers in Nairobi, Kenya: Emerging intersections with HIV

Figure 15: Publication on sex work and COVID 19 in Kenya

3.4.2c Inclusion of COVID related questions in existing studies

Evaluation of HIV Self Testing Interventions among men who have sex with men (MSM)

With funding by Bill and Melinda Gates Foundation, this project is being implemented in 3 counties in Kenya (Mombasa, Kiambu and Kisumu). PHDA partners with University of Manitoba, NASCOP, G10, and 3 MSM led CBOs in implementing this project. In quantifying the magnitude of COVID-19 in this study, several questions have been added in the end-line survey for select themes (Partnerships, Service Uptake, Violence, and Alcohol drinking behavior) which includes:

- During COVID-19 period (Specify months), was there a change in the number of male sexual partners you had per week?
- On average, how many different male sexual partners did you have in a week during the COVID-19 period (Specify months)?
- During COVID-19 (Specify months) pandemic, what were the different places/ locations where you met other male sexual partners?
- During COVID-19 period (Specify months) did you take an HIV test?
- During COVID-19 period (Specify months), which type of HIV test did you take?
- During COVID-19 period (Specify months), was your ability to get ARV reduced?
- During COVID-19 period (Specify months), was your ability to get PrEP medication reduced?
- During the COVID-19 period (Specify months), was your ability to get an HIV self-test affected?
- During COVID-19 Period (Specify months), was your physical contact with a peer educator affected?
- During COVID-19 period (Specify months), was your ability to visit a clinic or drop-in centre affected?
- During COVID-19 period (Specify months), how would you rate your alcohol drinking behavior compared to the norm?
- During COVID-19 period (Specify months), how would you rate your drug abuse behavior compared to the norm?
- During COVID-19 period (Specify months), did you experience an elevated risk of violence from the police/Law enforcers/ Authorities?
- During COVID-19 period (Specify months), did you experience an elevated risk of violence from an intimate partner?

Understanding the applicability of differentiated HIV service delivery among MSM in Kenya

This is a community-led study with support from the KP Technical Support Unit. The study is funded by East African Sexual Health & Rights Initiative (UHAI-EASHRI) and International AIDS Society (IAS). It seeks to understand HIV service delivery models being implemented where MSM seek HIV services and quality of prevention, testing, treatment, and care services for MSM populations across Kenya, and explore opportunities for Differentiated Service Delivery (DSD) for MSM in Kenya. The study could not be initiated due to the spread of COVID in Kenya, and imposion of restrictions on movement.

Adjustments had to be made to accommodate the changing times and assess the influence of COVID on differentiated HIV services for MSM in Kenya. The protocol has been adjusted to include virtual options of interviewing MSM on DSD and allow assessment for the impact of COVID-19 on service delivery. Questions added to the assessment tool include:

- Has there been any changes to your income since the outbreak of COVID-19?
- Which of the following best describes your sex life during the COVID-19 pandemic? Tick all that apply
- Have you attempted to collect your ARVs since the lockdown began?
- If you collected your ARV after COVID-19 began, at your last refill, what supply of ARVs were you given?
- Was your supply of ARVs less or more than the previous appointment, and what reasons were given for the difference?
- What was the main challenge when you attempted to collect your ARVs? (tick all that apply)
- What are you worried about during the COVID-19 pandemic? (tick all that apply):
- Have you done or used any of the following to cope with life during this COVID-19 pandemic
- During the COVID-19 (specify the months) pandemic, what were the different places/ locations where you met other male sexual partners?
- During the period of COVID-19, did you take an HIV test?
- During the period of COVID-19 which type of HIV test did you take?
- During the COVID-19 period, has there been a change in the experience of violence by family, peers, partner or others?

3.4.2e Mathematical modelling for PWID

Service delivery among the PWIDs has been negatively affected since the onset of COVID-19. Prohibition of gatherings exceeding 15 people has led to limitations in the provision of essential services which would have otherwise been provided through Peer to Peer contacts and outreach. A drop in the needle and syringe distribution by almost 50% and an increase in loss to follow up/defaulters among the MAT clients is a proxy indicator of reduced services. NASCOP TSU has devised innovative ways of reaching the PWIDs to mitigate the damaging effects of the pandemic. Consequent to this, KP TSU is supporting NASCOP in the process of gathering data to show the potential impact of COVID-19 on harm reduction interventions in Nairobi and Coast region in Kenya. To model the impact, monthly service data on the uptake of needles and syringes, HIV testing and treatment services, DIC activities and violence in the first five months of 2020, (the first two months being pre-COVID-19 months and the other three months being the COVID-19 months) will be examined. The model will focus on measuring the impact of COVID-19 on service delivery among the PWID occasioned by the interruptions and limitations in accessing services.

4

LESSONS LEARNT: INDIA AND KENYA

- Emergency preparedness is imperative for Government or Non-Government organizations providing services to most marginalized populations. This crisis taught us that programs may not get much time to adapt and resume services when an emergency strikes. In this case, not only everyone had to understand what this new virus is and how it spreads but also learn to alter or make changes in many practices to ensure continuity of services.
- Consultation with community and stakeholders is critical as we plan for a response. The virus disrupted not only services but caused a lot of economic and social stress. The response had to take into account clinical services and the need for food security, mental health, income loss, etc.
- The health system in Uttar Pradesh has been able to tackle and respond to an inflow of approximately 20 lakh migrants returning to the state with the help of a ground workforce of 1.5 lakh ASHAs, 6844 ASHA Sanginis, 23000 ANMs, 820 BCPMs highlighting their crucial role in community-based health management.
- Digital platforms can be fast and effective mechanisms for reaching out to the community and building FLW capacities directly.
- Uttar Pradesh's response to COVID-19 shows that efficient foundational health systems foster resilience to tackle massive public health challenges. Strong presence of human resources along with well-trained personnel, functional supply chain, and strong leadership are crucial to response and mitigation.
- During pandemics, it is of utmost importance to sustain community engagements, and during this pandemic,

the Government was flexible enough to assimilate other non-traditional methods of capacity building down to the last mile. Digital training platforms, self-learning modules, use of MDMs, weblinks are critical to build capacities when physical interaction and travel cannot be undertaken. Post COVID, it will be imperative to invest significantly in the same and reach out to FLWs and Government field staff collectively almost on a real-time basis.

- Mounting Government's response to COVID-19 brought the Government and its Partners closer as a functional unit. Numerous Whatsapp groups were formed that included both senior Government staff and partners to improve interactions, gather feedback on the draft policies, and share real-time on the ground functions and progress with the functional units.
- In this process everyone was involved, learning together and playing their part. While the policymakers provided guidance, the community-based organizations organized for food and shelter for their constituencies and other service providers adapted their services to cater people's needs.
- Mental health and its integration into routine services emerged as a great lesson in learning from this experience. Mental health support to take care of anxiety, fear, stress, social isolation is required by community and clients, as well as service providers.
- The pandemic tested human capacity to innovate and adapt, reminding us of human ingenuity's infinite potential to adapt and design new practices to ensure delivery of services till the last mile.

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