

**THEMATIC SEGMENT:  
COVID-19 and HIV—sustaining  
HIV gains and building back  
better and fairer HIV responses**

**Background note**

**In memoriam**

The COVID-19 pandemic has come at a great cost in human life, with losses felt deeply by loved ones, family members, friends and colleagues. There have been many losses among those who have lived through and worked in the HIV response to end AIDS—many of whom offered their compassion, learning, skills and experience in support of the response to COVID-19.

We recognize and honor the contribution of some of the many among our colleagues who have made a difference in their communities, countries and at regional and global levels.

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All case studies have been compiled as a Conference Room Paper (UNAIDS/PCB (48)/CRP4), which is available on the PCB website.

## ACRONYMS

ACT-A	Access to COVID-19 Tools Accelerator
ART	Antiretroviral therapy
ARV	Antiretroviral medicines
C19RM	COVID-19 Response Measure
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
IMF	International Monetary Fund
IPPPR	Independent Panel on Pandemic Preparedness and Response
MMD	Multi-month dispensing
OST	Opioid substitution therapy
PCB	UNAIDS Programme Coordinating Board
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
PEPFAR	United States President's Emergency Plan for AIDS Relief
STI	Sexually transmitted infection
WFP	World Food Programme
WHO	World Health Organization
WTO	World Trade Organization

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## SUMMARY

1. The COVID-19 pandemic continues to affect the global HIV response by disrupting vital HIV programmes and services. The pandemic has deepened inequalities within and between countries, and people living with, key populations and others at risk of HIV and TB have been affected.
  - Affected programmes and services include those focused on HIV prevention, treatment, care, and human rights, as well as HIV comorbidities, including TB.
  - Supply chains for vital health commodities have been disrupted, reducing availability, and increasing costs. Bottlenecks in the global supply of antiretroviral medicines threaten the health and lives of people living with HIV who depend on consistent supplies.
  - Human rights concerns have been raised in the context of COVID-19 restrictions on movement and on free speech, with disproportionate impacts on populations in vulnerable situations.
  - COVID-19 has pushed back gender equality. Key and other vulnerable populations have been left out of social protection programmes and new vulnerabilities are emerging in relation to livelihoods, including for HIV-affected populations.
2. While high-income countries have been severely impacted by COVID-19, the majority of excess deaths have occurred in low- and middle-income countries. Dying from COVID-19 is far more likely in countries where health systems are under-resourced, where there are insufficient intensive care facilities, and where drugs and other therapeutics, including oxygen, are lacking.
  - COVID-19 vaccines have the potential to reduce the severity of the global crisis, yet access to vaccines is severely imbalanced. Essential health-care workers and other service providers, including those supporting HIV care, are at risk of acquiring COVID-19 in the context of their work—especially if they cannot access vaccines.
  - Evidence supports the understanding that comorbidities among people living with HIV, especially TB, increase the severity of COVID-19 disease and increase mortality. Some countries have prioritized people living with HIV for vaccination, taking underlying comorbidities into account.
  - Efficient systems for COVID-19 testing and data analysis are crucial for detecting outbreaks and galvanizing responses. These essential data are not gathered systematically in many countries—especially in low-income countries, where testing rates are 70 times lower than in high-income countries.
  - Many therapeutics and equipment vital for effectively treating severe cases of COVID-19 are unaffordable in low-income countries, and fragile health systems are readily overwhelmed when caseloads intensify.
3. Although Africa shares only 2% of the cumulative reported total of COVID-19 cases, yet shares 3.7% of global mortality. The threat of significant COVID-19 outbreaks is ever-present, especially in high HIV prevalence countries. Risks of new epidemic waves in the region are underpinned by exposure to crowding in urban areas and public transport, low testing and vaccination rates, and poor uptake and inconsistent implementation of public health measures.
4. The architecture and leadership of the HIV response have been vital to supporting the COVID-19 response—especially strengthening data and health systems, engaging in multisectoral engagement and partnerships, rapidly mobilizing resources, deploying experts, mobilizing community and health system responses, identifying and

implementing innovations, addressing policy and legal barriers to treatment access and care, and emphasizing community-led and human rights-based approaches.

5. The Joint Programme and partners have developed insights, innovations and new approaches to improve the efficiency of COVID-19 response. They continue to contribute to best-practice examples and model interventions for the COVID-19 and HIV responses. Government, donor, civil society and community partnerships have supported rights- and equity-oriented systems for health. Solidarity and multilateral collaboration have contributed to social cohesion, while also reducing inequalities and strengthening community resilience.
6. Despite their close involvement in the response, community organizations have been marginalized from decision-making structures in many countries. There is a need to recognize their substantial knowledge and capacities, derived from decades of HIV work, and their new knowledge and expertise gathered in response to COVID-19.
7. International funding for HIV has declined through successive financial crises and is under threat in the COVID-19 context. It remains vital to focus on preserving gains to date and to pursue the new targets outlined in the Global AIDS Strategy 2021–2026. For 2025, these include 95–95–95 Fast-Track targets for all subpopulations and age groups, a deepened focus on women and children and all populations at risk of HIV, and pursuing the 10–10–10 targets that seek to remove societal and legal barriers that stand in the way of access to HIV services.
8. Opportunities have emerged to strengthen global and country responses to pandemics, including preparedness, advancing the cause of universal health coverage and importantly, building back better for HIV as the COVID-19 pandemic continues.
  - The bold and transformative targets set out in the new Global AIDS Strategy require an intensified response.
  - Innovations have been recognized and adopted more readily, demonstrating ongoing benefits in cost reductions and efficiencies.
  - The advantages of multidisease approaches and integration are more evident and relevant.
  - The vital role of communities has been clarified, as has the need to include community-led response and community systems in investment frameworks.
  - The relevance of people-centred primary health care and universal health coverage has been recognized.
  - Lessons learned in the response to COVID-19 serve as a platform for future successes, including for HIV.
  - No country can contain a pandemic alone. There is an opportunity for renewed momentum towards faster gains and improved capacity to meet goals in set timeframes. Building back better means solidarity in all its forms.
  - Fully funded and resourced responses bring faster gains. There is a need to ensure that current resources are mobilized most effectively, including through scaling up and entrenching cost-saving measures and innovations, and by prioritizing efficiencies when aligning the HIV response with the Global AIDS Strategy 2021–2026 Fast-Track targets.

## BACKGROUND

9. At its 47th meeting, the UNAIDS Programme Coordinating Board (PCB) decided that the theme of the thematic segment of the 48th PCB should be *COVID-19 and HIV—sustaining HIV gains and building back better and fairer HIV responses*. Since that decision, the COVID-19 pandemic has continued to evolve unpredictably and it remains a severe and deepening global crisis.
10. In the six months from 5 January 2021 to 5 June 2021, cumulative cases of COVID-19 globally more than doubled from over 84.2 million to more than 172.2 million. In the same period, deaths attributed to COVID-19 increased from over 1.8 million to over 3.7 million. Severe epidemics are emerging in previously less-affected populous countries such as India and other countries in South Asia. Large-scale epidemics in many Latin American countries have continued unabated. All countries are under threat of resurging epidemics.
11. The thematic segment provides an opportunity to take stock of progress, review and address challenges, and apply lessons learned to maintain and expand strategies and build preparedness, momentum and commitment towards common goals.
12. The COVID-19 pandemic has affected the HIV response by disrupting prevention, treatment and care programmes, and by reducing their impact. Inequalities and inequities within and between countries have deepened as a result of COVID-19, including diverse impacts on people living with and vulnerable to HIV and tuberculosis (TB). Inequalities related to gender, race, ethnicity, and socioeconomic status increase the risk of acquiring COVID-19, reduce access to social protection, and contribute to poorer health outcomes. While high-income countries have been severely affected by COVID-19, including high death rates, it is estimated that the majority of excess deaths have occurred in low- and middle-income countries.<sup>1</sup> Dying from COVID-19 is far more likely in low- and middle-income countries where health systems are under-resourced, where there are insufficient intensive care facilities, and where drugs and other therapies, including oxygen, are lacking.
13. The architecture and leadership of the HIV response have been vital to supporting the COVID-19 response—especially strengthening data and health systems, engaging in multisectoral engagement and partnerships, rapidly mobilizing resources, deploying experts, mobilizing community and health system responses, identifying and implementing innovations, addressing policy and legal barriers to treatment access and care, and emphasizing community-led and human rights-based approaches.
14. Initial rapid responses to COVID-19 and HIV were facilitated through reprogramming of funds by UNAIDS to support global and regional activities and through initiatives such as the COVID-19 Response Measure (C19RM) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), among others. Programmatic and systems-related adaptations and innovations at global and country levels ensured that many aspects of the HIV response recovered their momentum following initial COVID-19-related disruptions.
15. Achieving universal health coverage is a central component of the 2030 Agenda for Sustainable Development. Universal health coverage emphasizes equitable access to health care without financial hardship, including access to quality essential health-care services, and safe, effective, affordable essential medicines and vaccines for all.
16. While COVID-19 vaccines have the potential to bring the pandemic under control, access to vaccines globally is severely imbalanced. By 23 April 2021, low-income countries had received only 0.3% of the 950 million vaccines administered around the world.<sup>2</sup> Equitable



access has been prioritized through the People's Vaccine Alliance (a coalition of over 50 organizations, including UNAIDS, the African Alliance and Oxfam); government-led strategies to increase innovation, local production and access to health technologies;<sup>3</sup> and through support from COVAX (the vaccines pillar of the Access to COVID-19 Tools Accelerator, which was launched by the World Health Organization and partners in April 2020). However, progress has been held back by inadequate resources and cooperation, and limited vaccine supply/manufacturing capacity. The production of vaccines for COVAX has also been severely hampered in the context of the severe COVID-19 epidemic in India. The International Chamber of Commerce estimates that the global economy stands to lose as much as US\$ 9.2 trillion if governments fail to ensure access to COVID-19 vaccines for developing economies.<sup>4</sup>

17. India and South Africa proposed a temporary waiver of intellectual property rights to the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in October 2020. The proposal seeks suspension of intellectual property protections for COVID-19 for diagnostics, therapeutics, vaccines, and other technologies for the duration of the pandemic. This follows the successes achieved in lowering patent barriers for HIV treatment, an achievement that continues to save the lives of millions of people living with HIV.
18. By 22 May 2021, there were 62 cosponsors to the joint proposal and support from over 100 WTO members.<sup>5</sup> The United States of America has supported the waiver for COVID-19 vaccines specifically and has committed to ramp up vaccine manufacturing and distribution.<sup>6</sup> The European Parliament announced on 19 May 2021, that the European Union would engage with a time-limited and targeted waiver if it contributed to objectives of limiting the use of export restrictions, encouraging manufacturers to support vaccine rollout globally through licensing agreements, and supporting greater help with use of compulsory licensing instead of reverting to a TRIPS waiver.<sup>7</sup> While vaccine sharing by high-income countries with surplus doses provides a pathway to address some shortfalls, other barriers to vaccine scale-up have yet to be addressed. Those barriers include identifying suitable production facilities, addressing supply shortages for vaccine components, and managing the specialized logistics necessary for manufacturing.
19. Costa Rica and WHO have proposed a COVID-19 Technology Access Pool (C-TAP),<sup>8</sup> including the UNITAID Medicines Patent Pool and Open COVID-19 Pledge as implementing partners, which aims to stimulate the voluntary sharing and pooling of technology, data and intellectual property. This would enable governments and companies to maximize access to vaccines and vaccine production, as well as to other health technologies, including diagnostics and therapeutics. UNAIDS and the United Nations Development Programme (UNDP) are members of C-TAP Steering Committee.
20. Investment in COVID-19 vaccine preparedness is urgently needed—especially in low-income countries where infrastructure and financial resources are constrained and where vaccine hesitancy and limited reserve supply have not been adequately addressed.<sup>9</sup> Prioritization strategies in the context of limited supplies are also necessary, including emphasizing health-care and essential service workers, older age groups and other priority populations.
21. Efficient systems for COVID-19 testing and data analysis are crucial for detecting outbreaks and for galvanizing responses. Yet this essential data is not systematically gathered in many countries—particularly in low-income countries, where testing rates are 70 times lower than in high-income countries. Options for COVID-19 prophylaxis are limited, many therapeutics and equipment to effectively treat severe COVID-19 are unaffordable in low-income countries, and fragile health systems are readily overwhelmed when caseloads intensify.

22. COVID-19 also poses long-term challenges for people who have been infected with SARS-COV-2 and for health systems response. Survivors of COVID-19 may experience lingering effects of uncertain duration and severity,<sup>10</sup> including organ damage and aggravation of comorbidities in the post-acute phase—with physical, cognitive, and psychiatric symptoms requiring further care.<sup>11</sup> Approximately 10–30% of people who have had COVID-19, including milder or asymptomatic cases, develop post-COVID-19 conditions, including “long COVID”, which involves debilitating symptoms that continue to persist for months after initial infection.<sup>12</sup> Multi-organ effects and post-traumatic stress disorder are also experienced following severe COVID-19.<sup>13</sup>
23. The global response to COVID-19 has been undermined by a massive spread of misinformation and disinformation. Fertile ground for this global “infodemic” results from tensions between political and other vested interests, public health needs, and disingenuous and ill-informed opinions circulating through social and other media. Effective communication has also been undermined by a lack of transparency, scientific disagreements and a lack of consensus on response measures, causal aspects of SARS-COV-2 transmission and therapeutics. Risk communication and community engagement have been weak, and COVID-19 communication campaigns have failed to “lead the narrative”. Top-down approaches have marginalized communities and contributed to mistrust, and there has been a failure to communicate strategically to build solidarity among national and global publics.<sup>14</sup>
24. A report by the Independent Panel on Pandemic Preparedness and Response entitled *COVID-19: make it the last pandemic*, highlights significant gaps in the pandemic response—especially a failure to implement lessons learned and recommendations from previous pandemics.<sup>15</sup> When COVID-19 emerged, only a few countries took rapid action. The response by many countries was characterized by delays, hesitation, and denial despite clear evidence of a highly contagious pathogen. Critical supplies were not procured and the health workforce was unprepared.
25. Community responses and local engagement have been vital to successful responses to COVID-19, yet communities have not been brought into decision-making processes.<sup>16</sup> Community responses include mobilization of community health workers, community engagement to establish trust in government communication, and community support to strengthen and expand health and other services. The effectiveness and importance of community involvement, engagement and leadership has been shown in the HIV response globally; it remains a vital anchor to the HIV response in the COVID-19 context.
26. Research by the International Monetary Fund suggests that an investment of \$50 billion (including grants, national government resources and concessional financing) could bring the pandemic under control through a focus on vaccinating at least 40% of the population in all countries by the end of 2021 (and 60% by mid-2022). This would be done while managing downside risks such as virus variants, investing in testing, tracing and therapeutics, and implementing public health measures in settings where vaccination coverage is low.<sup>17</sup>
27. UNAIDS fully supports the call for G7 countries to commit to providing 60% of the US\$ 19 billion required for ACT-A in 2021 for vaccines, diagnostics, and therapeutics, and for strengthening health systems (the remainder being mobilized from the G20 and other higher-income countries).<sup>18</sup> It is recommended that a formula based on the ability to pay should be adopted to ensure predictable, sustainable and equitable financing in the context of a global public good on an ongoing basis.

## Responding to HIV in the COVID-19 context

28. UNAIDS has been closely tracking the COVID-19 pandemic and its effects on the HIV response to protect gains and minimize impacts. The Joint Programme has provided and supported essential and agile leadership at multiple levels. Financial resources and health and community systems have been mobilized, and lessons learned from the HIV response around the world have been leveraged to mitigate the impact of COVID-19 on HIV.
29. Inadequate disease monitoring, lack of testing and contact tracing, insufficient health system preparedness, and complacency are some of the hallmarks of successive, and typically more severe, waves of COVID-19 incidence in various countries. High incidence waves increase the extent to which health systems and HIV programmes are compromised.
30. The second round of the WHO “Pulse Survey” found that 94% of countries experienced disruption to essential health services in the first quarter of 2021.<sup>19</sup> Over 40% of countries reported disruptions to primary and other health care and 20% to potentially life-saving emergency and critical care. The most frequently reported disruptions for communicable diseases were TB diagnosis and treatment (51%), HIV services (49%) and HIV testing services (46%). In 66% of countries, health workforce-related disruptions were the most common cause of service disruptions, with community fear and mistrust affecting service demand in 57% of countries. Strategies for improving capabilities and preparedness for COVID-19 epidemics include increasing health workforces, improving communication, adapting services, delivering care in new and innovative ways, and increasing the use of telemedicine and other online platforms. Most countries (87%) have implemented policies and plans for continuity of essential health services in the COVID-19 context, and through effective strategies, the magnitude and extent of disruptions were reduced.
31. The Joint Programme and partners have developed insights, innovations, and new approaches to improve efficiency of COVID-19 response and they continue to contribute to best-practice examples and model interventions for the COVID-19 and HIV responses. Government, donor, civil society and community partnerships have supported rights- and equity-oriented systems for health. Solidarity and multilateral collaboration contribute to social cohesion, while reducing inequalities and strengthening community resilience.<sup>20</sup>
32. Government revenues in sub-Saharan Africa are declining, expenditures are increasing, and fiscal deficits are advancing across the region. The International Monetary Fund projects that sub-Saharan Africa will be the world's slowest-growing region in 2021. Already, an estimated 32 million people have been pushed into extreme poverty due to COVID-19 and the private sector is under severe stress.<sup>21</sup> These economic impacts pose an ongoing and long-term threat to effective HIV responses.
33. International funding for HIV has declined through successive financial crises and is under threat in the COVID-19 context. For the present, commitments to HIV funding continue from a number of countries. For example, the United States President's Emergency Plan for AIDS Relief (PEPFAR) received an allocation of US\$ 250 million as part of US\$ 11 billion committed to global investments in COVID-19 through the American Rescue Plan Act. US\$ 3.5 billion has also been committed to the Global Fund to help preserve the gains made in response to HIV, TB and malaria.
34. It remains vital to focus on preserving the gains made to date and to pursue the new targets outlined in the Global AIDS Strategy 2021–2026. For 2025, these include the 95–95–95 Fast-Track targets for all subpopulations and age groups, a deepened focus on women and children and all populations at risk of HIV and the introduction of the 10–10–

10 targets that seek to remove societal and legal barriers that stand in the way of access to HIV services. The UN General Assembly held a High-Level Meeting on HIV and AIDS from 8–10 June 2021 to assess progress, identify strategic priorities to reach the 2025 targets, and ensure sustained progress on HIV, including in the context of COVID-19.

## EPIDEMIOLOGY OF COVID-19 AND HIV

35. It is unclear whether people living with HIV are more susceptible to COVID-19. However, evidence supports the understanding that comorbidities among people living with HIV, especially TB, increase the severity of COVID-19 disease and increase mortality.<sup>22 23</sup> TB disproportionately affects people living with HIV, and HIV increases the risk of progression of TB from latent infection to active disease.<sup>24</sup> TB remains among the top causes of mortality in low- and middle-income countries and is most prevalent in South-East Asia, Africa and the western Pacific. In 2019, eight countries accounted for two-thirds of new TB cases globally: Bangladesh, China, India, Indonesia, Nigeria, Pakistan, the Philippines, and South Africa.<sup>25</sup> In March 2021, the WHO announced that the number of people accessing TB treatment around the world had dropped by more than one million due to COVID-19, potentially leading to an additional 500 000 TB deaths, including among people living with HIV.<sup>26</sup>
36. The impacts of COVID-19 on health and socioeconomic systems disrupt and compromise HIV prevention, treatment, and care, compounding the many underlying inequalities and drivers of the global HIV epidemic. The pandemic has led to gaps and disruptions in HIV prevention and treatment programmes and has also compromised the rights of populations living with and affected by HIV.
37. SARS-COV-2 variants of concern pose severe threats. These are variants of the virus genome with mutations that have the potential to impact public health by spreading more easily, causing more disease, and requiring alternate treatments or reducing the effectiveness of currently available vaccines. Four variants of concern—named "alpha", "beta", "gamma" and "delta" by WHO—have been identified and had been detected in 160, 113, 64 and 62 countries respectively by 31 May 2021.<sup>27</sup>

## Risk environments

38. Intensive and sustained public health measures with sound public cooperation dramatically slow COVID-19 epidemics. For example, the first wave of COVID-19 in China was resolved in around 100 days without a significant recurrence. COVID-19 epidemics were also kept at low levels throughout 2020 in Laos, Taiwan and Viet Nam, and in island states, including New Zealand and Greenland, following concerted public health interventions.
39. While international travel contributed to global spread, population density and mobility increase the likelihood of COVID-19 outbreaks at country-level. Most SARS-COV-2 infections have occurred in cities and urban settings, including slum areas. Around 1 billion people around the world live in slums and informal settlements.<sup>28</sup>
40. In sub-Saharan Africa, 60% of the urban population (30% of the region's total population) live in slums and informal settlements. SARS-COV-2 transmission risks in these settings are directly related to close quarter living arrangements, sharing essential water and sanitation facilities, and being exposed to crowded pedestrian traffic and public transport. Lockdowns and other social distancing measures are near impossible to implement in these areas.<sup>29</sup> Studies in Kenya, Namibia and South Africa have shown that HIV prevalence is higher in urban slums and informal areas.<sup>30</sup> COVID-19 is a continuing threat

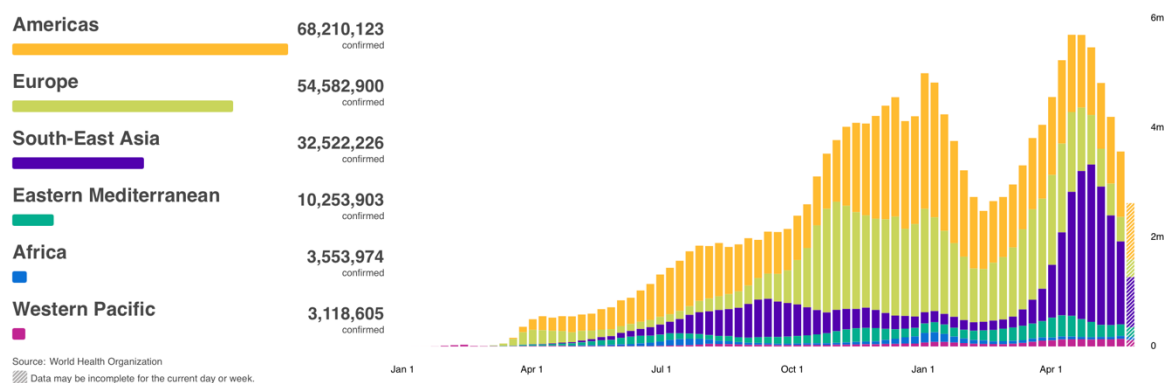
in high HIV prevalence countries in southern Africa, including Botswana, Eswatini, Namibia and South Africa, as well as in eastern Africa.

41. The recent surge of SARS-COV-2 infections in India has been attributed to travel and large gatherings for political rallies, religious celebrations and weddings, further exacerbated by easing COVID-19 restrictions and complacency related to prevention measures.<sup>31</sup> Compared to previous epidemic waves, clusters of new infections have occurred in multigenerational households, and the disease is spreading in rural areas.<sup>32</sup> More than 400 000 cases and more than 4 000 deaths per day were reported during May 2021.<sup>33</sup> Case numbers are also increasing in many other countries in the Asia Pacific region which is attributable to variants of concern, among other factors.<sup>34</sup>

### COVID-19 and HIV statistics

42. The COVID-19 pandemic is not under control. On 10 January 2021, the COVID-19 pandemic peaked at 823 088 daily new cases, declining to 228 719 daily new cases on 16 February 2021, and then increasing to a new high of 899 728 daily new cases on 23 April 2021.<sup>35</sup>
43. By 5 June 2021, more than 172 million COVID-19 cases and 3.7 million deaths had been documented (Annex 3). By WHO region, nearly half of the total cumulative COVID-19 cases (40%) have occurred in the Americas (approximately 68 million cases), with Europe and South-East Asia accounting for large proportions of the remaining cases (32% and 19%, respectively) (Figure 1). The largest proportional increase over six months has been in South-East Asia at 169%.<sup>36</sup>

**Figure 1: COVID-19 cases by WHO region: 1 Jan 2020 – 4 June 2021**



Source: WHO, COVID-19 Dashboard

44. There were 38 million people living with HIV globally in 2019, with over two thirds (68%) of all people living with HIV in 2019 residing in Africa (25.7 million), followed by the Americas (10%), South-East Asia (10%) and Europe (7%). New annual HIV infections have risen by 22% in the Middle East and North Africa. A majority of new HIV infections occur among key populations and their sex partners. In Brazil, where there are an estimated 920 000 people living with HIV, COVID-19 spread rapidly between states due to dense urban networks and utilization of public transport during peak periods.<sup>37</sup> In Peru, with 87 000 people living with HIV, contributory factors to the spread of COVID-19 include intergenerational housing, informal settlement, and mobility linked to a high proportion of jobs in the informal economy.<sup>38</sup>

45. Although Africa shares only 2.1% of the cumulative total of reported COVID-19 cases globally, the region accounts for 3% of all COVID-19 deaths. The threat of significant COVID-19 outbreaks is ever-present, especially in high HIV prevalence countries. By 5 June 2021, South Africa had the highest cumulative number of COVID-19 cases (almost 1.7 million), followed by Ethiopia (more than 272 000) and Kenya (almost 172 000). Risks of new epidemic waves in the region are underpinned by exposure due to crowding in urban areas and on public transport, low testing and vaccination rates, and inconsistent implementation of public health measures. A study of 46 African countries by the WHO found that three countries faced a very high risk of resurgence, 20 were at high risk, and 22 were at moderate risk.<sup>39</sup>

## COVID-19 IMPACTS ON HIV PROGRAMMING AND DEEPENS INEQUALITIES

### Disruptions to HIV services and supply chains

46. Vital HIV programmes and services have been disrupted by COVID-19, including HIV testing and counselling; prevention of mother-to-child transmission and maternal HIV; access to commodities, including condoms, pre-exposure prophylaxis and opioid substitution therapy (OST); voluntary male medical circumcision; sexually transmitted infections (STIs) screening and treatment; initiation of antiretroviral therapy (ART), viral load testing and other care; ART distribution; TB screening and treatment; and, services meeting sexual and reproductive health and rights needs.<sup>40</sup> Disruptions to programmes that address HIV comorbidities, especially TB programmes, pose a significant risk to people living with HIV.
47. Supply chains for vital commodities, including antiretroviral medicines (ARVs), TB treatment, condoms and HIV diagnostics, have been disrupted, reducing availability and increasing costs. Other prevention and treatment programmes relevant to HIV are under threat. For example, women living with HIV are at a six-fold higher risk of cervical cancer, and 85% of women with cervical cancer and HIV live in sub-Saharan Africa. Cervical cancer diagnosis and treatment, and human papillomavirus vaccination are among the programmes that have been disrupted.<sup>41</sup>
48. Bottlenecks in the global supply of ARVs threaten the health and lives of people living with HIV who depend on consistent supply. ARV supplies were constrained throughout 2020 due to cost increases, import delays and risks of stock-outs. A UNAIDS Survey of 15 low- and middle-income countries in November 2020 found that ARV procurements were more affected if they were performed directly by governments than via external partners such as the Global Fund and PEPFAR.<sup>42</sup> Six of 15 countries reported a high risk of stock-outs for certain regimens. Seven reported increased freight costs, and seven anticipated impacts on their 2021 annual HIV budgets.
49. Systems for ensuring sustainable and affordable access to ARVs need to be strengthened—especially in the context of the 95–95–95 targets for 2025 and the new technologies available to improve diagnostics and treatment, and prevention outcomes. Country-level procurements of ARVs remain uneven, and analysis of budget trends indicates that 18% of 42 countries anticipate reductions in their HIV budgets.<sup>43</sup> Price transparency remains a challenge, and some countries are procuring ARV regimens at over 110% of the average price in their region. COVID-19 affects the availability and cost of active pharmaceutical ingredients, factory workforces are impacted during outbreaks, freight costs increase, and currency fluctuations pose additional risks. Strategies to mitigate these risks include benchmarking prices and capacity building to improve logistical efficiencies.

50. COVID-19 disrupted or halted mental health services in 93% of 130 countries surveyed by WHO in 2020.<sup>44</sup> This included mental health services for children and adolescents (72%), older adults (70%) and women requiring antenatal or postnatal services (61%). School and workplace mental health services were also disrupted in many instances. Over half (51%) of surveyed countries included ensuring continuity of mental, neurological and substance use services in their list of essential services, and one-third (33%) reported complete or partial disruption across at least 75% of such interventions and services. More than two-thirds of countries (70%) used telemedicine and teletherapy to replace in-person consultations, and 68% included helplines, among other approaches.
51. While telemedicine or teletherapy approaches may address the gaps, such approaches are less readily applied in low-income countries where there is less access to communication technologies, less capacity to meet the costs of internet access, and less consistent access to communication networks. Although 89% of countries reported in the WHO survey that mental health and psychosocial support features in their national COVID-19 response plans, only 17% of those countries have sufficient additional funding to cover the activities.

### **Impact of COVID-19 pandemic on inequalities and disparities in the context of HIV**

52. HIV-related inequalities have deepened due to the COVID-19 pandemic. Negative impacts extend to people living with HIV and with TB, key populations and their partners, girls and women (particularly adolescent girls and young women), children, prisoners, migrants and refugees and other people on the move, homeless people, people living in slums and other areas of high population density. People with comorbidities, especially older people (including older people living with HIV, whether on ART or not), are at high risk of developing severe illness due to COVID-19. The Global AIDS Strategy 2021–2026 emphasizes using an inequalities lens as a vital element of HIV response.<sup>45</sup> The Strategy sets out to identify, reduce and end inequalities that represent barriers to ending AIDS.
53. Gender-based violence increased in communities and in households due to COVID-19, often in the context of limited access to support. In the early pandemic period, reports of domestic violence and demands for emergency shelter increased, along with calls to domestic violence helplines. Reports indicated a 40% rise in gender-based violence in some countries, including instances of severe violence.<sup>46</sup> Many national responses to COVID-19 have overlooked gender-based violence as part of pandemic planning. Action coalitions have been launched to address such omissions and emphasize other gender-related concerns.
54. A study of women from key populations and women living with HIV in eastern Europe and central Asia highlighted loss of income as a central impact of COVID-19.<sup>47</sup> Hunger and homelessness among women and children in vulnerable situations were not adequately addressed, and bureaucratic complications hampered the delivery of social assistance.
55. COVID-19 constrains income and impacts on livelihoods in lower-middle-income countries. In Bangladesh, for example, urban and slum areas have been slow to recover from epidemic waves. In 2020, there was a 4% rise in extreme poverty, a 15% increase in "new poor", and 41% of people employed in rural and urban sectors moved to less skilled sectors. The unemployment rate was five times higher for female-headed households in comparison to male-headed households, reverse migration (from urban to rural) is more common, social protection has not been prioritized, and debt burdens of households are increasing.<sup>48</sup>

56. Overburdened health systems overlook children's health needs and care. COVID-19 has disrupted food and nutrition programmes for children, increasing malnourishment and malnutrition. Schooling has been interrupted at some point for most children, and 346 million young people do not have internet access for remote learning. Such inequalities disrupt the life chances of children in these settings; they also have gender dimensions. For example, it is projected that 11 million girls may never return to school following the COVID-19 pandemic.<sup>49</sup> Economic hardship and loss of livelihoods have impacted families and increased poverty, also increasing risk factors for violence and abuse of children. According to UNICEF, paediatric ART and viral load testing declined by 50–70% in reporting countries. New treatment initiations among children living with HIV declined by 25–50%, and access to prevention services and commodities has been disrupted for many adolescents.<sup>50</sup>
57. Vulnerabilities are compounded when people are excluded from COVID-19 support mechanisms due to stigma and discrimination. For example, sex workers face challenges in accessing government social protection schemes. Gay men and other men who have sex with men and gender-diverse people seeking health care have faced harassment following COVID-19 restrictions. Prison populations are especially vulnerable to COVID-19, HIV and TB due to their confinement arrangements. Nearly two-thirds of countries (65%) of 130 countries surveyed by WHO in 2020<sup>51</sup> reported disruptions to critical harm reduction services and 45% to OST programmes, with a resulting increase in the risk of HIV acquisition among people who use drugs. A study on COVID-19 and mental health in African settings in 2020 found that OST was completely disrupted in 27% of countries and partially disrupted in 18% of countries.<sup>52</sup> The risks of acquiring COVID-19 are many times higher for some key populations due to their living circumstances and livelihoods—for example, prisoners are at risk because they live in close proximity to each other, and sex workers are at risk because their livelihoods depend on close interaction with clients.

**Case study: Peru**

Inclusion of key populations in social protection criteria

In Peru, a national programme on emergency cash transfers was implemented by the government to mitigate the economic impact of COVID-19 pandemic in Peruvian families, under the framework of social protection policies. Since the programme was supported in the national database on families receiving help from social programs, it did not include migrants and refugees, however. The Ministry of External Affairs asked the World Food Programme (WFP) to address this gap, with a focus on food security and migrants and refugees. Support was provided through a strategic alliance between WFP and UNAIDS to implement the programme, focusing on people living with HIV and key populations (transgender people, sex workers), including migrants, refugees and Peruvians. The pilot initiative clarified the vulnerability criteria for people affected by HIV, providing a basis for considering their inclusion in national social protection policies. It also provided insights into the potential for scale-up.

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58. Human rights concerns have been raised in the context of COVID-19-related restrictions on movement and on free speech, with some indication that these restrictions have had a disproportionate impact on populations in vulnerable situations or have been targeted towards journalists or people expressing opposition to government measures.
59. Countries have taken drastic actions to respond to the pandemic, including imposing limitations on free speech and movement and creating opportunities to target vulnerable



and criminalized groups, including sex workers, people who use drugs, migrants and refugees, people living with HIV, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people. In some places, actions have included the suspension of privacy rights and the sharing of sensitive health information, where law enforcement has had access to COVID-19 positive data.<sup>53</sup> Police actions have included fines and arrests.

60. Human Rights Watch has documented state repression in 83 countries through the use of laws and law enforcement measures that limit free speech in the COVID-19 context. Physical assaults of journalists or bloggers have been reported in 18 countries and arbitrary arrests in 51 countries.<sup>54</sup> A report by Amnesty international found that enforcement of COVID-19 restrictions disproportionately impacted marginalized groups, including refugees, asylum-seekers, migrant workers, gender nonconforming people, sex workers and homeless people, among others.<sup>55</sup> In some places, the existing context of punitive laws (including criminalization of HIV nondisclosure, exposure and transmission, as well as criminalization of key populations) has provided a basis for violations of privacy. In other places, COVID-19 created the circumstances for criminalization and enforcement of regulations that perpetuate rights violations against key and other vulnerable populations.
61. Essential health-care workers and other service providers, including those supporting HIV responses, are at risk of acquiring COVID-19 in the context of their work. Illness and mortality among health-care workers diminishes health system capacities. Impacts are greater in health systems where there is low per capita coverage of health professionals, including in countries where HIV is prevalent. At least 17 000 health-care workers were reported to have died from COVID-19 globally in the period up to March 2021.<sup>56</sup>

## KEY ISSUES, OPPORTUNITIES AND LESSONS LEARNED

62. Examples of HIV response by various actors, including UNAIDS Secretariat and the Joint Programme in the context of COVID-19 are provided in Annex 1. The examples include resource mobilization; risk contexts and livelihood support; civil society and community-led responses; protecting and preserving rights and supporting key and other vulnerable populations; maintaining a focus on girls, women and children; and various innovations.

### **Context of instability and opportunities to respond**

63. The COVID-19 pandemic continues unpredictably, yet there are opportunities for proactive responses. Although the approaches necessary to prevent new COVID-19 infections are well-known and feasible, complacency, weak public health responses, inadequate and fragmented risk communication, and variants of concern contribute to ongoing and escalating epidemics. Lack of coherent leadership is compounded by mistrust and inadequate collaboration that undermines global solidarity. The benefits of vigilance, disease monitoring and prompt and decisive action are clear. No country is free of risk unless all countries are free of risk. Solidarity between countries and within countries remains a vital ingredient for overcoming this threat to global health and security. While vaccines provide a pathway to stability, the scale-up of production and the feasibility of wide-reaching global distribution remains uncertain in the short- to medium-term. In this context, there are opportunities to intensify prevention responses, improve case detection, expand the mix of therapeutic measures, scale-up innovations and intensify community engagement and leadership, while continuing to pursue opportunities to expand vaccination coverage.

64. The COVID-19 pandemic has led to a health and economic "double shock" that has cost millions of lives and triggered an economic recession. Significant resources are needed for health and economic recovery and sustained resource flows are necessary to ensure universal health coverage. The International Monetary Fund projects that government per capita spending on health in 2021 and 2022 will decline, coinciding with lower household spending levels and possible declines in development assistance for health. Regaining the ground achieved through progress towards universal health coverage is vital for a sustainable and inclusive longer-term economic recovery. The health and economic crises are interdependent: spending on health must be prioritized. In a World Bank paper titled *From double shock to double recovery—implications and options for health financing in the time of COVID-19*, a case is made for ambitious health spending to bring the pandemic under control and preserve universal health coverage gains.<sup>57</sup> This entails increasing resource flows to health by 11% above pre-COVID-19 levels on average (and closer to 20% in low-income countries), in conjunction with improvements in equitable and efficient spending. There is a need to determine financing mechanisms to support governments.

### **Protecting HIV gains through agile responses**

65. Agile responses through the Joint Programme mitigated the impacts of COVID-19 on HIV. The Joint Programme mobilized rapidly, reprogramming funds to ensure that a focus on HIV was maintained while allowing for flexibility to simultaneously address COVID-19. A study to assess the impacts of reprogrammed funds found that seed funding had catalysed funding from other donors to support larger scale, more systematic actions to support the HIV response.<sup>58</sup> Immediate negative impacts on HIV were mitigated by building on existing linkages. HIV services and programmes were prioritized and sustained during crisis periods, and resilience was strengthened. As a result, innovations and new efficiencies are emerging.

- In Global HIV Prevention Coalition focus countries, safe continuation of outreach and online counselling was provided for young women and key populations, and needle and syringe dispensing and take-home OST dosages have supported harm reduction. HIV self-testing is a helpful option in the COVID-19 context and has been implemented in Burundi, Eswatini, Guatemala and Myanmar, among other countries.
- The use of virtual platforms has increased global networking to support the HIV and COVID-19 responses and has opened opportunities at multiple levels. Counselling and other support to people living with HIV and key populations can be provided via virtual platforms. There is also less dependence on physical attendance at health facilities for HIV treatment and other commodities, and access to self-testing is expanding.
- Human rights have been protected through awareness-raising, advocacy, and community action. There is a good understanding of the most immediate intersections between COVID-19 and HIV, and mitigation strategies are readily scaled up. Knowledge has been consolidated by developing and disseminating guidelines on key themes by UNAIDS and Joint Programme Cosponsors.

#### **Case study: Regional**

##### Engaging youth in eastern and western African countries

With the outbreak of COVID-19, the impact of COVID-19 on adolescents and youth living with HIV in Uganda were yet to be fully understood. Youth-led rapid response measures needed be taken to reduce exposure risk and retain clients with HIV care needs. The Elizabeth Glaser Pediatric AIDS Foundation's Committee of African Youth Advisors,

consisting of adolescents and youth living with HIV from 11 sub-Saharan African countries, worked on a rapid response and developed a set of recommendations for adolescent and youth programming amidst COVID-19.

The document was made available to stakeholders, especially providers, who also serve adolescents and youth living with HIV and essential health services to support the Foundation's programmes. The recommendations provide a youth-lens and use simple terminology to adjust clinical services. Multimonth dispensing (MMD) was expanded and across countries in which the Foundation works, and virtual support in the form of counselling and case management was provided and tailored for adolescent and youth populations.

In Lesotho, a phone script was developed to standardize support for phone based enhanced adherence counseling for adolescent and young people. Several countries also implemented virtual support groups, mostly through WhatsApp, to continue to engage with young people, and a question-and-answer approach supported adolescents and youth living with HIV. The engagement of young people across the cascade of response allowed for a more tailored, youth-responsive and youth-informed approach.

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66. Innovations that reduce costs and improve efficiencies continue to emerge. Many innovations have been inspired by community-based service models developed as part of HIV response efforts.

- Prior to the COVID-19 pandemic, known innovative approaches such as MMD of ARVs and other commodities were considered to be too complex to implement. However, concerns related to COVID-19 risks and response measures stimulated adoption of MMD, clarifying multiple benefits of the approach. For example, the European Network of People Who Use Drugs noted that take-home OST improved efficiencies, decreased stigma, increased autonomy and improved compliance with OST.<sup>59</sup> MMD has also saved many lives through ensuring ongoing access to ART. Other innovations that have been increasingly applied include HIV self-testing, differentiated service delivery, expansion of community engagement and leadership approaches, and providing assistance such as cash, food and shelter to marginalized and high-risk groups.
- Digital technology and virtual platforms have been mobilized to support many aspects of the HIV response in the COVID-19 context, providing opportunities to move away from interactions dependent on regular clinic visits and face-to-face interactions. Virtual platforms have been vital for sharing expert information, conducting policy discussions, data collation and review, global networking, supporting information dissemination and counselling, among many other applications. Emerging uses of digital technology inform longer-term HIV strategies and efficiencies. However, more work needs to be done to address privacy concerns for people living with HIV who should be able to opt-out of such tools if they do not want their data shared. In addition, it will be important to reflect carefully regarding who has access to the data on these platforms, and whether data protection protocols ensure and preserve the right to privacy and confidentiality.
- Laboratory services have been expanded. In a number of African countries, GeneXpert machines procured with HIV and TB funding were adapted to administer COVID-19 tests. Low-cost rapid diagnostic tests are being developed in Senegal and Uganda, and laboratory capacity was rapidly scaled up in Nigeria.
- In Georgia, home-based laboratory visits have allowed for sputum and blood collection, overcoming a 25% decrease in TB detection. Artificial intelligence-

assisted X-ray diagnosis was also used. People who used drugs were also able to take home five-day doses of OST for the first time. In St Petersburg, doctors supported HIV patients through electronic prescriptions and online consultations. In Kyrgyzstan, a WhatsApp-based service allowed people living with HIV in rural areas to ask questions and obtain advice.

- A multistakeholder task force headed by the President of Iran [Islamic Republic of] and including members of the national HIV care and treatment committee, addressed service delivery challenges for key populations. Training was provided to staff, mobile units were adapted to provide services in hotspots, arrangements were made for continuous provision of methadone and harm reduction services, and a protocol was developed for COVID-19 prevention and care in prisons.

### **Case study: Malawi**

#### An HIV multisectoral response model for COVID-19

Malawi experienced a second wave of COVID-19 in December 2020. Previous COVID-19 restrictions had led to increased domestic violence, loss of livelihoods, increases in the numbers of teenage pregnancies, and lack of and reduced access to quality health services.

To address these concerns, among others, the Country Coordination mechanism for HIV, TB and malaria was used to develop a funding proposal to address disruption of health service delivery following a "fast-track" approach through a multisectoral dialogue that included all Country Coordinating Mechanism constituencies. The National AIDS Commission served as a platform for epidemiological surveillance, stakeholder mobilization, community engagement, leadership mobilization and civil society subcontracting in the COVID-19 context. Civil society was included at various levels, with targeted funding resources including Global Fund Savings, the CR19 and sustainable development goal funding. Technical support spanned strategic information, modeling, laboratories, clinical guidelines, dashboards and the COVID-19 response plan. Beneficiaries included the general population, cross-border populations, sex workers and LGBTI people.

(UNAIDS/PCB(48/CRP4))

### **The need to address prevailing gaps**

67. Gaps in treatment access remain for HIV and TB. TB mortality has increased due to COVID-19. TB is inextricably linked with HIV, and the interactions between the two diseases increase morbidity and mortality. A snapshot survey by the Global Fund on the impacts of COVID-19 on HIV, TB and malaria services and systems for health in 502 health facilities in Africa and Asia, found that HIV referrals—which are crucial for HIV prevention and treatment access—declined by 37% in the second and third quarter in 2020 compared to 2019. Across all facilities surveyed, HIV testing fell by 41%, and there were also drops in access to prevention of vertical transmission services and deliveries of prevention packages through outreach. Globally, across 84 countries, 1.4 million fewer people received TB care in 2020 in comparison to 2019.<sup>60</sup> The largest shortfalls in monthly case notifications occurred in Indonesia (42%), South Africa (41%), Philippines (37%) and India (25%). TB referrals fell by 29% in Africa, and drug-sensitive TB diagnosis and screening services decreased by 28% overall—including by 58% in community sites. Across 24 countries in Africa, only 11% of health facilities could conduct COVID-19 antigen rapid diagnostic tests, and only 8% could conduct polymerase chain reaction

tests. Adaptations were, however, also made. For example, 68% of facilities adopted at least one adaptive measure such as managing health workers or community workers, adapting health delivery strategies for non-COVID-19 conditions, and attending to decreases in service utilization. Nonetheless,

- TB programmes remain significantly impacted by COVID-19 and have not been adequately prioritized. As a consequence, mortality estimates indicate that there may be hundreds of thousands of excess deaths due to TB during 2020;<sup>61</sup> and
- integration of services, including with TB services, has been a priority in the HIV response. Integration remains a necessary component of response and there is an urgent need for an expanded focus to monitor gaps and address impacts across health concerns that intersect with HIV.

68. Food insecurity is on the rise, and food prices have risen by 38% since January 2020. WFP estimates that, as of April 2021, 296 million people in the 35 countries where it works have insufficient food.<sup>62</sup> Food insecurity negatively impacts people living with HIV, including HIV treatment adherence.<sup>63</sup>

69. Despite the attention given to the importance addressing epidemics and pandemics, resources are not easily mobilized in the context of fragile health systems. Investment is needed for a coherent response with a focus on minimizing morbidity and mortality from multiple diseases together through investments in health systems and preparedness.

### **Responding to deepening inequalities**

70. Impacts of the COVID-19 pandemic on girls and young women have long-term implications. COVID-19 has pushed back gender equality. It is estimated that two and a half million more girls are at risk of child marriage in the next five years.<sup>64</sup> Around 34 million adolescent girls were out of school, and some may not return. Physical and sexual violence increased as the COVID-19 pandemic unfolded. Girls and women have borne the brunt of increased and unpaid domestic work, childcare, home schooling, and other work. Women have been at the forefront of health-care response, including meeting the intensive needs of COVID-19 treatment and facing challenges in informal and formal sector work. Against this background, it remains that girls and women remain highly vulnerable to HIV, and COVID-19 exacerbates these vulnerabilities. Building back better requires a gender lens, and gender-responsive programming and faster and more substantial changes must be targeted.

71. Social protection systems designed to reduce poverty have been mobilized to reduce impacts of COVID-19, but key and vulnerable populations have been overlooked. Social protection systems are well established in many low- and middle-income countries and have been expanded in the COVID-19 context, including through additional support from large scale donor programmes. However, social protection programmes are not readily accessible by sex workers, nor people who inject drug. Inequalities have deepened, and people continue to be left behind.

72. Communities have been left behind. COVID-19 has both increased inequalities and widened disparities in service access. HIV disproportionately affects some populations over others and living with HIV is far more challenging in low-income settings or in settings where stigma and discrimination negatively affected health and well-being. Inequalities related to gender, sexual orientation, social and economic status, ethnicity, race and human rights are pervasive and require diverse strategies to mitigate and resolve. New vulnerabilities are emerging in the COVID-19 context—especially in relation to livelihoods such as work in the informal sector, mobility, migration and refugee status—and many affected populations also face HIV risks. There is a need to deepen understandings of

inequality and disease vulnerability—especially in the context of overlapping diseases, including HIV, TB, COVID-19, among others. Multidisease strategies require population-specific responses and targeted resources, while also benefitting from integrated approaches. The momentum of the COVID-19 response provides an opportunity to highlight inequality as a fundamental underlying concern, with a view to mobilizing around common priorities.

### **Leveraging the HIV response for the COVID-19 response**

73. COVID-19 communication has been fragmented and inconsistent, and lessons from HIV communication have not been used. COVID-19 communication has been overwhelmed by misinformation and disinformation, and authentic voices have not stood out. Lessons learnt from HIV communication, which has focused on delivering accurate information on diverse themes, have not been fully utilized. In the HIV context, challenges related to HIV are articulated, rights and principles clarified, and solutions shared. Responsibility for clear communication is diversified, and information is disseminated to segmented audiences in culturally meaningful ways. A commitment to consistent, authentic messaging includes community engagement and mobilization. Clear strategies support communication campaigns through multiple media and wide-ranging networks. There are opportunities to incorporate these lessons into COVID-19 communication response.
74. Community organizations are vital to the COVID-19 and HIV responses. Community organizations have been marginalized from decision-making structures in many countries. There is a need to recognize the substantial knowledge and capacities they have derived from decades of work on HIV, and the new knowledge and expertise they have acquired in response to COVID-19. Going forward: (a) community-led organizations should be fully included and integrated into the pandemic response; (b) funding should be mobilized to support their involvement; (c) sources for longer-term funding should be established; (d) the information base clarifying the work and roles of community-led organizations should be expanded and deepened. Community-led approaches to addressing COVID-19 in high-risk high-density settlements and other vulnerable settings provide an opportunity to move from emergency response to operation consolidation and then to integration and normalization.<sup>65</sup>

### **Lessons from the COVID-19 response for the HIV response**

75. COVID-19 vaccines are considered safe for people living with HIV. People living with HIV should not be excluded from COVID-19 vaccine access plans, regardless of their immune status. Countries should consider including people living with HIV as a priority group for COVID-19 vaccination according to their epidemiological context. UNAIDS has been monitoring vaccine access for people living with HIV in Latin America and the Caribbean. In Argentina, Bolivia, Brazil, Colombia, Guatemala and Mexico, people living with HIV have been expressly included in groups prioritized for vaccination, taking higher rates of comorbidities into account. In Chile, the guidance is linked to a CD4 count (below 200) and viral load (below 1,000). In Panama, a medical prescription is required, and in Peru and Panama, people living with HIV have been included in the vaccination programme after initially having been denied access.
76. The development of COVID-19 vaccines is an opportunity for HIV. Vaccine development has been accelerated to respond to COVID-19, with unprecedented turnaround times. WHO continues to include additional vaccines in their Emergency Use Listing. Technologies explored for COVID-19 vaccine development provide lessons for HIV vaccine development. For example, mRNA vaccines can be developed in much shorter turnaround times, while reducing the time needed to evaluate new HIV vaccine candidates in clinical trials.<sup>66</sup> While the latent HIV viral reservoir is not readily eliminated, it

may be possible to combine an mRNA vaccine with other drugs to yield a functional cure.<sup>67</sup>

## **SUSTAINING HIV GAINS AND BUILDING BACK BETTER AND FAIRER HIV RESPONSES**

77. The COVID-19 crisis has impacted social and economic life and health, including HIV, and lessons from the HIV response inform pandemic response. COVID-19 has put HIV gains at risk. However, HIV infrastructure, including systems and expertise, were rapidly mobilized to respond to the new pandemic, contributing to efficiencies for both the COVID-19 and HIV response. Funding was generated from multiple sources and mechanisms. Leadership, including pandemic expertise, was rapidly mobilized to support COVID-19 response plans. Evidence-informed approaches and systems were followed. Gaps, barriers and challenges were monitored and adaptations were introduced. Human rights remained a focus and prompt actions were taken where rights were violated. Socioeconomic responses and recovery plans were sensitive to the needs of vulnerable populations, including people living with and affected with HIV and key populations. Countries that have provided financial support for people and/or supported them through, for example, minimum income guarantees, paid sick days and income support to stay home have fared better. In addition, the urgency of access to vaccines by all people in every country continues to be voiced and supported.
78. Building back better. There is an opportunity to turn the COVID-19 crisis into an opportunity to build back better for HIV. The pace towards the bold and transformative 95–95–95 and 10–10–10 targets expressed in the new Global AIDS Strategy 2021–2026 requires an intensified and focused response. Innovations have been more readily recognized and adopted in the COVID-19 context, with demonstrable benefits in cost reductions and efficiencies. The advantages of multidisease approaches and integration are more evident and relevant. The vital role of communities has been clarified, as has the need to include community-led response and community systems within investment frameworks. The relevance of people-centred primary health care and universal health coverage has been recognized, and commitments to health advanced through recognition of the vital importance of global solidarity for health. Lessons learned in the response to COVID-19 serve as a platform for future successes, including for HIV. Opportunities have emerged to strengthen global and country responses to pandemics, including preparedness, advancing towards universal health coverage and building back better for HIV, as the COVID-19 pandemic continues.

### **Reimagining systems for health**

79. Agile, adaptable people-centred services. Efforts to address the barriers imposed by COVID-19 have increased the focus on people-centred HIV services and the utilization of new technologies such as digital platforms. It has been possible to fast-track and embed innovations that were being adopted slowly before, such as MMD and differentiated service delivery. HIV self-testing and offering testing at a wider range of sites increases opportunities to meet the target of 95% of people living with HIV knowing their HIV status by 2025. Increased utilization of virtual platforms has opened opportunities for counselling, mental health support and supporting point-of-care education, without the need for in-person engagement. Even in the context of COVID-19 and disruptions of HIV programmes and services, it was possible to adapt, innovate and "bounce-back" with a vision for sustaining gains. Such approaches increase reach and improve efficiencies across health and other systems.

**Case study: Kazakhstan**

Online mental health support for key populations

UNAIDS Country Office in Kazakhstan conducted a needs assessment survey among people living with HIV and key populations during the COVID-19 lockdown early in 2020. The results showed that key populations and people living with HIV needed reliable information about COVID-19 and HIV, as well as psychosocial support and counselling.

UNAIDS and national partners, including the Republican Scientific and Practical Center of Mental Health and the Kazakh Scientific Institute of Dermatology and Infection, developed a website focused on supporting people living with HIV, people who inject drugs, sex workers, gay men and other men who have sex with men, and transgender persons. Targeted support was provided online following rapid assessments of mental health needs. The programme reached about 6,000 people and showed the viability of online services, including provision of centralized support by psychologists who are trained to work with key populations. The approach has potential for scale-up.

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80. Making communities the cornerstone of a comprehensive response. Communities are vital actors and provide support to effective demand creation, monitoring and supporting service delivery, informing planning and decision-making, and improving and expanding risk communication. People living with HIV, key populations, adolescents, young people, women, and people in communities in all their diversity are part of the solution. While initial responses to COVID-19 have been top-down, there has been a shift to broader inclusion, with a trajectory towards multisectoral and multilevel engagement. However, within both the HIV and COVID-19 responses, sectors closer to community-level have been less likely to be integrated into planning and decision-making structures and less likely to be adequately resourced. Funding allocations for community-led response remain inadequate and imbalanced. There is a need to fully recognize the role of communities who are at the forefront of responses, including acknowledging the need for fair resourcing to support primary health care and universal health coverage.
81. Multidisease approaches and integration produce better results. There has been a shift towards multidisease approaches that include HIV, TB, sexual and reproductive health and rights, noncommunicable diseases and COVID-19, as well as incorporating responses led by communities. The severe impact of COVID-19 on TB mortality must be addressed. There is an opportunity for such approaches to be immediately intensified to make efficiency gains, while also working against siloed approaches.
82. No country can contain a pandemic alone. No person is safe from COVID-19 until everyone is safe. There is an opportunity for renewed momentum towards faster gains and improved capacity to meet goals in set timeframes. Building back better means solidarity in all its forms. The interdependence of all people and countries in individual, community, societal and global health has been made starkly evident by the COVID-19 pandemic. While the pandemic's impact has caused a pause, rapid responses and innovations generate rapid results.
83. Societies are interconnected, and public health is a global public good. The burdens of COVID-19 are unequal within countries and between countries, yet interconnectedness includes interdependence. Solidarity is vital and COVID-19 will remain a global threat unless it is eradicated through national, regional and global cooperation. The HIV pandemic shifted from despair to hope when life-saving ARVs could be procured at low cost for people living with HIV in low- and middle-income countries. Manufacturing of generic drugs was rapidly brought to scale, and it was demonstrated that loss of



guaranteed patent protections does not substantially undermine the overall innovation system, and the profitability of pharmaceutical companies in wealthy nations.<sup>68</sup>

84. Increased and equitable access to vaccines, diagnostics and therapeutics provides a pathway to overcoming the pandemic. There are a number of options available to increase the production and distribution of vaccines, including sharing arrangements and various actions related to intellectual property in a pandemic context. Partnerships such as the People's Vaccine Alliance are in place. Mechanisms such as ACT-A and COVAX follow a fair burden-sharing approach and support rapid investment and deployment, especially emphasizing access to diagnostics, therapeutics and vaccines by low- and middle-income countries. Increased access to diagnostics ensures that country epidemics are adequately monitored, allowing for timely intensified response. Many low- and middle-income countries do not have the health infrastructure to provide intensive care at the scale required by high intensity waves of COVID-19, and mortality risks increase as a result. Improvements in therapeutics remain a priority, and access to vital commodities such as oxygen need to be part of preparedness measures.
85. Fully-funded and -resourced responses bring faster gains. HIV and other resources were rapidly mobilized to support the response to COVID-19. While commitments to sustain HIV funding have not been overlooked, the fiscal space and resources for HIV are projected to decline. In this context, there is a need to ensure that current resources are mobilized most effectively, including through scaling up and entrenching cost-saving measures, and by prioritizing efficiencies when aligning the HIV response with the Global AIDS Strategy 2021–2026 Fast-Track targets. The IPPPR has clarified that G7 and G20 countries need to move rapidly to resource key elements of the COVID-19 response, and the same priorities need to be highlighted for a fully-funded response to HIV.

#### **A whole-of-society response with a focus on inequalities**

86. COVID-19 has exposed inequalities and accentuated societal fault-lines. People living with HIV, key populations and people in vulnerable situations are less able to protect their health, livelihoods and well-being in the context of COVID-19 because of barriers in access to health services and commodities and to social protection and support. In the face of stark and increasing health threats, persistent barriers such as criminalization, stigma and discrimination, gender inequality, human rights violations and inequalities must be addressed through committed leadership and increased accountability.
87. Investment reaps benefits. Health systems that were strengthened through the HIV response have the capacity to meet the needs of HIV and COVID-19 together. Through HIV investments, testing and diagnostic capacities are more likely to be in place, laboratories can be adapted, health information systems can incorporate COVID-19 data, virtual platforms improve efficiencies, and new technologies can be rolled out.
88. Multisectoral and multistakeholder responses are needed. The HIV response has been characterized by decades of global solidarity. Multisectoral collaborations and partnerships between governments, donors, global health partners, civil society, communities and networks of people living with HIV and key populations are well-established, and strategies and commitments are clear. It includes meeting diverse needs, including food, shelter and other protections. Universal health coverage will only be effective if there is universal social protection.
89. Preparedness requires a whole-of-society response. It is necessary to sustain an emphasis on health systems strengthening alongside a vision for achieving universal health coverage through robust financing mechanisms and investing in health-care

worker availability and capacity development. It is also relevant for the HIV response to build pandemic preparedness measures. Immediate actions proposed by the IPPPR for the COVID-19 pandemic response include systematically and rigorously applying nonpharmaceutical public health measures to prevent COVID-19 in every country whenever the epidemiological situation requires it. High income countries with a vaccine pipeline should commit to providing vaccines to the 92 low- and middle-income countries of the COVAX Advance Market Commitment and intellectual property concerns should be resolved. Funding requirements of the ACT-A should be fast-tracked by G7 and G20 countries. Production and access to COVID-19 diagnostics and therapeutics must be rapidly scaled up, including with support through the Global Fund. Greater accountability is needed, and the WHO road map must be fast-tracked, including through oversight mechanisms.

## ANNEX 1: PRESERVING GAINS AND MITIGATING IMPACTS: EXAMPLES OF KEY RESPONSES

**Table 1: Resource mobilization**

Agencies and actors	Responses
Joint UN Teams on AIDS	<p>In 2020, Joint UN Teams on AIDS were encouraged to reprogramme up to 50% of UNAIDS country envelope funds and business unusual funds (US\$ 12.5 million), and UNAIDS Regional Support Team and Country Offices up to 50% of the 2020 UNAIDS Secretariat core funding (US\$ 4.4 million) for HIV- and COVID-19 related activities. UNAIDS ensured that a focus on HIV was maintained, including minimizing service disruptions, preserving human rights and addressing rights violations, and supporting and strengthening fragile health systems.</p> <p>Reprogramming of funds has ensured that lessons learned from HIV are translated into the COVID-19 response, including ensuring that access to commodities and services is sustained, and that the core principles of equitable response and human rights are preserved. A survey of reprogramming conducted in 2021 found that 66 of 84 country teams spent the reprogrammed funding in line with UNAIDS Guidance. The use of funds met the original intention to address emergent needs for HIV and COVID-19 and to catalyze additional financing. Key areas for funding included: (a) leveraging lessons learned and HIV infrastructure, including supporting agility in service delivery, leadership and response planning; (b) continuation of services across treatment and prevention, including MMD, differentiated service delivery, virtual platforms and mental health support; (c) socioeconomic responses, including recovery plans and economic support for key and vulnerable populations and people living with HIV; (d) human rights and gender equality; (e) political voice for rethinking systems for health, including the People’s Vaccine, provisions for universal health coverage and resilient systems for health.</p>
WHO	<p>The WHO COVID-19 Technology Access Pool (C-TAP) stimulates the pooling of technology, data and intellectual property, enabling companies to maximize the production of safe and effective vaccine doses across the world. The ACT-Accelerator partnership, focuses on driving equity and scale in the delivery of essential COVID-19 tools through political momentum and financing. Currently, there is a US\$ 22.1 billion funding gap for 2021. A call to action includes the need for countries to tap into fiscal stimulus and other funding sources to increase uptake of available and effective therapeutics and diagnostics, to increase vaccine production and counter vaccine nationalism, and to prioritize and support the COVAX facility over new bilateral deals.</p>
Global Fund	<p>The Global Fund has deployed considerable resources to COVID-19 response, while retaining focus on its core mandate. Nearly US\$1 billion was committed to more than 100 countries using redeployed internal funds and contributions from key donors. The COVID-19 Response Mechanism (C19RM) supports low- and middle-income countries and contributes to the targets of ACT-A. Under the C19RM, 55% of funding is committed to national COVID-19 responses, 34% for mitigating impacts on HIV, TB and malaria programmes, and 11% for strengthening health and community systems. Fast-track funding is available for urgent COVID-19 health products. By April 2021, an additional US\$ 3.7 billion had been raised against an estimated US\$ 10 billion needed to fulfil ACT-A goals and regain lost progress in the HIV, TB and malaria responses.</p> <p>While community, rights and gender interventions are vital for country responses to HIV, TB and malaria, only 6% of Global Fund funding has been awarded for such interventions. Civil society representatives have aired concerns that they have not adequately been consulted or integrated into decision-making processes, including in relation to COVID-19.<sup>69</sup></p>
World Bank	<p>The World Bank has committed nearly US\$ 24.7 billion to respond to COVID-19 through new operations in health, social protection, economic stimulus, and other</p>

	<p>sectors, as well as redeploying existing resources. Every month of delay in vaccines for the African continent is estimated to result in US\$13.8 billion in lost gross domestic product. The Bank is preparing emergency financing projects worth US\$ 1.85 billion in more than 30 African countries to support equitable access and logistics.</p> <p>Investments in job creation ensure economic survival for the poor across the region, "building back better" is supported through assistance to COVID-19 mitigation and reforms to aid economic recovery. More than US\$ 1.4 billion in new financing has been approved for social safety net programmes in Africa, and income support is being provided to farmers to ensure food security. Similar programmes are being conducted in Asia and the Pacific and in Latin America and the Caribbean.</p>
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**Table 2: Risk contexts and livelihood support**

<b>Agencies and actors</b>	<b>Responses</b>
UNAIDS	<p>UNAIDS joined the African Union Commission and the Africa Centres for Disease Control and Prevention (Africa CDC) to support in the implementation of its PACT (Partnership to Accelerate Covid 19 Testing) programme in six sub-Saharan African countries: Côte d'Ivoire, Gabon, Ghana, Madagascar, Malawi and Namibia. The project involves community HIV organizations mobilizing peer educators, community health-care workers, networks of key populations and people living with HIV to raise awareness and provide referrals for people living in slums. This includes identifying and reintegrating people living with HIV who have been lost to treatment and prevention services due to COVID-19, while also addressing COVID-19 risks and concerns.</p> <p>An analysis of policy options to mitigate shrinking fiscal space for health and HIV following the COVID-19 pandemic was conducted in the Democratic Republic of the Congo, Jamaica and Lesotho.<sup>70</sup> The analysis shows that the impact of COVID-19 on per capita gross domestic product is severe, leading to reduced health and HIV expenditures. UNAIDS' work with governments should therefore emphasize increasing the proportion of government expenditure allocated to health and HIV to pre-pandemic levels, alongside improvements in spending efficiency and support for debt forgiveness or debt restructuring. Short-term measures could include unconditional cash transfers to support access to health and HIV services.</p>
World Food Programme (WFP) and UNAIDS Secretariat	<p>To mitigate the impacts on vulnerable people living with HIV and key populations, the World Food Programme (WFP) and the UNAIDS Secretariat conducted pilot rapid cash transfer programmes in Burkina Faso, Cameroon, Côte d'Ivoire and Niger in the COVID-19 context. The programmes reached out to households of vulnerable people living with HIV and key populations to support access to food and assist with income-generating activities, school fees, health and other expenses.</p> <p>Cash assistance in a time of crisis benefits from flexibility in categories of expenditure. Lessons learned include: (a) engage civil society organizations at the outset as partners, facilitate shared ownership and include remuneration for their services; (b) follow bottom-up approaches through trusted outreach to reach marginalized groups, and engage beneficiaries to identify suitable outreach strategies; (c) ensure beneficiaries and community counsellors are well informed and trained on accountability; (d) involve government to leverage synergies and promote shared ownership; (e) conduct interventions with sensitivity, including ensuring confidentiality of beneficiary households to avoid stigma; (f) follow a people-centered approach to move beyond once-off support and consider sustainability objectives.</p>
UNDP	Sierra Leone has a safety net scheme for vulnerable populations, managed by the National Commission for Social Action which provides nutritional support and/or cash transfers. With WFP, UNDP supported a database to include all

	PLHIVs including those living in border communities. The survey ascertained the impact of COVID-19 on PLHIV in order to enhance appropriate decision-making regarding sustainable social services and protection interventions.
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**Table 3: Civil society and community-led responses**

Agencies and actors	Responses
Community-led organizations	Communities provide adaptive and contextually relevant support but are often left out of decision-making structures. A UNAIDS report explored demonstrated the important role of community-led organizations run by and for people living with and affected by HIV in relation to COVID-19 in 72 countries across six regions in 2020. Swift responses were noted, including reconfiguring services into virtual platforms, engaging in the distribution of ARVs, collecting donations and procuring food and other necessities for distribution to people in need, and liaising with governments to ensure adequate supplies. Other interventions included awareness-raising, providing counselling and guidance, assisting survivors of gender-based violence, distributing self-test kits for HIV and personal protective equipment for COVID-19 prevention.
UNICEF	Youth-focused response includes opportunities to engage and provide support through virtual platforms. In eastern and southern Africa, UNICEF introduced innovative ways to continue its critical peer-led programmes for supporting adolescents and young people. Text messages were used to raise awareness, and health adherence reminders were sent to ART clients in Eswatini. In Lesotho, person-to-person phone calls provided counselling and support, while WhatsApp groups enabled peer-sharing, care and support in many other countries, including Lesotho, South Africa, United Republic of Tanzania and Zimbabwe. Crowd-sourced health education was provided, including combined HIV and COVID-19 information, through UNICEF's U-Report and tele-peer support groups. In Botswana, UNICEF and the MTV Staying Alive Foundation adapted peer education sessions into COVID-19 prevention audio-visual materials for use through WhatsApp groups and social media platforms. Virtual programmes have also been helpful elsewhere.
UNAIDS Secretariat, UNFPA	In Southern African Development Community countries, the community-led HIV response includes structures that support community ownership and trust, and opportunities to empower communities to deal with COVID-19. A rapid assessment of the impact of COVID-19 on community-led HIV responses identified disconnects in coordination between government responses, including through national AIDS councils, and the civil society response to COVID-19 was insufficiently harnessed. <sup>71</sup> For example, centralized responses and lockdowns, including a focus on COVID-19 testing and isolation, contributed to stigma and hindered responses for key populations. There was a lack of engagement with community structures and networks, new funding for COVID-19 was mainly channelled through government structures, the emphasis on HIV through government was diminished, and innovations were not adequately pursued. Recommended strategies include putting communities at the centre of the crisis response, taking advantage of established structures and trust networks, and considering stigma reduction and empowerment as central approaches. <sup>72</sup>

**Table 4: Protecting and preserving rights and supporting key and other vulnerable populations**

Agencies and actors	Responses
UNAIDS Secretariat	In December 2020, UNAIDS launched a Solidarity Fund to support social entrepreneurs and microbusinesses owned by key populations that are facing special hardship during the COVID-19 pandemic. Initial piloting is underway five

	countries—Brazil, Ghana, India, Madagascar and Uganda—with a US\$ 250 000 budget from UNAIDS. Expansion is planned in other countries and the goal is to raise an additional US\$ 3 million to US\$ 5 million for 2021–2022.
UNAIDS Secretariat, UNFPA	Diverse response measures have emerged to tackle COVID-19-related human rights violations, including establishing multidisciplinary reaction teams and helplines, providing access to shelters and reception centres, and expanding virtual platforms. Networks of women living with HIV in Tunisia, Zimbabwe, Costa Rica, Mexico, Nepal, Ukraine and Viet Nam documented rights violations against women, including women from key populations. Support was mobilized to improve access to medicines, food and other essential supplies. In Venezuela, the UNAIDS Secretariat and UNFPA provided support to quarantined refugee women, providing access to contraceptives, voluntary HIV testing and information on gender-based violence and HIV.
UNHCR	Refugees, internally displaced persons, and other populations in humanitarian settings need consistent access to sexual and reproductive health services, including HIV prevention and treatment. More than five million Venezuelans have sought refuge in other countries, and those living with HIV have limited access to health services in host countries. Following advocacy from UNHCR and other partners, Venezuelan refugees and migrants in HIV prevention programmes were included in Global Fund programming as of July and August 2020, with further strengthening planned in 2021.
UNFPA, WFP	Meeting the needs of people requiring assistance during humanitarian emergencies in the COVID-19 context includes addressing HIV-related concerns. UNFPA's operations and supply chain provided emergency kits WFP provided enhanced supply chain and logistics support as part of Global Fund response to COVID-19, including through over 7,000 delivery points—many of which were in emergency settings. In South Sudan, the WFP supported approximately 70 000 malnourished people living with HIV and TB, and their families, by providing counselling, food, and nutrition support through implementing partners.
UNODC	UNODC, in consultation with WHO, the UNAIDS Secretariat and civil society, developed technical guidance documents for HIV, TB and viral hepatitis in the COVID-19 context. The materials are relevant for addressing drug use and HIV, including in prisons.
ILO	The ILO supported 63 countries to scale up social protection initiatives for vulnerable populations, including people living with HIV. Guidelines were developed to protect workers and maintain wellness programmes, including HIV programmes in the COVID-19 context.
UNDP	In Panama, UNDP and the Global Fund are working with community-led organisations to provide services to key populations. Partners are utilizing digital communication platforms to minimize the impact of COVID-19 on HIV prevention services for key populations. Using social media platforms, partners are delivering preventive health messages and offering follow-up to HIV prevention and treatment services.
UNDP	In the Democratic Republic of Congo, lockdown measures due to COVID-19 and related restrictions resulted in increased vulnerability of affected households, key and vulnerable populations, as well as people already affected by HIV, and increased their need for social and nutritional protection. Activities include: (a) virtual communications/awareness-building; (b) local production and distribution of hydroalcoholic solutions (in the absence of running water in some communities and in prisons) so that key and vulnerable populations had access to hygiene measures recommended for preventing COVID-19 transmission; (c) local production and distribution of fabric masks by women living with HIV as a

	measure to mitigate the socio-economic impact of COVID-19 in this vulnerable segment of the population; (d) capacity building for 141 health care providers and community actors on human rights, gender, SRH in the context of COVID-19; (e) HIV voluntary counselling and testing in prisons and in sex worker, MSM and transgender sites combined with the distribution of condoms and lubricants; and (f) sensitization training of 542 community activists/peer educators—from PLHIV, SW, MSM and TG communities—to conduct awareness on the fight against stigma and discrimination, identification of sexual violence cases.
UNDP	UNDP addressed the challenges of COVID-19 by supporting the adaptation of service delivery—for example, new and mobile testing points, digital tools and home tests in countries including Cuba, Kyrgyzstan, Uzbekistan; provided safe spaces for accessing prevention for gay and other men who have sex with men and trans people in challenging operational environments; training and education of service delivery personnel on COVID-19 safety protocols and distribution of PPE among key population beneficiaries of prevention services. UNDP also partnered with the UNAIDS Secretariat in ensuring that in the Dominican Republic, Guyana and Haiti COVID-19 relief actions include LGBTIQ+ communities and supported studies on COVID-19 on LGBTIQ+ persons in Barbados, Grenada, the Dominican Republic, Guyana, and St. Lucia

**Table 5: Maintaining focus on girls, women and children**

Agencies and actors	Responses
UNAIDS Secretariat	To understand the gender-related challenges emerging due to COVID-19, a series of virtual dialogues with 150 adolescent girls and young women was convened in eight SADC countries by the UNAIDS Regional Support Team. Lockdowns and fear of exposure to COVID-19 reduced access to health services leading to reduced access to HIV prevention and contraceptive support and prevention of vertical transmission. Lack of access to contraception contributed to teenage and unplanned pregnancies, potentially discouraging school attendance following lockdowns. There were fewer opportunities for involvement in empowerment initiatives, and girls and women have been excluded from COVID-19 response structures in many contexts.
UNICEF	UNICEF used digital technologies and virtual platforms and supported modification of guidelines to include MMD and HIV self-testing, and as well as providing support through home-based services. Community-led responses include a UNICEF-supported Young Mothers Programme in Lesotho, which distributed social protection packs through peer mentors, including food and cash support, and COVID-19 and HIV information. In 139 countries and territories, 263 million children globally were supported by UN-backed distance and home-based learning, 86 countries were supported in the integration of measures to address gender-based violence as part of COVID-19 response plans, and nearly 120 million people benefited from social protection schemes.
UNICEF, WHO, UNAIDS Secretariat	To mitigate impacts on paediatric HIV testing and treatment targets, UNICEF, together with other UN partners, adopted a range of digital technology solutions and innovative programme approaches. UNICEF's collaborations with WHO and UNAIDS in the United Republic of Tanzania reinforced health systems support for the rapid modification of guidelines. The Global Network of Young People Living with HIV, with support from UNAIDS, has launched the Y+ Social Aid Fund for young people living with HIV. It is being piloted in Malawi and Nigeria, with support from young people living with HIV, and include provision of financial assistance to counter impacts of COVID-19 restrictions.

UN Women	UN Women provided support to address violence against women and girls in the COVID-19 context including ensuring that female sex workers in Côte D'Ivoire can access gender-based violence services. Support was also provided in Sierra Leone to establish district-level "one-stop centres" for survivors of gender-based violence.
UNESCO	UNESCO improved understanding of the links between COVID-19 and the impact of school closures on girls' health and education. It also launched a "Let's Talk" campaign to respond to early and unintended pregnancies in southern and eastern Africa and to support continuous communication on sexual and reproductive health and rights with young people.
UNDP	In Eastern Europe and Central Asia, UNFPA and UNAIDS, UNDP supported community-led (EWNA) <a href="#">regional assessment</a> in 10 countries (Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russian Federation, Tajikistan, Uzbekistan, Ukraine) on the impacts of COVID-19 on women living with HIV and other vulnerable women to assess sexual reproductive health and GBV services and ARV treatment.

**Table 6: Examples of innovations**

Agencies and actors	Responses
UNICEF, UNITAID, WHO	Communities have been drawn into risk communication response in many countries, and mobile apps were used to combat misinformation. Essential medical products, including personal protective equipment, were produced locally, including adapting and repurposing existing products and production facilities. UNICEF, in partnership with UNITAID and WHO in sub-Saharan Africa, helped to strengthen laboratory systems by introducing and scaling up point-of-care tests for integrated testing for HIV, TB, COVID-19 and Ebola. Early infant diagnosis was fast-tracked in many testing sites across ten countries in Africa.
UNAIDS Secretariat, WHO	In Asia and the Pacific, HIV programmes have been reaching out to key populations, including through virtual platforms. Strategies include promotions and engagement through social media, communicating through influencers, and supporting aspects of the HIV cascade, such as appointments and screening. The UNAIDS Regional Support Team, in partnership with WHO and countries in the region, is mapping virtual interventions in 14 countries to support expanded use of virtual platforms.
WHO, UNAIDS Secretariat, Government of Sudan	A Search and Rescue Campaign by the Government of Sudan in partnership with WHO and UNAIDS to enhance ART retention rates included proactive tracing and reengagement of people living with HIV who were lost to follow-up. The campaign reached 66% of persons who were lost to follow-up, and 94% returned or planned to return for treatment. The Campaign demonstrated the value of investing in patient outreach, timely tracking, and support to people living with HIV to increase retention.
UNDP	With support from UNDP, nine Pacific Island countries are better able to capture data on populations disproportionately affected by HIV. In these countries, routine health registration forms will now ask patients to share basic behavioural information. For the first time, this data will be consistently captured and made available across nine Pacific countries, including the Cook Islands, Federated States of Micronesia, Kiribati, Marshall Islands, Palau, Samoa, Tonga, Tuvalu and Vanuatu. Moreover, in Burundi, Djibouti and Guinea-Bissau, the UNDP-Global Fund partnership in collaboration with governments have pioneered a new mobile technology initiative which introduced real-time monitoring using mobile tablets to digitize HIV, tuberculosis and malaria data to map, track, prevent and



	treat health outbreaks in real-time. These district health information systems have now been expanded to include COVID-19 data.
UNDP	UNDP is also supporting efforts to leverage innovations for COVID-19 response and recovery into stronger systems for addressing HIV and health. For example, in Lesotho, UNDP, through its Accelerator Lab, developed and deployed a mobile application for Community Health Care workers to monitor suspected and quarantined cases of COVID-19 within their communities. The application facilitated community health surveillance and linked community level with district and national platforms ensuring seamless coordination.
UNDP	UNDP supported 52 countries on digital innovation. In the Seychelles, UNDP is working with the Department of Health to roll out a digital surveillance and mapping mechanism for contact tracing and containment. The programme is designed to reach at risk communities, including the elderly, young people, people living with HIV and people with underlying health conditions.
Country-level: Burkina Faso, Cameroon, Cote d'Ivoire, Niger	COVID-19 affected income generation by people living with HIV and key populations, with stigma and criminalization compounding vulnerability. A cash transfer programme was piloted in the four countries, to demonstrate effective mitigation of economic and psychosocial stress. In Cameroon, it was necessary to ensure financial service providers could deliver country wide. Gaps were filled by civil society organizations, and it was clear that civil society inclusion should be considered at the outset. Contextualized approaches were followed in the other three countries, also informing lessons regarding community partnerships.
Country-level: India	Efforts were made to ensure that people living with HIV were linked to services, including migrant people living with HIV. Links were also made to various social welfare schemes, and in a context where income generation was compromised, dry rations and financial assistance was provided to key populations such as sex workers, without requiring proof of identity. OST distribution includes take-home doses, with flexible timing for OST dispensing to ensure ease of access.
Country-level: Kazakhstan	Lockdowns and isolation created anxiety among key populations and was addressed by providing an online platform that offered psychological services and support. The platform was developed with the participation of people from community organizations, representatives of key populations and activists.
Country-level: Moldova	Access to ART for people living with HIV in Moldova was mobilized through the Ministries of Health, Labour and Social protection, the National HIV Programme Management Unit, and the Positive Initiative. UNAIDS and the WHO bureau provided guidance and technical and financial support. The initiative ensured ART access in remote rural and other areas through support from nongovernmental organizations and people living with HIV.
Country-level: Namibia	In the context of border closures, people living with HIV in border regions could not access ART. In Namibia, community ART dispensing points were developed along the border with Angola to ensure that Angolan patients could access ART. These services were provided in prefabricated structures, makeshift sites under trees, and from vehicles. These innovations are readily transferable and respond rapidly to COVID-19 movement restrictions.
Country-level: Namibia	Lack of information and misinformation have included inadequacies regarding the links between HIV and COVID-19 and considerations for people living with HIV. The Ministry of Health and Social Services set up a hotline to provide essential information on HIV and COVID-19, including information on ART access points, HIV prevention, and other relevant information.

**ANNEX 2: COVID-19 AND HIV DATA**

**Table 2. Increases in cumulative reported COVID-19 cases from 5 January 2021 to 5 June 2021, and estimated HIV prevalence, incidence and AIDS-related deaths, 2019<sup>73</sup>**

WHO Region	COVID-19 cumulative reported cases 5 Jan 2021	COVID-19 cumulative reported cases, 5 June 2021	Increase in reported COVID-19 cases, 6 months	COVID-19 cumulative reported deaths, 5 June 2021	People living with HIV estimate, 2019	New HIV infections estimate, 2019	AIDS-related deaths estimate, 2019
Africa	1 978 166	3 553 974	1 575 808	88 107	25 700 000	970 000	440 000
	1%	2%	80%	3%	68%	57%	64%
Europe	27 059 283	54 582 900	27 523 617	1 156 747	2 600 000	190 000	39 000
	32%	32%	102%	34%	7%	11%	6%
Americas	36 943 389	68 210 123	31 266 734	1 790 533	3 700 000	170 000	52 000
	44%	40%	85%	48%	10%	10%	8%
South-East Asia	12 103 952	32 522 226	20 418 274	422 152	3 700 000	160 000	110 000
	14%	19%	169%	8%	10%	9%	16%
Eastern Mediterranean	5 020 842	10 253 903	5 233 061	204 646	420 000	44 000	15 000
	6%	6%	104%	6%	1%	3%	2%
Western Pacific	1 127 202	3 118 605	1 991 403	47 199	1 900 000	110 000	41 000
	1%	2%	177%	1%	5%	6%	6%
<b>Global</b>	<b>84 233 579</b>	<b>172 242 495</b>	<b>88 008 916</b>	<b>3 709 397</b>	<b>38 000 000</b>	<b>1 700 000</b>	<b>690 000</b>
	100%	100%	104%	100%	100%	100%	100%

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