Agenda item 6

UNAIDS/PCB (49)/21.29

FOLLOW-UP TO THE THEMATIC SEGMENT OF THE 48TH PCB MEETING

COVID-19 and HIV—sustaining HIV gains and building back better and fairer HIV responses

UNAIDS

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Additional documents for this item: *UNAIDS/PCB (48)/21.19; UNAIDS/PCB (48)/21.20; UNAIDS/PCB (48)/CRP5*

Action required at this meeting: The PCB is invited to**:**

39. *Take note* of the background note (UNAIDS/PCB (48)/21.20.rev2) and the summary report (UNAIDS/PCB (49)/21.29) of the Programme Coordinating Board thematic segment on "COVID-19 and HIV—sustaining HIV gains and building back better and fairer HIV responses";

40. Building on lessons from both the HIV response and the COVID-19 pandemic, *call* on Member States to:
    a. Sustain practices introduced and/or accelerated during the COVID-19 pandemic into HIV prevention, testing, treatment and care, including multimonth dispensing, leveraging virtual platforms, and scale-up of differentiated, people-centred and community- and home-based HIV services,
    b. Invest adequately and prioritize flexible funding arrangements to ensure HIV service continuity in the context of major public health emergencies;
    c. Continue to actively involve communities and civil society in the response to HIV, COVID-19 and future pandemics and provide sufficient investments in community-based programmes,
    d. Build forward better in a more equitable and inclusive manner from the COVID-19 pandemic and its impact on the global AIDS epidemic, including by providing equitable and stigma and discrimination-free access to HIV, health and social protection services, including for key populations[1] and other populations particularly impacted by the HIV and COVID-19 pandemics;

41. Call on the UNAIDS Joint Programme to:
    a. Continue to monitor the impact of COVID-19 pandemic on the global HIV response and on people living with and affected by HIV;
    b. Support countries and communities to build on practices and innovations introduced and/or accelerated during COVID-19, including through timely policy guidance, technical assistance and platforms to counter stigma and discrimination against people living with and affected by HIV;
    c. Contribute to the application of the lessons learned from the HIV pandemic and its response to improve pandemic preparedness and to prevent, detect and respond to future global public health threats
    d. Apply and build on lessons learned from the response to COVID-19 to protect the HIV gains and achieve the Global AIDS Strategy 2025 targets;
    e. Advocate for increased domestic and global investments in the responses to HIV and COVID-19.

Introduction

1. The moderator for the session, Andy Seale, senior adviser at WHO's Global HIV, Hepatitis and STI Programme, introduced the thematic segment. He began by requesting a moment of silence in solidarity with Namibian colleagues and others who had lost loved ones to COVID-19, and in memory of Manuel de Quinta, a staff member at the UNAIDS Secretariat, who had recently died of COVID-19.

2. The pandemic was pushing HIV responses off-track, Mr Seale said, but innovations and creative responses were also helping communities and countries recover momentum. Mr Seale told the meeting that this thematic segment would focus on key themes including how countries and communities were utilizing lessons learned from the HIV response and in many cases, the HIV infrastructure itself, to respond to the COVID-19 pandemic, as well as how the COVID-19 pandemic could support building back better and fairer HIV responses.

3. Winnie Byanyima, Executive Director of UNAIDS, said that COVID-19 continued to ravage much of the world as health systems around the world remained dangerously overburdened and access to vaccines continued to be limited, leading to regrettably avoidable loss of life. Health is a human right, not a privilege, she stressed. Like HIV, COVID-19 exposed deep inequalities. HIV and other services had been badly disrupted, with staff shortages responsible for 66% of service interruptions. In addition, during pandemic waves peaks as many as 90% of children could not attend school. Overall demand for gender-based violence support services rose, human rights abuses increased, and social restrictions limited people's movements.

4. Ms Byanyima told the meeting that the Joint Programme was focusing on protecting HIV services and providing socioeconomic support to marginalized and vulnerable populations. Three quarters of Joint Programme Country Teams had supported national COVID-19 response efforts with programme funds and generous funding from countries such as Germany. UNAIDS was closely working with the Africa CDC to help African continent countries with the risk communication and community engagement components of their vaccine rollouts alongside the scale-up of testing and contact tracing.

5. Lessons from the HIV response had to be applied to COVID-19, Ms Byanyima urged. Eleven million people had needlessly lost their lives early in the HIV response because HIV treatment access had been delayed in low- and middle-income countries. This was why UNAIDS was coleader of the People's Vaccine Alliance, she said. The Alliance focused on the following actions: sharing of technology and know-how via the WHO COVID-19 Technology Access Pool (C-TAP, based on the Medicines Patents Pool, which had been created at the height of the HIV epidemic); waiving intellectual property rules for COVID-19 products (i.e. a TRIPS waiver); investing in the manufacturing capacity of developing countries, especially in Africa; and sharing existing vaccine stocks with low- and middle-income countries.

6. Ms Byanyima stressed the need for socioeconomic programmes that address inequalities and for building a new public health order. Investments in health, education and social expenditures were essential investments in viable and resilient societies. Ending the HIV and COVID-19 pandemics required global solidarity to fight inequalities, she said.

7. Joe Phaahla, Deputy Minister of Health, South Africa, told the meeting that his country was again the epicentre of two colliding pandemics. It accounted for 50% of diagnosed COVID-19 cases in Africa and 30% of new HIV infections in eastern and southern Africa. It also had the largest HIV treatment programme in the world, and it was rolling

out a COVID-19 vaccination programme (3.1 million doses had been administered by late June 2021). About 60 000 South Africans had lost their lives to COVID-19.

8. South Africa had learned significant lessons from HIV, Mr Phaahla said. It had acted decisively against COVID-19, with strong political leadership (unlike the denialism early in the AIDS epidemic). HIV research, community health infrastructure and activists were being brought to bear on COVID-19. Lessons on truthfulness, transparency and good communications were being heeded, with daily and weekly top-level briefings, assisted by scientists. The social protection system was being expanded to cover people who had lost incomes; a social solidarity fund had been created to draw in private sector support. Manufacturing operations had also been repurposed for personal protective equipment and ventilators. South Africa had been instrumental in setting up an Africa-wide vaccine initiative and was advocating for a TRIPS waiver, he told the meeting.

9. However, the COVID-19 lockdowns had severely disrupted routine HIV and other health services. The health system was working hard to ensure services, but some momentum towards the 90–90–90 targets had been lost. Creative adjustments were recuperating services, Mr Phaahla continued. Digital access and other innovations had become important features and community provision of antiretroviral therapy was being expanded. More people living with HIV were collecting their antiretrovirals at pick-up points outside health facilities. Personal protective equipment and improved ventilations in households and public venues were more common, which could also help combat tuberculosis.

10. Naina Khanna, of the Positive Women's Network, United States of America, described her organization's work, particularly on inequalities. COVID-19 had exposed extreme fault lines, inequities and failures of political leadership, she said. The first year of the COVID-19 response had been plagued by some political leaders' distrust of scientific evidence and disregard for human rights and for marginalized and excluded people.

11. Ms Khanna described the work done by the Positive Women's Network, which included disseminating accurate information, providing emergency cash assistance and supporting women exposed to violence. Community-based organizations were filling gaps left by governments, and many were providing informal public health infrastructure. Responses tended to be stronger where communities were closely involved in COVID-19 activities, she said. Short-term emergency funding for community organizations was urgently needed.

12. Ms Khanna warned against pitting the COVID-19 and HIV responses against one another. Some COVID-19-related adaptations (e.g. moving services on-line, increased use of differentiated care models, take-home opioid substitution therapy and multimonth dispensing of antiretrovirals) would benefit the future HIV response. The COVID-19 response was also benefitting from HIV systems, infrastructure and workforces. However, the crisis was accompanied by human rights violations, suspensions of privacy rights, violence and restrictions on movement and free speech. Some countries were using the pandemic as a pretext to target key populations with harassment or repression.

13. Globally, disparities in vaccine access continued; the hoarding of vaccines by some countries was a crime, she said. Low- and middle-income countries had to be supported so that they can produce vaccines, and vaccine donations had to increase. She called for TRIPS waivers during global health emergencies, additional surge funding for pandemics, and increased funding for the Global Fund and PEPFAR.

14. Meg Doherty, Director of Global HIV, Hepatitis, STI programmes, WHO, updated the meeting on the latest COVID-19 data and the impact on people living with HIV. At 30

June 2021, there had been 182 million confirmed COVID-19 cases and over 3.9 million deaths. Major surges were underway in southern Africa and in South America, and the Delta variant was present in most of the world.

15. Turning to the relationship between COVID-19 and HIV, Ms Doherty summarized the current evidence. Recent reviews showed people living with HIV were at greater risk of COVID-19-related mortality, but this was based mainly on studies in Africa and the United States (the same correlation was not found in studies from Europe and Asia), so definitive conclusions were not yet possible, she said. WHO had set up a global clinical platform to track the evidence, which currently indicated that people living with HIV and hospitalized with COVID-19 had a very high known outcome of death (23%), though those data were mostly from South Africa.

16. Reviewing the vaccine roll-out, she said more than 15 vaccines had been developed and vaccine campaigns were underway in 210 countries and territories, though their progress was extremely uneven. Current evidence suggested that COVID-19 vaccines were protective for people living with HIV and that there was no interaction between the vaccines and antiretrovirals. She said WHO recommended that people living with HIV not be excluded from COVID-19 vaccine access plans and that they be included as priority groups, according to the epidemiological context.

17. Comparing the HIV and COVID-19 vaccine pipelines, Ms Doherty said that over the course of 35 years only 46 candidate vaccines for HIV had been developed (with US$ 14.5 billion invested), whereas 275 COVID-19 vaccine candidates had been developed within 15 months (6 based on HIV vaccine candidates), with US$ 10 billion invested. This showed what can be achieved with strong political will and adequate funding, she said.

18. Despite the adaptations, COVID-19 continued to disrupt HIV and other health services, with the biggest impact on prevention and testing, she continued. Globally, 38% of countries had reported disruptions to health services, with some countries experiencing severe disruptions. Ms Doherty described some of the disruptions and said many vaccine preventable disease campaigns had been suspended due to COVID-19, especially in Africa, Asia and Latin America. She briefly reviewed steps taken to maintain essential health services, including new care models, self-testing, multimonth dispensing of medicines, telehealth for delivering services and more.

19. PCB members and observers thanked the Secretariat for the comprehensive report and for arranging the thematic session. They also thanked UNAIDS for its outstanding work during the COVID-19 pandemic to mitigate and overcome disruptions of HIV programmes. COVID-19 was affecting HIV responses in many ways, they noted, while weak and incomplete public health systems were contributing to high COVID-19 mortality rates in regions. It was clearer than ever that health systems had to be strengthened and that everyone should have access to quality health care, without discrimination, speakers stressed. COVID-19 had put universal health coverage at the centre of the quest for sustainable solutions.

20. COVID-19 was both a health and societal challenge, and the pandemic response had to learn from the HIV response, speakers noted. Both pandemics thrived on and deepened inequalities and exclusion, which in turn shaped patterns of transmission. The impact was typically heaviest on the most vulnerable people and communities. It was important to tackle gender inequality and violence as crosscutting issues. Effective responses involved global solidarity and multistakeholder action, they said. Communities and civil society were integral to successful responses, yet were seldom present when decisions affecting their lives were made. Speakers called for increased investment in communities, which are at the heart of the HIV and COVID-19

responses.

21. Speakers highlighted the need for strong international commitment to ensure equitable access to vaccines and other health commodities. They urged stronger support for medicine and vaccine production in Africa, and for the Covax initiative. Members and observers (e.g. Brazil, China) described some of the innovations used to protect HIV services, as well as steps taken to ensure wide access to national vaccine programmes.

Panel 1: Turning a crisis into an opportunity—leveraging lessons learnt and the HIV infrastructure for responding to the colliding epidemics

22. Ruth Laibon Masha, CEO, National AIDS Control Council, Kenya, briefed the meeting on approaches that had worked in Kenya, including steps taken by the National AIDS Council. COVID-19 was highlighting longstanding gaps in access to health services, especially for vulnerable communities, she said. The country was experiencing a third COVID-19 wave, and fewer than 1 million people had been vaccinated. Pandemics such as HIV and COVID-19 showed the negative effects of poorly-designed programmes, which struggled to serve people living in poverty, with women especially affected. Burdens of care, domestic work and frontline services were predominantly performed by women. The pandemics also highlighted the need and opportunities to strengthen community-based services, she said.

23. Because Kenya had acted quickly against COVID-19, most HIV services had been protected, Ms Masha told the meeting. Facility-based HIV testing had decreased, but overall testing had recovered by October 2020. Health workforces were affected, though, and many patients were afraid to attend clinics and hospitals. Multimonth dispensing had been introduced, community treatment groups were collecting antiretrovirals for vulnerable people, virtual counselling platforms and mobile clinics were operating, and home distribution of medicines was occurring. She emphasized the need for campaigns and platforms to counter misinformation, and the importance of rights-based access to health services and medicines. Funding arrangements had to be flexible to allow for emergency services to continue during health crises.

24. Marcela Alsina, of the *Movimento Latinoamericano y del Carive de mujeres positivas* in Argentina, reminded the meeting of the inequalities experienced in Latin America. Civil society organizations had acted very quickly during the pandemic to provide food and other support to marginalized and vulnerable communities, using support from UNAIDS and other partners. However, public health services had experienced many problems, with sexual and reproductive health and HIV programmes especially affected. Only 5% of Latin America's population had been vaccinated to date. Civil society was at the heart of the response and needed reliable support, not just speeches, she urged.

25. Chinmoyee Das, Deputy Director of India's National AIDS Control Organization, told the meeting that India faced major challenges maintaining its HIV services during the pandemic. She summarized some of the steps taken, including a broader shift to virtual interventions. Artificial intelligence was being used widely for counselling and many activities were being conducted online. Information Technology platforms were being used in treatment services, including teleconsultation and for supporting treatment continuity, and other telemedicine initiatives and platforms were being scaled up. A self-verified treatment adherence system was being piloted and a hotline had been set up for people experiencing mental health issues. Beneficiary mobile apps had been launched and social media were being used to link migrant patients with treatment centres, while virtual platforms were being used to train health-care workers. India was trying to turn the crisis into an opportunity, but many challenges remained,

she said.

26. Speaking from the floor, PCB members and observers said it was important to recognize the scope of the COVID-19 challenge and how far the HIV response had been pushed off-track. Responses had to be agile and data-driven so that special attention could be directed where it was needed the most. They reminded the meeting that 9.8 million people living with HIV were not on treatment and that HIV incidence was not being reduced quickly enough. The HIV response had to be creatively adapted: prevention had to move out of facilities, and self-care and self-management had to be embraced, speakers said. Stronger ambitions were needed for HIV vaccine, and care research had to increase.

27. The coinciding impact of HIV, TB, malaria and COVID-19 epidemics had to be addressed in unison, speakers stressed—it was a not a zero-sum situation. New resources for HIV were needed, not reallocations of existing funding. Noting that health service investments supported entire public health systems, members commended the United States for the US$ 3.5 billion it had contributed to COVID-19 programmes via the Global Fund.

28. Pandemic-proof health programmes had to be built, which required strengthening community systems and responses. The Global AIDS Strategy recognized the importance of communities, but adequate support was needed to fully realize their potentials. Speakers highlighted the role of communities across epidemic responses, including the use of community-based service models for prevention and epidemic surveillance. They reminded the meeting that communities had been promoting differential service delivery for years, but it took COVID-19 for the approach to be adopted widely. Multimonth dispensing had been recommended by WHO since 2016; it was now a reality in numerous countries. Successful service adaptations during COVID-19 should be kept in place, speakers urged.

29. COVID-19 was aggravating the already-difficult situations of people who use drugs and prisoners, speakers noted. Preventive restrictions had led to the closure or reduction of harm reduction services, which also exacerbated the inequalities faced by women who use drugs. There were opportunities for harm reduction programmes to use more flexible models of service delivery (e.g. take-home opioid substitution therapy). People in prison were being systematically neglected, speakers said, even though closed settings were highly conducive to the transmission of infectious diseases. Prison health services should be improved and integrated with public health systems generally, and prison overcrowding should be reduced (e.g. through suspension of sentences for minor transgressions), they urged.

Panel 2: Building back better

30. David Wilson, Director of the Global AIDS Program Director at the World Bank, began by saying that COVID-19 could not be controlled without wide and equitable vaccine access. Enormous scientific progress had been made against COVID-19 and important innovations were being used to safeguard HIV and other health programmes. The use of telemedicine and multimonth dispensing had been accelerated by a decade, he said. It was clear that COVID-19 had increased inequalities, but it might also create new opportunities to address inequities in access to health.

31. Major challenges lay ahead, though. Mr Wilson predicted that HIV would be a contesting priority and that HIV advocacy would have to adapt; overall development assistance was likely to decline and health funding could be expected to prioritize health security preparedness. Single-disease advocacy was unlikely to be successful, he said. HIV actors should join with other health, education and social protection

actors to advocate for greater investment in human and social capital.

32. It was important to convey how COVID-19 was damaging human capital and to position HIV within the efforts to repair that damage. Governments were likely to focus initially on economic spending, while neglecting human capital investments. During the "budget repair" phase, human capital investments may also be squeezed, he suggested. It was therefore vital to integrate HIV into Universal Health Coverage and primary care, and to integrate advocacy for those priorities. Equitable global vaccine access had to be a top priority, he said in conclusion.

33. Thoraya Obaid, from the Independent Panel for Pandemic Preparedness and Response, said the focus should be on building forward, not building back better. She shared several lessons, based on the Panel's deliberations. COVID-19 showed weaknesses at every level, including an absence of global political leadership. The panel had emphasized the need for a long-term view of pandemics, which implied a global plan, without which there was a risk of losing a human rights focus. A high-level global threats council should be set up, led by Heads of States and Government, Ms Obaid told the PCB.

34. WHO's independence, authority and financing had to be strengthened, she added. The Panel had proposed a new global surveillance system, in which WHO would have explicit authority to publish data and despatch investigative teams. Greater investments were also needed in public health systems to ensure continuity of essential health services for all communities. The need for greater inclusiveness in pandemic preparedness and responses was another lesson; communities, civil society organizations, workers and the private sector must be included, with a two-way information flow and genuine participation in decisions that affect them.

35. Equity was a central theme in the Panel's work, Ms Obaid said, noting that COVID-19 was deepening inequalities, with an especially harsh impact on women. Vaccine inequalities in and between countries had to end. The Panel called for the redistribution of 1 billion vaccine doses by 1 September, 2021, and 2 billion doses by mid-2022 from high-income countries to low-income countries, she said. Also recommended was the creation of an international pandemic financing facility that can mobilize up to US$ 10 billion per year, which would be less than 1% of what governments had spent on economic stimulus packages during the crisis.

36. Another lesson was the experience of the HIV response in using compulsory licensing, under TRIPS provisions, which was not an easy instrument to use. The Panel therefore recommended a process, under the auspices of WHO and the World Trade Organization, to reach an agreement on technology transfers and voluntary licensing so that intellectual property rights are not barriers to vaccine access. Failing such an agreement, she said, a blanket waiver should apply. Finally, said Ms Obaid, it was important to remember that it had taken a triple alliance of science, politics and activism to drive the HIV response forward.

37. Kaythi Wynn, Asia-Pacific Network of Sex Workers, Myanmar, shared lessons community organizations had learned from the COVID-19 crisis. She said sex workers had been very hard-hit. They were subjected to harsh stigma and discrimination (targeted as "spreaders" of COVID-19) and harassment by the authorities, and were struggling to survive. Many sexual and reproductive health projects had been suspended, which put sex workers at additional risk. NGOs also had to suspend operations. Since most countries do not include sex workers in their social protection systems, sex workers have struggled to pay rent and buy food. Ms Wynn described how NGOs, in response, had modified some programmes and reallocated funding for emergency food aid and to support sex workers who had been made homeless. She

called on Member States and the Joint Programme to work closely with community-led organizations and key populations and to develop emergency response protocols.

Conclusion

38. Shannon Hader, Deputy Executive Director, UNAIDS, thanked the organizers and panellists. Although the HIV and COVID-19 pandemics were continuing, solidarity and creative responses would deliver solutions, she said. Social and financial investments in the HIV responses were paying off for both pandemics, even though the effects of chronic underinvestment in public health systems generally were also evident. Ms Hader said the dedication, energy and resources of communities were driving the innovations that would enable countries to overcome the pandemics.

Draft Decision Points: The PCB is invited to:

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    d. Apply and build on lessons learned from the response to COVID-19 to protect the HIV gains and achieve the Global AIDS Strategy 2025 targets;
    e. Advocate for increased domestic and global investments in the responses to HIV and COVID-19.

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