

TECHNICAL BRIEFING ON HIV AND COVID-19 PROGRAMMING



CONTENTS

INTRODUCTION	3
<hr/>	
SECTION 1: PRINCIPLES FOR HIV PROGRAMMING AND COVID-19	4
Human rights	4
Public health	5
Gender equality	5
Person-centred approach	6
Do no harm	6
<hr/>	
SECTION 2: GENERAL CONSIDERATIONS ON COVID-19 AND HIV	7
The global COVID-19 pandemic	7
COVID-19 infection: prevention, symptoms and available treatment	7
COVID-19 and people living with HIV	8
<hr/>	
SECTION 3: POSSIBLE IMPACT OF COVID-19 ON MARGINALISED POPULATIONS	9
Marginalised populations	9
Adolescent girls and young women	10
Caregivers (formal and informal)	11
<hr/>	
SECTION 4: TECHNICAL GUIDANCE TO MITIGATE THE IMPACT OF COVID-19	12
HIV prevention	12
Harm reduction	14
HIV continuum of care: HIV testing, HIV treatment and care services	14
Domestic and intimate partner violence	16
Other forms of gender-based violence	17
Sexual and reproductive health and rights	18
Economic justice	20
Human rights	20

Design: HD design

Cover photo: Participants in the Deep Engagement project in Mozambique.

©Frontline AIDS/Peter Caton 2019

INTRODUCTION

The Frontline AIDS Technical Briefing on HIV and COVID-19 Programming is a 'working document' to be used in conjunction with the Frontline AIDS [Information note](#): COVID-19 and HIV.

This technical brief is intended for Frontline AIDS partners (including Frontline Global) who are mitigating the impact of COVID-19 on their HIV programmes and addressing the secondary impact of COVID-19 in communities most impacted by AIDS.

With an overall objective to provide technical guidance on programming in different areas where COVID-19 and HIV intersect, the brief will:

- Introduce principles for HIV programming influenced by COVID-19.
- Discuss some general considerations relating to COVID-19 and HIV.
- Consider the possible impact of COVID-19 on marginalised populations - including sex workers, people who use drugs, LGBT people, and adolescent girls and young women – as well as their vulnerabilities, and existing and potential new needs.
- Provide guidance to mitigate the impact of COVID-19 in each technical area - HIV prevention, HIV treatment, harm reduction, sexual and reproductive health and rights (SRHR), gender, and human rights.¹

Person-centred programming has long been a cornerstone of the HIV community-based response. At a time of a new pandemic that has swept the world, it is an approach that is needed more than ever – decentralised, based in the community and peer-led. Now, more than ever, is the time to listen to and focus on marginalised populations who – as with the HIV epidemic – will be among the most affected by the current global public health crisis.

COVID-19 restrictions have exacerbated the many challenges that marginalised and vulnerable groups - including people living with HIV, women and girls, sex workers, LGBT people, people who use drugs, prisoners and migrants - already face on a daily basis. Their needs must be central to services - whether relating to HIV prevention or the continuum of care, to harm reduction, gender-based violence, sexual and reproductive health and rights, human rights, or to any intersection of these.

Marginalised populations must be prioritised in service delivery efforts, and any legal and regulatory efforts to limit COVID-19 infections must not disproportionately affect them or cause harm. Clinical and community partners servicing these populations must be recognised as key workers providing essential services and, as such, have access to the personal protective equipment and supplies that they need to be able to carry out their work in safety.

For all of this to happen, we need to support community leadership and the meaningful participation of affected communities in decision making which have long been a bedrock of HIV programming. Community members are trusted by those who are not always reached by health professionals; they know and understand the needs of their peers; and are better able to tailor services to those needs. In the current crisis, once again it is they who have shown their abilities and determination to rescue their communities.

When we intervene, we must ensure that our own actions do not inadvertently put people at risk and that we follow principles of do no harm. Rights-informed programming requires us to assess and prepare for possible safety and security risks of our own actions and do so collaboratively with our partners.

Our concerns about the impact of COVID-19 on the rights of those we serve must be accurately assessed. We are dealing both with human rights violations, and justifiable limitations to rights by the state that result from lawful restrictions to movement in order to control the epidemic, and we must treat each differently. Limitations on rights, including health status disclosure, forced quarantine and limits to personal freedoms must only be done in accordance with law, and only as a last resort.

Poverty, homelessness, and global inequalities – many of the structural drivers of HIV and compromised health – will all be made worse as fragile and threatened economies deal with COVID-19. We need to be watchful of the impact on health systems and advocate for comprehensive fully resourced responses that maintain life-saving HIV, SRHR and other connected services – and maintain them safely.

¹ This is a working document, it will be updated as we gain more experience across the partnership on HIV programming within the context of COVID-19. Topics such as HIV/TB and HIV/HCV co-infections, amongst others, have not yet been included because we are seeking partners' experience to include and update this technical briefing. Please contact innovation@frontlineaids.org if you would like to contribute and feedback.

SECTION 1

PRINCIPLES FOR HIV PROGRAMMING AND COVID-19



HUMAN RIGHTS

Working with civil society to advance rights and remove barriers to HIV-related services remains at the centre of our programming and advocacy: Our belief that the lives of all human beings are of equal value remains at the core of all our programming and influencing work, and we hold as a central premise that advancing rights is not only good, but necessary to ending AIDS. This approach must be centred on evidence, empowerment and community engagement.² Decision making must be based on reliable evidence of what works best, and not on politically driven agendas which are often counter-productive and undermine the COVID-19 response.

COVID-19 has left no right, or human need, untouched, and our programmes must consider and respond so as to 'meet people where they are at'. Human rights are inextricably linked. To address rights to accessing HIV-related services also necessitates that we address, to the extent that we can, other affected rights and needs. This might be done through our own direct intervention, but also by holding governments to account for providing basic and essential services and goods.

The state, as ultimate duty bearers, remains accountable for advancing human rights and maintaining rule of law: State institutions represented by government actors must do all that they can within the limits of their resources to respect, protect and promote the rights of individuals and communities served. It remains our responsibility as civil society actors and rights holders to make sure that state actors follow due process and the rule of law when limiting rights (such as restricting movement and the ability to earn a living) in the interests of epidemic control. Such restrictions must be for a limited duration, proportionate, necessary, evidence-

based, and reviewable by a court to be considered legitimate.³ States must also take measures to buffer the negative impact of these actions with medical, financial and social support services. Exceptions to restrictions must be considered where necessary for those most likely to experience disproportionate suffering as a result of blanket restrictions; this latter should be avoided where possible.

Our mission continues to centre around ensuring that state actors progressively realise the right to health for all, equally. The right to health is the assertion that everyone has the right to accessible, available, appropriate and quality health care regardless of who they are, where they are from and what they do. It also requires that states have a responsibility to progressively realise the right to health as far as resources allow, and where they fall short, to prioritise communities that are most in need, with the involvement of those communities in the prioritisation process.

As this new epidemic increasingly draws new lines of marginalisation (and "confirms" the old ones), it is crucial that we publicly denounce unlawful practices such as criminalising measures, support communities under threat, and ensure that our own programming at every step consistently follow rights-based principles. To do so, we must reasonably weigh public health imperatives on the one hand, with the advancement of human rights on the other. We should only accept limitations to rights from ourselves and others where it is absolutely necessary to meet a public health need, and only to the extent that is necessary to fulfil it.

² UNAIDS. Rights in the Time of COVID-19: Lessons from HIV for an effective, community-led response. May 2020. https://www.unaids.org/sites/default/files/media_asset/human-rights-and-covid-19_en.pdf

³ Ibid.

PUBLIC HEALTH

Public health is the science of protecting and improving the health of people and the communities they live in. It is therefore about addressing the determinants of ill health and the impact of illness and disease at population level. For this reason, public health is also about promoting healthcare equity, quality and accessibility which, together with human rights, form the pillars of the global health response.

The COVID-19 global health emergency in many countries has severely compromised health systems' abilities to protect the health of people and the communities they live in. The response so far has been primarily a public health response where individual movement limitations, travel restrictions and countrywide lockdown measures have been imposed on populations to stop and contain the COVID-19 virus.⁴

The HIV response is also a public health response and includes HIV prevention, treatment and care services for marginalised and vulnerable populations. Importantly, because HIV disproportionately affects women and girls and marginalised people⁵, the COVID-19 pandemic threatens to exacerbate their marginalisation and ability to access the services they need to stay healthy.

A public health response to both HIV and COVID-19 is primarily concerned with the well-being of people living with HIV and of anyone who is at high risk of acquiring HIV. It recognises both clinical and community partners as essential actors. It ensures that service implementers have access to personal protective equipment (PPE) and supplies, and are enabled to do their work with the necessary permits during lockdown conditions.

GENDER EQUALITY

Gender equality is a recognised human right. However, gender inequality remains a major barrier to human development and, in the context of HIV, women and girls are disproportionately impacted because of their unequal cultural, social and economic status in society. In addition, women typically shoulder most of the caregiving - both informally in the home and community, and in the formal care economy as health workers. Similarly, COVID-19 will affect people differently depending on their gender identity among several other socio-economic factors (wealth, age, health status, geography, sexuality, race), which could equally increase vulnerability to HIV and AIDS, as well as other SRHR issues.

USEFUL SOURCES OF INFORMATION ON COVID-19 GENDER, HIV, SRHR AND VAWG

ORGANISATION	MAIN AREA OF FOCUS
UN Women	Updates on all main areas, including gender-based violence GBV
Johns Hopkins School of Public Health - Gender and COVID-19 Working Group	All main areas
International Planned Parenthood Federation	Impact of COVID-19 on SRHR and SRH services as told by member associations
Coalition of Feminists for for Social Change (COFEM)	COVID-19 Resources for VAWG Mitigation and Prevention, Self and Collective Care, Assistance and more
Gender and Development Network - Feminist Responses to COVID-19	VAWG, economic justice, SRHR, voices from the South, humanitarian, feminist leadership, militarism, multilateral organisations, intersectionality, general
Development Connections (DVCN)	Collation of resources in Spanish on COVID-19 and VAWG Repositorio de recursos sobre COVID-19, violencia contra mujeres y niñas y temas conexos.

⁴ CDC Foundation (n.d.) What is Public Health? viewed 16 July 2020. <https://www.cdcfoundation.org/what-public-health>

⁵ We work with marginalised people who are denied HIV prevention, treatment and care simply because of who they are and where they live. This includes people living with HIV, sex workers, people who use drugs, transgender people, gay men and other men who have sex with men, as well as adolescent girls and women.

PERSON-CENTRED APPROACH

While there are many ways of defining person-centred approaches, they are all founded on common principles such as empowering and informing beneficiaries to enable them to participate in joint decision making; tailoring services to suit their context; respecting their preferences; and adapting and linking services to ensure that all their needs (physical, emotional and psychological) are met. Community and peer-led programmes, and especially those for marginalised populations, should always use a person-centred approach, and the COVID-19 epidemic is no exception. This translates into programmatic and advocacy work that take into consideration the multiple intersecting identities, realities, priorities, opportunities and risks that individuals experience throughout their lives.

Our approach will not label people as one homogenous group but will try to understand the complex realities of individuals' lives and adapt responses to these nuances rather than the other way around.

DO NO HARM

Social distancing and restrictions of movement imposed by governments as part of their COVID-19 responses create or exacerbate the potential for harm in relation to HIV. This could be in the form of interrupted treatment regimens; lack of access to services, information and commodities; greater exposure to gender-based violence, as well as loss of income, a fragmentation of support networks, and additional care burdens.

Where transmission of COVID-19 has been criminalised, there is the risk that these laws will disproportionately affect marginalised populations who are unable to apply social distancing, hygiene practices or adhere to other regulations such as mask wearing and curfews. The principle of doing no harm must apply to any measures that aim to prevent COVID-19 infections, and must recognise the relative needs of vulnerable populations. Moreover, states must be prevented from using COVID-19 regulations to deepen the disadvantage and harm that marginalised populations already face. Our work therefore includes the monitoring of human rights and COVID-19 regulations and their implementation, and must be vigilant to the potential harmful impact on the health and well-being of marginalised people.

Volunteers trained by Centre for Human Rights and Rehabilitation help reduce discrimination and violence in a refugee camp in Malawi.



© Gemma Taylor for Frontline AIDS

SECTION 2

GENERAL CONSIDERATIONS ON COVID-19 AND HIV

Mobile outreach by Convictus, an organisation that supports people who use drugs in Ukraine.



THE GLOBAL COVID-19 PANDEMIC

The COVID-19 pandemic is a global health crisis and one of the greatest emergencies the world has faced since World War II. Since its appearance in Asia late in 2019, the virus has spread to all continents, with the exception of Antarctica. In mid-June 2020, with cases still rising daily in Africa, the Americas and Europe, the World Health Organization (WHO) was reporting more than eight million COVID-19 cases and more than 430,000 deaths.

In order to slow and ultimately stop the spread of the virus, countries have initiated large test and treat programmes, carrying out contact tracing, imposing travel restrictions and quarantining citizens. The countries most affected by COVID-19 have also closed schools and universities and cancelled events and meetings that involved large gatherings of people.

However, COVID-19 is not just a health crisis. The impact of the virus on national health systems, and the lockdown measures and restrictions put in place to prevent its spread, have the potential to cause short- and long-term damage to the social, economic and political context. Many communities across the world have been heavily affected by COVID-19. Millions of people have lost jobs and income. Countries that are heavily dependent on tourism are already facing years of economic recession.

COVID-19 INFECTION: PREVENTION, SYMPTOMS AND AVAILABLE TREATMENT

Coronavirus disease, or COVID-19, is an illness caused by a virus belonging to a large family of viruses, altogether called coronaviruses. The virus causing coronavirus can affect both animals and humans. In humans, it can cause respiratory infections from the common cold to

more severe conditions like pneumonia, severe acute respiratory syndrome and sometimes death.

The most common symptoms of COVID-19 are fever, tiredness, and dry cough. Some people may have aches and pains, runny nose, sore throat, diarrhoea, and loss of sense of smell and taste. These symptoms are usually mild and begin gradually. Some become infected but don't develop any symptoms or don't feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Around one out of every six who get COVID-19 becomes seriously ill and develops difficulty breathing. Older people, and those with underlying medical problems like high blood pressure, heart problems or diabetes, are more likely to develop serious illness. People with fever, cough and difficulty breathing should seek medical attention.

People can catch COVID-19 from others who have the virus. The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Others can then catch COVID-19 by touching these objects or surfaces and then touching their eyes, nose or mouth. People can also catch it if they breathe in droplets from a person with COVID-19 who coughs or exhales droplets. Therefore, it is important to stay more than one metre (three feet) away from a person who is sick.

There are currently no drugs licensed for the treatment or prevention of COVID-19. While several drug trials are ongoing, there is currently no proof that any drug can cure or prevent COVID-19. WHO is coordinating efforts to develop and evaluate medicines to treat the virus.

For more general information about COVID-19 see [this WHO article](#).

COVID-19 AND PEOPLE LIVING WITH HIV

At present it is unknown whether people living with HIV have an increased risk of COVID-19 infection. People with advanced AIDS disease - those with a low CD4 count and high viral load and those who are not taking antiretroviral treatment (ART) - have an increased risk of infections in general. It is unknown if the immunosuppression caused by HIV will put a person at greater risk of COVID-19 and, for this reason and until more is known, additional precautions for all people with advanced HIV or poorly controlled HIV should be employed.

Similarly, there is no evidence that the risk of infection is different among people living with HIV who are clinically and immunologically stable on antiretroviral treatment when compared with the general population. Some people living with HIV may have known risk factors for COVID-19 complications such as diabetes, hypertension and other noncommunicable diseases and as such may have increased risk of COVID-19 unrelated to HIV.

People living with HIV should protect themselves (and those around them) from acquiring COVID-19 employing the same basic protective measures recommended for everyone. These include:

- Washing hands frequently and thoroughly cleaning with soap and water, or using an alcohol-based hand rub to kill viruses that may be on people's hands.
- Maintaining social distancing (at least one metre/ three feet) between people, and especially anyone who is coughing or sneezing, is critical to avoid breathing in droplets.
- Avoiding touching eyes, nose and mouth as, once contaminated, hands can transfer the virus to eyes, nose, or mouth. From there, the virus can enter the body.
- Practicing respiratory hygiene covering mouth and nose with bent elbow or tissue when coughing or sneezing and then disposing of the used tissue immediately.
- Staying home if you feel unwell. If you have a fever, cough and difficulty breathing, call your health provider to seek medical attention. Follow the directions of your local health authority.

Additionally, people living with HIV can prepare for a possible COVID-19 epidemic in their country by taking the following five actions:

- 1 Ensure ample supply of ART. It is recommended to have at least 30 days' supply available at all times.
- 2 If you suffer from any other illness like hypertension, lung or heart disease, asthma, diabetes,

tuberculosis, malaria, or if you have any other underlying health condition, make sure to have all the medications you need to stay healthy in good supply. Now is the time to make sure your underlying conditions are as controlled as possible and that you are as healthy as you can be.

- 3 If you can, keep vaccinations up to date, especially vaccinations against respiratory illnesses like influenza and bacterial pneumonia.
- 4 Establish a plan for clinical care should you need it, especially if you are asked to self-isolate or if you are quarantined. Depending on where you live you might consider seeking medical care via the phone, or using telemedicine options (for instance through physician online portals or live video).
- 5 Maintain a good social network but remotely. Reach out to your friends and family. Being connected to people around you is one of the most important things you can do to prepare for, respond to, and recover from an emergency. Social contact also helps us stay mentally healthy and fight boredom.

Given that COVID-19 prevention measures might force people to spend long periods of time at home, it is important to learn how to care for your own mental health. It is normal to feel sad, distressed, worried, confused, scared or angry during a crisis. People living with HIV may experience increased levels of stress or anxiety. If this happens, talk to people you trust, contact your friends and family. If you feel overwhelmed, consider talking to a health worker, a social worker or another trusted person in your community (e.g. religious leader or community elder).

To maintain good mental health during an epidemic, also consider the following tips:

- Exercise daily (e.g. yoga, tai chi, stretching) and try to maintain a healthy lifestyle (including a proper diet, sleep, exercise and social contact with loved ones at home, even virtually), especially if you must stay at home.
- Reduce the time spent looking for information (1-2 times a day, rather than every hour).
- Reduce the time spent listening at upsetting media coverage and looking at fearful images on TV.
- Draw on skills that you have used in the past during difficult times to manage your emotions during this outbreak.

For more information about COVID-19 and HIV see this [UNAIDS article](#) and the UN Inter Agency Standing Committee Briefing [Note](#).

SECTION 3

POSSIBLE IMPACT OF COVID-19 ON MARGINALISED POPULATIONS

Miss Diamond pageant, organised by Guyana Trans United.



© Jason Florio for Frontline AIDS

MARGINALISED POPULATIONS

Marginalised populations are populations most at risk of and most affected by HIV. These populations face a number of barriers in their access to and sustained uptake of HIV prevention, treatment and care. These barriers also influence their access to health services including COVID-19 screening, testing and treatment. Beyond access to health, sex workers, men who have sex with men and gay men, trans and gender diverse people, and people who use drugs are often criminalised and/or disproportionately targeted by punitive laws and regulations.

COVID-19 regulations have exacerbated the many challenges that marginalised people face – sex workers and their families are without any income; people who use drugs (PWUD) are facing severe health risks from withdrawal and increased risk in securing access to illicit drugs; and lesbian, gay, bisexual and transgender (LGBT) populations are confined to their homes where they may face violence. Structural factors inhibit marginalised populations' ability to protect themselves from public health (and other) crises and, for the most part, these populations are over-represented in economically marginalised, socially isolated, excluded and invisible groups.

The imperative to remove punitive laws and regulations that target marginalised populations is more urgent than ever. They are stigmatising and discriminatory, and their continuation makes it difficult to change attitudes and behaviours that impede progress to ending AIDS. While some countries have taken the laudable step to release non-violent offenders from overcrowded prisons, the laws that result in the arrest and incarceration of drug users, sex workers and other marginalised people remain in place.

COVID-19 and the lockdown measures taken in many countries have caused essential HIV prevention, testing and treatment services to be closed down, severely restricted or much less accessible. Opioid substitution treatment (OST) centres in Maputo, Mozambique, and Nairobi, Kenya, have stopped inducting new clients and current clients still have to come to the clinic on a daily basis, despite reduced transport services and other lockdown measures. In Kampala, Uganda, transport options have also severely limited access to HIV prevention and treatment services, while the planned start of OST has been delayed. In Nigeria, disruptions in the supply chain have delayed the start of the first needle and syringe programmes (NSP). In South Africa, TB testing and case finding have significantly reduced.

While many countries have managed to issue extended supplies of treatment to marginalised populations, the impact of COVID-19 regulations has resulted in displacement and it is a concern that many people may be lost to follow up as their three month supply of medication runs out. In Indonesia, even though multi-month dispensing is allowed, people living with HIV are still unable to access ART weekly in some places due to stock-outs. Due to these and other disruptions, a spike in new HIV infections is expected as well as a possible deterioration in the health of people whose ART and TB treatment has been interrupted. It is therefore essential to continue to support, resource and scale up community-led peer-driven services to reach marginalised populations with HIV and TB prevention, treatment and care, and to ensure these services are integrated with COVID-19 responses where appropriate.

Recommendations:

- 1 End punitive laws and criminalisation – decriminalise adult consensual sex work, consensual sex between adults of the same sex, criminalisation of HIV transmission and punitive laws against drug use.
- 2 Support community-based, peer-driven services and ensure that community health workers have access to PPE, and are recognised as essential workers.
- 3 Support efforts to build wider referral networks, more flexible and longer term treatment regimens that enable mobile populations to collect or refill their medication.
- 4 Increase flexibility in grant-making to allow for greater agility of responses.
- 5 Support advocacy efforts of sex worker, PWUD and LGBT organisations to ensure they are included in decision making structures on COVID-19 responses, for example in the development of regulations and health system spending, and inclusion of HIV actors when the cluster system is activated for humanitarian emergency response.
- 6 Marginalised populations must be specifically included in any social relief measures, such as but not limited to the distribution of food relief, water and sanitation supplies and other basic services.
- 7 Support marginalised populations to document human rights abuses and to develop advocacy strategies in response.
- 8 Focus on those furthest behind in the HIV response first. People who sell sex, trans and gender non-binary people, men who have sex with men and gay men, and people who use drugs must be prioritised in service delivery efforts. Any legal and regulatory efforts to limit COVID-19 infections must not disproportionately affect or target these populations or cause them harm.

ADOLESCENT GIRLS AND YOUNG WOMEN

Adolescent girls and young women have existing vulnerabilities to HIV (both biologically and socially), and are disproportionately impacted by HIV.⁶ Gender norms restrict adolescent girls and young women's choices and agency regarding their sexual and reproductive health and rights^{7,8}. These include limited access to

comprehensive sexuality education,⁹ high levels of coercion in sexual debut,¹⁰ limited autonomy to access services in a confidential way and gender-based violence among others. For women living with HIV, gender norms might also restrict access to and availability of treatment for co-morbidities such as cervical cancer.

The COVID-19 crisis has created additional constraints for adolescent girls and young women that intersect with gender norms and HIV vulnerability. For example, the interruption of peer education and SRHR outreach, in combination with limited transport options, might further limit women's access to information and services which can exacerbate unwanted pregnancies, untreated sexually transmitted infections (STIs), and HIV acquisition. Equally, treatment support networks for ART adherence might have been disrupted, caregiving responsibilities have probably increased, and for many young women working in the informal sectors, COVID-19 has meant loss of income and food insecurity. In some countries, lockdowns have also resulted in reported increases in domestic violence and intimate partner violence, both of which contribute to HIV acquisition for women as well as impacting on SRHR and mental health.

Please see sections on **caregivers (formal and informal)**, **domestic and intimate partner violence**, **sexual and reproductive health and rights (SRHR)**, and **economic justice** for more ways in which adolescent girls and young women have been affected.

Recommendations:

- 1 Provision of data bundles to adolescent girls and young women to ensure they can continue to access peer support services over the phone.¹¹
- 2 Meaningful involvement of adolescent girls and young women in decision making spaces to ensure that re-programming around COVID-19 takes into account their voices, needs and lived realities.
- 3 For parents and caregivers, create a safe space at home through love and support, strengthening family relations and paying attention to the doubts, fears and worries of adolescent girls and boys during this time.^{12,13}
- 4 For parents and caregivers, role modelling of equitable share of household chores to ensure that adolescent boys and young men contribute as much as adolescent girls and young women.¹⁴

⁶ UNAIDS (2019) Women and HIV – A spotlight on adolescent girls and young women. <https://www.unaids.org/en/resources/documents/2019/women-and-hiv>

⁷ UNFPA (2012) From Childhood to Womanhood: Meeting the Sexual and Reproductive Health Needs of Adolescent girls. <https://www.unfpa.org/sites/default/files/resource-pdf/EN-SRH%20fact%20sheet-Adolescent.pdf>

⁸ Dessalegn Y et al (2019) Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind? (2019) <https://gh.bmj.com/content/bmjgh/5/1/e002231.full.pdf>

⁹ UNESCO (2016) Strengthening Education in West and Central Africa by Improving Learner's Sexual and Reproductive Health. <https://unesdoc.unesco.org/ark:/48223/pf0000247151>

¹⁰ Ann M. Moore, Kofi Awusabo-Asare, [...], and Akwasi Kumi-Kyereme (2007) Coerced First Sex among Adolescent Girls in Sub-Saharan Africa: Prevalence and Context. African Journal of Reproductive Health. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367148/>

¹¹ Africaid supporting CATS with data bundles to continue peer support. Frontline AIDS (2020) READY Newsletter #7 COVID-19 Edition Part 1. <https://frontlineaids.org/wp-content/uploads/2019/11/READY-newsletter-7-part-1.pdf>

¹² Frontline AIDS (2020) COVID-19 and Gender: A Guide for Parents and Caregivers. <https://frontlineaids.org/wp-content/uploads/2020/06/COVID-19-and-gender-parents-A4-folded-to-A5-Web-ready-single-pages.pdf>

¹³ REPSSI calling for more involvement of men in the household. Frontline AIDS (2020) READY Newsletter #7 COVID-19 Edition Part 2. <https://frontlineaids.org/wp-content/uploads/2020/06/READY-newsletter-7-part-2.pdf>

¹⁴ Frontline AIDS (2020) COVID-19 and Gender: A Guide for Parents and Caregivers. <https://frontlineaids.org/wp-content/uploads/2020/06/COVID-19-and-gender-parents-A4-folded-to-A5-Web-ready-single-pages.pdf>

- 5 Support to parents and/or provision of equipment/ data bundles for adolescent girls and young women to stay engaged with the education system if schools have been disrupted.¹⁵
- 6 Continuation of SRHR information services (in person or virtual) for adolescent girls and boys, and young men and young women, in age-appropriate formats to reinforce messages of consent, joint decision making and safe sex.¹⁶
- 7 Continuation of crucial child abuse and domestic violence services (in person or virtual) like helplines, so that adolescent girls and young women can continue to report on violence and receive support such as counselling or shelter.¹⁷

Organisations' continued efforts to reach adolescent girls and young women

Examples include:

- **Frontline AIDS**, through the READY programme, creating age-appropriate information materials on COVID-19 and the gendered effects of COVID-19.
- Peer educators from **Youth Alive in Uganda** continuing to reach out to their peers via phone.
- **PEERU in Uganda** have equipped peer leaders with PPE and bicycles to collect antiretrovirals (ARVs) for other young people.
- **Africaid Zvandiri in Zimbabwe** has transformed its support groups into e-support groups for caregivers and children and young people living with HIV. Through WhatsApp, caregivers get support around COVID-19, access to chronic medication, coping with stress, anxiety and depression, GBV, ART adherence and linkages to food insecurity and protection services.
- **AMSED in Morocco** has started to combine COVID-19 education into its TB and HIV response for adolescent girls and young women.

CAREGIVERS (FORMAL AND INFORMAL)

In normal circumstances, women and girls shoulder a disproportionate burden of care,¹⁸ and this is exacerbated during health crises such as Ebola and COVID-19.¹⁹ Globally, 70% of the formal healthcare work force are women, so they are at greater risk of contracting COVID-19 through their work. Informally, women also do more childcare, housework and caregiving in the family setting than men, as well as caring for

elderly and sick family members. This could become doubly burdensome with lockdowns, children home from school, travel and shopping restrictions, and in trying to implement hygiene practices, or caring for others.²⁰ Women living with HIV do untold amounts of unpaid community mobilisation and peer support work²¹ and, during lockdowns, they are adapting their work to the emergency situation²² (see box below). The extension of women's caregiving roles during COVID-19 has come at the expense of other roles including their ability to earn an income.²³

Recommendations:

- 1 Ensure the availability of appropriate personal protective equipment, including for community health volunteers and peer supporters in clinics, institutional care and community settings. Ensure a supply in a range of fittings including suitable sizing for women.
- 2 Support HIV networks to develop and share tailored, gendered and HIV-sensitive information on COVID-19, including clear accurate information and messages about how COVID-19 is spread and how individuals, families and communities (including those living with and affected by HIV) can protect themselves and others. See for example the work of Alliance for Public Health in Ukraine who are providing information and advice on a human rights-based response to harm reduction during the pandemic.²⁴
- 3 Counter misinformation and myths about how COVID-19 spreads and how it can be prevented or treated, supporting organisations of people living with and affected by HIV to do so in each context that puts them at particular risk.
- 4 Support and fund networks of women living with and vulnerable to HIV working to address inequitable gender norms and the burden of care on women, so they can continue and adapt their work to provide care and/or encourage equitable childcare and domestic division of labour among all household members during the COVID-19 crisis and beyond.
- 5 Provide and advocate for flexible working arrangements for employees working from home, especially single parents/carers and those providing peer support to people living with and vulnerable to HIV. Extend childcare, for example through school places for parent/carer workers and allowing friends, families and neighbours to help parents they know.
- 6 Revalue care to ensure financial security for those performing care roles (who are predominantly women) and HIV peer support roles, through pay increases or basic income/minimum income guarantees as well as trust-based funding for organisations providing peer support.

¹⁵ Ibid.

¹⁶ Frontline AIDS (2020) COVID-19 and Gender: A Guide for Adolescents and Young people. <https://frontlineaids.org/wp-content/uploads/2020/06/Covid-19-and-gender-young-people-A4-folded-to-A5-web-ready-single-page.pdf>

¹⁷ Ibid.

¹⁸ OECD (2014) Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes - <https://www.oecd.org/dev/development-gender/Unpaid-care-work.pdf>

¹⁹ OECD (2020) Women at the core of the fight against COVID-19 crisis <https://www.oecd.org/coronavirus/policy-responses/women-at-the-core-of-the-fight-against-covid-19-crisis/>

²⁰ Ibid.

²¹ Salamander Trust et al (2020) The WHAVE Podcast Paper #1. Fund what works:

fund community-led women's rights organisations for an effective, ethical and sustainable response to HIV https://salamandertrust.net/wp-content/uploads/2019/02/20200331_The_WHAVE_paper1_Funding_Final.pdf

²² ICW, GNP+ and YP+ (2020) Positive Living in the Time of Covid-19 <https://www.gnpplus.net/assets/Positive-Women-Living-in-the-time-of-COVID-19-Newsletter-4-May-compressed.pdf>

²³ OECD (2020) Women at the core of the fight against COVID-19 crisis <http://www.oecd.org/coronavirus/policy-responses/women-at-the-core-of-the-fight-against-covid-19-crisis-553a8269/>

²⁴ APH website- <http://aph.org.ua/en/category/news/>

SECTION 4

TECHNICAL GUIDANCE TO MITIGATE THE IMPACT OF COVID-19

Youth group in Ethiopia handing out information leaflets to encourage HIV testing.



© Sheikh Rajibul Islam for Frontline AIDS

HIV PREVENTION

More than 17 million new HIV infections between 2010 and 2018 are telling us that we failed at HIV prevention. Over the last three years, the Global Prevention Coalition - established to reenergise the global prevention response - has worked to identify and address the main barriers experienced by countries in implementing a comprehensive prevention response. There is a lot of HIV prevention work that needs doing now, but COVID-19 risks destroying the momentum and the focus.

The COVID-19 pandemic and national responses are constantly changing and they will continue to do so as countries move through the different stages of the epidemic. This will require frequent assessment of the needs of people living with HIV, key populations and other marginalised groups, including adolescent girls and young women and their male partners in high HIV burden settings. These groups may be affected by COVID-19, but they also may be affected more widely by COVID-19 response measures, disruptions in HIV and other health services, loss of livelihoods and, importantly, by new aspects of discrimination.

During this unprecedented period, it's clearer than ever communities have a critical role to play in sustaining services and keeping people safe. Since the earliest days, communities and community organisations have been on the frontline of the HIV response, and already Frontline AIDS partners are adapting to protect people living with HIV and those most at risk from COVID-19.

Community organisations and networks, especially those run for and by key populations, need to be mobilised to provide support on both HIV and COVID-19 prevention.

Where community-led approaches can no longer be used, community engagement could be achieved through the expansion of online programmes and social media platforms (see also the specific recommendation below).

At the same time, global, regional and national HIV prevention advocacy needs to be strengthened and amplified. The HIV community must organise and advocate together to ensure that HIV prevention stays on the agenda, politically and financially.

This section highlights the critical actions and temporary modifications to HIV prevention programming that should be considered to prevent and mitigate the impact of COVID-19. The following recommendations have been adapted from the brief developed by the Global Prevention Coalition, *Maintaining and prioritizing HIV prevention services in the time of COVID-19*:

- 1 Leadership and financing - keep all major epidemics at the top of the global health agenda.** Resources are scarce but this is not the moment to shift the spotlight from any of the major epidemics of our time. COVID-19 presents a new challenge requiring new - not re-allocated - resources, renewed energy and robust enlightened leadership. Reducing resources for HIV prevention in the face of COVID-19 will only exacerbate the current HIV prevention crisis and threaten the gains that have been achieved so far. The universal right to health demands a determined focus on funding comprehensive, integrated and sustained approaches to existing, new and - inevitably - future global health challenges.

- 2 Support supply chain continuity for critical HIV prevention and contraception commodities. The COVID-19 response has absorbed resources, disrupted supplies and even led to reduced production of some health products such as condoms. These types of disruptions and delays will continue for the foreseeable future. It is therefore critical to include key HIV prevention supplies alongside HIV testing kits, antiretroviral medicines and contraceptive supplies as part of essential commodity security plans. This includes male and female condoms, lubricants, harm reduction commodities including methadone, buprenorphine and sterile injecting equipment, and contraceptives.
- 3 Deliver key HIV prevention and contraception services and commodities safely. This could include:
 - Multi-month prescribing (MMP) and dispensing (MMD) of antiretroviral medicines in the context of COVID-19 have already been issued by the World Health Organization. MMP and MMD also need to be considered for condoms, lubricants, pre-exposure prophylaxis (PrEP), harm reduction commodities including OST, take-home doses and contraceptives.
 - Delivery of condoms and harm reduction commodities through community service points that can support physical distancing, such as dispensers or other collection points.
 - Provision of condoms, contraceptives, HIV self-tests and other non-therapeutic/pharmaceutical supplies through vending machines, pharmacies and food retail outlets that remain open during the COVID-19 response, and through online ordering (also see #7).
 - Amending policies that may restrict the number of needle-syringes, condoms and/or lubricants that can be dispensed per person at one time.
 - Take-home doses for OST can be considered. Many countries are doing this already for periods of one week to two months, including for new patients. Given their inability to access street drugs, more people are going through withdrawal and may need treatment. Some countries are opening their OST programmes to include new patients for this reason.
 - Identifying new opportunities for delivering essential prevention products. For example, as community activities are often being restricted or stopped in the first wave of the COVID-19 response, emergency support services are being developed such as food deliveries for vulnerable households or the elderly and infirm. Linking with these community services for the delivery of condoms and other HIV prevention commodities may be possible.
- 4 Consider a temporary delay and repurposing of some prevention interventions such as voluntary medical male circumcision (VMMC) programmes and PrEP programmes. VMMC will often need to be delayed while mass gatherings are reduced. Decisions regarding the provision of PrEP services will likely be made at the local level. It is already recommended that people taking PrEP should be supplied with three months of tenofovir/emtricitabine (TDF/FTC). Longer term prescriptions have not been recommended because of the need for HIV testing. However, some flexibility could be considered, including through the provision of blood-based self-tests during PrEP continuation.
- 5 Provide community HIV prevention messaging and support making full use of virtual online channels and platforms. This could include interactive platforms, virtual counselling by peers or health workers, and video-observed options for PrEP, ART and OST. Online ordering of free or low-cost products such as condoms, needle-syringes or HIV self-tests could be considered in many settings. Associated online services could include violence prevention responses and mental health support.
- 6 Use the COVID-19 response to continue expanding, synergising and innovating in HIV prevention. The context of each country may provide opportunities for new synergies between COVID-19 and HIV responses. Can condoms and HIV self-tests be delivered alongside COVID-19 testing services at this time? Can information platforms be linked? Can the COVID-19 response provide new channels for communicating about HIV prevention? Preventing COVID-19, HIV and other infectious diseases jointly is a new area that will benefit from further learning.
- 7 Innovate in the time of physical distancing - consider all avenues to deliver prevention in the virtual space and, where this is not possible, consider innovation in community-led prevention approaches (such as secondary distribution of safer injection kits and peer distribution of ARVs). Take note that many people who might be most at risk, often do not have access to virtual spaces or safe spaces (especially since lockdowns have forced the closure of non-essential services).

HARM REDUCTION

Harm reduction is already extremely underfunded and is controversial in many countries. The current COVID-19 crisis therefore is the perfect opportunity for governments not only to further criminalise people who use drugs, but also to stall or disrupt essential harm reduction services, notably NSP and OST, known to be the most effective and cost-effective interventions to stop the spread of HIV among people who inject drugs.²⁵

Some community groups have successfully adapted to COVID-19. People who use drugs on the coast of Kenya are receiving methadone to take home. Though communities had been advocating for this for years, this was unthinkable until COVID-19 came along. In other countries such as Myanmar, people who had been incarcerated for non-violent drug and other crimes have been released from prison in an attempt to avoid COVID-19 outbreaks in these settings. It is important that such gains are not lost once the threat of and measures against COVID-19 are over.

Recommendations

During – and after – the COVID-19 pandemic it is of utmost importance to:

- 1 Consider harm reduction services as essential services.
- 2 Engage communities of people who use drugs, recognise them as essential workers and provide them with protective materials and the means of communication and transport to carry out their work.
- 3 Facilitate peer (secondary) distribution of safer injection kits and of ARVs through community ART groups.²⁶
- 4 Provide ARVs and safer injection kits for longer periods.
- 5 Deprioritise enforcement of laws prohibiting drug use and possession of drugs for personal use.
- 6 Release people who have been incarcerated for non-violent drug offences to decongest overcrowded prisons and jails.
- 7 Ensure people who use drugs have access to tailored information on how to protect themselves from COVID-19²⁷ as well as to essentials to protect themselves, for example soap and water and/or sanitiser in hotspots where drugs are procured and consumed, face masks for people who use drugs.

- 8 Advocate for increased induction of people on OST as street opioids may become scarcer and more adulterated.
- 9 Advocate for take-home doses of methadone and buprenorphine for clients who are stable on their dosage.
- 10 Provide food to people who use drugs who have lost their means of income.
- 11 Advocate for safe and voluntary shelter for people who use drugs who are homeless or don't have a safe place to stay.
- 12 Advocate for the distribution of naloxone among people who use drugs to avoid the risk of opioid overdose deaths when opiates become more available after lockdown.

HIV CONTINUUM OF CARE: HIV TREATMENT AND CARE SERVICES

The COVID-19 pandemic presents several barriers and challenges to the HIV care continuum. The implementation of social distancing, quarantines and other social containment measures can drastically limit (when not completely obliterate) regular access to HIV testing, treatment and care and routine HIV monitoring services.

Moreover, the COVID-19 epidemic might create or exacerbate existing needs of people living with HIV. For instance, job and income insecurity caused by lockdowns and quarantine measures can heavily impact the livelihood and nutrition needs of people living with HIV.

Similarly, people living with HIV with other health needs might find it difficult or impossible to access health facilities and hospitals; medical appointments might be cancelled or delayed because resources are focused on treating patients with COVID-19 or on prevention. Regular assessments of the needs and conditions of people living with HIV in areas affected by a COVID-19 epidemic are therefore highly recommended.

Preserving HIV care continuum services during the COVID-19 pandemic is vital for the wellbeing of people living with HIV. Increased efforts are needed to rethink and adapt service provision so that its continuation can be assured during a COVID-19 epidemic. Innovative products, technologies, policies and approaches that can support the delivery of care continuum services in the challenging circumstances imposed by COVID-19 should be fully used and prioritised.

²⁵ WHO (2016) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations 2016 update <https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

²⁶ Differentiated Service Delivery (2020) Client-Managed Groups <https://www.differentiatedcare.org/Models/ClientManagedGroup>

²⁷ INPUD (2020) COVID-19: Advice for People who Use Drugs <https://www.inpud.net/sites/default/files/COVID-19%20leaflet%20-%20UK.pdf>

Communities of people living with HIV and community-based organisations working for and with people living with HIV have an essential role to play in preserving HIV care continuum services. Their ability to continue working even under lockdown measures should be guaranteed and protected.

There are several more practical recommendations that HIV service planners and implementers - formal and informal caregivers, policy makers, community-based organisations - can follow in order to prepare for and mitigate the impact of COVID-19 on the HIV care continuum. These recommendations have been adapted from FHI 360's *Strategic Considerations for Mitigating the Impact of COVID-19 on Key Population-Focused HIV Programs*:

- 1** Ensure the provision of HIV testing, treatment and care services can take place considering social distancing measures. This might mean:
 - Preparing to contact and consult beneficiaries via phone, and other media, rather than on a physical basis.
 - Preparing outreach workers to work from home or remotely; giving them access to devices such as tablets/phones, airtime and/or mobile data plans to stay connected with their civil society organisation (CSO), programme support team, and beneficiaries in their cohort.
 - Preparing clinics to adopt systems to book appointments to better manage the flow of patients.
 - Helping clinics procure and use devices like tablets and smartphones, and mobile data plans to offer telemedicine services such as providing routine counselling and ART adherence support.
- 2** Where possible, continue the provision of community-based outreach services. If any physical peer outreach is still possible and advisable, reduce physical contact and large gatherings. For example, reduce frequency of outreach, limit maximum number of participants, or increase the number of service delivery points to avoid overcrowding and, where possible, consider prioritising clients at high risk of COVID-19 to receive virtual case management and to remain at home.
- 3** Explore the use of social network outreach to maintain contact with beneficiaries online, and reduce or end physical or hot spot-based outreach. Maximise use of phone calls, SMS, WhatsApp and other social media apps for audiences with better internet connectivity.
- 4** Continue the routine provision of facility-based HIV testing and, where possible, in community centres (safe spaces and drop-in). Where HIV testing is

routinely offered, such as in the context of antenatal care in high HIV burden settings, service delivery should continue.

- 5** Expand access to HIV self-testing which is an innovative way to provide access to testing safely by reducing the need for contact with others and by decreasing workload in health facilities. National self-testing programmes can be adapted and expanded to increase access to HIV testing with distribution of self-test kits through grocery stores, pharmacies and community sites where physical distancing can be maintained, as well as through clinical facilities. In countries that still have regulatory and policy barriers, it could be the right moment to advocate for HIV self-testing, a strategy that has the potential to reduce the burden on the health system.
- 6** Maintain and support access to HIV medicines. Support supply chain continuity for critical HIV medicines and HIV commodities. Delays and disruptions caused by the COVID-19 epidemic might affect the availability of critical HIV treatment and care health products. It is therefore vital to include all HIV medicines and supplies alongside HIV testing kits as part of essential commodity security plans. Testing, treatment and care commodities and services should be delivered safely. This could include rapidly scaling up three to six multi-month prescribing and dispensing of antiretroviral medicines. MMP and MMD are also recommended for any other co-morbidity medications, including TB preventive therapy, anti-TB drugs, and co-trimoxazole (CPT). Guidelines about this have already been issued by the World Health Organization.
- 7** Operationalise other adherence support measures such as the use of text messaging, online case management, etc.
- 8** Consider delaying routine viral load testing until the capacity of laboratory services normalises (but continue to provide ongoing support for adherence). Certain groups of PLHIV should be prioritised for viral load testing during this time. They include those who develop opportunistic infections, those with suspected treatment failure after enhanced adherence support, those who are yet to be virally suppressed, and pregnant women.
- 9** Consider systems for viral load sample collection at the community level such as the use of dry blood spot home collection, and testing at private facilities/laboratories. Prioritise viral load testing for unstable clients, especially those who were recently initiated on ART and eligible for viral load testing, and those with adherence challenges.

DOMESTIC AND INTIMATE PARTNER VIOLENCE (IPV)

There have been many reports of increased domestic or intimate partner violence linked to physical distancing/isolation or 'stay at home' responses.²⁸ According to the United Nations Population Fund (UNFPA), at least 15 million more cases of domestic violence are predicted around the world this year as a result of pandemic restrictions.²⁹ The World Health Organization advises policy makers to include essential services for violence against women in preparedness and response plans for the COVID-19 pandemic.³⁰

There is already a strong evidence base showing how intimate partner violence increases the vulnerability of individuals to HIV, particularly women and girls, and how HIV increases their vulnerability to violence. Domestic violence and IPV are also a barrier to uptake of HIV-related services and treatment adherence.³¹

1 Addressing GBV and domestic violence in the COVID-19 response

It is important that GBV and HIV-related services are adapted to COVID-19 restrictions, preserving confidentiality and making them available and accessible to women and girls and people from sexual and gender minorities, including those with disabilities.

Considerations for making COVID-19 GBV and domestic violence responses HIV-sensitive:

- Friendly and non-judgemental responses that make people living with HIV feel safe, confident that if they disclose their status their confidentiality will be maintained, and able to access the HIV treatment they need.
- GBV and domestic violence responses also take into account the needs and priorities of sexual and gender minorities and others vulnerable to HIV, and provide respectful and friendly care.
- Linkages and referrals to friendly and non-judgemental SRHR and HIV services which are adapted to the current situation.
- Make post-exposure prophylaxis (PEP) and other relevant commodities and services available during COVID-19 restrictions to those who have experienced sexual violence and are concerned about possible HIV exposure.
- Ensure confidential access to HIV-related treatment and advice is maintained, including in domestic violence shelters and refuges. HIV services including health, psychosocial and peer support services should also have information on GBV and domestic violence, and be able to confidently refer people living with HIV to respectful and friendly services.

However, reports of spikes in gender-based violence in the intimate/private sphere are not universal. South Africa, well known for its appalling rates of violence against girls and women, saw a significant drop in reporting, and trauma cases seen in hospitals. More inquiry is needed but [this article](#) by the Institute for Security Studies has some theories; [this story](#) also attempted to get to the bottom of the data.

Recommendations:

- 1 Ensure domestic violence services are included as an essential service package in the COVID-19 response. Fund them and identify ways to make them safely accessible in the context of physical distancing measures as recommended by the World Health Organization³², and include linkages between GBV, HIV- and SRHR-related services. This includes:
 - Prioritising and funding local and national domestic violence emergency response mechanisms such as refuges/safe houses and hotlines.
 - Ensuring that information on HIV and the interlinkages with violence is available to all providers, along with referral pathways to relevant services. Make sure that such service and information provision is adapted to the COVID-19 situation, for example ensuring accessible digital services, no-phone and low and no-tech contact options³³ for those experiencing or at risk from domestic violence.
 - The provision of medical commodities including PEP and emergency contraception through community pharmacies and other community services is key and should be supported.
- 2 Prioritise and fund a comprehensive response to domestic violence that is adapted to COVID-19 restrictions and that responds to the needs of people living with and vulnerable to HIV. This includes both domestic violence and HIV helplines, online forums, legal support (including legal aid), child care support, housing/shelter, transport, financial support, medical response (including ongoing and confidential supply of ARVs to people living with HIV), and psychosocial support for survivors of violence.

²⁸ Ford, L. (Tue 28 Apr 2020) 'Calamitous': domestic violence set to soar by 20% during global lockdown The Guardian - <https://www.theguardian.com/global-development/2020/apr/28/calamitous-domestic-violence-set-to-soar-by-20-during-global-lockdown-coronavirus>

²⁹ Ibid.

³⁰ WHO (2020) Q&A: Violence against women during COVID-19 <https://www.who.int/news-room/q-a-detail/violence-against-women-during-covid-19>

³¹ World Health Organization (2013) 16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool. https://www.who.int/reproductivehealth/publications/violence/yaw_hiv_epidemic/en/

³² WHO (April 7, 2020) COVID-19 and violence against women: What the health sector/system can do. <https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf>

³³ Erskine (2020) Not just hotlines and mobile phones: GBV Service provision during COVID-19. UNICEF <https://www.unicef.org/media/68086/file/GBV%20Service%20Provision%20During%20COVID-19.pdf>

- 3 Conduct public awareness and media campaigns about the risk of intimate partner violence and other forms of GBV in the context of COVID-19 and the links to HIV (see Box 1).
- 4 Support women's, LGBT+ and HIV organisations to continue and adapt their violence prevention and response work to the current situation (see Box 2).

2 Southern women's rights organisations continued efforts to respond and prevent VAWG

Examples include:

- **Musasa in Zimbabwe**, who have expanded and adapted their helpline and whose shelters remain open, are working with other women's organisations including the Zimbabwe Women's Lawyers Association and the Adult Rape Clinic.
- In April, the **Association for Women's Sanctuary and Development** and other members of the **Ethiopia Network of Women's Shelters** opened an emergency shelter for those fleeing violence.
- **Education as Vaccine in Nigeria** creates safe online spaces to share SRHR and VAWG information and services as well as radio jingles, and also hosts helplines and campaigns to include VAWG services as essential services.³⁴
- In Zimbabwe, under the DREAMS initiative supported by PEPFAR through USAID Zimbabwe, **Family AIDS Caring Trust (FACT)** and partners are currently holding a child abuse and gender-based violence awareness campaign in Zimunya Burma Valley, Gimboki and Dangamvura residential areas of Mutare.

OTHER FORMS OF GENDER-BASED VIOLENCE (GBV)

The restrictions on movement imposed by national COVID-19 responses have also heightened the risk of other forms of GBV, which increases vulnerability to HIV among marginalised communities and impedes access to services for those living with HIV. Types of violence may include persecution (including by the police) of LGBT+ and sex worker communities; sex workers' greater risk of violence from clients as they have less negotiating power and safety networks have been eroded by social distancing; and violence against homeless people, people who use drugs, and other vulnerable and marginalised populations. The emptying of public spaces

and lack of public transport may increase vulnerability to non-partner violence, when making necessary excursions (to shops, market, work, collecting water, services, etc).³⁵

*"Living in a shelter for homeless people shouldn't be illegal. But according to Ugandan police, 23 people arrested on March 29 living at a shelter serving lesbian, gay, bisexual, and transgender (LGBT) people in Kampala are guilty of 'a negligent act likely to spread infection of disease,' as well as 'disobedience of lawful orders.'"*³⁶

Recommendations:

- 1 Ensure support to community-led organisations of women and sexual and gender minorities living with and vulnerable to HIV - including organisations of people who use drugs, sex workers, migrants and refugees, people with disabilities, and other marginalised populations - to continue and adapt their work to address GBV under COVID-19 restrictions and GBV generally.
- 2 Clear guidance provided by community-led organisations of women and marginalised populations living with and vulnerable to HIV for police, prison staff, health providers and other professionals, to ensure that no-one is blamed or criminalised for 'spreading coronavirus', and that everyone is treated respectfully regardless of their identity, and whether or not they are deemed to be 'breaking the rules' relating to COVID-19 restrictions.
- 3 Expand/strengthen community-based monitoring. More broadly, the COVID-19 response has already seen a rise in incidents and new forms of gender-based violence against marginalised and vulnerable populations, including violence from police/law enforcement agents, clients, other family members, members of the public.
- 4 An intersectional lens is needed to understand how the pandemic impacts on different populations, and the intersecting structural determinants of health.
- 5 Disaggregate data.
- 6 Strengthen human rights monitoring and response mechanisms relating to HIV and GBV under COVID-19 restrictions.
- 7 Guarantee equitable, accessible and non-judgmental access to online, telephone and (where possible) in-person HIV-sensitive GBV services and advice for women and marginalised populations living with and vulnerable to HIV. This should include people in institutional care settings, refugee camps, prisons and other detention centres.

³⁴ The first 3 examples are from the UK Gender and Development Network VAWG Working Group. IDC inquiry on COVID-19 and developing countries.

³⁵ Ghoshal, N (2020) Uganda LGBT Shelter Residents Arrested on COVID-19 Pretext. Human Rights Watch - <https://www.hrw.org/news/2020/04/03/uganda-lgbt-shelter-residents-arrested-covid-19-pretext>

³⁶ INPUD (2020) In the time of COVID-19: Civil Society Statement on COVID-19 and People who use Drugs <https://www.inpud.net/en/time-covid-19-civil-society-statement-covid-19-and-people-who-use-drugs>

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

The COVID-19 pandemic is having a major impact on the delivery of sexual and reproductive healthcare around the world. A survey by the International Planned Parenthood Federation (IPPF) shows that 5,633 static and mobile clinics and community-based care outlets have already closed because of the outbreak across 64 countries.³⁷

Experience of the Ebola crisis sounds a warning bell: *"During the 2013-2016 Ebola outbreak in West Africa, women in Sierra Leone were not only at risk due to Ebola: their access to essential reproductive care was also disrupted. This resulted in as many, if not more, pregnancy-related deaths than deaths from Ebola itself."*³⁸ During the COVID-19 pandemic, we are likely to see spikes in unintended pregnancies, unsafe abortion, and HIV and maternal mortality/morbidity due to lack of access to contraceptives and condoms, safe abortion care, post-abortion care, and maternal/obstetric care.³⁹ For example, media reports from South Africa describe the collapse of the maternity ward at Dora Nginza Hospital in Nelson Mandela Bay, in the Eastern Cape of South Africa, citing fear of COVID-19 transmission among health staff as the cause.⁴⁰

*"Some 47 million women in 114 low- and middle-income countries are projected to be unable to use modern contraceptives if the average lockdown, or COVID-19-related disruption, continues 6 months with major disruptions to [...] If the lockdown continues for 6 months and there are major service disruptions due to COVID-19, an additional 7 million unintended pregnancies are expected to occur."*⁴¹

In a number of countries, COVID-19 is being used to push back on provision of safe abortion services.⁴² Concerns have been raised that COVID-19 has placed an immense burden on the health systems and health workers in caring for the sick⁴³ and it is possible that those seeking much needed sexual and reproductive health (SRH) services could face increased discriminatory and neglectful behaviour, particularly those from marginalised populations.

³⁹ UNFPA, with contributions from Avenir Health, Johns Hopkins University (USA) and Victoria University (Australia), (27 April 2020) Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage: Interim Technical Note: Summary article - https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

⁴⁰ Daily Maverick (24 June 2020) Nelson Mandela Bay state maternity services near collapse as workers stay away <https://www.dailymaverick.co.za/article/2020-06-24-nelson-mandela-bay-state-maternity-services-near-collapse-as-workers-stay-away/amp/>

⁴¹ UNFPA, with contributions from Avenir Health, Johns Hopkins University (USA) and Victoria University (Australia), (27 April 2020) Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage: Interim Technical Note: Summary article - https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

⁴² IPPF (April 8, 2020) Failures to guarantee safe access to abortion endangers health of women, girls amid COVID-19 <https://www.ippf.org/news/failures-guarantee-safe-access-abortion-endangers-health-women-girls-amid-covid-19>

⁴³ WHO (April 7, 2020) COVID-19 and violence against women: What the health sector/system can do. <https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf>

- 8 Ensure that an analysis of the risk of violence and how to mitigate this underpins COVID-19 adaptations to ensure access to SRHR services and commodities including PrEP, PEP and ARVs, and distribution of condoms, lubricant and clean needles.
- 9 Emergency financial support and minimum income guarantees for all including women, sex workers of all genders, and others, to provide everyone with social protection and minimise the harm caused by physical distancing/stay at home measures.
- 10 Advocate for gender-based violence response services to be included in essential services.
- 11 Expand harm reduction approaches.

3 Recommendations for HIV-sensitive and gender-just COVID-19 responses

Many community-led organisations of women and marginalised populations living with HIV and vulnerable to HIV have made statements with recommendations for the COVID-19 response, at global and national levels. These include:

- A call to African leaders to accelerate action on COVID-19 from the **International Community of Women Living with HIV East Africa**
- **Global Network of Sex Work Projects and UNAIDS - Joint Statement: Sex workers must not be left behind in the response to COVID-19**
- In the midst of the global coronavirus outbreak, **Humsafar Trust - India's oldest LGBT+ organisation** - launched a social media campaign to highlight the discrimination, stigma and inequality faced by the transgender community.
- **BONELA calls For A Rights-Based Approach Amid COVID-19 Crisis.**
- **Letter to Dr Z L Mkhize Minister of Health National Department of Health, from the Sexual and Reproductive Justice Coalition**, requesting an 'unequivocal undertaking that sexual and reproductive health services, including access to abortion, is an essential medical service; and that women may continue to access such services from the state during the lockdown in a manner that is safe, free from violence and discrimination, and free from stigma.'

If you are a community-led organisation and have recommendations for a gender-just and HIV sensitive response to COVID-19, please get in touch and we will add them to this brief.

³⁷ IPPF (April 9, 2020) COVID-19 pandemic cuts access to sexual and reproductive healthcare for women around the world <https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world>

³⁸ Sochas L, Channon AA, Nam S (2017) 'Counting indirect crisis-related deaths in the context of a low-resilience: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone.' Health Policy Plan. 2017 Nov 1;32(suppl_3):iii32-iii39. <https://www.ncbi.nlm.nih.gov/pubmed/29149310>

Recommendations:

- 1 Ensure funding and support to community-led organisations - including organisations of women, LGBT+ people, people who use drugs, sex workers, migrants and refugees, people with disabilities, and other marginalised populations - to continue their work to address SRHR and adapt it to the COVID-19 restrictions.
- 2 Recognise and maintain SRHR services as essential life-saving services and adapt to the current situation under COVID-19 (see Box 4). Services and information must be HIV and gender-sensitive, treat everyone respectfully regardless of their identity, and follow recommendations from community-led organisations of women and marginalised populations living with and vulnerable to HIV. Guidance on linked SRH and HIV services during COVID-19 is urgently needed. Current information from UNAIDS, INGOs etc. does not cover this.⁴⁴

Some examples of organisations that have tailored their work on SRHR:

- In South Africa, the **Sexual and Reproductive Justice Coalition** has tailored its services and information provision on abortion, fertility planning, emergency contraception, conflict and violence and SRH to the COVID-19 situation.
- In Sri Lanka, IPPF's **Member Association Family Planning Association** has activated a hotline call centre called Happy Life to give directions for sexual and reproductive healthcare during this difficult period. It has also sent messages to all of its clients about ongoing family planning services and their contraceptives are available in over 5,000 pharmacies for the public to order. Under the curfew, FPASL provided 5,000 sanitary napkins to six quarantine centres run by the state for returning migrants, which includes many Sri Lankan students who have been stranded overseas.

4 Adapting SRHR and HIV services at a time of COVID-19

- Making available and promoting the use of self-care SRHR options such as home HIV⁴⁵ and STI tests, medical abortion pills,⁴⁶ and self-administered contraception including emergency contraception.
- Providing larger refills of ARVs⁴⁷ (six-month refills rather than one or three months) by delivery if possible, as well as adequate supplies of sterile needles, opioid substitution therapies, condoms, PrEP, gender-affirming hormone therapy and contraceptives.^{48 49}
- Ensuring menstrual products are available to all who need them and can be accessed even in lockdown.⁵⁰
- Adaptations to services, such as providing mobile clinic services by motorbike, with drivers equipped with PPE (as supported by Frontline AIDS Rapid Response Fund.)⁵¹



Satellite clinic in a brothel in Bangladesh, supporting sex workers' sexual and reproductive health and rights.

- 3 Maintain and fund peer support for ARV adherence, HIV and SRHR counselling, and psychosocial support through online or physically distanced visits. Ensuring safety of volunteers is paramount.
- 4 Provide emergency transport to maternal health services for pregnant women living with HIV, to ensure they can access antenatal care, and maternity and postnatal care including prevention of vertical transmission.
- 5 Ensure the safety of all SRH service providers, including when going to and from work in curfew and lockdown settings. Safety may be compromised by, for example, police over-interpreting curfew laws or by empty streets and lack of public transport.
- 6 Provide protective equipment for service providers and other key workers who need it in SRHR and HIV settings.
- 7 Support and promote existing online forums/apps/digital platforms for SRHR and HIV information, and use them to provide comprehensive sexuality education.

⁴⁴ For example, The Frontline AIDS' information note: COVID 19 and HIV', covers HIV treatment, and treatment for co-morbidities, but does not address SRHR for people living with HIV - <https://frontlineaids.org/wp-content/uploads/2020/03/COVID-19-HIV-Information-Note.pdf>; UNAIDS (19 MARCH 2020) What people living with HIV need to know about HIV and COVID-19- https://www.unaids.org/en/resources/documents/2020/HIV_COVID-19_brochure

⁴⁵ Jiang, H., Zhou, Y., & Tang, W. (2020). Maintaining HIV care during the COVID-19 pandemic. The Lancet HIV [https://www.thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018\(20\)30105-3.pdf](https://www.thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018(20)30105-3.pdf).

⁴⁶ Marie Stopes International (2020) Our response to the crisis <https://www.marie-stopes.org/covid-19/#responsehttps://www.marie-stopes.org/covid-19/#response>

⁴⁷ WHO (2020) Q&A: HIV, antiretrovirals and COVID-19 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-hiv-and-antiretrovirals>

⁴⁸ WHO (2020) Q&A: Contraception/Family planning and COVID-19 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/contraception-family-planning-and-covid-19>

⁴⁹ UNAIDS (2020) HIV and Covid-19 <https://www.unaids.org/en/resources/infographics/hiv-and-covid-19>

⁵⁰ UNICEF (2020) Mitigating the impacts of Covid-19 on menstrual health and hygiene <https://www.unicef.org/sites/default/files/2020-05/UNICEF-Brief-Mitigating-the-impacts-of-COVID-19-on-menstrual-health-and-hygiene.pdf>

⁵¹ Frontline AIDS (2020) Emergency appeal launched to increase funding for LGBT people impacted by Covid-19, as demand for support triples <https://frontlineaids.org/emergency-appeal-lgbt-people-covid-19/>

ECONOMIC JUSTICE

Women living with HIV and women in all their diversity from marginalised population groups, including LGBT+, sex workers and those who use drugs, experience economic injustice, insecure work, and low pay. Work in the informal sector and sex work becomes even more difficult under lockdown. This disruption to livelihoods will increase poverty, affecting health, well-being and access to basic needs and services. Furthermore, it will potentially exacerbate household conflicts and violence. As resources become scarcer, women and LGBT+ people may be at greater risk for experiencing economic injustice.⁵² Additionally, medical treatment for COVID-19 has the potential to cause enormous economic distress to people in contexts where healthcare is not free.⁵³ People should not be worrying about whether they can afford to pay for medical testing and treatment if they become ill with COVID-19 or any other condition. This crisis highlights the importance of universal health care which is free at point of use.

Recommendations:

- 1 COVID-19 emergency funds for marginalised groups who are living with or vulnerable to HIV, including undocumented immigrant women, domestic workers, women with disabilities, sex workers and sex trafficking survivors.
- 2 Universal basic income or minimum income guarantee to ensure that all people, regardless of employment status, HIV status, sexuality and gender identity, are able to cover their basic needs. This would contribute to ensuring that people in care and peer support roles are acknowledged and valued.
- 3 Decriminalisation of sex work and recognition of rights for sex workers, which would also ensure that sex workers are able to access social protection and welfare systems.
- 4 Universal health care which is free at point of use.

HUMAN RIGHTS

The fact that COVID-19 is a communicable disease of pandemic proportions and with serious health impacts makes the ability to balance rights with the need to protect public health ever more challenging. As a result, an ever-increasing range of human rights is being encroached upon by the advent of COVID-19, worsening pre-existing rights-related barriers to HIV related to stigma, discrimination and violence, exacerbating poverty and affecting the most basic humanitarian needs to food, water, shelter, sanitation and basic medical support.

The wide-ranging impact that COVID-19 has had has constrained the ability of rights-based organisations to operate effectively and sufficiently. An in-depth analysis of this impact has been documented from applications made for support from beneficiaries of the Rapid Response Fund (RRF) and from a survey from partners in countries where the REAct tool is being implemented. An in-depth analysis of this impact has been documented from applications made for support from beneficiaries of the Rapid Response Fund (RRF) and from a survey from partners in countries where the REAct tool is being implemented. These are the overarching human rights challenges experienced by individuals:

Supply chain disruptions and inundated government services: Difficulty accessing basic essential commodities and services like food, water and medical services. This could be as a result of movement restrictions that have disrupted supply chains, inundated state health facilities, or the closure/limited service available or accessible through community service providers.

Inability to earn a living, exacerbating poverty and financial dependence: Difficulty for individuals to continue earning an income or making a living which is putting people's livelihoods at risk, causing and exacerbating homelessness and deepening poverty, and increasing dependence on government provisions and community services.

Greater surveillance causing communities to be that much more reluctant to access government support: Fears around safety and security - including fears of being outed, arrested, physically harmed, or discriminated against by public service providers - are causing the populations with whom we work not to seek out or demand government-provided food parcels, services and other provisions.

Inequitable provision of government support and services to marginalised populations: Government services are not being provided equitably, with indications that criminalised groups of sex workers, LGBT community members or other marginalised communities are being denied access, or deliberately overlooked.

High demand for provisions from community organisations despite being under threat and having low capacity and resources: Community organisations are being inundated with requests for humanitarian support despite not always having the financial means to assist, or are constrained by limitations to movement. Human rights defenders and community service providers are experiencing hostility and threats of violence and police arrests in their attempts to help their communities.

⁵² UN (2020) Policy Brief: The Impact of COVID-19 on Women - <https://www.reliefweb.int/sites/reliefweb.int/files/resources/policy-brief-the-impact-of-covid-19-on-women-en.pdf>

⁵³ The Independent (March 21, 2020) 'Coronavirus: Woman charged \$35,000 by hospital for testing and treatment' <https://www.independent.co.uk/news/world/americas/coronavirus-latest-cost-us-healthcare-covid-19-treatment-health-insurance-a9415641.html>

Active enforcement of criminalisation of COVID-19 transmission plus criminalisation of key populations is causing significant rights violations: Criminalised and highly stigmatised groups of people who use drugs, sex workers, LGBT are being actively targeted and unlawfully arrested and detained, in some cases in large groups. The police and prison authorities have consistently violated individuals' substantive and procedural rights including to accessing medical care whilst in custody, to legal representation and to a speedy trial.

Police impunity intensified: State of emergency proclamations giving state actors extended powers has intensified unlawful and dangerous conduct by police in their treatment of communities, who report police harassment and violence, extortion, blackmail, unlawful entry of residences and raids of community organisations. Pre-existing challenges accessing legal representation, lack of protection from the police, and the limitations of court activities permitting only the most urgent court hearing have only served to intensify police impunity.

Intensified hostility towards marginalised populations by families and communities: Marginalised communities are also experiencing serious safety and security risks and human rights abuse within their own homes and communities. Individuals are stuck with hostile, stigmatising, and often violent family members from whom they cannot escape. Violence against women and children in the home is increasing. LGBT and sex workers are being blamed for spreading COVID-19 in their communities and being 'outed', harassed and physically harmed, with no means of protection.

Recommendations:

- 1 Empower communities with knowledge about COVID-19 and their rights. Communities need to know what they can expect from their state to ensure that the least restrictive means, in terms of the impact on their lives and livelihoods, to containing the epidemic will be employed, and how to access support, services and goods. Decisions on reprogramming the public health response to COVID-19 must be done with the involvement of and guidance by communities served by the response who know what is most needed and can help inform the prioritisation process.
- 2 Strengthen community legal literacy, and implement human rights data monitoring and response mechanisms. Communities are best placed to monitor and respond to human rights violations and hold governments to account. If communities are knowledgeable about the scope of state power they can regulate their own behaviour, and also serve as checks and balances on the exercise of that power. The data gathered can also be used to challenge and advocate for systemic change.

- 3 Establish safety and security preparedness and response protocols from programme design onward. The nature of the groups with whom we work, the issues that we discuss and the risks involved require us to build in safety and security risk mitigation and responses at every step of our programme cycle. The COVID-19 context has made this more important than ever.
- 4 Mobilise crisis management funding and establish a humanitarian service provider referral network. Where possible, invest re-programmed budgets towards supporting humanitarian needs. Where this is not possible, consider how these needs - if not met - might hinder or undermine the impact of programmes. Then build in strategies for overcoming these barriers into programming, such as by expanding referral networks to encompass humanitarian services providers. The ability to enjoy one's rights to health and access to HIV-related services depend on the ability to enjoy a whole host of other rights which have also been severely limited, such as to water, food and shelter. We must therefore find ways to respond to these basic needs as well. The RRF is exploring options for also meeting basic essential needs such as purchase of PPE for staff/volunteers to continue service provision, and supply of essential resources such as food or mobiles.
- 5 Denounce unfounded politically-driven, restrictive, stigmatising and punitive measures for meeting public health objectives. These include continued criminalisation of marginalised groups such as sex workers, LGBT and people who use drugs. They also include legislation criminalising transmission, whether enacted specifically for COVID-19, or more generally for communicable diseases. The application of criminal law for public health purposes undermines the response to COVID-19 as it did for HIV and perpetuates further human rights abuses. It discourages people from seeking out services and support and has created the conditions for police impunity: police violence, unlawful detentions and arrests, and police-instigated black mail and extortion. This legislation has also tended to directly target and disproportionately affect key and marginalised groups.

The Global Fund, committed to human rights and gender equality, has published [guidance on human rights](#) in the time of the pandemic. It provides some key messages, lessons, and makes recommendations from the HIV response that are applicable to COVID-19.

HYPERLINKED RESOURCES FOR REFERENCE

P5

ORGANISATION	LINKS
UN Women	https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response
Johns Hopkins School of Public Health - Gender and COVID-19 Working Group	https://docs.google.com/document/d/1_QfLS6Z9ow_1rPM-jdeKC_IQXTcwA8Z4kF8Z5CerZrk/edit
International Planned Parenthood Federation	https://www.ippf.org/covid19
Coalition of Feminists for Social Change (COFEM)	https://cofemsocialchange.org/covid-19-resources-for-vaw-mitigation-and-prevention-self-and-collective-care-assistance-and-more/
Gender and Development Network - Feminist Responses to COVID-19	https://gadnetwork.org/gadn-resources/feminist-responses-to-covid-19
Development Connections (DVCN)	https://dvcncampus.org/mod/data/view.php?id=1367

P3

Information note: COVID-19 and HIV..

<https://www.frontlineaids.org/resources/information-note-covid-19-and-hiv/>

P7

For more general information about COVID-19 see this WHO article.

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

P8

For more information about COVID-19 and HIV see this UNAIDS article

<https://www.unaids.org/en/covid19>

and the UN Inter Agency Standing Committee Briefing Note

<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psycho-social-support-emergency-settings/interim-briefing>

P15

These recommendations have been adapted from FHI 360's *Strategic Considerations for Mitigating the Impact of COVID-19 on Key Population-Focused HIV Programs*:

https://www.unaids.org/sites/default/files/media_asset/kp-strategic-considerations-covid19_en.pdf

P16

More inquiry is needed but this article by the Institute for Security Studies has some theories;

<https://issafrica.org/iss-today/gender-based-violence-during-lockdown-looking-for-answers>

this story also attempted to get to the bottom of the data.

<https://www.themarshallproject.org/2020/04/22/is-domestic-violence-rising-during-the-coronavirus-shutdown-here-s-what-the-data-shows>

P21

The Global Fund, committed to human rights and gender equality, has published guidance on human rights in the time of the pandemic.

https://www.theglobalfund.org/media/9538/covid19_humanrights_guidancenote_en.pdf



© Syed Latif Hossain for Frontline AIDS

Panna, 22, is a sex worker in Bangladesh. She participated in the Link Up project, which provided SRHR support to marginalised communities.



JOIN US. END IT.

www.frontlineaids.org