



HOW TO PROTECT THE HIV RESPONSE DURING PANDEMICS AND HEALTH EMERGENCIES

**A PROGRAMME MODEL FROM THE
MIDDLE EAST AND NORTH AFRICA**

ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, 1.5 million people were infected with HIV in 2021 and 650,000 died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.



Together for change
Sustaining HIV services in MENA

Nadoum aims to accelerate action to sustain and improve HIV services for people who are most vulnerable to HIV in Egypt, Jordan, Lebanon, Morocco and Tunisia. The multi-country grant is implemented by a diverse and multi-disciplinary partnership of organisations across the Middle East and North Africa – *Ajem, ALCS, AHSUD, AMSED, Association Tunisienne de Lutte Contre les MST et le SIDA, ATP+, Caritas Egypt, Coalition Plus, Dar Al Amal, El Nour, FOCCEC, Freedom, Frontline AIDS, ITPC MENA, MENAHRA, MENANPUD, MENA Rosa, Ness, Qodrat, RANAA, SIBA, SIDC, Skoun and Vivre Positif*. The programme is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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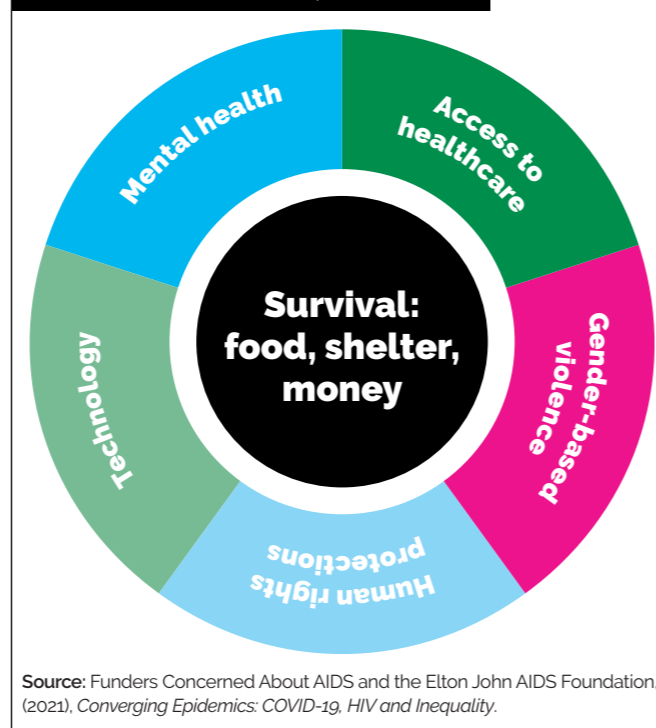
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SECTION 1:

INTRODUCTION

The COVID-19 crisis has left an indelible mark on societies and communities. During the worst of the COVID-19 pandemic, the needs of communities most impacted by HIV¹ fell into six categories, as illustrated by the graphic below.

KEY NEEDS OF COMMUNITIES DURING THE COVID-19 PANDEMIC



Despite extensive efforts to expand social protection mechanisms, at the height of the COVID-19 pandemic – and since – communities most impacted by HIV, and the civil society organisations (CSOs) that serve them, were left to build their own responses to meet these needs. And everywhere, the need was greater than the support available.

This paper shows how to build a programme to meet the needs of communities most impacted by HIV when other pandemics or health emergencies happen. It is based on evidence of how CSOs and organisations led by or working with communities most impacted by HIV in the Middle East and North Africa (MENA) responded to the COVID-19 pandemic and the needs that arose from it.

1. Throughout this report, communities most impacted by HIV are defined as people living with HIV and key populations, including sex workers, men who have sex with men, transgender women, people who inject drugs, and people living in prison or detention.
www.theglobalfund.org/en/key-populations

This guide will be useful for CSOs, community-based organisations (CBOs) and development partners working to achieve global targets to end AIDS as a health threat by 2030, in line with UNAIDS' Global AIDS Strategy and the Sustainable Development Goals, operating in a context of ongoing or new health emergencies.

WHY THIS MODEL WORKS

Our model has been designed for use at the points where the threats that arise from pandemics and health emergencies collide with HIV. When people's actions or behaviours during a health emergency heighten their risk of acquiring both HIV and the emerging health condition. When resources are diverted away from HIV prevention, treatment, care and support to control an emerging health threat. When new disease prevention or containment measures increase the risk of gender-based violence or other human rights abuses which undermine the HIV response. And when pandemic response measures disrupt the education, livelihoods and economic security of communities most impacted by HIV and result in a disabling environment for sexual and reproductive health and rights (SRHR), including HIV prevention, treatment and care services.

OUR GUIDING PRINCIPLES

Community engagement and leadership. At the very centre of the model are the expressed needs and priorities of communities most impacted by HIV. The model recognises that these communities are best placed to identify solutions that will work for them and are best placed to deliver them through decentralised and differentiated models² of service delivery. This means that a participatory approach – which at every stage meaningfully engages the community or communities being served and promotes community leadership – is critical to the model's success.

Diversity. The HIV response has taught us that a one-size-fits-all approach doesn't work. Response to pandemics and other health emergencies must recognise the diversity of communities most impacted by HIV and respond to these differing needs accordingly.



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Human rights and gender equality. To safeguard the HIV response, it is essential that emergency responses are grounded in approaches that promote, protect and fulfil the human rights of communities most impacted by HIV. It is also essential that emergency responses advance gender equality.

Promoting agency and equity. Communities most impacted by HIV experience structural barriers that erode their agency and deny them equitable access to services. These barriers include social stigma and the criminalised status of sex work, drug use, HIV transmission and same-sex relations. Programmes must combine short-term interventions to meet immediate needs with long-term interventions to advocate for a more equitable distribution of power. And there needs to be an acknowledgment of the complex (often connected) barriers that marginalised communities face which stop them from being heard, being free to act and receiving care and support that reflects their needs.

Evidence-informed. Age and sex-disaggregated data is essential to inform the design and implementation of programmes, and programme monitoring and evaluation should be similarly disaggregated (at a minimum). If possible, programme data can be further disaggregated by population. It should be a core advocacy issue if age and sex-disaggregation and population size estimates are lacking. Communities most impacted by HIV have a key role to play in addressing data gaps through participatory research and community consultation, shadow reporting and community-led monitoring.

2. Differentiated services are services that are designed in different ways to suit different people's needs and lives, which is why this approach is often described as 'people centred'.

SECTION 2:

THE PROGRAMME MODEL

THE FOUR BUILDING BLOCKS

The model consists of four overlapping and mutually supporting building blocks.



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BUILDING BLOCK 1 IN ACTION

The Middle East and North Africa Harm Reduction Association (MENA HRA) conducted a participatory process of developing country-specific emergency preparedness plans (EPPs) with and for harm reduction organisations and other organisations for communities most impacted by HIV. The process included conducting needs assessments at community level and drafting and validating the EPPs with cross-sector stakeholders, including ministries of health and humanitarian actors. It also included training workshops for CSOs and CBOs, in which participants validated the proposed EPPs. Advocacy was also conducted with various stakeholders at country level for the EPPs to be integrated into the government response and implemented.

1. ADVOCATING FOR CROSS-SECTOR POLICIES AND PROGRAMMES TO PROMOTE SOCIAL PROTECTION FOR COMMUNITIES MOST IMPACTED BY HIV

2. TAILORED INFORMATION-SHARING, RESPONDING TO THE NEEDS OF COMMUNITIES MOST IMPACTED BY HIV

BUILDING BLOCK 2 IN ACTION

During the COVID-19 crisis, SIDC used mobile dating applications, such as Tinder, Scruff and Growlr to run 'online outreach' sessions aimed at raising awareness among people vulnerable to HIV, including LGBT+ people, and sex workers. Trained peer educators/outreach workers ran the sessions, which covered subjects such as sexual and reproductive health (SRH), HIV, sexually transmitted infections (STIs), substance use, sexual orientation, gender identity and expression, mental health and gender-based violence. SIDC also shared information about services available through the organisation and referred people to services provided by sexual health and harm reduction centres.



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4. PROVIDING ADAPTIVE SERVICES AND ENABLING ACCESS TO THEM, INCLUDING ENSURING PEOPLE MOST AFFECTED BY HIV CAN MEET THEIR BASIC NEEDS

3. SHIFTING SOCIAL AND GENDER NORMS TO ADDRESS STIGMA, DISCRIMINATION AND VIOLENCE AFFECTING COMMUNITIES MOST IMPACTED BY HIV

BUILDING BLOCK 3 IN ACTION

In parallel with seminars for marginalised populations on how to reduce the risk of COVID-19 and stay on HIV treatment during the pandemic, Caritas held seminars for healthcare providers in Egypt on COVID-19-related stigma and discrimination, looking at how this intersects with HIV-related stigma and discrimination. They also built the capacity of ten national civil society organisations to strengthen their role in social mobilisation and advocacy for the COVID-19 response.



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BUILDING BLOCK 4 IN ACTION

MENA Rosa provided mental health support to their focal points who were on the frontline of supporting women living with HIV in countries throughout the region. Often, focal points were affected by secondary or 'vicarious' trauma because of the numbers of women needing their help and because supply chain issues and COVID-19 confinement policies often meant they weren't able to provide the support the women needed. This feeling of impotence led to depression and anxiety among focal points.

SECTION 3:

APPLICABILITY AND ADAPTABILITY

The model sets our four essential building blocks. Together, these building blocks form a comprehensive way to protect the HIV response during health emergencies. The model will need to be adapted to context, based on a needs assessment led with and for people living with and most at risk of HIV. When doing this, here are some things to consider:

- **Stand-alone projects:** This model can be applied to a standalone project which focuses on safeguarding the HIV response in pandemics and health emergencies. When planning this as a standalone project, it is advisable to include programmatic elements from each of the four building blocks which can be achieved through context-specific key interventions.
- **Part of integrated programmes:** This model can also be delivered as part of an SRHR programme or a multi-sectoral project. It can be combined with other programme models to ensure comprehensive SRHR programming targeted at HIV. It is also important to include interventions that support the provision of CSE and quality SRHR services, tailored to the needs of people most impacted by HIV.
- **Different communities/age groups:** The model does not target a specific age group or population, rather it incorporates interventions that target various groups. These groups include families, people living with HIV, populations most at risk of HIV, refugees/ migrants, faith leaders and healthcare providers.
- **Humanitarian settings:** The model can be used as a guide while designing and implementing projects in humanitarian settings by developing interventions that are responsive to the needs of marginalised populations.
- **Programme length:** The model does not have a fixed timeline; it can be adapted to a range of lengths, depending on the context and available budget.

TIPS TO SUPPORT SUCCESSFUL IMPLEMENTATION OF THE MODEL

- The **availability of accurate, reliable data related to communities most impacted by HIV is essential to guide large-scale HIV** funding and programmatic responses.
- The COVID-19 pandemic has shown the importance of community leadership in rapidly changing environments, especially in reaching those furthest behind. **Fostering community-led responses, and ensuring community-led organisations and networks are sustained** is key to protecting the HIV response in pandemics and health emergencies.
- The following strategies can achieve sustainability:
 - Domestic financing
 - Long-term programming
 - Providing flexible funding for community-based organisations which allows them to invest in what they think is necessary to achieve their goals
 - Capacity strengthening for community-based organisations
 - Addressing community-based organisations' technical needs
- **Meaningful youth engagement and the leadership of young people** most impacted by HIV should be an essential element of HIV programming, from the inception phase to monitoring and evaluation.
- The context in which this model is being implemented must be carefully considered. This includes the **country's laws, policies, epidemiological data, available services and gender and social norms.**
- Break down silos using a collaborative approach between key stakeholders, and provide **comprehensive health services for HIV prevention, diagnosis, treatment and care** for marginalised populations. For example, during the COVID-19 pandemic some CSOs provided basic needs for marginalised populations, which required close coordination with various actors in the HIV response, including the Ministry of Health, humanitarian actors and donors.
- Ensure the **accessibility, acceptability, quality and affordability** of services tailored for, and in response to, the needs of communities most impacted by HIV.



BUILDING BLOCK 1

Advocating for cross-sector policies and programmes for communities most impacted by HIV which support social protection, human rights, access to services and comprehensive sexuality education during health emergencies or pandemics.

The COVID-19 crisis clearly demonstrated that the needs of communities most affected by HIV became more acute during a humanitarian or crisis situation. Yet these communities' needs, rights and wellbeing were less likely to be protected than other people's. At the same time, communities most impacted by HIV are more likely to live and work in informal spaces, to experience social stigma, and be affected by punitive legislation, policies and strategies, such as laws that criminalise same-sex sexual activities, sex work and drug use.

BUILDING BLOCK 1: KEY INTERVENTIONS

- **Develop and/or strengthen policies and programmes** that ensure a comprehensive, multi-disciplinary, coordinated, systematic and sustained response to human rights violations against communities most impacted by HIV.
- **Engaging and building the capacity of people living with HIV and most marginalised populations** to embed their voices in the decision making processes during pandemics and health emergencies, to ensure they respond to their lived realities, needs and priorities
- **Revisit legislation and policies that create barriers to accessing SRHR services and effective HIV prevention, treatment care and support**, such as criminalisation laws and deportation policies. In some instances, fear of prosecution can prevent people most impacted by HIV from seeking testing and treatment.
- **Build the resilience of organisations led by and serving communities most impacted by HIV by using emergency preparedness and planning** to strengthen their response to future emergencies. (See case study 1 on page 4.)
- **Advocate for the adoption of human rights-based principles throughout all laws, policies and programmes**, particularly those relating to health and communities more impacted by HIV, in line with continental and regional agreements, resolutions and conventions. Emergency response and social protection mechanisms should utilise existing forms of social capital and resilience among marginalised populations.
- **Advocate for and ensure that migrants and foreign residents living with HIV are included in the national AIDS programme and have access to HIV treatment services in health emergencies.** During the COVID-19 pandemic, in some countries people living with HIV who were not registered experienced treatment interruptions, as they were not able to receive their normal medications from abroad and were sometimes unable to disclose their HIV status out of fear of detainment and/or deportation. *In Egypt, the International Organization for Migration has recently signed an agreement with the ministry of health that allows migrants to be included in its national AIDS programme registry so migrants can access HIV treatment. This is a good practice which other countries in the region can adapt.*
- **Advocate for people living with HIV to be prioritised to receive the COVID-19 vaccine.** People living with HIV are at a heightened risk of getting COVID-19, and they may be a greater risk of severe illness, hospitalisation, and/or long covid (although the evidence on this is limited). *Civil society in Morocco and Jordan have successfully advocated for people living with HIV to be among the priority groups for the COVID-19 vaccination.*
- **Provide a comprehensive response to the survivors of gender-based violence from communities most affected by HIV**, in collaboration with the justice system. This includes providing information and service referrals, ensuring that case management and psychosocial support services are survivor-centred, and providing legal assistance in partnership with local police and shelters.
- **Monitor and respond to human rights abuses and use data for advocacy** to promote and protect the rights of the most marginalised. *In Lebanon, SIDC had started using Rights, Evidence, Action (REAct) before COVID-19 struck, but rights violations and gender-based violence experienced by LGBT+ communities spiked during the pandemic.*



BUILDING BLOCK 2

Information sharing, tailored to the needs of communities most impacted by HIV relating to disease/virus awareness, control and prevention; diagnosis, treatment and vaccination; mental health and wellbeing; addressing misconceptions, and to promote the adapted services on offer.

During COVID-19, one of the biggest challenges communities most impacted by HIV faced was the absence of information around available services and misinformation about the pandemic, including the safety of the vaccine which affected vaccine uptake among people living with HIV. For example, in Egypt there were concerns, based on false information, that the vaccine could kill people living with HIV and that antiretroviral treatment (ART) could increase people's susceptibility to COVID-19.

BUILDING BLOCK 2: KEY INTERVENTIONS

- **Ensure public access to information about the pandemic or health emergency during the crisis.** For communities most impacted by HIV, access to up-to-date, reliable information is essential for making decisions about testing, treatment and accessing services. Information must be provided in accessible formats, including local languages, sign language and braille.
- **Put in place robust digital systems** to disseminate information, communication and educational (IEC) materials in Arabic, English, French and Sign Language, via media such as online platforms, radio and television. This information should include key pandemic prevention measures, such as hand hygiene, respiratory etiquette, physical distancing and vaccine safety. *In Egypt during the COVID-19 pandemic, for example, civil society played a role in promoting healthy behaviours and encouraging people living with HIV to get vaccinated.*
- **Continue to provide or start to provide comprehensive sexuality education (CSE) using digital media.** One of the best ways for communities most impacted by HIV to receive credible information about their SRHR is through CSE lessons and trainings tailored to their needs. These sessions should include information about prevention, testing and treatment. During pandemics and health emergencies, CSE can be delivered online through Facebook and WhatsApp groups by peer educators and/ or staff from community organisations.
- **Provide information on available services,** including existing testing centres, treatment services, support services for survivors of gender-based violence, psychosocial support and SRHR services. (See case study 2 on page 5.)
- **Support networks of people living with HIV and community-led organisations.** Community-led organisations and networks are instrumental in empowering communities most impacted by HIV to access services and take action to improve their health and wellbeing. Support can be provided for these vital organisations and networks through the provision of capacity strengthening and funding opportunities, along with any needed technical support.
- **Promote peer-to-peer support for people from communities most impacted by HIV** by forming and supporting virtual, peer-based support groups, especially during pandemics and health emergencies. The peer guidance provided in these groups should include information around how to access services, addressing myths and misconceptions about vaccines and promoting self-testing. *In Lebanon, peer educators from SIDC were given special training to conduct field outreach sessions on HIV, STIs, substance use, gender based violence and COVID-19 prevention and vaccinations, to encourage uptake*



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BUILDING BLOCK 3

Shifting social and gender norms by working with communities and key stakeholders to address stigma, discrimination and violence against communities most impacted by HIV during health emergencies and pandemics.

In MENA – as in other regions - stigma and discrimination against communities most impacted by HIV is a major challenge to the HIV response. And the COVID-19 response made things worse. When the circumstances, lifestyles or behaviours associated with communities most impacted by HIV were contra to COVID-19 regulations this was used as an excuse to target these groups, many of which are already criminalised.

BUILDING BLOCK 3: KEY INTERVENTIONS

- **Social and behavioural change communication** plays a vital role in shifting social and gender norms and addressing stigma and discrimination against communities most impacted by HIV. In the context of a global pandemic, awareness-raising which targets various community groups can take place virtually through webinars, 'couch' talks (informal online chats), podcasts and also through offline media, such as radio and television.
- **Address stigma and discrimination in healthcare settings against communities most impacted by HIV.** Marginalised people experience stigma and discrimination in healthcare settings, particularly those living with HIV and those who use drugs and are seeking services. This means there is a need to provide routine, in-service training sessions for healthcare staff on HIV, human rights, the populations most at risk of HIV, stigma reduction, non-discrimination, gender-sensitisation and medical ethics. This training should be given to all health facility staff, including non-healthcare staff such as receptionists and data clerks. (See case study 3 on page 5.)
- **Fight the stigma surrounding mental illness and ensure marginalised populations can access appropriate psychosocial support.** Psychosocial support and mental health services for communities most impacted by HIV is critical, but often these services do not exist. To meet the mental and emotional needs of marginalised people, it is important to break the stigma around mental illness while ensuring equal access to these services.
- **Build the capacity of the police to support survivors of gender-based violence from marginalised populations.** Women from populations most at risk of HIV and LGBT+ people experience higher rates of gender-based violence than other people, especially when sex work, personal drug consumption and same-sex sexuality are criminalised. The COVID-19 crisis saw spikes in gender-based violence in MENA as in other regions fuelled by stay-at-home policies and police curfews. In Lebanon, LGBT+ people were particularly vulnerable to violence from hostile family members, yet lockdown measures made it hard to put safety plans in place or for people to access support. *In Lebanon, SIDC has been working with the police to both build their capacity to respond to gender-based violence among key populations, and to reduce the violence and secondary trauma or victimisation often experienced at the hands of law enforcement agents. SIDC has also developed standard operating procedures (SOPs) for Internal Security Forces on how to treat marginalised populations including people living with HIV during detention and in prison.*
- **Broaden faith leaders' knowledge on the needs and challenges communities most impacted by HIV face.** In MENA, faith leaders are a trusted source of information for marginalised communities, so working closely with faith leaders to reduce the stigma and discrimination marginalised people face can be very effective.
- **Sensitise service providers, police and policy-makers on the need to protect the privacy of people living with HIV** while ensuring they can access treatment. In Jordan, government counselling and testing centres closed down during COVID-19 and people living with HIV had their ART delivered directly to their homes. This caused problems for people whose family were unaware of their HIV status, and it affected adherence. In contrast, *in Morocco and Tunisia people were given the opportunity to choose between having their ART delivered directly to their homes and collecting it from the nearest health centre so that their privacy would not be compromised.*

4

BUILDING BLOCK 4

Provide communities most impacted by HIV with adaptive services (or enable access) to respond to their needs during health emergencies.

The impact of the COVID-19 crisis on people most impacted by HIV in MENA mirrors what happened in other parts of the world. HIV services were stopped or interrupted, leading to fears about treatment interruptions and stockouts. Viral load tests and CD4 counts were unavailable, and there were shortages of paediatric ART. In some places, condoms were in short supply, and those that were available were sometimes so expensive that sex workers stopped buying them.

COVID-19 prevention measures exacerbated people's HIV risk. For example, in many countries, stay-at-home policies to control the spread of COVID-19 contributed to spikes in intimate partner violence, which increases a woman's risk of HIV acquisition by up to 50%. School closures resulted in a lack of comprehensive sexuality education, spikes in adolescent pregnancy and other SRHR challenges.



BUILDING BLOCK 4: KEY INTERVENTIONS

- Meet the basic survival needs of communities most impacted by HIV by providing basic needs such as food vouchers, hygiene kits, housing and income support.** The economic impact of COVID-19 prevention measures also heightened people's risk of HIV acquisition, and it interrupted people's ART and HIV care. For example, sex workers had to choose between complying with COVID-19 measures and losing income. For some, this amounted to a choice between food for themselves and their family and COVID-19 safety. Those who chose to maintain their income and financial security by continuing to meet clients risked exposure to COVID-19 (and potentially arrest, fines and police brutality), with potentially fewer protections from violence and less negotiating power to insist on safer sex practices. Safe housing was an issue for LGBT+ people in MENA who often didn't feel safe to return to their family home but couldn't afford to pay rent as they had lost income during lockdown. *In Egypt, food and hygiene boxes provided by Caritas Alexandria responded to a real desperate need among the beneficiaries enrolled in the C19RM project. The boxes also functioned as a good way of maintaining links between people most impacted by HIV and the two drop-in-centres, as a reliable source of information and support. They also enabled Caritas and their partners to promote vaccine uptake among most-at-risk populations.*
- Promote the provision of multi-month dispensing for people on HIV treatment.** People living with HIV need an uninterrupted supply of ART to stay healthy. This is also critical for controlling the HIV epidemic. But COVID-19 disease and/or prevention measures interrupted HIV treatment due to travel restrictions, health facility closures, stock-outs, loss of privacy and confidentiality, and people's fears that involuntary disclosure would increase. In times of crises, there is a need to ensure the availability of ART as well as the dispensation of 3-month or 6-month supplies of HIV medications so people do not have to interrupt their treatment. *Differentiated service delivery and/or mobile ART delivery models were implemented throughout the region.*

- Continue to provide voluntary counselling and testing (VCT) services during lockdowns and pandemics.** In several countries in MENA, HIV testing was suspended during total lockdowns. This includes viral load tests and CD4 counts. Some organisations in the region were able to opt for permission to move around by car to provide testing services in the community, promote self-testing, or advocate with the ministry of health to do viral load tests for people living with HIV during the health crisis. But people's access to smartphones and the internet is uneven so this can create a digital divide. *Caritas Alexandria was able to keep its drop-in-centre open for HIV counselling and testing, and also provided some VCT services online.*
- Foster the provision of psychosocial support and mental health services for marginalised populations and frontline workers during pandemics.** A lot of people experienced mental health challenges due to fear and anxiety about COVID-19, particularly in relation to whether they could still access treatment, their loss of income, violence or fear of violence, loneliness, isolation, and the general uncertainty of the situation. People from communities most impacted by HIV, outreach workers and service providers need to be able to access mental health services, either virtually or through hotlines. (See case study 4 on page 4.)
- Prioritise SRHR services, such as PEP, PrEP, condoms and contraceptives. And prioritise comprehensive gender-based violence support services which are tailored to the needs of communities most impacted by HIV.** The deprioritisation of SRHR and gender-based violence services in MENA resulted in SRHR services and commodities being interrupted and gender-based violence increasing. Some countries in the region maintained gender-based violence services during COVID-19 lockdowns. But in countries where same-sex sexuality is criminalised, it was almost impossible for LGBT+ people to use these services. *SIDC was able to continue providing gender-based violence case management for LGBT people by trained social workers, as well as linking clients to available – and trusted – services. SIDC offered counselling and support sessions for those who had experienced online bullying and violence, and sessions to raise awareness on cyber bullying, how to recognise it, what to do to avoid it, and how/where to report it.*



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KEY RESOURCES

- Frontline AIDS (2019), [REAct User Guide](#).
- Frontline AIDS (2021), [Gender REAct User Guide](#).
- Frontline AIDS (2020), [Technical brief on COVID-19 and HIV programming](#).
- World Health Organization (2022), [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#).
- World Health Organization (2017), [Strategic framework for emergency preparedness](#).



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