

COVID-19 AND HIV

Lessons learned, country actions and responses by the Joint Programme

Executive Summary

The COVID-19 pandemic is a health, humanitarian and development crisis, which intersects with and exacerbates the ongoing global HIV pandemic. It threatens the continuity of HIV services and adds to the vulnerability of already HIV-vulnerable populations. HIV has shown that a multisectoral, people-centred and rights-based approach is the best way of dealing with a pandemic, with specific lessons that can guide more effective COVID-19 responses. Leaders from the HIV response are being tapped at global, national and front-line clinical levels to respond to COVID-19, bringing in the type of effective leadership – courageous, inclusive and driven by scientific evidence and human rights – characteristic of the HIV response.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has applied its learnings gained from a quarter century of the AIDS response. It is supporting COVID-19 responses to place affected communities at the centre: in governance and planning, direct service delivery and community monitoring, and accountability. It is supporting governments to ensure that responses are grounded in human rights and gender equality, with particular attention to creating enabling environments and removing punitive, arbitrary and discriminatory legal and policy measures that increase marginalization and undermine access to essential prevention and treatment services. The Joint Programme has reinforced multi-sectoral COVID-19 responses to address social and structural inequalities that increase vulnerability and impede service uptake.

This conference room paper presents examples of specific actions by the Joint Programme to mitigate the risks the COVID-19 pandemic poses to the needs and rights of people living with and affected by HIV and to progress in HIV treatment and prevention. It also presents how leadership and assets created in the HIV response have been deployed to address the COVID-19 pandemic, in the following areas:

- **Access to health services:** modelling shows that a six-month interruption to HIV treatment would cause AIDS deaths to double, with half a million additional AIDS-related deaths this year in sub-Saharan Africa alone, bringing us back to 2008 AIDS mortality rates. The Joint Programme has identified supply chain weaknesses and taken mitigating action. Many countries have been assisted to accelerate multi-month dispensing of antiretroviral treatment (ART) and overcome stock barriers to its implementation, and emergency ART access has been provided to people stranded by border closures. Key populations have been reached with ART support. Guidance has been provided to countries on continuity of essential services in HIV, harm reduction and sexual and reproductive health. Alongside reinforcement of the health workforce, health service overload has been alleviated with additional community-based delivery of HIV testing, prevention and harm reduction services. Meanwhile, multisectoral HIV networks and communication channels have been rapidly deployed to respond to COVID-19 shocks. And lab services created with HIV-investment have been used to meet urgent COVID-19 needs. Support has been given to the leadership role of women living with HIV in COVID-19 responses. Finally, the demand for equity in the health response to COVID-19 has been reinforced, as evidenced in wide support for the call, co-organized by UNAIDS, for ‘a People’s Vaccine’.
- **Socio-economic impacts and social protection:** experience of the Joint Programme in multisectoral responses has been applied to ensuring vulnerable and HIV-affected populations are reached in low- and middle-income countries in the context of COVID-19. Needs assessments of people living with HIV have been undertaken in a number of countries, revealing COVID-19 related concerns in relation to ART access and stigma, loss of employment and therefore income, as well

as access to food. Social protection for people living with and affected by HIV as well as for key populations, including sex workers, migrants and the food insecure, has been bolstered. The Joint Programme's experience of reaching the most marginalized has been applied to COVID-19 responses. Interruptions to young people's schooling has been a key concern as has the impact on their HIV risks and sexual and reproductive health. The Joint Programme has supported the Global Network of Young People Living with HIV to deliver targeted COVID-19 responses. Integrated gender responses have been cross-cutting in social protection.

- **Community engagement and community-led responses:** the Joint Programme has assisted communities to play a key role in countries' COVID-19 responses and draw on HIV-related community-led infrastructure. COVID-19 misinformation has damaged trust and impeded health access for people living with HIV. The Joint Programme has mitigated these effects by supporting the engagement of many national HIV associations in building community trust and delivering accurate information. Community monitoring infrastructure is being applied to improve COVID-19 responses. Women's leadership in community engagement has been supported by the Joint Programme. Community mobilization and support has been particularly needed and valuable to marginalized communities such as LGBTI communities, sex worker groups and communities of people who use drugs.
- **Enhancing the protection and fulfilment of rights:** UNAIDS was one of the first organizations to [provide guidance](#) on the principles for human rights in the COVID-19 pandemic. The Joint Programme has responded to cases where stigmatization or rights violations have escalated under cover of the COVID-19 pandemic, including in relation to sex workers, LGBTI populations and people who use drugs. The Joint Programme has drawn on the experience of the HIV pandemic that responses are improved when the lived experience of people affected by HIV is at the core to support the voices of those affected by COVID-19 in directing the response. The Joint Programme has supported many countries across all regions to take policy and programmatic action to respond to increased gender-based violence.
- **Innovation and financing:** the economic crisis that has accompanied COVID-19 has been a key focus of the Joint Programme, with support in three phases: the initial emergency response, social protection and other needs as the crisis deepens, and funds for recovery. The scale of the crisis requires innovative responses, and the Health Innovation Exchange created by UNAIDS has been a forum for innovations to be developed and shared. UN Country Teams have been permitted to reprogramme up to 50% of their UNAIDS funding envelopes to respond to COVID-19 needs, and the Joint Programme has supported the responses of key partners, including PEPFAR and the Global Fund.

The Joint Programme's strengths are as vital for tackling the COVID-19 pandemic as they are for ending AIDS: uniting a global partnership; speaking out in solidarity with the people most affected and in defense of human dignity, human rights and gender equality; mobilizing political, technical, scientific and financial resources; supporting inclusive country leadership; and holding itself and others accountable for results. While we have made substantive contributions to both COVID-19 and HIV responses during this historic upheaval, we are aware that we could have done better, we could have done more – and we must do both going forward. After the initial shock of COVID-19, there is now an opportunity to build back better, systematically supporting COVID-19 responses and systems for health that are accessible, rights-based, integrated and people-centred.

The goal of ending AIDS is integral to achieving the Sustainable Development Goals and the resilient systems that will be needed to achieve them. The COVID-19 pandemic has not altered the direction of this ambition – it has just made it all the more urgent.

Introduction

1. The COVID-19 pandemic is a health crisis, as well as a humanitarian and development crisis, that threatens to leave deep social, economic, and political scars in the years to come, particularly for the most vulnerable communities. The COVID-19 pandemic intersects with the ongoing global HIV pandemic in many ways, including risks to the continuity of HIV services, and adding to the vulnerability of HIV-affected populations. Conversely, lessons learnt in the HIV response can and are being drawn upon to guide responses to this new pandemic.
2. There has been remarkable progress in the global AIDS response over the past 40 years, but significant challenges remain to ending AIDS as a public health threat by 2030. As with HIV, the COVID-19 pandemic is throwing a spotlight on inequalities, as the virus exploits weak systems for health, and social, economic and structural fault lines in all countries. Nonetheless, the global challenge of COVID-19 can be a catalyst to address vulnerabilities, reverse underinvestment in health and social protection, and address global and local inequalities.
3. While it is nearly six months since the World Health Organization (WHO) declared COVID-19 a Public Health Emergency of International Concern, the pandemic as yet shows no signs of abating. The harsh reality is that for many low- and middle-income countries [the worst of the epidemic may be yet to come](#), and the wave of economic dislocation brought with the epidemic is yet to peak.
4. The COVID-19 response has also unleashed destructive forces driven by fear that have undermined social solidarity and effective responses. These include COVID-19-related stigma, (re)ignition of long-standing ethnic, racial and other social prejudices, including in relation to gender, and the rapid spread of misinformation and mistrust. While these are familiar dynamics to the HIV response, the speed and virulence of misinformation in response to COVID-19 is unprecedented, accelerated by social media.
5. Both the response to HIV and the Joint Programme offer important lessons to address COVID-19. Early responses to HIV were often marked by official indifference and societal stigmatization, and many official responses were characterized by biomedicalisation of the condition. But people living with HIV, activists and community networks demanded a different kind of response. Later, nearly 20 years into the pandemic, focus moved to more effective ways to address its multisectoral dimensions and ensure a people-centred approach, and UN coordination was embodied in a new Joint Programme.
6. The Joint Programme remains a uniquely configured partnership in the UN system, bringing together the mandate of the 11 UNAIDS Cosponsors with the Secretariat in partnership with NGOs in a multisectoral global effort against AIDS. In considering the twin pandemics of HIV and COVID-19, it is evident that a systems approach is needed for both to protect the gains of the AIDS response while meeting urgent needs in COVID-19 responses and recovery.
7. Another lesson painfully learnt in response to HIV remains valid: it is vital to hear directly from those most closely affected by the virus and draw on their lived experience to guide the leadership of COVID-19 responses. For this to happen, effectively addressing stigma and discrimination from the outset is critical.
8. Evidence gathered by the Joint Programme shows countries are tapping into experience and investments from the HIV response and identifying the steps needed to “build back

better” (Box 1). This includes strengthening systems for health and social protection that are effective, accountable, inclusive, gender transformative, and equitable, and resourced to a level sufficient to guarantee access and meet a tailored, integrated set of needs from a people-centred perspective.

9. The Joint Programme is collaborating at country, regional and global level to support communities and countries in their COVID-19 responses, building on the lessons learnt from the HIV response. Action is being taken to scale up multisectoral health responses, establish partnerships for financing, highlight the important role of communities and ensure the meaningful engagement of vulnerable populations while calling for countries to ensure human rights principles guide responses.
10. This paper reports on some of the activities of the Joint Programme in the COVID-19 response, drawing on illustrative examples of the work of Cosponsors, individually and collectively, as well as that of the Secretariat at global, regional and country levels. The body of experience gained by these partners over the past quarter of a century is now being applied across sectors with urgency to the COVID-19 response and the impact of this new pandemic on the still unfinished business of ending AIDS. The paper reports on the specific actions taken to mitigate the risks of negative impact of COVID-19 on progress in HIV treatment and prevention, and ways in which lessons learnt and assets created in the HIV response are being and can be further mobilized to support measures to address and mitigate the COVID-19 pandemic. In each of the five substantive areas of the paper (access to health services, socio-economic impacts, community engagement and community-led responses, enhancing rights, and innovation and financing), attention is drawn to the impacts on the most vulnerable populations as well as specific measures to empower women in the COVID-19 response.

Access to health services

11. Under the leadership of UN Resident Coordinators and WHO, Joint UN Teams on AIDS are supporting countries to maintain, strengthen and transform HIV and health systems in the face of COVID-19. This includes procuring urgently needed health and medical supplies, strengthening health infrastructure, and assuring treatment continuity by diversifying service delivery, including promoting multi-month dispensing and strong community facility linkages. In many cases, HIV programmes and services are being adjusted to better complement emerging needs in responding to COVID-19 or are being repurposed to serve the twin goals of supporting COVID-19 and HIV responses. The needs are especially acute where people with HIV were already in situations of heightened vulnerability, for example among the [one in 14](#) people who are affected by pre-COVID-19 humanitarian emergencies.
12. Systems for health, including those addressing COVID-19, need to take into account the special needs of people living with and affected by HIV. Disruption to HIV prevention and treatment programmes would have a devastating impact. In particular, the 24.5 million people globally receiving antiretroviral treatment (ART) would have their lives put at risk with any interruption to ART accessibility. The HIV Modelling Consortium, in collaboration with WHO and UNAIDS, suggests that in a worst-case scenario – were HIV treatment to be unavailable for a six-month period – within a year, AIDS-related deaths would more than double. In sub-Saharan Africa, there would be 500 000 extra AIDS-related deaths. Likewise, a six-month service disruption in programmes to prevent mother-to-child transmission (PMTCT) would cause new HIV infections among children to rise by 83% in Mozambique, 162% in Malawi, 106% in Zimbabwe and 139% in Uganda. A lack of access to contraceptives owing to lockdown measures could exacerbate these estimated increases in new infections in children. Modelling suggests

that in high burden LMIC settings, the excess AIDS-related deaths caused by the COVID-19 pandemic will include a 20% increase in TB-related deaths over 5 years, driven by less timely diagnosis and treatment of new TB cases. This impact on increased mortality is estimated to be of the same order of magnitude as the direct impact from COVID-19.

Box 1. South Africa – Tapping into the AIDS movement to guide responses to COVID-19

Experience gained in the fight against AIDS in South Africa has been embraced in the battle with COVID-19. As with the HIV response, communities are leading the response. The rapid mobilization of communities, time spent listening to them and empowering them to take the lead has been transformational. The Civil Society Forum, at the South Africa National AIDS Council, led the formation of the Civil Society COVID-19 Front, the development of a Civil Society COVID-19 Plan and engaged in activism in solidarity with vulnerable people. The UN worked with the COVID 19 Coalition – a group of 400 community organizations working on social justice and humanitarian issues – to provide livelihood support.

Acknowledgement of the grave costs of past inaction on AIDS has played a role; with COVID-19, under the leadership of the President, who also chairs of the African Union, the government was fast to mount a robust response based on available scientific evidence. A Ministerial Advisory Committee (MAC) was established to inform government action. Many leading HIV scientists are members of the MAC, which is chaired by Professor Salim Abdool Karim, a world-renowned HIV scientist.

Many of the structures developed for coordinating HIV/TB responses have geared up for COVID-19. For example, the provincial and district AIDS structures, including nerve centres, have been largely transformed into COVID-19 response and command centres.

Working closely with the government and partners, the UN has developed a flash appeal on the immediate needs of people, including access to medicines, HIV prevention and testing services, food security, education, social protection and community resilience. UNAIDS worked with partners to coordinate this plan, providing support to strategic information, community engagement and communication. Approximately one-quarter of funds already available to the United Nations Joint Team on HIV/AIDS are being reprogrammed to ensure that civil society, people living with HIV, key populations and vulnerable communities continue to be supported in the AIDS response while addressing new challenges from COVID-19. Meanwhile, UNAIDS staff based in provinces with a high HIV/TB burden are helping to coordinate the response in the national and provincial COVID-19 command centres and supporting community health workers engaged in screening, contact tracing and voluntary testing.

Multi-month dispensing and supply chains

13. COVID-19 control measures at the point of origin and destination of essential health commodities are resulting in considerable delays in the delivery of medications and other commodities.¹ WHO and UNAIDS have conducted an [analysis](#) of the potential impacts on the ART supply chain of COVID-19. It shows that lockdowns have had a negative impact both on the transport of goods across the value chain of production (including active pharmaceutical ingredients—APIs) and the distribution of HIV medicines. Barriers

¹ It should be noted that condom supply is now threatened by disruption to transportation supply chains for some of the major condom manufacturers

to the supply chain and a forecast economic shock indicate a fluctuation in the availability of ARVs and an increase in market prices. Manufacturers are facing logistics issues that portend potential disruptions in the next few months. UNAIDS has recommended that countries identify the risk level for the stocks of all antiretroviral medicines. Coordinated action by governments is needed to secure the supply chain and the distribution of medicines to facilities. UNAIDS is continuing to proactively monitor the situation in India as well as in China, the source country of most APIs, in order to be alert to any potential supply chain disruptions, and in the Asia Pacific region UNAIDS is collaborating with the Global Fund and PEFAR to proactively monitor stock positions.

14. Procurement and supply management systems have been strengthened through HIV investments. [Procurement](#) by the Global Fund alone accounts for 10% of the global public health market. The systems and know-how made possible through the HIV response can help inform commodity procurement and supply management for COVID-19 commodities, including testing kits and components, personal protective equipment, current and future treatments and eventually one or more preventive vaccines.

Box 2. China – Early, urgent engagement in uncharted territory

As China was the first country to suffer from COVID-19, UNAIDS and the wider UN system did not have time to undertake detailed planning. Numbers rose dramatically, demanding a quick emergency response: communication, information, joint action, results.

For its part, UNAIDS did what it does best, turning to communities and utilizing its unparalleled (within the UN) access through its network of associations of people living with HIV and key populations across the country. UNAIDS paid particular attention to the epi-centre of the outbreak - Hubei province - where 65 million people faced unprecedented movement restrictions.

UNAIDS worked rapidly with networks of people living with HIV to activate online communication platforms nationwide and established a dedicated hotline in Wuhan to understand the concerns of people living with HIV, recognizing that an evidence base to validate and amplify the concerns of communities was critical.. UNAIDS' distinct competence in gathering strategic information and conducting rapid surveys proved instrumental. Our tools drew immediate attention to the need for alternative emergency distribution mechanisms for ARV refills in the short-term, and multi-month dispensing of ARVs and OSTs in the medium-term; non-hospital-based methods for administering refills; the need to better understand COVID-19 and HIV co-infection; and the need for urgent psycho-social support and safe-guards for PLHIV and key populations. A mechanism was quickly established for delivering ARV refills with volunteers from the Wuhan LGBT Centre, with the support of UNAIDS. UNICEF led Joint Team efforts to ensure that frontline responders for PLHIV and key populations had access to PPE. And later, when COVID-19 stigma and discrimination became apparent both in China and in the region, UNAIDS led the UN system's anti-discrimination campaign.

15. COVID-19 is contributing to increased use of WHO-recommended differentiated service delivery models for HIV in order to mitigate the impact of restrictions on mobility and to minimize the burden on the health care system—including telemedicine (Box 2). For stable patients, multi-month dispensing (MMD) of medicines for HIV and opportunistic infections is being implemented to free up health worker capacity to manage COVID-19. This has the added benefit of reducing contact and thus reducing the risk of COVID-19 transmission. In the most recent survey of UNAIDS country offices, almost half (33 of 68) reported that national policy or implementation had shifted towards MMD of ART since the outbreak of COVID-19. However, despite the shift of policy directives towards MMD, supply constraints, or concern about potential future constraints, have restricted such

dispensing in practice. The UNAIDS COVID-19 portal, which collects regularly updated information from UNAIDS country offices on the impact of COVID-19, indicates that in approximately 25% (21 of 82) of countries responding, 30% or more of people living with HIV are reported to receive only one month of medicines.

16. Across the Joint Programme, efforts have been made to respond to the needs of particular populations in relation to continuous ART supply, including multi-month dispensing. For example, in Eastern and Southern Africa, UNICEF has provided support to national governments to develop and roll out programmes for MMD for pregnant women, children and adolescents. There is also a need to find innovative ways of getting HIV prevention commodities to the people who need them, for example making available longer-term quantities of condoms, lubricants, needles, syringes, oral substitution therapy (OST) and PrEP drugs. This also involves ensuring distribution centres remain open during lockdowns and protecting community distribution. In Bangladesh, UNHCR has supported drop in centres for male, female and transgender sex workers to remain operational.
17. The UNAIDS COVID-19 Portal shows a number of innovative responses to the challenge of adapting service delivery – for example, with a voucher system for social protection developed in Guyana, and new arrangements for home use of OST (Armenia, Belarus). UNODC has assisted countries to ensure access to harm reduction services, including OST (e.g. in Belarus, Kenya, Nigeria, Ukraine and Viet Nam) and supported the implementation of OST take-home dosages (e.g. in Kenya, Moldova, and Viet Nam). UNODC has also supported the coordination of methadone supply (e.g. in Moldova and Seychelles) as well as the procurement of hygiene materials and personal protective equipment for harm reduction staff, outreach workers and people who use drugs (e.g. in Kenya, Kyrgyzstan, Moldova and South Africa).
18. In relation to the supply of reproductive health commodities, and in light of significant challenges faced by manufacturers, UNFPA has sought to ensure continued access, including dignity kits, [condoms](#) and lubricant, maternal health supplies, HIV/STI test kits, as well as emergency reproductive health kits for humanitarian affected populations.

Emergency ART access

19. The closure of borders and restrictions on movement have impacted the accessibility of treatment for many people living with HIV who are on the move. Recognizing that in humanitarian settings COVID-19 exacerbates the threat of treatment interruption, UNHCR and WFP with the Inter-Agency Task Team on HIV in Emergencies developed and disseminated guidance on HIV and COVID-19 in Humanitarian Situations, including for key populations. UNHCR is also supporting activities that aim to protect refugees from exposure to COVID-19, including through the provision of longer refills of ART and advising on continuity of essential HIV prevention services for refugees. For example, in Chad 3-months ART were given to refugees in the camps, and psychosocial counsellors were tasked with community distribution.
20. UNODC, WHO and UNAIDS have developed an on-line platform to share best practices on ensuring the continuity of harm reduction services for people who use drugs during the COVID-19 pandemic. This includes targeted technical guidance and regional webinars to enable the implementation of take-home supply for opioid substitution treatment (OST) as well as implementation of evidence-based and human rights-based policies that ensure access to effective programmes for people who use drugs and those in prisons and other closed settings, especially in the Eastern Europe and Central Asia (EECA) and Asia Pacific regions and the Middle East and North Africa (MENA).

21. COVID-19 is bringing to light the consequences when health services are reserved for national citizens, depriving migrant populations of their human right to health. A number of countries have decreed free health care for all persons suspected or confirmed with COVID-19 infection and UNHCR has strived to ensure that refugees are included in these provisions. HIV responses have demonstrated that more inclusive policies are possible. The recent decision by the Government of Botswana to provide free ART to all residents, regardless of their citizenship status, provides one such example. Likewise, while the HIV response has prioritized the free provision of ART, realization of this aspiration has been impeded by the imposition in many settings of user fees for health services. Some progress has been made to reduce these barriers to access in response to COVID-19, for example Burkina Faso, Cameroon and Côte D'Ivoire have sought to eliminate user fees for HIV and antenatal care services while fees have been temporarily lifted in Ethiopia, Gabon and Kazakhstan.

Health workforce and infrastructure

22. COVID-19 responses have the potential to piggyback on the important infrastructure that HIV investments have created. For example, the newly trained and credentialed health personnel that HIV investments have deployed – including more than 280 000 new health care workers trained by PEPFAR – are currently assisting as first responders to COVID-19 in many LMICs.

23. Addressing the health workforce has an important gender dimension: globally, women make up 70% of workers in the health and social sector and their work in the front-line of COVID-19 responses places them at increased risk. Women, particularly those living with HIV, are also serving as community mobilizers, service providers and volunteers. The Joint Programme, particularly UN Women, has been advocating for women on the frontlines of the response to receive priority support, including better access to protective equipment, menstrual hygiene products and psychological support.

24. A key measure to extend the capacity of an over-stretched health workforce is to deliver services outside formal settings. Through self-care models, advocacy and mobile and internet technology, people living with HIV have supported one another as active, controlling agents in the management of their own health and the health of their families and communities. These models are especially suited to COVID-19, as most care management will occur in community settings. Successfully leveraging of HIV infrastructure for COVID-19 goes hand in hand with implementing agile, flexible, and differentiated approaches to ensure HIV service continuation and enables a shift in both HIV and COVID-19 services out of the facility infrastructure.

25. HIV self-testing provides a route through which to reduce contact with other people and service burden on health facilities. It took many years before HIV self-testing was established as an effective testing modality, even after the technical advances had been made to develop easy-to-administer tests. This experience should be drawn on as countries move to decentralize COVID-19 testing.

26. The African Union and the Africa Centres for Disease Control and Prevention's new PACT (Partnership to Accelerate COVID-19 Testing in Africa) is working with UNAIDS to leverage the HIV response's community links and sentinel surveillance sites to support diagnosis and contact tracing for COVID-19.

27. COVID-19 responses are also benefiting from laboratory systems that have been vastly expanded and improved as a result of HIV investments (Box 3). Each year, PEPFAR provides US\$ 140 million in support to more than 3000 laboratories and 28 reference laboratories, primarily in sub-Saharan Africa. WHO is leading a consortium of diagnostics experts to strengthen COVID-19 testing. Especially with the increasing emphasis of HIV investments on multiplex laboratory technologies, the value of these adaptable diagnostic platforms for COVID-19 is clear. In Nigeria, the Republic of Moldova and Tajikistan, HIV laboratories are already contributing to the analysis of COVID-19 testing.[7] In DRC, UNHCR has used reprogrammed funds to complement the planned purchase of HIV viral load monitoring with compatible COVID-19 testing capacity.
28. Service delivery systems created through HIV investments are serving as primary service sites for people experiencing COVID-19. In Morocco, for example, the 17 HIV treatment reference centres are now functioning as the first line for COVID-19 treatment services. Likewise, Mozambique has designated certain HIV clinics as sites for suspected or confirmed COVID-19 cases.
29. The HIV response has demonstrated that there need not be a trade-off between service reach and service quality: effectively managed, reach and quality should go hand in hand to maximize equitable health outcomes. By monitoring outcomes at each essential stage of service delivery – such as diagnosis, linkage to care, treatment initiation, retention in care and viral suppression – HIV programmes can rapidly identify service breakdowns or bottlenecks and devise locally tailored strategies for closing gaps. Similar strategies are informing COVID-19 responses.

Box 3. Algeria – Ensuring the continuity of HIV services in the COVID-19 context

To respond to the COVID-19 pandemic, Algeria, on the instructions of the President, set up a national scientific monitoring committee. The spokesperson of this committee is Dr Djamel Fourar, former representative of Algeria to the UNAIDS Board. In developing the epidemiological surveillance system for COVID-19, the government drew heavily on experience gained in the response to HIV. Among other things, the manager of the National AIDS Control Programme and national experts in HIV virological monitoring played key roles in establishing the surveillance system and COVID-19 monitoring relied on labs typically used for monitoring HIV viral load.

In the government's preparedness and response Plan to COVID-19, PLHIV were identified as priority populations. To improve the services provided to PLHIV and key and vulnerable populations, the Ministry of Health (MOH), with the support of UNAIDS, and in close collaboration with communities and organizations representing people living with HIV, organized a rapid assessment of needs across the country.

UNAIDS has been a key player in coordinating UN support for the COVID-19 response, including the continuity of HIV prevention, treatment and care services. It has done so in close collaboration with the MOH, CSOs and PLHIV organizations and the Global Fund. As a result, multi-month dispensing was established to deliver ARVs to PLHIV using volunteers from five NGOs and mail order companies. Screening equipment and PPE was provided through a partnership involving UNDP to ensure continuity of treatment for sex workers, gay men and migrants in ten sites, while a similar partnership involving UNODC ensured continued services for people who use drugs.

Multi-sectoral, partnership approaches

30. Multi-sectoral, rights-based and community-led policies and services have been core to advances in preventing new HIV infections and getting and retaining people on treatment. Partnerships between people living with and affected by HIV, government, communities, civil society, including faith-based organisations, and the private sector have been critical to HIV and also need to inform scaling up of effective COVID-19 prevention programmes. Maintaining and scaling up the most critical prevention activities and healthcare services for HIV, TB and malaria could significantly reduce the impact of COVID-19. In South Africa, a multi-sectoral response to COVID-19 and HIV is being coordinated through the Joint National Economic Development Labour Advisory Council, the South African National AIDS Council, ILO and other UN agencies to strengthen the work of the Civil Society Command Centre on COVID-19 and HIV).
31. TB is the most significant co-morbidity contributing to AIDS mortality. It is not yet clear the extent to which TB increases the severity of COVID-19, nonetheless there is a need to maintain TB detection and treatment services. Data from the UNAIDS COVID-19 Portal suggests that of the 82 countries responding, 12 reported disruption of TB service due to COVID-19, three an improvement and 67 no change. Multi-month dispensing for TB preventive therapy was only provided by 19 of 76 countries (3-months 3HP in 7 countries, and 12 countries giving 6-months isoniazid). The majority of countries (60 of 83) still use directly observed therapy to monitor TB treatment adherence which is misaligned with multi-month dispensing for ART.
32. A partnership approach begins with gathering information and including multiple stakeholders in decision-making. The UNAIDS COVID-19 Portal shows that 48% of country offices report that civil society has been consulted on the COVID-19 related policies in their countries. Consultation with people living with HIV is especially important both to assess the immediate impacts of COVID-19 on their needs but also to draw on their experiencing in shaping COVID-19 responses. The UNAIDS Secretariat, in many instances with Cosponsors, is conducting (and/or planning) rapid assessments with networks of people living with HIV and partners in 82 countries, with similar assessments being conducted among key populations most vulnerable to HIV.
33. The multi-sectoral HIV response infrastructure has served to boost health sector responses across a number of diseases and is now being leveraged to assist the response to COVID-19. This infrastructure extends beyond health facilities, encompassing community-led service delivery models as well as actors and interventions outside the formal sector. Specific measures building on the infrastructure include the use of service infrastructure (e.g. testing facilities, treatment platforms, health personnel, networks of community health workers), research capacity (e.g. the many well established HIV vaccine trial sites and networks that are being used for COVID-19 vaccines, rights-based advocacy and law reform (e.g. use of criminal laws, stigma and discrimination, and creating enabling legal environments) and access-enabling policies (e.g. pooled procurement, health services free of charge) (Box 4).
34. In 2019 the Global Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination (Global Partnership) launched its implementation phase, which to date has seen 16 countries commit to delivering interventions to address HIV stigma and discrimination across six settings: Healthcare, Household, Justice, Workplace, Education and Emergency/Humanitarian. The Global Partnership is led by the UNAIDS PCB NGO Delegation and co-convened by UNDP, UN Women, UNAIDS and GNP+ and supported by a Technical Working Group of 20 community organizations and 10 UN agencies. In response to reports of violence and abuse perpetuated against [healthcare workers](#), [sex](#)

[workers](#), [women and girls](#), [people who use drugs](#), the [LGBT population](#) and [vulnerable groups](#) such as [prisoners and migrants](#) in the COVID-19 context, the Global Partnership developed an action plan to strengthen community-led responses to COVID-19.

Box 4. A People's Vaccine

The principle that health is a fundamental right that must be available to all is a key demand of the HIV movement. Among other things, activists and supportive leaders focused on barriers to access to medicines by speeding up clinical trials and regulatory approval processes, lobbied on affordability, and promoted generic competition, including through the use of TRIPS flexibilities, voluntary licenses and procurement by both domestic and donor development assistance programmes. The boldness and audacity of the HIV movement calls on us to be visionary and courageous today in responding to the global COVID-19 emergency.

As international discussions and commitments to accelerate research and development of COVID-19 vaccines got underway, UNAIDS co-initiated the mobilization of a movement for a People's Vaccine. A group of over 150 world leaders and experts led by South African President Cyril Ramaphosa, and backed by civil society, academic experts, thought leaders and philanthropic organizations, united in an open [letter](#) calling on all governments and other actors to ensure that any quality-assured vaccines, treatments and tests for COVID-19 be free of exclusive rights, produced at sufficient scale, distributed equitably and made available to all people, in all countries, free of charge. In early June, UN Secretary-General Antonio Guterres voiced his strong support, maintaining that a COVID-19 vaccine must be seen as “a global public good – a people's vaccine” to which “every person, everywhere, has access”. UNAIDS is working with allied movements and partners to influence the debates that will make this a reality.

Strategic information

35. Multi-sectoral COVID-19 responses will need to be underpinned by robust strategic information systems capable of delivering timely, accurate and disaggregated data – to identify new outbreaks, guide decision-making regarding control measures and determine whether responses are having their desired effects and are avoiding undesirable side-effects. The expertise, analytical capacity, and surveillance and monitoring systems developed through HIV funding have great potential to support COVID-19 responses.
36. Since 2003, UNAIDS has supported highly affected countries with Strategic Information Advisers (SIA). SIAs support national counterparts and strengthen capacity in health information systems and data use efforts. Cosponsors (such as WHO and UNICEF) are developing similar skill sets, and an interagency coordinating mechanism for work in this area is the Global Health Data collaborative, with UNAIDS Secretariat co-chairing its multilateral constituency. Cosponsors use different platforms to promote the use of such data. UNAIDS focuses on empowering national partners to access HIV and other related (such as TB) data and analytics through “Health Situation Rooms” in 10 countries. The Health Situation Room platform has been adapted to include COVID-19 data in at least six countries (Kenya, Lesotho, Malawi, Uganda, Zambia, Zimbabwe) with more in the

process of doing so. The platform enables COVID-19 data to be updated on a daily basis and serves as a unified repository to guide decision makers.

37. Health-specific data platforms are complemented by other data sources. UN Women's COVID-19 Dashboard provides data by sex on the health impact of COVID-19 (produced in collaboration with WHO), as well as 29 gender-related SDG indicators in ten policy priority areas to respond to COVID-19.

Applying a gender-transformative approach

38. Gender inequality is deepening in the face of the COVID-19 outbreak, increasing the risk of HIV for women and girls, and hampering their ability to remain on treatment, and mitigate the impact of HIV.
39. COVID-19 has reflected a general tendency in too many health systems to inadequately disaggregate service and clinical data, including on sex. Calls have been made by members of the Joint Programme, and particularly UN Women, for greater publication of such data. A COVID-19 sex disaggregated data [tracker](#) found that, as of 16 June, only 47 out of 115 countries assessed were publishing data disaggregated by sex on both cases and deaths. Without sex disaggregated data, important aspects of the complex interaction between health status, epidemic dynamics and the social burden of the response are hidden from view. Responding to these calls, UN Women has created a COVID-19 section in the Women Count Data Hub. Additional insight into COVID-19 impacts on women has come from UN Women's rapid consultations.

Socio-economic impacts and responses

40. When a shock like COVID-19 arrives, especially in countries with weak social protection systems, people living in poverty and subsistence conditions have little capacity to adopt physical distancing and have no economic reserves with which to withstand economic shocks. The ILO, in partnership with UN agencies and national stakeholders, is undertaking a variety of rapid assessments including on: the socio-economic impact of COVID-19 on people living with HIV (India), on poverty vulnerability and HIV in the midst of COVID-19 (China), on COVID-19 and HIV (Mozambique), and on the impact of COVID-19 on people living with HIV (Indonesia).
41. Because social and structural factors are key determinants of health outcomes, the HIV response has been carried forward through multi-sectoral strategies. [Eighty-seven percent](#) of the 90 countries reporting data to UNAIDS in 2019 indicated having a national HIV strategy in place developed through a multi-sectoral process. The multi-sectoral actions which are similarly needed to guide COVID-19 responses have been established slowly, with few if any civil society representatives or experts in social and structural issues included in [national COVID-19 task forces](#) to date.

Targeting social protections

42. The Joint Programme has conducted surveys of people living with HIV across all regions. Primary among their concerns are the fear of contracting COVID-19; lack of accessibility to HIV clinics without public transport; having to disclose HIV status to get through checkpoints in order to access ARVs; difficulty obtaining condoms, financial assistance, food, employment, and psychosocial support; and increased anxiety and depression.

43. The UNAIDS COVID-19 Portal illustrates that many countries have focused on special assistance to vulnerable populations, including people living with and affected by HIV. Reports include support for cash transfers to migrants (Algeria), support to street-based and other key populations including sex workers (Bangladesh), food assistance to the most vulnerable including people living with HIV (Kyrgyzstan, Liberia, India focused on youth), outreach to elderly people living with HIV especially vulnerable to COVID-19 (China), and those in informal settlements and the informal economy (Tanzania, South Africa). Mental health support has been a particular focus for a number of countries (Bolivia, Brazil, Egypt, Peru).
44. To support the conduct of quick assessments, the ILO produced a *Rapid Diagnostics Tool for Assessing the Country Level Impact of COVID-19 on the Economy and Labour Market* which is being used to assess the impact of COVID-19 in several countries. The ILO and World Bank-led Social Protection Interagency Cooperation Board (SPIAC-B) issued a [Joint Statement on the Role of Social Protection in Responding to COVID-19](#) which called on member States to take specific actions to mitigate the impact of the pandemic. Women are hit harder by the economic impact of COVID-19, as they are disproportionately represented in informal labour. Movement restrictions limit women's ability to make a living and meet their own and their families' needs.
45. Cosponsors are supporting a variety of social protection measures. In Eswatini, WFP is rolling out a suite of integrated HIV/TB/SRH/nutrition services via mass media and TV, providing cash-transfers to support food insecure PLHIV and supporting orphan and vulnerable children with take home food rations and adapting existing point-of-care centres with PPE and handwashing facilities. Furthermore, WFP is supporting governments by offering protective rations of cereals and beans to all vulnerable individuals, including PLHIV. In Madagascar, for instance, WFP has contributed to strengthening the national social protection systems, and integrating TB infection as a vulnerability in the response to COVID-19, by establishing a quick targeting approach and registry platform that is already up and running, offering assistance and delivery operations to more than 100,000 households, in coordination with the Government, the World Bank, and a consortium of NGOs. The Mozambique government is currently benefiting from World Bank funding and has been working closely with WFP in the implementation of a cash-based transfer programme. Households with PLHIV are targeted under this programme and WFP, through its social protection team and together with UNICEF, is working with the government to expand the targeting to include social and behavioral change communication and nutritionally vulnerable households. In South Africa, UN Women has conducted rapid assessments of COVID-19 impact on women in the informal sector, with a focus on ensuring social protection policy measures for women living with HIV, including young women and adolescent girls.
46. Preparing for COVID-19 in the context of violent conflict, climate disasters and large-scale population movement is key. The AIDS response provides a template. UNAIDS spearheads the crafting and rolling out of disaster HIV preparedness and response plans for countries in dealing with these challenges. These plans contribute to meet the need for data readiness and promote community-based action that underpins resource mobilization efforts ensuring that accountability platforms include networks of PLHIV and other vulnerable groups. This approach helps integrate HIV into humanitarian country plans within the health cluster and as a core cross-cutting theme along with social protection and measures to prevent all forms of sexual and gender-based violence.
47. UNHCR has sought to ensure that refugees are included in access to COVID-19 related health care as well as reinforcing cash-based interventions for people with specific socio-economic vulnerabilities, including people living with HIV. Similarly, the Joint Programme, including UNHCR and UNICEF, have devoted special attention to migrants

and refugees who may be confined to camps and settlements, or living in urban slums with overcrowding, poor sanitation, and overstretched or inaccessible health services. These efforts are vital given that substantial COVID-19 transmission, illness and mortality has been reported among migrant workers in parts of [Asia](#), the [Gulf and the Middle East](#), with their vulnerability exacerbated by economic dependence, limited agency and the crowded conditions in which they live. The [projected sharp decline of at least 20% in remittances](#) as a result of COVID-19 will have ramifications across migrant communities and those dependent on labour migrants, creating another layer of social protection needs and possibly driving risks associated with HIV, STIs, TB and other health conditions.

48. The Joint Programme is supporting countries to connect people living with HIV and key populations to social protection programmes, including those programmes which have been expanded in the COVID-19 context. Social protection measures have been adopted or adapted as part of the government measures against COVID-19 in over 171 countries. As of May 22, 2020, 190 countries and territories have planned, introduced or adapted 937 social protection measures in response to COVID-19. The overall global volume of social protection response to COVID-19 is 0.6% of global GDP (nearly \$85 trillion) according to World Bank research. Properly designed and implemented social protection interventions have demonstrated an impact on the prevention of HIV and that they can increase testing, treatment and adherence to life saving HIV and TB drugs. This is even more so in times of health and economic shock, such as during and after COVID-19. Surveys of people living with HIV and key populations conducted since the outset of the COVID-19 pandemic are increasingly indicating social protection – food, livelihood support, protection and economic strengthening – as key priorities alongside continuation of HIV services.
49. One key population that has been disproportionately affected in the COVID-19 context is sex workers. A telling example was in the DRC in April/May 2020 where a group of 168 sex workers and their children were stranded due to COVID-related lockdown. They urgently needed food aid and protection from high levels of violence and increased risk of HIV infection. The UNAIDS Country Office with UNDP provided financial relief to support emergency needs. Meanwhile, in Kenya a large number of female sex workers were arrested for breaking COVID-19 rules/curfew and placed in 2-weeks quarantine; UNAIDS Emergency Fund was activated to facilitate access to treatment, care and support including food while in detention and/or quarantine and support of the children. In the Asia-Pacific region, UNFPA is making efforts to identify alternative sources of financial support for sex workers and other key populations. In Cote D'Ivoire, UN Women's partnership with the national network of women living with HIV resulted in female sex workers being able to access gender-based violence services and being linked to HIV testing and treatment. UNHCR in Ecuador is providing food assistance and hygiene kits in coordination with community-based organizations supporting Venezuelan and national sex workers. Further advocacy is needed with Member States to enable all persons in informal work sectors to access COVID-19 social protection and assistance.

Young people

50. While the majority of severe cases and deaths caused by COVID-19 are amongst people over 60, the pandemic has also had a catastrophic impact on young people. In large part this is because the pandemic has had an unprecedented impact on education around the world, with school closures impacting over 91% of the world's student population, and more than 320 million children now missing out on school meals due to school closures. Through its Global Education Coalition, UNESCO has rallied international organizations – including WHO, UNICEF, UNHCR, ILO, WFP, the World Bank and UNAIDS

Secretariat – as well as civil society and private sector partners to mitigate the impact of school closures and facilitate the continuity of education for all through remote learning.

51. As part of UNESCO's work supporting countries to mitigate the impacts of school closures, particularly for more vulnerable communities, UNESCO is reaching out to 33 countries in sub-Saharan Africa through the Our Rights, Our Lives, Our Future (03) programme to ensure that children and young people understand basic, age-appropriate information about COVID-19, including its symptoms, complications, how it is transmitted and how to prevent transmission. This will include work to help young people cope with school closures and ensure they continue to receive HIV prevention and SRH information.
52. We already face an HIV crisis among adolescent girls and young women; and COVID-19 poses additional threats that can roll back the fragile gains achieved. Many girls are at risk of not going back to school after the lockdowns are lifted. The Joint Initiative by the executive leadership of UNAIDS, UNESCO, UNICEF, UNFPA and UN Women to ensure girls have equal opportunities to access secondary education and economic opportunities to thrive and be free of HIV is therefore key to the COVID-19 response.
53. The UNAIDS Secretariat is supporting the Global Network of Young People Living with HIV (Y+) in the establishment of the Y+ Social Aid Fund to respond to the emergency needs of adolescents and youth between the ages of 10-30 years living with HIV. The Fund will provide support to access food, sanitary wear, transport to health facilities, and treatment delivery. The Fund will also support advocacy initiatives that call on governments to establish social support mechanisms. UNICEF has partnered with Y+ Global and country-level networks of adolescents and young people living with HIV to solicit information about their biggest concerns related to COVID-19. The most frequently asked questions on social media were developed into a widely shared Q&A publication. In Cameroon, Guinea Bissau and Sierra Leone, UNICEF has used tools such as U-report – a social platform created by UNICEF, available via SMS, Facebook and Twitter, where young people express their opinion and act as positive agents of change in their communities – to develop messages for behaviour change.
54. In the Asia Pacific region, the Interagency Task Team on Young Key Populations, which includes UNICEF, UNFPA, UNESCO, UNDP, UNWOMEN, UNODC, the UNAIDS Secretariat and key population regional networks (Youth Lead, APCASO, YVC, Y-Peer, among others) has launched a rapid response survey to assess information needs, medication on hand, and ability to access HIV services and support networks among young key populations and young people living with HIV during the COVID-19 outbreak. Results are highlighted in this [blog](#) which focuses on the impact of COVID-19 on mental health and quality of life. In another youth-focused initiative, UNFPA has teamed up with Prezi to help inform young people around the world about COVID-19 and what they can do to keep their friends, families, and communities safe. This resulted in the development of [videos](#) on topics covering Sex, Sexual Health and COVID-19; and Youth, Gender and COVID-19, which were recreated over 200 times in more than 20 languages, with more than 500,000 views.

Applying a gender-transformative approach

55. Drawing on the multi-sectoral nature of the HIV response, gender analysis with the necessary disaggregated data, must inform and shape COVID-19 response and recovery plans, budgets and accountability frameworks. COVID-19 recovery responses which 'build back better' should be guided by SDG target 5.4 to "recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies, and the promotion of shared responsibility within the

household and the family”. The additional burdens on women of care and education responsibilities have been very evident in the period of COVID-19 lockdowns, although some have taken hope from tentative [countervailing signs](#) of a new willingness to address long-standing gender disparities in the crisis. However, exacerbating the unfair share of the burden of unpaid work falling on women in the COVID-19 are the structural inequalities in paid work, with nearly 60 per cent of women’s paid work being in the informal economy which has been made even more precarious by COVID-19, putting women at greater risk of falling into poverty, together with the impact of food insecurity which falls disproportionately on women and children. Mitigation strategies, and above all women’s empowerment, need to be systematically supported to ease the economic impact of the pandemic.

56. A guidance note is being developed by the UN Inter-Agency network on Women and Gender Equality working group (IANGWE) on ‘minimum criteria’ for the integration of gender considerations in the COVID-19 response, aligned to the UN framework for the immediate socio-economic response to COVID-19, including on the gendered impacts of the health crisis. This guidance will be disseminated to country and regional offices and via the IANWGE Secretariat and the UN Development Coordination Office (DCO), including a webinar for gender theme groups at country level.

Community engagement and community-led services

57. While many of the initial COVID-19 responses have been in emergency mode and focused on the rapid establishment of stand-alone facilities, [the experience of HIV](#) has been that innovation driven by communities of affected people has shifted HIV testing, treatment delivery and adherence support from facilities to communities, decongesting overburdened health clinics and generating outcomes that are as good as and often superior to those reported in health facilities. Implementing these community-led service models required flexibility and far-reaching health policy change, such as encouragement of task shifting for clinical service delivery, endorsement of service delivery by lay providers and approval of new, community-centred health tools, such as HIV self-testing kits. Community workers who go door-to-door to deliver essential testing and treatment services, build demand for testing, prevention and treatment services and provide peer support that [improves retention](#) in care.
58. Effective COVID-19 responses also place affected communities at the centre: in governance and planning, direct service delivery and community monitoring and accountability. The UNAIDS COVID-19 Portal indicates that progress in this dimension of the response has been significant but only partial: 91% (representing 81 countries) of responding UNAIDS Country Offices report having been able to ensure meaningful engagement of networks and other communities in the response generally, but in relation to a specific role in the planning and governance of COVID-19 responses, to date only 54% report that networks of PLHIV and other affected communities are playing this role.
59. Many COVID-19 responses have sought to keep people who do not need acute services out of the formal health care system, in order to prevent health systems from collapsing, minimize further transmission and preserve finite health resources. For example, in Burkina Faso, community-based HIV organizations are engaged in the COVID-19 response, using differentiated approaches to mobilize communities, follow contacts of people with confirmed COVID-19 diagnosis and re-engage individuals who have been lost to follow-up.² As health facilities in Mozambique are being converted into COVID-19

² UNAIDS, *Internal UNAIDS Data*. 2020.

centres, a buddy-system of peer navigators is being developed to strengthen linkage and referral of patients. In Uganda, WFP is exploring alternative and innovative approaches to ensure continuity of nutrition services for people living with HIV without burdening health systems, such as use of mobile clinics and community outreach, as well as the use of pre-recorded messages to replace individualized counselling in order to reduce contact and reduce waiting times.

Addressing misinformation at community level

60. Countries have expressed concerns about misinformation about COVID-19. This is not an unusual occurrence in disease outbreaks: in the recent Ebola epidemic in West Africa, early community resistance, mistrust of government and health systems, fear, stigma and misinformation [hindered efforts](#) to bring outbreaks under control. The Joint Programme has engaged in efforts to address the flow of information. Working with WhatsApp, WHO, UNICEF and UNDP have created an information hub that aims to dispel misinformation and provide a platform for telemedicine and virtual classrooms.
61. An important lesson of the HIV response is that measures to reduce HIV-related stigma and discrimination have drawn strength from the visibility and leadership of people living with HIV, suggesting that communities of COVID-19 patients have a meaningful role to play in reducing COVID-19-related stigma, myths and misconceptions. As more people have contact with those who have recovered from COVID-19 infection, unnecessary fears can be tackled, and so it will be important to support self-organizing of people who have been affected by COVID-19 so that they can play this community-building role.
62. Communities have been stepping forward to lead local COVID-19 responses, challenging misinformation and stigmatization. According to a recent survey of 160 civil society organizations, undertaken by the Civil Society Institute for HIV & Health West and Central Africa, with the support of UNAIDS, most (72%) HIV-focused organizations in the region are working to raise COVID-19 awareness in the general population. The Lesotho Ministry of Health and UNICEF, through its implementing partner Help Lesotho, are providing remote health counselling using WhatsApp to deliver COVID-19 information, and psychosocial support through teleconsultations for pregnant and breastfeeding adolescent girls and young women and their children participating in the 2gether 4 SRHR Young Mothers Programme. This is a joint UN initiative funded by the government of Sweden to support SRHR programming for adolescent girls' and young women's (AGYW) HIV prevention. The consultations are also capturing information through a survey which includes questions on continuity and access to maternal and childcare, PMTCT, sexual and reproductive health, HIV prevention and testing, mental health, birth registration, and prevention of sexual and gender based violence.
63. UNHCR has supported COVID-19 communications tailored to communities taking into account age, gender, and diversity considerations, translated into local languages, and with appropriate visuals so they are up to date and readily understandable. The COVID-19 West and Central Africa Risk Communication and Community Engagement digital platform was launched in March 2020 by a large number of partners and has now reached 15 000 unique visitors. Using broadcast and social media channels, twice a week, UNHCR in coordination with IOM and MSF, share dozens of new graphic, audio and video tools to assist community mobilisers to reach migrants, refugees and internally displaced and other populations. In Cote D'Ivoire, Ethiopia, Guatemala, Liberia, Nigeria, South Africa, Tanzania and Zimbabwe, UN Women has supported women living with HIV to prevent COVID-19 and disseminate accurate information via community radio, social media and peer support groups, as well as enhancing their access to protective equipment and menstrual hygiene products.

64. To improve programming through knowledge exchange, UNICEF has launched the webinar series COVID-19 and HIV: What Paediatric HIV Programmes Need to Know and a weekly digest of news and updates on COVID-19 and HIV. Through the Children and AIDS Learning Collaborative, a community of practice with over 3000 members, UNICEF is regularly sharing new learning and maintaining a COVID-19 and HIV resource library.

Community monitoring and accountability

65. Communities are an important element in ensuring the accountability of the HIV response. In many countries, community monitoring alerts officials to medication stock-outs and generates a range of service utilization and quality data that informs national HIV responses. This monitoring complements the community delivery of essential HIV prevention, treatment, and harm reduction services as well as the non-biomedical support that improves health outcomes, and enables underserved people who are not effectively engaged by health facilities to be reached. UNAIDS is partnering with The International Treatment Preparedness Coalition (ITPC) to support networks of people living with HIV and treatment activists in four countries as well across Latin America and the Caribbean to provide ARV delivery for people who cannot get to clinics and to rapidly shift community-led monitoring of HIV services to safe virtual platforms and to expand such monitoring to include impacts of the COVID-19 response.
66. Human rights monitoring is another critical feature of the HIV response and a function of the Joint Programme. Such work is underway in many countries. In Mozambique, UNDP in collaboration with ILO, UNODC, UN Women and the UNAIDS Secretariat is supporting the Ministry of Justice, the national human rights commission, the Office of the Ombudsman and civil society to monitor HIV and COVID-19 related human rights violations and harassment by service providers, police and community leaders during the delivery of essential services.
67. Most people with COVID-19 will have mild cases that are managed in the community. In many low- and middle-income countries with fragile health systems, community-based management will also be needed for more severely affected people due to the scarcity of health resources. In COVID-19 responses, communities are [delivering essential supplies](#) to the vulnerable and organizing local support systems. By empowering and partnering with communities, responses can achieve a reach, impact and equity that government facilities could never realize on their own.

Applying a gender-transformative approach

68. Women, particularly those living with HIV, are leading essential community support, disseminating accurate information on HIV and COVID-19, boosting peer-to-peer support and promoting effective treatment access. Gender expertise must be built into response teams, public health messaging must target women, and support must be given to women on the frontlines. In HIV and COVID-19 responses, better outcomes will arise if women lead, with equal representation and decision-making power.
69. UN Women has a comprehensive response framework to COVID-19 which focuses on five priorities to address the impact of COVID-19 on women and girls: a) incidence and impact of gender-based violence, including domestic violence, is mitigated and reduced; b) social protection and economic stimulus packages serve women and girls; c) people support and practice the equal sharing of the burden of care; d) women and girls lead and participate in COVID-19 response planning and decision-making; and e) gender is mainstreamed into national, regional and global efforts including through gender data and coordination mechanisms. The UNAIDS Secretariat has advocated for a similar

framework to respond to the needs of women in the COVID-19 pandemic and has documented the increasing levels of violence faced by women, especially young women and adolescents, the needs of rural and poor women, of sex workers, lesbians, bisexual and transgender people, migrant women, and women in prison.

70. UN Women is increasing flexible funding for civil society organizations working on violence against women by providing core funding to help them adjust to challenges arising as a result of the COVID-19 crisis and to ensure the stability of projects and sustainability of the organization in the longer term. In partnership with the Spotlight Initiative and the UN Trust Fund to End Violence Against Women, US\$ 9 million has been allocated for immediate support to women's organizations in sub-Saharan Africa with a primary focus on the institutional response, risk mitigation and recovery in the context of the COVID-19 pandemic.
71. The role women play in responding to both the HIV and COVID-19 epidemics – as frontline health care workers, caregivers and as community leaders – must be acknowledged, supported and harnessed. Women living with HIV must be part of the decision-making fora for COVID-19 response, exercising their voice and agency and bringing upfront needs and priorities of those who are impacted the most. Women living with HIV organizations and networks should be adequately financed to sustain their critical contribution and leadership role.

Enhancing the protection and fulfilment of rights

72. UNAIDS acted quickly to issue guidance around the need for a human rights-based approach to COVID-19, releasing on 20 March guidance on lessons learnt from HIV that should be incorporated into the COVID-19 response on the basis that only a response grounded in human rights will be effective. Its seven recommendations were: to engage affected communities from the beginning in all response measures in order to build trust; combat all forms of stigma and discrimination; ensure access to free or affordable screening, testing and care for the most vulnerable; remove barriers to people protecting their own health including fear of unemployment, misinformation, lack of infrastructure; restrictions to protect public health must be of limited duration and proportionate; countries must support each other by sharing information, knowledge, resources and technical expertise; and support and protect health care workers.
73. Regrettably, in some cases the COVID-19 pandemic has been used to undermine rights. Governments have used emergency powers for COVID-19 lockdowns to [target key populations](#), in a misuse of emergency powers to lessen human rights protections for the most vulnerable. Examples which have drawn international condemnation include the use of emergency powers by Hungary to restrict rights of transgender people; and the use of the emergency by Poland to increase the penalties for HIV transmission, exposure and non-disclosure.
74. Gay men and other men who have sex with men account for almost 20% of new HIV infections globally. Many of these men face high levels of stigma, discrimination and physical violence. The COVID-19 is compounding the challenges that lesbian, gay, bisexual, transgender and intersex (LGBTI) people already face in realising their rights, including safe and quality health services. People of diverse sexual orientations and gender identities are often some of the first targets and among the most impacted by increased policing and surveillance efforts. In March 2020, this fear was realized as 20 young LGBTI people were arrested at a shelter in Uganda with authorities claiming it was due to disobeying social distancing procedures. For 50 days, local human rights

defenders worked to secure their release with the support of UNAIDS and other UN agencies. Spurious claims against LGBT people have emerged throughout the world, and UNAIDS has stood in solidarity and worked with communities to counter such claims, discrimination and rights abuses.

75. Just as sex workers have historically been stigmatized and accused of “spreading HIV” and caught under discriminatory laws and enforcement practices, so too have they been targeted and subject to arrest under COVID-19 responses. As a consequence of the epidemic, they have lost considerable income and many have become impoverished, increasing their risk of engagement in riskier sex. In Uganda over 117 sex workers were [arrested](#) over a two-week period. Over 800 sex workers were [arrested](#) in Kenya. Sex workers have often also been excluded from financial support packages and social protection on the basis that their work is not recognized as work or is criminalized, leaving sex workers and their families to starve. UNAIDS responded by releasing a [joint statement with the Network of Sex Worker Projects](#) providing guidance to countries on how best to support and work with sex workers during the COVID-19 pandemic.
76. Drug users have also been the target of inappropriate policing and harassment in the context of COVID-19. One area of elevated risk to drug users is the nexus between drug use and imprisonment or compulsory detention in drug rehabilitation centres. Such centres have been found to be ineffective in addressing drug use, given very high rates of return to drug use by those detained, and have been associated with severe abuse of rights. A [Joint UN Statement on compulsory drug detention and rehabilitation centres in Asia and the Pacific in the context of COVID-19](#) was signed by 16 regional directors of 13 United Nations entities covering the region, including all UNAIDS Cosponsors. The statement calls on UN Member States to permanently close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community. The Statement was prepared by the UNAIDS Asia Pacific Regional Office in partnership with OHCHR Asia as part of ongoing advocacy efforts to transition to voluntary community-based treatment and services for people who use drugs.
77. Analysis by the UNAIDS Secretariat has found that there is a link between community engagement and rights protections which cut across both HIV and COVID-19 contexts: where human rights principles are least likely to be in place, networks of PLHIV and other affected communities are largely reported not to be part of the COVID-19 planning/governance process. Enabling legal and policy environments and programmes to reduce stigma and discrimination are critical for encouraging people to come forward for testing and treatment and to access services and support. Countries where, for example, sex work is not criminalized, sex workers have been able to register to receive income support during this time. At the requests of two networks, NSWP and MPact, UNAIDS joined in urgent calls to action to address issues of violence, discrimination, housing, income and safety for sex workers and gay and bisexual men and other men who have sex with men. UNAIDS is working with GNP+ to respond to urgent needs in more than two dozen countries, ranging from access to ARVs, food, and PPE to human rights issues of policy and policing.
78. The UN must champion community-led responses which build on the lived experiences of people affected by COVID-19. Rights protections are most acute in closed settings. People in prisons are at higher risk for COVID-19 because of overcrowding and other prison conditions. The UNAIDS COVID-19 Portal finds that many countries are putting in place special measures for people who are incarcerated or in detention, particularly release of prisoners and cancellation of visitations. Implementation of special measures for people who are incarcerated or in detention varies by region. While non-custodial sentences for minor offences have been a common response in many regions, they

were not reported in Eastern Europe and Central Asia, and decongestion of prisons by moving prisoners to other prisons or improvements to living arrangements was not reported in the Latin America and Caribbean region. UNODC, WHO, UNAIDS and OHCHR have issued the [UN Joint Statement on COVID-19 in Prisons and Closed Settings](#) to urge key measures to protect those in prison and other closed settings from the acute risks that COVID-19 poses. In addition, to address overcrowding and mitigate the risk of COVID-19 transmission in prison, UNODC has advocated for efforts to curb the inflow of prisoners and accelerate the release of suitable categories of prisoners, including through alternatives to imprisonment and to pre-trial detention, the temporary suspension of certain sentences and the early release of people in prison (e.g. in Malawi, Moldova, Myanmar and Zambia), in line with national policies and without compromising public health and safety. In Myanmar, UNODC is also supporting the development and distribution of release packages which include information about COVID-19, antiretroviral therapy, opioid substitution therapy, and drug overdose prevention and management.

79. In numerous countries, members of the Joint Programme, particularly but not exclusively UNDP, are documenting rights violations against people living with and affected by HIV and key populations and are working with community groups, the judiciary and others to address those violations and the attendant needs that arise. This work includes, for example, support from UNDP to the Eurasian Key Populations Health Network (EKHN) and other partners to measure the impacts of COVID-19 on trans health (including mental health) and trans health care systems. In Barbados, Grenada, Guyana and St Lucia, UNDP is conducting a study to understand the socio-economic impact of the COVID-19 pandemic on LGBTI communities. The results will be used to inform programmatic activities and will serve as a baseline assessment of the impact of public health measures on the community as the pandemic unfolds.

Applying a gender-transformative approach

80. Gender based violence is on the rise as countries put in place confinement policies, and with it, increased risk of HIV. The emergence of COVID-19 has led to [increases in domestic violence](#) among households in lockdown. A number of countries have recorded more than a 30% increase in reports of violence or calls to emergency hotlines and LGBT persons are at increased risk of violence and harassment from families in lockdown. [Violence](#) increases the risk of acquiring HIV for women, particularly young women. As countries adapt services for survivors of violence in the context of COVID-19 it is particularly important to integrate services for women who are also at risk of HIV. The Joint Programme is advocating for services to address violence against women to be designated as 'essential services' and be accessible to survivors as a safe space.
81. The UNAIDS COVID-19 portal reports that 70% of 86 countries supported by the UNAIDS Secretariat have put measures in place to protect women and children from violence, including domestic violence. Measures include government hotlines (e.g. in Myanmar and Uzbekistan), support to shelters (e.g. Dominican Republic and Zambia), free 24-hour emergency medical services (Kenya), and mobile gender-based violence (GBV) clinics (Mozambique). Many of these measures have received support from the Joint Programme: for example, in South Africa, UN Women supports a project in the Eastern Cape to accelerate service delivery for survivors of GBV as part of the Presidency's Emergency Plan on GBV. UNFPA is adapting referral pathways for GBV survivors and case management service delivery models. Such services include the clinical management of rape, with protocols in place to reduce the risk of infection among frontline service providers including an adequate supply of PPE. UNFPA is also ensuring that health workers have the skills and resources to deal with sensitive GBV-related information, that any disclosures are met with respect, empathy and confidentiality and

that services apply a survivor-centred approach. Importantly, UNFPA is ensuring these services include mental health and psycho-social support while encompassing infection control and protection measures for counsellors.

82. COVID-19 creates an opportunity to “Build Back Better” in responses for women and girls – to advance key actions that have always been needed but require intensified political will and investment. The Joint Programme launched a [guide](#) entitled “Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic”. It is designed to provide recommendations to governments to confront the gendered and discriminatory impact of COVID-19. The guide covers: differing needs of women and girls, particularly those most marginalized; access to essential health services; the neglected epidemic of gender-based violence against women and girls; misuse of criminal and punitive laws; adolescent girls’ and young women’s education, health and well-being; and valuing women’s work and making unpaid care work everybody’s work. The guide builds on the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination which provides a platform and an opportunity to accelerate action on ending HIV- and COVID-related stigma and discrimination, repealing discriminatory laws, and removing barriers that deter women from accessing services.

Innovation and financing in COVID-19 context

83. The response to COVID-19 has been marked by a dramatic expansion of innovation in multiple areas as the pandemic profoundly disrupted health systems, economies and societies at large. The Joint Programme has worked closely with a range of innovators in repurposing innovations to respond to the pandemic. In China, the ongoing partnership with Infervision on use of AI for TB screening was repurposed to screen for COVID-19 and deployed in several hospitals in Wuhan to support early diagnosis. UNICEF, WHO TDR and the UNAIDS Secretariat are hosting an online Health Innovation Exchange marketplace that will showcase more than 20 innovations for health, including for COVID-19, on 1-2 July. Another collaboration involves UNICEF, WHO and the Secretariat collaborating with GNP+, the Global Fund and AIDSFonds to develop an AIDS alert that will provide real time information to address the concerns of PLHIV on HIV and COVID-19. Working with Startup Blink, a global leader on innovation ecosystem mapping, UNAIDS has mapped over 1000 innovations for COVID-19.

Resources for HIV responses in the COVID-19 context

84. Beginning in early March, the World Bank Group initiated a three-phased response. The first phase is a \$14 billion emergency one. The second is focused on social assistance with \$20 billion to be disbursed through cash transfers, and community driven development and public works programmes. The third includes up to \$160 billion for recovery. The first phase includes a \$6 billion fund that is helping countries with support for the health care system in order to provide optimal medical care, including continuation of HIV services, maintain essential community services, and minimize risks for patients and health personnel. As of 22 May, the Bank has emergency health operations approved and up and running in over 100 developing countries. Additional resources for health and other key sectors critical to the HIV response are also being leveraged through other World Bank mechanisms including existing programming.
85. UNICEF has launched a global Humanitarian Action for Children (HAC) appeal for COVID-19 to support a broad-based humanitarian assistance programmes in countries. As of 5 June, US\$494 million has been mobilized to support national programmes in two

priority areas: 1) the public health response to reduce COVID-19 transmission and mortality; and 2) continuity of health, HIV, nutrition, education, child protection and other social services to address the immediate impacts of the COVID-19 response.

86. Despite these resource mobilization and redeployment efforts to ensure financing for systems for health and for social protection, as this paper has demonstrated, the AIDS response is simultaneously facing major opportunities and challenges. The opportunities involving bringing to bear on COVID-19 responses the relevant know-how from decades of learning in the AIDS response – including the expertise and mandate of the Joint Programme. The challenges revolve around ensuring that the response to HIV is accelerated, as it has to if we are to end AIDS in the next decade, even in the context of another pandemic which makes that acceleration more challenging than it was just a few months ago.
87. In consultation with the CCO Chair, and following the briefing to the PCB membership on UNAIDS work in the context of COVID-19, the Secretariat has empowered Joint UN Country Teams to reprogramme up to 50% of the 2020 UNAIDS country envelope fund, amounting to US\$ 12.5 million, for COVID-19 related activities. Similarly, the decision was taken to use of up to fifty percent of the UNAIDS Secretariat's 2020 core activity budget, amounting to US\$ 8.5 million, for COVID-19 related activities. Teams were requested to prioritize reprogramming options based on the country context, bearing in mind Government priorities, investments by partners and counterparts, and co-funding opportunities (e.g., appeals), and aim to achieve the greatest impact for people from these consolidated interventions. In Somalia, for example, 50% of the country team envelope has been re-programmed to provide cash transfers to PLHIV in response to COVID-19 under the leadership of UNICEF and the Secretariat. And in DRC, UNHCR complemented planned purchase of HIV viral load monitoring with compatible COVID-19 testing material to increase diagnostic capacity in remote areas.
88. UNAIDS has asked its partners to reprogramme and access new HIV funds in response to COVID-19. This included inputs to Global Fund guidance for COVID-19 funding opportunities and targeted technical support in selected countries to access Global Fund COVID-19 financing (including support to avail grant flexibilities and of the COVID-19 Response Mechanism. UNAIDS country offices have been: i) coordinating the joint UN team to support development of response plans and funding requests for Fund applications; ii) ensuring critical partners, particularly communities, are engaged; iii) ensuring that the needs of key and vulnerable populations are covered in the applications; and iv) ensuring that HIV testing, prevention and treatment services are not lost or minimized as a result of the focus on the COVID-19 response. UNAIDS country offices report reprogramming of Global Fund grants in 18 countries in West and Central Africa, 16 countries in East and Southern Africa, 12 countries in Asia Pacific, 10 countries in Latin America and the Caribbean, eight countries in Eastern Europe and Central Asia, and six countries in the Middle East and North Africa. While progress has been made, we must improve both in terms of the number of countries applying and the substance of their applications, so the Joint Programme will redouble its efforts. UNAIDS is now invited to provide comments on funding requests before they are reviewed by the Global Fund COVID-19 Secretariat.
89. The US President's Emergency Plan for AIDS Relief (PEPFAR) is providing its country and regional teams with flexibility to determine how to optimally serve HIV clients affected by COVID-19 based on local contexts. UNAIDS country offices are continuously engaged with PEPFAR counterparts to coordinate, share strategic information and direct investments where they most needed. In Zimbabwe, for example, the UCO meets

weekly with PEPFAR, and in Tanzania, the UCO is facilitating the use of PEPFAR supported programmes to adapt to COVID-19 exigencies.

90. UNAIDS country offices are also working with other development partners to support HIV programming in the COVID-19 context. In Tanzania, for example, the UCO has reprogrammed some funds from Irish Aid, originally earmarked for a stigma and discrimination campaign, to support the COVID-19 response.
91. The financial impacts of the pandemic are still subject to considerable uncertainty. The World Bank expects global GDP to shrink by over 5% this year and estimates that 90% of the world's economies will suffer falling levels of GDP in 2020. Investments in the HIV response (and similarly the Joint Programme) need to be maintained to mitigate the social and economic effects resulting from colliding pandemics of HIV and COVID-19, especially in poorer countries and the overwhelming evidence of the returns to social investments.

Conclusion

92. The response to and recovery from COVID-19 can help to steer the world onto a safer, healthier, more just and sustainable path. Conversely, poor policy choices risk worsening inequality and undermining health and development gains. The opportunity to build back better must be seized, as it will not only maximize the effectiveness of efforts against COVID-19, it will enable the world to get back on track to end AIDS as a public health threat and achieve other health-related targets by 2030.
93. We face a transformational moment where norms, values and institutions are being tested, assessed and in some cases reimaged. Leadership for the AIDS response has been led by people living with and affected by HIV who were not content with the status quo and who often suffered from marginalized, violence of willful negligence. The AIDS movement has learned much about leadership over four decades. Political leadership for HIV has been strong, consistent, courageous, inclusive and driven by scientific evidence – signposts for effective leadership in the COVID-19 response. Leaders from the HIV response, and the Joint Programme (Box 5), are being tapped at global, national and front-line clinical levels to respond to COVID-19.
94. Committed leadership for the COVID-19 response can draw on HIV experience to unite diverse stakeholders in a common undertaking, with agreed milestones for success; earn the trust of the public through consistent, accurate messaging; mobilize essential financing; rapidly adapt systems to respond to new and evolving challenges; and undertake strategic and results-driven planning for the use of finite resources. Senior political leaders, parliamentarians and regional bodies have championed the fight against HIV; the G7 and G20 groups have elevated HIV as a global priority; faith-based leaders emerged as pillars of national responses; and recent years have seen greater engagement on HIV by the private sector, as reflected by the launch of the Business Alliance to End AIDS by 2030, the impact of which can be maximized through the active inclusion and support from workers' organizations. Community activism has played a central role in focusing decision-makers on addressing the HIV pandemic.

Box 5. The Joint Programme – Leading UN COVID-19 responses

UNAIDS Country Teams possess vital experience in coordinating and marshalling buy-in from Cosponsors. As a result, a number of UNAIDS Country Directors have been asked to take on the role of UN COVID-19 Coordinator. The roles have also fed into wider national processes. In Chad, the Joint Programme, under the leadership of the UNAIDS Country Director, helped ensure that the national COVID-19 contingency plans contained measures to safeguard access to treatment and care for people living with HIV. In Kenya, alongside direct responsibilities as UN COVID-19 coordinator, the UNAIDS Country Director helped establish a United Nations Kenya solidarity fund to support people in need.

Across the world, United Nations Resident Coordinators have established COVID-19 response teams whose role includes ensuring United Nations staff and their dependents can access health care. In many countries, including Burkina Faso, Cambodia, Chad, El Salvador and Kenya, the UNAIDS Country Director has been appointed to coordinate the UN response team.

In Cambodia, the Joint Programme, led by the UNAIDS Country Director, developed a contingency plan for the 2500 members of the UN family, including medical evacuation procedures. In Chad, with 7000 United Nations employees and dependents spread out across the country, the UNAIDS Country Director led UN efforts to ensure that intensive care units were expanded and a strong referral system for the management of severe cases established. It has been reported that responding to the crisis has helped bring UN country teams together, and the effort has been appreciated: in a Cambodia survey of staff, 90% said that the United Nations leadership at the country level is making the right decisions managing the crisis.

95. HIV leadership has also been audacious and ambitious. Although the early target of three million people by 2005 for HIV treatment was regarded by many as unrealistic, as of June 2019, 24.5 million (65%) people were receiving antiretroviral therapy. Similar skepticism greeted the G7 pledge to provide at least US\$ 60 billion in HIV assistance to sub-Saharan Africa in 2007-2012, yet this [commitment was kept](#), helping spur extraordinary health gains across the region. In South Africa, home to one in five people living with HIV, early denial about the seriousness of the HIV epidemic has been supplanted by inspired political leadership, with the domestic public sector now covering more than [76% of all HIV-related spending](#) in the country.
96. By taking on board lessons learned through HIV, fighting COVID-19 can aid in re-imagining systems of health to make good on the health-related commitments of the 2030 Agenda. At the same time that the HIV experience helps inform COVID-19 responses, the unfolding response to the evolving COVID-19 pandemic will undoubtedly yield lessons that can benefit both the HIV response as well as broader efforts to strengthen health systems to ensure health, rights and dignity for all, everywhere.
97. The Joint Programme's strengths are as vital for ending AIDS as they are for tackling the COVID-19 threat: uniting a global partnership, speaking out in solidarity with the people most affected and in defense of human dignity, human rights and gender equality, mobilizing political, technical, scientific and financial resources and holding itself and others accountable for results and in supporting inclusive country leadership to end AIDS. The goal of ending AIDS is integral to achieving the SDGs and the resilient systems that will be needed to achieve them. The COVID-19 pandemic has not altered the direction of this ambition – it has just made it all the more urgent.

Annex. Selected resources on COVID-19 and HIV

- UNAIDS. [What people living with HIV need to know about HIV and COVID-19](#)
- UNAIDS. [Rights in the time of COVID-19 Lessons from HIV for an effective, community-led response](#)
- UNAIDS. [Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic](#)
- UN Secretary-General. [Policy Brief: The Impact of COVID-19 on women](#)
- UN Women. [UN Women's response to COVID-19](#)
- UN Women. [In Focus: Gender equality matters in COVID-19 response](#)
- UN Women. [COVID-19: Emerging gender data and why it matters](#)
- ILO. [Addressing stigma and discrimination in the COVID-19 response: Key lessons from the response to HIV and AIDS](#)
- UNFPA. [Sexual and Reproductive Health and Rights, Maternal and Newborn Health & COVID-19](#)
- FHI360, in collaboration with UNAIDS and WHO. [Strategic considerations for mitigating the impact of COVID-19 on key-population-focused HIV programs](#)
- UNODC. [COVID-19: HIV prevention, care and support for people who use drugs and people in prisons](#)
- WHO. [HIV, antiretrovirals and COVID-19](#)
- UNAIDS and MPact. [Joint statement with MPACT on LGBT communities](#)
- Joint UN statement. [Compulsory drug detention and rehabilitation centres in Asia and the Pacific in the context of COVID-19](#)
- Global Network of Sex Work Projects (NSWP) and UNAIDS. [Joint statement calling on governments not to leave sex workers behind in their COVID-19 responses](#)
- UNAIDS. [Statement on Hungary expressing concern at the use of emergency powers to restrict the rights of transgender people to be legally recognized by their proper gender and name](#)
- UNAIDS. [Statement on the misuse of emergency powers by Governments to target key populations and people living with HIV, including in Poland, Hungary, Kenya and Uganda](#)
- UNAIDS. [Statement on HIV community-led responses as essential services](#)
- UNODC, WHO, UNAIDS and OHCHR. [Joint statement on COVID-19 in prisons and other closed settings](#)
- UNAIDS. [The cost of inaction: COVID-19-related service disruption could cause hundreds of thousands of extra deaths from HIV](#)
- Puras D et al. [The right to health must guide responses to COVID-19](#)
- Global HIV Prevention Coalition and UNAIDS. [Maintaining and prioritizing HIV prevention services in the time of COVID-19](#)
- Global HIV Prevention Coalition, UNFPA and UNAIDS. [Condoms and lubricants in the time of COVID-19](#)
- Global HIV Prevention Coalition and UNAIDS. [Lessons from HIV prevention for preventing COVID-19 in low- and middle-income countries](#)

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