Agenda item 10

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COVID-19 AND HIV

Progress report 2020

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Action required at this meeting—the Programme Coordinating Board is invited to:

See draft decision points in the paragraphs below:

89. *Take note* of the report on COVID-19 and HIV;

90. *Request* the Joint Programme and countries to monitor the health and social impacts of the HIV and COVID-19 pandemics in real time, to allow all stakeholders to understand and address the drivers and mitigate the effects;

91. *Request* the Joint Programme and countries to continue leveraging HIV infrastructure and following a combined approach to both pandemics to contribute to resilient systems for health fully capable for detecting and addressing pandemics;

92. *Recognize* that the lessons learned from the multisectoral response to HIV epidemic should continue to inform epidemic preparedness;

93. *Request* the Joint Programme to support countries and communities to intensify, improve and sustain HIV prevention, treatment and care response in the context of COVID-19 by building on and sharing lessons learned, best practices and innovations, including multimonth dispensing and community engagement, to gain ground lost and improve agility, performance and efficiency towards achieving the goal of ending AIDS by 2030; and

94. *Call* upon donors and member states to protect and intensify investments, resource allocations and social protection measures for vulnerable and key populations most impacted by the dual HIV and COVID-19 pandemics.

Cost implications for the implementation of the decisions: none

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Executive summary

1. In response to the sustained COVID-19 pandemic, the Joint Programme and countries affected by HIV have mobilised the expertise and experience of decades-long response to the HIV pandemic to address challenges posed by the dual pandemics. While there have been notable successes in moderating the most severe impacts on HIV prevention, treatment and care programmes, the unpredictable COVID-19 pandemic necessitates a commitment to rapid response and innovation remains urgent.

2. The intersections between COVID-19 and HIV involve adverse health and socioeconomic impacts on pre-existing vulnerabilities, fragile health systems, limited social protection, and high HIV prevalence. COVID-19 response measures have in some ways negatively impacted HIV programmes, undermined human rights and solidarity, and exacerbated inequalities.

3. Poverty and marginalisation increase HIV-related vulnerabilities and the COVID-19 pandemic poses a threat to the global economy. Major declines in GDP are predicted with disproportionate negative impacts on low- and middle-income countries. Food and nutrition are critical components of care and support for people living with HIV, and food insecurity and poverty are underlying drivers of HIV risk. HIV vulnerable populations, including women and girls and key populations, are likely to be disproportionally impacted.

4. The Joint Programme, countries, and other key partners acted swiftly to mobilize a coherent response to COVID-19 across all regions with impacts, gaps and nuances related to HIV being addressed simultaneously. There has been significant work across the HIV response to mobilise coalitions and alliances, increase multisectoral engagement at country level, strengthen health systems, and ensure that lessons learned from the HIV response are shared globally. Nevertheless, gaps remain, and vigilance is necessary.

5. Notable aspects of the Joint Programme's mobilisation include flexibility to reprogramme country envelope funds to meet diverse and urgent needs and differentiated models of care, including community-led approaches that reduce stress on health services and improve their efficiency. In many countries, there has been successful implementation of multi-month dispensing of antiretroviral drugs, tuberculosis therapies, condoms, pre-exposure prophylaxis, and opioid substitution therapy. Innovative social protection approaches have also been developed.

6. UNAIDS Secretariat also plays a leading role in the People's Vaccine coalition, co-chairing this vital initiative that advocates for COVID-19 vaccines as global public goods. This process builds on historical experiences that led to lower-cost therapeutics for HIV. The UN General Assembly supports resource mobilisation through the Access to COVID-19 Tools Accelerator (ACT-A) and the COVAX Vaccines Facility. UNAIDS serves on the steering committee of the WHO COVID-19 Technology Access Pool (C-TAP) and is involved in the UN Technology Transfer Bank through the Technology Access Partnership.

7. The Joint Programme has emphasised human rights as a core concern for HIV and COVID-19 responses, and diverse guidance and support has been provided. Health service strengthening and community-led responses have been emphasised, prevention

and treatment have been addressed, attention has been placed on gender and other inequalities, and innovations continue to emerge to address dual epidemic concerns.

Background

8. Lessons learned, country actions and responses by the Joint Programme to COVID-19 were consolidated and presented to the PCB in June 2020—six months after the emergence of COVID-19 and in the context of a rapidly evolving pandemic.[1]

9. While the Joint Programme and countries affected by HIV have been able to mobilize the expertise and experience of decades-long response to the HIV pandemic to address challenges emerging due to COVID-19, there remain significant challenges ahead. A coordinated response has moderated the severity of the impacts of COVID-19 in countries during initial outbreaks, although the unpredictable future pathway of the pandemic and ongoing impact on HIV remain uncertain. Commitment to rapid response and innovation remains urgent.

10. Through the mandate of the eleven UNAIDS Cosponsors with the Secretariat, the Joint Programme has demonstrated value in addressing the intersections between the HIV and COVID-19 pandemics as a uniquely configured partnership in the UN system along with government, donor, civil society and community partnerships. Responses that are grounded in human rights and gender equality, engaging communities and supporting community-led activities are emphasized in conjunction with ensuring access to essential prevention, treatment and care services for HIV and COVID-19.

11. This report provides the PCB with a basis for discussing how diverse aspects of the HIV response should be adapted and leveraged in the context of current and emerging epidemics and pandemics, with a focus on the present and future intersections between HIV and COVID-19.

COVID-19 and HIV

12. COVID-19 threatens to derail progress towards the Sustainable Development Goals (SDGs), including those related to health, HIV and socioeconomic advancement. However, it can also offer an opportunity to respond to inequality and to build stronger, equity-oriented systems for health, strengthen social protection systems and improve public services with a focus on sustainability, solidarity and multilateral collaboration to support social cohesion, reduce inequality and support community resilience.[2]

Epidemiology

13. The COVID-19 pandemic follows a rapidly evolving heterogeneous and unpredictable path globally. By 1 November 2020, approximately 46 million cumulative cases and 1.2 million deaths had been recorded. New diagnoses continue to increase rapidly with regional distributions of cases and deaths varying over time.[3]

14. Almost half (45%) of cumulative COVID-19 cases globally have occurred in the WHO Region of the Americas, with the European Region and South-East Asia Region accounting for large proportions of the remainder (24% and 20% respectively) (Table 1).

15. In the HIV epidemic, the majority of new HIV infections occur in sub-Saharan Africa. HIV incidence is highest in southern and east Africa, especially among adolescent girls and

young women. Beyond sub-Saharan Africa, key populations and their sexual partners are most at risk of HIV infection.[4]

Table 1. Epidemiological data for COVID-19, at 18 October 2020, and for HIV, 2019

WHO Region	COVID-19 cumulative cases	COVID-19 mortality*	People living with HIV, 2019	New HIV infections in 2019	People receiving ART, 2019	AIDS-related mortality, 2019
Africa	1 324 258	29 785	25 700 000	970 000	17 800 000	440 000
	3%	2%	68%	57%	70%	64%
Europe	11 088 612	285 402	2 600 000	190 000	1 500 000	39 000
	24%	24%	7%	11%	6%	6%
Americas	20 477 535	639 353	3 700 000	170 000	2 500 000	52 000
	45%	54%	10%	10%	10%	8%
South-East Asia	9 251 788	144 194	3 700 000	160 000	2 200 000	110 000
	20%	12%	10%	9%	9%	16%
Eastern Mediterranean	3 092 037	78 599	420 000	44 000	100 000	15 000
	7%	7%	1%	3%	<1%	2%
Western Pacific	733 828	15 565	1 900 000	110 000	1 300 000	41 000
	2%	1%	5%	6%	5%	6%
Global	**45 968 799**	**1 192 911**	**38 000 000**	**1 700 000**	**400 000**	**690 000**

16. The intersections between COVID-19 and HIV involve adverse health and socioeconomic impacts that arise due to successive waves of high COVID-19 in contexts marked by pre-existing vulnerabilities, fragile health systems, limited social protection, and high HIV prevalence.[5] New outbreaks and successive waves of COVID-19 continue to occur, and the magnitude and severity of the pandemic remains unpredictable.

17. Whereas the HIV pandemic is long-standing and is addressed through well-established evidence-based approaches for prevention, treatment and care, the response to COVID-19 continues to be developed and assessed. Progress continues on therapeutics for the clinical management of COVID-19,[6] and research into vaccines is underway.[7] There is good evidence for the effectiveness of various preventive strategies, including the use of face masks, physical distancing, hygiene measures and moderating exposure indoors and in enclosed spaces.[8]

18. Systematic reviews of research have found that people living with HIV who have well-controlled HIV through ART are not at greater risk of contracting COVID-19 and do not have a higher COVID-19 mortality risk.[9] [10] Nonetheless, a South African study found that previous or current tuberculosis (TB) infection or current HIV infection—irrespective of viraemia or immunosuppression—was associated with around twice the risk COVID-19 mortality when compared to people without either condition.[11]

19. Underlying socioeconomic and other circumstantial factors predispose people living with HIV to SARS-COV-2 infection: for example, sex workers living with HIV have a higher risk of exposure due to the nature of their work. People who use drugs are face heightened vulnerability to COVID-19 due to underlying health issues, stigma, social marginalization and aggravated economic and social vulnerabilities, including a lack of access to housing and health care. People in slums or prison settings are especially at risk of acquiring COVID-19 when there is community spread due to their confinement and control measures involving physical distancing that are not an option in many countries.[12]

20. A mid-2020 United Nations (UN) report on the comprehensive response to COVID-19 has highlighted regional concerns in Africa linked to the potential for food insecurity, loss of income and livelihood, a debt crisis, and political and security risks due to new infections.[13] In Latin America, a sharp rise in unemployment, poverty, and undernutrition is anticipated, along with potential for heightened social unrest and political conflict. While economies are stronger in the Arab States, gender and other inequalities may be magnified by the pandemic. Although many of these challenges are long-standing, there is an opportunity to mount a concerted recovery through a coordinated and comprehensive response.

21. Responding to COVID-19 and HIV together requires a focus on key populations and other vulnerable people to address prevention, treatment, care and support needs. UNAIDS has highlighted the commitments to the 2030 Agenda for Sustainable Development to strengthen social protection systems in the face of COVID-19 pandemic.[14] In the context of HIV, key populations include sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and prisoners. Other vulnerable people include adolescent girls and young women, children, migrants and refugees, homeless people, clients of sex workers and sexual partners of all key populations, people living in under-resourced high-density settings, and older people.

22. The 2020 Fast-Track targets for HIV prevention and treatment have not been met, and this poses a particular challenge in the context of the parallel COVID-19 pandemic. Between 2015 and 2020, 3.5 million more new infections and 820 000 more deaths occurred than would have been the case if the targets had been achieved.[4] Targets for result areas such as health and wellbeing, reduced inequalities, gender equality, resource mobilization and partnerships for the response were also not met. New and innovative approaches are necessary to accelerate the response, and the forthcoming period must involve more intensive and focused programmes to ensure that the goal of ending the AIDS epidemic by 2030 is achieved.

Programmatic impacts

23. Responses to COVID-19 include localized and country-level lockdown measures such as restrictions on public gatherings, workplace and school closures, curtailment of public transport and international travel, restrictions on internal movement and stay-at-home orders.[15] Such measures have negatively impacted on HIV prevention, treatment and care programmes and have undermined human rights and social solidarity in many settings—including exacerbating inequalities related to gender and circumstances of key populations. There are emerging inequalities regarding access to resources necessary for supporting fragile health systems, accessing therapeutics and treatment for HIV and COVID-19 (and future COVID-19 vaccines), and access to resources for ameliorating socioeconomic disruptions.

24. The COVID-19 pandemic disrupts HIV services, and UNAIDS and WHO collaborated with the HIV Modelling Consortium to identify potential impacts on HIV. Modelling studies in Malawi, Mozambique, Uganda and Zimbabwe indicate that disruptions of ART services for six months for 50% of the people living with HIV could result in 760 000 AIDS related deaths in Sub-Saharan Africa. Disruption of PMTCT services could result in dramatic increases in new HIV infections among children in Sub-Saharan Africa – with 162% projected increase in Malawi, 139% increase in Uganda, 103% increase in Zimbabwe, and 83% increase in Mozambique.[16] [17]

25. Uptake of HIV testing and access to ART (including ART for the prevention of mother to child transmission, or PMTCT) has been reduced due to COVID-19, as has access to therapies for tuberculosis (TB) and opioid substitution therapy.[18] Other challenges include curtailed diagnostic services, lack of mental health support,[19] gaps in access to services and antiretroviral drugs (ARVs) by children,[20] and disruptions to livelihoods.[21]

26. In very high HIV prevalence settings in Africa, it is estimated that the impacts of COVID-19 in a high reproduction number (3.0) could contribute to a 10% increase in HIV deaths over five years compared to a "no COVID-19" scenario. In high and moderate TB burden settings, such as southern Africa and South America, estimates indicate that TB-related deaths could increase by 20% over the same period.[22]

27. The effects of the COVID-19 pandemic include concerns about mental health. A WHO survey of 130 countries found that 65% of them had experienced disruptions to harm reduction services and 45% to treatment for opioid dependence.[23] A survey in Asia and the Pacific found that 70% of youth in key populations or living with HIV felt anxious and were concerned about their health, family members health, loss of income, medication access and isolation, among other factors.[24]

28. Exploitation and violence against women and girls increase their HIV infection risks and are on the rise among women working in the informal sector and migrant women. [25] Gender-based violence services which moderate these risks, including shelters for survivors, have been disrupted. Legal and forensic services supporting victims of violence were also disrupted.[26]

29. Supply chain continuity is vital for many HIV commodities, including HIV medicines. A review by UNAIDS on the value chain of production and distribution of ARVs found that lockdowns impacted negatively on various aspects of production and distribution.[27] For example, reduced access to raw materials, labour shortages, downscaling of customs services, and storage limitations. While these constraints were reduced as the first-wave of the pandemic receded, successive waves of COVID-19 pose ongoing threats to the supply chain.

30. While strategies such as multimonth dispensing (MMD) can improve access to ARVs and other commodities, the initial rollout of this strategy was challenging. For example, out of 138 countries providing data to the UNAIDS COVID-19 portal, 30 indicated that MMD implementation was constrained by policy limitations, while 25 countries reported constraints related to clinical guidelines such as viral load requirements or provider considerations. Stock-related factors were identified as a challenge in more than half of the countries surveyed.[28]

Economic impacts

31. Global events such as recessions, emergencies and health crises deplete resources and reshape funding agendas for health concerns. International funding for HIV declined during the previous financial crisis and the Eurozone debt crisis, and COVID-19 impacts on high-income countries may constrain donor commitments in the medium term.

32. Social protection measures including cash transfers, expanded access to health care, family-friendly employment policies, and strengthened public finance response are crucial in lower- and middle-income countries. Such measures have been vital during previous financial, food and fuel crises, yet 4 billion people (including two thirds of children) currently lack such support and the COVID-19 pandemic amplifies these needs.[29]

33. The negative economic consequences of COVID-19 for HIV treatment are considerable. Costs of raw materials for ARVs and other vital HIV commodities have increased, currency fluctuations impact on affordability, and economic impacts of the pandemic on countries reduces their capacity to fund HIV response or absorb cost increases. Impacts have been noted on lead times for commodities – which have increased by four to twelve weeks, packaging supplies are constrained, and workforce shortages occur during high COVID-19 incidence periods in manufacturing and receiving countries.[27]

34. Poverty and marginalization increase HIV-related vulnerabilities and the COVID-19 pandemic poses a threat to the global economy. The International Monetary Fund projects gross domestic product declines of 8% in advanced economies and 3% in emerging markets and developing economies in 2020.[30] The World Trade Organization projects a 32% decline in global trade in 2020. It is anticipated that a global economic downturn will lead to disproportionately negative impacts on low- and middle-income countries, resulting in significant job losses that are likely to push at least 71 million more people into extreme poverty.[31] The World Bank estimates that increased poverty will impact an additional 150 million people by 2021.[32]

35. A large proportion of people in key populations reside in urban areas, and the vast majority of COVID-19 cases have occurred in cities, posing risks to health and livelihoods in slums and informal settlements. COVID-19 prevention measures such as social distancing is much harder to implement in slums and crowded residences, and outbreaks are not easily controlled in informal settlements. People in cities face heightened challenges in accessing health services, including HIV services due to COVID-19.[33]

36. Food and nutrition are critical components of care and support for people living with HIV, and food insecurity is an underlying driver of HIV risk. There have been severe impacts on informal employment which represents 90% of employment in low-income countries and 67% of employment in middle-income countries.[34] Remittances from migrants to families in their home countries have declined significantly. Migrant workers also face joblessness abroad and when returning home.[35] It is estimated that 265 million people in low- and middle-income countries will face acute food insecurity in 2020 due to COVID-19, an increase of 130 million compared with 2019.[36]

Rising inequality

37. Vulnerability to HIV and gaps and barriers related to HIV prevention and treatment are directly influenced by gender, education, economic and other inequalities. COVID-19 has widened gender, education and economic inequalities. Female workers are especially prone to losing their livelihoods due to the fact that they are more likely to be employed in hard-hit sections of the economies, particularly the service sector. Gender-based violence—which contributes to HIV transmission and undermines access to treatment and care—has increased during periods when stay-at-home restrictions were imposed. The burden of unpaid domestic work for women has also increased, and families are required to provide support to home schooling and additional childcare among other new responsibilities.[37]

38. New HIV infections among women are increasing in eastern Europe and central Asia, the Middle East and North Africa, and Latin America. Girls and young women are disproportionately likely to be living with HIV in sub-Saharan Africa and are more affected by service disruptions, gender-based violence and economic impacts in this region.[38] School closures expose of girls to heightened risk of teenage pregnancies,

exploitation and abuse, and in some countries, increases in child marriages are anticipated due to economic stress on households, and other factors.[39]

39. Sex workers face the loss of their primary source of income due to COVID-related restrictions, social distancing requirements, closure of workplaces, harassment by authorities. Sex workers are typically not eligible for emergency economic support or social benefits.[40] A survey of sex workers in lower-income countries found that most had dramatically reduced their prices for sex. Many did not have alternate sources of income and did not have access to savings.[41]

40. Migrants and poor people are, in general, less able to moderate their risks of exposure to SARS-COV-2, the virus that leads to COVID-19. Many low-income workers are vulnerable to workplace closures or job-losses due to the collapse of sectors where work involves physical labour.[42] Low-income workers and essential workers have high exposure to SARS-COV-2 on multiple fronts, including at work and by using public or shared transport for commuting to and from work.

41. An estimated 1 in 14 people living with HIV were affected by humanitarian emergencies in 2016, resulting in reduced access to prevention, treatment, care and support services. COVID-19 is harder to control in humanitarian situations due to the fragility of health and other systems in crisis and post-crisis environments.[43]

42. Poorer households include smaller residential spaces, many with multiple generations or multiple families living together. People in these contexts are more likely to be living with or affected by HIV in comparison to other settings. Extended family structures are common in low- and middle-income countries: 45% of people in Asia-Pacific live in extended families, as do 35% of people in sub-Saharan Africa and 32% of people in Latin America and the Caribbean.[44]

43. Older people are more vulnerable to social isolation and discrimination, and face heightened risks of severe COVID-19 illness and death. They also play important roles in caregiving and family stability, enabling economic activity and enabling production by extended family members. They are influential in shaping knowledge and social norms and occupy crucial roles in community life that have a bearing on health and wellbeing.[2]

44. People with disabilities have a heightened risk of HIV infection. They face stigma and discrimination, constrained access to health and education services, increased exposure to gender-based violence and are financially more vulnerable.[45] Disability is a cross-cutting consideration among key and other vulnerable populations, and the inequalities of people with disability are heightened by COVID-19, including the risk of more severe health impacts and higher rates of mortality.[46]

Joint Programme response to COVID-19 and HIV

45. The Joint Programme in collaboration with countries and other key partners acted swiftly to mobilize a coherent response to COVID-19 across all regions with impacts, gaps and nuances related to HIV being addressed simultaneously. Key strategic lessons include building strong community-led responses early on, establishing multisectoral coalitions including beyond health, ensuring that key and vulnerable populations are not left behind, and clearly defining packages and pillars for response.[47]

Leveraging lessons learned from HIV

46. While COVID-19 has immediate effects on health, there are many longer-term social and economic consequences that exacerbate the challenges for HIV response. A recent report on HIV and COVID-19 ("Moment, Epidemic, Opportunities: towards reinvigorating global health and rights") highlighted several key elements.[48] They include building on the HIV response by placing communities at the centre with regard to governance and planning, as well as service delivery and accountability, emphasizing human rights and equality, and following a multisectoral approach. The HIV response includes substantial infrastructure, strategic know-how, and political and scientific leadership, and there are opportunities to leverage these lessons and frameworks to build new and improved systems for health.

47. There has been significant work across the HIV response to mobilise coalitions and alliances, increase multisectoral engagement at country level, strengthen health systems, and ensure that lessons learned from the HIV response are shared globally. This multinational infrastructure represents a robust resource for a continued response to both HIV and COVID-19. Sustained political will is necessary to provide leadership that unites diverse stakeholders responding to a pandemic. Nevertheless, it remains that gaps exist in the responses, and that the pathway of COVID-19 and its interrelation and impacts on HIV may follow unanticipated directions. Vigilance is necessary to ensure ongoing preparedness and sustaining robust health systems.

48. Responses should involve precision public health approaches that foster agility and adaptability of inclusive services, place people living with HIV at the centre and ensure that communities play a leadership role. Such approaches have allowed for the possibility of reimagining resilient health systems that respond to HIV and COVID-19 together.

49. In recognition of their expertise in responding to pandemics, HIV experts have been drawn into COVID-19 advisory committees and management teams. National AIDS Council directors and personnel served on those committees in sub-Saharan Africa, Latin America, the Middle East and North America. For example, in South Africa, the COVID-19 response committee was led and supported by numerous HIV experts. National AIDS directors in Angola, Brazil, China, the Democratic Republic of the Congo, Ethiopia, Guatemala, Guinea, the Islamic Republic of Iran, Kenya, Malawi, Mexico, Nigeria and Zambia are serving as members of national planning and decision-making bodies for national COVID-19 responses. Health services and diagnostic systems that had been strengthened during the response to HIV have provided a vital foundation for COVID-19 response, especially in low- and middle-income countries.

50. UNAIDS has partnered with the Africa Centers for Disease Control to support the Partnership to Accelerate COVID-19 testing Initiative. PACT has three pillars—Test, Trace and Treat—and covers the procurement and distribution of test kits, the deployment and training of 1 million community health workers to support contact tracing, monitoring and COVID-19 sensitization measures. UNAIDS is leveraging and mobilizing linkages with HIV communities to support the rollout of the initiative in eight selected countries in western and central Africa (Côte d'Ivoire, Gabon, Ghana), eastern and southern Africa (Madagascar, Malawi, Namibia, Zambia) and the Middle-East and North Africa (Algeria).

51. Community-led responses have been the linchpin for societal resilience in sustaining the HIV response and for minimizing the impacts of COVID-19. Communities of affected people serving affected people have pioneered many innovations that have improved

access to HIV services and contributed to the efficiency of services. Community empowerment and leadership are effective for mobilizing prevention behaviours and improving access to prevention commodities, especially among key populations. There are also benefits to accurate, culturally appropriate and trusted communication that is developed and conveyed through community leaders and networks.

Mobilizing HIV response and infrastructure

52. The Joint Programme has been working to leverage international and country partnerships alongside civil society formations and communities. These efforts aim to inform strategic, evidence-informed multisectoral action that is collaborative and people-centred. The Joint Programme has supported the coordination of efforts from donors and governments, networks of people living with HIV, key populations and communities to ensure that no-one is left behind in the responses to COVID-19 and HIV.

53. Responses of key partners—including the United States President's Emergency Plan for AIDS Relief and the Global Fund to fight AIDS, Tuberculosis and Malaria—have been strengthened to address the most pressing gaps and to mobilize infrastructure and human resources developed through the HIV response.[49]

54. Strategic information has been vital to the HIV response. Well-established data systems already gather subnational and disaggregated data, which provide detailed information that can guide policy and strategy adjustments and improve the targeting of services and programmes. Such systems have been mobilized to incorporate COVID-19 data needs. Granular, real-time data has been mobilized to provide vital insights, inform policies, guide strategies, improve targeting and help to clarify resource requirements. This has made it possible to address stock availability and confidence by making policy adjustments to support the securing of minimum stock supplies and improving forecasting.

55. Joint UN Teams on HIV were encouraged to reprogramme up to 50% of the 2020 UNAIDS country envelope funds and business unusual funds (USD 12.5 million), and UNAIDS Regional Support Team and Country Offices up to 50% of the 2020 UNAIDS Secretariat core funding (USD 4.4 million) for HIV and COVID-19 related activities. Reprogramming allowed for rapid responses to meet the diverse needs of people living with HIV, girls and women, key populations and emerging vulnerable groups such as migrants. Personal protective equipment supplies for health-care and prison settings, and for people living with HIV, were also augmented. Of the special UNAIDS headquarters fund of USD 1 million made available for COVID-19 response, by early November 2020, USD 708 800 has been spent on macroeconomic assessment and analysis, as well as on support to communities.

56. In western Africa, the WFP and UNAIDS collaborated in designing and piloting a cash transfer initiative in four priority countries (Burkina Faso, Cameroon, Côte d'Ivoire and Niger), providing cash transfers to people living with HIV and key populations and their households. The pilot initiative offers lessons learned for wider implementation and informs advocacy with diverse partners and funders.[50] UNAIDS is collaborating with UNICEF to build the capacity of UN Joint Team members in western and central Africa and to partner with government authorities in providing social protection services for people living with HIV and key populations.

Continuity of services

57. Differentiated models of care, including community-led approaches, reduce stress on health services and improve their efficiency. Multimonth dispensing (MMD) allows clinics to be decongested, reduces pressure on health-care workers and decreases SARS-COV-2 exposure risks for health-care workers and clients. MMD is directly applicable to ART, TB treatment, TB preventive therapy, condoms, pre-exposure prophylaxis for key populations, and opioid substitution therapy for people who use drugs, among other HIV-related commodities. MMD for ART reduces the risks of severe COVID-19 illness in people living with HIV.

58. Implementation of MMD policies is estimated to have halved the number of clinic visits by people living with HIV, and full implementation of current polices could lead to a further 20% reduction in clinic visits.[15] WHO guidelines allow for medication dispensing outside health facilities, and community service delivery approaches, including community ARV distribution and peer-led adherence clubs, reduce reliance on formal health services. [51]

59. Rapid introduction of MMD has minimized disruptions to ART dispensing. Several sub-Saharan Africa countries reported improved access to ART, and viral load suppression estimates have remained stable in many settings. Although prevention of mother-to-child transmission services declined initially due to COVID-19, levels recovered by July in most countries, according to the UNAIDS HIV services tracking database.

60. Many dedicated HIV programmes for HIV affected, at risk and key populations were disrupted due to COVID-19, although some countries have managed to sustain such programmes. While condom distribution to gay men and other men who have sex with men and transgender women declined in the early part of 2020, distribution in most countries had largely recovered by July. Free needle and syringe and opioid substitution therapy programmes for people who use drugs did not appear to be severely affected.

61. A WHO survey of 144 countries in July found that 129 countries (90% of those surveyed) had adopted MMD strategies for ARV drugs, typically involving 3-month prescription, though some countries were offering a 6-month option. MMD for opioid substitution therapy was provided in 24 out 62 countries. Globally, 24 out of 84 countries reported limited stocks of ARVs (three months or less). Disruptions to ARV supply were attributed to manufacturer shut-downs, health system capacity constraints, access to services and financial constraints, and movement restrictions.

62. The most affected HIV services were HIV testing, viral load monitoring, key population services, condom provision and VMMC (which was suspended in most of the priority countries). Viral hepatitis B and C and sexually transmitted infection services were also disrupted.[52]

63. People living with HIV and their networks have become advocates for MMD policies in some countries, and there is a growing understanding of the benefits of this approach, such as cost- and time-saving. Alongside these networks, UNAIDS continues to advocate for MMD by engaging with health authorities, and it is tracking implementation through COVID-19 Portal. Regional Support Teams and UNAIDS Country Offices serve a liaison and advocacy function.

64. To support sustained supply of condoms and lubricants, UNAIDS, and the Global Prevention Coalition developed a guideline emphasizing people-centred approaches in combination with strengthening logistics and ensuring adequate supply. Innovative

demand-generation approaches that were identified include the use of social and other media.[53]

Therapeutics and vaccines

65. Ensuring access to therapeutics for people living with HIV in low- and middle-income countries has been a long-standing goal of the global AIDS movement and the Joint Programme. Access to low-cost ARVs was assured through the Doha Declaration on Trade-Related Aspects of Intellectual Property Rights and Public Health and this key success in the AIDS response paved the way for the expansion of HIV treatment, which has saved millions of lives.[54]

66. The UN Secretary General has endorsed a COVID-19 vaccine as a global public good.[55] Efforts are underway to ensure fair access to a vaccine, for example via the People's Vaccine Alliance and resource mobilization via the Access to COVID-19 Tools Accelerator (ACT-A) and the COVAX Vaccines Facility. A letter from COVID-19 survivors in 37 countries under the auspices of the People's Vaccine Alliance provided further endorsement.

67. The COVID-19 People's Vaccine Alliance draws on lessons learned through campaigns to ensure affordable, widescale access to ART. The alliance urges that all vaccines, treatments and tests be monopoly-free, mass produced, distributed fairly and made available to all people, in all countries, free of charge. By October 2020, more than 140 leaders and advocates globally had endorsed this call. As co-chair of the Alliance, the UNAIDS Secretariat advocates for COVID-19 vaccines as global public goods. A group of more than 150 current and former world leaders stand by this call.

68. ACT-A was established by multilateral public health entities including the WHO and the Global Fund. It sets out to accelerate the development, production and equitable global access to new COVID-19 essential health technologies, including expedited access to innovative diagnostics, therapeutics and vaccines.[56] The COVAX initiative, the vaccine pillar of ACT-A (co-led by WHO, the GAVI vaccine alliance and the Coalition for Epidemic Preparedness Innovations), focuses on reaching the most vulnerable populations on the African continent. The initiative includes self-financing by higher and middle-income countries and support to lower-income countries. Eight middle-income countries have signed up to self-finance, and 46 countries in Africa are eligible for support.

69. UNAIDS serves on the steering committee of the WHO COVID-19 Technology Access Pool (C-TAP) and is involved in the UN Technology Transfer Bank through the Technology Access Partnership. The initiative aims to foster local production of health technologies to expand access to COVID-19 prevention, diagnostic and treatment in lower and middle-income countries.

Addressing socioeconomic impacts

70. The UN Secretary-General launched an immediate socio-economic response to COVID-19, with a focus on ensuring that no one is left behind, that vulnerability to future pandemics is reduced, that resilience to shocks is enhanced, and that severe and systemic inequalities exposed by COVID-19 are overcome.[57] The framework supporting this response[58] strongly emphasises support and engagement with social cohesion and community resilience as a core pillar of the response.

71. To offset COVID-19 economic impacts, the World Bank and G20 Finance Ministers have endorsed a Debt Service Suspension Initiative for poor countries which includes USD 12 billion, to be provided through the World Bank, and a debt relief programme, managed by the International Monetary Fund.[59]

72. Social protection contributes to the progressive realization of human rights and the narrowing of broad economic, spatial and social and gendered inequalities. Many countries and territories have leveraged social protection measures in support of the COVID-19 and HIV responses, equivalent to USD 541.7 billion or 0.6% of global gross domestic product. These measures provide for basic needs, including food and access to essential services including health and education and reducing inequality. Such support reduces negative coping strategies among the most vulnerable such as selling assets or taking children out of school.[14]

73. The Global Fund has made USD 1 billion available to fight COVID-19, mitigate impacts on HIV, support TB and malaria programmes and mitigate impacts on health systems. By 24 September 2020, USD 736 million had been approved for 104 countries and 12 multicountry programmes. Approximately one third of the funding (35%) is committed for the adaptation of HIV, TB and malaria programmes.[60]

74. The Joint Programme conducted a scenario planning exercise to assess the implications of a potential post-COVID-19 decrease in fiscal space for health and HIV. The findings inform understanding of how best to leverage country-level and external resources to ensure equity is protected, with UNAIDS having an advocacy role in supporting efficient and effective resource mobilization.

75. In Asia-Pacific, civil society and community groups of key populations, supported by UNAIDS, advocated for financial resources from the Global Fund under the COVID Relief Fund.

76. Cosponsors of the Joint Programme, including the International Labour Organization, United Nation's Children Fund, World Food Programme, and the UNAIDS Secretariat launched a call to action on social protection, highlighting the needs of people living with HIV and key populations in the context of COVID-19. The emphasis was on linkages to community-led services and civil society organizations, actions to ensure continued access to schooling and social protection programmes, and support for long-term sustainable livelihoods through economic activity.[61]

Upholding human rights

77. Emphasizing human rights in the response to HIV has helped to address impediments due to social, cultural and economic inequalities are addressed. Human rights have been undermined by the urgency and exigencies of controlling the COVID-19 pandemic, including disproportionate use of police powers, harassment, discrimination and gender-based violence.

78. Drawing on lessons learned from the HIV response, UNAIDS shared guidance on 10 immediate areas for action to support governments as they build effective rights-based responses to COVID-19. This was done through a report which addressed experiences during lockdowns, drawing attention to the rights of marginalized and vulnerable communities.[62] UNDP, the WHO and the O'Neill Institute have also developed an online resource for COVID-19 laws and policies (COVIDlawlab.org).[63]

79. UNHCR, UNODC, WHO and UNAIDS Secretariat have advocated for the decongestion of prisons by releasing nonviolent offenders and prisoners who had served most of their sentences. High-level representatives signed a joint statement to decongest prisons and places of detention in the face of COVID-19. Countries used the call to advocate with prisons authorities to decongest prisons by releasing nonviolent offenders and prisoners who had served most of their sentences. Prisoner releases occurred in Indonesia, Iran (Islamic Republic of), Myanmar, Niger, Senegal, Togo, United Republic of Tanzania, Zambia and Zimbabwe.

80. While research globally indicates that stigma and discrimination continues to affect people living with HIV, key populations and vulnerable groups, people and groups associated with COVID-19 have also experienced negative perceptions and actions. Examples include xenophobia based on ethnicity or country of origin bringing in COVID-19, or fear of people exposed to the disease including health care workers, hospital patients and families of people who have or have had COVID-19. Vulnerable and marginalized populations continue to be stigmatized, and this includes intersections with HIV and COVID-19—for example, people living in poverty, the homeless, refugees, migrants, sex workers, people who use drugs and lesbian, gay, bisexual, transgender and intersex people. Drawing on experiences in the HIV response, UNAIDS developed specific guidance for addressing stigma and discrimination related to COVID-19, including strategies for communities, workplaces, education and health-care facilities, and justice and emergency/humanitarian settings.[64]

Addressing gender inequality

81. Gender inequalities aggravate the HIV-related vulnerabilities of girls, women and key populations. Joint Programme work has included developing a "Minimum Requirements checklist for integrating gender equality in the implementation of the UN Framework for the Socioeconomic Response to COVID-19"[65] and the COVID-19 Global Gender Response Tracker.[66] The Minimum Requirements checklist places emphasis on leadership and participation, protection and safety, and economic wellbeing and serves as a resource for UN Country Teams—especially gender theme groups—to assess, design, implement, monitor and evaluate COVID-19 responses. The Global Response Tracker provides insight into policy measures adopted globally to address COVID-19 that have integrated a gender lens.

82. UNAIDS recommends six concrete measures to support women and girls and all their diversity in the context of the COVID-19 pandemic.[67] These include weighting response based on different needs and giving attention to the most marginalized women and girls, ensuring access to essential services, addressing gender-based violence, engaging with the misuse of criminal laws, prioritizing education and health of adolescent girls and addressing unpaid care work.

Global and regional responses and innovations

83. This section outlines global and regional responses and innovations that have emerged through Joint Programme, individual Cosponsor and partner activities to support countries and to strengthen the COVID-19 and HIV response.

Strengthening health services and information

Table 2: COVID-19 and HIV response: Strengthening health services and information

Agencies and partners	Activities to address COVID-19 and HIV
The Global Action Plan for healthy lives and wellbeing for all, and Joint Programme	• "Leveraging the Gap "to fill in gaps and add value to existing global, regional and national coordination mechanisms in the response to the COVID-19 pandemic
Regional Support Team in Latin America and the Caribbean; Pan American Health Organization (PAHO); UNICEF; World Bank	• Through the *Every Woman Every Child* platform, ensured continuity of access to adolescent and sexual and reproductive health services. Support provided to multimonth dispensing and supply chain strengthening.
UNAIDS Secretariat; WHO; UNICEF	• Building on the annual Global AIDS Monitoring data collection from all UN member states, collecting monthly data on key HIV services to identify service disruptions and alerting partners to action in countering them. Over 80 countries have started providing such data.
UNAIDS Secretariat and StartupBlink	• Implemented a coronavirus innovation map (coronavirus.startupblink.com). This interactive tool maps innovative responses to the COVID-19 pandemic globally, with up-to-date ranking tables of cities and countries that have produced the innovations.
The Joint Programme; UN agencies	• Calls for stronger action and support to address overabundant and rapid spread of harmful misinformation and disinformation that has reduced trust in science and public health and has put many lives at risk.[68]

HIV prevention and treatment

Table 3: COVID-19 and HIV response: HIV prevention and treatment

Agencies and	Activities to address COVID-19 and HIV
GPC	• Identified a series of actions to preserve the momentum and focus on HIV prevention within the COVID-19 response. These actions included emphasizing leadership and financing of both pandemics, supporting supply chain continuity for HIV prevention and contraception commodities, assessing changing HIV programme needs and the needs of key and other priority populations, and adapting prevention services and programmes.[69]
Joint Programme	• Support to a high-level meeting on HIV prevention at the ICPD+20 Summit in Nairobi, where 28 participating countries renewed their commitment to specific HIV prevention outcomes.
Fast-Track Cities network; UNAIDS Secretariat	• In the Philippines, a "Love on Wheels" initiative used e-bikes and bicycles to ensure continued access to HIV services for key populations. • In Nigeria, COVID-19 and HIV were addressed through neighbourhood markets, telemedicine, door-to-door surveillance, testing and home-based care.

UNAIDS Country Offices in sub-Saharan Africa	• In Nigeria, community pharmacists were enlisted to support collection and home delivery of antiretrovirals. • In Kenya, vulnerable communities in informal settlements were supported, with training provided to community health volunteers to disseminate COVID-19 information in communities safely. Low-cost non-touch hand wash machines were developed. • In Angola, training was provided to 2225 peer educators to focus on door-to-door support to elderly populations including personal preventive equipment and information materials. • In Malawi, gender-based violence response services were expanded and materials and commodities made available at gender-based violence service points. • In Zimbabwe, women were engaged to make various types of personal preventive equipment. • In Lesotho, mobile clinics were repurposed for ART service provision. • In South Africa, a Community Constituency COVID-19 Front was established to promote WHO standards and provide support to vulnerable communities, including food, water and income support.
UNAIDS Country Offices in Latin America and the Caribbean	• Support to Voluntariado por las Américas of the Latin American Network of Women Living with HIV.
UNAIDS Country Offices in Asia and the Pacific	• In Wuhan, China, the Lesbian, Gay, Bisexual and Transgender centre organized volunteer groups to deliver ARVs and other support to people living with HIV—an innovation that expanded to community organizations in other cities. • Community organizations in India were engaged to deliver prevention and treatment services in conjunction with food rations and shelter at their premises. • With support from UNFPA in Indonesia, the Sex Worker Network developed guidance on how to keep working but avoid exposure to COVID-19. • In Pakistan, Government postal services were mobilized to send ARVs to organizations of people living with HIV who then dispensed them in communities. • In Myanmar, dispensations for unhindered movement allowed health volunteers to dispense essential HIV commodities. Prisoners, including those living with HIV, were pardoned and released.

People living with HIV and vulnerable and key populations

Table 4: COVID-19 and the HIV response: people living with HIV, vulnerable and key populations

Agencies and	Activities to address COVID-19 and HIV
GNP+; Aidsfonds; Global Fund; WHO; UNAIDS Secretariat	• Conceptualized and mobilized resources for the VOICE+ platform that aims to develop an online community of people living with HIV. The platform is currently piloted in Uganda and has the potential to mobilize the collective voices and influence of people living with HIV to address challenges faced in the HIV response.
Regional Support Team, Latin America and the Caribbean	• Explored continuity of HIV services, including promoting community empowerment and protecting the rights of people living with HIV and key populations in a COVID-19 context. Loans and donations were coordinated between countries, and technical and financial support was provided to the Latin American and Caribbean Movement of Positive Women to support people living with HIV during the COVID-19 pandemic. Needs and responses for refugees, migrants, displaced persons and returnees were also explored.

UNODC, UNDP and UNFPA	• Developed guidance on key populations and access to nondiscriminatory HIV services.[70]
Regional Support Team, Latin America and the Caribbean	• A survey on the impact of COVID-19 was conducted on the impact of COVID-19 on key populations and young people to enable advocacy for protective COVID-19 policies and strategies, and ensure that human rights and social protections are being reinforced through other partnerships. Tools have been developed and training provided to support care, treatment and COVID-19 impact mitigation for migrants and refugees.

Community-led responses

84. In Cameroon, a COVID-19 community task force was established to ensure community-led approaches are reflected in the national COVID-19 response plan. HIV service delivery models that emphasize self-care and reduce physical contact also benefit the COVID-19 response. Initiatives such as self-testing ensure continuity of HIV services, especially for populations who are at high risk of HIV infection. Burundi, Eswatini, Guatemala and Myanmar expanded self-testing as part of their COVID-19 responses. In Poland, self-testing was linked to telephone counselling and supported by delivery of self-test kits by mail.

85. In Latin America, 26 organizations were supported to conduct "catalytic" community-led projects addressing convergences between COVID-19 and HIV, including prevention, the continuum of care, human rights, and addressing stigma and violence.[71] In New York City, supportive housing was provided for people living with HIV and the homeless, while in Burkina Faso, HIV organizations used differentiated approaches to help with COVID-19 testing and follow-up.

86. Key populations in the Middle East and North Africa have taken a proactive approach, including diversified communication and addressing needs for psychological assistance. Despite political and economic crises in the region, organizations were able to mobilize to access and distribute food, HIV commodities and medicines and provide links to economic assistance. Lack of external support led some organizations to reallocate HIV resources to COVID-19, while others were forced to cut wages.[72]

87. Sex workers in eastern Europe collaborated to distribute food packages and condoms and shared information and resources on social media. Online counselling was provided, and NGOs continued ensuring access to HIV prevention commodities and to HIV testing.

Conclusion

88. As detailed in this report, in the face of an unprecedented situation, countries, communities, key partners, and the Joint Programme have worked to leverage HIV infrastructure and lessons learned to tackle the dual pandemics of HIV and COVID-19. In some cases, these efforts have positively contributed to innovations to minimize treatment service disruption and to promote people centred responses. However, COVID-19 remains a crisis that threatens to undo the gains in the HIV response: to disrupt services, exacerbate inequalities, and limit funding. We must be vigilant about these risks and continue to work together to tackle these dual epidemics.

Proposed Decision Points

The Programme Coordinating Board is invited to:

89. *Take note* of the report on COVID-19 and HIV;

90. *Request* the Joint Programme and countries to monitor the health and social impacts of the HIV and COVID-19 pandemics in real time, to allow all stakeholders to understand and address the drivers and mitigate the effects;

91. *Request* the Joint Programme and countries to continue leveraging HIV infrastructure and following a mutually supportive approach to both pandemics to contribute to resilient systems for health fully capable of detecting and addressing pandemics;

92. *Recognize* that the lessons learned from the multisectoral response to HIV epidemic should continue to inform epidemic preparedness;

93. *Request* the Joint Programme to support countries and communities to intensify, improve and sustain HIV prevention, treatment and care response in the context of COVID-19 by building on and sharing lessons learned, best practices and innovations, including multimonth dispensing and community engagement, to gain ground lost and improve agility, performance and efficiency towards achieving the goal of ending AIDS by 2030; and

94. *Call* upon donors and Member States to protect and intensify investments, resource allocations and social protection measures for vulnerable and key populations most impacted by the dual HIV and COVID-19 pandemics.

[Annexes follow]

Annex 1

Tools and publications by Joint Programme Cosponsors on COVID-19 and HIV

HIV and COVID-19 intersections and programming

UNAIDS. COVID-19 and HIV: 1 Moment. 2 Epidemics. 3 Opportunities. Geneva: UNAIDS; 2020 (https://www.unaids.org/sites/default/files/media_asset/20200909_Lessons-HIV-COVID19.pdf)

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Vulnerable and key populations

Inter-Agency Task Team to address HIV in humanitarian emergencies. COVID-19 and HIV in Humanitarian situations. Rome: WFP; 2020. (https://library.unaids.org/?publication=inter-agency-task-team-for-hiv-in-emergency-situations-covid-19-brief)

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UNFPA. Implications of COVID-19 for Older Persons: Responding to the Pandemic. New York: UNFPA; 2020. (https://www.unfpa.org/resources/implications-covid-19-older-persons-responding-pandemic)

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Socioeconomic aspects

ILO. COVID-19 and the world of work: A focus on people living with HIV. Geneva: ILO; 2020. (https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_747263.pdf)

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Human rights

UNAIDS. Addressing stigma and discrimination in the COVID-19 response. Geneva: UNAIDS; 2020 (https://www.unaids.org/sites/default/files/media_asset/covid19-stigma-brief_en.pdf)

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Gender inequality

UNAIDS. Actions for improved clinical and prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence. Geneva: UNAIDS; 2020. (https://www.unaids.org/sites/default/files/media_asset/preventing-hiv-sti-among-women-girls-using-contraceptive-services_en.pdf)

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