DEMANDING HEALTH FOR ALL:

DRAWING ON EXPERIENCES OF PEOPLE LIVING WITH HIV DURING COVID-19

BEYOND LIVING

GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

ICW INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

CONTENTS

EXECUTIVE SUMMARY

This report documents how COVID-19 has exposed and exacerbated existing inequities. As with the HIV epidemic before, the most marginalised members of our societies have been the worst hit. Not only have COVID-19 and the related restrictions cost lives and livelihoods the world over but they have also set back the slow progress that was being made on HIV and health more broadly.

As the global networks of people living with HIV (GNP+, ICW and Y+ Global) our primary focus is to advocate for the rights of people living with HIV and to improve their quality of life. We have seen the devastating impact COVID-19 has had on our communities and been frustrated by the inadequate responses of our governments and institutions. It doesn't have to be like this. We know there is a better way.

The HIV movement has decades of experience dealing with a global health epidemic. We have learnt many lessons over those years, developed skills and expertise that make us perfectly placed to, guide, advise and drive forward the response to COVID-19 and to help find solutions to deliver health to everyone.

This report looks at each of the three key pillars of universal health coverage (UHC) through the lens of our times. We look at the experiences of people living with HIV during the COVID-19 pandemic and consider what lessons can be drawn from their experiences to help bring about the realisation of health for all.

- Beginning with equitable access we see how human rights abuses have increased under COVID-19 and how the most marginalised members of our societies have been the worst affected. We reaffirm the connection between human rights and health and call for health care solutions to be part of a wider enabling framework of policies grounded in human rights and designed to address inequalities and remove stigma and discrimination.

- We look at the quality of health care that people living with HIV have received during the COVID-19 pandemic and see how dependent they have been on their peers and communities to continue to access the essential health services that they need. We find hope for the future in person-centred approaches and strong, well-equipped and financially resourced community-led responses.

- Finally, we turn to concerns around financial hardship. We outline how the high burden of healthcare costs on individuals has been a barrier to accessing services during COVID-19, just as it was before the pandemic. Critically we also see how far reaching the socio-economic consequences of COVID-19 have been and how essential it is that we invest heavily in social enablers as well as health systems.

Our experiences to date of COVID-19 strengthen our resolve to find ways to achieve health for all, including marginalised people and people living with HIV.

OUR RECOMMENDATIONS

TO ENSURE EQUITABLE ACCESS

- Governments and donors must urgently invest in and scale up efforts to remove the structural barriers that prevent people living with HIV from accessing health care – barriers that perpetuate gender inequality, gender-based violence, stigma, discrimination and human rights abuses.
- Governments must ensure that laws and policies are grounded in evidence and human rights and designed to enable people to access health care, including SRHR.
- Laws that criminalise and punish people and communities – for their health status, gender identity, sexual orientation, drug use or sex work – must be repealed.
- Governments and health care providers must ensure that everyone, including marginalised communities, has access to health services that respect their rights and dignity.
- Community-led organisations must be resourced and supported to design and deliver services, advocate for human rights and hold governments, pharmaceutical companies and donors to account.

TO PROVIDE QUALITY SERVICES

- Governments and health care providers must ensure non-judgmental and respectful health care for all communities. Every country must meet the global commitment to end all stigma and discrimination in health care settings.
- Governments must build on the opportunities and changes made during COVID-19 to scale up approaches such as differentiated service delivery, task shifting and self-care interventions. This includes scaling up the use of telehealth and digital platforms, including for psychosocial counselling and support, while protecting people's right to confidentiality and privacy.
- Governments and donors must scale up their investment in building strong health systems, especially at primary health care level to ensure that people can access the quality health services they need to manage their health and well-being.
- Governments and donors need to invest in community systems for health, including community-led services that are effective in reaching and retaining people in care, even in the most difficult circumstances, and community-led monitoring and accountability initiatives that give feedback on the quality of services.
- Governments must meet their commitments to build stronger partnerships with communities, such as through social contracting mechanisms, so that civil society and community-led organisations are adequately supported to deliver health services and play a full part in achieving UHC.

TO MINIMISE FINANCIAL HARDSHIP

- Governments need to abolish user fees immediately. The evidence is clear, user fees remain a barrier for people to access HIV, TB, COVID-19 and other healthcare services.
- Governments must ensure social protection is available to all and financing mechanisms for UHC must not exclude communities who are marginalised, disenfranchised or criminalised.
- Governments and donors need to step up and increase their investment in health – both domestic and international funding falls far short of what is needed. The world needs to be better prepared for future health crises. We cannot allow the poorest and most marginalised communities to bear the burden of health spending.
- Governments and donors must also finance social enablers such as public outreach and information programmes, prevention of intimate partner violence initiatives, and law and policy reform in order to make health services accessible to all.

OUR RESEARCH PROCESS

This report brings together some of the advocacy priorities identified by **Beyond LIVING** during the past 6 months. Beyond LIVING is a consultation and advocacy process led by GNP+, ICW and Y+ Global, the global networks of people living with HIV. We are guided by a diverse and creative Life Force – 11 people from across regions with different lived experiences, helping us to connect our global advocacy to the realities of countries and communities.

As part of the research for this report, some members of the Life Force conducted interviews with national networks representing women, young people and people living with HIV in eight countries. We share their results here in dedicated 'countries in focus' pages. This report also draws on our joint work on COVID-19, including fortnightly newsletters (April-July), a survey report (July) and a series of regional COVID conversations (October).

TOWARDS UNIVERSAL HEALTH COVERAGE

" [The COVID-19 pandemic] has laid bare risks we have ignored for decades: inadequate health systems; gaps in social protection; structural inequalities; environmental degradation; the climate crisis. Entire regions that were making progress on eradicating poverty and narrowing inequality have been set back years, in a matter of months. The virus poses the greatest risk to the most vulnerable: those living in poverty, older people, and people with disabilities and pre-existing conditions." [1]

António Guterres, United Nations (UN) Secretary-General

The COVID-19 pandemic has demonstrated how essential health is for people, for communities and for economies. It has underlined the need to see health as interconnected to other developmental goals and to work across national borders. In recent years many global and national health discussions have been framed in the context of universal health coverage (UHC) as a means to achieve Health for All. It is important to remember that this is not a new aspiration. Ever since the Universal Declaration of Human Rights in 1948, the right to health has been recognised. In the same year, the World Health Organisation (WHO) constitution declared **"the highest attainable standard of health is one of the fundamental rights of every human being"**.[2] And in 1978, the Health for All agenda was set by the Alma Ata declaration at the historic International Conference on Primary Health Care. Unfortunately, despite these global commitments, countries have not adequately invested funds or made the necessary changes to health systems. As a result, the majority of countries have ultimately failed to meet this political and moral aspiration.

"At least half the world's population still lacks access to essential health services and about 100 million people are pushed into extreme poverty each year due to their health expenditures." [3]

WHO and World Bank Group

In the early 1980s, HIV and AIDS emerged as a global epidemic. In the past four decades, 33 million people have died from AIDS-related illness. While there is still no cure or vaccine, there was significant scientific progress and there are now strategies and medicines to prevent and treat HIV. In the early years, these essential treatments were not available to most people. In response, people living with HIV and their allies mobilised for their communities' right to health. They used the power of global solidarity to set ambitious targets for universal access to treatment, care and support and mobilised to raise the political will and funding needed to meet these targets.

1 Tackling the Inequality Pandemic: A New Social Contract for a New Era. United Nations Secretary-General's Nelson Mandela Lecture. July 2020 (http://webtv.un.org/search/ant%C3%B3nio-guterres-un-secretary-general-at-the-18th-nelson-mandela-annual-lecture/6172833929001/?term=&lan=english&page=2)

2 Article 25.1 of the UN Declaration of Human Rights. 1948 (https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf), see also Article 12 of the International Covenant on Economic, Social and Cultural Rights. 1966. https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

3 Tracking universal health coverage: 2017 Global Monitoring Report, WHO & World Bank. 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/)

Today, many challenges remain, and the struggle continues

- to ensure the communities that are most affected by HIV have access to and can benefit from the latest and best interventions to prevent and treat HIV and co-morbidities
- to campaign for person-centred approaches so that communities not only have access to the care they need but also lead on how their health care is designed and delivered
- to mobilise sufficient funding for community-led and human rights-based responses against stigma, violence, gender inequality and harmful laws and practices that continues to hold back progress on HIV and other diseases.

These challenges have once again been highlighted during the COVID-19 pandemic and must be addressed if countries are to build more sustainable, equitable and resilient systems of health. In particular they will need to be better prepared to deal with the next pandemic.

WHAT UHC OFFERS

UHC means that every person, wherever they are, should be able to access and afford quality health services.

UHC should be based on strong, people-centred primary health care. Robust primary health care systems are rooted in communities and meet the majority of a person's health needs throughout their lifetime. The focus should not only be on preventing and treating disease and illness, but also on helping to improve physical, mental and social well-being and quality of life.

UHC HAS 3 PILLARS:

Equitable access: everyone who needs health services should get them, not only those who can pay for them

Quality services: quality of the health services should be good enough to improve the health of those who receive these services

Minimising financial hardship: the cost of using health services should not put people at risk of financial harm

SUSTAINABLE DEVELOPMENT GOALS (SDGs)

Goal 3: Healthy lives and promote well-being for all at all ages.

Target 3.8:

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Measured by SDG indicators:

- 3.8.1: Coverage of essential health services (the average coverage of essential services that include reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access; among the general and the most disadvantaged population).
- 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

LAST MILE FIRST

" The logic, and moral obligation, is clear. If universal health coverage works for the poorest and most marginalised – including people living with HIV and other key and vulnerable communities (who are directly and disproportionately affected by diseases and poor health) – it will work for everyone." [4]

GNP+

The COVID-19 pandemic has highlighted the critical need for universal health care and stronger health systems to ensure that everyone, everywhere can fully enjoy their fundamental right to health. It is no longer enough to simply offer services equally to everyone: responsiveness and equity are essential. Healthcare systems must account for the fact that some people will need additional support to be able access those services. According to WHO, "**the principle of 'No One Left Behind' should guide countries to put people first when designing their UHC systems – people who are marginalised, underserved and face discrimination. This will require approaches and investments that are based on human rights, equity and gender equality**." [5]

The HIV movement knows only too well how people living with HIV are excluded and denied health care across the world. We are discriminated against and even criminalised because of our HIV status, our sexual orientation, our gender identity, our race, our citizenship or the choices we make.

We know that COVID-19 will not be resolved through the arrival and roll-out of a vaccine. While it is critical that health services are accessible to all regardless of their ability to pay, we also know that UHC cannot just be about how to finance health services – it should be about reaching everyone with quality services.

The HIV movement has championed the meaningful engagement of communities, equitable access and a human rights-based approach to public health. We believe that these principles are the only way to make Health for All a reality.

As networks of people living with HIV, we were quick to join the frontlines of the COVID-19 response. [6] And we are increasingly part of larger movements to address systemic issues such as racism, gender inequality and social injustice. Our right to health remains a political issue and a moral imperative.

4 Putting the last mile first: position statement on universal health coverage, GNP+. 2019 (https://www.gnpplus.net/assets/GNP-UHC-Position-Paper-April-2019.pdf)

5 Together on the road to universal health coverage: a call to action, WHO. 2017 (https://apps.who.int/iris/bitstream/handle/10665/258962/WHO-HIS-HGF-17.1-eng.pdf;jsessionid=D15122A0480F9C51FC931F10BD7EF0A2?sequence=1)

6 Living with HIV in the time of COVID-19, GNP+, ICW and Y+. 2020. (https://www.gnpplus.net/resources/living-with-hiv-in-the-time-of-covid-19-report-from-a-survey-of-networks-of-people-living-with-hiv/)

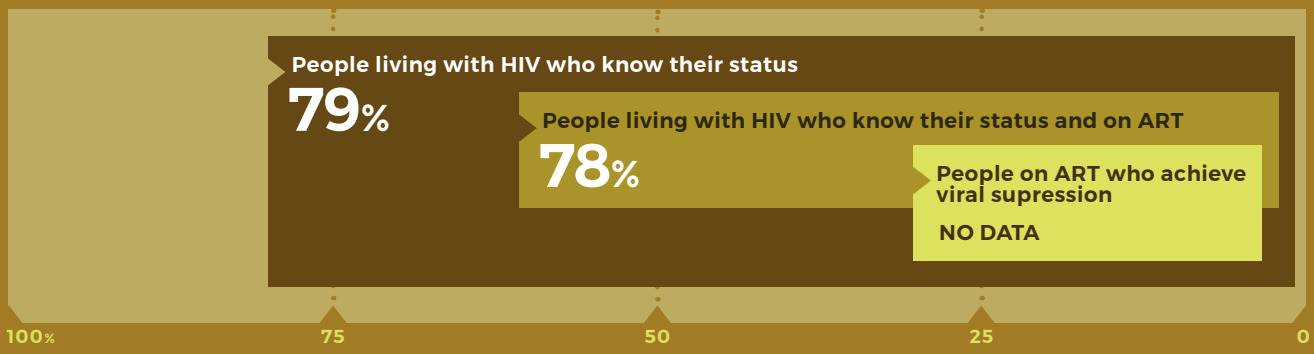
CAMEROON

Cameroon's HIV activists are pushing for the promises of UHC to become a reality. They have focussed on the financing of UHC and are calling for their government to respect its commitments made under the Abuja Declaration to dedicate a minimum of 15% of the national budget to health care. In a positive step forward, the government has abolished user fees for people living with HIV. Civil society groups are now pushing for the elimination of indirect costs and the reimbursement of costs for the treatment and care of opportunistic diseases.

The COVID-19 pandemic has led to significant adaptations to health service delivery in Cameroon. A civil society task force has worked with government to achieve change. As a result, digital platforms and teleworking are being used to share information, provide support and offer follow up to clients. Multi-month dispensing of ARVs has also been introduced. Alongside this, ways have been found to reduce the time people need to spend in health facilities, for example, dispensing ARVs through a system of shifts.

In 2016, the National AIDS Council (CNLS) recommended the use of a community-based ARV dispensing strategy. Many hospitals were reluctant and slow to adopt the strategy, despite civil society group's willingness. However, as a result of COVID-19 there has been a rapid acceleration of community dispensing and civil society is advocating to ensure this is maintained beyond the COVID-19 crisis.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

32.7%

(UNAIDS AIDS info, in 2014)

SRHR

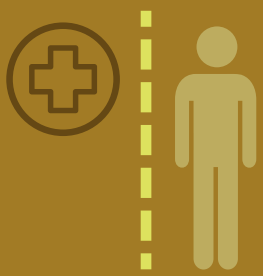
Adolescents needing parental consent to access SRHR services

no laws

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status



2%

(PLHIV Stigma Index, 2012)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

46%

Population with large health expenditure as a share of their total expenditure or income

10.9%

(UHC Data Portal)

KENYA

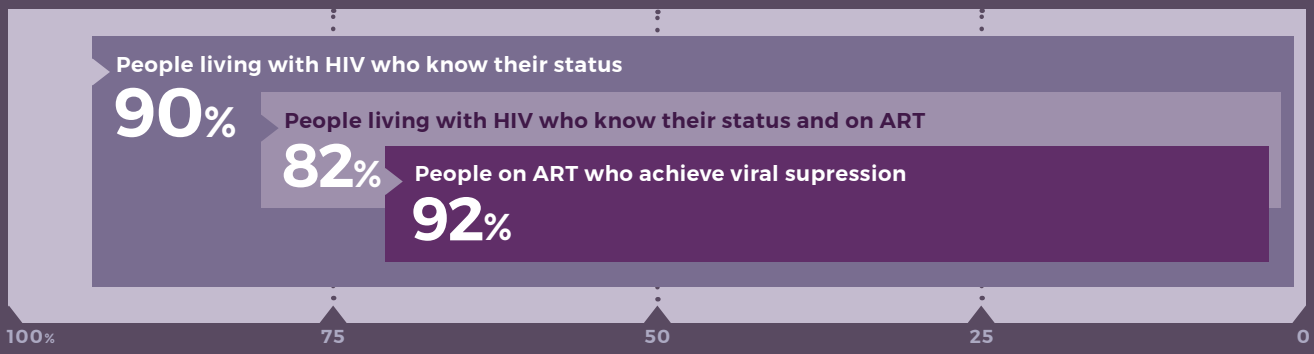
In Kenya, the government is committed to putting its UHC policies into practice, but civil society groups are concerned that they will find it difficult given the challenges that over-stretched health services already face.

A coalition of like-minded organisations, including networks of people living with HIV, is advocating for national funds to be earmarked for HIV, TB and malaria rather than being over reliant on the Global Fund. They are also asking for HIV services to be integrated into the UHC essential services package; for the National Hospital Insurance Fund to be reformed to include UHC; and for flexibility to enable people to choose their health facilities.

Alongside this, work is being done to educate communities on UHC and encourage people to access services that are offered within the UHC package. However, progress towards the UHC target has faltered as funds have been redirected towards the COVID-19 response.

As COVID-19 began to impact on health services, community groups advocated for more differentiated service delivery approaches. This led to the introduction of multi-month dispensing of ARVs. Local organisations increased their role as service providers and delivered prevention and treatment services direct to communities that had previously only been available in health facilities. HIV activists are now lobbying to ensure that these flexible approaches continue beyond the COVID-19 pandemic.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

25%

(UNAIDS AIDS info)

SRHR

Adolescents needing parental consent to access SRHR services

under 18 yrs

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status

10.3%

(PLHIV Stigma Index, 2011)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

55%

Population with large health expenditure as a share of their total expenditure or income

5%

(UHC Data Portal)

MEXICO

Mexico has a mixed health system with a combination of private and public health services. Built into the structure is an oversight system that ensures that the Mexican government complies with its commitments. HIV-related treatment and care are included within public health services. In 2020, the Mexican government proposed that a large percentage of money that was earmarked for a 'Welfare Health Fund' should be diverted to buying COVID-19 vaccines. Civil society groups are concerned this may impact funding for chronic diseases that would otherwise be financed from that Fund (including cancer and HIV).

During the COVID-19 pandemic the Mexican government followed WHO advice and introduced three-month dispensing of ARVs. However, the extent to which each region is able to continue offering different health services depends on their rate of COVID-19 infection. Some areas, including Mexico City, where infection rates have been high, have seen many essential health services stopped. This has included viral load and CD4 testing, and consultations with infectious diseases doctors.

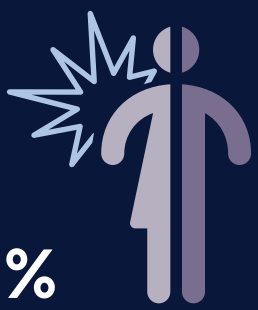
There have also been positive developments, the Mexican government has acknowledged the added vulnerabilities of some marginalised populations and put in place an economic support package for trans people, sex workers and homeless people.

HIV TREATMENT CASCADE

(CENSIDA)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)



8.1%

(UNAIDS AIDS info, in 2016)

SRHR

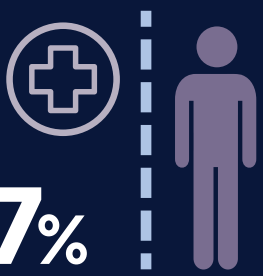
Adolescents needing parental consent to access SRHR services

under 18 yrs

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status

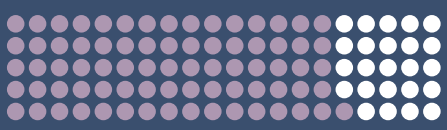


13.7%

(PLHIV Stigma Index, 2010)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services



76%

Population with large health expenditure as a share of their total expenditure or income

1.6%

(UHC Data Portal)

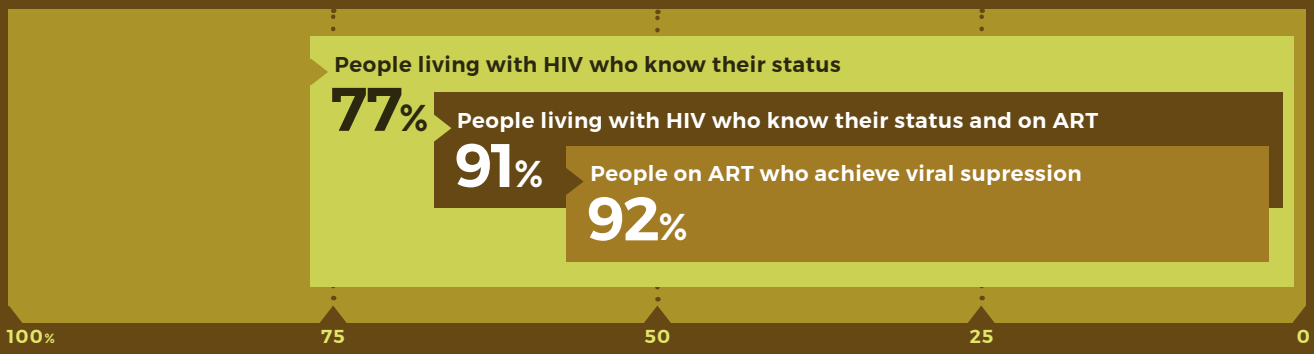
MOROCCO

The government has made significant progress towards the goal of achieving UHC by 2030. Under the health system anyone who does not have medical insurance or a social security number is given access to free health services. However, more than 50% of total health expenditure is still paid by households. Civil society groups are advocating for this to be addressed. The government includes a wide range of services in its essential service package from family planning to HIV and TB treatment, but advocates are demanding the inclusion of hepatitis treatment also.

In response to COVID-19, the Moroccan government initiated a system that allowed multi-month refills of ARVs for all communities. The Ministry of Health coordinated a system whereby medication was delivered direct to people's homes wherever possible. This policy was welcomed by civil society groups who are calling for it to be continued longer term.

During lockdown restrictions, service delivery was adapted with more tasks being performed by communities. For example, members of the community (sex workers, gay men and other groups) delivered testing, prevention and treatment services directly to their communities. Civil society groups are advocating for investment in this community-led service delivery so that it can continue into the future.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

no data

SRHR

Adolescents needing parental consent to access SRHR services

under 18 yrs

(UNAIDS AIDS info)

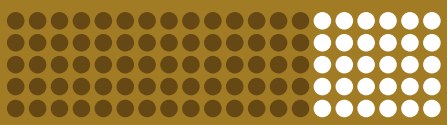
STIGMA

People living with HIV denied health services because of their HIV status

no data

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services



70%

Population with large health expenditure as a share of their total expenditure or income

22%

(UHC Data Portal)

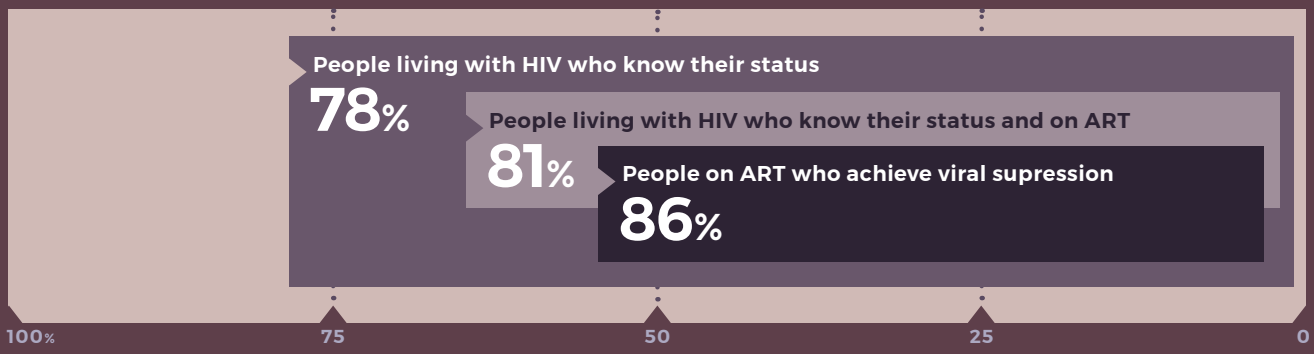
NEPAL

The UHC service package currently includes 16 essential services. Gradual progress has been made with services relating to reproductive, maternal, new-born and child health as well as infectious diseases. However, progress on non-communicable diseases is lagging behind.

Networks of people living with HIV have come together to advocate for the inclusion of children living with HIV in the government's social protection scheme. They are also working to facilitate the enrolment of people living with HIV into government sponsored free social health insurance.

During the COVID-19 lockdowns, resources were focused on COVID-19 treatment and HIV services were badly disrupted. Civil society advocated for essential health services to be maintained throughout the COVID-19 crisis and secured delivery of ARVs directly to the homes of people living with HIV. There has also been ongoing advocacy to try to secure multi-month dispensing of ARVs. Since most COVID-19 restrictions have been lifted, they continue to highlight their concerns about people living with HIV and call for a rapid re-introduction of services that were cut back, including viral load sample collection and community-led testing.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

11.2%

(UNAIDS AIDS info, in 2016)

SRHR

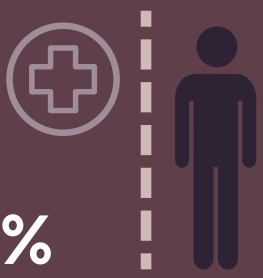
Adolescents needing parental consent to access SRHR services

under 16 yrs

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status



7.3%

(PLHIV Stigma Index, 2011)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

48%

Population with large health expenditure as a share of their total expenditure or income

10.7%

(UHC Data Portal)

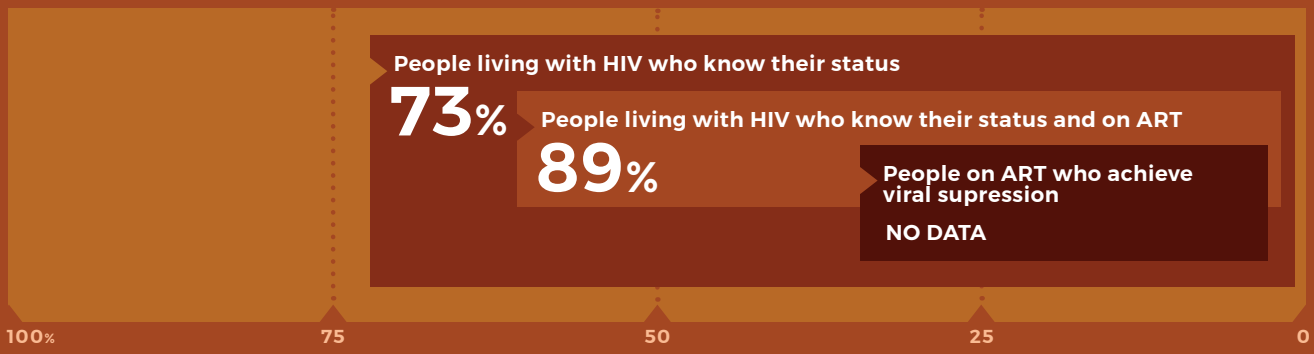
NIGERIA

In Nigeria, a national UHC advocacy network pulls together the government, UNAIDS, WHO, UNITAID and civil society. Civil society is working to ensure that this opportunity for improving health service provision is maximised, that the government is held accountable to its promises, while increasing awareness and understanding of UHC to mobilise funds.

Some initial signs are good. The government has allocated 1% of its annual consolidated revenue fund (CRF) budget to a Basic Care Provision Fund – 50% of this goes to the National Health Insurance Scheme, 45% to the National Primary Health Care Development Board and 5% for emergency medical support. Civil society groups are advocating for the essential service package to include HIV, SRHR, TB and malaria. A key concern is not to leave some groups of people behind, particularly young people.

In response to the arrival of COVID-19, three-month prescriptions for ART have been introduced and community activists have been collecting medications and delivering them to patients in their homes where needed. Civil society is keen to see this new flexible approach continue.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

13.8%

(UNAIDS AIDS info, in 2018)

SRHR

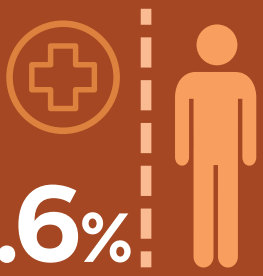
Adolescents needing parental consent to access SRHR services

under 18 yrs

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status



20.6%

(PLHIV Stigma Index, 2012)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

42%

Population with large health expenditure as a share of their total expenditure or income

15%

(UHC Data Portal)

RUSSIA

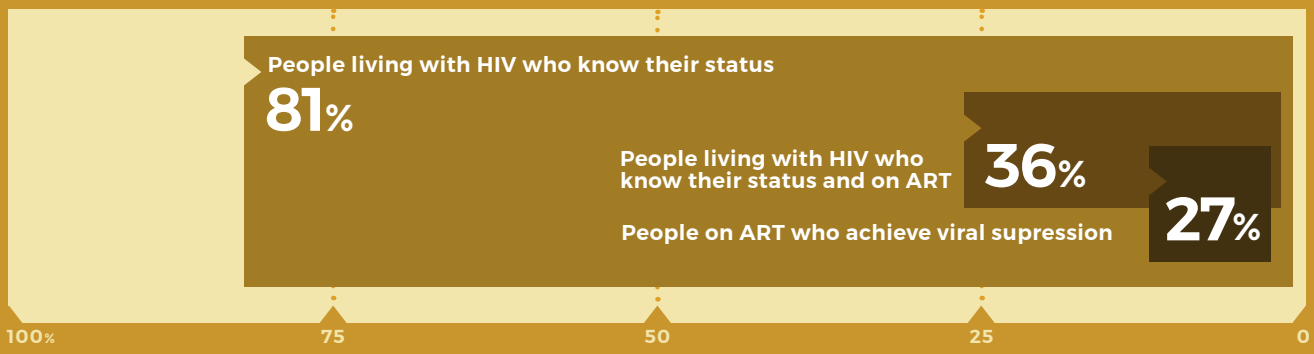
As the government's official position is that UHC is fully implemented in Russia, there are no consultations with NGOs and civil society around UHC. There is also a law regarding "foreign agents NGOs" which is used to prevent NGOs working on HIV from being active in advocacy and delivering services to marginalised populations.

Activists believe there are many aspects of government policy that lead to rights violations for marginalised people and restrict their access to health services – from criminalisation of HIV transmission to a refusal to offer harm reduction services. Worryingly, the age requiring parental consent for HIV testing was raised to 18 in 2019.

There are reports that COVID-19 has resulted in disruption to supplies of ARVs in some regions. Only short-term refills were supplied and some people living with HIV had to change to different regimens of ARVs. Some mobile testing units that normally serve key populations were temporarily stopped but civil society groups took on the role of delivering self-testing kits and prevention tools. They also set up virtual counselling and support services using platforms including Zoom and WhatsApp. They hope to continue using these remote support services after the pandemic as they have been extremely effective.

Civil society groups are now lobbying for the redirection of resources back to HIV, a reliable supply of ARVs and for PrEP and PEP to be made available for communities.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

no data

SRHR

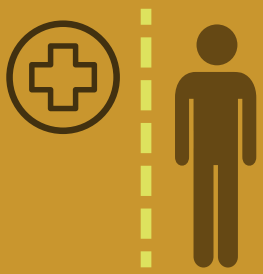
Adolescents needing parental consent to access SRHR services

under 14 yrs

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status



no data

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

74%

Population with large health expenditure as a share of their total expenditure or income

4.9%

(UHC Data Portal)

TANZANIA

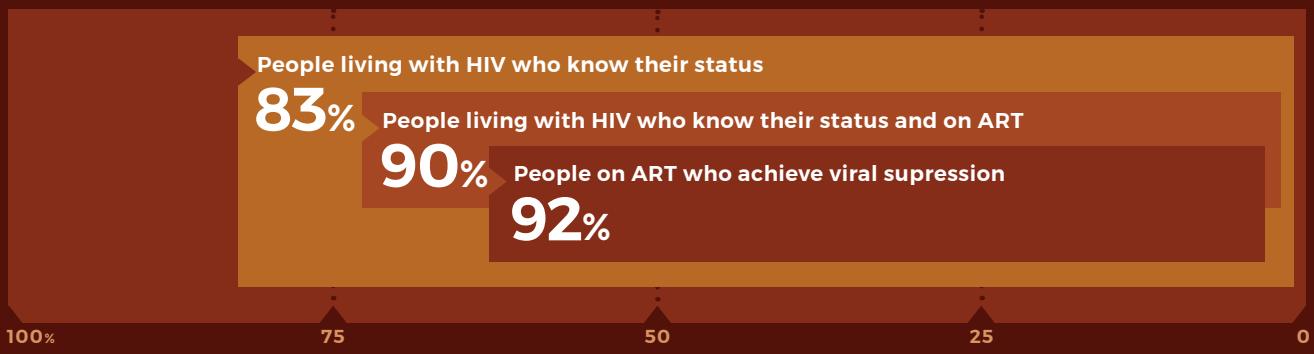
The government is working to reduce the costs of community health insurance to make it more affordable to everyone while also ensuring that it covers opportunistic infections, especially for people living with HIV. The UHC service package currently includes free medication and HIV-related treatment and testing such as viral load tests.

Although there have been some positive developments, civil society groups are concerned the government will struggle to ensure that UHC reaches everyone when large numbers of people currently do not get the healthcare they need. For example, only approximately 43% of people living with HIV are enrolled in health care across Tanzania.

Networks of people living with HIV had a recent victory when the government passed a new regulation lowering the minimum age for HIV testing from 18 down to 15 years.

When COVID-19 arrived, networks of people living with HIV advocated for multi-month dispensing of ARVs and secured three to six month supplies. They collaborated with community groups to support health workers to run a door-to-door service for people living with HIV. Other adaptations included encouraging people to pre-book health centre appointments to ensure distancing. Civil society groups are concerned that several political leaders deny there is COVID-19 in Tanzania, so they are calling for all political leaders to acknowledge its existence and support prevention measures.

HIV TREATMENT CASCADE



(UNAIDS AIDS info)

VIOLENCE

Prevalence of intimate partner violence (15-49 yrs)

29.5%

(UNAIDS AIDS info, in 2015)

SRHR

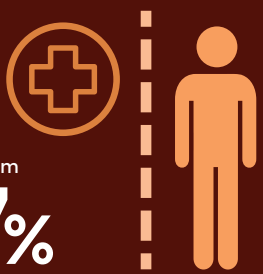
Adolescents needing parental consent to access SRHR services

no laws

(UNAIDS AIDS info)

STIGMA

People living with HIV denied health services because of their HIV status



in Dar es Salaam

8.7%

(PLHIV Stigma Index, 2013)

UNIVERSAL HEALTH COVERAGE

Coverage of essential health services

43%

Population with large health expenditure as a share of their total expenditure or income

3.8%

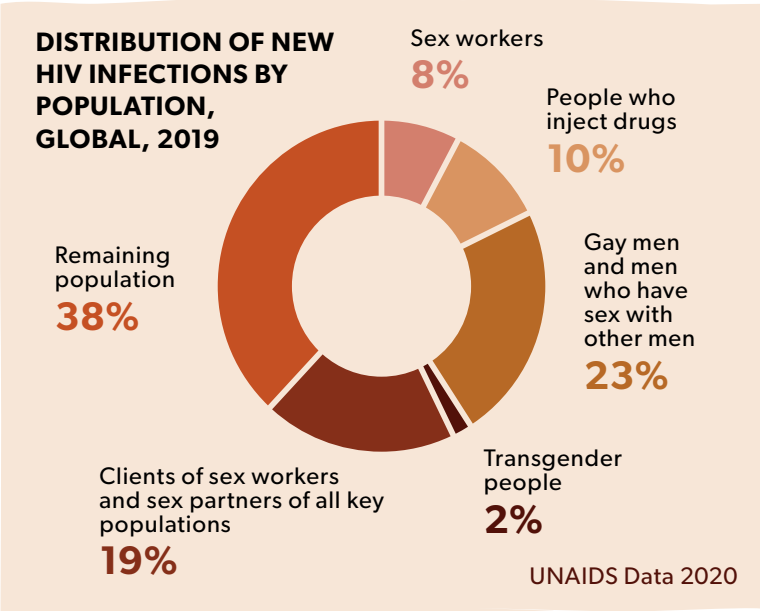
(UHC Data Portal)

EQUITABLE ACCESS

" [We] demand universal health coverage that embodies rights and equity with legal and policy frameworks that address the full range of, and barriers to, social determinants of health, especially for key and affected communities." [7]

GNP+

The HIV response has made significant advances. Yet, even as the number of people on treatment has gone up, more and more evidence shows that marginalised groups continue to be left behind in the HIV response.



62% of new adult HIV infections globally are among key populations and their sexual partners. [8]

We will not see an end to AIDS until the HIV response ensures equitable access to prevention, treatment and care for everyone. Equally, UHC will never transition from theory to reality without a concerted effort to identify and dismantle the barriers that prevent people accessing services - including the structural barriers that perpetuate gender inequality, persistent stigma faced by people living with HIV and human rights abuses experienced by criminalised communities.

The Political Declaration from the UN High Level meeting on UHC emphasises: **"We recognize the fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in health-care settings to ensure universal and equitable access to quality health services without financial hardship for all people, particularly for those who are vulnerable or in vulnerable situations."** [9]

We have learned that the best way to ensure the HIV response meets the needs of people living with HIV in all their diversity is to make sure they are meaningfully engaged in it. The greater involvement of people living with HIV is a guiding principle that calls for the active and meaningful participation of people living with HIV in the inception, development, implementation, monitoring and evaluation of all policies and programmes that affect them. [10] This approach moves away from seeing people living with HIV as just "patients", it values their experiences and acknowledges their right to self-determination and participation in decisions that affect their lives.

7 Putting the last mile first: position statement on universal health coverage, GNP+. 2019 (https://www.gnpplus.net/assets/GNP-UHC-Position-Paper-April-2019.pdf)

8 UNAIDS Data 2020 (https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf)

9 Political declaration of the high-level meeting on universal health coverage, UN. 2019 (https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf)

10 The Greater Involvement of People Living with HIV, Policy brief, UNAIDS. 2007 (https://data.unaids.org/pub/briefingnote/2007/jc1299_policy_brief_gipa.pdf)

If we are to ensure that human rights abuses do not prevent us achieving health for all, marginalised people must be part of the solution. As the LGBTI (lesbian, gay, bisexual, transgender and intersex) stakeholder group says, the answer lies in: **"fully funding community-led monitoring and reporting initiatives for LGBTI human rights and ... meaningfully including LGBTI people in all decision-making processes concerning them."**[11] The same message is echoed by other marginalised communities from young people, women and sex workers to people who use drugs – 'include us in the response'.

HUMAN RIGHTS

" The COVID-19 pandemic is a public health emergency — but it is far more. It is an economic crisis. A social crisis. And a human crisis that is fast becoming a human rights crisis ... We see the disproportionate effects on certain communities, the rise of hate speech, the targeting of vulnerable groups, and the risks of heavy-handed security responses undermining the health response." [12]

António Guterres, United Nations (UN) Secretary-General

During 40 years of the AIDS epidemic, we have seen a clear link between protecting, respecting and fulfilling human rights and positive public health outcomes. In 2020, from watching governments respond to COVID-19, it is evident that the global community still has a lot to learn.

Some policies introduced to combat COVID-19 have directly caused human rights violations. Our report 'Living with HIV in the time of COVID-19' [13] highlighted some examples of this, such as in eSwatini, where people living with HIV were forced to show their medical booklet to security forces to be allowed to travel to collect their medication. In the process they revealed their HIV status and lost their right to confidentiality.

There have also been unintended negative consequences of the 'lockdowns' put in place in response to the pandemic. Many human rights violations have come about as an indirect result of COVID-19 restrictions on movement. For example, people living with HIV have struggled to get the medication they need or been unable to visit health facilities to access essential services.

Most concerning, are the numerous reports of COVID-19 being used as a cover for human rights abuses, particularly targeting vulnerable groups. Members of the LGBTI community have been arbitrarily arrested or detained, accused of breaking restrictions on movement. There are also numerous reports of emergency powers being used by law enforcement officers to target people who use drugs and sex workers. [14]

11 Ensuring Inclusion of LGBTI People in COVID-19 Response Efforts, LGBTI Stakeholder Group. 21 May 2020 (https://mpactglobal.org/ensuring-inclusion-of-lgbti-people-in-covid-19-response-efforts/)

12 Speech by Antonio Guterres, Secretary General, United Nations. 23 April 2020 (https://www.un.org/en/un-coronavirus-communications-team/we-are-all-together-human-rights-and-covid-19-response-and)

13 Living with HIV in the time of COVID-19, GNP+, ICW, Y+. 2020 (https://www.gnpplus.net/assets/wbb_file_updown/8170/BeyondLIVING_COVID-19_Updated.pdf)

14 INPUD Online Survey on COVID-19 and people who use drugs, Data Report 2. 2020 (https://www.inpud.net/sites/default/files/COVID-19%20Survey%20Data%20Report%202_0.pdf)

GENDER EQUITY

" Women and girls in all their diversity are experiencing the greatest impact of the [COVID-19] crisis. Their disparate experience is related not only to the virus but also to existing discrimination, gender stereotypes and deeply rooted inequalities including lack of equal access to food, clean water, housing and health services." [15]

ICWAP and UNAIDS Asia Pacific

We have seen from the HIV response that inequality, violence, stigma, discrimination and poor access to HIV information and services fuel the HIV epidemic among women. Now the evidence seems to show that while men experience higher rates of COVID-19-related deaths, women and girls in all their diversity are disproportionally affected by the wider impacts of the pandemic and governments' emergency responses. [16] They are experiencing more domestic violence, have difficulties accessing essential health services, have a greater caretaking burden and are facing economic insecurity.

Although lockdowns have been imposed to halt the spread of COVID-19 and protect people's health, they have also locked many girls and women into their homes with their aggressors. It is estimated that globally 243 million women and girls aged 15–49 years have been subjected to sexual and/or physical violence perpetrated by an intimate partner in the past 12 months. [17] The evidence shows that these women are unlikely to report violence or seek care in part due to the stigma, blame and fear that they experience. [18]

These problems are exacerbated for women who are already marginalised including sex workers, gender diverse people and women who use drugs, who face added challenges accessing health care or support services due to fear of discrimination, harassment or criminalisation. There have been reports of women being harassed by law enforcement officers for breaking restrictions on movement when they were fleeing from violence or continuing to work to survive.

It is not only during this pandemic that laws and policies can prevent women from accessing the health services that they need. Laws prohibiting abortion are just one example of how a woman's access to health services can be legally denied. [19] Laws relating to the age of consent may be intended to offer protection to young people, but they also act as a barrier to good health, preventing adolescents accessing sexual and reproductive health (SRHR) services as well as HIV testing and treatment services. [20] In 2017, 68 of 108 reporting countries had laws requiring people under age 18 to have parental consent to access SRHR services. [21]

15 Stepping up for Women and Girls During COVID-19, ICWAP and UNAIDS Asia Pacific. 2020

16 Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic,UNAIDS. 2020 (https://www.unaids.org/en/resources/documents/2020/women-girls-covid19)

17 As above

18 Primary health care on the road to universal health coverage, WHO. 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf)

19 https://reproductiverights.org/worldabortionlaws

20 Seizing the moment: Tackling entrenched inequalities to end epidemics, UNAIDS. 2020 (https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf)

21 Primary healthcare on the road to universal health coverage, WHO. 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/)

CRIMINALISATION

" Criminalisation is not an evidence-based response to public health issues. In fact, the use of the criminal law most often undermines public health by creating barriers to prevention, testing, care, and treatment." [22]

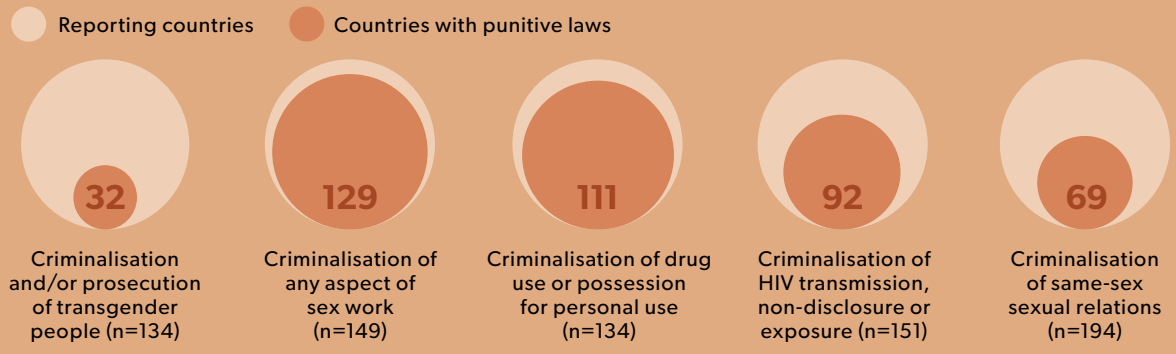
HIV Justice Worldwide

Across the world criminal laws and penalties have been used to enforce compliance with COVID-19 rules and restrictions. As a result, tens of thousands of people have been arrested. [23] This continues despite the fact that evidence shows that this approach does not work for public health. Criminalisation increases barriers and the vulnerabilities of already marginalised people instead of empowering communities to play an active part in halting the spread of the virus.

Many vulnerable populations have found themselves at greater risk than before. Trans people, other members of the LGBTI community, sex workers and people who use drugs have all faced arbitrary arrest or detention. For example, NSWP (Global Network of Sex Work Projects) and UNAIDS report punitive crackdowns against sex workers, resulting in the raiding of homes, compulsory COVID-19 testing, and the arrest and threatened deportation of migrant sex workers. [24] UNAIDS has expressed its concern that **"the COVID-19 epidemic is being used as an excuse to target marginalized and vulnerable populations, restrict civil society space and increase police powers."** [25]

Despite shrinking civic space, civil society groups are continuing to advocate for an end to criminalisation of marginalised groups and for COVID-19 to act as the impetus for change. Work has been done to sensitise law enforcement officers, members of the judicial system and decision makers. There are signs that, in some places, this has begun to have an impact. For example, there is increasing recognition of the particular needs of street-based people and some law enforcement officers are now allowing them to break lockdown rules to access the services that they need. Some countries have released from detention people who were incarcerated for non-violent minor offences (such as possession of drugs), particularly those being held on remand.

COUNTRIES WITH DISCRIMINATORY AND PUNITIVE LAWS, GLOBAL, 2019



Source: UNAIDS, Prevailing against pandemics by putting people at the centre, 2020

22 Steering Committee Statement on COVID-19 Criminalisation, HIV Justice Worldwide. 25 March 2020 (https://www.hivjustice.net/news/hiv-justice-worldwide-steering-committee-statement-on-covid-19-criminalisation/)

23 Rights in a pandemic – Lockdowns, rights and lessons from HIV in the early response to COVID-19, UNAIDS. 2020 (https://www.unaids.org/sites/default/files/media_asset/rights-in-a-pandemic_en.pdf)

24 Sex workers must not be left behind in the response to COVID-19, NSWP & UNAIDS. 2020 (https://www.nswp.org/page/covid-19)

25 UNAIDS condemns misuse and abuse of emergency powers to target marginalized and vulnerable populations, UNAIDS. 9 April 2020 (https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2020/april/20200409_laws-covid19)

STIGMA

" From the history of the HIV epidemic, we have seen how stigma and discrimination negatively affect people's physical and mental health and social support ... UNAIDS' experience is that such stigma only serves to send people and communities underground and ultimately threatens the success of any response." [26]

UNAIDS

Pandemics are often accompanied by stigma — from HIV and TB to Ebola and now COVID-19. Our societies, the media, health and even the law blame individuals and groups for the spread of viruses. This can not only lead to emotional and physical suffering but also stand in the way of effective public health responses, prevent delivery and uptake of health services and worsen existing inequalities.

People who have acquired COVID-19 have been blamed for ongoing transmission of the virus. Seemingly learning nothing from the HIV epidemic and the years of evidence that language matters, the media and politicians have talked of "super-spreaders" and sought scapegoats. In some countries, LGBTI people have been singled out and blamed for COVID-19, leading to an increase in animosity, stigma, and violence against the community and those that defend their rights. [27] People with TB have also reported experiencing increased stigma due to the similar symptoms of both respiratory diseases.[28]

In some countries law enforcement officers have insisted that people living with HIV disclose their status to be able to leave their homes to seek medical services – as a result there are reports of additional stigma. Restrictions on movement have also meant that many people have been forced to stay at home. This has been particularly difficult for some, including young people and transgender people, who have been exposed to discrimination and stigma within their homes, unable to access safe spaces where they can be themselves, free from judgement.

In its role as co-convener of the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination, UNAIDS has developed a brief focused on addressing stigma and discrimination in the COVID-19 response. [29] It draws on the experiences of the HIV response and outlines interventions designed to address stigma across different settings. Key themes emerge repeatedly — the need for: accurate information to dispel myths; counselling and support services for those affected by stigma; support to identify stigma and discrimination; training and sensitisation initiatives; means to measure stigma; and people affected by COVID-19 to be involved in planning and implementing the response.

There is evidence of some of these interventions being put into practice. For example, civil society groups in various countries have reported attempting to sensitise those in authority from prison guards to policy makers. Equally, numerous community-based organisations have developed educational materials and shared accurate information about COVID-19.

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

27 Joint statement to the UN Human Rights Council from a coalition of 187 organisations. 4 June 2020 (https://mpactglobal.org/wp-content/uploads/2020/06/Joint-Written-Statement-LGBTI-and-COVID-19.pdf)

28 The impact of COVID-19 on the TB epidemic: a community perspective, Stop TB Partnerships and others. 2020 (https://www.stoptb.org/assets/documents/resources/publications/acsm/Civil%20Society%20Report%20on%20TB%20and%20COVID.pdf)

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

ENSURING EQUITABLE ACCESS WITHIN UHC

The response to COVID-19 does not seem to have learnt from the HIV response – human rights, equity and community engagement are key to responding to epidemics. No community or group of people should be denied their right to health – this goal can only be realised if the needs of those who are currently excluded or criminalised are put first.

RECOMMENDATIONS

- Governments and donors must urgently invest in and scale up efforts to remove the structural barriers that prevent people living with HIV from accessing health care – barriers that perpetuate gender inequality, gender-based violence, stigma, discrimination and human rights abuses.
- Governments must ensure that laws and policies are grounded in evidence and human rights and designed to enable people to access health care, including SRHR.
- Laws that criminalise and punish people and communities – for their health status, gender identity, sexual orientation, drug use or sex work – must be repealed.
- Governments and health care providers must ensure that everyone, including marginalised communities, has access to health services that respect their rights and dignity.
- Community-led organisations must be resourced and supported to design and deliver services, advocate for human rights and hold governments, pharmaceutical companies and donors to account.

QUALITY HEALTH CARE

While there has been remarkable progress to ensure more people living with HIV have access to treatment, the quality of care they get is often poor. HIV remains a highly stigmatised disease and as the last section shows, in many countries it disproportionately affects marginalised communities. Quality of care is compromised by the stigma and discrimination that people living with HIV face in health care settings.

In 2018, The Lancet Global Health Commission on High-Quality Health Systems in the SDG era defined a high-quality health system as one that is **"consistently delivering care that improves or maintains health, being valued and trusted by all people, and responding to changing population needs."** [30] The authors recognised that **"health systems are first and foremost for people, and they should embrace people-centredness, equity, efficiency, and resilience as core values."**

Gradually health services are adapting to use differentiated service delivery models – where services are designed to meet the needs of a specific group of people and delivered in a way that is accessible and acceptable to them. These person-centred approaches are particularly effective for marginalised people, allowing services to be designed and delivered in ways to suit specific communities such as sex workers or young LGBTI people.[31]

The HIV movement has long campaigned to ensure that communities are informed and empowered to understand and demand quality health care. We continue to advocate for integrated services and person-centred care that respects and promotes our dignity, well-being and rights – during COVID-19 and beyond. The 2016 UN Political Declaration on Ending AIDS affirmed the critical role of communities when governments committed to ensuring at least 30% of services are community-led by 2030. [32]

COVID-19 IMPACT MODELLING

According to modelling exercises from the HIV Modelling Consortium in collaboration with the WHO and UNAIDS, a six-month 50% disruption in HIV treatment could lead to 300,000 extra AIDS-related deaths in sub-Saharan Africa over a one-year period, a region where 440,000 people died of AIDS-related illnesses in 2019 — returning us to 2011 AIDS-related mortality levels. [33] Likewise, a six-month service disruption in programmes to prevent mother-to-child transmission of HIV could cause new HIV infections among children to increase by 40–80% in high-burden countries. [34]

30 High-quality health systems in the Sustainable Development Goals era: time for a revolution. Kruk ME, Gage AD, Arsenault C, et al. Lancet Global Health. 2018 (http://dx.doi.org/10.1016/S2214-109X(18)30386-3.)

31 Differentiated service delivery for HIV treatment: Summary of published evidence, DSD. 2020 (https://www.differentiatedservicedelivery.org/Resources/Resource-Library/DSD_Evidence_Summaries)

32 UN Political Declaration on Ending AIDS. 2016 (https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS)

33 Potential impact of the COVID-19 pandemic on HIV, tuberculosis, and malaria in low-income and middle-income countries: a modelling study. Hogan AB, Jewell BL, et al. Lancet Global Health. 2020.

34 Potential effects of disruption to HIV programmes in sub-Saharan Africa caused by COVID-19: results from multiple mathematical models. Jewell BL, Mudimu E, et al. The Lancet HIV. 2020.

HIV TREATMENT

" In many countries, a shortage of medicines (or simply the fear of stock outs) has caused health providers to only issue prescriptions that last for a matter of weeks despite clear WHO guidance on providing a minimum three-month supply for people living with HIV who are stable on treatment." [35]

GNP+, ICW and Y+ Global

For people living with HIV, treatment is a lifelong commitment with adherence to antiretroviral therapy (ART) critical to suppressing the virus and keeping healthy. WHO's guidelines for maintaining essential health services within the context of COVID-19 included continuation of HIV treatment. [36] However, many countries have reported disruption of HIV services, including HIV treatment, especially during lockdowns. [37] While most countries managed to address this, there are worrying reports of continued reductions from a few, including South Africa, the country with the largest population of people living with HIV. [38] Many countries also reported reductions in HIV testing and initiating newly diagnosed people onto treatment. The UN warned that children and adolescents with chronic illnesses, including those living with HIV, are at risk of reduced access to medicines and care. [39]

Reasons for the disruption to HIV treatment varied across countries and included both demand and supply challenges. Some of the common issues reported were: [40]

- Re-deployment of ART clinics for COVID-19 or reduced hours at clinics
- Stockouts or fear of shortages of medicines
- Restrictions on movement and lack of transport during lockdowns
- Fear of going to health facilities during COVID-19
- Fear of disclosure of HIV status and stigma
- Concern about taking antiretrovirals (ARVs) without enough food
- Inability to access peer support groups and psychosocial support particularly impacted adolescents and young people.

In addition, there were logistical and supply chain issues hampering the generic production of ARVs, due to lockdowns in India and China. [41]

35 Living with HIV in the time of COVID-19, GNP+, ICW, Y+. 2020 (https://www.gnpplus.net/assets/wbb_file_updown/8170/BeyondLIVING_COVID-19_Updated.pdf)

36 Maintaining essential health services: operational guidance for the COVID-19 context, WHO. 2020 (https://apps.who.int/iris/rest/bitstreams/1279080/retrieve)

37 Pulse survey on continuity of essential health services during the COVID-19 pandemic, WHO. (https://www.who.int/publications-detail-redirect/WHO-2019-nCoV-EHS_continuity-survey-2020.)

38 Prevailing against pandemics; by putting people at the centre, UNAIDS. 2020 (https://www.unaids.org/sites/default/files/media_asset/prevailing-against-pandemics_en.pdf)

39 Policy Brief: the impact of COIVD-19 on children, UN. 2020 (https://childrenandaids.org/sites/default/files/2020-10/Brief%20on%20COVID-19%20impact%20on%20Children.pdf)

40 https://www.gnpplus.net/covid-19-and-hiv/

41 The impact of the COVID-19 response on the supply chain, availability and cost of generic antiretroviral medicines for HIV in low- and middle-income countries, UNAIDS. 2020. (https://www.unaids.org/en/resources/documents/2020/covid19-supply-chain-availability-cost-generic-arv)

It was clear from country reports and the modelling (see box on page 24) that urgent action was needed to stop disruptions to HIV treatment that would put millions of lives at risk and lead to an increase in new HIV infections. Global health agencies and donors, including WHO, UNAIDS, the Global Fund for AIDS, TB and Malaria (Global Fund) and PEPFAR have taken actions to mitigate against the impact of COVID-19 on the HIV, TB and malaria responses.

The remarkable mobilisation of communities themselves can act as a reminder of the power and solidarity of the HIV movement. In country after country, networks of people living with HIV and other community-led organisations galvanised to ensure that their communities continued to access HIV treatment. Surveys and interviews we conducted from March- July 2020 highlighted the many creative and inspiring actions taken by our communities.[42] In countries such as the Philippines and Uganda, young peer supporters donned masks and cycled to deliver ARVs directly to the homes of people who needed them. In India and Kenya, activists negotiated with the police for special permits for peer supporters to travel during lockdown, and in South Asia and Eastern Europe regional initiatives delivered ARVs to migrant workers and people who were away from their home country.

THE REALITY OF MULTI-MONTH DISPENSING

COUNTRY	PEOPLE LIVING WITH HIV RECEIVING 1 MONTH OR LESS SUPPLY OF ARVS	PEOPLE LIVING WITH HIV RECEIVING MORE THAN 1 BUT LESS THAN 3 MONTHS' SUPPLY OF ARVS	PEOPLE LIVING WITH HIV RECEIVING MORE THAN 3 MONTHS' SUPPLY OF ARVS
CAMEROON	40%	50%	1%
KENYA	10%	80%	10%
MEXICO	-	-	-
MOROCCO	10%	50%	0%
NEPAL	100%	0	0
NIGERIA	29%	59%	12%
RUSSIA	0%	0%	0%
TANZANIA	37%	57%	6%

Source: UNAIDS COVID-19 Portal November 2020, data only included for countries where interviews were conducted for this report.

42 https://www.gnpplus.net/covid-19-and-hiv/

MULTI-MONTH DISPENSING OF MEDICINES

One of the most common measures adopted to ensure continuity of HIV treatment during COVID-19 has been multi-month dispensing of medicines. This allows people who are stable on their HIV treatment to collect three to six months' supply of ARVs, reducing the need to visit health facilities.

The policy was recommended by WHO in 2016, long before COVID-19. HIV activists have since campaigned for its implementation and while many countries adopted the policy, not all have put it into practice. COVID-19 spurred further activism on this issue, with mixed results. Many governments have either expanded (such as Tunisia, Liberia) or fast-tracked (such as Uganda) their implementation of this policy. According to data gathered by UNAIDS, **"of 80 countries, 48% report that there has been a change in multi-month dispensing practices due to COVID-19"**.[43] However, other countries have failed to implement this policy or even gone backwards.

During our COVID conversations[44] held with national networks of people living with HIV in October 2020, activists from Cambodia and Indonesia reported that multi-month dispensing was not being fully implemented due to shortages of ARVs. Another worrying concern raised by both countries was that some people living with HIV, including children, were being asked to switch to older or alternative regimens.

A rapid survey conducted by Indonesia Positive Network (JIP) in August 2020 showed that out of 1,035 respondents, 52% reported having only one month supply of ART and 47% had less than that.[45] Similarly, a survey in Armenia showed 64% had ART supplies for 1-2 months, 11% for 2-3 weeks, and 14% had reserve of less than two weeks.[46] Even in the high burden region of Eastern and Southern Africa, countries such as Botswana, Tanzania and Uganda reported that a considerable proportion of people living with HIV (ranging from 45% to 70%) receive only one month of medicines.[47]

CHALLENGES IN IMPLEMENTATION

Countries report various challenges in implementing a multi-month dispensing policy:

- **Supply chains:** e.g in Armenia, Argentina, Belarus, Cambodia, Cameroon, Indonesia, Fiji, Kyrgyzstan, Ukraine
- **Stock shortages:** e.g in South Africa, Lao PDR, Uzbekistan
- **Low paediatric stocks:** e.g in Mozambique, Sierra Leone
- **Distance and movement restrictions:** e.g in Morocco, Kyrgyzstan

Administrative restrictions forbid multi-month dispensing for foreigners in Morocco, and Lesotho has experienced resistance to multi-month dispensing from health care workers.[48]

43 Data from UNAIDS COVID-19 Portal shared in November 2020

44 COVID conversations - a series of regional webinars for national networks of people living with HIV to share their updates in an informal setting, organised by GNP+, ICW, Y+ Global in October 2020.

45 The Needs of People Living with HIV/AIDS (PLHIV) in Indonesia During COVID-19 Pandemic and Adapt to New Normal, Indonesia Positive Network (JIP). August 2020

46 Data from UNAIDS COVID-19 Portal shared in November 2020

47 As above

48 As above

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

UNFPA report that more than 47 million women could lose access to contraception during the pandemic, leading to 7 million additional unintended pregnancies. [49]

Like other health and humanitarian crises, the new pandemic is having a disproportionate impact on women, adolescents and girls – in particular those from marginalised communities. As health systems are increasingly focused on the COVID-19 response, some governments have deprioritised sexual and reproductive health and rights (SRHR) contrary to guidance from WHO [50] and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).[51] In Asia-Pacific, many pregnant women living with HIV reported challenges accessing prevention of mother to child transmission (PMTCT) services and ARVs, increasing the risk of transmitting HIV to their babies. [52] Restrictions on travel also made it difficult to access reproductive, maternal, newborn, child and adolescent health services. Even access to contraceptives has been affected leading to a potential increase in unwanted pregnancies and greater risk of sexually-transmitted infections (STIs) and HIV among adolescent girls and women. This is borne out by an ICW survey in Asia and the Pacific: **"more than eighty percent of the respondents lacked access to sexual and reproductive health and rights, including contraception, during COVID-19."** [53]

Young key populations have been particularly badly impacted by COVID-19. Both young LGBTI people and young people who use drugs have reported increasing vulnerabilities. Many of the targeted services that they would normally access are closed or inaccessible because of lockdowns and they cannot rely on their families to give consent and the support they need to be able to access health services. [54]

Networks of women living with HIV in many countries advocated for SRHR services to be considered essential even during lockdowns. In some countries they successfully negotiated for pregnant women to be exempt from the travel restrictions so they could access maternal care. [55] In others, women's groups delivered dignity kits and contraception directly to women in need. Telehealth services were launched and remote consultations used to ensure uninterrupted access to SRHR services.

COVID-19 has exacerbated existing problems accessing quality healthcare including the numerous social, cultural, financial and legal barriers preventing women and girls from meeting their SRHR needs. According to a WHO report in 2019: **"an estimated 40% of women of reproductive age (ages 15–49) did not have four antenatal care visits during pregnancy, and 38% of sexually active women were not using modern contraceptives."** [56]

49 New UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues, United Nations Population Fund. 2020 (https://www.unfpa.org/press/new-unfpa-projections-predictcalamitous-impact-womens-health-covid-19-pandemic-continues?fbclid=IwAR0vD9WiUZeKxlEq5Hslexi5ec_ DpYrX6M2KaDxp17ZHmsinLykGvNiJje8).

50 COVID-19: operational guidance for maintaining essential health services during an outbreak—interim Guidance, WHO. 2020 (https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak).

51 Guidance note on CEDAW and COVID-19, Committee on the Elimination of Discrimination against Women. 2020 (https://www.ohchr.org/EN/HRBodies/CEDAW/Pages/CEDAWIndex.aspx).

52 Impact of COVID-19 on women and girls living with HIV in Asia and the Pacific, ICWAP. July 2020 https://www.wlhiv.org/knowledge-generation-and-sharing

53 As above

54 COVID-19: Ensuring access to quality, safe, and non-discriminatory services for HIV key populations and migrants,UNDP. 2020 (https://www.undp.org/content/undp/en/home/news-centre/news/2020/-----statement-of-the-joint-unprogramme-on-hiv-aids--unaids--.html).

55 https://www.gnpplus.net/covid-19-and-hiv/

56 Primary Health Care: On the road to Universal Health Coverage, WHO. 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/)

OTHER HEALTH SERVICES

" Up to 75% of HIV, TB and malaria programs have been disrupted due to lockdowns, transport stoppages and resources diverted to COVID-19. Recent studies show that deaths from HIV, TB and malaria may be as much as double in the coming year as a knock-on effect of COVID-19." [57]

Global Fund

Many people living with HIV have co-morbidities and need regular health care beyond their HIV treatment. COVID-19 has disrupted services to test and treat TB around the world. WHO [58] and the Global Fund [59] have highlighted how the new pandemic threatens to reverse recent gains in the global TB response. Across Africa, Asia and Latin America harm reduction services were also severely disrupted. [60] A WHO survey in 155 countries showed that people living with non-communicable diseases were not able to access services for their health conditions, which is of significant concern as they are at higher risk of COVID-19-related illness and death. [61]

There has been a scale-up of mobile clinics that are helping to get HIV and other testing services to remote areas. Services have been integrated, for example, some mobile clinics have carried out TB and COVID-19 tests at the same time. Laboratory tests, data systems and health infrastructure built for HIV and Ebola are being used for COVID-19 too. TB programmes are increasingly using telemedicine, digital health technologies, virtual care and community-based monitoring solutions. [62] According to WHO, 108 countries have expanded the use of digital technologies to provide remote advice and support, and many countries are encouraging home-based treatment and ensuring that TB patients have an adequate supply of drugs. [63]

Self-care interventions, such as pre-exposure prophylaxis (PrEP) and self-testing are particularly important for communities who are criminalised or excluded, offering them and their peers a chance to take control and use these interventions for health promotion, disease prevention and for staying healthy.

Harm reduction activists have won significant policy and programmatic changes in many countries for people who use drugs with the expansion of take-home methadone and other opioid agonist therapy (OAT) medications to treat addiction. [64] Harm Reduction International reports that, **"out of the 84 countries worldwide where OAT is available, 47 countries (with at least one country in every region) expanded take home capacities providing for longer take-home periods."** [65]

57 Mitigating the impact of COVID-19 on countries affected by HIV, tuberculosis and malaria, The Global Fund. June 2020 (https://www.theglobalfund.org/media/9819/covid19_mitigatingimpact_report_en.pdf)

58 Global Tuberculosis Report, WHO. 2020 (https://www.who.int/docs/default-source/documents/tuberculosis/execsumm11nov2020.pdf?sfvrsn=e1d925f_4)

59 Results 2020 – At a glance, The Global Fund. 2020 (https://www.theglobalfund.org/media/10155/corporate_2020resultsreport_executivesummary_en.pdf?u=637381115118030000).

60 Global State of Harm Reduction 2020, Harm Reduction International. 2020 (https://www.hri.global/global-state-of-harm-reduction-2020)

61 COVID-19 significantly impacts health services for noncommunicable diseases, WHO. 1 June 2020 (https://www.who.int/news/item/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases)

62 The impact of COVID-19 on the TB epidemic: a community perspective, Stop TB Partnerships and others. 2020 (https://www.stoptb.org/assets/documents/resources/publications/acsm/Civil%20Society%20Report%20on%20TB%20and%20COVID.pdf)

63 Global Tuberculosis Report, WHO. 2020 (https://www.who.int/docs/default-source/documents/tuberculosis/execsumm11nov2020.pdf?sfvrsn=e1d925f_4)

64 Mapping expanded access to opioid agonist treatments during COVID-19, Harm Reduction International. 2020

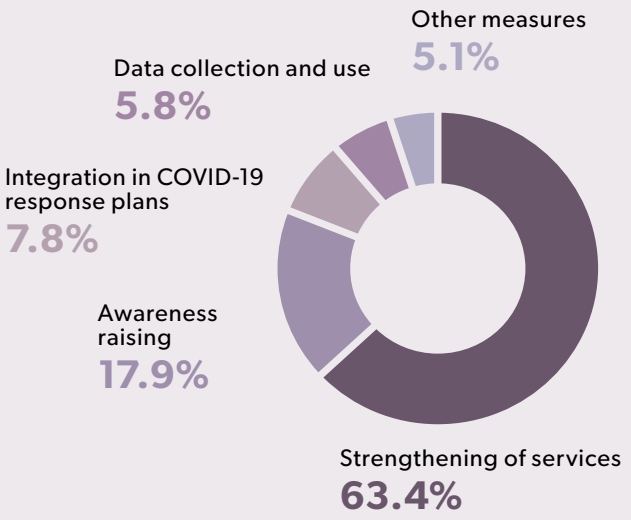
65 The Global state of harm reduction, Harm Reduction International, 2020 (https://www.hri.global/global-state-of-harm-reduction-2020)

SEXUAL AND GENDER-BASED VIOLENCE

Globally around 243 million women and girls aged 15–49 years have been subjected to sexual and/or physical violence by an intimate partner in the past year. [66]

Strategies that were needed to address COVID-19 such as lockdowns and self-isolation led to an increase in sexual and gender-based violence (SGBV) – in homes and in informal settlements. Around the world, sex workers lost their livelihoods and faced greater risk of arrest, detention and violence. Adolescent girls in many countries experience very high rates of SGBV. School closures during lockdowns put young girls at even greater risk of SGBV and unwanted pregnancies. For women living with HIV, gender-based violence impedes their access to health care.

TYPES OF MEASURES TAKEN IN RESPONSE TO VIOLENCE AGAINST WOMEN DURING COVID-19



Source:
UNDP-UN Women COVID-19 Global Gender Response Tracker.

Worldwide, women's groups stepped up to ensure access to hotlines, virtual support and other services despite the challenging times. Networks of women living with HIV advocated for governments to integrate these new services into HIV responses and to ensure that these services are seen as essential and continued during COVID-19. Several government and NGO services expanded online platforms for hotlines and opened up additional temporary shelters as the need grew during lockdowns.

See section on gender equity on page 20 for more about gender-based violence.

MENTAL HEALTH

In low- and middle- income countries between 76% and 85% of people with mental health conditions receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context. [67]

In May 2020 the UN warned, **"although the COVID-19 crisis is, in the first instance, a physical health crisis, it has the seeds of a major mental health crisis as well, if action is not taken. It must be front and centre of every country's response to and recovery from the COVID-19 pandemic."** [68]

66 The shadow pandemic: violence against women and girls and COVID-19, UN women. 2020 (https://data.unwomen.org/sites/default/files/documents/COVID19/Infographic_VAW-COVID19.pdf)

67 Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Wang et al., The Lancet, 2007

68 Policy Brief: COVID-19 and the Need for Action on Mental Health, UN. 2020 (https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf).

While estimates vary, depression is a common occurrence among people living with HIV.[69] Being diagnosed with HIV, starting and adhering to lifelong treatment, facing internal and external stigma can all impact emotional health. This is more so for sex workers, people who use drugs and LGBTI people who are excluded and criminalised by society. Adolescents living with HIV or in families affected by HIV are more likely to experience depression, anxiety and trauma and these conditions impact on their ability to access and benefit from other health services.[70] The challenge for health services is to ensure that these mental health problems are detected and addressed.

As the COVID-19 pandemic evolved, one of the most pressing challenges reported by many communities of people living with HIV was the impact on mental health. For example, in a rapid survey of women living with HIV in Asia, 65% of the respondents reported anxiety due to the burden of care of family members and 50% reported anxiety due to COVID-19. [71]

YOUNG PEOPLE AND MENTAL HEALTH

In May 2020, during the COVID-19 outbreak, the Interagency Task Team (IATT) on Young Key Populations in Asia and the Pacific conducted a rapid survey of young key populations and young people living with HIV in the region. Half of young people living with HIV who completed the survey said that counselling for anxiety, depression, or other conditions is essential to adhering to their HIV treatment. Among young people who reported needing mental health services, 47% said they had experienced delays or disruption in accessing psychosocial support as a result of the pandemic. [72]

In another survey, 74% of young people living with HIV reported that they did not feel there was adequate funding for mental health support and services in their country and 72% did not know if there were mental health services available to them or where to access them. [73]

People living with HIV have long raised the importance of emotional well-being and dignity as critical to their quality of life. Networks of people living with HIV have deployed peer supporters to provide counselling and emotional support to improve uptake of testing, treatment and adherence to care. During COVID-19, networks – especially those supporting adolescents and young people – moved their counselling and psychosocial support services online. Increasingly, support is being provided by phone or using digital platforms and social media. Community groups are helping to cover the additional costs such as those for airtime or data.

69 Noncommunicable diseases among HIV-infected persons in low-income and middle-income countries: a systematic review and meta-analysis, NIH HIV/NCD Project Disease Condition Technical Operating Group. AIDS. 2018;32 (suppl 1)

70 Adolescent HIV prevention. Turning the tide against AIDS will require more concentrated focus on adolescents and young people, UNICEF. 2018 (https://data.unicef.org/topic/hivaids/adolescents-young-people/)73 Impact of COVID-19 on women and girls living with HIV in Asia and the Pacific, ICWAP. July 2020

71 Impact of COVID-19 on women and girls living with HIV in Asia and the Pacific, ICWAP. July 2020 (https://www.wlhiv.org/knowledge-generation-and-sharing)

72 UNAIDS webpage, https://unaids-ap.org/2020/05/29/impact-on-mental-health-and-quality-of-life-in-time-of-covid-19-for-ykp-and-yplhiv-2/

73 Youth Stop AIDS website, 2020 (http://youthstopaids.org/mental-health/)

PROVIDING QUALITY SERVICES WITHIN UHC

COVID-19 has exposed weaknesses but also provided lessons on how to build better systems for health. Each person should have access to quality health care that is comprehensive, competent and centred around their evolving needs.

RECOMMENDATIONS

- Governments and health care providers must ensure non-judgmental and respectful health care for all communities. Every country must meet the global commitment to end all stigma and discrimination in health care settings.
- Governments must build on the opportunities and changes made during COVID-19 to scale up approaches such as differentiated service delivery, task shifting and self-care interventions. This includes scaling up the use of telehealth and digital platforms, including for psychosocial counselling and support, while protecting people's right to confidentiality and privacy.
- Governments and donors must scale up their investment in building strong health systems, especially at primary health care level to ensure that people can access the quality health services they need to manage their health and well-being.
- Governments and donors need to invest in community systems for health, including community-led services that are effective in reaching and retaining people in care, even in the most difficult circumstances, and community-led monitoring and accountability initiatives that give feedback on the quality of services.
- Governments must meet their commitments to build stronger partnerships with communities, such as through social contracting mechanisms, so that civil society and community-led organisations are adequately supported to deliver health services and play a full part in achieving UHC.

MINIMISING FINANCIAL HARDSHIP

While service coverage has been increasing since 2000 at 2.3% a year, financial protection has not improved – the number of people with catastrophic expenditures has risen on average by 3.6% a year. [74]

WHO

People's access to health care should not be dependent on where they live or whether they are rich or poor. And the cost of health care should not force families to choose between medicines, food or education.

COVID-19 has starkly exposed the high levels of inequities in countries and the disproportionate impact a pandemic has on the most marginalised communities and the poorest families.

In our survey, we heard multiple stories of how the socio-economic consequences of the pandemic contributed to increased anxiety and depression among different communities of people living with HIV. Women raised their fears about the impact on children living with HIV, many more of whom will be going to bed hungry. [75] An estimated 42-66 million children could fall into extreme poverty as a result of the crisis this year, adding to the estimated 386 million children already in extreme poverty in 2019. [76] In a study among young key populations including young people living with HIV in Asia Pacific 59% of young people reported anxiety due to loss of income and 39% were not able to work as they usually would. [77]

BURDEN OF HEALTH SPENDING

Each year about 100 million people are pushed into "extreme poverty" (defined as living on US$1.90 or less a day) because they have to pay for health care. [78]

WHO/ World Bank Group

People living with HIV have long campaigned for an end to unaffordable prices for medicines, diagnostic tests and user fees. Despite ARVs now being provided free of charge around the world, many people living with HIV are poor and struggle to afford costs associated with accessing health services and leading healthy lives.

74 Primary healthcare on the road to universal health coverage. WHO 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/)

75 Living with HIV in the time of COVID-19, GNP+, ICW and Y+. 2020. (https://www.gnpplus.net/resources/living-with-hiv-in-the-time-of-covid-19-report-from-a-survey-of-networks-of-people-living-with-hiv/)

76 Policy Brief: the impact of COIVD-19 on children, UN. 2020 (https://childrenandaids.org/sites/default/files/2020-10/Brief%20on%20COVID-19%20impact%20on%20Children.pdf)

77 Impact on mental health and quality of life in time of COVID-19 for YKP and YPLHIV, UNAIDS. 29 May 2020 (https://unaids-ap.org/2020/05/29/impact-on-mental-health-and-quality-of-life-in-time-of-covid-19-for-ykp-and-yplhiv-2/)

78 Tracking universal health coverage: 2017 Global Monitoring Report, WHO & World Bank. 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/)

A critical pillar for UHC is that people should be able to access quality health services without suffering financial hardship. However, despite governments and donors recognising the importance of investing in resilient and sustainable systems for health, the vast majority of health expenditure is still borne by individuals. A 2019 World Bank report [79] revealed that people in developing countries spend half a trillion dollars annually — over US$80 per person — out of their own pockets to access health services, and such expenses hit poor people the hardest. The report calls for increased domestic and international investment to close the substantial UHC financing gap.

Direct payments made by individuals to health care providers at the time of using a service are known as out-of-pocket spending on health. As the World Bank report above shows, this is an enormous hardship for people, particularly the poor. Evidence from South-East Asia, Europe and other countries mostly in Africa suggests that medicines account for the largest share of out-of-pocket health spending particularly among the poorest households. In South East Asia, except in the Maldives and Thailand, government spending on health ranges from 0.4% to 2.5% of gross domestic product (GDP), less than the amount estimated necessary to achieve UHC. [80]

Despite WHO recommending that countries abolish user fees to offset the financial difficulties people may be facing in accessing health care, only 14% of countries reported removal of user fees. [81] According to UNAIDS in many of the countries reporting user fees prior to COVID-19, these were mostly HIV private clinic testing and laboratory fees. Encouragingly a few countries report abolishing user fees (Burkina Faso and Cameroon) in response to COVID-19, and others report that user fees have been temporarily lifted (Ethiopia, Gabon, Kazakhstan). However, in the vast majority of countries, there has been no policy change regarding user fees in response to COVID-19. Worryingly, there are also reports of informal user fees being introduced in some countries as healthcare workers and facilities feel stretched and under-resourced, including for personal protective equipment. [82]

HIGHER BURDEN ON WOMEN

One study into out-of-pocket health spending and financial protection used surveys from Bolivia, Guatemala, Nicaragua and Peru finding that average individual out-of-pocket health spending was always higher among women than among men. In Guatemala and Nicaragua, differences in out-of-pocket health spending between women and men were even greater among those with social health insurance coverage, suggesting this type of insurance mechanism's failure to protect, especially women. [83]

However there has also been some progress as many countries have abolished user fees for maternal and child health services, reducing some of the financial barriers to accessing health care. Of 155 reporting countries, most have no user fees for maternal and child immunisations (97%), HIV testing and treatment (82%), antenatal care (80%), normal deliveries (71%), family planning (70%), caesarean sections (68%) or contraceptives for adolescents (65%). [84]

79 High-Performance Health Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century, World Bank Group. 2019 (http://documents.worldbank.org/curated/en/641451561043585615/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century)

80 What level of domestic government health expenditure should we aspire to for universal health coverage? Mcintyre D, Meheus F, Røttingen JA. Health Economics, Policy and Law. 2017 Apr;12(2):125–37.

81 Pulse survey on continuity of essential health services during the COVID-19 pandemic, WHO. 2020. (https://www.who.int/publications-detail-redirect/WHO-2019-nCoV-EHS_continuity-survey-2020.)

82 UNAIDS COVID Portal Data November 2020

83 Primary healthcare on the road to universal health coverage. WHO 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/)

84 As above

POVERTY AND SOCIAL PROTECTION

" The world failed to reach the target of 75% of people living with, at risk of and affected by HIV, benefiting from HIV-sensitive social protection. Only five of the 21 countries with a high HIV burden that have social protection strategies that specifically mention people living with HIV as key beneficiaries reported achieving coverage of at least 50% for at least one social protection benefit." [85]

UNAIDS

As we know, COVID-19 is not just a health emergency but a social, economic and humanitarian crisis. The global pandemic is deeply linked to widespread inequalities within and across countries. It impacts poorer and marginalised communities both in rich countries and developing countries and it has deepened these inequalities.

Around the world sex workers have lost their livelihoods and sometimes their homes. Many have been left with little choice but to continue working, putting their safety, health and lives at increased risk. [86] They struggle to pay for food and face the threat of criminal proceedings if they have to continue working. The same can be said for many people who rely upon the informal economy, such as people who use drugs who are street based and do ad hoc jobs, like washing car windows, to earn an income.

Access to clean water and nutritious food is important for everyone. For people living with HIV, hunger and food insecurity affect their ability to adhere to their treatment, strengthen their immune system and live well. In many countries, one of the first responses from networks of people living with HIV and other community organisations was to provide food and other essentials such as dignity kits for women to families in need.

In the same way that providing health services is not enough without removing the barriers that prevent people from accessing them, financing health services is not enough without other measures. The 2016 UN Political Declaration on Ending AIDS highlighted the importance of related issues such as access to education, prevention of intimate partner violence and reduction of stigma and called for 6% of funding to be allocated to these social enablers. [87]

The UN also issued guidance to countries for mitigating the socio-economic impact, learning from previous pandemics and recognising that **"During the Ebola outbreak in West Africa in 2014, more people died from the interruption of social services and economic breakdown than from the virus itself. This should not have happened, and the world cannot let it happen again"**. [88] Many countries put in place extensive social protection packages to help people cope with the economic impacts of COVID-19, including for people living with HIV. The special measures that have been offered during COVID-19 ranged from cash transfers and livelihood or housing support to free food and masks. While there were efforts made to reach vulnerable and marginalised groups such as migrants, prisoners and sex workers, often there were additional barriers that meant they were excluded.

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

86 Sex workers must not be left behind in the response to COVID-19, NSWP and UNAIDS joint statement. April 2020 (https://www.nswp.org/page/covid-19)

87 Political Declaration on Ending AIDS, UN. 2016 (https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS)

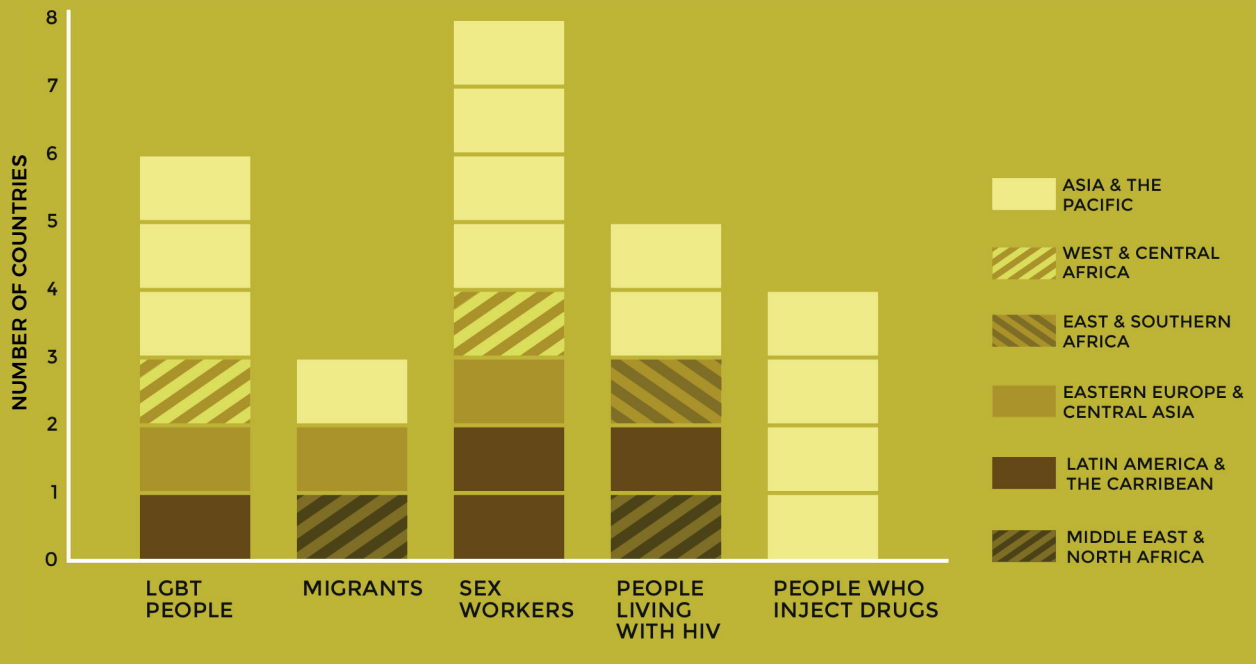
88 A UN framework for the immediate socio-economic response to COVID-19, UN. April 2020 (https://unsdg.un.org/sites/default/files/2020-04/UN-framework-for-the-immediate-socio-economic-response-to-COVID-19.pdf)

For many people the problem is a lack of the relevant documentation required to access government services. This is a particular challenge for criminalised communities and those living outside the formal economy. Transgender people have reported a reluctance to visit government-run treatment centres because they feel at risk of both greater vulnerability to COVID-19 and heightened stigma.[89] In countries where sex work is not considered to be work, sex workers are excluded from COVID-19 social protection responses. In the NSWP's COVID-19 impact survey, sex workers spoke about their difficulties accessing government support schemes because they were unable to provide proof that their work had been lost or reduced.[90] Even in countries where some sex work is legal, sex workers are falling through the gaps and unable to access support. People who are street-based are experiencing similar difficulties, for example, unable to access free HIV treatment without identification and residence registration.[91]

A large proportion of women work in the informal sector – in low-paid informal activities or domestic work or in unpaid work looking after their families. Globally, more than 740 million women work in informal employment and in Africa 90% of employed women work in informal employment. [92] They are not covered by social health protection schemes and were deeply affected by COVID-19. Moreover, even where women are employed or earn an income, gender norms and power relations in the household can mean that they have less control over how to spend the household income. This affects not only their own access to health care but often also their children's.

COUNTRIES WHERE KEY POPULATIONS HAVE REPORTED EXPERIENCING BARRIERS TO ACCESSING COVID-19 RELATED SOCIAL PROTECTION MEASURES

*only countries that have shared data with UNAIDS for the COVID Portal



89 Keeping HIV treatment available in Pakistan during COVID-19, UNAIDS. 15 April 2020 (https://www.unaids.org/en/resources/presscentre/featurestories/2020/april/20200415_pakistan)

90 COVID-19 Impact Survey, NSWP. April 2020 (https://www.nswp.org/news/nswp-launch-covid-19-impact-survey)

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

92 Women and men in the informal economy: a statistical picture (third edition), ILO. 2018. (https://www.ilo.org/global/publications/books/WCMS_626831/lang--en/index.htm)

MINIMISING FINANCIAL HARDSHIP WITHIN UHC

Echoing the HIV response, COVID-19 is again revealing the ways in which health is interconnected to poverty and inequality. People's ability to access quality health care should not be based on their ability to pay – the goal of equitable and universal access is impossible without addressing growing inequalities.

RECOMMENDATIONS

- Governments need to abolish user fees immediately. The evidence is clear, user fees remain a barrier for people to access HIV, TB, COVID-19 and other healthcare services.
- Governments must ensure social protection is available to all and financing mechanisms for UHC must not exclude communities who are marginalised, disenfranchised or criminalised.
- Governments and donors need to step up and increase their investment in health – both domestic and international funding falls far short of what is needed. The world needs to be better prepared for future health crises. We cannot allow the poorest and most marginalised communities to bear the burden of health spending.
- Governments and donors must also finance social enablers such as public outreach and information programmes, prevention of intimate partner violence initiatives, and law and policy reform in order to make health services accessible to all.

ACKNOWLEDGEMENTS

We would like to thank the organisations and Life Force members who provided information for the countries in focus section.

Life Force members: Jean Paul Enama, Vladimir Grichishkin, Doreen Morraa Moracha, Ayoub Nahed, Miguel Subero

Cameroon
Cameroon Civil society Coalition against AIDS, Malaria, Tuberculosis and Hepatitis
International Community of Women Living with HIV (ICW) Central Africa

Kenya
International Community of Women Living with HIV (ICW) Kenya
The Movement of Men against AIDS in Kenya (MMAAK)
Most at risk young mothers and teenage girls living with HIV Initiative (MOYOTE)
The National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)

Mexico
Red Mexicana de Jovenes y Adolescentes Positivos (J+MEX)

Morocco
Association de Lutte Contre le Sida (ALCS)

Nepal
National Association of People Living with HIV/AIDS in Nepal (NAP+N)

Nigeria
African Network of Adolescent and Young Persons Development (ANAYD)

Russia
Humanitarian Project
Teenergizer

Tanzania
The National Council of People Living with HIV (NACOPHA)
The Network of Young People Living with HIV and AIDS in Tanzania (NYP+)

Report writing: Aditi Sharma and Laura Davies

We are grateful for input from: Thara Wielaart, Lycias Zembe, Juliet Heller, Herieth Mduma, Sophie Brion, Georgina Caswell, Tinashe Rufurwadzo, Igor Kuchin, Olena Stryzhak, Jessica Whitbread and Alexandra Volgina

Design: Anthea Duce
Cover photo: Tommy Trenchard/Panos Pictures

Published by:
Global Network of People Living with HIV (GNP+) **www.gnpplus.net**
International Community of Women Living with HIV (ICW) **www.wlhiv.org**
Global Network of Young People Living with HIV (Y+ Global) **www.yplusglobal.org**

Suggested citation: GNP+, ICW, Y+ Global. December 2020. Demanding health for all: drawing on experiences of people living with HIV.


BEYOND