PITCH

Accelerating community-led HIV responses: adapting positive practice beyond the COVID-19 crisis

PITCH Partnership to Inspire, Transform and Connect the HIV response

aidsfonds

FRONTLINE AIDS

Ministry of Foreign Affairs

idpc International Drug Policy Consortium

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A health worker conducts an HIV test at a mobile testing unit in Ecuador.

Foreword

We are at a critical juncture in the global HIV response. COVID-19 has presented fundamental challenges and changes in national policy landscapes. More than two decades of progress on HIV is at risk of reversal, particularly where health systems are fragile and under-resourced.

Communities and civil society are incubators and multipliers of critical innovations which drive the HIV response. These same communities have responded in equal measure to the huge challenges of the global pandemic. They have achieved important gains despite – and even in response to – this pandemic.

This paper highlights specific and inspiring examples of positive shifts in policy, programme and service delivery as well as rights protections for people living with and at greatest risk of HIV, in response to the COVID-19 pandemic.

It draws on powerful examples from the Partnership to Inspire Transform and Connect the HIV response (PITCH) - a strategic partnership between Aidsfonds, Frontline AIDS and the Dutch Ministry of Foreign Affairs that ran between 2016 and 2020. PITCH enabled people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health and rights services.[1]

PITCH partners have contributed to policy and programmatic changes since the start of the COVID-19 pandemic, many of which are the result

of years of sustained advocacy before this crisis emerged. The HIV infrastructure, particularly community-led responses, and courageous community leadership have responded to the COVID-19 pandemic by sustaining services during lockdowns and introducing innovations through technology, integrated service delivery and localised responses. These innovations have enabled the continuation of service delivery and improved social care systems. They need to be sustained.

The paper also shares initiatives from regions and contexts beyond the geographical focus of PITCH[2], as they provide rich sources of information for civil society advocacy in their own contexts. They put forward developments that should be continued during the ongoing pandemic as well as fed into the pandemic preparedness frameworks being developed.

The findings are aimed at community-based and national civil society organisations working with marginalised communities. We hope that the successful adaptations documented here might support existing or future advocacy toward decision-makers, or inspire adaptations in your own strategic approach.

The paper can be read cover to cover, or as individual pull-out chapters. Six chapters are included - one on each marginalised population that PITCH works with: people who use drugs, sex workers, transgender people, men who have sex with men in their diversity, and adolescent girls and young women. A final chapter looks at intersectional issues. Case studies in each chapter detail what were the tipping points and ingredients for securing change; the steps taken which led to advocacy success; and what can be learned from the process.

Now is the time to amplify our impact. We have new opportunities to advance community-led HIV responses and to accelerate health and community systems strengthening. We must hold governments to account for implementation of the targets[3] on community-led responses and social enablers, which are included in the Political Declaration at the 2021 High Level Meeting on AIDS[4]. WHO's 'One Health'[5] approach offers civil society the chance to expand cross-sectoral collaboration and strengthen community-led responses across multiple sectors.

Community-led HIV responses and the innovations they create have been critical to an effective COVID-19 response and should feed into planning for future pandemic responses. To ensure these gains are sustained, and to bring similar changes in other contexts, ongoing support for community advocacy is critical[6].

Lois Chingandu

Director: Evidence & Influence, Frontline AIDS

Endnotes

[1] The PITCH programme (2016-2020) strengthened community-based organisations' capacity to uphold the rights of populations most affected by HIV by engaging in effective advocacy, generating robust evidence and developing meaningful policy

[2] PITCH countries were: Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam, and Zimbabwe. The two PITCH regions are Eastern Europe and Central Asia, and Southern Africa.

[3] Increasing the proportion of HIV services delivered by communities: 30% of testing and treatment services, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy; 80% of HIV prevention services for populations at high risk of HIV infection, including for women within those populations; 60% of programmes to support the achievement of societal enablers. The 10-10-10 endorsed targets to end all inequalities faced by people living with HIV, key and other priority populations by 2025, by reducing to 10% or less the proportion of women, girls, people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence; countries with restrictive legal and policy frameworks that lead to the denial or limitation of access to services; people experiencing stigma and discrimination.

[4] https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids

[5] 'One Health' is an approach to designing and implementing programmes, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes, outlined at https://www.who.int/news-room/q-a-detail/one-health.

[6] To read more about how communities innovate to respond to COVID-19 and transform the HIV response, read Frontline AIDS 'Transforming the HIV response'.

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This paper has been developed using data and examples from Frontline AIDS' and Aidsfonds' crisis funds and partner surveys, and from PITCH partners. We thank the partners for their courageous work to address COVID-19 and HIV/AIDS during these difficult times.

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organisation
CSE	Comprehensive sexuality education
CSO	Civil society organisation
COPD	Chronic obstructive pulmonary disorder
DSD	Differentiated service delivery
HIV	Human immunodeficiency virus
LGBTQ	Lesbian, gay, bisexual, transgender and queer
MMD	Multi month dispensing
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
OAT	Opioid agonist therapy
PEP	Post-exposure prophylaxis
PITCH	Partnership to Inspire Transform and Connect the HIV response
PPE	Personal protective equipment
PrEP	Pre-exposure prophylaxis
REAct	Rights, Evidence, Action
SGBV	Sexual and gender-based violence
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
WFP	World Food Programme

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1. People who use drugs: the response from harm reduction services

Introduction

The COVID-19 pandemic and its related restrictions have brought many changes to the lives of people around the globe. Most notably, the pandemic's impact has magnified existing inequalities, stigma and repression faced by certain marginalised communities such as people who use drugs. However, the response to COVID-19 has also catalysed – or accelerated – some positive developments which are central to the wellbeing of people who use drugs. This report aims to provide a non-comprehensive review of some of the challenges, and the responses that have been applied to best protect the health and rights of people who use drugs.

It has been written to sit alongside a sister report focused on civil society advocacy during the pandemic: Innovation and Resilience in Times of Crisis: Civil society advocacy for drug policy reform under the COVID-19 pandemic.[1]

People who use drugs - Innovation and resilience

Closure of premises deemed non-essential

Various confinement and physical distancing measures have been introduced globally in response to COVID-19, such as curfews and lockdowns, as well as executive orders calling for

the closure of premises and activities deemed as non-essential. This has led to the closure of many harm reduction, health, and community centres and services catering to the basic needs of people who use drugs. Though such services have a critical, lifesaving purpose, in some countries they are not officially recognised as essential public services. In other jurisdictions, harm reduction services have been able to continue to support people who use drugs, but COVID-19 restrictions have often impeded their capacity, accessibility and efficiency. Outreach activities have also been disrupted by movement restrictions, further magnifying health risks for people who use drugs facing intersecting inequalities, such as street-based people who use drugs.[2]

Lack of coordinated public health efforts in response to COVID-19

Most governments acted relatively quickly in declaring a state of emergency, as well as in implementing restrictive measures to curb COVID-19 outbreaks. But only in a handful of jurisdictions have such measures been accompanied with coordinated public health programmes in response to COVID-19, particularly with regard to prevention, symptom screening, testing and treatment.[3]

Even before COVID-19, people who use drugs were likely to be particularly affected by inadequate public health responses, partly due to the prevalence of underlying medical conditions attributed to several factors, such as lack of access to healthcare and marginalisation. For example, injecting and smoking drugs is associated with a higher prevalence of HIV, hepatitis, tuberculosis (TB) and chronic obstructive pulmonary disorder, all of which may also leave people at greater risk of developing more severe COVID-19 symptoms. Similarly, public health directives such as social and physical distancing may be impossible for some groups of people who use drugs, such as people experiencing homelessness or otherwise unstable housing conditions.[4,5]

Growing repression and criminalisation

In some countries the implementation of COVID-19- related restrictions has encouraged highly punitive law enforcement (and even militarised) responses, resulting in increasing levels of criminalisation of people who cannot or do not comply with various national COVID-19 restrictions. These include people who use drugs, particularly those who are homeless or street-based (and hence become more visible and vulnerable during lockdowns), as well as those working in the informal sector, people of colour, and people from vulnerable socioeconomic backgrounds. As reported by the International Network of People who Use Drugs (INPUD),[6] punitive and restrictive measures have also been experienced by people who use drugs accessing harm reduction services during the pandemic. These measures include mandatory urine testing, forced reductions in medication levels, mandatory attendance in recovery programmes, nonconsensual discharge from treatment, and new age restrictions.

Furthermore, COVID-19 confinement measures and physical distancing rules have had significant impacts on democratic processes and spaces.[7] Bans and restrictions on gatherings and protests, for example, have further shrunk the space for civic mobilisation, and reduced opportunities for community-led organisations to effectively advocate for their rights or voice concerns about harmful policies.

Disruption in drug markets

People who use drugs have experienced disruptions in local drug supply and markets. These include reduced quality (including the growing appearance of adulterated substances), increasing prices, and a general decrease in availability, all of which have driven up health risks for people who use drugs. As reported by several respondents to the International Drug Policy Consortium (IDPC)'s COVID-19 survey, these trends in drug markets have been seen in Albania, India, the Netherlands, Nigeria and South Africa.[8] In June 2020, INPUD reported that 60% of respondents of its online

survey indicated that they (or their acquaintances) had experienced 'involuntary withdrawal due to changes in the drug market'. Comments included: 'People are trying any sorts of drugs to manage their withdrawals' and 'isolation has increased alcohol use to offset difficulties in acquiring drugs of choice'.[9] In addition, growing state control over people's movements and activities, including the intensifying of policing in the context of COVID-19 restrictions, has heightened risk of arrests, criminalisation, and various forms of harassment experienced by people who use drugs, in particular those interacting with local drug markets.[10]

COVID-19 measures and movement restrictions have also led to the suspension of many economic activities. This has resulted in the loss of both formal and informal incomes which some people who use drugs depend on for their basic needs. Options to apply for welfare schemes are available in some jurisdictions, but procedural and legal barriers often prevail, such as mandatory drug testing to qualify for benefits.[11]

Exacerbated risks in prisons and other closed settings

Across the globe, punitive policies towards drug use and possession have resulted in the unjust criminalisation and incarceration of people who use drugs, and hundreds of thousands are still detained in closed settings – in jails, prisons, pre-trial detention, or in compulsory drug detention and rehabilitation centres – despite various prison release measures taken in the context of the pandemic.[12] As frequently noted by communities, experts, civil society actors and policy makers for decades, people in closed settings generally have limited, unreliable or no access to basic health services, including harm reduction services. Opioid Agonist Therapy (OAT) in prisons can only be found in 59 countries (an increase of four since 2018), while needle and syringe programmes in prisons exist in just 10 countries.[13] Millions are forced to live in overcrowded cells where disease outbreaks and human rights violations often occur.

Since the World Health Organization declared COVID-19 to be a pandemic in March 2020,[14] over 548,000 prisoners in 122 countries have contracted COVID-19, and more than 3,968 prisoners in 47 countries have died due to COVID-19.[15]

These figures are likely to be a serious underestimate, as many countries do not provide appropriate testing in prison settings. While some countries have embarked on 'decarceration' programmes to release people from closed settings and pre-trial detention in response to COVID-19, this has largely not benefited people who use drugs (see below), and there remain around half a million people held in jails and prisons due to drug possession for personal use.[16]

Positive practices adopted during the COVID-19 pandemic[17]

Take-home medication

The most widespread positive reform introduced as a response to the pandemic has been the expansion of take-home OAT such as methadone or buprenorphine treatment for people who use opioids such as heroin. Permitting take-home doses gives people who use drugs greater flexibility and makes the service more accessible, while also limiting potential exposure to COVID-19 in (and travelling to and from) medical facilities. Out of the 84 countries worldwide where OAT is available, at least 47 have provided longer take-home periods since March 2020, and several introduced take-home OAT for the first time including India and Morocco. In some countries, this approach had been proposed by civil society well before COVID-19's arrival. This is the case in Ukraine (see case study) and in India, for example, where take-home OAT was supposed to be approved in mid-2019.[18]

The exact nature of reforms undertaken in 2020 varied – the take-home period ranged from just two days' supply to one month. Other innovations included shorter initiation times (the time that OAT must be prescribed before take-home doses are permitted) and increased distribution of

naloxone (a lifesaving medicine that can reverse the effects of an opioid overdose). In India, take-home buprenorphine and methadone have been approved as an emergency measure in some states, and the success of these measures is raising hopes for their continuation beyond the pandemic, offering greater flexibility for people who are prescribed OAT.

However, this expansion was by no means universal, and almost half of the countries where OAT was available prior to the pandemic have failed to expand the availability of take-home doses. For example, such alterations were rejected by health authorities in Argentina despite civil society advocacy.

Home delivery, outreach, online services, and increased flexibility

Home delivery of services and harm reduction commodities, combined with expanded outreach, helped to ensure that people who require harm reduction services did not have to attend fixed-site services and risk potential exposure to COVID-19. In at least 23 countries, distribution became more accessible with home delivery of OAT medication, offering dosing at community pharmacies, or distributing OAT in outreach settings. In many of these countries, other harm reduction services were also provided on this basis, including needle and syringe programmes (NSP) and naloxone distribution.

OAT home delivery has been recorded in every world region, including in Kazakhstan, Palestine and Senegal. In Russia, civil society organisations ensured that kits including masks, disinfectant and other hygiene materials were delivered directly to clients through courier services.

Home delivery has also provided a unique opportunity for integrated services. For example, the Centre de Prise en Charge Intégrée des Addictions de Dakar (CEPIAD) in Senegal set up a delivery service for some OAT clients, delivered sterile injection equipment and picked up used equipment. Home delivery, outreach and online services for harm reduction have ensured continued and expanded access among those in need, while minimising the risk of COVID-19 transmission.

"As a drug user, I deserve a better life like the rest of the young. Methadone services are essential."

Alongside home delivery, in many countries outreach work has been expanded to ensure that services reach those who need them, without increasing the risk of exposure to COVID-19. For example, in Palestine and Morocco, outreach workers were provided with permits for travel movements, allowing them to Coavpetircoonm peen ndaintigonal and local isolation measures.

Online services were also expanded in many locations to reduce in-person interactions. The New Zealand Needle Exchange Programme set up an online shop for purchasing sterile injecting equipment for those unable or unwilling to access services during the pandemic. In many countries online meetings replaced face-to-face counselling, support groups and consultations although these are limited by the need to access stable internet connections.

Meanwhile, there are examples of both government and civil society-run services making their operations more flexible to address the challenges of COVID-19. In Algeria, Bahrain and Palestine, as well as in many European countries, services increased the number of syringes a client could receive in a visit to an NSP. Drug consumption rooms and harm reduction centres in Europe have also increased their capacity and/or adjusted their operating hours in order to continue serving those in need while complying with COVID-19 restrictions.

Peer-led support and services

In many countries, peer involvement became more pronounced in service delivery. Peer networks provided secondary needle exchange and outreach services, and disseminated information on lockdown measures and COVID-19.

In the city of Tshwane, South Africa, the Community Oriented Substance Use Programme (COSUP) coordinated the community-oriented provision of health services, including COVID-19 symptom screening primary care services, and OAT (methadone), for approximately 2,000 homeless people who use drugs residing at a temporary shelter created in response to the pandemic. Meanwhile, members of the South African Network of People Who Use Drugs (SANPUD) have been providing harm reduction services for street-based people who use drugs, including needles and syringes, stimulant packs, hygiene and educational materials, as well as symptomatic medication packs for those experiencing opioid-related withdrawal.[19]

The Kenyan Network of People who Use Drugs and VOCAL Kenya have collaborated to equip peers to respond to rising violence against women who use drugs in Nairobi during the pandemic. The peers have been trained in counselling, mediation and conflict resolution, and are able to act as first responders in cases of violence and provide linkage to health and legal services.[20] In Tanzania, local community-led organisations such as the Tanzania Network of People who Use Drugs and SALVAGE have been working together, with the support of UNAIDS, to continue peer-led support for women who use drugs and their families living in often overpopulated camps and settlements in Dar es Salaam, particularly by providing food, hygiene materials and COVID-19 protective equipment, as well as various health services, including TB screening at the local OAT clinic.[21]

Prison releases and harm reduction expansion in prisons

More than 11 million people are imprisoned worldwide, and more than half of national prison systems operate beyond their capacity. There are currently around half a million people held in jails and prisons due to drug possession for personal use – as noted by the United Nations Office on Drugs and Crime in June 2020.[22] Prisons, particularly those that are overcrowded, represent high risk environments for the transmission of infectious diseases, not least COVID-19, and people in prison are also more likely to be living with chronic health problems, including TB and HIV.

To address this risk, countries across the world have committed to releasing significant numbers of people from prison either permanently or temporarily. According to data from June 2020

collected by Harm Reduction International, more than 66,000 people had been released in India, more than 39,000 in Indonesia, and around 19,000 in South Africa, while as of July 2020, more than 26,000 people had been released from US jails.[23] While these early releases are welcome, they also pose new challenges which must be addressed to ensure continuity of care and prevent the increased risk of overdose and homelessness.

However, these decongestion measures only reduced the global prison population by around 6%. Additionally, a quarter of countries implementing these so-called 'decarceration' programmes explicitly excluded people incarcerated for drug offences, thereby prioritising punitive drug control over the health of individuals in prison and the prison population as a whole.[24] These release measures have also not reached compulsory drug detention and rehabilitation centres and the disproportionate criminalisation and punishment of people who use drugs continue to represent a significant threat to global health.

Civil society and community-led organisations have played a vital role in advocating for decarceration, as well as for the protection of human rights and health of people in jails and prisons. In Nigeria[25] and the Philippines,[26] for example, activists have engaged with key stakeholders (such as prison authorities) and taken up legal cases to secure the release of people from prisons, especially people held for drug-related offences.

Beyond these decongestion measures, the primary way in which states have attempted to prevent the spread of the virus in prison settings has been to completely isolate prisons from the community. For people who remained incarcerated throughout the pandemic, in many cases this has meant the suspension of family visits, and restricted access to legal aid, health and drug services. For instance, civil society in Colombia have reported that the situation in women's prisons worsened significantly at the outset of the pandemic, as women had previously relied on family visits to provide essential health and hygiene products, including menstrual pads, and state authorities did not replace them.[27] In Ireland, the NGO Fusion Community Links, which works with people who use drugs in prisons, noted that ten months after the pandemic social workers were solely getting limited access to clients in some prisons through video calls. By December 2020 there were still clients with whom they had had no contact at all since March 2020, despite repeated efforts.[28]

In April 2020, Kenya's first in-prison methadone dispensing clinic was opened at the Shimo La Tewa Prison in Mombasa County, which has helped reduce the flow of clients – and thereby also risks of COVID-19 transmission.[29] However, in at least some prisons in countries like Canada, Kyrgyzstan or Moldova, harm reduction services were restricted, or suspended, at the outset of the pandemic.[30]

Effective civil society responses

During the pandemic, civil society and community-led organisations have shown themselves to be adaptable, effective and resilient – both in service provision and in stepping up advocacy for essential services for people who use drugs. One organisation in Algeria established a mask manufacturing unit managed and staffed by women living with HIV.[31] Masks manufactured are distributed to key populations including people living with HIV and people who inject drugs.

In March 2020, Rebirth, a civil society organisation in Iran, created a COVID-19 prevention and control working group, bringing together cvil society, community representatives, academics, medical professionals and policy makers. Its aim is to strengthen collaboration between government and non-government sectors and develop an equitable COVID-19 response among people who use drugs.[32] The West Africa Drug Policy Network, a coalition of more than 600 NGOs from 17 countries, has been an active advocate for the rights of people who use drugs. The coalition has supported the continuity of harm reduction services, disseminated messages on COVID-19

prevention, and supplied food to people who inject drugs who are unemployed or experiencing homelessness.[33]

Advocacy work by civil society has also continued despite the disruptive impact of reduced travel on interpersonal relationships and face-to-face interactions. Indeed, this has led to new, creative and innovative – and sometimes even more inclusive – forms of advocacy and organising. For example, COVID-19 restrictions did not prevent organisations from participating in the Support Don't Punish Global Day of Action on 26 June 2020 – with many creatively combining awareness, education and advocacy campaigns around humane drug policies in the COVID-19 context. Activities were organised in 85 countries, many addressing the intersecting vulnerabilities experienced by the highly diverse communities of people who use drugs.[34] For example, in Senegal, activists from the Association Sénégalaise de Réduction des Risques infectieux (ASRDR) provided protective kits and information on COVID-19 to streetbased people who use drugs.

Mobilising funds

Across the world, civil society and donor organisations are mobilising funds to purchase prevention tools, ensure uninterrupted service delivery and respond to emerging needs. Key donors have responded by offering rapid emergency grants to a range of implementing organisations – although in some instances, this has been at the expense of existing programmes and grantees. International NGOs have also assisted in securing new funding: for example, IDPC has secured small grants from the Open Society Foundations, Aidsfonds and the Elton John AIDS Foundation to directly support local-level work by partners in Brazil, Hungary, Indonesia, Malaysia and Thailand. Peer-led groups such as INPUD have also mobilised funding to safeguard and/or reallocate funds for communities, and to ensure that resources are available to grassroots communities.

© YouthRISE Nigeria

YouthRISE Nigeria campaigns to change the criminal justice system in Nigeria to support the rights of people who use drugs.

Case study

Take-home treatment and other positive developments in Ukraine

Thanks to many years of civil society advocacy, innovation and delivery, Ukraine currently serves the highest number of OAT clients in Eastern Europe and Central Asia. Ukraine's OAT programmes are fully funded by the government, reaching a total of 13,700 people. Nevertheless, a number of barriers prevail, such as the requirement to receive approval from a medical facility (regarding the need for the person to access OAT), the need to collect and consume their medicine from the treatment centre on a daily basis, and the obligation to cease drug use during OAT. Take-home dosages are mainly reserved for people who have been enrolled in an OAT programme for at least six months.

For years, people who use drugs in Ukraine have advocated for reforms to abolish these barriers and to improve accessibility for take-home dosages. These advocacy efforts have been made possible, and have become more meaningful and impactful, thanks to the inclusion of people who use drugs. For example, people who use drugs participate in decision-making mechanisms such as the Cabinet of Ministers' advisory body where they 'have equal seats/votes to the Ministry of Health, Ministry of Justice, or even the Vice-Prime Minister', as explained by Anton Basenko of Alliance for Public Health and Country Focal Point of PITCH in Ukraine.

Though rarely acknowledged, formal and informal networks of people who use drugs and allied NGOs have played a significant role in the expansion of take-home OAT during COVID-19. At the beginning of the pandemic, the community-led organisation Hope and Trust – which also manages Ukraine's national OAT hotline – submitted an official written appeal to the Ministry of Health, resulting in an official call for all OAT providers 'to move all

Advocates bring attention to the health and rights of people who use drugs during the 'Support Don't Punish' global day of action

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patients to take-home for the period of lockdown', according to Anton Basenko.[35] Before COVID-19 restrictions proliferated, only around half of all the people enrolled in OAT were able to access 10 days' worth of take-home dosages of their medicines.

By late April 2020, the number of people granted access to take-home dosages rose to 90% of all OAT clients. The amount of take-home dosage also increased – some were able to receive up to 15 days' worth of medicine, and one region provided up to 30 days' worth.[36] This has helped minimise in-person contact at treatment centres and therefore the risk of COVID-19 transmission, while ensuring that more clients have continued to access treatment.

In addition to making take-home OAT more accessible, COVID-19 has also led to the adoption of home delivery of ART medications (of four to nine months' worth of supply) – managed by an NGO – in six regions of the country. Similar developments occurred for TB and, to a lesser degree, hepatitis C medications.[37] However, unlike for OAT, these changes did not require specific approval from the Ministry since these medications are less tightly controlled than those used in OAT.

Online and phone counselling services for people who use drugs have also expanded during COVID-19. The NGO VOLNA has become an important model for this kind of peer-led harm reduction delivery.[38] Andriy Klepikov, Executive Director of Alliance for Public Health in Ukraine, also noted that the 'PITCH project created a unique partnership which allowed bringing changes and innovations not where it is easier to do, but where is the most relevant and needed! With prioritising [a] person focused approach nowadays in the time of COVID pandemic [the] PITCH project helps communities and patients to have even improved access to services using technologies and Apps, having access to 24/7 hotline and chatbots'.

People who use drugs in Ukraine will continue to advocate towards policy makers to maintain access to take-home OAT and other life-saving harm reduction programmes, recognising the essential roles of peers and community-led networks in managing – and sustaining – these programmes during and beyond COVID-19. As Anton Basenko remarked in INPUD's Peers in the Pandemic campaign, take-home OAT 'is simply a constitutional right'.[39]

Recommendations

Maintain harm reduction services

The pandemic has demonstrated that harm reduction services are responsive and innovative, and can effectively connect marginalised populations to other key social and health services. Harm reduction must therefore be recognised as essential services and included in basic healthcare packages.

Expand access to harm reduction in prisons

Even though people deprived of liberty are fully entitled to their right to health, in most countries access to harm reduction in prisons is far more limited, and of worse quality, than in the community. In many countries, measures taken to prevent the spread of COVID-19 in prisons have led to even further restrictions. As the pandemic continues to develop, states must ensure the sustainable and safe provision of harm reduction in prisons.

Continue adaptations in OAT, NSP and other health services

Many of the changes provoked by the COVID-19 pandemic have long been advocated for by civil society and community-led organisations. New approaches with longer take-home periods, less restrictive initiation procedures and home delivery have shown that these interventions are feasible and beneficial.

Extend and strengthen community and peer involvement

Formal and informal networks of people who use drugs have played an important role during the pandemic, expanding service delivery, providing expert advice to professionals working in harm reduction, and disseminating crucial health information to other people who use drugs. Peer involvement must also be extended to provide more accessible services tailored to the needs of the community.

Safeguard funding for harm reduction and health programmes for people who use drugs

COVID-19 has prompted donors and governments to reallocate funds to address the pandemic. Though this is important, it should not be done at the expense of existing grants and programmes for harm reduction and related services, especially as these were already struggling to secure sustainable funding before COVID-19. More support – financial or otherwise – is required to ensure that harm reduction and health services reach all those in need.

Remove all legal and administrative barriers to welfare programmes

COVID-19 has led to a significant loss of income and livelihoods, as well as access to basic needs such as food, housing, and medicine. All barriers, such as mandatory drug testing and criminal record screening, should immediately be lifted to make sure that welfare programmes reach those most in need.

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people who use drugs were forced to experience severe withdrawal symptoms, while some faced higher risks of overdose as they began mixing certain substances with pharmaceutical drugs.

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"I love my colourful community. Even though many LGBTQ+ people have to stay hidden, we still have a brightness." Nigeria

2. Men who have sex with men in their diversity

Challenges faced by men who have sex with men in their diversity during COVID-19

Devastation of livelihoods

Even before the COVID-19 pandemic, men who have sex with men in their diversity[1] were disproportionately affected by the social and structural inequalities and intersecting vulnerabilities which lead to increased health disparities. In many settings, discrimination has limited the employment opportunities of men who have sex with men in their diversity, and they are also more likely to be employed in the informal sector, or in sectors which have borne the brunt of COVID-19 in terms of revenue loss, such as the hospitality industry.[2] An organisation for men who have sex with men in Uganda reported that "There is currently a large number of our members jobless and many others doing some of the casual jobs that are currently on hold". In May 2020, a rapid survey of over 2,700 gay men and other men who have sex with men on the social networking app, Hornet indicated that 40% of respondents from around the world anticipate an income reduction of over 30% due to the COVID-19 pandemic, with 19% reporting having reduced meal sizes or cutting meals completely to save money[3]. COVID-19 intensified the economic crisis in Lebanon and the food crisis in Zimbabwe with people struggling to pay rent or buy food[4]. In Kenya, as motels and massage parlours were shut down, male sex workers lost their livelihoods, becoming homeless and facing violence.[5]

Some countries have introduced social protection schemes to support vulnerable citizens during the pandemic. However, criminalisation, discrimination and social marginalisation may prevent this support from being available to gay and bisexual men[6]. For example, in the Philippines, the government social grant does not include people living with HIV or lesbian, gay, bisexual, transgender or queer (LGBTQ)-led families[7].

Housing insecurity

The economic fallout, combined with lockdown measures, led many men who have sex with men in their diversity to have to move in with their families, or else be confined to accommodation with relatives or housemates who were intolerant and judgmental of their identities. In Botswana, a community-based organisation (CBO) for men who have sex with men described how some of their members are "moving from home to home living with friends and partners. It has currently become worse, as they are pressured to move by family members of friends, or partners, but the lockdown has restricted their movement". Across the Middle East and North Africa, it was reported that gay men had to tone down or hide their sexuality because of homophobic living environments[8].

Mental health

Globally, it was reported that many men who have sex with men in their diversity were struggling with mental health issues due to the multiple challenges they faced. For example, a survey by an LGBTQ organisation in Lebanon showed that 62% of community members needed mental health support[9]. The prolonged lockdowns and social isolation in hostile environments led to an increase in violence, including intimate partner violence, and mental health challenges such as anxiety and depression, even leading to suicide, which was reported in Sri Lanka[10], Morocco[11] and Zimbabwe[12].

Human rights violations

Stigma and discrimination have increased, as men who have sex with men in their diversity have been scapegoated as "COVID-19 spreaders"[13], a worrying trend which is all too reminiscent of the HIV experience. For example, in Armenia, the New Generation Humanitarian NGO reported that "It is widely believed in our society that it is these groups that spread not only HIV but also COVID-19, which is why they are expelled from work or from society".[14] In South Korea, an upswing in COVID-19 cases was attributed to LGBTQ clubs, leading to increased homophobia and a fear among the gay community of being outed by contact tracing measures[15]. In Morocco, a public outing of LGBTQ people led to them being blackmailed or kicked out of their homes.[16]

In Belize, reports have detailed abuse of a gay man who was arrested for breaking the curfew, beaten, and mocked by the police in a video which went viral. The man was living with HIV and died two weeks later, apparently as a result of complications sustained from injuries inflicted by the police[17]. In March 2020, in Uganda police raided Children of the Sun Foundation, a shelter for homeless LGBTQ people and arrested 23 people, and incarcerated 20, claiming that they were flouting the ban on mass gatherings and disobeying social distancing orders. The group spent 50 days in detention, where they were allegedly tortured, beaten and flogged. All charges were subsequently dropped against them.
On their release, they were compensated by the state for being denied access to legal counsel during their detention. They are seeking further legal redress for the human rights violations they experienced[18].

Interruptions to critical HIV and Sexual and Reproductive Health services

Across the world, health services were reoriented to focus on COVID-19 and in many countries HIV services were halted, often without a clear plan or instructions as to how patients were supposed to continue treatment. In Zimbabwe, a survey found that 41% of LGBTQ people were failing to access health services because most of the LGBTQ-sensitised health facilities were converted into COVID-19 response centres.[19] Similarly, in Uganda, a community-based organisation (CBO) reported that men who have sex with men were

unable to get refills of antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP), and also unable to obtain post-exposure prophylaxis (PEP) or condoms, as most of their delivery centres were closed.

Another barrier to accessing health care was restrictions on movement. In Wuhan, China, an LGBTQ organisation reported that thousands of LGBTQ people living with HIV could not go to hospitals for medication without stating the reason for their travel. Afraid of the stigma and discrimination associated with being HIV positive, they were cautious about revealing their status to community officials. Many would rather risk not taking their medication than have their family or community discover their status[20].

In addition, the fact that many HIV-positive men who have sex with men went hungry had a negative impact on their immunity, as taking some ART medicines on an empty stomach leads to unpleasant side effects.

Positive approaches adopted during the COVID-19 pandemic

Rapid needs assessments enable informed emergency responses

With the sudden and dramatic onset of COVID-19, LGBTQ organisations needed to rapidly assess the impact the pandemic and the associated containment measures were having on their members. This enabled them to plan how best to respond and mobilise resources, as well as how to advocate for attention to the community's needs with governments, donors and development partners. Online surveys played an important role: many organisations and networks, including OutRight International[21], APCOM in the Asia Pacific Region[22], and Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM)[23] as well as numerous CBOs conducted rapid online surveys, and quickly compiled reports highlighting the results.

"There needs to be more, non-judgmental, sexual health services for people who use drugs. I didn't know the risks, and when did I get an STI, I didn't want to go to the clinic as I knew that I would face judgement." Myanmar.

As assessments showed that livelihood, health and human rights needs were critical, the need for rapid response grants soon became apparent. Members of LGBTQ community-led organisations stepped up to volunteer, and at the same time, several LGBTQ global and regional networks found ways of providing emergency grants for community-based LGBTQ organisations. For example Arab Foundation for Freedoms and Equality (AFEMENA) put out a call for proposals, and initially were able to provide grants for three LGBTQ organisations to support the distribution of food and commodities to prevent the spread of COVID-19, like hand sanitiser and masks, as well as to provide mental health support. They also advocated amongst the broader community for people to donate their money or time to the emergency response, mobilising people to recognise their shared responsibility. Outright International has also issued three rounds of emergency grants, and promoted the emergency fund online.

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Donors which support community organisations working with men who have sex with men in their diversity including Frontline AIDS, Aidsfonds, and the Elton John AIDS Foundation, made emergency funding available and simplified application procedures. Frontline AIDS' rapid response fund supported a range of needs identified by community members themselves – from maintaining HIV services to providing personal protective equipment (PPE) or supplying food or shelter – costs that are often not covered by more traditional funding mechanisms.

Meeting emergency needs for food and shelter

LGBTQ community organisations distributed packages containing food and other necessities to members who were struggling. They are also providing emergency shelter for community members who became homeless or fled situations of domestic violence and psychological abuse. For example, New Generation Humanitarian NGO, Armenia, provided temporary shelter, food packages, and legal support for men who have sex with men, and other key populations. In June 2020 they opened a shelter – Safe Space – in the centre of Yerevan. The three-storey building gives men who have sex with men in their diversity, and other key populations, a safe refuge and space to access legal and psychological support, with volunteers on duty 24 hours a day[24].

Although LGBTQ people have often been excluded from humanitarian relief schemes, the World Food Programme (WFP) in some countries, including Lesotho[25] and Honduras[26] has recognised that LGBTQ people are one of the most vulnerable groups impacted by the epidemic, and has intentionally included them in relief efforts. In Honduras, 800 LGBTQ households were given a WFP pre-paid e-card to buy food. A leader of a local LGBTQ organisation said, "For a group that has traditionally been neglected and stigmatized, being included among the recipients of this assistance has historic significance".[27]

Responding to human rights violations

Community-based LGBTQ organisations and their allies have stepped up to highlight, document and respond to the human rights violations experienced by the community during the pandemic. In June 2020, a coalition of 187 organisations submitted an appeal to the UN Human Rights Council to ensure that the pandemic would neither exacerbate existing misconceptions, prejudices, inequalities or structural barriers, nor lead to increased violence and discrimination against people with diverse sexual orientations, gender identities and expressions or sex characteristics (SOGIESC)[28].

In the Ugandan case of the arrest of 23 people from Children of the Sun Foundation LGBTQ youth shelter, described above, the NGO Human Rights Awareness and Promotion Forum (HRAPF) supported and represented the detainees, ultimately securing their release and an award of damages for being initially denied access to legal counsel.[29]

LGBTQ organisations which had been trained by Frontline AIDS to use the Rights, Evidence Action (REAct) tool to document and respond to human rights violations, have continued to do so, but needed to adapt to the new realities. In Ukraine, the Alliance for Public Health (APH) supports LGBTQ communities in Georgia, Moldova, Kyrgyzstan and Tajikistan to use REAct. When COVID-19 emerged, they risked losing contact with both the people on the ground who are implementing REAct (REActors) and their clients. APH responded by ensuring that all the outreach workers, street lawyers and community activists had mobile phones and internet access, and set up hotlines in some of the countries to provide support to community members. In Georgia, REActors used the dating app Tinder to market the service among from the LGBTQ community. APH explained that, initially, there was uncertainty about which rights were and were not protected during emergencies, and so APH implemented training to provide REActors and lawyers with up-to-date knowledge[30].

Digitalisation and new ways of mobilising

Online meetings have become the 'new normal' during the pandemic. When LGBTQ organisations realised that COVID-19-related interruptions to travelling and meeting were not going to be a temporary measure, they adapted their ways of working, harnessing technology to move their meetings, workshops and other events online. For most this required learning new skills. For example, MPact Global Action for Gay Men's Health and Rights provided an online training for their partners in eSwatini on how to use social media as a creative, community-focused, and cost-efficient way to reach new audiences, share resources and information with the LGBTQ and broader community, and even to learn more about their target audiences through online engagement[31]. Also in eSwatini, a community based LGBTQ organisation converted the training which it usually provides to nurses to an online format – recording the lectures and designing online assessments.

LGBTQ organisations are also developing larger innovative hybrid meeting platforms. For example, APCOM held a summit for LGBTQ and HIV advocates and allies in Thailand, starting with a community summit, and followed by the first regional trade fair forum on diversity and inclusion in the private sector. The summit consisted of an innovative blend of offline and online interactive workshops and discussions[32].

Decentralised service delivery

With the barriers to accessing health facilities for HIV services, and the mandatory closure of some key population drop-in centres, LGBTQ community organisations responded by reaching out to community members in their homes. This was helped by the fact that, in many countries, COVID-19 precipitated the acceleration of multi-month antiretroviral (ARV) therapy dispensing for those who were stable and adherent to treatment. Many community organisations that stepped in were nothing short of heroic: including Iliolo Pride Team in Philippines, ALCS in Morocco, HOYMAS in Kenya, LEGABIBO in Botswana and the Wuhan LGBT Centre in China, collecting ARV refills from clinics and delivering them to community members' homes. The Wuhan LGBT Centre in China mobilised 22 volunteers and managed to deliver medicine to an average of 200 people daily during the three months of lockdown[33]. In Uganda, an LGBT community-led organisation was able to procure bicycles to reach its members. While delivering medication, peer educators and volunteers also distributed food parcels, cared for those who were ill or bedridden and provided mental health support.

Online service delivery

Community organisations for men who have sex with men in their diversity are using digital technology to innovate: keeping track of community members in need of HIV and sexual health services; supporting them to remain on treatment; and referring them to care. For example, in eSwatini, Botswana and Kenya, outreach workers conducted virtual outreach and support groups using social media, WhatsApp and online forums[34]. When drop-in centres and clinics reopened, social distancing regulations limited the number of people who could attend at any one time or reduced operating hours. In response, an LGBTQ organisation in eSwatini created an online booking and referral system for selected LGBTQ-friendly clinics.

The pandemic also inspired innovative educational videos to keep men who have sex with men in their diversity aware of their sexual health. For example, MPact teamed up with St James Infirmary and TrishTV to develop a fun, sex-positive video campaign on sexual health and harm reduction, 'Anal About My Health', featuring drag performers sharing stories about their experiences with sexually transmitted infections (STIs) and other topics such as harm reduction, living with HIV, sex workers' rights, and anal health[35]. The series was linked to a twitter campaign #AnalAboutMyHealth, for the global community to connect and share stories about how they were affected by COVID-19.

Case study

Developing digital healthcare infrastructure in Africa

In 2020 MPact Global Action for Gay Men's Health and Rights developed a programme with the Center for Public Health and Human Rights (CPHHR) at Johns Hopkins University, to train healthcare providers from Botswana, Kenya, Tanzania and Zimbabwe on the health of men who have sex with men in their diversity[36]. The 2020 training was rolled-out in consultation with community based LGBTQ organisations, including Bonela, LEGABIBO, and Men for Health in Botswana; Ishtar, MAAYGO, and PEMA in Kenya; CENTA in Tanzania; and GALZ, Sexual Rights Centre and TIRZ in Zimbabwe.

When the COVID-19 pandemic hit, the organisers decided to move the training online. They created a virtual training programme spread over a three-month period. Sixty-eight applicants were selected to attend, trebling the number who would have originally attended in person. Participants represented a mix of health care workers – from doctors and nurses to non-clinical staff – and outreach workers from marginalised community organisations, including those who are gay or bisexual themselves. This mix enhanced peer-to-peer learning and sharing about the lived experiences of men who have sex with men in their diversity

To support participants, 12 mentors were engaged from the participating community based LGBTQ organisations. Each mentor was assigned four or five mentees from their country, and hosted weekly online discussion groups. For example, one session was on community empowerment, with content informed by the global guidance Implementing comprehensive HIV and STI programmes with men who have sex with men[37] (commonly known as the MSMIT). Participants were asked to develop a concept for a community empowerment activity, and had a week to consult with their mentors about their ideas. Besides the group discussion workshops, mentees could also engage in one-to-one discussions with their mentors over WhatsApp.

The virtual training was well received. Pre-and post-training assessments were conducted online in quiz format, and participants were generally very positive, with some saying the training was an eye-opener. Fifty-five participants successfully completed the course, and a graduation ceremony was held via Zoom.

In reviewing the online training, MPact reflected on the pros and cons: it is labour intensive; risks excluding people who lack reliable access to the internet; and lacks some of the important 'secondary' outcomes of real-world training such as the vibrant debates, forming of connections, and discussions that often occur between and after sessions. They concluded that online training will definitely be used going forward, but will never fully replace real world workshops.

Amend to "LBGTQ community organisations are increasing access to mobile and digital services."

Recommendations

Increase use of rapid needs assessment to adapt responses

Where relevant, organisations working with men who have sex with men in their diversity should continue using online platforms to conduct rapid surveys to assess the needs of their members. Organisations should use data from these assessments to plan swift responses, adapt services, mobilise resources, and support advocacy for the community's needs. As endorsed by the 2021 High-Level Meeting on AIDS Political Declaration, 'community-generated data' should be 'used to tailor HIV responses to protect the rights and meet the needs of people living with, at risk of and affected by HIV'.[38]

Establish and continue use of rapid funding mechanisms to meet basic needs

The use of rapid response grants to meet urgent livelihood, health and human rights needs has been demonstrated to be effective. Donors and their intermediaries which support LGBTQ health and rights should continue to ensure agile, responsive granting mechanisms for community-based LGBTQ organisations and communities.

Continue meeting emergency need for shelter, food

Community-led organisations have effectively provided emergency support to men who have sex with men in their diversity, distributing food packages and providing emergency housing and shelter, and legal support. They should be supported to continue to meet these emergency needs through adequate funding, and through the inclusion of men who have sex with men in their diversity in humanitarian relief schemes – which the World Food Programme demonstrated is easily achievable when the will to intentionally include people supports it.

Advocate to protect livelihoods

COVID-19 has highlighted the economic vulnerability of men who have sex with men in their diversity. Over the short-term, social protections and relief measures, implemented by both governments and humanitarian organisations, should be alert to, and should respond to the socioeconomic impact of the pandemic on men who have sex with men in their diversity. Over the long-term, more attention should be paid to how discrimination towards men who have sex with men in their diversity throughout their lives – in education, workplaces and communities – has contributed to negative outcomes in terms of their ability to study, get decent employment, and progress professionally.

Uphold and protect human rights

Civil society has been a critical protector of human rights and must continue to highlight, document and respond to the human rights violations experienced by the community during the pandemic, including through the use of monitoring tools such as REAct.
It is essential that civil society hold states accountable to upholding human rights of men who have sex with men in their diversity.

Online mobilising and service delivery

The value of community organisations for men who have sex with men in their diversity taking their information and service systems online has been clearly demonstrated. This approach would be of continued benefit even with a gradual return to in person service delivery in some contexts, and in the longer term. Where evidenced as effective, further digitalisation of service delivery and community mobilising should be funded and supported. Appropriate digital integration skills building for CSOs needs to be undertaken. At the same time, governments should not use COVID-19 as the justification to restrict civil society participation. Some services will always need to be delivered in person.

Expand differentiated service delivery

Organisations serving and led by men who have sex with men in their diversity should continue to offer their clients a range of differentiated, person-centred options for accessing health care. Community organisations have a particular role to play in providing and supporting health services, including COVID-19 related services, delivered in community settings – be it in clients' homes, drop-in-centres and safe spaces, or other convenient, stigma-free locations. Advocacy by civil society for strong social contracting mechanisms needs to be undertaken so that governments have mechanisms to contract and fund services delivery and other activities undertaken by civil society and community-led organisations.

Endnotes

[1] We use the term 'men who have sex with men in their diversity', to acknowledge that the outcome of stigma and discrimination is keenly felt both by gay and bisexual men, and by men who have sex with men who do not identify as gay or bisexual. Even though these men may be less visible, they are hard to reach, far less likely to access services, test for HIV and stay on treatment.

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3. Transgender People

Challenges faced by transgender people during COVID-19

Unemployment and precarious employment

Even before COVID-19, transgender people and people with diverse gender expressions and identities, experienced significantly higher barriers to completing their education (including discriminatory policies, curricula, and practices, disproportionately harsh discipline and victimisation in schools)[1], which in turn contributes to significantly higher unemployment rates amongst transgender people compared to cisgender people[2]. For example, in Argentina, up to 90% of transgender people are unemployed[3]. Globally, amongst those who are employed, they are affected by both formal and informal discrimination and stigma in the workplace, and by economic disparities[4]. COVID-19 has amplified these challenges, with one global study reporting that 77% of transgender people surveyed expected income reductions[5].

Economic marginalisation also contributes to a relatively high proportion of transgender people (particularly trans women) being involved in sex work[6]. During the pandemic, sex workers have experienced a sudden and devastating loss of their livelihoods, and with a lack of inclusion in social protection schemes and relief efforts, many have been left struggling for survival, especially in lower income countries and countries that criminalise[7,8] sex work.

Human rights violations

The 'states of emergency' that were imposed in many countries during the pandemic were used as a pretext for a surge in human rights violations

and rollbacks against the few legal protections in place for transgender people. For example, in Hungary and Russia, laws were proposed and/or passed preventing or restricting transgender people from legally changing their gender in identity documents[9]. Several Latin American countries enacted mobility restrictions based on gender (such as Perú, Colombia and Panamá), for example only allowing people to leave home for essential services every other day depending on their legal gender, as indicated in their national identity document. These restrictions exposed gender diverse and transgender people to harassment, detention, torture and humiliation[10]. Transgender people either had to risk exposure and harassment if their identity documents were checked by police; or risk being harassed for being the "wrong gender".

On Transgender Day of Remembrance 2020, it was reported that 350 transgender and gender diverse people were killed in the past year[11], more than in any previous year. The statistics also highlight the intersecting forms of discrimination many transgender people face: people of colour made up 79% of transgender people murdered in the USA; and 62% of murdered transgender people whose occupation was known were sex workers.

In one case in South Africa, transgender sex work activist Robyn Montsumi died under suspicious circumstances while in police custody[12]. In addition, arbitrary arrests of transgender people were reported in Egypt, Tanzania and Uganda[13], and transgender refugees in a camp in Kenya were attacked and their property destroyed[14].

Homelessness and housing insecurity

Transgender people are more likely to be homeless, or experience insecure housing, due to the discrimination they face. A US study found that 42% of transgender people had experienced homelessness in their lives, compared with the 30% average for all LGBTQ people[15]. In the same study, 40% had experienced some form of housing discrimination or instability, including eviction or being denied a home or apartment because they are transgender . These effects were compounded when transgender people were black. Homeless transgender people are also less likely to be accommodated in homeless shelters, because single-sex shelters often insist on allocating transgender people to spaces on the basis of their assigned sex as opposed to their gender identity. At least three homeless South African transgender sex workers died since the emergence of the COVID-19 pandemic, when their pre-existing health conditions were exacerbated by neglect and isolation while living outdoors.[17]

Interruptions in health care services, including gender-affirming health care

The scarcity of data on transgender people's access to health care is indicative of their marginalisation, but importantly, is also a barrier to understanding the extent of exclusion from health care, and planning programmes to address those barriers. For example, only a handful of countries report HIV-related data on transgender people to UNAIDS[18].

Mental health burden

All these challenges have had a notable impact on transgender peoples' mental health during COVID-19. More than a third (38.0%) of individuals reported that the pandemic had reduced or completely eliminated their ability to live according to their gender[19], which can exacerbate experiences of gender dysphoria[20] and lead to increased rates of depression, anxiety and suicide. Globally, around half of transgender people met the criteria for a diagnosis of depression and/or anxiety (depression: 50.4%; anxiety: 45.8%)[21] during the pandemic.

For young transgender people in particular, staying at home, being locked down with transphobic family members, and cut off from social support, heightened gender dysphoria.

Positive practices adopted during the COVID-19 pandemic

Training and sensitising to open up work opportunities

Transgender community organisations around the world are striving to support members who are out of work. In Argentina, the Impacto Digital is improving employment opportunities for transgender people, by training organisations in transgender inclusion, and placing transgender people in jobs. When COVID-19 arrived, the Contrata Trans (Hire Transgender) project moved its training module to an online format. The course sensitises companies and organisations to the challenges faced by transgender people, creates awareness about gender identity and expression, and suggests workplace 'do's and don'ts'. Going online enabled Impacto Digital to reach 7,000 people - far more than if it had been in person. Over a two-month period Contrata Trans placed eight transgender people in employment, despite the recession triggered by COVID-19. Impacto Digital plans to expand the programme to other Latin American countries[22].

Meeting food, housing and health needs

Trans-led organisations and allied organisations from across the world, including RedTrans in Peru, Khawaja Sira Society in Pakistan, BDS in Nepal, TransBantu in Zambia and Kimirina in Ecuador stepped in to help their community survive during the pandemic. Although most transgender organisations were not primed or funded to provide livelihood support, and were overstretched, they collected donations and partnered with humanitarian and charitable organisations to distribute food and hygiene parcels. They also continued to provide community-based health care to the transgender community, including home deliveries of medication, visits to sick homeless transgender people and accompanying them to hospital.

In some countries, safe spaces and homeless shelters were opened for marginalised LGBTQ people. For example, in Haiti, the country's first safe house for transgender people was opened in Port-au-Prince. Yaisah Val of Community Action for the Integration of Vulnerable Women was the first person in Haiti's history to publicly identify as transgender. She started taking homeless transgender people into her home, and as the need grew, raised funds to open the Kay Trans Ayiti safe house in November 2020[23]. In South Africa, activists made a video on how COVID-19 had affected homeless transgender sex workers, calling attention to the shared histories of abuse, rejection, stigma and violence, and the power of sisterhood and solidarity to bring them together[24]. A group of queer activists, including transgender and gender non-binary people, occupied a mansion in an elite neighbourhood, which sparked debate over racially inequitable access to housing, and drew attention to the dire situation of black queer people in particular[25].

Addressing human rights violations

Transgender activists have not allowed COVID-19 to silence their demand for rights. In Panama, Human Rights Watch and transgender organisations Trans Men Panama and the Panamanian Association of Trans People, advocated for an end to the gendered quarantine measures. In July, the government made a statement acknowledging transphobia and affirming that Panama respects "the diversity of identity and expression". It also announced sanctions for those found guilty of discrimination[26]. While activists appreciate the statement, they are hoping to see greater awareness and sensitivity to diversity with regard to sexual orientation and gender identity and expression in future.

To support transgender activists to continue to monitor human rights violations, Frontline AIDS facilitated online training in the Rights, Evidence Action (REAct) tool. For example, in Southern Africa, transgender activists from several countries in the region attended an online REAct training. This assisted participants to identify, classify and respond to human rights violations, including those which occurred in the COVID-19 context[27]. Frontline AIDS also supported (through

a ViiV Health Care grant) a COVID-19 Impact Survey[28] on transgender led organisations in the Southern Africa Trans Forum (SATF), which demonstrated that these organisations needed urgent support for their continued operation during COVID-19 restrictions, including support for work-from-home strategies, skills and digital infrastructure.

Sustaining community support virtually

Recognising the potential for mental health challenges during COVID-19 as a result of social isolation and the closing of physical spaces where transgender people can meet to socialise and support each other, transgender organisations provided online spaces where people could connect. Many organisations developed online advice and guidance on how transgender people could stay safe and healthy during COVID-19, including Transgender Equality Uganda (TEU), TransWave Jamaica, BDS in Nepal, and Gender Dynamix in South Africa. Others created links to online resources where trans people could go for support. In Pakistan, Khawaja Sira Society partnered with Pehchan Theater Group to launch a video challenge, inviting members of the community to submit a short video, showcasing some of the winning entries on youtube. TEU also produced a kit on mental health and rights for transgender people, a long-identified need in the community.

Scaling up telemedicine

Seeing the need for continuity in supportive gender-affirming health services, transgender-led organisations and their allies have advocated for governments, policymakers and health practitioners to recognise gender-affirming health services as an essential service[29,30], and especially to ensure that hormone therapy is not interrupted. One way to do this is through telemedicine. For example, a private medical practitioner in South Africa started providing gender-affirming health care through online consultations. After the consultation, she would send the prescription either to the patient themselves, or to the pharmacy of their choice.

This development was facilitated by a directive from the Health Professions Council of South Africa (HPCSA), in March 2020, conditionally endorsing telemedicine. The HPCSA released a statement saying that it: "does not regard telemedicine as a replacement for normal 'face-to-face' healthcare but an add-on meant to enhance access to healthcare for South Africans who are disadvantaged and outside of the health services reach such as specialists"[31].

South African transgender-led community organisation Gender Dynamix sees potential value in telemedicine for increasing access to health care for transgender people, not just during the COVID-19 pandemic, but in the future. In its efforts to broaden the base of health care professionals who are able to provide sensitive, gender-affirming health care, Gender Dynamix provides training for health care providers. The organisation continued to do so during COVID-19, by providing the training online[32].

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Recommendations

Implement training and sensitisation to open up work opportunities

Organisations working with and led by transgender people should continue to intervene to reduce stigma towards transgender people in the multiple spheres where it manifests; this includes education and the workplace. Although transgender people should be meaningfully included in designing and implementing stigma reduction programmes, all sectors should continually assess the extent to which they are transgender friendly, and remove any barriers to inclusion.

Meet food, housing and health needs

Transgender people must be recognised as being highly vulnerable to economic shocks and humanitarian crises – with regard to food and housing insecurity, and disruptions in health care. Civil society and community organisations working with transgender people should advocate for their inclusion in humanitarian responses and social protections provided by governments and development partners.

Address human rights violations

The struggle for the advancement of transgender rights must be intensified, through among other strategies: continued advocacy for legal and policy reform; awareness raising amongst transgender people of their human rights, and avenues for redress if rights are violated; and documenting and responding to human rights violations.

States, policymakers, service providers and law enforcement must consistently and strongly be held accountable for discrimination and human rights violations. Impunity for human rights violations against transgender people must end.

Sustain virtual community support

Online social networking makes a huge difference in reducing the isolation which transgender people may feel, and which has been exacerbated during COVID-19. This applies particularly to people who live in rural areas, or in countries or communities where they cannot express their gender identity. Online social networking creates a virtual community, and can make a real difference to mental health. Transgender-led organisations should therefore be supported to use social media as key vehicles to connect with their constituencies. However, non-virtual ways to connect should be preserved so that transgender people who do not have access to the internet, or whose privacy and security are not guaranteed, are not left behind.

Scale up telemedicine

Internet-based provision of health services should be scaled up as it can help address some of the barriers which transgender people face to accessing gender-affirming health care, such as scarcity of qualified, and sensitised service providers. Transgender-led community organisations must support planning, demand creation and implementation of such services. Organisations (not just transgender-led organisations) should advocate for gender-affirming health care, for it to be affordable for all transgender people, and to be included as an essential health service as countries progress towards universal health coverage.

Accessing health services has been challenging for transgender people in Ecuador during COVID-19.

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4. Sex Workers

Challenges faced by sex workers during COVID-19

Disrupted livelihoods and lack of social protection

COVID-19 containment measures – which in most countries include social distancing, curfews, restrictions in movement and closure of many businesses – mean that sex workers can no longer operate normally and earn a living. The entertainment venues where many sex workers meet their clients – brothels, hotels, guest houses, bars and clubs – have closed down. Curfews in most countries have meant that sex workers cannot travel or be seen on the streets. Stay-at-home orders, border closures, and restrictions on travel and movement of all except essential workers, as well as economic downturns, have dramatically reduced the number of sex workers' clients. Out of desperation, many sex workers accept lower fees, and accede to client's requests for risky practices, such as condomless sex[1]. The sudden loss of income leaves them unable to pay

for food, housing and other basic needs. Unable to work in their usual venues, many sex workers have migrated out of urban areas, either to their family villages, or to rural or peri-urban areas where lockdowns were less stringently enforced, seeking new clients.

To reduce the impact of business closures, many governments, charities and development partners provided social protection in the form of grants, vouchers, food parcels and other relief to the most vulnerable communities. However, sex workers are were not always able to access this support due to lack of information, stigma and discrimination, and lack of identity documents or proof of address. Sex workers are also unable to apply for any unemployment insurance that may be available as their work is illegal and not recognised[2].

Migrant sex workers have been particularly badly hit by the loss of livelihoods: with borders closed, they are unable to return home to their families, and are typically ineligible for social protection[3].

Rights violations, discrimination and violence

In many countries, grave concern has been expressed about the heavy-handed way in which states have enforced lockdowns on their citizens, with reports of incidents of excessive violence, harassment, torture and even murder by law enforcement[4]. Against this backdrop, sex workers report an increase in police arrests, fines, violence, rape, extortion, disruption in law enforcement, requests for bribes, and compulsory deportation. The dire situation fuels concerns that the pandemic has intensified stigma, discrimination, and repressive policing[5,6]. In a survey conducted by the African Sex Worker Alliance (ASWA) amongst its members, in response to a question as to how often they heard about cases of violence against sex workers during the COVID-19 pandemic, 63% replied 'every day', and 22% replied 'a few times per week'.

For many sex workers, having to move in with their families, or being locked down with their intimate partners, also brings challenges. Under normal circumstances, sex workers experience high rates of intimate partner violence[7], and in the pressure-cooker context of lockdowns, this is exacerbated.

Finally, reminiscent of the scapegoating which sex workers have experienced during the HIV epidemic, they have been accused of being the vectors of COVID-19. For example, in Uganda and Tanzania, sex workers were blamed on social media, and even by some political leaders, of being responsible for the spread of COVID-19[8].

Interruptions to health services

During the pandemic, in many countries, while public health facilities stayed open, they reoriented their services to gear up for the anticipated rise in COVID-19 infections, reducing all but emergency health services. In some cases, even emergency services have been compromised, as illustrated by the following report from Malawi:

> "They (sex workers) are not able to access medical health services, because to enter the gate for the hospital they need ID [identity document] that many sex workers don't have. For instance, what happened here in our workplace - a sex worker was pregnant and the time to deliver came. When she went to the hospital gate, they chased her away saying that she must enter with ID, or she is not a Malawian. She went back and met us at our office, where suddenly the time to deliver came, and she delivered a baby in our office."
>
> Sex worker peer educator, Malawi[9]

COVID-19 has also caused major interruptions to HIV and sexual and reproductive health (SRH) services, including those provided by sex worker programmes. These interruptions have included the closure of ARV clinics; medication stockouts; halting of HIV and STI testing services; shortages in condoms and lubricants; and disruptions to family planning and termination of pregnancy services. The displacement of many sex workers to rural areas also means that links to HIV services have been lost, with sex workers also reluctant to attend clinics in communities where their families live, fearful of stigma, discrimination or exposure. Many organisations are unable to conduct outreach to sex workers due to lock downs and restrictions on movement or public transport. Drop-in centres are closed. Hunger also deters sex workers who are HIV positive from taking their medication. All these challenges have led to many sex workers defaulting on their ARV medication. In one study in East and Southern Africa, several AIDS-related deaths were reported by participants[10].

Positive approaches adopted during the COVID-19 pandemic

Rapid needs assessments and accessing emergency funding

Adapting to COVID-19 has required a rapid reorientation of programmes to meet sex workers' most pressing needs. Planning had to be based on data from sex workers themselves, and organisations working with them at grassroots level. Community-led and community-based sex worker organisations, and the networks representing them, were the first to respond. Many of these organisations conducted rapid online surveys amongst their members. For example, the Global Network of Sex Work Projects (NSWP) launched an online survey which it shared with members, to gauge how sex workers and sex worker organisations were impacted by the pandemic; how the community were supporting each other; and what support they were receiving (or not) from their governments[11]. The survey was circulated in English, French, Spanish, Russian and Chinese. NSWP developed regional impact reports for Africa, Asia Pacific, Europe, Latin America, and North America and the Caribbean. They used these reports to advocate to international and national policy makers to ensure that the needs of sex workers were not neglected. The website is continually updated with stories from the ground – both good and bad – on how sex workers are responding to the pandemic.

Regional networks such as ASWA also conducted surveys to gather data to inform engagement with donors on the reprogramming of grants and the adaptation of budgets.

The rapid assessments revealed that the most urgent need for sex workers was livelihood support, but this is not traditionally an area for which sex worker organisations have been funded. Many donors who traditionally support the health and human rights of key populations, including Frontline AIDS, Aidsfonds and Elton John AIDS Foundation, set up emergency COVID-19 relief funds, focused on speeding up service delivery to communities where funds were urgently needed. They simplified the application process and reduced turnaround times. It has also been important for grant managers to listen to what community organisations articulate as their most critical needs. The most common requests have been personal protective equipment (PPE), food parcels, communication costs, and transport for either staff or beneficiaries[12].

Despite the urgency, the response of larger donors has generally been too slow or bureaucratic, and some small community organisations are ineligible. Thus, the sex worker community stepped up to raise the necessary funds. For example, ASWA used the results of their survey to advocate for reprogramming of grants from its donors, and then used the reprogrammed funds to sub-grant to 20 member organisations. Sex worker organisations in Kenya, South Africa, Canada, Australia, Norway and the United Kingdom started crowdfunding campaigns of their own, and utelised online mechanisms as pathways for donations.

"We launched a humanitarian relief appeal that was very successful. We initially put a target of R20,000 (approximately US$1,200) on it but ended up raising over R250,000 (about US$15,180), which along with reallocations of donor funds allowed us to provide large scale relief to hundreds of sex workers across the country."

SWEAT, South Africa[13]

Mobilising online

Sex worker organisations have had to rapidly adapt to COVID-19 containment measures, shifting to working from home, and providing virtual support for their members, including disseminating information, responding to requests for livelihood assistance, advocating for sex workers' rights, monitoring and responding to human rights violations, ensuring uninterrupted health care, and referring sex workers to services.

To coordinate support for sex workers in Australia, the Scarlett Alliance, along with other Australian sex worker organisations, formed a working group called the 'National Cabinet of Whores'[14]. The Cabinet met virtually every week, to respond to sex workers' challenges during the pandemic, including developing guidance for accessing relief, harm reduction guides for those who had to continue working, and advice for sex workers transitioning to providing their services online.

One notable shift has been the rise of webinars, replacing physical meetings as a means of consultation. Donors and sex worker organisations held joint webinars to highlight the challenges sex workers were facing, and producing recommendations to address these. Interestingly, participants have observed that although webinars are not ideal, they have extended participation to those who may not traditionally have attended meetings, and have brought new voices into debates.

WhatsApp has also emerged as a lifeline during the pandemic. Across the world, sex worker organisations have used WhatsApp to hear from their members how they are being affected.

WhatsApp also overcomes literacy barriers in that people can send voice notes or videos. For example, Sex Workers Education and Advocacy Taskforce (SWEAT) in South Africa posted voice notes it received from its members (with permission) on its website, including one from a sex worker mother describing how at that moment she had no food to feed her children[15].

Providing COVID-19 information for sex workers

Sex workers needed COVID-19 information and advice which addressed their specific needs, including how to reduce their risk of contracting COVID-19. Several organisations published guidelines to help sex workers understand symptoms of COVID-19, less risky ways of working with social distancing regulations and protecting human rights during States of Emergency. These included ASWA, HODSAS in Democratic Republic of Congo[16], SWEAT in South Africa[17], SWARM and Prepster in the United Kingdom, Butterfly Asian and Migrants Sex Workers Support Network and Maggie's Toronto Sex Worker Action Project in Canada[18]. Encouragingly, some government agencies have adopted a harm reduction approach instead of a punitive one, such as the intergovernmental Caribbean Public Health Agency[19] and the Queensland State Government in Australia[20], which collaborated with sex worker organisations to issue guidance on how sex workers could continue working, if necessary, whilst minimising the COVID-19 risk for themselves and their clients.

Inclusion in social protection schemes and humanitarian responses

Social protection schemes implemented by governments during the pandemic have included income support and unemployment benefits; cash and voucher assistance; food and hygiene parcels; rent or mortgage relief; bans on evictions; and emergency housing.

Although many countries excluded sex workers from social protection schemes, there are some examples of governments extending them to sex workers. Often, this occurred as a result of years of advocacy by sex worker organisations for sex work to be recognised as work, backed up with intensified advocacy during the pandemic. For example, the governments of Japan, Thailand[21], Zambia[22] and Madagascar[23], on paper at least, included sex workers in income support schemes. Another example of how sex worker advocacy led to government recognition of sex workers' rights is explored in the case study from India below.

In practice there are many barriers to accessing this support, such as requirements for identity documents, proof of citizenship, proof of salary and lost income, or proof of address – which many sex workers lack due to their criminalised and stigmatised status. Still, the recognition of sex work as work is a historic, symbolic victory in shifting narratives around sex work.

In addition, while there were reports of sex workers being excluded from humanitarian relief, there were also cases where sex worker organisations engaged proactively with humanitarian organisations, often leveraging partnerships formed during the AIDS response, to ensure that emergency relief reached sex workers. For example, KESWA in Kenya partnered with the International Red Cross to distribute food and hygiene parcels to around 8000 sex workers throughout Kenya's 47 counties[24].

In the Asia Pacific region, UNFPA noted that sex workers were often not included in humanitarian relief from other UN partners, such as the World Food Programme (WFP), because they were not recognised as a 'vulnerable group' in their assessments[25]. UNFPA therefore initiated a partnership with UNAIDS, UNDP, regional and national sex worker networks, and WFP, to pilot community-based vulnerability mapping amongst sex workers in Bangladesh and Myanmar. They gathered information on food insecurity and nutrition; coping strategies; access to cash/voucher assistance; access to SRH commodities, HIV treatment and prevention; and SGBV referral mechanisms. Sex worker-led organisations were supported to collect and analyse vulnerability mapping for their communities. The information will be used to advocate for better support and services and to develop a technical guide on the inclusion of sex workers in humanitarian food security responses, targeting UN agencies.[26].

Differentiated service delivery

Crises can be accelerators of innovation, and COVID-19 has led many organisations to speed up the implementation of strategies which were in their infancy. Differentiated service delivery is person-centred health care, which moves away from a 'one size fits all' model, and emphasises convenience and user-friendliness for patients. For example, several countries shifted to multi-month dispensing (MMD) of ARVs, pre-exposure prophylaxis (PrEP) and TB medication, over three or six months, for patients who were stable and adherent. While some countries already had MMD policies in place, others fast-tracked approval of these policies or relaxed their eligibility criteria, to increase the number of people who could receive 6MMD (6-month multi-month dispensing)[27]. Sometimes, sex worker organisations needed to advocate with Ministries of Health, to ensure that sex workers were included in MMD plans, as was the case with Soppeku in Senegal[28].

Many organisations employing peer educators adapted their service delivery models to reduce congestion at health facilities. For example, Hoymas and BHESP in Kenya, Care for Basotho in Lesotho, and the EpiC (Meeting Targets and Maintaining Epidemic Control, formerly

LINKAGES) programme in eSwatini, Botswana and Malawi mobilised peers to distribute PREP, ARV's, HIV self-testing kits, and prevention commodities to sex workers at their homes.

Peer educators who work for HIV programmes and use a microplanning approach kept in touch with their cohort of service users by phone. 'Microplanning' is used to decentralise outreach management and planning to grassroots-level workers, allowing them to decide how best to reach the maximum number of community members[29]. The approach has ensured that displaced sex workers on treatment have not been lost, and can be referred to local services.

Economic empowerment

Recognising sex workers' difficulties with working during the pandemic, some sex worker organisations instituted economic empowerment projects. These can enable sex workers to develop financial literacy, save money, develop skills which can increase their income, or enable them to find temporary, alternative sources of income, and expand their options. For example, in eSwatini, sex workers had previously formed savings clubs and during the pandemic, they used these savings to start small scale agriculture and sell produce at market stalls. In Malawi, sex workers applied for emergency funds to buy sewing machines to make and sell protective masks. In Fiji, the Survival Advocacy Network worked with partners to implement income generating initiatives for sex workers including catering and garden maintenance[30], while in Ecuador, emergency funds were used to support sex workers to start small businesses.

> "What we have a shown during this pandemic is that sex workers are very resilient, and they have been very well coordinated with other organisations they have worked with. In Ecuador, for example, with funds from CARE, sex workers can create a little business so they can have some income until they can start doing sex work again. For example, little restaurants in their houses or little clothes stores."
>
> PLAPERTS, Latin American platform for sex worker-led organisations[31]

Although the impact of the pandemic has been overwhelmingly negative, some sex workers have been able to adapt by using the internet to solicit and communicate with clients[32]. To bridge the 'digital divide', several sex worker organisations have provided tech support to sex workers to help them move their business online[33]. For example, Fundacion Margen in Chile is using younger tech-savvy sex workers to teach older sex workers the necessary skills[34].

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Mercedes, a sex worker, gets a COVID-19 test in Quito, Ecuador.

Case study

Community-led advocacy expands social protection schemes for sex workers in India

In India, in response to the economic hardship caused by COVID-related lockdown measures, the government formulated emergency social protection measures to provide basic necessities to economically vulnerable groups. Initially sex workers were excluded from these relief measures.

Under Indian law 'seducing any person for the purpose of prostitution' or running a brothel is illegal. The Immoral Traffic Prevention Act 1956 equates 'prostitution' with exploitation, which in effect criminalises consensual sex work[35]. The law exacerbates stigma, discrimination, and violence towards India's sex workers. For decades, collectives have tried to remove the association of sex work with trafficking and exploitation, advocating for sex work to be recognised as work, for sex work to be decriminalised, and for sex workers' self-determination.

During COVID-19, sex workers have faced many barriers to accessing relief schemes: they often lack government-approved identification like voter IDs, ration cards and Below Poverty Line (BPL) cards. They are unable to provide proof of residence, as most sex workers live in the brothels where they work, which are illegal.

Unable to work during lockdown, India's sex workers face poverty, food insecurity and interruptions in essential health services. A 32-year-old sex worker from Pune said in April 2020: "I am now reduced to a beggar and rely entirely on free cooked meals distributed in our area,"[36]. The lockdown and the fear of COVID-19 meant that this primary bread winner of her family of five had no source of income, perhaps for months to come.

Decriminalising sex work can improve access to social protection schemes

The National Network of Sex Workers (NNSW), representing 20 sex worker-led organisations and allies, highlighted the devastating impact of the pandemic on its members, and advocated for their protection by the government. NNSW distributed dry ration kits to the most desperate sex workers[37]. However, this temporary relief was not enough.

In July, the State of Maharashtra issued an advisory, ordering state officials to ensure that sex workers receive "free ration and essential services", recognising that "women in sex work... have lost their income generation options"[38]. The NNSW praised the State of Maharashtra, and recommended that other states follow suit[39].

Then, in October, the National Human Rights Council issued an advisory on the rights of women during the COVID-19 pandemic[40], and – historically – recognised sex workers as 'women who work'. The advisory recommended that all state governments follow the example of Maharashtra and aid and relief to sex workers. They further advised that sex workers should be eligible for the same unemployment benefits as other informal workers, that migrant sex workers should be eligible for the relief measures given to all migrant workers, and that sex workers who lacked proper documentation should be issued with temporary documents.

Sex worker organisations, who had advocated for these changes, welcomed the decision. Aarthi Pai from sex worker organisation Sangram explained its significance:

> "The understanding of sex workers as informal sector workers is a move forward not just for the immediate pandemic, but also the medium to long-term benefit they will get... Their recognition as out-of-work workers and their right to unemployment benefits moves the discussion to the next level, where you are looking at their demands through the rubric of workers' rights"[41].

This case study is an outstanding example how community-led advocacy by sex workers expanded social protection schemes in India, helping sex workers to survive during COVID-19.

Recommendations

Sustain online mobilisation

Sex worker organisations should continue to use the internet, and especially social networking apps, to connect with their members and beneficiaries. Even before the pandemic, more and more sex workers have been moving away from venue-based sex work, to working online. COVID-19 has dramatically accelerated this transition. Sex worker organisations should stay abreast of these changes, and ensure that they are able to connect with sex workers virtually, while also considering safety and security in their digital adaptations.

Digital platforms should be used to strengthen sex worker programmes for community mobilisation, capacity-building, advocacy, peer outreach, dissemination of health and human rights information, adherence monitoring, and referrals. Advocates must continue to encourage donors and governments to fund investment in technology, as well as training and technical support to ensure equal access. Sex workers must play a key role in shaping digital interventions, carefully assessing the risks and dangers as well as the benefits and outcomes. Online communication should not replace meeting in person and interacting in groups, so partners need to plan strategically whether online, in-person, or blended approaches are best suited for different interventions. Vigilance is required to ensure that legal provisions on privacy and access to information do not leave sex workers out nor do they unfairly target sex workers working online, for instance through surveillance or de-platforming sex workers or restricting their digital presence.

Expand differentiated service delivery

Differentiated service delivery (DSD) acknowledges that one size does not fit all. Sex worker-led organisations and those providing services to sex workers should take advantage of the mainstreaming of DSD: they should continue to advocate for options which promote greater and more equitable access to health care. They should also build their own capacity to provide DSD to sex workers themselves.

Advocate for sex worker inclusion in social protection schemes and the humanitarian response

In countries where sex workers have been included in social protection and humanitarian responses during the COVID-19 pandemic, this was largely on the back of years of advocacy from sex worker organisations for the recognition of sex workers' rights. This advocacy should continue so that momentum is not lost. Sex worker organisations should engage with both governments and humanitarian actors so that sex workers' vulnerabilities are better understood. Barriers to accessing social protection, such as lack of identity documents, should be addressed.

Strengthen economic empowerment

Economic empowerment programmes for sex workers should be strengthened, as they reduce sex workers' vulnerability, and can both help mitigate the impact of economic shocks on sex workers, and sustain livelihoods during crises. Economic empowerment programmes should not be confused with so-called exit programmes or rehabilitation programmes, which frame sex workers as victims to be rescued or criminals to be rehabilitated. Instead, economic empowerment programmes are rights-based, respect the agency of sex workers and are based on the principle that whether sex workers opt to remain in sex work or not, they should have access to programmes that empower them, build their skill base and expand their range of income generating options[42,43].

Advocate for funding and strengthening of community-led sex worker organisations

Community-based and community-led sex worker organisations have shown they are best placed to respond to the needs of sex workers in crises, and should be adequately funded and supported to provide holistic, integrated, person-centred services to sex workers. Sex worker organisations should advocate for both domestic governments and donors to substantially increase support for these programmes. Resources are needed urgently in the short-term, as sex workers are still experiencing the adverse effects of economic

downturns on their livelihoods from COVID-19. In addition, community systems and social capital need to be continually strengthened to protect against future crises.

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5. Adolescent girls and young women

Challenges faced by adolescent girls and young women during COVID-19

Humanitarian crises exacerbate gender inequality, and disproportionately impact women and girls in multiple ways, including an increase in sexual and gender-based violence (SGBV), and in unwanted pregnancies; disruptions in sexual and reproductive health and rights (SRHR) services; an increased burden of care for dependents; and greater economic vulnerability in general.[1] The COVID-19 pandemic is no exception. However, organisations led by and working with adolescent girls and young women have stepped up and are showing ingenuity, agility and creativity in ensuring that they are not left behind during the pandemic response.

"Women's work"

Women have been disproportionately affected by the economic fallout that has occurred as a result of the COVID-19 pandemic. Even before the pandemic, working women were more likely than men to be living in extreme poverty[2]. Some of the labour sectors hardest hit by the pandemic have been those in which women predominate, and which are characterised by low pay and poor working conditions, including lack of basic labour protections like paid sick and family leave. These include the hospitality and food service sectors, domestic workers, and the personal care sectors. Women are also more likely to be on the frontline when it comes to providing essential health and social services, placing them at increased risk of becoming infected with COVID-19.

Moreover, pervasive gender norms dictate that housework and childcare are the responsibility of women and girls, and with families being locked down at home, girls and women have also been disproportionately burdened with (unpaid) domestic work and childcare. During lockdowns, mothers of young children have faced impossible trade-offs between continuing to earn a living, and looking after children affected by school closures. UN Women, in its #HeForSheAtHome campaign highlighted that women make up 70% of workers in the health and social sector and do three times as much unpaid care work at home as men. The campaign called on men to take on their equal share of domestic and care work[3].

Under these circumstances, school-going girls have struggled to continue their education, especially where girls' education is not valued or is undermined. While online schooling can help ensure continuous education, this is not an option for many girls and women who carry the burden of domestic work and/or lack the necessary resources and devices to access the internet.

Interruptions in SRHR services, and increase in unintended pregnanciess

One of the major impacts of the COVID-19 pandemic's containment measures has been the interruption in SRHR services, including testing and treatment for HIV and sexually-transmitted infections (STIs), condom programmes, family planning, termination of pregnancy services and maternal health care. Health facilities had to reorientate to deal with surges in COVID-19 cases, and halted all but emergency services. In April 2020, a survey by the International Planned Parenthood Federation (IPPF) showed that 5,633 static and mobile clinics and community-based care SRHR outlets across 64 countries had been closed because of the outbreak[4]. According to research in five African countries, the most disrupted HIV-related services have been those meant to prevent new infections, especially among marginalised groups[5].

With schools being closed, comprehensive sexuality education (CSE) has also been impacted.

In addition, the broader protections which being in school provides for girls, with regard to prevention of unintended pregnancies and SGBV[6], have been lost. Experience from the Ebola epidemic in West Africa showed that less interaction with school-based SRH programmes and more time out of school led to an increase in unplanned pregnancies[7]. UNFPA has reported that more than 47 million women could lose access to contraception during the COVID-19 pandemic, leading to seven million additional unintended pregnancies. Previous health emergencies have shown that, not only do unintended pregnancies increase, but interruptions in reproductive health care can have deadly consequences: the Ebola outbreak in West Africa from 2013-2015 led to as many, if not more, pregnancy-related deaths than deaths from Ebola itself[8]. In addition, several countries, such as Togo, Equatorial Guinea and Tanzania, expel pregnant girls from school and ban them from returning, effectively destroying their education and employment prospects.

Increase in child marriages

Many of the complex factors that drive child marriage are exacerbated during emergencies, as family and community structures, as well as education, are disrupted, household income is threatened, and the risk of household violence is elevated.[9] Save the Children has warned that 500,000 more girls were at risk of being forced into child marriage in 2020 alone[10].

Marriage is often seen by other family members as a preventative option to protect girls from rape or sexual assault, and from the social stigma that can follow[11]. Before the pandemic, India, which accounts for one in three child marriages globally, had become a world leader in working to reduce child marriage, through education and awareness. But a harsh, long lockdown has pushed millions of Indian families into poverty and forced them to consider child marriage to alleviate poverty[12].

Escalating sexual and gender-based violence

There has been a surge in SGBV globally during the COVID-19 pandemic, and a disturbing increase in cases of women being murdered by their intimate partners[13]. History shows that SGBV increases in times of crisis, fuelled by harmful gender norms and inequalities, and economic and social stress. In the context of the COVID-19 pandemic, these factors are intensified by restricted movement and social isolation measures. Many adolescent girls and young women have been in lockdown at home with abusive partners or family members, often in overcrowded conditions, cut off from normal support services. In some countries, resources have been diverted away from SGBV response services, to address the COVID-19 emergency. In April 2020, UNFPA predicted an additional 31 million SGBV cases in a six-month global quarantine situation. This would rise to an additional 45 million in a nine-month quarantine.[14] Besides being a violation in and of itself, SGBV is also linked to an increase in vulnerability to HIV, poor mental health and poor educational outcomes, amongst others.

Mental health

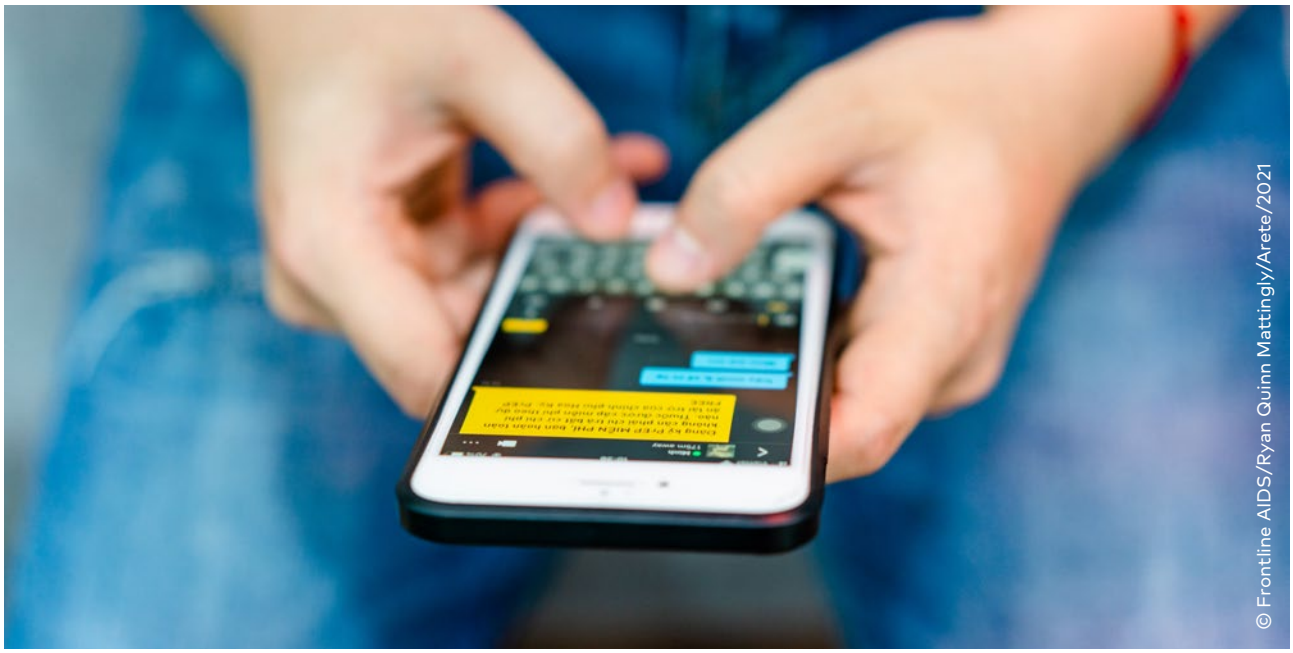
COVID-19 containment measures, particularly quarantines and lockdowns, have had a negative impact on young people's mental health, as studies from a range of countries have shown[15,16] with increases of depression, anxiety and trauma. Many adolescents have been cut off their peer groups, and have experienced loneliness and social isolation. School-going adolescents worry about how the interruptions in their education will affect their future, and are also affected by the economic and social stress their families are going through. Young gay, lesbian, trans and gender diverse people have also faced significant isolation, exacerbating already increased risk of suicide and depression among this group.

Positive approaches adopted during the COVID-19 pandemic

Adolescent girls and young women, and the organisations working with them, have shown themselves to be agile and resourceful in the face of the multiple challenges unleashed by the pandemic.

Virtual community support

Community-based and community-led organisations which mobilise, empower, raise awareness and support adolescent girls and young women quickly found ways to provide these services online. They used messaging services such as WhatsApp, social media apps



Organisations such as Mobile outreach services via dating apps provide health advice and support.

such as Instagram, Facebook and Twitter, and videoconferencing platforms such as Zoom to maintain contact with the adolescent girls and young women, and respond to their needs.

For example, in Africa, adolescent girls and young women used the Athena Network #WhatWomenWant and #WhatGirlsWant platforms to share experiences and advocate for human rights[17]. In Botswana, Malawi, Zambia and Zimbabwe, SRHR Africa Trust (SAT) engaged with young activists via YouthWyz Facebook groups, and did training on blogging and podcasting to help them organise and advocate online. In Kenya, LVCT Health held support groups for adolescents on Zoom. The young people shared their challenges and experiences with counsellors and with each other. Through these support groups LVCT Health became aware of the problems that many adolescents are facing and have been able to offer help through a number of digital interventions, including a website called One2One.

Teenergizer, an HIV and SRH organisation for teenagers in Ukraine, Russia, Kazakhstan and Kyrgyzstan began to provide online services. These included facilitation of confidential support groups for adolescents living with HIV, peer-to-peer online counselling, and live broadcasts, videos and articles on social media. Through these channels thousands of adolescents and young people were reached with information on COVID-19 and coping with lockdown and quarantine, as well as information on sexuality, SRH, and HIV[18].

Moving comprehensive sexuality education online

Hundreds of digital sexuality education platforms have been launched during the pandemic, at least partially filling the gap in CSE caused by school closures and demonstrating that CSE provision in non-educational settings can work successfully[19]. These include platforms from across the world, in many different languages, and those which address young peoples' sexuality in all its diversity. These platforms have several advantages over school-based CSE: questions can be asked confidentially, and information is provided in a non-shaming, non-judgemental way.

For example, the Frisky App, hosted by Education as a Vaccine (EVA), a youth-led community organisation in Nigeria, provides SRH information on topics such as body image, sexual abuse, abortion, HIV and AIDS, female genital mutilation/cutting, contraceptives, SGBV, puberty, sexual dysfunction, and early and forced marriages. Through the app, young people can assess their sexual health risks and learn ways to minimise them. Embedded in the app, is the 'My Question and Answer Service' that allows adolescents and young people to connect to a trained counsellor through SMS, phone call or WhatsApp, and to access SRH information and locate youth-friendly services at their convenience. With the onset of the pandemic in Nigeria, young people started using the service to ask questions about COVID-19. In response, EVA updated the app content to bust misconceptions and share accurate information.

Self-care and telemedicine

The COVID-19 pandemic has accelerated innovations in health care delivery, including differentiated service delivery, which is defined as person-centred health care, moving away from a 'one size fits all' model, and emphasising convenience and user-friendliness for patients. This includes self-administered interventions which can be done at home, privately. Such self-care methods reduce congestion in health care facilities, and have another key advantage for adolescent girls and young women: they prevent the judgement, blame or stigma which they often experience from health care workers when they seek SRH care.
One self-care intervention which has taken off during the pandemic is self-management of medical abortion. According to WHO, self-management of medical abortion in the first trimester of pregnancy has three components: self-assessing eligibility; managing the mifepristone and misoprostol medication without direct supervision of a health care provider; and self-assessing completion of the abortion process using pregnancy tests and checklists.[20]

For example, in July 2020, Marie Stopes South Africa gave 700 patients telephonic support to terminate pregnancies at home[21]. Marie Stopes counselled clients who phoned their helpline, and explained the procedure to them, and then couriered packages containing abortion-inducing drugs, as well as a short-acting contraceptive, and a pregnancy test to be conducted three to four weeks after the procedure. Similarly, in Chile, women's organisation Con las Amigas y en la Casa provided information about self-managed abortion during the lockdown, using Instagram Live to host workshops[22].

Advancing sexual and reproductive health and rights

The anticipated rise in adolescent pregnancies with the onset of the COVID-19 crisis is already becoming a reality. Thus the need for rights-based initiatives to prevent and respond to adolescent girls' SRH needs are more urgent than ever. Years of experience gained in implementing multi-layered interventions to empower vulnerable adolescent girls and young women have, to some extent, increased resilience to the new challenges which have emerged during COVID-19.

For example, in Malawi, the Spotlight Initiative has been supporting safe spaces and mentorship for adolescent girls. Their theory of change is that supporting adolescent girls psychologically, socially and educationally, and increasing their awareness of SRHR will achieve three key outcomes: reduce their vulnerability to SGBV; reduce child marriages; and increase their agency to decide when, whether, and how many children they want. Mentorship sessions have equipped a cadre of 7000 young women with knowledge and assertiveness skills. The programme has reported zero teenage pregnancies during the COVID-19 pandemic[23].

There have also been encouraging changes in the legal and policy environment regarding adolescent pregnancies. In a policy landmark, the governments of Sierra Leone and Zimbabwe recently lifted bans on pregnant girls attending school. In Sierra Leone, this happened after the Economic Community of West African States (ECOWAS) Court of Justice ruled that the policy was discriminatory, by denying girls their right to education. The Sierra Leone government has also initiated a nationwide campaign to protect girls and prevent teenage pregnancy during school closures due to COVID-19.[24] In Zimbabwe, a legal amendment criminalising the expulsion of pregnant learners was passed in August 2020.

Addressing sexual and gender-based violence

Organisations have also stepped up to ensure that services to prevent and respond to SGBV are sustained, and adapted to the new realities. Activists often continued their work in communities, while adapting to social distancing and preventative measures. For example, in Nampula Province, Mozambique, young anti-SGBV activists had to suspend door-to-door awareness raising activities, but continued to visit neighbourhoods, wearing masks, and using megaphones to encourage women to report and seek support if they experience SGBV[25].

Across the world, organisations have set up hotlines which adolescent girls and young women can call for counselling, support and advice on appropriate services. In Zimbabwe, Youth Advocates Zimbabwe (YAZ), provides free, confidential counselling and advice to young people on their SRHR. During the pandemic, YAZ was supported by UNFPA Zimbabwe to extend its helpline to marginalised communities, recognising the difficulties many were facing under lockdown. According to YAZ director, Tatenda Songore, "the helpline came in handy in providing a confidential, tailored service because of the high levels of anonymity and the trust that we have built from the youth friendly service provision trainings"[26]. In Jamaica, the Ministry of Health and Welfare established a COVID-19 hotline staffed by volunteers and fields thousands of calls from people seeking information. Seizing the opportunity to reach women at risk of SGBV, the Pan American Health Organisation collaborated with the Ministry of Health and Welfare to train a new cadre of volunteers in SGBV sensitisation and prevention through their online training, ensuring the helpline team are sensitive to cues that callers may be experiencing SGBV.

Some countries have established temporary shelters for survivors of intimate partner and domestic violence. In Ethiopia, the Association for Women's Sanctuary and Development and other members of the Ethiopia Network of Women's Shelters opened an emergency shelter for those fleeing violence[27], In Tunisia, the Ministry of Women's Affairs set up a new temporary shelter for survivors of SGBV, and provided personal protective equipment to three existing shelters[28].

Teenage pregnancies rose during COVID-19

Case study

Technology advancements enable uninterrupted access to treatment services for adolescents in Zimbabwe

Africaid Zvandiri is a community-based Zimbabwean organisation which seeks to ensure that children, adolescents and young people living with HIV have the knowledge, skills and confidence to live happy, healthy, safe, fulfilled lives. To support adolescents living with HIV, Zvandiri employs a team of Community Adolescent Treatment Supporters (CATS). CATS are HIV-positive people aged 18-24, who visit young people at their homes to link them to health facilities, and to increase uptake of testing, adherence, retention in care, and both SRH and mental health services. CATS work with health facilities supervised by the Ministry of Health, and with social workers, community health workers and clinic health workers. They also facilitate monthly community-based support groups for youth living with HIV. Through these interventions, the Zvandiri programme builds mental, emotional, and physical resilience. The CATS are supervised by mentors, who are adult health professionals.

Since its inception, the CATS model has been scaled up to 51 districts in Zimbabwe, and has been adopted in Mozambique, eSwatini, Namibia, Rwanda, Tanzania and Uganda.

When COVID-19 containment measures were introduced in Zimbabwe, Zvandiri had to adapt its CATS model to keep young people safe. They started by developing youth-friendly Youtube videos and comics in English, Shona and Ndebele, explaining what COVID-19 is, how to take care of their mental health during COVID-19, and tips for young people living with HIV[29]. Zvandiri also uses a free SMS monitoring tool with the videos and comics, so that young people can respond, ask questions, and participate in polls, as well as share on social media.

Zvandiri also shifted to virtual case management, to cut down clinic visits. The mentors started using WhatsApp for most of their consultations, sharing information on when and how to collect ARVs from the clinic; providing adherence monitoring, support and counselling; screening for symptoms of COVID-19; screening for SGBV; and providing psychosocial support. The CATS also switched to supporting their cohort of adolescents virtually: either one-to-one, or in support groups, to reduce isolation and maintain connections.

However, not all young people have access to devices and internet, so Zvandiri mentors still continue home visits to some young people, including those at high-risk or living in vulnerable circumstances, and those who are unable to attend clinic or have not collected their ARV refills.

The pandemic and subsequent economic hardship have taken their toll on adolescents' caregivers too, with food and housing insecurity increasing stress within families. Therefore Zvandiri also provides virtual support to caregivers, including emotional support; support for people experiencing SGBV; advice on chronic medication; and referrals for services, as well as emergency relief schemes.

Digitalising treatment support for adolescents in Zimbabwe by community-led organisations has increased access to COVID-19 related information, and supports adolescents and young people to adapt to living through the pandemic.

Recommendations

Sustain virtual support and information sharing

Digital platforms can be convenient, reduce costs, enhance privacy and potentially reach more people with services. Community-led and community-based organisations working with adolescent girls and young women in their diversity should continue to equip themselves with the technology and skills to shift to virtual ways of working. This way they can harness young peoples' extensive use of social media and the internet for learning and connecting with each other. However, service providers should also ensure that online service delivery does not widen the 'digital divide', by excluding poor, rural or marginalised adolescent girls and young women who do not haveaccess. Moreover skills building for young people must include aspects of online rights, safety and security considerations, acknowledging that online spaces, like any spaces, can be sites for exclusion, sexism and sexual and gender based violence.

Expand differentiated service delivery, including self-care and telemedicine

SRHR services are essential to adolescents' and young women's health and equality. During COVID-19, organisations working with adolescent girls and young women have striven to ensure that these services, including HIV and STI prevention, diagnosis, and treatment, family planning, safe abortion and post-abortion services, and maternal health services were not interrupted. These efforts should be sustained and expanded. Organisations should continue to explore and implement innovative service delivery, including self-care options and telemedicine for SRH and HIV.

Advance sexual rights and agency

Evidence- and rights-based programmes which aim to end child marriage, address harmful social and gender norms, improve access to SRHR, and improve agency for adolescent girls and young women must be sustained.

Multi-layered interventions to keep girls in school are more critical now than ever. Proven strategies which enhance girls' retention in school should be sustained. Specifically, multiple platforms for expanding access to CSE, both in and out of school settings, should be scaled up. CSOs should also continue to advocate for adequate social protection mechanisms for adolescent girls, including school feeding, food and hygiene parcels, and free mobile data. Finally, CSOs should continue to advocate for governments to urgently review policy barriers which limit girls' access to education, such as laws banning pregnant learners from returning to school.

End sexual and gender-based violence

COVID-19 has exposed the extent of SGBV, and activists must seize the moment, intensifying advocacy for policies, plans, interventions and resources to address SGBV. Organisations working to end SGBV should continue to advocate for governments to honour their obligations to protect adolescent girls and young women from SGBV, and hold perpetrators accountable. They should ensure that adolescent girls and young women who are victims or at risk of SGBV, have access to swift, effective, non-judgemental and non-stigmatising justice and support. This should include protection orders, legal advice and support; health care; psychosocial support; and shelters. Community-led and community-based initiatives to respond to survivors of SGBV, including psychosocial support and counselling, safe spaces and shelters, and hotlines, must be funded and sustained.

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"I was young, I liked to socialise, and I started using drugs. I've suffered, I've spent time in prison, and I've lost everything. The discrimination hurts. I am a chronic patient, not a criminal. Please don't leave me behind." Myanmar.

6. Intersections across marginalised populations

Challenges for intersections across marginalised populations during COVID-19

Intersectionality means understanding that human beings are shaped by the interaction of multiple different social locations or positions, such as race, gender, sexual orientation, gender identity and expression, class, geography, age, dis/ability, migration status, indigenous status and religion. These interactions occur within connected systems and structures of power. Intersecting identities, experiences and barriers combine and compound social exclusion in ways that go beyond a single aspect of identity, and this in turn increases negative health outcomes, including for HIV and COVID-19. Indeed, the pandemic has highlighted the impact of global inequalities along multiple dimensions.

As each chapter on individual marginalised populations has shown, the impacts of COVID-19 on marginalised groups have frequently been severe and have heightened existing inequalities. While there were common challenges across all six groups in this study, the impacts for some people were increased by pre-existing conditions that complicated their health and well-being and worsened their already precarious position. Agency and freedom, personal boundaries and bodily integrity are progressively eroded with every marginalisation. Some inter-generational

impacts of this marginalisation are inherited, others a result of life experiences or precariousness resulting from poverty or inequality.

The tendency to see key populations as homogenous and with a single story, ignores the complexity of needs and experiences that directly impact on individual agency. Some marginalised people are more criminalised than others. According to the UNAIDS Global Update[1], 69 countries criminalise men who have sex with men in their diversity, while 19 of the 134 countries included in reporting, criminalised transgender people. This data ignores the disproportionate risk that transgender people, and transgender women in particular face from the enforcement of anti-homosexuality laws. Since transgender people's gender identity is ignored, and many transgender women are highly visible, they are targeted both by laws against homosexuality and those that criminalise transgender identities. It also makes invisible the disproportionate impact of many other laws on specific populations.

These laws, and others – including punitive drug laws and petty offence laws such as vagrancy, loitering, begging, touting or failure to pay debts – result in people of colour, those living in poverty, transgender people, people who use drugs and people who sell sex being disproportionally represented among people incarcerated in almost all countries.

States of Emergency and Disaster regulations imposed in response to COVID-19 have added to the existing burden of criminalisation – because key populations and those affected by poverty and other forms of intersectional marginalisation were less able to comply with stay-at-home and social distancing orders, and faced arrest and the threat of criminal records if they were unable to do so.

An increased rate of incarceration and of violence also has implications for people's ability to get and remain employed, as well as to access basic needs such as housing. Moreover, incarceration itself poses a significant threat to health as many languish in congested prisons with inadequate health and sanitation and face the increased risk of COVID-19 as well as other diseases like tuberculosis (TB).

The extent to which marginalised populations' living conditions were affected by the COVID-19 pandemic also clearly demonstrated the intersectionality of marginalisation. For example, while all lesbian, gay, bisexual, transgender and queer (LGBTQ) people are more likely to experience insecure housing compared to the general population, transgender people are the most likely to be affected. In the USA, 42% of transgender people have experienced homelessness in their lives, compared with the 30% average for all LGBTQ people[2], and 40% of transgender people had experienced some form of housing discrimination or instability, including eviction or being denied a home or apartment because they are transgender[3]. These effects were compounded when transgender people were black.

In addition, homeless transgender people are also less likely to be accommodated in homeless shelters, because single-sex shelters often insist on allocating transgender people to spaces on the basis of their birth sex as opposed to their gender identity.

In Thailand, transgender women who sell sex, and who use drugs, face compounded discrimination, violence, imprisonment and oppression, especially from law enforcement, due to their multiple marginalised identities. During the pandemic, they have been unable to work in the sex industry due to the closure of the entertainment industry, but they were also unable to access social protections as many lacked the necessary identity documentation. Added to this, outreach by sex worker organisations was halted due to lock downs and restrictions on movement.

For many transgender sex workers, being locked down or moving back to live with families or intimate partners, compounded with the frustrations of a lack of income, exacerbated

rates of sexual and gender-based violence (SGBV). Under normal circumstances, sex workers experience high rates of intimate partner violence[4], just as LGBTQ people face increases in violence after prolonged exposure in homo- and transphobic environments. Lockdown has worsened this, leading to mental health challenges. A survey by an LGBTQ organisation in Lebanon showed that 62% of community members needed mental health support.

In South Africa, homeless transgender sex workers, many of whom also use drugs and are living with HIV and TB, were unable to earn an income. They were removed from the streets and relocated to a quarantine camp, where transgender women reported being bullied and assaulted by men. The South African Human Rights Commission later ordered the camp to be shut down because it was congested, unhygienic, and had violated multiple human rights[5]. The camp provided little to no harm reduction services to residents many of whom were ill from the effects of drug withdrawal. Those who stayed on the streets experienced deteriorating conditions and increased visibility to law enforcement. At least two of the women died during this time, due to diarrhoea which exacerbated their existing health conditions[6]. Another, Robyn Montsumi, a black lesbian transgender sex worker activist was arrested for drug possession and died under suspicious circumstances in police cells days after her arrest[7].

Positive approaches adopted during the COVID 19 pandemic

Recognising the diversity of needs and responding to those most in need

Communities of marginalised people have demonstrated their solidarity with each other during the COVID-19 crisis. Support for those most affected by the economic crisis and loss of livelihoods emerged within the community from the local to global level. For example, members of communities opened their homes to others who had nowhere to stay, and volunteered their time collecting donations and distributing food parcels

Care support packages with condoms and information are given to the LGBT community in Hanoi, Vietnam.

to those most in need. Community-based and -led organisations were the first responders, mobilising to meet the emergency needs of community members. And members of marginalised populations in higher income countries donated generously to crowdfunding campaigns launched by organisations in lower- and middle-income countries.

For example, Sex Workers Education and Advocacy Taskforce (SWEAT) and Sisonke sex workers movement in South Africa launched a crowdfunding campaign to support sex workers who lost their livelihoods and supported their dependent children: acknowledging that women who sell sex are breadwinners and mothers. The funding supported 704 adults and 939 children from April to October 2020[8].

Mother's for the Future, a project hosted by SWEAT, specifically embraces sex worker mothers and offers peer support for them, as well as pregnant and new mothers. The project recognises that sex workers with dependents face additional pressures to make money and may take additional risks to do so. It also recognises that women of colour living in poverty and who sell sex have increased risk of pregnancy-related complications and struggle to access quality SRH services. During COVID-19, the project also offered assistance to mothers who faced additional childcare responsibilities and who could not work due to lockdown measures.

Cross-cutting interventions

Responsive, flexible, local solutions, developed by and with people with multiple marginalised identities can address the complexity of people's lived experiences. For example, the Kenyan Network of People Who Use Drugs (KeNPUD) and VOCAL Kenya have collaborated to equip people who use drugs to respond to rising violence against their peers in Nairobi during the pandemic. Trained in counselling, mediation and conflict resolution, as well as directly linked with communities of people who use drugs, they can act as first responders in cases of violence and refer to health and legal services[9]. Meanwhile in Pattaya, Thailand, a community of transgender sex workers who use drugs have built a network of support systems amid COVID-19, from community-led dissemination of food and hygiene packages to a harm reduction gathering[10].

Uniting to amplify and address common needs and challenges

The building of alliances and solidarity across communities and movements during the HIV response has taken time and effort, yet it has paid off during the pandemic.

As an example of solidarity amongst key populations, global networks issued joint key population statement on World AIDS Day 2020, highlighting the parallels between HIV and COVID-19, both in terms of the vulnerability key populations face, but also in terms of the power, reach and value of strong, community-led networks[11]. And in a welcome move, UNAIDS announced on Human Rights Day, 10 December 2020, the launch of a Solidarity Fund to support social entrepreneurs and small-scale businesses owned by people living with HIV, women or members of marginalised communities, acknowledging the particular precariousness faced by these groups during COVID-19.

Frontline AIDS, as an organisation working closely with communities of marginalised people, acknowledges that COVID-19 has placed increased pressure on community-based services. It expanded its support via the Rapid Response Fund (RRF) to a wider number of communities through its grant mechanism, and partnered with regional networks of marginalised populations to ensure funding was well placed. From April to July 2020, using reallocated unrestricted funds, the RRF issued 88 grants to support LGBTQ people, sex workers, people who use drugs and people living with HIV. The Fund also issued seven additional COVID-19 grants from other funding sources, including one grant targeting people who use drugs, and another for sex workers.

Advocacy to reduce marginalisation and exclusion

Adopting an intersectional approach means calling attention to immediate needs, while at the same time recognising and addressing the structures and systems which perpetuate and entrench inequity, oppression and exclusion – including along lines of racial and ethnic identities. Structural barriers impact on all aspects of the health and wellbeing of marginalised people.

In 2020, The African Court for Human and People's Rights heard a petition brought by the Campaign on the Decriminalisation of Petty Offences in Africa. In December 2020, the Court ruled that archaic vagrancy and petty offense laws, which are often relics from the colonial era, are not compatible with the African Charter on Human and Peoples' Rights, the African Charter on the Rights and Welfare of the Child and the Maputo Protocol on the Rights of Women. The Court found that these laws disproportionately target people who are poor and homeless, and that many African countries abuse vagrancy laws to arrest and detain people even when there is no proof of criminal conduct. The Court instructed member states to repeal and reform these laws.

PITCH partner, the AIDS and Rights Alliance for Southern Africa (ARASA), engaged with many marginalised population groups across the region, to mobilise them around advocacy to address structural barriers to HIV prevention[12]. Organisations representing sex workers, people who use drugs, and LGBTQ people came together to agree a regional plan. This action continued in 2020, supporting country efforts in Zimbabwe and Mozambique, which included engaging with the Southern African Development Community (SADC) with UNAIDS support.

As humans, we have the right to life and to carry out our daily activities without discrimination. Mainstream HIV programming considers us as data. How many tested? How many reached? How many positive? When we are reduced to statics, our emotional needs and mental wellbeing is forgotten. We are humans, not numbers.

Case study

Addressing intersecting needs and vulnerabilities of male sex workers via community-led responses in Kenya

HOYMAS is a male sex worker-led organisation, in Nairobi, Kenya. This case study describes how they were affected by the COVID-19 pandemic and restrictions, how they adapted to meet their clients' changing needs, and some of the barriers they faced in doing so. The case study consists of excerpts from 'Sexual health among Kenyan male sex workers in a time of COVID-19' by Macharia et al[13].

HOYMAS has a network of specialised clinics run by and for men who have sex with men. It has created safe spaces where male sex workers, who are doubly stigmatised, can take control of their sexual health.

Specialist services are needed to meet the health needs of gay men and men who have sex with men.

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When the government announced Nairobi's lockdown in March 2020, HOYMAS peer educators quickly adapted their roles towards sensitising sex workers to the threat of COVID-19. Face-to-face meetings were halted but peer education was moved onto virtual channels, including WhatsApp groups, Facebook and other online forums. These platforms gave members the chance to discuss the situation and ask questions.

However, given the financial problems facing men who sell sex during the pandemic, challenges quickly emerged. Since many HOYMAS members own 'pay-as-you-go' cell phones, they were unable to afford or access these platforms, and unable to download the information and education materials developed by the outreach team.

Recognising the psychosocial needs of their members also, HOYMAS initially set up support groups at the drop-in centre. These were limited to six people and had a two-metre distancing rule. However, attendance dropped when matatu (local transport) costs doubled after the government placed restrictions on the number of passengers they were allowed to carry.

Prior to COVID-19, HOYMAS was providing regular testing, counselling and treatment for sexually-transmitted infections (STIs) and HIV for over 5,000 members. But over recent years, they had struggled to have their clinic officially recognised by the county government. This prevented them from recruiting more clinical staff, and in the pandemic context, prevented them from accessing personal protective equipment.

HOYMAS' crisis centre, staffed by trained paralegal workers, has shut due to COVID-19 and its mandatory curfews. This has left people with severe mental health problems without services, and since community paralegals are not categorised as 'essential' health workers, they are banned from going out at night to respond to incidents of violence.

All these challenges, amidst dwindling resources, underscore the vital role of organisations like HOYMAS, trying to meet the health needs of 5,000 highly stigmatised men who remain largely excluded from the public health system, and face the double stigmatisation of being men who have sex with men and sex workers. The delivery of vital, life-saving services is at risk of collapse. Support for community-led organisations, like HOYMAS, is essential as they are the key way to deliver effective responses to the most marginalised populations, who are at the greatest risk of COVID-19.

Recommendations

Engage community-based and community-led organisations in crisis responses

COVID-19 has shown that community-based and community-led organisations serving marginalised people are best placed to address intersectionality, and the often-complex needs of individuals. In addition, COVID-19 response mechanisms which are responsive to and inclusive of diverse voices and experiences are more likely to be appropriate, acceptable and effective.

Community-based and -led organisations should assertively claim their space in decision-making platforms to ensure communities historically and presently most impacted by exclusion are included, resourced and their needs accounted for. This needs to move beyond inclusion to approaches that shift power, including along lines of race, to support movements and activists to advocate beyond consultative platforms, for transformative policy, legislation and systemic change. It also may mean providing training for the most marginalised to be able to meaningfully engage and participate, focusing on equity not equality. Mainstream health and HIV service providers must learn from, politically support, and fund community-led responses to address intersectionality.

Improve policy and legislation to protect the rights of marginalised groups

Civil society and community led organisations should collaborate in their efforts to advocate for the decriminalisation of sex work, homosexuality, cross-dressing, drug use and possession, HIV transmission, and laws which punish adolescent girls and young women for sexual behaviour or pregnancy, or restrict their access to SRH services. Using an intersectional lens, they should also consider other laws, policies and practices that disproportionally target marginalised communities by compounding social exclusion and progressively eroding people's resilience and re-integration. These include petty offense laws and regulations, as well as local authority by-laws.

Legal protections against violence, abuse, and discrimination are seldom used by marginalised people. Thus, active measures must be taken by law enforcement agencies to help them access these protections. Additional protective measures can be put in place in the form of standard operating procedures to protect the most marginalised from violence and other human rights violations, and to enable them to access services. States are increasingly recognising the negative impact of punitive laws and policies, including the economic cost of these laws. Reviewing such approaches, and adopting evidence informed legal frameworks and policies to achieve the most beneficial health outcomes must be considered.

Focus social protection and economic recovery plans on those most at risk

An approach which is not intersectional often renders forms of marginalisation invisible, and gives the illusion of homogeneity. Methods of gathering data on who is most vulnerable need to be more sophisticated and disaggregated to provide a clearer picture of the impact of intersectional marginalisation. With more robust data, decision-making around social protections can be better targeted to those most in need. In recovering from the impact of COVID-19, humanitarian responses, social protection schemes and plans for economic recovery should cover the needs of marginalised populations.

Harness digital opportunities, and bridge the digital divide

COVID-19 has been an accelerator of digital innovations, but for many people digital platforms are not affordable, accessible or trustworthy. Moreover, the rapid growth of digital health interventions has not always been coordinated or well considered.

Civil society and community organisations should embrace digital innovations in their own work and continue to build their own skills, infrastructure, vigilance and policy frameworks in this area. They

must also demand that implementers of digital solutions engage communities in planning, design, implementation and evaluation of the application of digital tools in the COVID-19 and HIV response. In addition, they should continue to call attention to the digital divide, reminding donors and governments that the most marginalised people are least likely to have access to the internet, which has the potential to marginalise them further. Finally, they should request donors to support capacity strengthening of community advocates to navigate digital advocacy spaces and further strengthen their activism in the digital health space.

Connect with social justice initiatives

Community-based and -led organisations are increasingly joining global struggles to transform structures and power imbalances that entrench and reproduce inequalities. These efforts must be sustained, and lessons drawn from these struggles can be integrated into HIV, TB and other health challenges. For instance, in addition to sensitising and training police, it is also vital to transform policing practices to address bias and abuse of power, and call for greater accountability in the broader criminal justice system. Without engaging in a transformational agenda individual experiences of injustice will continue to be repeated generation after generation.

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Conclusion: Learning from the COVID-19 experience can transform HIV community-led responses and feed into future pandemic planning

The paper highlights how the impact of COVID-19 and the resulting restrictions have wrought havoc on the lives of people across the globe – no one is untouched. But as with HIV, the pandemic's impact falls disproportionately on marginalised communities, who already experience entrenched inequalities, criminalisation, discrimination, stigma and rights abuses.

As community-based and -led organisations mobilised to support their communities through lockdowns and other emergency measures, they confronted huge challenges. In many countries COVID-19 has led to quarantines, restrictive movement, social isolation and shrinking civic space with increasing human rights violations, sexual and gender-based violence and criminalisation compounding this. There have been widespread disruptions to health services, including STI and HIV treatment, mental health and harm reduction services. Numbers of unintended pregnancies are rising exponentially,

with young people unable to access contraceptives and SRH services. Governments have failed to meet the basic needs of marginalised communities – many relying on community organisations to support them with food packages, protective equipment and home delivery of ARVs. As the pandemic continues, the longer-term repercussions for livelihoods and economies are concerning, and must be prepared for.

What is striking about this analysis, is that the challenges revealed do not stem from the virus itself, but from emergency measures introduced in response to the pandemic. And many of these challenges are not new. As we know from the HIV experience, crises can catalyse innovation, but they can also bring repression and rollback on rights.

A common thread runs through the paper: that marginalisation is not evenly experienced. People who have multiple identities that intersect to compound discrimination – particularly along lines of race, transgender identity, sex worker status – face the greatest rights abuses, stigma and lack of support.

In the face of these challenges, what shines through these stories of resilience is a sense of solidarity among networks and organisations of marginalised communities. Despite working under extreme pressure throughout the crisis, community-led organisations have emerged as best equipped to respond to the diverse and complex needs of their communities, including those related to COVID-19, and have always done so. They have remained agile and continued to advocate, mobilise and adapt to the changing context. Their responses have been swift and creative, motivated by the need to keep services running and reach those most vulnerable.

It is important to remember that many of the positive practices highlighted here may have been triggered by COVID-19, but have been hard fought for by communities for years. These include longer take-home prescriptions for OAT and ARVs; telemedicine for medical abortions; recognition of sex work as work leading to inclusion in social protection schemes; recognition of transgender people in their correct gender identities in public space; and directives by regional rights bodies to decriminalise petty offences, and ban the expulsion of pregnant adolescent learners from school. The rapid way in which decisions were made as well as policies and approaches changed tells us that the biggest barriers were often in political will. Policy-makers have often feared the political consequences of enacting changes called for by communities. But this backlash has not materialised. Indeed, decision-makers can gain credibility and political capital by supporting policies that will bring positive changes, if they work more closely with communities, particularly during the COVID-19 pandemic. The paper demonstrates HIV community-led responses and the innovations they create are the backbone of the effective COVID-19 response. Preparedness for future pandemics will be strengthened if these responses are sustained.

For communities and civil society organisations (CSOs), there are many lessons to be learnt from the COVID-19 response, and many opportunities to be harnessed. Going forward, the top, cross-cutting recommendations for communities and CSOs are:

- Advocate for governments and donors to provide political and financial support for community-led responses and recognise community-led organisations as official service-providers, particularly during the constant changes wrought by multiple lock-downs and fluctuating COVID-19 infections.

- Engage with governments on the pandemic preparedness agenda, particularly the Pandemic Preparedness Treaty decisions which will be discussed at the 2021 World Health Assembly.

- Strengthen efforts to end inequalities and hold governments accountable for commitments to end inequalities[1] and implementation of new targets[2] on community-led responses and social enablers adopted in the 2021 High Level Meeting on AIDS Political Declaration[3].

- Adopt an intersectional approach, ensuring no one is left behind.

- Build coalitions and connect across movements, including those working on pandemic preparedness.

- Claim space at decision-making tables, particularly within COVID-19 country response mechanisms, pandemic preparedness discussions and COVID-19 diagnostics, treatment and vaccination national technical working groups.

- Advocate for an end to punitive, harmful and discriminatory laws.

- Where there are protective laws, increase legal literacy and access to justice.

- Embrace digital advocacy and service delivery strategies while remaining vigilant on their appropriateness, impact and accessibility.

- Strengthen and expand person-centred HIV health and community-led services.

We may have to live with COVID-19 for some time, and it will continue to affect those with pre-existing or underlying vulnerabilities disproportionately, including those who are already living with or at greatest risk of acquiring HIV. Resources must now be channelled to the ongoing response and then recovery from the pandemic to get community-based and -led initiatives back to their strength and capacity.

Many of the successes cited in this paper are the result of PITCH funding for advocacy. With this funding ended in 2020, we hope these approaches can provide partners with points of learning and inspiration for stronger advocacy approaches to take forward into their own contexts.

Endnotes

[1] 'Paragraph 57. Pledge to end all inequalities faced by people living with, at risk of and affected by HIV and by communities, and to end inequalities within and among countries, which are barriers to ending AIDS' https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf

[2] Increasing the proportion of HIV services delivered by communities: 30% of testing and treatment services, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy; 80% of HIV prevention services for populations at high risk of HIV infection, including for women within those populations; 60% of programmes to support the achievement of societal enablers.
The 10-10-10 endorsed targets to end all inequalities faced by people living with HIV, key and other priority populations by 2025, by reducing to 10% or less the proportion of women, girls, people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence; countries with restrictive legal and policy frameworks that lead to the denial or limitation of access to services; people experiencing stigma and discrimination.

[3] https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids

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Irrespective of our sexuality, gender identity, language, culture, occupation and circumstances, we are all one. We need unity, acceptance and love.

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