**UNAIDS Response to 2021 Questionnaire of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health**

**Sexual and Reproductive Health during COVID-19**

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) welcomes the opportunity to make a submission to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Drawing on the experience and learnings in applying a human rights-based and gender-transformative approach to the HIV epidemic, UNAIDS issued guidance on women and girls during COVID-19: [*Six concrete measures to support women and girls in all their diversity in the context of the COVID-19 pandemic*](https://www.unaids.org/en/resources/documents/2020/women-girls-covid19)*,* a report on the impact of COVID-19 and the response on the human rights of people living with and vulnerable to HIV in [*Rights in a Pandemic*](https://www.unaids.org/en/resources/documents/2020/rights-in-a-pandemic)*,* and later guidance on the lessons learned from the first phase of the pandemic [*Prevailing a**gainst pandemics by putting people at the center-World AIDS Day Report 2020*](https://www.unaids.org/sites/default/files/media_asset/prevailing-against-pandemics_en.pdf)*.* UNAIDS has recently produced a [background paper](https://www.unaids.org/en/resources/documents/2021/PCB48_Thematic_Segment_Background_Note) for the Programme Coordinating Board on the impact of the COVID-19 pandemic on the HIV response.

The submission below should be considered in addition to the findings and recommendations made in these publications.

**Contact Details**

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| --- | --- |
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| Can we attribute responses to this questionnaire to your State publicly\*?  \*On OHCHR website, under the section of SR health | Yes No  Comments (if any): Please feel free to attribute our responses to UNAIDS publicly. |

1. **Since the beginning of COVID-19 pandemic, States have adopted new policies, laws and other measures in response to the crisis. Please refer to the relevant measures in your country (or countries in focus) and their impact on the right to sexual and reproductive health. Please share information on opportunities and challenges.**

Since early 2020, UNAIDS has monitored the measures taken by governments in response to COVID-19 and the impact on the HIV response, and sexual and reproductive health more generally. UNAIDS has found that the measures taken by countries, particularly lock-downs, travel restrictions and border closures, have had a significant impact upon the HIV response, in both the provision of services and their accessibility.

Lockdowns and border closures have disrupted supply chains for key HIV commodities, leading to stockouts in some countries, and affected the provision of HIV related services.[[1]](#footnote-2) Even where countries have classified sexual and reproductive health services as essential, barriers such as transportation and mobility bans prevent patients and providers from travelling to clinics.[[2]](#footnote-3) [[3]](#footnote-4) In the early stages of the pandemic, exceptions were not always provided to seek emergency medical care or onerous administrative requirements were put in place to obtain permission to leave home even for emergencies. This affected their ability to protect their health, avoid unwanted pregnancies, and prevent or manage HIV and other sexually transmitted infections. In a number of countries, UNAIDS documented cases of pregnant women being unable to access emergency reproductive health services due to mobility restrictions or lack of available personnel in the hospitals, with tragic results. In many cases these barriers were quickly rectified to allow for travel to and from emergency health services. [[4]](#footnote-5) [[5]](#footnote-6)

Emergency measures put in place to contain COVID19, particularly broad and vague lockdown laws, have been used to disproportionately target vulnerable and marginalised communities, increasing violence, stigma and discrimination. For example, in Uganda 20 people were arrested in an LGBTI shelter and charged with a negligent act likely to spread infection or disease, though the charges were later dropped.[[6]](#footnote-7) For a discussion on the impact on sex workers and transgender people, please see further below.

Community health workers and community-led service delivery is essential for HIV and broader SRH service delivery and access. In a UNAIDS study of 16 countries[[7]](#footnote-8) from sub-Saharan Africa and Latin America and the Caribbean, most, but not all, governments designated community health workers and community-led services providers as essential workers, although arrests and harassment have been documented in several settings. Community health workers and community-led service providers often lack official recognition, credentials or certification guaranteeing them recognition. Some are public employees, but others are less formally employed in the private or nongovernmental sector—and thus their status, and the protections and equipment they receive, are far more tenuous if they are not explicitly exempted from limitations on movement. This also has a significant impact on women given that over 70% of community health workers are women, and already in low wage, low recognition jobs. COVID-19 has revealed the extent of the health systems’ dependence upon women health workers and also their vulnerability, poor working conditions and exploiation[[8]](#footnote-9) [[9]](#footnote-10) [[10]](#footnote-11) [[11]](#footnote-12)

The pandemic has also provided opportunities including enhancing the role and recognition of community health workers in ensuring the continuity of services and in some countries an effort to elevate their recognition and status; increasing uptake of innovations such as multi-month dispensing; diversification of channels for information and support; greater reliance on indigenous, contextually appropriate solutions – spawning in turn cost effective innovations and local resilience.

**Please also specify legal or other measures introduced during the pandemic aiming at recognizing, or restricting, banning or criminalizing: a) access to legal abortion; b) consensual sex between adults; c) same sex sexual relations, d) consensual sex between adolescents of similar ages, e) sex work, f) same sex marriage, g) information on the right to sexual and reproductive health; h) HIV transmission and i) autonomy and free decision making on one’s body and sexual and reproductive health.**

**e)** Sex workers have been disproportionately affected by COVID-19 containment measures that have often restricted legal sex work because of the risk of transmission. In many countries all non-essential public places, including brothels were closed and face to face activities were banned including sex work.[[12]](#footnote-13) A survey by the Global Network of Sex Worker Projects of 156 sex workers from 55 countries also found that most respondents in every region except Europe reported reduced access to condoms, lubricants, and testing and treatment for sexually transmitted infections.[[13]](#footnote-14). With their income at risk or entirely eliminated, and often ineligible for financial support due to the legal status of their work, or general stigma against sex work, many sex workers report having to choose between physical distancing and meeting basic needs, with many sex workers arrested globally.[[14]](#footnote-15)

**i)** The pandemic was used to introduce new legislation to limit the right to gender affirming treatments. In Hungary, a new bill was introduced to remove the right of people to change their gender and name on official documents to ensure conformity with their gender identity, in clear breach of international human rights to legal recognition of gender identity.[[15]](#footnote-16) Government lockdown policies that designate days to leave the home by gender have led to additional discrimination, harassment, and violence. According to reports in a number of countries, some transgender people were unable to access public services, or faced harassment and arrest because they were out on the day corresponding to their gender identity rather than their identity documents.[[16]](#footnote-17)

**h)** Poland passed a fast-tracked amendment to the criminal law that increases the penalties for HIV exposure, non-disclosure and transmission. It provides for a minimum of six months in prison (from no minimum) and increased the maximum penalty from three to eight years in prison has been passed—a clear contravention of international human rights obligations to remove HIV-specific criminal laws.[[17]](#footnote-18)

1. **Regarding sexual and reproductive health care, what services, goods and information is being provided in your country (or countries in focus), during the pandemic?**

Please see our answer to question 1.

**2.1. Any changes compared to pre-COVID 19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?**

This new pandemic has had far-reaching effects on health systems and other public services. HIV services have been disrupted, and supply chains for key commodities have been stretched.

Early on in many countries, sexual and reproductive health-care funding and supplies were not included in emergency health frameworks or financing schemes. Existing sexual and reproductive health supplies and providers were diverted to COVID-19 efforts. Some governments moved funds regularly earmarked for reproductive health care to combating COVID-19.[[18]](#footnote-19)

**2.2**. **Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID – 19.**

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HIV services have been disrupted and supply chains fr key commodities have been stretched.

Testing: The impact is reflected in dips in lower monthly numbers of new HIV diagnoses and treatment initiations. Of the 19 countries reporting sufficient data, most have reported large and sustained decreases in HIV testing. Only one country did not experience any disruptions while two of those countries had rebounded to pre-COVID-19 testing levels by September 2020. In 16 others—including eastern and southern African countries with large HIV testing programmes—the number of HIV tests being conducted remains below the levels of January and February 2020, as at December 2020.[[19]](#footnote-20) Among 13 countries reporting sufficient data on in the number of pregnant women tested for HIV per month, compared to baseline, only one has not experienced disruptions, while 6 countries experienced disruptions and then fully rebounded by September and 6 countries experienced sustained disruptions.[[20]](#footnote-21)

Starting Treatment: Fewer people are starting antiretroviral therapy, which is curbing increases in the total number of people living with HIV who are on treatment. Declines in the number of people living with HIV who are initiating treatment have been reported by all but one of the 28 countries that have reported sufficient monthly data. Only six countries had seen treatment initiations return to the same levels as in January and February 2020.[[21]](#footnote-22) An estimated 26.0 million people were on treatment as of mid-June 2020, up only 2.4% from an estimate of 25.4 million at the end of 2019. By comparison, treatment coverage increased by an estimated 4.8% between January and June of 2019. Overall, an additional 4 million people would have needed to be accessing treatment to reach the target for the end of 2020 of 30.0 million, in reality only 27.4million were on treatment by that date.[[22]](#footnote-23) [[23]](#footnote-24)

Treatment retention: Treatment retention has been better than testing and initiation. Among 25 countries reporting sufficient monthly data on treatment service utilization as of September 2020, most have shown no decline since April 2020 in the total number of people living with HIV who are receiving antiretroviral therapy, meaning people already on treatment are managing to maintain their treatment and viral load suppression. 16 countries did not experience any disruptions, 3 countries experienced disruptions of at least one month and then fully rebounded and 6 countries experienced more severe disruptions.[[24]](#footnote-25)

The data reported to UNAIDS by countries thus far have been used to project the potential long-term impact of the COVID-19 pandemic on the HIV response. Projections warn that COVID-19-related disruptions may result in 123 000 to 293 000 additional HIV infections and 69 000 to 148 000 additional AIDS-related deaths globally.[[25]](#footnote-26)

**2.3.** **Please also share information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected.**

A UNAIDS global survey among lesbian, gay, bisexual, transgender and intersex (LGBTI) people using a social networking app in October and November 2020 found that six per cent of more than 12 600 survey participants reported lower access to condoms and/or lubricant during the COVID-19 crisis, and 12% of the 1397 respondents who had ever taken PrEP were no longer using it due to COVID-19.[[26]](#footnote-27) Access to HIV prevention services for gay men and other men who have sex with men was reduced in most of the 13 countries that submitted sufficient monthly data.[[27]](#footnote-28)

Harm-reduction centers have been closed in many places[[28]](#footnote-29) although according to online survey by the International Network of People Who Use Drugs in May 2020 found that 65% of respondents reported that harm reduction services were available in their area.[[29]](#footnote-30)

Surveys indicate that access and service provision is not the only new or exacerbated barrier to services, but that increased stigma and harassment are also contributing to lack of access to services. An online survey undertaken by UNAIDS of 2300 people in 28 countries in Latin America and the Caribbean found that seven in 10 respondents do not currently have enough antiretroviral medicines for a lockdown of more than 60 days. Five in 10 respondents reported difficulties in obtaining antiretroviral therapy during the pandemic. The same survey found that 56% of respondents believed they could experience physical, psychological or verbal violence due to living with HIV in the midst of the COVID-19 pandemic. Fear of HIV-related discrimination also caused three in 10 respondents to stop accessing services in the midst of lockdowns[[30]](#footnote-31)

Even before the COVID-19 pandemic, domestic violence was already one of the most significant human rights violations, but the pandemic has made a challenging situation even worse. Confinement is increasing the stress caused by security, health and money worries and is increasing the isolation of women with violent partners, separating them from the people and resources that can best help them. According to a survey conducted by the International Community of Women Living with HIV in Asia and the Pacific (ICWAP) with support from the UNAIDS Regional Support Team for Asia and the Pacific, in June 2020 almost 30% of the respondents experienced some form of gender-based violence, including stigma and discrimination. In addition, more than 80% reported a lack of access to sexual and reproductive health services, including contraception.[[31]](#footnote-32) This further exacerbates HIV risks and vulnerabilities for women, at the same time that access to gender-based violence services, as well as HIV and other sexual and reproductive health services, are being reduced or are unavailable during the pandemic. Violence against women is a major factor driving risks for HIV—in areas with a high HIV burden, such as sub-Saharan Africa, women subjected to intimate partner violence are 50% more likely to be living with HIV. Men who are perpetrators of violence against women tend to be at higher risk of HIV themselves and to use condoms less frequently, thus increasing the risk of HIV transmission.[[32]](#footnote-33)

**2.4. Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.**

Stay at home orders, lockdowns and curfews have led health authorities to adopt differentiated and novel forms of service delivery in terms of HIV testing, treatment and care.

Many countries have sought to reduce the number of clinic visits by people living with HIV by accelerating implementation of multimonth dispensing of antiretrovirals, wherein individuals are provided with multiple months’ worth of medication. UNAIDS analysis of treatment data in 46 countries found that by mid-2020, accelerated implementation of multimonth dispensing had reduced the number of clinic visits by more than half. [[33]](#footnote-34) According to Harm Reduction International, 47 of the 84 countries that provide opioid substitution therapy were providing expanded take-home supplies to clients in 2020, and 23 countries provided home delivery or dosing through pharmacies or outreach programmes to ensure continued access[[34]](#footnote-35)

Communities of people living with HIV and key populations have stepped up and organized to provide their peers with ARVs during the lockdowns. They have developed systems of front door delivery of ARVs in many countries including Zambia, Vietnam, Uganda Moldova[[35]](#footnote-36) and Jamaica.

The Eurasian Women’s network on AIDS with support from UNFPA launched a hotline to help people living with HIV and key populations who have difficulties accessing antiretroviral therapy services and reproductive health services.[[36]](#footnote-37)

In the Asia Pacific region, a regional COVID19 relief fund supported 12 organizations led by young people in 9 countries with various projects including the delivery of antiretroviral therapy to the doorsteps of People living with HIV.[[37]](#footnote-38)

The pandemic has also spawned the use of digital technologies to enable patients to access essential healthcare services remotely without having to leave their home in order not to risk exposure to COVID19 on their way to or in the health center. In Lesotho the Ministry of Health and UNICEF are providing remote health counseling, via WhatsApp messages and phone calls including sexual and reproductive health for young men and pregnant or breastfeeding adolescent girls and women.[[38]](#footnote-39) UNESCO has adapted the existing Let’s Talk campaign in 21 countries in eastern and southern Africa by using social media to generate dialogue and information on education, health and rights.[[39]](#footnote-40) The Eurasian Union of Adolescents, Teenergizer, has provided sex education and reliable information on COVID19 and HIV through live broadcasts, videos and articles on social media.[[40]](#footnote-41)

England, France and Ireland are allowing remote consultations for patients seeking abortions and France is ensuring continued delivery of contraceptive pills even if they were not able to renew their prescriptions.[[41]](#footnote-42)

UNAIDS has helped hundreds of stranded people living with HIV, who were unable to return home due to COVID19 travel restrictions, by helping them to obtain ARV therapy abroad in Eastern Europe, Angola and India.[[42]](#footnote-43)

**In connection to questions 1 to 3, please also share other relevant information on legal, policy or other changes affecting the right to sexual and reproductive health and related health care in your country or countries in focus, unrelated to COVID-19.**

Please refer to the UNAIDS additional submission for information on the new strategy and political declaration and other work by UNAIDS is this area.

1. **Please indicate if your country, institution or organization has been affected by a decreased in financial support or aid, including through international cooperation, compared to pre-COVID time, and how this has affected sexual and reproductive health care.**

The annual funding which UNAIDS receives from the United Kingdom of Great Britain and Northern Ireland has been reduced by more than 80% in 2021 compared to pre-COVID levels from 2020. It has gone from 15 million GBP to 2.5 million GBP.

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