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MENA

COMPILATION OF THE RESULTS OF COMMUNITY CONSULTATIONS ORGANIZED ON THE OCCASION OF THE PREPARATION OF C19RM GRANT APPLICATIONS FROM THE GLOBAL FUND IN EGYPT, MOROCCO, MAURITANIA, SOMALIA SUDAN AND TUNISIA

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Amira Medimagh
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TABLE OF CONTENTS

ABBREVIATION 2

EXECUTIVE SUMMARY 3

I. INTRODUCTION 4

II. COMMUNITY CONSULTATION FRAMEWORK: THE COVID-19 RESPONSE MECHANISM (C19RM) 4

III. GF GUIDELINES FOR COMMUNITY PARTICIPATION AND PRIORITIZATION OF NEEDS ..5

1. Seven categories of intervention related to community systems 6
2. Active engagement of communities and civil society in Global Fund processes during the COVID-19 crisis 6
3. Human rights and gender equality 7
4. Priority programming for key and vulnerable populations 7

IV. COUNTRY PROCESSES 8

V. COMMUNITY CONSULTATION RESULTS 9

1. Mitigations for control programs 9
2. Prevention of gender-based violence and care for victims of violence 14
3. Responses to human rights and gender-related barriers to accessing services 15
4. COVID-19 CSR (Community Systems Strengthening): Community Monitoring 17
5. COVID-19 RSC: Institutional Capacity Building of Community-Based Organizations 19

VI. FINDINGS AND CHALLENGES 19

1. Effective inclusion/engagement of communities most vulnerable to the three diseases 19
2. Deadlines and periods for preparing the grant application 19
3. Themes/interventions discussed and prioritized 19
4. Place of the community response to COVID-19/ "Competition" with the share of the grant dedicated to COVID-19 control in the country 20
5. Opportunity to build community and program resilience? 20
6. Innovation in proposals/opportunities to accelerate the response? 20
7. Re-imagining how GF grants are managed? 20

VII. RECOMMENDATIONS 21

VIII. CONCLUSION 21

ANNEXE 22

ABBREVIATIONS

AGD	Association of Managers for Development
ATP+	Tunisian Association of Positive Prevention
CCM	Country coordination mechanism
PPE	Personal protective equipment
GF	Global Fund
MSM	Men who have sex with men
ITPC	International Treatment Preparedness Coalition
LGBTIQ	Lesbian, Gay, Bisexual, Trans, Intersex, Queer
MENA	Middle East and North Africa
KVP	Key and vulnerable populations
PLWHIV	Person Living with HIV
RDR Morocco	National Association for Drug Harm Reduction
AIDS	Acquired Immune Deficiency Syndrome
TB	Tuberculosis
ICT	Information and communication technologies
TS	Sex worker
UDI	Injectable Drug Users
HIV	Human Immunodeficiency Virus

EXECUTIVE SUMMARY

The objective of this document is to compile the recommendations from the various **community consultations** conducted in 6 countries (Egypt, Morocco, Mauritania, Somalia, Sudan and Tunisia) between May and July 2021 and supported by the ITPC-MENA platform, to analyze the results and to draw out the challenges and learnings for the next opportunities to support communities in responding to the three diseases.

The disruption of **HIV, TB and Malaria** prevention and care services due to the health crisis was noted in all countries. All countries emphasized the need to bring **HIV and TB** care and prevention services closer to the most **vulnerable groups and key populations**. The establishment of community-based models for the distribution of drugs (ARV and TPT) with the delivery of treatment for several months was recommended in all dialogues. The need to establish a social contract between the relevant authorities and civil society to strengthen access to **HIV**, **TB and Malaria** services in times of **COVID-19** was recommended in several countries (Somalia, Mauritania, Morocco), which would represent a considerable step forward in the fight against the 3 diseases and guarantee a rapid adaptation to crises. The Moroccan workshop highlighted the importance of scaling up PrEP and self-testing in order to catch up with the **HIV** response during the health crisis.

The epidemiological situation has aggravated the isolation and precariousness of the most vulnerable, the accentuation of stigmatization as well as the violence of the authorities towards **key populations** has accentuated the social malaise and its impact on mental health. The recommendation to strengthen the psychological support capacities of the **KVPs** was made in almost all the meetings. It was also proposed to develop active listening services and discussion groups for people living with **HIV** and **key populations**. The provision of nutritional support for **KVPs** and **PLWHIV** most affected by the crisis as well as the provision of emergency shelter assistance for those who have been rejected from their homes or victims of violence was also a recommendation made in all countries. The issue of security and training for community workers was raised in several countries, including the need to provide the necessary authorizations for community workers and to institutionalize their status.

Several proposals were put forward to fight stigmatization, such as better knowledge of the human rights obstacles faced by the communities most affected by the three diseases and sensitization of health professionals working in the **COVID-19** management services. Strengthening the existing community observatory mechanisms was the main recommendation for supporting community monitoring.

The challenges noted are mainly related to the representation of the **KVPs** in the workshops organized in this framework, as not all groups were represented, the question of representativeness is also to be considered. The very short deadlines imposed on all the countries to prepare the proposals also had an impact on the involvement of the **KVP**. It was noted that the themes of "community monitoring", "community mobilization" and "advocacy and community research" were the least developed during the meetings, and few recommendations were developed around them. The issue of CSO resilience and the response in general was not addressed.

It is recommended that, following these 6 **community dialogues**, communication on the **C19RM** be made in advance to the response actors in order to guarantee favorable conditions for the preparation of future grant applications under this mechanism, to better adapt the deadlines for submitting applications to the resources and constraints of the country teams, to advocate for a clear positioning of the GF as to the share of the grant that should be dedicated to the strengthening of community action, and to place resilience among the priorities to be discussed by the response actors on the occasion of new grants. It would also be relevant to conduct an in-depth analysis of how the results of the **community dialogues** are taken into account in the final grant applications in terms of the nature of the activities taken into account and the percentage of the budget dedicated.

I. INTRODUCTION

The Global Fund's regional platform for North Africa and the Middle East, in its mission to support civil society organizations and communities in the region's countries in strengthening their role in the response to the three diseases, supported six countries (Egypt, Morocco, Mauritania, Somalia, Sudan, and Tunisia) in conducting dialogue with communities as part of the preparation of the **C19-RM** grant applications of the GF.

The objective of this document is to compile the results of the various **community dialogues** and consultations conducted in the countries supported in order to analyze the processes put in place and the results achieved with a view to drawing lessons and learning. This compilation will be a practical tool for countries to use for future funding requests in order to better integrate the action priorities identified by the most affected communities in the response to the three diseases.

This document is therefore organized around 5 main sections:

1. **Community Consultation** Framework;
2. GF Guidelines for Community Involvement and Prioritization of Community Needs;
3. Country processes;
4. **Community Consultation** Results;
5. Findings and challenges;
6. Recommendations.

This report is based on an in-depth reading of the reports of the **community dialogues** as well as on information gathered during interviews with experts who accompanied the **community dialogues** in the countries.

The technical notes produced by the GF as part of the country support for the response to **COVID-19** were used to structure the presentation of the results of the dialogues and to analyze them.

II. COMMUNITY CONSULTATION FRAMEWORK: THE COVID-19 RESPONSE MECHANISM (C19RM)

The **C19RM** is a support mechanism launched by the GF in 2020 to help countries address **COVID-19** and mitigate its impact on **HIV**, **TB, and malaria** programs. The **COVID-19** pandemic continues to have a devastating impact on global health systems, jeopardizing the fight against **HIV**, **TB, and malaria** and progress toward the 2030 targets for these three diseases[1].

The GF launched a first installment of the **C19RM** in 2020 and is launching a second in 2021.

The C19RM is intended to help eligible countries address **COVID-19** in three ways:

1. **COVID-19** control and containment interventions, including personal protective equipment (PPE), diagnostics, treatments, communications, and other public measures as provided for in the World Health Organization (WHO) guidelines;

2. **COVID-19** risk mitigation measures for **HIV, TB, and malaria** programs, including support for **COVID-19** interventions required to safely implement campaigns and programs for the three diseases at the health center and community levels. Reducing delivery and procurement costs for the three diseases to prevent disruption due to the pandemic is also targeted;

3. Increased strengthening of key aspects of health systems (laboratory networks, supply chains, community-based response systems) to address advocacy, services, accountability and human rights approaches.

[1] COVID-19 Response Facility Guidelines, April 27, 2021

Applicants may apply for **C19RM** funding in two stages:

1. **C19RM** Fast Track Application: Applicants may submit an initial application for C19RM Fast Track funding to address urgent needs for **COVID-19** health products (PPE, diagnostic equipment, and treatments, as defined in the optimal category of the Health Product Segmentation Framework).

2. Full **C19RM** funding application: after submitting a fast-track **C19RM** funding application, applicants have additional time to prepare and submit the remainder of their C19RM funding application, which includes additional interventions, if needed, under the three eligible investment categories. In addition to full CCM approval, the **COVID-19** control and containment interventions under the full funding application must be approved by the national **COVID-19** response coordinating body.

This is a rather exceptional granting mechanism as it requires the involvement of all stakeholders in the **COVID-19** response to define the country's needs in the fight against the disease. The interventions developed must be fully in line with the national response plan for **COVID-19** and the WHO guidelines (the 9 pillars of the WHO Global Strategic Response Plan).

For full **C19RM** funding applications, effective community and civil society participation, including support for community-based initiatives, remains essential to the development of a robust response to the pandemic, both in terms of mitigating the impacts on **HIV, TB and malaria** services and strengthening the national response to **COVID-19**. Countries are required to consult, at a minimum, with national **HIV, TB, and malaria** program managers; civil society; key and vulnerable populations; and communities, especially those most severely affected by **COVID-19**. This includes CCM members and representatives of entities other than the CCM.

III. GF GUIDELINES FOR COMMUNITY PARTICIPATION AND PRIORITIZATION OF NEEDS

The threats posed to countries by the **COVID-19** pandemic are significant and multifaceted, with potentially devastating effects on morbidity and mortality for individuals and on health systems. In addition, a disproportionate, discriminatory, or unscientific response also threatens basic health rights, particularly access to health services for the most marginalized communities. On the one hand, well-established **HIV, tuberculosis, and malaria** services may be disrupted, and on the other hand, some people from **key populations** (who already faced many barriers to accessing services before the **COVID-19** pandemic) may face social rejection and denial of care (as undeserving of care) in health facilities overwhelmed by an influx of potential disease patients. Quarantine or isolation can lead to coercive measures or situations in which the basic needs of those quarantined are not met. Women, children and adolescents may find themselves trapped in their homes and facing interpersonal violence with no possibility of escape. Detainees, migrants, and refugees, among others, will face increased risk of exposure to disease. They may not be able to comply with physical restraints and, in many cases, have access to adequate sanitation facilities for regular and effective hand washing. Stateless or irregular persons may also face additional difficulties in accessing information and medication. Other measures, including legislative or policy measures, adopted by governments to control the spread of **COVID-19** may be implemented in ways that result in human rights violations (including violence and other abuses). In addition, some measures proposed for public health reasons may not be consistent with international human rights standards, notably because they are unnecessary, disproportionate, or discriminatory. In some cases, these measures may interfere with the dissemination of scientific information about **COVID-19**, if governments believe that such information, while factual, is disruptive or even contradictory to the messages they wish to convey about the pandemic and the response to it. Finally, a positive diagnosis of **COVID-19** may lead to rejection in families, communities, homes and workplaces, even if the affected person has fully recovered[2].

[2] Guidance Note: Human Rights in a Time of Pandemic from COVID-19, April 2020

1. SEVEN CATEGORIES OF INTERVENTION RELATED TO COMMUNITY SYSTEMS

Six interventions address community systems and responses. They focus on removing human rights and gender-related barriers to accessing services, community monitoring, community-led advocacy and research, social mobilization, strengthening community linkages and coordination, institutional capacity building, planning and leadership development, and gender-based violence prevention and care. The input of communities, including **key and vulnerable populations**, into community-based systems and responses is an essential component of the response to **COVID-19**.

A seventh category of intervention that requires community participation is that related to mitigating the impact of **COVID-19** on the three disease programs.

2. ACTIVE ENGAGEMENT OF COMMUNITIES AND CIVIL SOCIETY IN GLOBAL FUND PROCESSES DURING THE COVID-19 CRISIS

Strong community mobilization is critical to maintain the momentum to meet global targets and to ensure that the **COVID-19** pandemic and the response to it do not lead to negative consequences such as increased discrimination **against key populations**[3].

Surveys show that human and financial resources from government disease control programs have been reallocated to the **COVID-19** response. Communities are needed more than ever and are ideally positioned to provide warning, advice and services.

To respond effectively to the challenges posed by the **COVID-19** pandemic, communities must be involved in all phases of an activity: design, decision making, implementation, and monitoring. These activities will need to take into account the gendered impacts of the pandemic, including in areas such as the gender digital divide, the increase in gender-based and intimate partner violence, and the particularly sharp increase in poverty among women. Communities need to be able to communicate, provide relevant information, and protect their frontline health workers.

[3] Examples of community, rights and gender-related investments during the COVID-19 pandemic: synthesis of policy briefs and recommendations from civil society and communities, 20 April 2021

3. HUMAN RIGHTS AND GENDER EQUALITY

During this crisis, a rights-based and gender equality approach is important to consider in adapting and implementing programs. This will allow countries to respond more effectively to **COVID-19** and mitigate the potential negative impact of the pandemic on programs. In order to do this, it is recommended to:

a) Paying due attention to the most vulnerable and **marginalized populations**;

b) Restrict disproportionate, unscientific or discriminatory measures;

c) Promote community participation in its programming, policy and decision-making processes.

The Global Fund has also established five minimum standards that all implementers must meet (a mandatory requirement in any grant agreement signed with the Fund):

a) Ensure access to services for all without discrimination, including those in detention;

b) Use only scientifically approved and proven medications or medical practices;

c) Not use methods that constitute torture or are cruel, inhuman or degrading;

d) Respect and protect informed consent, confidentiality and privacy rights regarding medical screening, treatment or health services;

e) Avoid medical detention and involuntary segregation, which should be used only as a last resort.2

4. PRIORITY PROGRAMMING FOR **KEY AND VULNERABLE POPULATIONS**

These populations are particularly vulnerable to **COVID-19** and during the **COVID-19** pandemic because of the number of risks, behaviors, and pre-existing social rejection and discrimination, as well as the threat of service disruption. The response to **COVID-19** in many settings exacerbates the problems that many **key populations** face, including economic distress and access to health care that does not result in social rejection. **Key and vulnerable populations** need access to services such as: prevention services, adherence support, testing, multi-month antiretroviral payment, pre-exposure prophylaxis, intimate partner violence services, and LGBTQI-friendly shelters.[2]

IV. COUNTRY PROCESSES

Between May and July, the MENA regional platform supported community dialogues in six countries alongside other partners in the preparation of full **C19RM** grant applications.

Country	Period	Events	Organizer	Actors involved	Support available
Egypt	June 22-24, 2021	A face-to-face workshop	Al Shehab	NACP, representatives of 11 NGOs from 6 governorates, PC, **PLWHIV**	ITPC-MENA, UNDP
Mauritania	May 20, 2021	Face-to-face workshop	AGD	The network of associations of people living with **HIV**, The network of **tuberculosis** organizations, The Association representing **key populations Malaria**, The SOS Pairs Educators association, The STOP SIDA association Nouakchott Solidarity Mauritanian Association for Mother and Child Health	ITPC-MENA
Morocco	May 20, 2021	Face-to-face workshop	RDR-Morocco	Representatives of **key populations** (sex workers (SWs), injecting drug users (IDUs), men who have sex with men (MSM), and **PLWHIV**) in the CCM Morocco and a representative of youth, non-CCM Morocco and CCM Morocco member and non-member associations	ITPC-MENA, CRF, AHSUD
Somalia	May 10-18, 2021	More than 10 virtual meetings with CSOs	GF Steering Committee (GFSC)	Civil society, KVP, GFSC member community representatives and the **C19RM** technical working group	ITPC-MENA CRG through Frontline Aids
Sudan	June 2021	5 focus groups	CCM	PLWHIV, CSOs human rights and GBV, CSOs Malaria and private sector, MSM	ITPC-MENA
Tunisia	Between June and July 2021	13 focus groups and a feedback workshop	ATP+.	MSM, MSM, PLWHIV, Women who are GBV, IDU, LGBTQI++	ITPC-MENA, CRG through Initiative 5%, Expertise France

V. COMMUNITY CONSULTATION RESULTS

The results of the **community dialogues** held in the six countries are presented here by type of intervention and activity as they appear in the GF Modular Framework[4]. The full list of recommendations by country is in the appendix.

Interventions related to advocacy and community research and social mobilization were grouped with interventions related to addressing human rights barriers due to the overlap of recommendations between the three themes and the limited development of these themes in the community meetings.

1. MITIGATIONS FOR CONTROL PROGRAMS

Since the start of the **COVID-19** pandemic, prevention services for **key populations**, testing for the disease, and provision of antiretroviral treatment have been heavily impacted. Countries have been called upon to adapt and innovate across the **HIV** service cascade, including in the following areas

HIV prevention: revive, adapt, and increase the supply of integrated sexual and reproductive health and **HIV** prevention services, focusing on populations with the greatest needs (key populations in all geographic areas; adolescent girls and young women and their sexual partners in high burden settings).

HIV testing: stay focused on early diagnosis: prioritize differentiated testing strategies, scale up self-testing (especially for populations that do not come forward or do not have access to facility-based testing). Continue screening in prenatal care and early infant diagnosis. Ensure linkages to provide access to antiretroviral treatment.

The management of **COVID-19** for **PLWH** (protection, testing, and vaccination) should be in accordance with local guidelines.

Commodity security: anticipate inventory and supply issues (shipping delays, potential increase in needs, adaptations required to deliver essential health commodities to people living with **HIV**)

Health workers: Protect the safety and morale of all health worker teams providing **HIV** services and help them perform new tasks when reassigned.

Social protection and human rights: Strengthen existing service delivery platforms to address human rights violations, including gender-based violence.

Community Response: support the development, adaptation and delivery of additional services through community-based organizations and the expansion of community monitoring.

Ongoing adaptation of pandemic-resilient service delivery: adopt person-centered models using pharmacies and other service and product delivery channels. Accelerate the use of digital health platforms and tools, as well as mobile applications, for communication, data visualization, and delivery of **HIV** prevention, testing and treatment services.

[4] COVID-19 Modular Framework, April 19, 2021

HIV treatment and related health care: Focus on early initiation of antiretroviral therapy following diagnosis and continuation of such therapy, ensuring its continuous supply to maintain or suppress viral load. People living with **HIV** (**PLWHIV**) in advanced stages should be cared for by skilled providers. The needs of different populations, including children and adolescents, must be considered[5].

- Adaptation of **HIV and TB** service delivery for prevention, testing, and treatment, with priority given to innovative service delivery methods, such as community-based models (e.g., point-of-sale, pharmacies, parapharmacies (drugstores) for product distribution; self-testing for **HIV**; community-based care) and "walk-in" models; take-home dosing (multi-month dispensing) for key prevention and treatment products; and accommodation in health facilities and community centers to modify patient flow and distribution.

A CLOSE CARE

Service delivery should be continuously adjusted to reduce the number of visits to health facilities by people who respond well to first-line antiretroviral therapy, and to reserve access to facilities for patients with advanced **HIV** infection or poor response to antiretroviral therapy. Minimize patient congregation by modifying the method of drug delivery or patient flow. There are currently no international recommendations to prioritize **PLWHIV** for prevention of **COVID-19**. These individuals must follow specific national guidelines.

The disruption of **HIV** prevention and care services due to the health crisis has been noted in all countries. Travel restrictions, confinement, and fear of infection on the way to services, as well as the deteriorating economic conditions of **PLWHIV** and **key groups**, are the main obstacles to accessing care facilities for **PLWHIV** and prevention services for **PLWHIV**.

All countries emphasized the need to bring **HIV and TB** care and prevention services closer to the most **vulnerable groups** and **key populations**.

The establishment of community-based models for the distribution of drugs (ARVs and TPT) with the delivery of treatment for several months was recommended in all dialogues. Covering the cost of transportation to treatment centers for the poorest was mentioned in Tunisia and Somalia.

The problem of access to follow-up biological examinations for PLWHA was discussed in Morocco and Tunisia, as laboratory resources were directed primarily towards **COVID-19** screening, which hinders quality follow-up of **PLWHA**. It was therefore recommended to facilitate the access of **PLWHIV** to biological monitoring services by setting up a partnership with the private sector (Morocco).

In Sudan, it was recommended that home-based care and mobile clinics be established for the follow-up of **PLWHIV** as well as for the distribution of malaria drugs. Community representatives in Sudan also emphasized the need to involve NGOs in the distribution of bed nets and indoor residual spraying. Logistical capacity building for NGOs is needed beforehand, as well as training for NGO staff and volunteers.

In Tunisia, the participants in the focus groups on **PLWHIV** recommended "developing telemedicine for diagnosis and prescriptions to avoid hospitalization and relieve congestion in emergency services."

THE SOCIAL CONTRACT

In Somalia, the need to revise policies for the implementation of community-based services for **HIV, TB and Malaria** was highlighted. In Mauritania, it was recommended to "Promote contractualization

> **Social contracting** refers to the use of government resources to fund civil society organizations to provide health services that are the responsibility of the government.

[5] Briefing Note: Mitigating the Impact of COVID-19 on HIV, Tuberculosis and Malaria Services and Programs, April 9, 2021

and partnership between public services and civil society in terms of intervention aimed at **key populations**.″**.** Indeed, the social contract is one of the mechanisms by which countries could integrate the programming and financing of **key populations** into national health programs and budgets[6].

In Morocco the general recommendation was to "Develop the national strategy for the community health system with the participation of CSO representatives and **key populations** and **vulnerable communities**".

COVID-19 AND HIV-TB-MALARIA

Bidirectional TB-COVID-19 screening: This has been recommended in Somalia, as studies have shown that a history of active and latent **TB** is an important risk factor for **SARS-CoV-2** infection. This not only increases vulnerability, but also leads to rapid and severe symptom development and disease progression.

It is therefore necessary to consider screening for **COVID-19** in patients with **TB** and vice versa in settings of high concurrent exposure to both diseases. This will entail the development of diagnostic algorithms, planning and building laboratory capacity to meet the needs of both diseases, and adherence to necessary infection control and prevention measures.5

Other recommendations for service integration are:

- Sensitization of **TB** patients on the importance of vaccination against **COVID** (Mauritania)
- Raising awareness among **PLWHIV** about the importance of vaccination against **COVID** (Mauritania)

Prioritizing key and vulnerable populations in accessing prevention services

In Morocco, recommendations were made for :

- Expanding access to PrEP and self-testing, including accelerating access to PrEP for sero-discordant couples,
- Accelerating access to testing, vaccination and care for key populations, PLWHIV, migrants, refugees and **TB** patients.

6 HIV and Key Populations Technical Briefing Note, October 2019, The FM

In Tunisia, IDUs drew attention to the challenges of accessing substitution therapy and recommended strengthening this aspect of the response. LGBTQI++ people raised the issue of the interruption of access to hormone treatments for people in transition.

In Somalia, the extension of services to migrant and displaced populations and refugees was discussed. The provision of mobile services to nomadic populations and to the prison population was recommended.

In Egypt, it was recommended that condom and syringe distribution be continued at new **key population** gathering places or focal points.

SOCIAL PROTECTION AND MENTAL HEALTH OF KVP

The **COVID-19** pandemic has amplified existing inequalities. KVPers often face many issues that are compounded by the pandemic-criminalization of behavior, stigma, discrimination, violence, loss of housing, food insecurity-that can increase their vulnerability to **COVID-19**[3].

Considerations specific to COVID-19

- **COVID-19** testing of **PLWH**: WHO recommends that countries focus on the use of molecular testing (or, if not available, rapid diagnostic tests [RDTs] for antigen detection) for clinically symptomatic people, but not for asymptomatic people. No specific recommendations were made regarding more frequent screening of **PLWH**.
- Vaccination against **COVID-19**: At this time, WHO does not recommend prioritizing vaccination of **PLHIV**. There is also no evidence that vaccination against **COVID-19** is less effective in these individuals. **PLHIV** should be vaccinated in accordance with national eligibility plans, prioritized according to age, health status (immune status, possible comorbidities), employment, and other factors (e.g., people living in health facilities).
- PPE: Regardless of vaccination status, PHAs should follow local guidelines for preventive measures against **SARS-CoV-2**.

The epidemiological situation has indeed aggravated the isolation and precariousness of the most vulnerable, the accentuation of stigmatization as well as the violence of the authorities towards **key populations** has accentuated the social malaise and its impact on mental health. Associations in Tunisia, for example, have been overwhelmed by the demand for psychological support and their resources have been rapidly exceeded. The recommendation to strengthen the psychological support capacities of the KVPs was indeed made in almost all the meetings. It was also proposed to develop active listening services and discussion groups for people living with **HIV and key populations**.

In Morocco, it was suggested to hold ***"Information and awareness campaigns on the psycho-social consequences of the COVID-19 pandemic"*** and to create mutual aid networks between community members as well as to support citizen initiatives of music, dance, theater...

The establishment of hotlines for psychological support was discussed during the workshop in Egypt as well as in Tunisia.

To ensure continued access to prevention services for **key and vulnerable populations** and to help those on treatment improve their health status, social protection may be necessary:

Nutritional support (and other livelihoods programs) for KVP and selected people living with or affected by diseases (**HIV, TB, malaria**);
Deploy existing rapid response mechanisms, including transitional shelters that provide comprehensive services to victims of gender-based violence and human rights violations;

This was recommended during meetings with communities in all countries:

"Helping key populations to ensure their self-sufficiency during containment through the availability of food and foodstuffs" (Mauritania)

"Provision of a food basket to PLWHIV to reduce the negative economic impact of containment and COVID19 in general." (Sudan)

PROTECTION AND TRAINING OF HEALTH WORKERS

Health workers in all teams (facility-based providers, community health workers, peer educators, outreach workers) are critical to the response to **COVID-19** and to the delivery of **HIV** services. Programs must protect their safety and morale and ensure that they are appropriately trained to provide **HIV** services and to perform new tasks when reassigned.5 In settings where containment is a concern, the program must ensure that all staff are trained to provide **HIV** services. In strict containment settings, ensure that program implementers, including community-based workers, have written authorization for the provision of goods/services to prevent police harassment, and that they also have the necessary personal protective equipment[7].

The issue of security and training of community agents was raised in Morocco, Tunisia, Mauritania, Somalia and Egypt

The recommendations were as follows:

Capacity building of community agents on **COVID-19** issues (Tunisia, Morocco, Mauritania)
PPE provision for community workers
Guarantee the safety of community agents during field missions (authorizations and PPE):
"Protection of community agents from any abuse by agents of authority" (Morocco)
Guaranteeing community agents their rights at work and ***"Supporting the initiation of advocacy for the institutionalization of the work of community agents" (Morocco***). In Tunisia, the issue of the security of community agents was also discussed at length during the workshop with the CSOs, as well as the formalization of their function and its recognition by the ministry.
Psychological support to NGO professionals to avoid burn-outs (Egypt).

Development and intensification of electronic information dissemination, behavior change communication and virtual platforms and social networks; digital health platforms.

Virtual **HIV and TB** service interventions can address critical bottlenecks in **HIV** programs today, including mitigating the impact of **COVID-19** on traditional face-to-face outreach and service delivery activities, while modernizing them for the mobile generation especially with the increasing use of digital technologies among **key and priority populations**. However, the slow adoption of these approaches left many programs without alternative modes of service delivery when **COVID-19** hit. Since 2020, the physical distance and containment measures associated with **COVID-19** have limited **HIV** outreach and face-to-face service delivery and threaten to stall progress in the global HIV response.

CSO representatives in Morocco suggest the ***"Creation of virtual platforms for launching messages on self-care.***

In Tunisia, focus groups with the MSM/LGBTQI population made recommendations regarding the use of digital means to disseminate information and raise awareness about SRH issues: ***"Improve digital prevention related to sexual and reproductive health and the AIDS response.***

[7] COVID-19 Guidance Note: Community, Rights and Gender, May 2020

Technical assistance in the development and implementation of costed mitigation plans with service adaptations.

The health crisis related to **COVID-19** is expected to continue, according to the experts, so it is important for CSOs and national programs to adapt to the situation and anticipate the risks. The **C19RM** represents an interesting opportunity for eligible countries to strengthen the resilience of the response and in particular to analyze risks and develop a budgeted mitigation plan. This is particularly relevant as some countries are in the process of post-GF transition or will be in the near future.

This issue was raised in Tunisia and Morocco. In Tunisia, the recommendations were to strengthen the actors in crisis response. In Morocco, the associations participating in the dialogue clearly recommended conducting a study on the impact of **COVID-19** on **HIV and TB** programs.

2. PREVENTION OF GENDER-BASED VIOLENCE AND CARE FOR VICTIMS OF VIOLENCE

Lockdowns, curfews, and other restrictions on movement save millions of lives in times of pandemic. For women and girls, however, these measures increase the risk of violence and violent death. There has been an increase in gender-based violence since the beginning of the **COVID** pandemic[8].19 Some countries have reported a 56 percent increase in gender-based violence since the beginning of the pandemic. Some countries have reported a 56% increase in GBV events in the first two weeks of containment (UN Women). In low-income countries, an estimated 37% of women have experienced intimate partner violence, a proportion that may be as high as 50% in some countries (WHO). Exposure to GBV and IPV is strongly associated with an increased risk of **HIV** infection or, for those living with **HIV**, a deterioration in their health status.8

In several countries in the region, CSOs have faced increased demands for support for LGBTQI people and women experiencing domestic violence, including a demand for emergency shelter assistance.

Training for frontline staff and volunteers on psychological first aid, referral pathways for victims of gender-based violence, support for survivors, and dissemination of information about available services, including remote services such as hotlines.

The recommendations in this sense were:

> Training and sensitization of law enforcement officials on human rights and GBV issues and training of doctors and nurses who provide medical care to survivors (Sudan).
> Train frontline workers, peers, and volunteers during **COVID-19** interventions on psychological first aid and referrals to hospital, police, legal support, social protection, and other support (Somalia).

[8] Briefing Note on the COVID-19 Response System, April 8, 2021

Support to existing help lines (temporary staff, training materials, communication tools, etc.) in Sudan, the one hosted by the Ministry of Social Affairs.

Counseling, referral and linkage to post-exposure prophylaxis for victims, clinical investigations, medical management, clinical care, forensic management, forensic services, and psychosocial support, including mental health services and counseling in relation to pandemic control measures

In Sudan, it was proposed to improve the infrastructure of police stations (as a starting point, support the three women and children protection units present in Khartoum) with the provision of post-exposure prophylaxis.

Development and implementation of systems for liaison with protective services (police, neighborhood watch, peer counsellors, etc.)

In Somalia, CSOs have proposed forcing women's activities in communities to act as a bridge between women and services for victims of violence.

Support for women and key affected populations , with linkages to access to justice or legal remedies interventions for human rights violations arising from restrictive pandemic measures.

In Tunisia, during focus groups with CPs and women victims of violence, the absence of emergency assistance mechanisms for women and MSM victims of violence was clearly noted.

It was recommended to ***"strengthen support mechanisms for women victims of violence (material aid, emergency accommodation, housing aid, care, psychological support, transportation costs, hygiene products)"***, and to make more human and financial resources available to support institutional actors in their role of accompanying vulnerable persons.

In Sudan, drop-in centers have been proposed to provide comprehensive care and shelter for victims of gender-based violence.

3. RESPONSES TO HUMAN RIGHTS AND GENDERRELATED BARRIERS TO ACCESSING SERVICES

During the health crisis, the problems that some populations may encounter:

- Sex workers: crackdowns on sex work, brothels, or sex worker collectives in the name of combating the **COVID-19** epidemic; lack of safety nets for those who lose their livelihoods to the epidemic; insufficient access to information and harm reduction for those who would continue to work.
- Transgender people and men who have sex with men: crackdown on safe spaces in the name of addressing the **COVID-19** epidemic; lack of resources, including prevention commodities, etc.
- Drug users: limited access to basic services that were in place prior to the pandemic, including daily availability of sterile smoking and injection equipment, access to daily opioid agonist treatment, access to **HIV** or hepatitis C treatment, etc.; for opioid agonist treatment, provide at least one week's or even one month's supply to limit visits to health facilities; needle distribution programs to exchange more needles. For opioid agonist treatments, provide dispensation for at least one week or even one month to limit visits to health facilities; syringe distribution programs that allow for the exchange of more than one syringe at a time (a good practice already developed to prevent **HIV** or HCV infection, and now even more important to limit visits to distribution points); scientifically-based information on the risks of transmission of **SARS-CoV-2** through contaminated injection equipment, the risks associated with the presence of underlying medical conditions, the importance of physical distancing, etc.
- Refugees, asylum seekers, and others forced to migrate: increased difficulties in accessing health services, including VCT services.19 Program planners and implementers should refer to the Global Fund guidance note on programming for human rights and gender interventions in difficult settings.
- Minorities and indigenous peoples who experience entrenched systemic discrimination limiting their access to health services are likely to lack information about how to prevent disease, due to

language barriers or limited access to national media. They may also experience increased rejection by a stressed health care system that may prioritize others.2

Reducing stigma and discrimination: Activities to reduce **HIV- and TB**-related stigma and discrimination, including media campaigns, can be modified to include stigma reduction and the rights of patients and health care workers in the context of the **COVID-19** pandemic. Advocates experienced in stigma-reduction efforts should be empowered to monitor and combat stigma related to **COVID-19**, including medically unnecessary measures such as publishing the names or contact information of those diagnosed with the disease.

It was clear during the meetings with community representatives in all countries that the increased stigma towards **PLWHIV** and PCs since the beginning of the crisis and the exacerbation of the effects of this rejection on the lives of these groups is a common concern. Indeed, this aspect has been prioritized in the majority of countries and the recommendations for reducing discrimination are as follows:

- Collect data on the situation of **PLWHIV** and **PLWHIV** and the obstacles to accessing human rights in the context of **COVID-19** (Tunisia, Morocco). Create an observatory of human rights in health (Morocco).
- Community mapping of legal, policy and other barriers that impede/limit the community response (including barriers to registration and funding of community-based organizations). (Mauritania)
- To sensitize health professionals working in VCT-19 services on issues of stigma and discrimination against CPs and **PLWHIV** as well as VCT and **TB** patients. (Tunisia, Somalia)
- Involve religious and community leaders in raising awareness about the violation of KVP rights in the context of **COVID**. (Somalia)
- Develop information, education and communication campaigns aimed at stakeholders working in the field of health, the police, the media, etc., in order to fight discrimination and stigmatization against people living with **HIV and key populations** (Tunisia, Morocco)

Training of health care workers in human rights and medical ethics: Instead of large face-to-face training sessions for health care workers, these trainings can be delivered in a different way and can include information about **COVID-19**, including messages about stigma and the need to provide services to **key and vulnerable populations** without discrimination, as well as the importance of confidentiality and informed consent. Health care workers will also need to be regularly informed of their rights to protection from disease and compensation in the event of occupational infection.

In Somalia, it was recommended that human rights and anti-stigma issues be integrated into the training curriculum for health professionals in response to **COVID-19** and in educational settings.

Sensitization of legislators and law enforcement officials: There has been an increase in violence by law enforcement officials against CPs and community workers, and restrictions on movement and confinement have contributed greatly to this. Targeting these actors becomes essential in limiting the obstacles related to human rights violations.

In Tunisia and Morocco, it was recommended that information and awareness campaigns be organized for law enforcement officers. It is certain that formalizing the status of community workers and/or granting the necessary authorizations by the competent ministries could contribute significantly to limiting violence and police repression.

Legal Services: If legal or legal aid services can continue to operate over the Internet or by telephone, they will need to be supported in order to address **COVID-19** issues. However, the support they usually receive will need to be maintained or even increased so that they can focus on the continuing needs and rights of key populations for **HIV, TB, and malaria**, and those of recently released prisoners, as well as issues such as interpersonal violence in quarantine situations, all of which may be exacerbated in the context of the **COVID-19** pandemic.

In Tunisia, CPs and PLWHIV strongly recommend building the capacity of community-based organizations offering legal support so that they can meet the increasing demand and adapt their services to the **COVID-19** context. The use of new tools for delivering legal aid such as telephone consultations was also suggested by MSM.

The need to support migrants and asylum seekers in regularizing their administrative situation in Tunisia was clearly expressed during the focus group with migrants.

Legal Education or "Know Your Rights": These programs currently focus on **HIV, TB, and malaria** and can be expanded to include simple and accessible information about VCT-19 services, the rights of people diagnosed with the disease, the rights of people in isolation or quarantine, and the rights of health care workers.3

In Morocco and Tunisia, representatives of CPs and **PLWHIV** felt that it was important to build their capacity to better understand their rights and the avenues available to defend them.

PCs' use of digital tools to overcome stigma-related barriers

The ability of community-based organizations and **key population groups** to reach their constituents with information about VCT-19 and other health services is critical. If face-to-face meetings are not possible, these groups and organizations should be encouraged and supported to establish and use networks via cell phones, Internet platforms, community radio, or other means to reach **key populations**. Community-based organizations should be supported to develop accessible information about **COVID-19** tailored to the needs of particular **key populations**, and to maintain, where possible, non-traditional venues where health services are offered to key populations (drop-in centers, etc.).2

The use of digital tools to increase access to **HIV and TB** services was discussed in the majority of countries.

In Egypt, community representatives discussed the possibility of developing WhatsApp groups to reach out to **PLWHIV** to set up the appointment and counseling system and to use Zoom to share educational videos.

In Tunisia and Sudan, PC participants suggested the establishment of online **HIV** and **COVID-19** information and referral services.

4. COVID-19 CSR (COMMUNITY SYSTEMS STRENGTHENING): COMMUNITY MONITORING

Definition of community monitoring by the Global Fund

Mechanisms that service users or local communities use to gather, analyze, and use information on an ongoing basis to improve access to, and the quality and impact of, services, holding service providers and decision makers accountable.

Community monitoring refers to the evaluation by service users of the effectiveness, quality, accessibility and impact of the health services and programs they receive. It includes any type of monitoring conducted by communities. However, an essential element of community monitoring is that communities decide what they will evaluate and act on the data collected.
In contrast to health systems-led or -directed monitoring, community-based monitoring initiatives essentially result in advocacy that is based on evidence and collected observations[9].

Development, support and strengthening of community-based mechanisms to monitor: availability, accessibility, acceptability and quality of services (e.g., observatories, alert systems, dashboards); health policy, budget, resources and funding allocation decisions; and complaints and grievance mechanisms:

In Somalia, discussions with CSOs about community monitoring revolved around scaling up existing initiatives. For example, it was recommended that the Citizen Monitoring and Advocacy (CMA) initiative already in place in some regions be expanded. Several local organizations working with communities will benefit from training in community monitoring and will be able to empower individuals and groups to monitor and report cases of GBV, violation of rights and stigmatization, as well as obstacles to accessing **HIV, TB and malaria** services.

In the other countries, the recommendations of the associations were directed towards strengthening the community observatory of RDR Morocco and ITPC in Morocco and the FORSS project of ATP+ in Tunisia.

In Sudan, it has been proposed to establish mechanisms for community monitoring and reporting of malaria drug stock-outs with the support of the Ministry of Health.

Technical assistance and training in community monitoring:

In Tunisia, the concept of community-based surveillance was unknown to the majority of the participants in the focus group. The recommendations resulting from the country dialogue in this context are to promote the concept and the approach of community surveillance among associative actors, people living with **HIV and key populations** and to strengthen the capacities of people living with **HIV and key populations** in terms of leadership and community surveillance.

[9] Community Monitoring: Overview, May 2020, The Global Fund

5. COVID-19 RSC: INSTITUTIONAL CAPACITY BUILDING OF COMMUNITY-BASED ORGANIZATIONS

The need to strengthen civil society actors in crisis management and fundraising came out clearly as a recommendation in the country dialogue in Tunisia. It was also proposed to strengthen the associations for the use of ICT in their communication with the beneficiaries and to promote distance work (provide computer equipment, connection...). In Morocco, the associations proposed capacity building in leadership and networking.

VI. FINDINGS AND CHALLENGES

1. EFFECTIVE INCLUSION/ENGAGEMENT OF COMMUNITIES MOST VULNERABLE TO THE THREE DISEASES

Representation

Key populations were not represented in all dialogues. In some cases, this was due to the absence of community organizations representing them, and in other cases it was due to time constraints in mobilizing them.

In general, migrants, prisoners, youth and adolescents were poorly represented in the **community dialogues** and this was reflected in the recommendations from the meetings. Transgender people were also missing in almost all groups, so issues specific to these groups were hardly discussed.

Representativeness

It is legitimate to ask to what extent the persons or associations present can represent the **vulnerable groups** and thus accurately report their concerns and proposals.

The issue of legitimacy of constituency representatives in CCMs in MENA countries has been raised on several occasions. The dialogues in this framework brought together representatives of the CCMs of the countries.

Participation in discussions

Attendance at the events organized under this framework does not necessarily imply actual participation in the discussions. Representatives of **key populations** do not have the same capacity to speak and represent their group in their contributions.

2. DEADLINES AND PERIODS FOR PREPARING THE GRANT APPLICATION

All of the experts reported the challenge of the very short time frame allotted to the preparation of such a large grant application. These conditions did not always allow for the engagement of representatives from all affected communities or for representatives to return to their groups.

For Egypt, the preparation period for the **C19RM** application coincided with the country's **HIV and TB** grant, which also did not help to bring forward the needs and recommendations of the groups involved in the specific context of **COVID-19**.

3. THEMES/INTERVENTIONS DISCUSSED AND PRIORITIZED

The first theme, program impact mitigation, was the most developed in the country dialogues. Many recommendations came out of the discussions. However, as we move on to the other themes, notably community monitoring, community advocacy and community mobilization, the content of the discussions is increasingly poor and the recommendations few. This may be due to a lack of understanding of the topics discussed and the use of technical jargon that is inaccessible to those who do not work in the NGO sphere.

This is also true for gender-based violence. Indeed, the results of the discussions did not highlight the link between violence and **HIV** and the actions that can be implemented to strengthen the fight against GBV in the context of **COVID-19**.

In the majority of countries, prioritization was done according to activities, whereas what is needed for the grant application is a prioritization of interventions as they appear in the GF Modular Framework.

4. PLACE OF THE COMMUNITY RESPONSE TO COVID-19/ "COMPETITION" WITH THE SHARE OF THE GRANT DEDICATED TO COVID-19 CONTROL IN THE COUNTRY

Unfortunately, since we were not able to access the grant applications submitted by the countries to the MF, it was not possible to determine the percentage of the total grant budget that was dedicated to community interventions in each country or the degree to which the results of the dialogues were taken into account. It would be useful to conduct an in-depth analysis of the extent to which the results of the community dialogues were taken into account in the final grant applications in terms of the nature of the activities considered and the percentage of the budget dedicated.

In Somalia, a strong negotiation took place to keep at least 10% of the grant for community activities, but in the end less than 10% was dedicated to this component.

In the same country, discussions have taken place with the MF so that funds do not go through the PR but are disbursed directly to the RHs, which could be a new model for managing MF grants that gives more prerogatives to community associations while accompanying them.

5. OPPORTUNITY TO BUILD COMMUNITY AND PROGRAM RESILIENCE?

The **C19RM** represents a clear opportunity for countries to build or strengthen the resilience of the response system to the three diseases by anticipating risks and planning mitigation measures. Unfortunately, the issue of resilience was not addressed during the community dialogues. The related recommendations concern the development of an **HIV** program adaptation plan.

6. INNOVATION IN PROPOSALS/OPPORTUNITIES TO ACCELERATE THE RESPONSE?

PrEP and self-testing

The **C19RM** is an opportunity to scale up PrEP and self-testing programs in countries of the region that are relatively lagging behind in this area despite recommendations by UNAIDS and WHO.
This issue has been discussed in Morocco and recommendations have been made. In other countries no reference was made to it.

The social contract

Mentioned in two countries, if the recommendations are incorporated into grant applications, this could serve as an example to other countries in the region.

The use of digital tools

This aspect was widely discussed in the dialogues and a range of recommendations were made in this regard. The proposal of online services for awareness and information on the three diseases as well as to facilitate access to care services is ultimately an aspect to be developed by the countries of the region, while taking care that this does not exclude a category among the **vulnerable populations** not equipped with the necessary technical tools.

7. RE-IMAGINING HOW GF GRANTS ARE MANAGED?

The negotiations in Sudan open the door to questions about the adequacy of the current grant management arrangements. The **C19-RM** offers more flexible measures to adapt to the crisis

context, but these need to be strengthened. Community-based organizations could be a force for proposal in this context.

VII. RECOMMENDATIONS

- Ensure proactive communication about the **C19RM** to the response actors to ensure favorable conditions for the preparation of future grant applications under this mechanism.
- Better adapt application deadlines to the resources and constraints of country teams.
- Advocate for a clear GF position on how much of the grant should be dedicated to strengthening community action.
- Place resilience among the priorities to be discussed by the response actors on the occasion of new grants.
- Conduct an in-depth analysis of the extent to which the results of the **community dialogues** are taken into account in the final grant applications in terms of the nature of the activities considered and the percentage of the budget dedicated.

VIII. CONCLUSION

The **C19-RM** funding mechanism is an important opportunity for countries to address the **COVID-19** health crisis and adapt the response to the three diseases, which has been very disruptive. The CCMs in the six countries led the grant preparation process, managing the constraints of relatively short timelines, mobilizing **key and vulnerable groups**, and mobilizing resources for technical support.

Lessons must be learned from this experience, which will certainly be repeated in the coming months in order to ensure a response that is as close as possible to the needs of communities while strengthening their resilience to crises. Complementarity with other ongoing GF grants is also important to consider; the **C19-RM** should be an opportunity to accelerate the implementation or scaling up of differentiated approaches such as PrEP, self-testing, the use of digital tools to bring services closer together, the social contract between the HC and the authorities, and the integration of three-disease services into the **COVID-19** screening and management services

However, the **C19-MR** should not slow down the process of preparing for the post-GF transition that has begun in several countries and should contribute to the integration of **HIV, TB and Malaria** issues into other health programs as well as to the strengthening of national leadership in the response to the three diseases. Strong advocacy should be done in this regard, particularly by CSOs and national programs to fight the three diseases, with the GF and health authorities.

ANNEX: LIST OF RECOMMENDATIONS BY COUNTRY AND TYPE OF INTERVENTION ACCORDING TO THE GF MODULAR FRAMEWORK

Intervention according to modular framework	Tunisia
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	Improving digital prevention related to sexual and reproductive health and the AIDS response- Developing telemedicine for diagnosis and prescriptions to avoid hospitalization and relieve emergency services- Enabling safe access to essential health services for people living with HIV and key populations during times of crisis- Ensuring better access to prevention and care services related to sexual and reproductive health for people living with HIV and key populations in times of crisis - Promote access to HIV testing, in times of crisis- Provide psychological support to people living with HIV and key populations affected by the health crisis- Limit disruptions to access to antiretroviral treatment for people living with HIV by improving supply and providing multi-month treatment- Promote access to sterile injection equipment for injecting drug users, Make transitional procedures, such as hormonal treatments, surgical interventions and psychological support, more accessible to transgender people- Provide free means of prevention (hydroalcoholic gel, mask) against HIV to people in vulnerable situations- Strengthen the capacity of health professionals in crisis management Develop telemedicine for diagnoses and prescriptions and offer online consultations to avoid hospitalizations and relieve emergency services, in the context of COVID Provide free COVID prevention supplies (hydroalcoholic gel, mask) to gay and bisexual men and outreach workers To improve access to HIV services for gay and bisexual men while minimizing potential exposure to COVID-19 and promoting personal safety
2. Prevention of gender-based violence and care for victims of violence	Strengthen support mechanisms for women victims of violence, particularly those living with HIV (material assistance, emergency shelter, housing assistance, care, psychological support, transportation costs, hygiene products) Establish support mechanisms for LGBTQI+ people in vulnerable situations (material assistance, emergency shelter, housing assistance, care, psychological support, transportation costs, hygiene products) Fight against all forms of stigma, discrimination and violence against LGBTQI+ people in different contexts Promote the code of ethics respecting human rights and dignity to law enforcement and health care professionals Educate law enforcement on non-discrimination against women victims of violence and LGBTQI+ individuals
3. Responses to human rights and gender-related barriers to accessing services	Collect data on the human rights situation of people living with HIV and key populations, including discrimination based on gender, homophobia, HIV status, nationality, etc. Make more human and financial resources available to support institutional actors in their role of providing legal support to people living with HIV and key populations, especially those in vulnerable situations Develop and implement awareness campaigns on legal support for people living with HIV and key populations Build the human rights capacity of people living with HIV and key populations, including those in vulnerable situations Develop information, education and communication campaigns aimed at stakeholders working in the field of health, the police, the media, etc., in order to fight discrimination and stigmatization against people living with HIV and key populations Support migrants and asylum seekers in regularizing their administrative situation in Tunisia
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	Promote the concept and approach of community-based monitoring to community stakeholders and their beneficiaries, particularly in the context of COVID Build community members' capacity for community-based surveillance, particularly in the context of COVID-19 Developing leadership among selected community members, particularly in the context of COVID Strengthening the ATP+ community observatory
5. **COVID-19 CHR**: Community-based Advocacy and Research	Support the engagement of human rights-sensitive organizations, including the engagement of LGBTQI+ people, to conduct advocacy activities Promote the use of information and communication technologies in advocacy, particularly in the context of COVID
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	Promote the use of information and communication technologies to foster connections between community members, in the context of COVID-19 Organize face-to-face events in accordance with health protocol Develop active listening services, particularly in the context of COVID Implementing discussion groups, particularly in the context of COVID-19
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	Develop staff capacity in crisis management, including COVID-19 Promote remote work (provide computer equipment, connection, etc.), particularly in the context of COVID Strengthen the capacity of associations to interact with beneficiaries through information and communication technologies and digital prevention among gay and bisexual men, in the context of COVID-19 Develop internet discussion forums in the context of COVID-19 Strengthen institutional capacity for fundraising during crises, including COVID-19

Intervention according to modular framework	Morocco
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	Accelerating access to Prep for HIV discordant couples Scaling up HIV self-testing Accelerate access to testing, vaccination and COVID-19 management for key populations, PLWHIV, migrants, refugees and ex-TB patients. Scaling up SRH services geographically and to key populations, PLWHIV, migrants, youth and adolescents. Protection of community workers from abuse by police or law enforcement agents Prioritization of community workers' access to various HIV and COVID-19 health services Equipping community workers Training community health workers in COVID-19 (5) Facilitating and accelerating access to biological monitoring services for PLWHIV and IDU by setting up health/biological monitoring clinics in partnership with the private sector Accelerated resumption of psycho-social support activities Improvement of the mental health of key populations, PLWHA, migrants, refugees and youth**:** Information and awareness campaign on the psycho-social consequences of the COVID-19 pandemic (2) Creation of self-help networks between community members (2) Support for the realization of citizen activities and initiatives (music, theater, dance...etc) (2) **Continuation of HIV treatment and related health care**: ----Distribution of ARVs to PLWHIV in remote sites not covered by therapeutic mediators and other community agents (1) Updating of therapeutic education methods by community associations (2) Creation of virtual platforms for launching messages on self-care (4) Acceleration of access of key populations, PLWHIV, migrants, refugees and ex-TB patients to screening, vaccination and COVID-19 management services. Support for strengthening permanent outreach services for PLWHIV and key populations **Training of** community workers in issues related to COVID-19 Health protection of community workers (prioritization and guarantee of easy access to COVID-19, HIV and tuberculosis services) Equipment of community workers (telephone, tablet, information support, internet and other means) Safety of community workers during intervention in the field Capitalization on the protection of community agents **Protected and generalized access to Prep** Geographic scaling up to different vulnerable communities in partnership with community associations Support for the study on the impact of COVID-19 on HIV and TB programs Access to social protection for PCs and PLWHIV Support for advocacy for easy access to social protection for PCs and PLWHIV Intervention of community workers in security and guarantee of their labor rights Support for the initiation of advocacy for the institutionalization of the work of community workers.
2. Prevention of gender-based violence and care for victims of violence	Support for the creation of virtual spaces for gender prevention and support for victims of violence among vulnerable communities
3. Responses to human rights and gender-related barriers to accessing services	Socio-economic support to key populations, PLWHIV, migrants and refugees. Capitalization of IGAs created and set up, profitable Support for the creation and management of profitable IGAs with key populations, PLWHA, migrants. Defense of human rights and fight against stigmatization and discrimination Informal networking Training and use of recourses Advocacy training using social networks and other means of social mobilization Initiation of community-based research studies on obstacles to access to human rights for key populations, PLWHIV, migrants and refugees. Social mobilization campaign in favor of the use of the inclusive language of communities Social mobilization campaign in favor of the human rights of key populations, PLWHIV, migrants and refugees Reflect and create an observatory on human rights in health;
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	Strengthening of the community observatory on RoR and ITPC (1) Reflect on and create an observatory on human rights in health;
5. **COVID-19 CHR**: Community-based Advocacy and Research	
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	Training in the network approach Accompanying leaders of key populations, PLWHIV and vulnerable communities in networking Social mobilization campaign in favor of the use of inclusive language of communities Social mobilization campaign in favor of the human rights of key populations, PLWHIV, migrants and refugees
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	Leadership Training Training for community leaders in leadership Training in the network approach.

Intervention according to modular framework	Mauritania
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	- Sensitize PLWHIV on the importance of vaccination against covid 19. - Availability of inputs for covid19 patients (LLINs, TIM TRD) in the fight against malaria. - Sensitization of TB patients and lost persons on the importance of vaccination against covid 19. Develop innovative approaches that allow for continued safe delivery of services and mitigate the impacts of COVID-19 disruptions on HIV, TB and malaria services. Make changes in the management of health workers and community health workers. Implementing facility-based health service delivery adaptations. Training community providers on the diagnosis and management of covid-19 Ensure the equipment (material and inputs) of community structures for the management of key populations affected by Covid-19. Promote contractualization and partnership between public services and civil society in terms of intervention in the direction of key populations.
2. Prevention of gender-based violence and care for victims of violence	Establish a hotline connected to care services to address gender-based violence and intimate partner violence.
3. Responses to human rights and gender-related barriers to accessing services	Assist key populations to ensure their self-sufficiency during containment through the availability of food and foodstuffs. Conduct community mapping of legal, policy and other barriers that impede/limit the community response (including barriers to registration and funding of community organizations). Build capacity in the use of new information communication tools and technologies that are appropriate and accessible to key populations. Develop and/or revise tools and other support for community organizations and networks. - Strengthening community spaces for more equitable support
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	
5. **COVID-19 CHR**: Community-based Advocacy and Research	
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	

Intervention according to modular framework	Sudan
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	Using of outreach services such as Home-based care for PLWHIV to increase access to health services and medications. In addition, for those who can reach the ART center, provision of medications enough for 3 to 6 months. Malaria To enhance access to treatment and testing services, implement mobile clinics and home-based care at the level of the community by CSOs - Inclusion of NGOs in distribution of bed nets and Indoor Residual Spraying (strengthen the logistic systems of the organization and training of NGOs volunteers and staff (possible areas of training include how to implement needs assessment, health promotion protocols). CSOs to take into consideration special groups such as migrants and nomads. Provision of PPEs to peer educators (MMS and FSW)
2. Prevention of gender-based violence and care for victims of violence	Training of law enforcers and sensitization of these groups in issues related to human rights and GBV and training of doctors and nurses providing medical care to survivors. Establishment of drop-in centers for comprehensive management of cases and provision of sheltering services. The group recommended considering other states in the response to GBV. - Development of comprehensive response strategy to GBV - multisectoral response (gender desks (women detectives) as a start and advocacy to prioritize legal cases related to GBV (do not get impacted with lockdown, reduced working hours or workforce or other measures during COVID19) - Strengthen the hotline services provided by the ministry of social welfare - Provision of PPEs to service providers (including law enforcers) preferably reusable to reduce the cost - National Observatory to monitor cases and response to GBV (offices in universities, governmental institutions, religious institutions, and civil society organizations) - Interventions to restore trust between policy makers in health and citizens - Support research related to covid-19 and GBV - Avail/improve infrastructure to police center (as a start, support of the three protection of women and children units present in Khartoum) with PPEs and preventative measures
3. Responses to human rights and gender-related barriers to accessing services	- Provision of food basket tp PLWHIV to reduce the negative economic impact of the lockdown and COVID19 in general. MMS and FSW - Provision of transportation mean with clearance to deliver condoms to those who need during movement restrictions. - Use of online means for peer meetings can be used for awareness raising about COVID19 and HIV prevention - Increase incentives for peers - high cost of fuel and prices of transportation - Mobile clinic in hot spots to enhance access to awareness raising, counseling and prevention Training in HIV prevention and corona
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	Malaria - Community-led monitoring mechanisms implemented by the NGOs with the support of the ministry to strengthen timely reporting to government in case of shortages.
5. **COVID-19 CHR**: Community-based Advocacy and Research	
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	

Intervention according to modular framework	Somalia
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	- Review policies and plans, and train public health, CSOs and Community Health Workers to extend Covid-19 support to communities: - Support policy revision to allow easier access to HIV, TB, and malaria services, including: - Support for Multi-month dispensing of medicines and third-party collection of treatment. - Extend Covid-19 vaccination through community outreach for vaccinations, distribution of Covid-19 kits at safe spaces and other community sites. - Support costs of transport, orientation, communication, health registers and data collection to extend the service delivery approach from health facilities into community outreach and peer based approaches. - Expand the provision of community-led services - HIV, TB, malaria rapid testing to COVID-19 vaccination, TB/COVID-19 bidirectional active case finding, screening, and testing, management, and community tracing. - Expand service provision to IDP and Refugee Camps, rural areas and provide mobile outreach to nomadic communities. Support access to services for people in prison
2. Prevention of gender-based violence and care for victims of violence	Improve Management of Intimate Partner and Sexual and Gender Based Violence - Improve prevention and management of SGBV: Assist SGBV survivors to access essential services (health, psychosocial, and legal services): Post violence counseling, referral, and linkages to provision of post exposure prophylaxis (PEP), clinical investigations, medical management, clinical care, forensics management and medical-legal linkages, psychosocial support, including mental health services and counseling required as a result of COVID-19 restrictions. - Engage at community level, where women are trained as activists to mobilize communities, and at the institutional level with the aim of achieving improved access for women and girls to high quality SGBV services. - Train frontline workers, peers, and volunteers during COVID-19 response on psychological first aid, and GBV referral to hospital, police, legal support, social protection, and other support. - Develop and implement systems for linkages to protection services (i.e., police, religious and community leaders, teachers, peer counselors). - Support women and girls with access-to- justice interventions or to legal redress for SGBV and human rights violations experienced as a result of COVID-19 restriction.
3. Responses to human rights and gender-related barriers to accessing services	Integrate Covid-19 and anti-stigma and antidiscrimination training in health worker disease response training and that in educational institutions. Sensitize COVID-19 health care workers, frontline CHW and peer counselors, religious leaders, and networks on issues of stigma, discrimination, bias against KVPs and people living with HIV (PLWHIV), Covid-19 and TB, as well as stigma and discrimination against health workers. - Engage religious and community leaders and raise awareness on the potential rights violations against Key and vulnerable populations in the context of COVID-19. Provide Social Protection and mental health services. - Provide nutritional support to a limited number of TB patients and PLWHIV in some areas, who have lost their livelihood due to Covid-19. - Provide counseling to severely affected patients and families.
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	Scale up Community-Led Monitoring - At the community level partners propose expansion of Community Led Monitoring and Social Mobilization and advocacy as implemented in some regions of Somalia through Citizen Monitoring and Advocacy (CMA). - Several local partner organizations operating within communities will be trained and capacitates to carry out community led monitoring through the GF, GIZ and partner Community Led Monitoring guidelines; these will in turn enable individuals and community groups to monitor and report on cases of SGBV, rights violations, stigma, and discrimination as well as access to Covid-19, HIV, TB, and malaria services. - At policy level, evidence will be collected on a continuous basis by communities following training by some Trainers of Trainers (ToTs) at sub-national and national level.
5. **COVID-19 CHR**: Community-based Advocacy and Research	Engage religious and community leaders and raise awareness on the potential rights violations against Key and vulnerable populations in the context of COVID-19.
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	- Strengthen existing community platforms (drop-in centers, safe spaces, community-based clinics) as well as community networks to deliver services (related to GBV/Intimate partner violence (IPV), HIV, TB, malaria, and COVID-19.)
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	Provide institutional support to community-based organizations and NGOs to expand prevention and service delivery. - Equip CHWs, CBOs, service delivery sites and KVP networks with PPEs and Covid-19 kits - Provide support to CSOs to engage and orient more community health workers and peer counselors. - Procure cell phone and social media data bundles to better reach hidden KVPs and enable remote support to patients.

Intervention according to modular framework	Egypt
1. Mitigations for control programs/service adaptation Health services for key populations Prevention treatment	Continue distributing the condoms and syringes to the new gathering places of KPs or focal person.
2. Prevention of gender-based violence and care for victims of violence	
3. Responses to human rights and gender-related barriers to accessing services	- Nutritional support of PLWHIV by distributing staple foods. - Developing WhatsApp group to contact PLWHIV and conducted phone calls for those who could not manage WhatsApp. - Using Zoom platform to share educational videos. - Include houses where PWIDs gather to the outreach plan. - Psychological support to NGOs staff to avoid burn out.
4. **COVID-19 CSR** (Community Systems Strengthening): Community Monitoring	
5. **COVID-19 CHR**: Community-based Advocacy and Research	
6. **COVID-19 CHR**: Social Mobilization / Social Mobilization, Community Building and Coordination	
7. **COVID-19 CHR**: Institutional Capacity Building of Community-Based Organizations	

Amira Medimagh

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