

TESTING

IS A RIGHT

NOT

A PRIVILEGE

INTERNATIONAL

TESTING

WEEK

23-29.11.20

## PRESENTATION OF COALITION PLUS

Coalition PLUS is an international union of community-based associations in the fight against HIV/AIDS and viral hepatitis created in 2008, operating in 52 countries and alongside some one hundred civil society organizations.

Our member and partner associations involve the communities most vulnerable to

HIV/AIDS and hepatitis in the determination and implementation of prevention, care and advocacy programs.

They promote innovative methods adapted to the individuals facing the most discrimination in access to healthcare. **Our values: respect for diversity and non-discrimination, solidarity and innovation.**



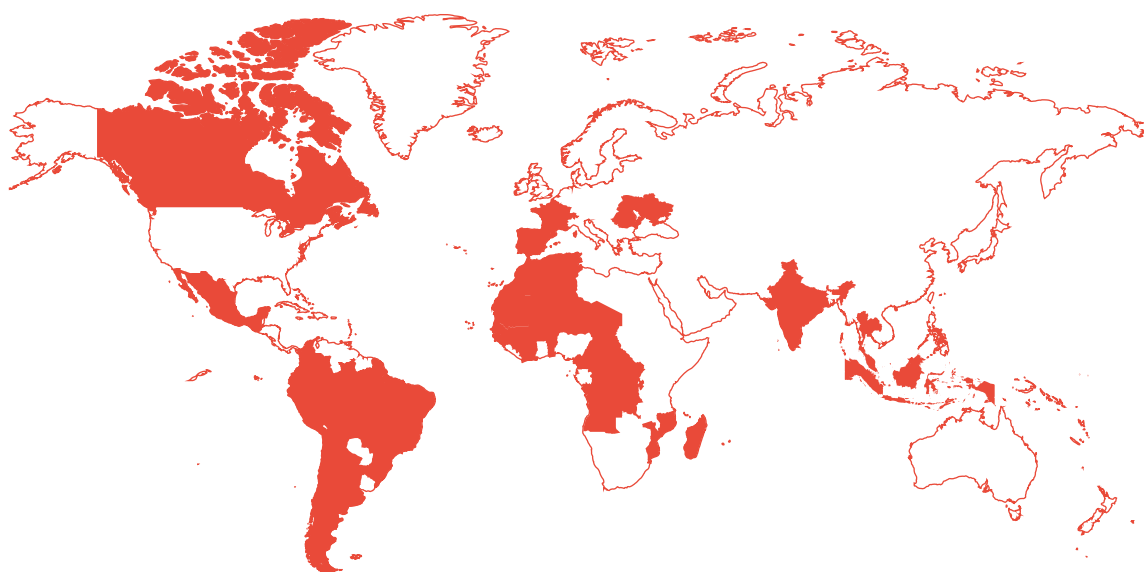
16  
member  
organizations



52  
countries



100+  
partner  
associations



### NETWORK

#### All countries listed below

#### Offices

Pantin (France)  
Brussels (Belgium)  
Geneva (Switzerland)  
Dakar (Senegal)

#### Members

100% LIFE, Ukraine  
AIDES, France  
ALCS, Morocco  
ANCS, Senegal  
ANSS, Burundi  
ARAS, Romania  
ARCAD Santé PLUS, Mali  
COCQ-SIDA, Canada (Quebec)  
GAT, Portugal  
Groupe sida Genève, Switzerland  
Fundación Huésped, Argentina  
IDH, Bolivia  
Kimirina, Ecuador  
Malaysian AIDS Council, Malaysia  
PILS, Mauritius  
REVS PLUS, Burkina Faso

### OUR THEMATIC, LINGUISTIC AND GEOGRAPHIC NETWORKS

#### MENA Platform

Morocco, Algeria, Tunisia, Mauritania, Lebanon

#### West Africa Platform

Mali, Côte d'Ivoire, Benin, Burkina Faso, Togo, Guinea Conakry, Niger, Senegal

#### Central and East Africa Platform

Burundi, Rwanda, DRC, Congo-Brazzaville, CAR, Chad, Cameroon

#### Indian Ocean Platform

Comoros, Madagascar, Mauritius, Seychelles, Mauritius, Rodrigues, France (Mayotte and Réunion)

#### Europe Platform

France, Portugal, Romania, Switzerland (Geneva), Ukraine, Belgium

#### Americas-Caribbean Platform

Ecuador, Bolivia, Canada (Quebec), Colombia, Guatemala, France (French Guyana, Martinique, Guadeloupe, Saint-Martin)

#### Hepatitis C

Brazil, Colombia, Malaysia, Morocco, India

#### RIGHT PLUS

Spain, Peru, Mexico, Chile, Portugal, Brazil, Bolivia, Guatemala

#### AGCS PLUS

Algeria, Tunisia, Morocco, Mali, Côte d'Ivoire, Benin, Burkina Faso, Togo, Senegal, Cameroon, Burundi

#### Lusophone network

Portugal, Brazil, East Timor, Guinea-Bissau, Angola, Mozambique, Cape Verde, São Tomé and Príncipe

**Testing is the first step to eliminating AIDS and viral hepatitis.** Yet we are still a long way off the target set by the international community. Whereas 90% of all people living with HIV were supposed to know their status by 2020, some 20% are still unaware of their HIV-positive status today<sup>1</sup>. Regarding hepatitis C, which affects a large number of people living with HIV<sup>2</sup>, the WHO estimated that in 2015, only one in five individuals knew they were infected<sup>3</sup>! These figures are all the more worrying given that they do not take into account major social inequalities in health, which render access to testing even more difficult for some people, particularly among men who have sex with men, sex workers, trans people, and people who inject drugs.



Yet a person's knowledge of their HIV status is vital. On an individual level, it enables the tested person to take control of their own health and to receive appropriate treatment. At the collective level, testing is a key tool in the prevention of new infections, particularly when it targets the communities most vulnerable to HIV and viral hepatitis.

Indeed, due to the stigmatization and discrimination that drive them away from care, people from these communities, as well as their partners, currently represent almost two-thirds of new HIV infections worldwide<sup>4</sup>. If we want to end AIDS, we must guarantee access to healthcare for all, and therefore to the most marginalized. HIV testing, even more so when carried out by peers, represents a true – and often the only – gateway to care for these individuals.

**That is why, true to their primary mission, the community-based associations united within Coalition PLUS are putting in place innovative rapid testing measures by and for individuals vulnerable to HIV and viral hepatitis.** Beyond HIV testing, it is a question of reaching out to key populations, and in particular to the most excluded individuals within these populations, in order to offer them local care services as part of a comprehensive approach to their health. Our ambition is to be able to offer comprehensive testing services linked to sexual health, including viral hepatitis, sexually transmitted infections and anal and cervical cancer.

Our community-based organisations, pioneers in the AIDS response, have proven expertise in managing pandemics. **As part of the first edition of the International Testing Week, organized by Coalition PLUS, its members and its partners, we wish to reiterate the importance of involving civil society in the development and implementation of public policy in the Covid-19 response, including testing.** A guarantee of effectiveness, the participation of our associations will also guarantee the necessary consideration of the specific needs of marginalized individuals, while building on national efforts to cope with this new crisis thanks to the resources and expertise of the community-based health system.

**Hakima Himmich**  
Chairperson of Coalition PLUS

<sup>1</sup> UNAIDS, 2020 fact sheet – Global HIV & AIDS statistics  
<sup>2</sup> According to the latest WHO estimates, 2.3 million people living with HIV globally have serological evidence of past or present HCV infection. WHO, Global Hepatitis Report, 2017  
<sup>3</sup> Ibid. / <sup>4</sup> UNAIDS, op. cit.

## CONTEXT

To mark International Testing Week from 23 to 29 November 2020, Coalition PLUS is launching a **call for testing, testing that acts as a gateway to care and which constitutes a cornerstone in ending the HIV and HCV epidemics**. Working with communities and all health professionals makes it possible to reach a maximum number of people in order to organize prevention and care for all populations.

Nowadays, the **HIV epidemic** is more concentrated among the population groups that suffer most from discrimination<sup>1</sup> and continues to take a heavy toll. Key populations and their sexual partners represent over 60% of new cases of infection among 15 to 49-year-olds worldwide: notably among men who have sex with men, sex workers and people who use drugs, and

transgender people, for whom solely the relentless work of community-based actors has proven effective in responding to their specific needs.

In eastern Europe, Asia, the Pacific, Europe, North America, the Middle East and North Africa, the above-mentioned groups represent over 95% of new HIV cases<sup>2</sup>.

For example, in **France**, homosexual or bisexual men represent 44% of positive HIV results. To overcome this, a range of protection/prevention tools exist, such as: **easy access to testing, PrEP, PEP (post-exposure prophylaxis), condoms. Rapid tests and self-testing have greatly facilitated diagnosis and the link to treatment and care.**

# 200 x

Greater risk for men who have sex with men of exposure to HIV than men who have heterosexual sex.

# 16%

In Paris, men who have sex with men are particularly vulnerable to HIV. Almost 16% of men visiting homosexual social venues are HIV-positive, according to the ANRS PREVAGAY 2015 survey.

*(Source: Vih.org - Le VIH en 2019 : Les Clefs pour comprendre)*

In contrast, in **Africa**, HIV is still prevalent among the general population but with growth in new infections among key groups. According to the WHO, over two thirds of all people living with HIV live in the African Region, i.e. 25.7 million people.

Within the African context, differentiated approaches to community-based testing are what have enabled Coalition PLUS member and partner organizations to reach those individuals most marginalized and

most affected by discrimination in order to bring them into the care system. It is in this aspect that our community-based expertise brings added value, and that our impact on the epidemic is most significant. Currently, this community-based expertise goes beyond testing, with task shifting, and by also ensuring treatment (*initiation into and distribution of antiretroviral treatment*) and follow-up (*community viral load*), in full complementarity with the traditional healthcare system.

<sup>1</sup> WHO website on HIV/AIDS - 6 July 2020 / <sup>2</sup> Ibid.

Concerning **hepatitis C**, any avenue leading to the goal of eliminating the infection must focus on its elimination among the groups with the highest incidence, particularly people who inject drugs (*PWID, who are also the most affected by HIV/HCV co-infection*). As such, **community-based testing and support for the most marginalized populations such as PWIDs are a vital part of HCV elimination programs, as in the program led by Coalition PLUS.**

Although the availability of epidemiological data remains insufficient, on a country-specific scale and on a disaggregated basis, some reference figures are given below:

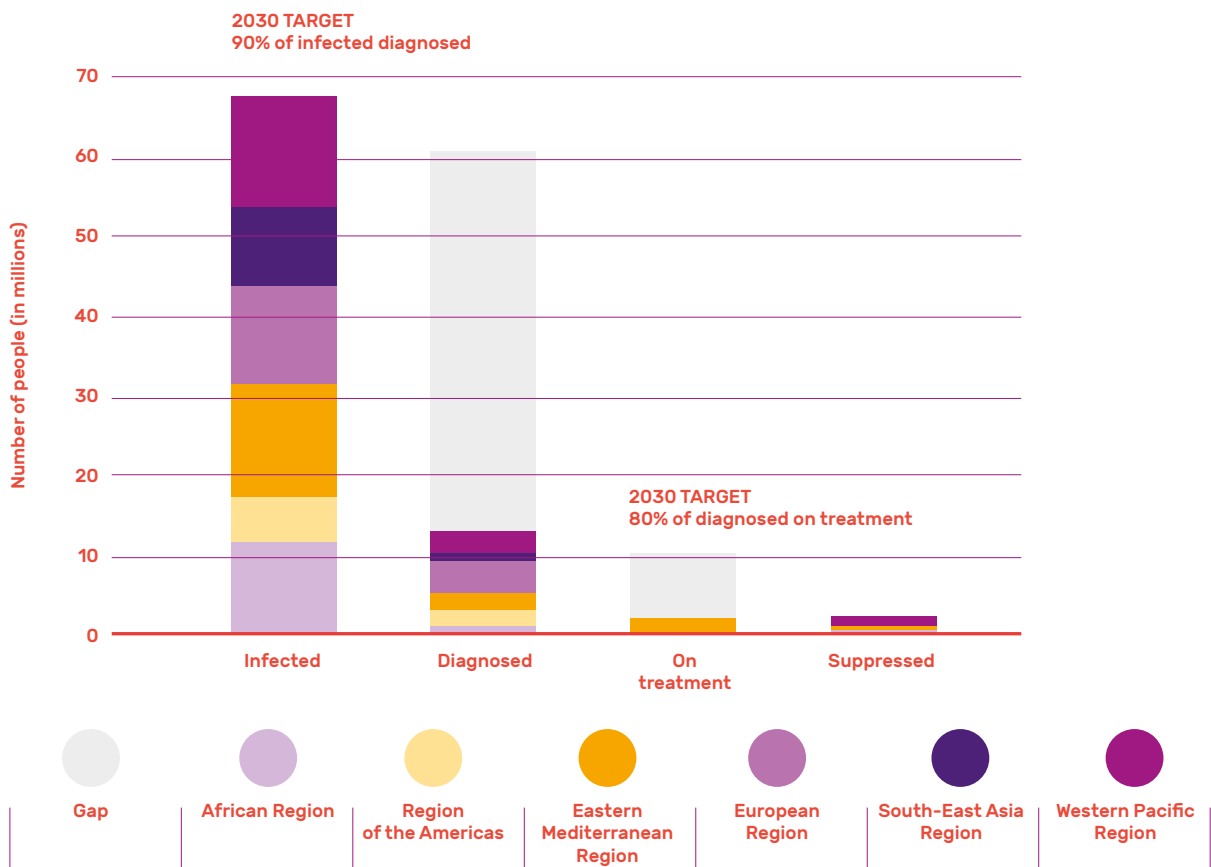
In 2017, the WHO estimated that 71 million people worldwide were chronically infected with hepatitis C virus (HCV). Globally, 23% of new HCV infections and one in three HCV

deaths are attributable to injecting drug use. HCV is also a major concern for people detained in prisons and other closed settings – available data demonstrate that one in four detainees are HCV-positive.

According to the latest data collected by the WHO (2015), 2.3 million people living with HIV (PLHIV) had been infected with HCV. Indeed, chronic liver disease represents a major cause of morbidity and mortality among persons living with HIV globally.

**HCV testing** is paramount to achieving this goal of total elimination, all the more so as only very few people are aware of their status. While there is a wide gap globally between infected individuals and those that know their status, this gap is even more considerable in Asia, Sub-Saharan Africa and Latin America.

### — Cascade of care for HCV infection by WHO region, 2016

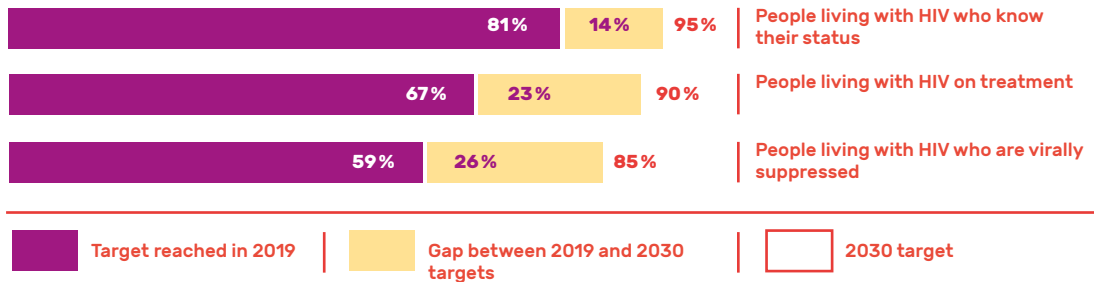


## CHALLENGES REMAIN

Although the annual number of new infections (all ages) seems to be falling (*declined from 2.1 million to 1.7 million in 2018, a 16% reduction*), it is far off the 2020 target of

fewer than 500,000 new HIV infections annually<sup>3</sup>. If testing is deficient, the entire cascade is affected.

### HIV Testing and Treatment Cascade (2019)



These figures show that 29% of PLHIV do not know their status. Given that according to the 2019 UNAIDS annual report, the risks of infection remain very high among the categories of key populations, those most at risk of transmission, these populations must be targeted as a priority in order to have an impact on the epidemic.

Particular focus must therefore be placed on **increasing testing activities to reach those most exposed and above all to reach them as early as possible after infection**. All differentiated approaches and approaches adapted to the reality of countries, as recommended by the WHO and UNAIDS, should be implemented in order to achieve this.

### CURRENT SITUATION?

#### HOW TO ACCELERATE THE HIV/HCV TEST-TREAT-RETAIN CASCADE?

We must support and reinforce political changes, the development and deployment of innovative HIV/HCV services, rec-

ommended by the WHO and UNAIDS, that enable access to care for all, starting with **testing** as a gateway.

**Winnie Byanyima,**  
**Executive Director of the Joint**  
**United Nations Programme**  
**on HIV/AIDS (UNAIDS)**  
*in her interview with Afrique*  
*Renouveau in June 2020:*

“Our priority for the next 10 years is to work extremely hard on **prevention**, especially among vulnerable groups.”

At global level, compared to the general population, the risk of acquiring HIV is<sup>4</sup> :

**30 x**

higher for sex workers

**29 x**

higher among people who inject drugs

**26 x**

higher among men who have sex with men



## COMMUNITY INVOLVEMENT = THE SOLUTION

Coalition PLUS has already demonstrated the relevance of this community involvement that is so crucial through its members and partners. Community-based interventions help reach the most marginalized populations that are at the center of the epidemic dynamics we are combating. This does not mean more testing, but more efficient testing and therefore a greater impact on incidence.

Because the community-based approach, complementary to the traditional care approach, is adapted to populations with specific needs. Indeed, the increased ease of **communication between peers, the respect for confidentiality and the freedom to discuss their sexual practices in a non-judgmental environment** are advantages that have made it possible to reach the most at-risk populations.

In countries where the different tools recommended by the WHO are available, prevention approaches such as **self-testing** (assisted or not) and **PrEP** allow individuals to live with their HIV status in complete **confidentiality and discretion**, in strict observance of human rights. Within the framework

of its actions, Coalition PLUS, through its members, supports and promotes these different approaches and tools in order to adapt responses to the groups concerned and to the context of each country.

Beyond testing, communities have always been very involved in the entire HIV prevention component, notably for the provision of classic prevention tools like condoms for key populations, currently pre-exposure prophylaxis (PrEP) as a preventive treatment prior to the risk of exposure, as well as post-exposure prophylaxis (PEP) or 'emergency treatment' which avoids HIV infection after risk of exposure. All of these methods have made substantial contributions towards reducing infections.

Donors, governments and health professionals must grasp the need and urgency of incorporating the community-based approach into the national health system in order to have a greater impact, by reaching those who do not have access to care and who are most at risk of transmission.

**The Global Fund on Community Responses & Systems**<sup>5</sup>:

“Communities play a central role in strengthening responses to HIV, tuberculosis and malaria. They reach, educate and link people, including those who are neglected, marginalized or criminalized, to services along the entire prevention and treatment continuum. **Support for community systems and responses is a key component of the Global Fund’s mission** to accelerate the end of HIV, tuberculosis and malaria as epidemics.”

<sup>3</sup> Rapport ONUSIDA 2019

<sup>4</sup> <https://www.unaids.org/fr/resources/fact-sheet>

<sup>5</sup> <https://www.theglobalfund.org/fr/community-responses-systems/>

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## HCV TESTING

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The members of Coalition PLUS have been able to take an active part in HCV testing, according to their context. Greater impetus has been given since 2015 within the hepatitis network to the inclusion of communities in the implementation of policies

to eliminate hepatitis C. Community-based HCV testing is not yet widespread. Coalition PLUS has supported its partners in advocating its recognition at local and international level and to organize testing initiatives for the most marginalized populations.

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### THE EXAMPLE OF CoNE, COALITION PLUS PARTNER, IN INDIA

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In an initial phase, the government approved and officially adopted the CoNE standard operating procedures as directives in the state of Manipur to combat HCV. These include a specific testing approach for high-risk groups which is not included in federal directives to manage and treat hepatitis C. This enabled CoNE to contribute to the implementation of the National Viral Hepatitis Control Program (NVHCP) in Manipur and improved the program's results, rating the Manipur program second in India after Punjab in terms of the number of people involved.

In 2019, 1,428 people were contacted, out of whom 1,050 underwent hepatitis C antibody testing. Out of these individuals, 399 were reactive to hepatitis C antibodies. Of

this total, 185 received an RNA confirmatory test, the results of which came back positive for hepatitis C infection in 148 cases, and 131 were referred for treatment within the framework of the national program.

Based on these findings, CoNE succeeded in convincing the government to have the NVHCP recognize the results of community-based serological testing; patients with positive anti-HCV results were able to directly integrate the care continuum at the viral suppression step. This has had a major impact on the process of decentralizing care and has contributed to reducing waiting lists at HCV treatment centers in Manipur as well as the number of visits needed to complete the diagnosis procedure.

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**Dr Rosie, State Nodal Officer, National Viral Hepatitis Control Program, Manipur, attested to the importance of the role of communities:**

“CoNE is one of the community-based organizations in the state of Manipur that plays an important role in raising the awareness of populations difficult to reach in the different regions of the state, in bringing people to testing, diagnosis, treatment and follow-up for defaulting patients. With the constant support of these community-based associations, Manipur would be on course to meet the objectives of the NVHCP.”



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## SELF-TESTING

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**Self-testing**, as recommended by the WHO in 2016, should be offered as an additional approach to HIV testing services, even though its cost remains an obstacle to its accessibility, notably in the Global South. One of the major advantages of self-testing is the guaranteed confidentiality, which

makes it a particularly attractive complementary testing tool for criminalized key populations. In most cases in the Global South, self-testing implies the presence of a peer educator trained in this type of testing. This also provides a link to treatment in the event of a positive result.

### THE EXAMPLE OF THE ANSS, COALITION PLUS PARTNER, IN BURUNDI

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Before the start of HIV/AIDS self-testing in June 2018 in **Burundi**, men who have sex with men (MSM) and transgender people (MSM/TG) were very reluctant to go to health structures for testing, due to the stigmatization surrounding sexual orientation.

As part of the implementation of the LINK-AGES/USAID/PEPFAR project, the ANSS introduced self-testing for its MSM targets and the situation improved; with a notable increase in the number of HIV tests among MSM/TG (and the number of positive results). The project, which aimed to accelerate the tracing of HIV-positive individuals to be put on antiretrovirals, saw an improvement in its results.

16 peer educators were trained in assisted self-testing. This enabled MSM/TG with a reactive test result to have the result confirmed at a health structure and if they are HIV-positive, to receive comprehensive HIV care, particularly antiretroviral (ARV) treatment and subsequent viral load tests. In addition, individuals with a non-reactive HIV test result have the opportunity to obtain information to allow them to remain HIV-negative.

As a result of the work of the peer educators dedicated to self-testing, 520 self-test kits were distributed between June 2018 and May 2019 to MSM/TG (their peers who had not yet been tested). Out of the **131 MSM/TG** who discovered their HIV infection within these same dates using various methods, **57** had carried out a **self-test** (i.e. **over 43%**). Self-test results thus represent around 29% of all MSM/TG put on ARV during the duration of the project.

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## PRE-EXPOSURE PROPHYLAXIS (PREP)

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**Pre-exposure prophylaxis (PrEP)**, which consists of the preventive use of an antiretroviral treatment for HIV-negative individ-

uals to protect against HIV infection, has proven to be an extremely effective tool in reducing the number of infections.

“Community-based organizations – especially those working with key populations – should play a significant role in the roll-out of PrEP by engaging people at substantial risk, providing information about the availability and use of PrEP and promoting linkages between PrEP providers and other health, social and community support services.”

*(Source: WHO, Consolidated guidelines on the use of antiretroviral drugs for treatment and preventing HIV infection, 2016)*

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### THE EXAMPLE OF KIMIRINA, IN ECUADOR

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In 2019, a sexual health scheme for key populations and people living with HIV was put in place by Kimirina, **Ecuador**, in two provinces (Quito and Guayaquil). Vigorous advocacy with the technical and political teams of the Ministry of Health was needed to outline a cooperation agreement for the implementation of this project.

The health services offered include testing and diagnosis for HIV and other STIs. In the event of a positive result, patient referral to the units run by the Ministry of Public Health is ensured. In the event of a negative result, the service includes pre-exposure prophylaxis (PrEP), condoms and lubricating gels.

Most users of these centers identify as men who have sex with men (MSM) and transgender women. The PrEP target was 30 people; 390 people receive sexual health care (STI and HIV detection), which corresponds to around 48% of the estimated transgender population in the city of Quito (818 according to Maple research, 2015).

The breakdown of consultations is on average 60% for PrEP, 20% for STIs, 5% for PEP. Which proves that there was an incontestable need for a service adapted to the real needs of communities. As evidenced by the increased numbers of visitors to these community centers: the number of users of these services increased sharply with the implementation of this scheme, doubling in Quito and tripling in Guayaquil between August and November 2019.

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## DEMEDICALIZED COMMUNITY-BASED TESTING

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Coalition PLUS has worked on the gradual implementation of **demedicalized community-based testing** in a certain number of countries. The members and partners have come up against legal barriers in states, which prohibit non-carers from carrying out screening tests as this is considered a medical procedure reserved for carers only. Under the impetus of Coalition PLUS,

our member and partner associations have engaged in a much-needed dialog with the public authorities to convince them of the added value of community-based testing in terms of geographic but also social and cultural proximity to key populations, thus optimizing its quality, targeting and accessibility.

### SOME RESULTS

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Thanks to the outreach testing strategy in its different forms, the Coalition PLUS partner associations in **seven African countries** (Morocco, Mauritania, Cameroon, Senegal, Togo, Niger, Mauritius) tested 34,000 people from key populations (MSM, transgender, people who inject drugs) in 2019. Almost 3 out of 4 were **first-time testers** and the **average HIV-positive rate was 7.8%** within these three categories of key populations.

Our partner MAC carried out community-based testing **in Malaysia** during the first half of 2020. 17,463 people from key populations were reached in their living environments, of which 93% were first-time testers. In terms of the breakdown of key populations, 47% of people tested are MSM, 33% drug users, 14% transgender, and 6% sex workers.

### WHAT IS THE CONTRIBUTION OF TASK SHIFTING IN THIS CONTEXT?

– In some countries, it helps offset **the insufficient number of doctors compared to patient numbers**. It also solves **the problem of the long distances to cover to arrive at treatment sites**, and thus reach the maximum number of people.

– Adapting to groups through considerable **mobility and flexibility regarding schedules** by offering **counseling and testing sessions at times that best suit certain populations** (at night, for example). Furthermore, **testing can be carried out at community health centers or directly within communities and thus reach new populations who would never seek out the healthcare system**.

– Fostering **confidence and dialog**: The proximity of community workers with key groups from which they themselves come is a major asset for the adherence of the individuals concerned. This approach has a **positive effect on reducing stigmatization/discrimination**, which remain both present and dissuasive in traditional health centers particularly in contexts where sex work, homosexuality and drug use are criminalized.

## THE BARRIERS?

### Current situation? .....

Since 2015, the WHO has published official recommendations on task shifting from doctors to nurses and from doctors to community health workers (CHW) in testing, issuing and refilling prescriptions, and delivery of antiretroviral therapy.

**=> We must not delay in allowing access for all to prevention tools, including the latest innovations. Coalition PLUS is launching a passionate call to immediately remove barriers to the decentralization of testing and treatment to accelerate the response to HIV and viral hepatitis.**

### WHY?

- **Institutional barriers** (*political, legal and administrative*) and **dysfunctions which constitute an obstacle to care for key populations.**

Repressive laws do not allow associations formed by the people concerned (identity-based networks) to structure themselves and to demand services relevant to them or to have access to funding. The stigmatization and discrimination that hang over them prevent key populations from spontaneously seeking care, without danger.

- **Reservations regarding the broad development of task shifting** as a strategy complementary to the AIDS/HIV response from some care staff.

This often stems from lack of recognition of the quality of community work. To end AIDS and hepatitis C, it is vital to reach out to these marginalized people at high risk of infection, in their workplace, at times that suit them, without judgment, and in complete confidentiality and confidence. This strategy is complementary to the measures and services in the traditional healthcare system.

The WHO and UNAIDS recommend all **out-reach strategies along the cascade: community-based prevention and testing** (community-based demedicalized testing, PrEP, self-testing, community post-exposure prophylaxis), **community-based treatment and follow-up** (shifting of initiation and delivery of ARV, community viral load, support for patient compliance). However, their **scale-up** and even their **implementation** remain problematic.

**Winnie Byanyima,**  
Executive Director of UNAIDS

"We have to work on human rights because as long as gay men and sex workers remain criminalized, they are driven underground and hence don't come forward for prevention or treatment. It's important to remove those criminal laws, so that these people can come forward for testing, prevention, and treatment."

Advocating for an environment enabling access to care for all remains a challenge. The defense of human rights and minorities is still lagging behind in programs targeting key populations, even though this is a key aspect in stepping up the fight to end the AIDS and viral hepatitis epidemics.

**Pr Mehdi Karkouri, President of the ALCS (Morocco) and Coalition PLUS administrator:**

"Given the current global climate focused on combined prevention, the alignment of testing strategies and the targeting of key populations can have nothing but a positive impact on the HIV response. I say this as a doctor: those best placed to carry out this testing are not health professionals but rather people from these communities trained in RDTs\* to screen their peers."

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## COVID-19 THREATENS TO JEOPARDIZE ACHIEVEMENTS

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**Covid-19 jeopardizes HIV and HCV prevention, testing and treatment:** the health and political crisis triggered by this coronavirus will have severe consequences on these epidemics. In France, for example, the number of HIV tests and the number of people beginning pre-exposure prophylaxis (PrEP) have dropped significantly, both during lockdown and after, to half the expected number.

The strategy to fight the HIV epidemic should inform the response to the Covid-19 pandemic, according to the United Nations, which believes that this approach grounded in human rights is key to tackling the current crisis.

— “This is a serious and difficult situation for everyone. To come through, we must draw on our valuable experience from responding to other global epidemics, such as HIV: ground the response in human rights, engage communities and leave no one behind.”

**Winnie Byanyima,**  
Executive Director of UNAIDS

This is the first course of action and a guarantee of effectiveness in the face of the epidemic, UNAIDS has affirmed. Involving the communities affected since the start of the crisis has helped build trust, avoid harm and ensure frequent sharing of information.

For example, in **Morocco**, within the context of the health crisis, the Association de lutte contre le sida was actively involved in delivering ARV to PLHIV during lockdown at the request of the Ministry of Health – through official collaboration with the Ministry of Health as part of the national state of health emergency.

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\*RDTs: rapid diagnostic tests carried out by community workers or peer educators trained in screening but with no medical training

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## OUR DEMANDS

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### Today, it is essential that:

- Community-based testing be integrated into official testing policies as well as monitoring of the effective implementation of these policies
- Community-based HCV testing is supported by the WHO
- Prevention tools and the different forms of testing adopted by the WHO be widely disseminated in the Global South
- The WHO add a recommendation to its guidelines concerning HCV self-testing which could foster research in this area
- The barriers to access to care for key populations and to the improvement of the legal (punitive laws for KP) and social (discrimination and stigmatization of KP) framework be removed
- A comprehensive testing package be offered to all: HIV, HCV, STI, cancer (cervical, anal)
- Civil society actors – where they so wish – be incorporated into Covid-19 testing measures, particularly for those already putting in place HIV and HCV testing in order to increase the efficiency of our interventions for key populations

### For states

- Invest domestic funds in community-based differentiated approaches
- Facilitate/authorize community-based testing
- Involve community-based organizations and the affected populations in HIV and viral hepatitis response systems (decision-making bodies)
- Involve communities in the implementation of health policies concerning them
- Apply the official recommendations of the WHO to task shifting from doctors to nurses and community health workers
- Ensure the availability of the required inputs and prevention tools for the effective scale-up of these recommendations
- Eliminate legal and regulatory barriers that curb the application of differentiated community-based approaches to prevention, treatment and follow-up
- Involve civil society actors in secure Covid-19 testing measures

### For the WHO

- Ensure that existing recommendations and policies approved at country level are applied on the ground in countries
- Ensure that the recommendations issued at global level that take into account the specific needs of key populations are adopted at country level
- Expand the comprehensive testing package as an indivisible service (HIV, HCV, STI, cervical and anal cancer)

### For UNAIDS

- Step-up monitoring of the implementation of catch-up plans for each country concerned
- Push for countries to update baseline data, especially data on key populations

### For donors

- Increase funding for community-based interventions
- Put in place/Increase civil society funding for viral hepatitis

### For health professionals

- Strengthen the link between traditional health services and community stakeholders for effective complementarity
- Overcome reservations surrounding task shifting that hinder its effective application
- Create a secure environment for key populations at treatment sites
- Train staff in discrimination/stigmatization-free reception



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November 2020

Available for download  
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