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EFFECTS OF COVID-19 ON HIV-VULNERABLE POPULATIONS IN WEST AFRICA AND SENEGAL

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FEMINISTS
FOR A PEOPLE'S
VACCINE

ACRONYMS

CNLS	Conseil National de Lutte contre le Sida (National AIDS Council)
STI	Sexually Transmitted Infection
DU	Drug User
SW	Sex Worker
MSM	Men who have Sex with Men
PLHIV	People living with HIV
IDU	Injecting Drug Users
TS	Transgender
SW	Sex workers
LGBTQ	Lesbian Gays Bi sexual Transsexual Queer
FM	Global Fund

CONTENTS

1. CONTEXT

1.1 COVID-19 IN WEST AFRICA

The COVID-19 pandemic that began in China, more precisely in Wuhan in December 2019, was one of the most virulent in human history. It spread rapidly around the world, paralyzing all sectors of activity. The first cases of COVID-19 were reported in West Africa, in Senegal, in March 2020. Most countries were quick to adopt public health measures in response to the pandemic. All member countries of the Economic Community of West African States (ECOWAS), with the exception of Liberia, closed their borders and banned gatherings (Jaffré & Hane, 2020; Petit & Robin, 2020). The rapid response was due to experiences of epidemics and pandemics of which Africa has been the epicenter (Eboko, 2020). When the pandemic started, Africa was less affected than other regions of the world, notably Europe and the United States. However, the WHO warned of the potential for spread "in countries where health systems are weaker" and above all the impact of the new coronavirus on the implementation of such essential programs as HIV/AIDS, malaria and tuberculosis (WHO, 2020). In January 2023, the number of cases of Covid in West Africa was estimated at 952,804, including 929, 297 cured cases and 12367 deaths (1.3 percent approximately). The most affected countries are Nigeria, Ghana, Senegal, Côte d'Ivoire and Mauritania. The number of COVID-19 -positive cases in the entire region corresponds to just 0.22% of cases worldwide and 0.18% of deaths.

While the overall prevalence of the pandemic and deaths are lower in Africa than in northern countries, and far from the "catastrophic scenarios" predicted at the outset, the effects of the pandemic have been far-reaching, particularly for the most vulnerable populations. In an initial phase, as the pandemic flared up in Europe, African countries protected themselves and initiated the first preventive measures. When cases of COVID-19 appeared in Africa, the rapid implementation of screening, treatment and isolation protocols and exceptional measures covered by the state of health emergency were applied. In some countries, accompanying social measures were put in place, such as food and economic aid for needy families. Despite these responses, the COVID-19 pandemic has increased poverty among West African populations. In fact, according to a study by the ECOWAS Commission, the proportion of people living on less than $1.90 a day has risen from 2.3% in 2020 to 2.9% in 2021. Workers in the informal sector were particularly hard hit. The food security of the poorest populations was affected, with nearly 25 million people

unable to meet their food requirements, representing a 34% increase compared to 2020. The pandemic has also exacerbated social inequalities, with an increase in violence to enforce restrictions affecting the poorest, and gender-based violence, in particular domestic violence against young women unable to escape confinement (Wallace et al., 2020).

A study on gender and COVID-19 in West Africa carried out by the NGO CARE, based on interviews with 266 people in 12 countries, highlighted serious economic, health and financial repercussions, which were particularly severe for women (Laouan, 2020). Indeed, most of them were engaged in economic activities linked to the informal sector that had been impacted by COVID-19, sometimes leading them to suspend their loans and repayments in a context where solidarity mechanisms had crumbled. The study reported an increase in cases of gender-based violence linked to the consequences of "promiscuity and general social stress combined with growing tensions" related to the confinement of many people in a limited space with difficulties in satisfying their basic needs. The data showed that some young people were increasing their use of social networks, increasing the risk of being exposed to abusive relationships involving sexual transactions. The survey data highlighted the difficulties women faced in accessing reproductive health services, particularly younger women (Laouan, 2020).

From the point of view of public finances, the COVID-19-induced crisis had a dual impact in West Africa: a drop in budget revenues, particularly tax revenues, and an explosion in health and social spending (Errol, 2020). Moreover, the 'disruption of drug and equipment supply chains, the interruption of therapies and the under-detection of new cases produce excess morbidity and mortality linked to many other diseases, including HIV, malaria and tuberculosis' (Ray, 2021).

The social and health measures taken by governments in response to the pandemic were sometimes perceived as contradictory by those who had to comply with them (for example, between the imperative to apply physical interpersonal distances in public transport, which halved the number of available seats and therefore doubled travel times, and the imperative to be home by curfew time). The economic consequences of the restrictions on grouping and travel, and the difficulties encountered by certain socio-professional categories, had gradually generated a feeling of inequality, tensions and protests in several West African countries.

In terms of vaccination, which is considered an effective technique and inexpensive if supported by the public health systems, structural inequalities in access created the main barriers to COVID-19 vaccines. Indeed, the proportion of the population of sub-Saharan Africa having access to the vaccine would have been 29% in 2023, compared with almost 70% in Northern countries. Factors linked to access, availability and population hesitancy (and, more broadly, negative representations of vaccines) have been identified.

1.2. COVID-19 IN SENEGAL

Senegal recorded its 1st case of COVID-19 on March 2, 2020. As soon as the pandemic broke out, the State took emergency measures to protect the Senegalese people and prevent the spread of the virus and its socio-economic and health consequences throughout the country. A state of health emergency was declared on March 23, 2020, with the imposition of a curfew. These emergency measures, in addition to individual precautions, included the declaration of a nationwide state of emergency, the closure of borders, a ban on public demonstrations, and the cancellation of activities scheduled for April 4, 2020 to mark the country's 60th anniversary of independence. The allocation of 1,000 billion FCFA to the COVID-19 Response and Solidarity Fund (Force-Covid-19), to mitigate the effects of the pandemic on the national economy and the closure of schools and universities, the compulsory wearing of masks in public and private services, shops and transport were some of the measures taken.

On the social front, the State had taken a number of support measures, including the distribution of food kits, payment of electricity bills, cash transfers and financial subsidies for sectors in difficulty or categories operating in the informal sector. Despite this support, the measures taken to combat COVID-19 were widely contested. Indeed, the economic consequences of restrictions on grouping and travel, and the difficulties encountered by certain socio-professional categories, gradually generated tensions and protests, particularly among informal sector workers, who account for 96.4% of jobs in Senegal (ANSD, 2017). But while the reaction was swift, the content of the response remained classic, dominated by biomedical and vertical solutions influenced by the fight against Ebola in the past (Ridde and Faye, 2021).

1.3. HIV IN THE CONTEXT OF COVID-19 IN WEST AFRICA: AN OVERVIEW

When COVID-19 broke out in 2019, the fight against AIDS was robust. Even though the number of people living with HIV remained high, with an increase in access to antiretrovirals, the incidence of HIV had reduced and the number of deaths fallen by 33% between 2010 and 2018. Vulnerability to HIV is among specific populations called 'key populations' such as sex workers, men who have sex with men, transgender people and Injectable Drug Users. According to UNAIDS, 59% of new HIV infections worldwide in 2019 were expected to occur in sub-Saharan Africa [2]. A new population cohort, adolescent girls and young women aged 15 to 24 had been noted to be twice as likely to be living with HIV as young men of the same age. They represent only 10% of the population but accounted for 25% of all new HIV infections worldwide in 2017. (UNAIDS).

The relatively higher HIV prevalence in Africa combined with COVID-19 had a negative impact on access to healthcare due to pre-existing vulnerabilities, a fragile healthcare system and limited social protection [2]. The measures put in place to combat Covid-19, namely social distancing, limited transport, mobilization of personnel and infrastructure, led to a reduction in the frequency of use of health facilities, with consequences for access to screening and treatment of HIV infection. A survey carried out by the Global Fund in 502 health facilities in 32 countries reported an average 41% drop-in HIV screening rates between April and September 2020 compared with the same period in 2019 [7]. The effects of the pandemic exacerbated situations of food insecurity, particularly among People living with HIV (PLHIV) (McLinden & al., 2020). According to UNAIDS, during COVID-19, sex workers around the world were confronted with situations of distress, repressive measures, arrests and closures of their workplaces, which pushed some of them into precariousness (UNAIDS, 2022). This was also the case for MSM, who also faced increased risks of violence and harassment (UNAIDS, 2022). Our focus will be on all populations vulnerable to HIV in West Africa: men who have sex with men, sex workers, IDUs, people living with HIV and young girls. What were the effects of COVID-19 on these populations, and what are the social, economic and health consequences? Did Covid reinforce stigmatization and discrimination against populations already vulnerable to HIV?

2. OBJECTIVES

- Analyze the social and health effects of COVID-19 on the vulnerability of populations most vulnerable to HIV, such as sex workers, men who have sex with men, PLHIV and young girls
- Identify constraints, difficulties and resilience factors
- Propose recommendations based on lessons learned from the COVID-19 pandemic for the protection of vulnerable populations in the event of a new pandemic

3. METHODOLOGY

A combination of approaches was used. A literature review was carried out on the following themes: experiences, inequalities of PLHIV, sex workers and MSM in West Africa and Senegal during Covid. The following search engines were consulted: Google Schoolar; DOAJ (Directory of Open Access Journals), OpenEdition Journals; MyScienceWork; Érudit; Persée; HAL (Archives ouvertes); CAIRN info; PubMed and ScienceDirect.

Data from a survey conducted in June 2021 by the Conseil National de Lutte contre le Sida to document the strategies put in place to mitigate the impact of COVID-19 on the HIV program in Senegal was utilised. The results of 2 surveys carried out just after the COVID-19 pandemic in 2022 and 2023 by a multidisciplinary CRCF team (anthropologist, public health specialists, doctors, community actors, research assistants, community actors from key populations or civil society) were used. A qualitative methodology combining several data collection techniques: participant observation, life histories, qualitative interviews and focus groups with key informants from key populations and health or community players were deployed.

The first survey, conducted from January 2022 to June 2023, aimed to understand the social vulnerability factors of key populations MSM, Sex Workers, Drug User with regard to HIV, focusing on the experiences of “transgenders” in order to facilitate the development of adapted strategies for screening, treatment and retention in care. Investigations were carried out in Dakar and in 8 regions. Surveys targeted: 180 MSM; 56 TS and 25 health workers). Interviews and focus groups were all recorded, transcribed and analyzed using Dedoose software. Several workshops were organized to develop the tools and analyze the results. The second survey,

carried out from November 10 to December 23, 2022, is an action research project to assess people's perceptions of access to COVID-19 vaccination for people living with HIV (PLHIV) and key populations (MSM, SW, DU). A qualitative methodology was based on individual interviews and focus groups with PLHIV and key populations. A total of 78 people were interviewed, including 22 PLHIV, 24 MSM, 09 DU, 21 SW and 02 health professionals. Complementary interviews in 2024 were conducted with leaders of sex workers and MSM.

4. FINDINGS

4.1. REPRESSIVE POLITICAL MANAGEMENT AND MULTIFACETED VIOLENCE

The scale and exceptional nature of the COVID-19 pandemic led to the immediate involvement of senior political leaders, who influenced the mechanisms and forms of pandemic management (Soumahoro, Tounkara, 2020). In most West African countries, an early presidential address dominated the media and set the tone for political handling of the pandemic (Samaké, Diouf, 2021; Annan, 2021). Various legal and administrative measures enabled the extension of legal, sanitary and social powers, which were rapidly put to use by political authorities to implement authoritarian, restrictive and repressive measures in various forms: restrictions on movement, closure of spaces, curfews, closure of neighborhood markets and bans on the sale of prepared food in the streets. A state of emergency was declared in many West African countries. People were subjected to multiple and varied forms of violence, affecting different aspects of social, economic and political life (Plan International, 2020; Save the Children, 2020). The forces of law and order used violent means to enforce confinement and curfew measures (Tchamyou, V. S., Asongu, 2021). The economic and social consequences of restrictions on gathering and travel, as well as the difficulties encountered by certain socio-professional categories, generated tensions and protests, particularly among most informal sector workers. Most states favored the use of force, with the deployment of security forces.

In Senegal, for example, the first refusals to comply with the ban on collective prayers in mosques led to police arrests. People were beaten, arbitrary arrests were made, and, in some cases, live ammunition was fired. Various forms of abuse of power, extortion of resources, or unjustified forms of violence were reported (Ouédraougo, 2021). In some countries such as the Sahel, armed groups perpetrated violence, including attacks on civilians, despite the pandemic. These groups

exploited the context of the health crisis to intensify their attacks, taking advantage of the distraction and fragility of governments (Ouedraogo,2021). This worsened the security and humanitarian situation in the region, putting further pressure on health systems and pandemic response efforts.

Violence against West African populations during the COVID-19 pandemic was multiple and varied, affecting different aspects of social, economic and political life (Ouédraougo, 2021). The COVID-19 pandemic not only exacerbated pre-existing violence but also created new dynamics of violence and conflict in West Africa, profoundly affecting vulnerable populations (International Crisis Group, 2020). Countries such as Mali, Niger, Nigeria[1] and Burkina Faso, already under attack from armed groups, experienced increased attacks during the Covid pandemic, leading to massacres, kidnappings and massive population displacements, exacerbating an already difficult humanitarian crisis. The COVID-19 pandemic also increased domestic violence in West Africa (Al Jazeera, BBC News, 2020), particularly affecting women and girls. Loss of income and economic insecurity, confinement and curfew measures forced many families to stay at home in confined spaces, exacerbating household stress. Cases of physical and psychological violence, emotional abuse, threats, humiliation and sometimes rape, including marital rape reported a rise. Because of travel restrictions, many victims were unable to seek help or refuge elsewhere and continued to be exposed to their aggressors. Specific situations of vulnerability, violence and abuse particularly exposed already socially vulnerable populations such as young girls, people living with HIV, sex workers or MSM.

4.2. THE CHALLENGES OF HIV INFECTION AND COVID-19 IN AFRICA: INVISIBLITY OF YOUNG GIRLS

During the COVID-19 pandemic, advanced age, HIV and chronic illness were considered risk factors for severe cases and death (Ejaz, 2020). Declining service quality and ARV supply disruptions (WHO, 2020; Jewell et al, 2020) increased AIDS-related mortality and morbidity in Africa. UNAIDS had warned that progress in HIV prevention risked being reversed by the COVID-19 pandemic. This happened in a context where quality of life for PLWHA had improved significantly due to prevention efforts and easier access to ARVs (Anti-retrovirals). This had provided

1- In December 2020, Boko Haram claimed responsibility for the kidnapping of over 300 schoolchildren in Katsina State, and in November 2020, an attack on agricultural workers in Borno State left over 110 dead

a gateway to care that enabled HIV-positive people to benefit from treatment, preventing worsening of their health problems, and reducing risks of HIV transmission. According to UNAIDS, a survey carried out in 502 health facilities in 32 countries reported an average 41% drop in the rate of HIV testing during the pandemic between April and September 2020, compared with the same period in 2019, due to a decline in the use of health services.

In a context where 25% of new infections occur among young girls aged 15 to 24, difficulties in accessing screening have affected them. For several years now, UNAIDS and others like Economist Impact (2023) had been warning of an increase in the proportion of new infections among young people, particularly girls in sub-Saharan Africa. They are three times more likely to be infected than their male peers. This is the case in West Africa, where they still face persistent structural, family, social and cultural constraints, in addition to biological factors that continue to expose them to HIV. What's more, in a context where funding for the fight against AIDS continues to decline, few awareness-raising or prevention activities target the specific needs of young girls. Stigma and gender discrimination have worked against young girls to make informed decisions and limited their ability to seek health services, increasing their exposure to HIV infections. Combined with gender-based violence, it is a potent cocktail where safe-sex is compromised.

In most West African countries, adolescents and young girls face numerous constraints in gaining access to reproductive health services adapted to their needs. The socio-cultural contexts of these countries are marked by underdeveloped sex education, limited and inaccessible healthcare provision, socio-cultural taboos, and states with little commitment to policies supporting young girls' reproductive health. Most effective preventive tools to prevent the risk of HIV transmission, such as condoms, spermicides, ARVs for prevention or PrEP, are not accessible to them. Falling through the cracks of reproductive health services that cater to older women added to the situation, as well as draconian measures that prevented women and young girls from earning incomes, thereby increasing their vulnerabilities to HIV.

One study showed the lack of consensus on sexual rights and legal protection for adolescent girls against all forms of sexual abuse and violence. The data also reveals differences in the age at which sexual relations become legal, ranging from 13 in Nigeria and Burkina Faso to 16 in Ghana and Mali. Some countries, such as Benin, Niger and Senegal, have not defined a legal age. Even where such laws exist, they are rarely enforced. Furthermore, the study reveals that, despite the efforts made in the

fight against AIDS, the specific needs of adolescent girls have been neglected, despite the fact that their proportion of the population is growing (Plan International, 2009). These structural constraints and inadequacies, reinforced by the COVID-19 crisis, will increase the vulnerability of young girls, some of whom may be subjected to non-consensual sexual relations or opt for other forms of sexual transaction to ensure their survival, even though they have no access to preventive sexual health services.

4.3. "PANIC-STRICKEN" PEOPLE LIVING WITH HIV IN WEST AFRICA

The high mortality rates of COVID-19 in 2020-2021, when little was known about the virus, created specific challenges for PLHIV. Restricted or no access to ARVs, check-ups, meant compromised immune systems and heightened vulnerabity to COVID-19 and other infections. Messages about high risk of complications for PLHIV created anxiety (Joska et al., 2020) while accessing health care services became difficult as health infrastructure and personnel (doctors, nurses etc) were repurposed to cater to Covid-19 management and treatment, deterring visits to the clinics. Stock-outs and shortages of lab reagents, difficulties in transporting samples led to an increase in precarity of PLHIV. Financial constraints added to the picture

In addition, other support systems by civil society organizations specializing in the fight against HIV, through awareness-building, discussion groups, adherence clubs and distribution of HIV self-tests, condoms and lubricants were disrupted. The effects of the COVID-19 pandemic also created several difficulties (security conditions, lack of personnel and logistics) which impacted on the delivery of viral load samples to laboratories. This had a negative impact on the dispensing of several months' supply of ARVs to patients.

In Senegal, an anthropological survey of PLHIV conducted during COVID-19 highlighted the fear that having HIV might expose them to COVID-19 and compromise the efficacy of their therapy. The continuous dissemination of information on the negative effects of COVID-19 fostered a collective fear and anxiety over being contaminated by COVID-19 and dying as a result. As 40-year-old Assane, who has been on antiretroviral therapy for 9 years, put it: "The Ministry of Health's daily bulletin, broadcast every morning, was listened to very carefully and kept the fear alive. It was not uncommon for several generations of the same family to gather around the radio or television to listen to and comment on this

news." As a result, most of thm adhered to the restrictions, limiting their movements, confining themselves and asking or even demanding that those around them respect the measures. PLHIV, most of whom work in the informal sector, suffered the social effects of the crisis. Some of them had been forced to abandon their activities because of the restrictive measures, or because they had been dismissed from their jobs, or because of the increase in transport prices.

Faced with this situation, civil society organizations, with the help of the National AIDS Council organized a chain of solidarity to ensure the continuity of HIV care and support for PLHIV. First and foremost, associations of PLHIV, aided by specialized NGOs, mobilized to ensure the distribution of ARVs outside care facilities to their peers who could no longer travel to health facilities because of the restrictive measures. They donated protective equipment (masks, hydroalcoholic gel) and food kits containing basic products (rice, oil, sugar, pasta). Some of them also received similar assistance from the government, but the allocation procedures were more complex, sometimes based on political rather than social criteria. As a result, PLHIV associations were able to innovate rapidly during the Covid pandemic and set up medical, psychological and economic support for State structures (CNLS, Division de lutte contre le sida et les IST [DLSI]) and health systems specializing in HIV care. The support from NGOs was critical in providing hygiene and food product kits, training, and support and structuring for home drug distribution. This rapid, tailored response bore fruit: disruptions in the supply of ARVs to patients were avoided in many intervention sites (Ndiaye et al., 2022; Bâ et al., 2022).

4.4. SEX WORKERS IN PRECARIOUS SITUATIONS

Right from the start of the pandemic, a group of researchers warned that sex workers' vulnerabilities to COVID-19 must not be forgotten in the COVID-19 response, as COVID-19 -related containment and distancing measures forced many of them to suspend their economic activities (Platt, 2020). The authors showed that sex workers faced a drastic drop in income during the COVID-19 crisis due to a fall in the number of clients (Toh et al., 2020). Their work highlighted the link between falling incomes and the adoption of risky sexual behavior by a significant proportion of Sex Workers who, in a context of dwindling client numbers, resorted to unprotected sex as a coping mechanism to benefit from certain income bonuses to offset the drop in incomes resulting from COVID-19 (Toh et al., 2020).

In sub-Saharan Africa, UNAIDS reported that SW had tried to adapt to travel

restrictions by going to their clients' homes, which put them in a position of increased vulnerability to physical violence from their partners. To avoid these situations, some of them preferred to go home and sometimes violated curfew hours, were arrested by the police and were sometimes abused. Sex workers reported being victims of police violence, stigmatization and the halting of interventions to combat the risks of HIV transmission. The drop in condom use was heavily concentrated among disadvantaged sex workers (UNAIDS, 2021). In Lomé, a study on the consequences of restricting the freedom of movement of sex workers (SWs) showed that the curfew degraded their work and accentuated their economic vulnerability (Mawussi et al, 2023). With bars and restaurants closed, some were able to carry on their activities with the support of social networks, while others began a process of professional retraining or continued to see their regular customers (Mawussi et al, 2023).

In Senegal, testimonials confirm the difficulties experienced by sex workers who had to stop working. Amina, aged 45, explained :

> "It was really hard because everyone avoided us. We didn't have enough money to support our children. Our usual partners were wary of the risk of contamination. We didn't see anyone. We stayed inactive until things got back to normal and we could go back to work. Nobody gave us any money, so it wasn't easy at all. Because of the 8 p.m. curfew, no one would come to see us. Poverty and famine were knocking at our door, and we had nothing left. Even our relatives, who sometimes helped us, avoided us."

> "All our activities take place at night because during the day people have other things to do than have sex. Now with the restrictions, the confinement, we've been deprived of the night. Some young sex workers who live with families can't host their partners at home, and motels were closed. So affording a room is a problem."

An article published in 2020 in the newspaper "le Monde Afrique" described the implications of the state of emergency in Senegal for sex workers and the resilience strategies they adopted to maintain their professional activities in a context of restricted freedom of movement. Sex workers reported that the closure of borders had reduced the number of clients and changed their profile, depriving them of foreign clients who were more profitable than those residing locally. They found it

difficult to meet their family and social obligations, but developed various forms of solidarity and support among themselves.

Data analysis of the interviews we conducted with leaders of sex workers in Senegal confirmed this peer-to-peer support, with the backing of various partners such as the Global Fund. Indeed, the interviewees confirmed that during COVID-19 , they created a WhatsApp group bringing together members of an association of 350 FSWs to serve as a platform for sharing health prescriptions, which also played a crucial role in managing the loneliness of some FSWs who were off work, by enabling them to benefit from a space for exchange where they could confide in each other and share their questions and concerns. They also benefited from donations of food and hygiene kits for several months, thanks to the dynamism of civil society organizations, which had been able to obtain funding with the help of their partners.

In some northern countries, such as France, a number of initiatives were launched to draw attention to the deterioration in living conditions and "the distress faced by sex workers and people in prostitution as a result of the health crisis". Despite these calls, the state did not react, and it was civil society organizations and associations that supported the SWs (Liotard, 2020).

4.5. MSM EVEN MORE ISOLATED AND VULNERABLE

In the African context, a "double life" prevails among people who are homosexual, but conceal this through their heterosexual practices or unions (Broqua, 2012). According to Broqua (2012), "heterosexual practice is a crucial condition of possibility for homosexual practice". Violent reactions from the population, reflecting opposition to the spread and appropriation of new Western models of affirmation of African homosexuality, have been observed in several African countries including Senegal, where some religious leaders have portrayed homosexuality as a sign of "depravity" (Broqua, 2012).

Data from our survey in Senegal confirms that the life course of most MSM is marked by experiences of stigmatization, sometimes leading to recurring situations of suffering: withdrawal and isolation, feelings of hatred and frustration, suicidal ideation and attempts to act out; as well as physical and psychosocial violence (childhood sexual abuse, arrests, expulsion from the family home, etc.) caused by family, school or professional circles. Accentuated by the rise in homophobia, this violence forces them to live out their sexual orientation clandestinely, leading to

multiple forms of sexual transaction and even prostitution that expose them to HIV. The people we interviewed spoke of the reality of unprotected oral and anal sex and the recurrence of STIs in their community.

During COVID-19, they reported having been victims of new forms of violence and stigmatization, which reinforced their withdrawal, avoidance of social relations and isolation. Indeed, some of them reported that they were accused of being responsible for the outbreak of the COVID-19 pandemic, a form of divine punishment linked to their practices. They reported that the constraints experienced during confinement and financial difficulties in meeting survival costs had accentuated their difficulties, and increased the stigmatization they have always been subjected to. Some of them also reported having experienced difficult sexual frustrations that led them to adopt risky practices.

5. DISCUSSION AND CONCLUSION

Fundamental principles of a conceptual framework based on Equality, Diversity and Inclusivity (EDI) of all populations, will enable us to analyze our data. Use of this concept ensures that all people have equitable access to resources, care and information. All are recognized and the differences between individuals and groups are not held against them but valued. Everyone's socio-economic, gender, and physical and mental abilities are acknowledged and taken into account, and decision-making and implementation of public health interventions involve groups who have been marginalised.

The strategic axes of this tool enables us to measure, firstly, whether equitable access to healthcare has been achieved through the implementation of specific support systems for vulnerable groups and the availability of biomedical equipment distributed equitably. A second dimension concerns communication and information, through transparent information accessible to all, including people with disabilities. The third dimension is community participation, involving the population from the design to the implementation of interventions, with the possibility of gathering their feedback for readjustments. Protection of human rights is the final dimension, which makes it possible to prevent and combat any form of discrimination or stigmatization linked to the pandemic, through emergency measures that respect fundamental human rights. EDI dimensions can be operationalized through an AAAQ framework that measures Availability, Accessibility, Acceptability and Quality of social and health services.
Applying EDI principles and AAAQ framework to our data reveals the discrimination

and violations suffered by PLHIV, sex workers, young girls and MSM in West Africa during the COVID-19 pandemic. The application of restrictive measures in the same way for everyone, without taking into account differences in situation and power relations between social groups, reinforced the vulnerability of these groups. No services or protective measures were thought of or offered to young girls forced to remain locked up in domestic spaces at risk of sexual abuse. Risks associated with halting the movement of people living with HIV, who need access to ongoing consultations and treatment, were not anticipated, forcing civil society actors to organize themselves to circumvent the constraints associated with access to and availability of services essential to their survival.

The consequences of restrictive measures on sex worker's activities were completely ignored, leaving them without any resources to ensure their basic needs. No support or accompaniment was put in place to help them overcome their difficulties. On the contrary, in most countries, they were subjected to increased violence by security forces, which further increased their vulnerability. No attention was paid to the effects of COVID-19 on already marginalized MSM. Many of them found themselves trapped in hostile environments with no possibility of travel or work, and were also subjected to various forms of violence which made them even more vulnerable. Communication strategies focused on respecting barrier measures as a COVID-19 response were aimed at the general population, without taking into account the specific realities and information needs for vulnerable groups.

There was no campaign to prevent violence targeting young girls or other exposed groups, despite warnings. Most representatives of these groups were not involved in the pandemic's management by political and biomedical actors. No approach or measure to combat stigmatization, discrimination or protect human rights of vulnerable groups was taken during the response to COVID-19 in various West African countries. Thus, the application of EDI and AAAQ frameworks to realities experienced by these populations confirmed that the COVID-19 response was neither equitable, egalitarian, inclusive nor respectful of the rights of marginalized populations in the West African countries we studied. Measures put in place were restrictive, uniform "one-size-for-all", and failed to take into account experiences, realities, adverse effects and specific vulnerabilities associated with each group.

Lessons learned from the COVID-19 pandemic show that the pandemic's management increased violence, suffering and reinforced structural inequalities for already vulnerable populations such as young girls, sex workers, PLHIV and

MSM. During a serious health crisis, vulnerable populations need special attention to prevent further stigmatization or violence reinforcing their suffering and difficulties and compounding the negative impact of Covid on HIV prevention and care systems.

Civil society organisations which work closely with and are witness to experiences of vulnerable communities have developed more specific responses that directly address their needs, taking into account socio-cultural contexts. However, these organisations were limited by centralised medical pandemic management without enough responsibility for communities, and difficulties in accessing funding. But in most West African countries, funding from The Global Fund helped to mitigate the effects of COVID-19 on vulnerable populations in respect to HIV. Fortunately, in some countries, The Global Fund enabled the use of available funding to deal with the first health emergencies linked to the pandemic and launched a funding mechanism for COVID-19 -related interventions. Thus, gaps and limitations in the pandemic response can be recognized and analysed through the use of an EDI and AAAQ framework that takes into account the specificities and needs of marginalized social identities to prepare for and respond to emerging and re-emerging pandemics, while respecting ethics and human rights.

The following recommendations and methods can be proposed in the event of new pandemics:

1. Carry out a SWOT analysis (Successes, Weaknesses, Opportunities, Threats) incorporating EDI and AAAQ frameworks for vulnerable groups such as young girls, sex workers, PLHIV and MSM. In most countries, national AIDS programmes have carried out assessments of COVID-19 pandemic effects on HIV vulnerable populations. A great deal of economic, social, political and public health research has been carried out and published in various West African countries and at the regional level. Results could be used as the basis for developing a briefing note, policy document or advocacy document to understand, analyse and recognise specific difficulties experienced by these groups during new pandemics. This work should help to achieve a consensus at country and sub-regional level to recognise marginalisation of vulnerable groups in the context of a sudden-onset crisis such as a pandemic or a humanitarian disaster of any kind.

2. Facilitate community participation of various vulnerable groups, including their representatives, in consultation and decision-making forums at all levels of the pandemic management pyramid. Civil society organisations must ensure that

representatives of groups most vulnerable groups are included in the epidemic/pandemic monitoring and management structures and mechanisms at national and sub-regional level. In many countries, a community surveillance system for diseases with pandemic potential exists. Representatives of vulnerable groups should be included in these groups. Their participation could be facilitated by a community or social sciences research system for enabling available data and information from communities to be fed back into the system.

3. Integrate risks incurred, potential effects and needs adapted to the socio-cultural specificities and vulnerabilities of vulnerable groups to pandemic response and preparedness plans. In each country, pandemic management structures have drawn up preparedness and response documents. Representatives of vulnerable groups must ensure that national response plans take their needs into account. The lessons learned from covid showed how sex workers were forced to suspend all their activities and found themselves without any income. But they were not provided for in the aid and support schemes put in place by the State. In some West African countries, they have sometimes been forced to take risks in order to meet their basic needs. This work must also be carried out at a sub-regional level with sub-regional or international health organisations and technical and financial partners. An advocacy note could be drawn up jointly by civil society organisations and representatives of vulnerable groups to alert the WHO in charge of pandemics/pandemic response and all technical and financial partners to risks and needs identified by the most vulnerable groups in event an pandemic.

4. Implement quality services that are adapted to the priorities identified, accessible and acceptable in the light of their realities. The specific needs of each vulnerable group should enable the identification of specific services to be put in place based on the lessons learned during the covid. Examples of PLWHA associations supported by CNLS, that facilitated access to ARV treatment discreetly for their members confined at home highlight how community dynamism made it possible to avoid treatment breaks so dangerous for their health.

5. Promote access to funding and support mechanisms for organisations working with vulnerable groups in the event of a pandemic. The lessons learned from COVID-19 have shown the importance of the various financial needs of vulnerable people, whose needs are not prioritised by the authorities. The example of The Global Fund to Fight AIDS, which urgently redeployed funding to support vulnerable people affected by COVID-19, is interesting. To meet these needs, they must be able to

benefit from rapid financing arrangements that can be mobilised urgently through simplified procedures. Specific provisions must be incorporated into pandemic financing plans to make this possible. Partners who support the funding of pandemic preparedness and response must be made aware of the need to provide funding quotas for vulnerable groups.

6. Develop a communication plan adapted to the needs and challenges of each vulnerable group and integrate the basic elements into national communication. The experience of different countries in dealing with COVID-19 has highlighted the negative effects of non-targeted communication on the less visible realities experienced by vulnerable groups, and the negative consequences of the circulation of misinformation in their lives. In the event of a pandemic, communication campaigns must specifically target all these vulnerable groups, highlighting the specific information they need to protect themselves from the pandemic and its effects, as well as from any form of violence or discrimination.

7. Integrate measures to respect human rights and combat discrimination and stigmatisation, taking into account the specific characteristics and vulnerabilities linked to gender and sexual orientation, into the management of the pandemic. Pandemic preparedness and response plans must anticipate the legal and social protection of vulnerable groups. Advocacy is needed to ensure that these issues are included in the documents. Mechanisms for communication and prevention of all forms of abuse, violence and discrimination must be put in place. Technical and financial partners involved in the management of pandemics must be approached to ensure that these aspects are included in the standards for the preparation of documents.

8. Set up a warning, support and rights protection system specifically for vulnerable groups in the event of a pandemic. Violence alert and protection services for girls or young women, sex workers and LGBTQ populations must be planned and implemented in the event of a pandemic. The COVID-19 experience has shown that the availability of free phone helplines led to many cases of sexual abuse and other forms of violence against vulnerable groups being reported. Shelter services for isolated people can also provide support for people experiencing family breakdown. Victims of violence or abuse should benefit from legal and social support measures. Pandemic response plans must include the provision of these services.

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