

A young woman with short dark hair is looking directly at the camera. She is wearing a black face mask with a white and yellow pattern. Her jacket is very colorful, featuring a mix of blue, pink, green, and black patterns. The background is a plain, light-colored wall.

THINKING OUT OF THE BOX

A Collection of Innovative Case Studies from UNFPA and Partners

BUILDING SYNERGIES AMONG THE RESPONSES TO COVID-19, HIV AND SEXUAL AND REPRODUCTIVE HEALTH IN EAST AND SOUTHERN AFRICA

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ACKNOWLEDGMENTS

Taking an innovative idea from brainstorming and planning to implementation on the ground during the COVID-19 crisis required multisectoral collaboration, quick action, and a strong commitment to the people we serve.

The new approaches and interventions collected in this report would not have been possible without the joint efforts of our national partner organizations, Ministries of Health, sister UN agencies, donors, UNFPA staff, activists and communities.

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Foremost, we thank the people of ESA who inspire us every day with their strength and resilience.

Cover photo: © UN Mozambique/Helvisney Cardoso

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
AGYP	Adolescent girls and young people
AYP	Adolescents and young people
CSO	Civil society organization
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
FP	Family planning
FSW	Female sex worker
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HMIS	Health Management Information Systems
KP	Key populations
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex persons
MSM	Men who have sex with men
MoH	Ministry of Health
PLHIV	People living with HIV
PPE	Personal protective equipment
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations

MESSAGE FROM THE REGIONAL DIRECTOR

SPARKING INNOVATION WHEN HEALTH SYSTEMS ARE OVERSTRETCHED

Since East and Southern African countries were placed on COVID-19 related lockdowns earlier this year, I have been following with deep concern the evidence-based findings regarding the negative impact of the pandemic response on health services for HIV and sexual and reproductive health and rights (SRHR).

My heart sinks when I learn about the rise in teenage pregnancies in Malawi, the drastic declines in contraceptive use in Namibia and Zimbabwe, and the drop in monthly condom distribution in Uganda, from 16 million to four million.

These are worrisome outcomes that compromise the health of generations of men and women and the work of the past two decades.

East and Southern Africa (ESA) is the epicentre of the HIV pandemic, with more than half of the global HIV population residing in this area. To a great extent, what happens in the region will influence the outcome of Sustainable Development Goal 3.3 - to end AIDS as a public health threat by 2030.

But the COVID-19 pandemic will make it extremely difficult to reach the 2030 target unless drastic action is taken to minimize disruptions to health services.

In this, the problems are manifold:

Firstly, barriers to accessing health care range from fewer staff available to work - due to sickness, repurposing, and lack of personal protective equipment - to people's reluctance to seek medical assistance at health centres for fear of contracting the virus.

Secondly, community-based programming is negated by the need for physical distancing.

Thirdly, key populations may struggle to access services delivered at hotspots.

Fourthly, supply chains, such as those for condom imports and distribution, may be disrupted.

Lastly, HIV funding may dwindle as resources are diverted to the COVID-19 response, and as the knock-on effect causes development partners to feel the pinch in their economies.

And yet, despite these forebodings, I felt a sense of hope when I saw how quickly and nimbly UNFPA and its partners rose to the challenge and found innovative and alternative ways to deliver information and services to safeguard the gains made to date in HIV prevention and SRHR.

Here, we share ten cases studies that describe a variety of strategies adopted by UNFPA and its partners in ESA to ensure service delivery in these difficult times.

The lessons learned will have value beyond the COVID-19 pandemic, and even beyond HIV prevention. They can be applied to the wider SRHR agenda, especially in humanitarian settings and in any adverse environment.

We encourage our country offices and partners to document and share these innovations, and report what worked and what did not. One thing does not change across the board: our work at UNFPA prioritizes the most vulnerable, disempowered and marginalized populations of our region. We are working extremely hard to ensure that we leave no one behind.

Dr. Julitta Onabanjo,
Regional Director for UNFPA
East and Southern Africa



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HIV IN EAST AND SOUTHERN AFRICA

REGIONAL



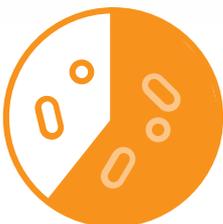
30,000
PEOPLE DIED DUE
TO AIDS-RELATED
ILLNESSES IN 2019

PROGRESS:
AIDS-RELATED DEATHS
HAVE NEARLY HALVED
SINCE 2010 – THE
LARGEST DECREASE IN
THE WORLD.

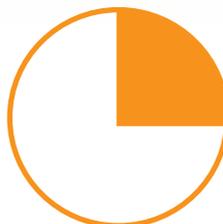
GENDER DYNAMICS OF THE HIV
EPIDEMIC IN ESA



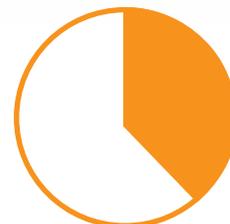
The incidence of HIV infections among adolescent girls and young women (aged 15 to 24 years) is 2.5 times higher than among their male peers.



In 2019, 3 in 5 new infections were among women.



About one quarter of new infections are among key populations and their sexual partners.



36% of sex workers are HIV positive.

COVID-19 IN ESA COUNTRIES

REGION

EASTERN AFRICA

5,558
DEATHS

297,888
CASES

226,202
RECOVERIES

SOUTHERN AFRICA

25,021
DEATHS

968,020
CASES

849,599
RECOVERIES

Source: AFRICA CDC on 16 December 2020 / <https://africacdc.org/covid-19>

The pandemic at a glance in selected ESA countries -
WHO data as of 13 December 2020

Country	Total Cases	Total Deaths	Recovered Cases	Fatality Ratio	Health worker Infections
Kenya	91,892	1,587	73,028	1.7	2,939
Uganda	27,532	221	9,826	0.8	1,644
Namibia	16,536	160	14,684	1	641
Zimbabwe	11,246	307	9,451	2.7	248
Eswatini	6,768	127	6,378	1.9	336
Malawi	6,066	187	5,491	3.1	563
Lesotho	2,150	44	1,278	2.0	30



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HIV AND COVID-19: ADAPT, INNOVATE, COLLABORATE

Starting in March and April 2020, the swift change of gears by health systems to cope with the COVID-19 pandemic has disrupted other equally essential health services across East and Southern Africa (ESA). The result is that the huge gains achieved by ESA in

prevention and treatment of HIV, as well as in sexual and reproductive health (SRH), are being fast eroded by the COVID-19 response.

Since the 1990s, ESA has been the region of the world hardest hit by HIV and AIDS, but in the last 20 years, it has made significant



progress in turning the tide (see p3). The region saw sharp declines in deaths, vertical transmission and new infections, a massive upswing in testing and treatment, and less stigmatization. This was achieved through the vast coordinated efforts of governments, development partners, activists and communities.

However, there is no room for complacency. New infections, especially among young women and key populations are alarmingly high (see p4). Poverty, gender inequalities, gender-based violence (GBV), weak health systems, especially in rural, remote and poor areas, together with cultural norms and values, are among the factors standing in the way of progress.

Within this context, the impact on HIV and SRH programmes of the hard lockdowns implemented to flatten COVID-19 infection curves is devastating.

Restrictions on imports and transport have interrupted supply chains and blocked delivery of health commodities, from condoms to contraceptive pills. The prohibition on gatherings cancelled outreach and demand-creation activities. Misinformation or lack of information about still-functional health centres, coupled with fear of contracting the virus in these centres, kept people away from clinics. Months-long closure of schools and universities left students idle, at risk of engaging or being forced into unprotected sex. Millions of pupils went hungry without school meals. Meanwhile, livelihoods were lost,

poverty spread, and income for health-related expenditure diminished.

The impact on public health was soon evident, with sharp drops in testing for HIV, TB and STDs, in antiretroviral medication (ART) pickups, in antenatal consultations and in the uptake of contraceptives. Some countries have seen a significant rise in teenage pregnancies. Many people were unable to access medicines for chronic conditions, condoms, or even sanitary pads.

The situation required nimble, out-of-the-box thinking and quick action to find solutions, repurpose programming, identify new opportunities and partners, and build synergies between the COVID-19 and HIV/SRH responses.

This document describes the creative approaches to sustaining HIV and SRH interventions adopted by UNFPA and its partners in seven countries – Eswatini, Lesotho, Kenya, Malawi, Namibia, Uganda and Zimbabwe. These approaches draw on our vast and shared experience in linking HIV, SRRH and GBV services and reaching key populations in the region.

Within the variety of people-centred, rights-based, gender-sensitive strategies, some common themes emerged:

- Inform users through messenger apps and digital platforms about available health services (Eswatini, Uganda);
- Bring health services closer to users, especially to key populations such as female sex workers, and to priority populations such as young women and their male partners (mobile clinics in Eswatini, Namibia);
- Leverage the comparative advantages of UN agencies through the UN as ONE partnership (Eswatini, Zimbabwe);
- Combine COVID-19 prevention, screening and testing drives at community level with information and/or services for HIV, STDs and SRH (Eswatini, Malawi);
- Link COVID-19 emergency support interventions, such as distributions of food parcels, food vouchers, water and sanitizer, to the delivery of products for prevention of HIV, STDs and unplanned pregnancies (Malawi, Zimbabwe);
- Identify new opportunities and actors to deliver HIV and SRH products, from condoms and lubricants to sanitary pads, to communities (Namibia, Uganda);
- Use peer educators/navigators and micro-sessions for HIV treatment support instead of visits to health centres (Lesotho, Kenya);
- Adapt and adopt new strategies that comply with lockdown and social distancing, such as telecounselling instead of face-to-face counselling for female sex workers on ART (Kenya), online support for mental health (Uganda), and door-to-door campaigns (Namibia);
- Identify hotspots of movement (both legal and illegal) during lockdown, such as busy border crossings with their potential for infection with COVID-19, HIV and STDs, and provide migrants, long distance truckers and the local population with information, referrals and services (Lesotho);
- Change the methods of health services delivery by shifting to community-based health services that encourage self-care and autonomy, while at the same time limiting the burden on clinics. Examples include home delivery of PrEP (pre-exposure prophylaxis) and ART in multi-month dispensing (MMD) quantities (Kenya);

- Expand the use of online platforms, such as social media and messenger apps, while not forgetting radio and TV, for health messaging and psychosocial support (Uganda);
- Secure the supply of condoms for triple protection (HIV, STDs and unplanned pregnancy) at all levels, from national buffer stocks to the increasing of the quantities dispensed to clients (see guide below).

Guide to dispensing condoms during lockdown

Population groups	Estimated annual consumption	Estimated 3 months' supply
PLHIV (discordant couple)	100	25
Sex workers	600	150
MSM (men who have sex with men)	200	50
Young people	50	15
Women and men with non-regular partners	50	15
PWID (people who inject drugs)	200	50
Couples using condoms for FP	100	25



© UNFPA Lesotho

BUILDING SYNERGIES AND NEW STRATEGIES

A. STRATEGIC PARTNERSHIPS: Leveraging UN partnerships to deliver services to the populations we serve

In the spirit of the UN Delivering as One agenda, where UN agencies work together at country level, UNFPA partnered with the UN World Food Programme (WFP) in Eswatini and Zimbabwe. WFP's mechanism for food distribution was twinned with provision of SRH and HIV prevention services in two ways: distribution of condoms in Zimbabwe along with food, and an SMS campaign about the

availability of family planning to recipients of food aid in Eswatini. These partnerships boost efficiency, save costs, and pull together the system-wide expertise and capacities of the UN to support the 2030 Agenda and, in this case, to respond to crises. In addition, the WFP/UNFPA partnerships have effectively strengthened the humanitarian/development/health nexus.



ZIMBABWE

Linking emergency food aid with HIV prevention and family planning

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In recent years, Zimbabwe has been ravaged by economic crisis, drought, cholera, food insecurity, political instability and, in 2019, Cyclone Idai. The country's HIV prevalence rate is 12.7 per cent. More than two thirds of its population of 13.6 million people are rural and 32 per cent are urban.

Lockdown measures put in place on 31 March prohibited movement and face-to-face interaction, except for essential services.

FAST FACTS

1.3 million people live with HIV.

12.7 per cent HIV prevalence among people 15–49 years.

New HIV infections among young women aged 15–24 years (9,000) are more than double those among their male peers (4,200).

22,000 people died from an AIDS-related illness.

Source: UNAIDS Global Report 2020. Figures for 2018

“This initiative is in the spirit of Delivering as One UN, maximizing existing platforms deep in the communities and enabling efficient use of resources.”

WFP Country Director, Eddie Rowe.



Although family planning was considered an essential health service, misinformation about COVID-19 transmission fuelled fear of going to clinics. Some health facilities had to close when staff donned tools to protest the scarcity of personal protective equipment (PPE). Security officers often stopped people

on the way to health centres. This situation severely dented all health-care provision, especially SRHR services (see table below), and threatened Zimbabwe’s achievements in its high contraceptive prevalence rate (68 per cent) and high condom use.



Zimbabwe has the lowest reported unmet need for family planning (FP) among married women (15.2 per cent) in sub-Saharan Africa and is one of only five countries to meet or exceed the UNFPA’s regional benchmark of 30 male condoms per man per year.¹

Acting on the evidence collected by a rapid assessment of the lockdown’s impact on sexual and reproductive health care, the UNFPA Country Office, in collaboration with the Ministry of Health and Child Care and the Zimbabwe National Family Planning Council (ZNFPC), quickly explored new options to

¹ Source: UNFPA/UNAIDS (2016) Prevention Gap Report

Family Planning Service Utilization, Zimbabwe, January - April 2019 and 2020

Data element	2019					2020					Performance	
	Jan	Feb	March	April	Total	Jan	Feb	March	April	Total	2019 2020	
Combined Oral Pills - New Clients	8,208	7,393	8,756	7,262	31,619	8,560	7,443	7,113	6,630	29,746	2019 2020	↓
IUD - New Clients	537	690	1,058	847	3,132	1,376	1,027	851	214	3,468	2019 2020	↓
Implants - New Clients	4,541	6,778	6,977	6,548	24,844	6,097	6,459	6,419	2,182	21,157	2019 2020	↓
Injectables - New Clients	13,146	6,807	7,497	7,115	34,565	6,168	5,145	7,037	6,223	24,573	2019 2020	↓
Progestogen-Only Pills - New Clients	11,696	11,045	11,560	12,064	46,365	12,222	9,781	9,902	7,635	39,540	2019 2020	↓
Tubal Ligation - New Clients	65	83	109	54	311	112	69	88	33	302		
Vasectomy - New Clients	13	5	33	20	71	11	0	0	0	11	2019 2020	↓

Source: Rapid Assessment of COVID-19 Response in the Context of Maternal and Sexual and Reproductive Health in Zimbabwe. MoH.

secure access to HIV/FP/SRH commodities for the most vulnerable people.

In a context of compromised health services, where unprotected heterosexual sex remains the main transmission route for new HIV infections (38,000 in 2018), maintaining a regular condom supply is a priority for HIV prevention.

The creative strategy adopted was to partner with the UN World Food Programme and use its vast and efficient food aid network to deliver COVID-19 information and HIV prevention and FP products.

WFP delivers nutritious food in 60 of the country's 63 districts through more than 1,500 points that reach 311,160 poor households. Providing male and female condoms and information on HIV/FP/SRHR and COVID-19 during food distributions equips the poorest rural and urban people with dual protection against HIV/STIs and unintended pregnancy without their having to visit health centres. This intervention is complemented with educational sessions on family planning, gender-based violence and COVID-19 at the distribution points.

The first step was to repurpose an existing UNFPA/WFP Memorandum of Understanding (MoU) to supply food to maternity waiting homes. The MoU was reviewed and found adequate for this new task.

The consensus-building and technical process involved several ministries,

parastatals, UN agencies and NGO partners. Local community health workers were trained and local health centres engaged. The Infection Prevention and Control Technical Working Group of the National COVID-19 Response Task Force was consulted and advised on adherence to strict hygiene protocols at every stage of implementation. The estimated quantity of condoms required was based on the number of eligible users in each recipient household (see guide on page 10). A reporting tool was developed to ensure that service utilization data is submitted to the District Medical Office and incorporated into HMIS.

RESULTS

From June to mid-August the partnership had delivered nearly 2.9 million male condoms, 88,900 female condoms, 25,000 FP posters and 96,000 brochures in English, and 8,000 FP posters in Shona and Ndebele.

Less stress for Charity

Charity Fabeni, 35, was elated to see condoms supplied along with her monthly food parcel: "For three weeks now my husband and I have been using condoms to prevent pregnancy because we couldn't get a family planning method from our local clinic due to lockdown. I have six children and the thought of getting pregnant again really stressed me." Ms. Fabeni lives near Kamutanho village, in Mutare district, Eastern Zimbabwe.

LESSONS LEARNED

- Partnering with other UN agencies creates efficiencies in reaching remote communities with essential services.
- Explore the feasibility of providing oral contraceptives and clinical outreach services at food distribution points.
- Cooperation among units at UNFPA Country Office (RH, HIV, Gender) was essential.



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ESWATINI

Messenger apps for family planning reminders

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FAST FACTS

HIV prevalence in girls aged 15-19 years is 10.2 per cent, and 1.9 per cent in male peers.

HIV incidence in girls aged 15-19 years is 3.84, and 0.84 in male peers.

Total lockdown started 17 March 2020. Partial lockdown from end of March until mid-May 2020.

Source: UNAIDS Global Report 2020. Figures for 2018

From mid-March onwards, Eswatini's COVID-19 lockdown interrupted access to most health services. The consequences were soon visible. A 47 per cent drop in women's uptake of family planning and a 67 per cent drop in young people's uptake of SRH services were observed from January to May 2020 compared to the same period in 2019. Antenatal care also suffered. A survey of selected health facilities revealed that about 800 women had registered for antenatal care in May 2019 compared to 300 in May 2020.

These declines in SR health care are likely to increase HIV and STI infections, unintended pregnancies, pregnancy complications, unsafe abortion, and maternal mortality, which currently stands at 452 per 100,000 live births.

Compounding the problem, Eswatini has the world's highest percentage of people living with HIV. About one third of its adult

population lives with HIV and many are co-infected with TB. During lockdown, peer educators and community health agents could not distribute condoms or replenish their supplies, which raises the incidence of unprotected sex and with it, the chances of unintended pregnancy, HIV and STIs.

Sending family planning information to food aid recipients through messenger apps

Although health centres were open and mobility was less restricted during partial lockdown in April, attendance was still low due to misinformation about available services, fear of contracting COVID-19 at clinics, and transport costs amid rising economic hardship.

In partnership with the UN World Food Programme, UNFPA devised an SMS campaign to inform women that integrated SRH services, including contraceptives and condoms, were available at local health centres. A complementary message encouraged women to use a contraceptive method together with a condom for dual protection against pregnancy and HIV/STIs. The SMSes were sent to 80,000 women who receive monthly food parcels from WFP.

This WFP/UNFPA partnership effectively strengthened the humanitarian/development/health nexus and the UN Delivering as One agenda.

At the SADC Parliamentary Forum on SRHR, HIV and AIDS Governance, UNFPA shared the concern about the drop in antenatal care. The media picked it up and generated considerable support for the SMS initiative.

“I felt very encouraged to learn that amid COVID-19 I could visit any clinic for my contraceptive needs.”

Nolwazi Myeni, 24. She is studying to be a primary school teacher and has a six-year-old daughter.

LESSONS LEARNED

- Increase frequency of messaging to weekly or bi-weekly.
- Increase targets of mobile clinics to reach most vulnerable groups.
- Include mobile clinics in the food distribution sites.

B. EXPANDING ONLINE OPPORTUNITIES TO REACH COMMUNITIES

To counter the harmful effect of fake news about COVID-19, coupled with the loss of access to reliable SRHR information and services faced by adolescents and young people, digital platforms are a powerful tool – without neglecting radio and TV for those not online. Tailored messaging that promotes healthy behaviour and self-care based on accurate information empowers youth to navigate through the difficult COVID-19 pandemic.



© Communication for Development Foundation Uganda

UGANDA

Go Mobile: Expanding Online Opportunities to Reach Young People

FAST FACTS

1.4 million people live with HIV.

5.7 per cent HIV prevalence among adults (15–49 years).

53,000 people were newly infected with HIV.

Source: UNAIDS Global Report 2020. Figures for 2018

As COVID-19 spread through the world, fake news and misinformation about the pandemic also flooded social media in Uganda and elsewhere. People living with HIV and TB faced the additional anxiety of not knowing how the disease would affect them. As the group most plugged into social media, young people were prone to receiving and forwarding fake news. With schools and universities closed, enforced idleness increased the opportunities of adolescents and young people to have sex, whether consensual, forced, transactional, unprotected or safe.

Adolescent girls were at particular risk. Of the 1,000 weekly new HIV infections, four in ten are among adolescent girls and young women. Low contraceptive prevalence rate (36 per

cent) and high rates of teenage pregnancy (25 per cent) compound the risk.

In cultural settings where frank discussion of sexuality within the family is taboo, many students learn about HIV and SRHR at school through comprehensive sexuality education, teachers, counsellors, peer educators and health workers. These trusted channels of information and safe spaces were inaccessible during lockdown.

The easiest way to reach young people is via their cell phones and social media. There are 26.8 million mobile subscribers in 2020 and a large proportion are young. An estimated 70 per cent of the population has a mobile connection. Mobile broadband networks (G3-G4) cover four in five people and G2 networks cover nearly all the country.

Thus, mobile technology could bridge the gap in young people's access to COVID-19, HIV and SRHR information during lockdown. UNFPA partners with a youth-led organization, Reach a Hand UGANDA (RAHU), that specializes in youth empowerment programmes in livelihoods, skills development, behaviour change, SRHR, and HIV prevention. Leveraging RAHU's experience and vast reach, a core team of UNFPA and RAHU staff conceptualized a



© UNFPA

mini-campaign for digital and mainstream media around COVID-19 risk management, SRH/HIV/GVB information, and linkages to services.

With the approval of the donor, the Embassy of Ireland, UNFPA repurposed funds from the 2020 workplan, and within the first month of lockdown, the campaign took off.

The campaign used social media, radio, TV, and the Unstructured Supplementary Service Data (USSD or Quick Codes), a free communications protocol accessible on all local mobile networks by dialling *284*15# on either a smart or feature phone.

The core team developed key messages aligned with the government's COVID-19 protocols. National programming was in English, while programming for Karamoja, the least developed region, where UNFPA and RAHU implement SRHR programmes for youth, was in local languages.

Local leaders, resource persons from partners, and trained youth SRHR champions in each district of Karamoja and nationwide facilitated talk shows on prime time on popular radio and TV stations. Journalists were trained to report accurately on SRH/HIV/GBV/COVID-19.

Setting up the USSD took two months. Every mobile phone user in Uganda can now access free, reliable information on COVID-19, family planning, SRHR, HIV/AIDS, information on

health centre locations and contact details, NGO and government toll-free lines, and other useful content, which is regularly updated.

Since its launch in June 2020, the USSD has registered 1,015 subscribers and 14,400 requests for information.

LESSONS LEARNED

- Choose the right technology for maximum impact. With USSD, users with basic feature phones and smart phones can access information.
- Since mainstream media such as radio and TV were dominated by COVID-19 news to the detriment of other health issues, mobile technology was an effective alternative channel for HIV/SRHR/GBV content.
- Flexibility in programming enables innovation.

C. RECALIBRATING SERVICE DELIVERY: shifting from health facilities to community-based health services

An emergency of the magnitude of COVID-19 requires multisectoral collaboration and a quick shift in service delivery. Both are crucial in responding to the pandemic and maintaining equitable access to essential SRH/HIV services. To avoid deepening health inequalities and reversing gains made, UNFPA and partners quickly found alternative ways to deliver HIV/SRHR care that minimized COVID-19 risks and complied with hygiene protocols and lockdown rules. Basically, if people from underserved communities cannot come to the clinic, the clinic must come to them.

NAMIBIA

Expanding Equitable Access to Health Care through Mobile Clinics

FAST FACTS

11.5 per cent HIV prevalence among adults aged 15-49.

210,000 people live with HIV.

29 per cent of new infections are among youth aged 15-24.

Source: UNAIDS Global Report 2020. Figures for 2018

As Namibia's health system geared up to cope with the COVID-19 pandemic, some public health facilities were re-purposed for the COVID-19 response and essential health services were diverted elsewhere, sometimes inadequately. Confusing and conflicting information about the availability and location of health services, as well as fear of acquiring the virus, lowered clinic attendance.

People living in informal settlements and rural populations were worst hit. Loss of income, cost of transport, distances to clinics and restrictions in movement were formidable barriers to accessing health care.

As a stop-gap decentralizing measure, UNFPA, in partnership with the Society for Family Health and the Namibia Planned Parenthood Association, operated mobile outreach services in towns and informal settlements with the highest HIV prevalence and teenage pregnancy rates in the country. These included suburbs of main towns and rural and urban informal settlements in the Khomas, Kavango East, Omusati, Ohangwena and Zambezi regions. In Windhoek, the capital, where nearly half a million people live (out of a population of 2.2 million) and more than half are young, the mobile clinics served 49 informal settlements.

From April to July 2020, the mobile clinics operated Monday to Saturday from 8 a.m. to 5 p.m., each day at a different location. Once lockdown was eased, the mobile clinics were stationed close to malls and markets to capitalize on the flow of people.

RESULTS: MOBILE CLINICS April-July 2020

SRH/HIV services provided	Number of clients
Information on and screening for COVID-19	1,700
HIV prevention information	1,700
HIV counselling and testing	1,675
Clients initiated on PrEP	70
SRH Information and counselling	825
Condoms distributed	29,234
Lubricants	290
Clients accessing FP /contraceptives	434
Pregnancy test	69
STI treatment and counselling	44
Clients started on ART	119
Referrals	3

Each mobile outreach team consisted of a nurse (responsible for family planning and STI screening and treatment), a community health worker (HIV counselling and testing), and two trained youth activists (information and COVID-19 screening). Hygiene protocols were strictly maintained among both staff and users.

Services included HIV prevention information, testing, ART initiation, PrEP, condoms, contraceptives, STI screening and treatment, cervical cancer screening, and SRHR and GBV information.

Youth were the biggest users. Eight in ten clients were young people. Seven in ten clients who were tested for HIV were between 20 and 24 years of age. More than half of those provided with contraceptives were aged 14-25 years. (See table on p19.)

LESSONS LEARNED

- Good collaboration among partners and institutions is crucial to plan and coordinate new ways of maintaining essential HIV/SRH services.
- Emergency preparedness must be part of on-going planning and delivery of health services.
- Timely planning and resourcing, and prior community mobilization are key to the success of new strategies.
- Local health facilities should be involved at the planning stage because the outreach team may need them to replenish commodities.
- Bringing services closer to poor communities is cost-effective, saves money, and encourages attendance.
- Integration of health services requires fewer visits and promotes efficiency.



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Learning curve

Procurement of PPE, clinical materials and health commodities delayed the start under lockdown.

Frequent requests for contraceptive implants could not be met in the mobile units.

WHAT YOUNG USERS SAID:

“I am really happy for the services we received today. I could talk freely about my health, especially sexual and reproductive health issues.”

“Going to the clinics is a challenge because of the long queues and slow progress. We are really delighted for this service.”

ESWATINI

Bringing SRH Services Closer to People

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Through this pilot project, UNFPA, in collaboration with UNICEF and the Ministry of Health, organized outreach days with a mobile clinic to provide integrated SRH services to some 600 young women working in a textile factory in Matsapha, in central Eswatini. The women work long hours and only finish work when health centres have closed.

The intervention had two components. The HIV unit offered information, testing and condoms, while the mobile clinic offered contraceptives (injection, pills, IUDs and condoms), ART initiation and refills, screening for breast cancer, pregnancy, STI and TB, and counselling for cervical cancer, sexual abuse, STIs, HIV and family planning. Both units gave information and advice on COVID-19.

Family Life Association (FLAS), Swaziland Action Group Against Abuse (SWAGAA) and Women and Law in Southern Africa (WLSA) collaborated in providing services.

In four days in July, 152 workers accessed 1,548 health services. A big advantage is that in just one visit users can deal with several health-care needs.

“Getting all the health services within the workplace and during working hours, that’s very good for us,” said Tsakasile Bhembe, a factory worker and mother of a seven-year-old girl.

“I understand the importance of family planning now. You need to have the number of children that you wish to have. Not less and not more,” Ms. Bhembe said. “The important thing is to be able to provide for the material and emotional needs of your children.”

LESSONS LEARNED

- Increase targets of mobile clinics to reach most vulnerable groups.
- Include mobile clinics in the food distribution sites.

D. INTEGRATING COVID-19 PREVENTION WITH THE HIV RESPONSE

In settings of high HIV prevalence and high teen pregnancy, it is essential that male and female condoms for dual protection remain accessible to all people, especially the poor, the rural, and the young. Marrying HIV prevention interventions to the COVID-19 response ensures greater efficiency and mutual benefit. In Namibia, UNFPA and partners explored a non-judgmental, user-friendly, community-owned alternative way to promote condom use and simultaneously give correct information on COVID-19 at household level. Because Namibians, especially those in rural areas, are generally comfortable welcoming community workers into their homes, a countrywide door-to-door campaign worked well.



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NAMIBIA

A Door-to-Door Approach to Condom Promotion and Information-Sharing

On 17 March 2020, the government declared a state of emergency and a nationwide lockdown that was subsequently eased in early May. Alarming, by April a steep decline in the uptake of HIV and SRH services was observed.

A UNAIDS rapid assessment among people living with HIV in April 2020 found that 39 per cent lacked information on COVID-19, 16 per cent did not have enough stock of medicines, and 42 per cent wanted psychological support. WHO reported a big drop in the number of new patients started on ART between January and April 2020, especially in Khomas and Kavango East regions. In the same period, a decline in contraceptive use was observed by UNFPA and the Ministry of Health and Social Services (MOHSS).

These declines are attributed to the health system's shift in its priority to COVID-19, disruptions in the supply chain of health commodities, and restrictions on people's movement.

Although Namibia has achieved tremendous progress in stabilizing the HIV epidemic in the last 15 years, exceeding most of the 90-90-90 targets set by UNAIDS in 2014, the HIV prevalence rate remains among the highest in the world (one in 10 adults). HIV incidence is much higher among women aged 15-24 years (0.99 per cent) than among their male peers (0.03 per cent).

Thus, minimizing interruptions in the supply and demand for condoms was critical for prevention of HIV and unintended pregnancy, and as important as giving correct information on COVID-19 to communities.

Meeting these two needs with a door-to-door campaign to provide both information and condoms was the solution found by UNFPA and its partners: National Youth Council, African Youth and Adolescents Network (AfriYAN), Society for Family Health, Namibia Planned Parenthood Association, Namibia Red Cross Society and the MOHSS.

The project trained and deployed 584 community workers and activists. Wearing their institution's branded gear and following strict hygiene protocols, they fanned out through all 14 regions, reaching 9,680 households. The local leadership was informed in advance. Permission was sought



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from each household and, once granted, an interactive session of information-sharing and condom promotion took place. The activists used the community engagement toolkit for COVID-19 developed by MOHSS with UNFPA support.

Generally, the reception was positive, although some people, fearful of the coronavirus, refused to talk. Some adolescents were a bit shy to talk about safe sex, while many older people expressed a sense of relief being able to learn about COVID-19 and HIV.

RESULTS

From March to June 2020, 584 activists reached 9,680 households in 121 constituencies in 14 regions and distributed 238,600 male and female condoms, mostly in the Khomas region, which is close to the capital.

LESSONS LEARNED

- Prevention of HIV, unintended pregnancy and COVID-19 can be delivered as an integrated package of services to the community.
- The door-to-door visits fostered a deeper understanding of people's SRH health needs during the pandemic.
- People, especially adolescents, appreciated getting free condoms and SRH/HIV/COVID-19 information in the comfort and safety of their homes.
- Community mobilization prior to the intervention is essential to its success.
- Supply chain disruptions limited the availability of condoms to satisfy demand.
- Disruption in family planning services can be minimized through preparedness, crisis response, and coordinated transition back to routine services.



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MALAWI

Girl Power in Action in Mangochi District

FAST FACTS

1 million people live with HIV.

9.2 per cent HIV prevalence among adults (15-49 years).

38,000 people newly infected with HIV.

Among youth (15-24 years), less than half have correct knowledge of how to prevent HIV.

Among HIV-positive youth (15-24 years), half are unaware of their status.

Among youth (15-24 years), 19 per cent of males and nearly 9 per cent of females had sex before age 15.

Source: UNAIDS Global Report 2020. Figures for 2018

Since schools closed under shelter-in-place measures in April, Malawi has seen a spike in teenage pregnancies.

This is a matter of concern. For decades Malawi has worked hard to bring down its high rates of early sex, early pregnancy, early marriage, and girls' dropout from primary school. There have been big improvements but more are needed. More than four in ten women are married by age 18, and one in ten before age 15. Net female secondary school enrollment is 35 per cent.

Worryingly, teenage pregnancy increased from 25 per cent to 29 per cent between 2010 and 2016, according to the Demographic Health Survey. In the southern region, one-third of girls aged 15-19 have begun childbearing. This indicates low contraceptive use among sexually active adolescents.

While Malawi is on track to achieve the UN 90-90-90 HIV targets, young women remain at particular risk. Young people (aged 15-24) account for one-third of new HIV infections, and the rate of new infections among young women (9,900) is more than double that of young men (4,200).

Over the years, UNFPA and partners have supported successful interventions for adolescent girls, their families, and for schools



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in three districts, including Mangochi. The achievements in keeping girls in school, HIV-free, and empowered to avoid early marriage and unintended pregnancy, are fast being eroded by the pandemic.

Schools closure left students with unsupervised free time, cut off from safe spaces, life skills classes, and from trusted teachers and health agents.

Meanwhile, government and NGO activities have shifted their focus to COVID-19 at the expense of HIV prevention and SRHR issues.

In Mangochi district, UNFPA and its long-time partner the Malawi Girl Guides Association (MAGGA), have developed a strategy that combines COVID-19 and HIV prevention, menstrual hygiene, and SRH information.

Trained MAGGA members distribute face masks, sanitizer, menstrual hygiene pads, and brochures with information about HIV, family planning, and GBV. The intervention reaches thousands of adolescent girls and young women who have previously participated in MAGGA activities. Girl-to-girl support, both in person and through the active MAGGA Facebook page, can bridge the gap until schools reopen.

LESSONS LEARNED

- Despite COVID-19 disruptions, existing platforms and programmes can be effectively repurposed for HIV/COVID-19 prevention activities.
- COVID-19 funds can support SRH/HIV service delivery if the services are well integrated.

E. LEAVING NO ONE BEHIND: Innovating to Reach Key Populations

Huge progress has taken place in HIV high-burden countries of East and Southern Africa to reach key and priority populations, particularly sex workers and their clients. High HIV and STI prevalence rates among them fell sharply, condom use rose, and targeted health-care services multiplied, but these gains are threatened by COVID-19. Programmes for key populations must assess their unique needs and vulnerabilities, and adapt in order to mitigate the negative impact of the pandemic on key populations. Kenya, Uganda and Lesotho have found creative ways to maintain, and even improve, their HIV/SHRH programmes for key populations.

KENYA

Innovation, Adaptation, and Community Resilience: how to maintain continuity and improve HIV/SRHR services for female sex workers

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FAST FACTS

1.6 million people live with HIV.

4.7 per cent HIV prevalence among adults 15 to 49 years.

46,000 people newly infected with HIV.

Source: UNAIDS Global Report 2020. Figures for 2018

Since 2012, UNFPA has supported a successful SRHR programme for female sex workers (FSW) premised on peer education and friendly drop-in centres (DICs) in Kilifi and Mombasa counties in coastal Kenya.

The COVID-19 lockdown compelled the programme to substantially change its strategy to ensure continuity of services and compliance with lockdown rules: smaller and more tailored outreach, home visits, tele-counselling, and more efficient use of technology and data analysis, among other innovations. The changes involved active agency of the sex workers to protect their health and their livelihoods.

Before the COVID-19 outbreak, the women could access most clinical services at the DICs and access peer education, including risk-reduction counselling, at their workplaces in hotspots and in their communities.

The lockdown from mid-March 2020 threw the programme into disarray. Peer education and visits to DICs were disrupted by movement restrictions and the ban on gatherings of more than 15 persons. Premises where meetings were held were



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shut, while the dusk-to-dawn curfew reduced the DICs' operating hours.

The interruption of peer education affected information, support, condom distribution, and referral to services, while the disruption in clinical services affected diagnosis, treatment, and linkage to care. The need for masks and hand hygiene drove up operational costs. Fear of infection led to a decline in attendance.

Among the innovations:

Telephone counselling coupled with home visits enabled peer navigators to check on clients' health, confirm ART adherence, identify cases of GBV, and refer clients for clinical services where needed. A mapping of PrEP and ART users informed home delivery of multi-month (three) prescriptions of PrEP and ART following MoH guidelines. Follow-up by telephone prioritized women starting ART, with high viral load, or due for viral load testing. Clinicians visited clients with high viral loads at home.

Service providers linked up across facilities to ensure none of the sex workers defaulted on their medication. Micro-sessions for ART adherence for a maximum of four sex workers were conducted both inside and outside the DICs. Tailored support was provided for groups of women with high viral load and for those newly diagnosed.



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RESULTS – January to June 2020

- 3,750 sex workers received services, of whom 1,561 were enrolled for the first time, and 1,400 received services more than once.
- 192 FSWs enrolled on PrEP: 170 are new, 22 restarted.
- 102 clients received MMD of ARVs.
- 40 peer educators engaged.
- 8 micro-sessions conducted per month, 4 per DIC.
- 294,000 male condoms and 428 female condoms were distributed in the first quarter, rising to 328,000 male condoms and 1,781 female condoms in the second quarter.

While the number of FSWs accessing services dropped quarter on quarter from 2,970 to 2,243, surprisingly, family planning, requests for condoms, and linkages to care after testing increased during the pandemic.

The uptake of FP services more than tripled, from 90 women in the first quarter to 339 in the second quarter. This was partly attributed to sex workers spending more time and having unprotected sex with live-in partners.

No cases of GBV were reported in the first quarter but 55 cases of GBV and intimate partner violence were reported in the second quarter. This was attributed to a longer time spent with clients due to curfew and with live-in partners due to lockdown and loss of livelihoods.

LESSONS LEARNED

- Service continuity and improvement are feasible in a pandemic environment, using minimal additional resources, through innovation, adaptation, and community resilience.
- The innovations proved efficient and should be integrated into routine programme delivery and scaled up beyond the pandemic.
- The FSW community showed ability to regroup and identify new business venues to meet clients while adhering to lockdown rules and COVID-19 prevention.
- GBV continues during pandemics and requires continuous vigilance and a swift response.
- Focus group discussions must be conducted to understand the factors that led to a higher uptake of FP, condoms and linkage to care in order to maintain the momentum.

Lockdown woes

Police roadblocks during lockdown prevented Pendo, 32, a sex worker in Mombasa, from getting her monthly PrEP and condoms at the UNFPA-supported drop-in centres. “We organized with my doctor and my peer educator to meet at a church very close to my home. They delivered the meds, the doctor counselled me, and insisted I should call them if I didn’t feel well,” says Pendo (not her real name).

There were other problems too. As income dried up, many sex workers were going hungry. In collaboration with the county hospitals, the programme supplied a weekly bag of fortified *uji* (porridge) to those who were pregnant, sick, HIV-positive or young.

With bars and nightclubs closed, the women worked on roads and parks or jointly rented rooms and flats to meet clients before curfew. Pendo says these arrangements increased unsafe sex and sexual and physical violence. Working at hotels, brothels or bars gives more protection through client registration books, closed circuit television, ejection by bouncers of violent clients, and peer-led responses to sexual violence.

Loss of income led some sex workers to have live-in partners who provided financial support and intimacy, but also led to more unprotected sex, either through trust or inability to negotiate using a condom.

Since 2012, the programme has provided SRH/HIV services to more than 4,000 female sex workers annually. The package includes HIV testing, STI screening and treatment, provision of PrEP and ART, counselling, contraceptives, male and female condoms and lubricants, cervical cancer screening and SGBV response and management.





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LESOTHO

Reaching Key and Priority Populations at Border Posts

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FAST FACTS

23 per cent HIV prevalence among adults 15–49 years.

13,000 people newly infected with HIV.

6,100 people died from an AIDS-related illness.

Source: UNAIDS Global Report 2020. Figures for 2018

Lesotho imposed strict lockdown regulations on 18 March 2020. While these have since been relaxed, restrictions on movement, transport and public gatherings remain. This has been particularly bad for UNFPA’s robust HIV prevention programme, based on peer education, outreach, condom distribution and demand-creation activities.

Prevention is critical due to the fact that Lesotho has the second highest HIV prevalence in the world. In a population of 2.2 million, 340,000 people live with HIV.

HIV prevalence is especially high among key and priority populations: sex workers (72 per cent), men who have sex with men (32 per cent) and migrant populations (30 per cent).

A sizable number of Lesotho nationals live and work in neighbouring South Africa. Since April, when both formal and informal jobs vanished during South Africa’s strict lockdown, tens of thousands of Basotho went home. Border crossings, official or not, are hotspots of agglomeration with a potential for HIV/STD infection. A high TB burden compounds the health challenges of the impoverished, mountainous nation.

To maintain the HIV prevention momentum among key populations, UNFPA and its partner the Lesotho Planned Parenthood Association (LPPA) implemented an eight-month project in the three busiest border posts - Maseru, Maputsoe and Van Rooyens Gate - from May 2020. The project targets migrants, long distance truck drivers, sex workers, youth, and other key populations living in or transiting through the border towns, including unofficial crossings. The aim is to increase knowledge

about HIV prevention, to promote adoption of safer sexual behaviour, and reduce new HIV infections.

To comply with lockdown rules, the project shifted its strategy from peer education through community outreaches to one-on-one peer navigation. Peer navigators work with clients to identify and overcome barriers to HIV prevention, treatment and care. For example, since female sex workers (FSW) could not access their usual hotspots, peer navigators reached them at home with information, condoms, ART support and HIV/STI screening. The new strategy emphasizes one-on-one sessions and uses digital platforms like WhatsApp to talk to clients.

The project employed nine peer educators and trained them in SRHR/HIV/GBV and COVID-19. Their tasks involve:

- Mobilizing and facilitating the access of target populations to the local LPPA clinics for integrated SRHR/HIV services.
- Organizing outreach micro-sessions on HIV/SRHR/GBV/COVID-19 for key populations.
- Refilling hundreds of Condo Cans located in hotspots identified in a previous mapping.
- Following all pandemic health protocols (PPE, sanitizer, hand washing, social distance) in their work.

The project put up billboards with prevention messages, procured PPE and mobile “tippy taps” for hand hygiene, and produced a directory of LPPA services.

RESULTS

As of mid-August 2020, the project had reached nearly 800 key populations:

- 441 truck drivers received condoms, lubricants, and HIV/COVID-19 prevention information.
- 18 truck drivers were referred to the LPPA clinics for services.
- 91 MSM and 161 FSWs attended interpersonal sessions.
- 89 FSWs were referred to services.
- 153 young people and 19 LGBTIQ people received information at Maputsoe.

At the micro-sessions, participants strategized how to access services and psychosocial support during lockdown. As a result, the project set up an online mental health support group facilitated by an LPPA nurse and peer navigators. The group discusses treatment adherence, nutrition, livelihoods of sex workers during lockdown, and pandemic-related anxiety, among other issues.

LESSONS LEARNED

- Technological platforms such as WhatsApp and Zoom can be used efficiently for training, information, and client support.
- Peer networks create safe spaces for key populations. Members should be supported and trained to be more results-oriented.
- Partnerships among CSOs leverage each other’s comparative advantage.



On the road

Truck drivers Mosekeseke Sehlabaka and Machabe Ramasala typically spend two to three days on the road several times a month ferrying groceries from Maputsoe Bridge to Durban and Johannesburg in South Africa.

“When we are resting at truck parking sites, sex workers knock, offering their company. If we refuse, we wake up to find the tyres have been slashed or pierced with nails. It was easier to protect the truck by having sex but we had unprotected sex until this project came along. The peer educators teach us about protection and give us plenty of condoms and lubricant, which we didn't know about. We also learned about PrEP and PEP, how to negotiate safe sex or no sex, and which clinics are friendly to us..”

Mosiua Motseare, 37, is a peer educator who works with truck drivers, their assistants and truck packers at Maputsoe border area.

Initially truck drivers were reluctant to attend his sessions because they were in a hurry and feared COVID-19 contagion, so Motseare is strict about setting up the tippy taps, supplying masks and sanitizer, and maintaining physical distance.

The trickiest part was reaching sex workers because bars and shebeens are closed. Luckily, the registers from previous outreach activities listed their phone numbers so Motseare could call them. Because he is a local, he knows where many live and can do one-on-one support visits, or ask other key population peers to follow-up. Once lockdown is over, he hopes the project will do a road show to expand its impact.



UGANDA

Sustaining Access to HIV/SRH Services for Female Sex Workers during Lockdown

Over the years, SRH/HIV programming for female sex workers and other key populations has expanded in scope and coverage in Uganda. These are critical interventions because one in three female sex workers lives with HIV (at 33 per cent, their HIV prevalence is five times higher than the national prevalence). A study found that female sex workers, their clients and their partners contributed 20 per cent of new HIV infections in 2014.

The five-year-old programme for key populations run by the AIDS Information Centre with UNFPA support delivered a wide

range of services to female sex workers (FSWs), from counselling to condoms, STI screening and treatment, PrEP and HIV self-testing at clinics and drop-in centres, and through targeted outreaches and peer mechanisms linked to mapped hotspots.

These activities came to a standstill when total lockdown was announced on 28 March 2020. The curfew from 7 p.m. to 6 a.m., ban on public transport, and closure of bars and nightclubs wiped out both the livelihoods of FSWs and their access to health services.

Stigmatization and violence, already widespread, surged because of the association of FSWs with long-distance truck drivers, who – because they were allowed to travel under lockdown – were perceived to be coronavirus spreaders. Some adolescent

FSW were locked down in unregulated brothels. The loss of formal and informal jobs led more adolescent and young women into transactional and commercial sex.

These layered vulnerabilities increased the risks – of unintended pregnancies, acquiring HIV and STIs, and missing drug refills for ART and PrEP – and required an urgent response, but with community and peer outreach suspended from end of March to August, a new strategy was needed.

The AIDS Information Centre (AIC) and UNFPA staff brainstormed ways to shift the service delivery approach. The solution was a combination of house-to-house visits and mobile clinics to bring the services not only to FSWs but to entire neighbourhoods. These were selected based on a 2019 mapping of key populations in 14 districts that identified urban and semi-urban slums where many FSWs and vulnerable young women live. UNFPA then repurposed resources allocated to community outreaches planned for the 14 districts.

AIC engaged the city and district health departments for clearance, support, and guidance in adhering to the MoH strict COVID-19 protocols, as well as local leadership and community organizations such as Role Model Men and others.

The sex-worker-led Alliance of Women Advocating for Change (AWAC) identified community peer mobilizers. They went house to house to inform occupants of the schedule for the mobile clinic and the free HIV/SRHR services available.

Each team comprised a nurse, a counsellor, a laboratory technician and a community mobilizer. The package of services included HIV testing and counselling, GBV screening and management, STI and TB screening and treatment, ANC and referral, ART and adherence support and referral, PrEP, cervical cancer screening, post-abortion counselling and referral for care, free male and female condoms, and COVID-19 information.

Districts covered: Abim, Amuria, Kaabong, Kaberamaido, Kiryandongo, Kotido, Napak, Nakapiripirit, Pader, Yumbe, Moroto, Gulu, Bundibugyo and the Nakawa, Central, Rubaga, Kawempe and Makindye divisions in Kampala City.

RESULTS

- During April and May, the mobile clinics reached more than 68,000 people, including 4,245 female sex workers and vulnerable adolescent and young women.

Based on this success, another suspended activity restarted. Working with district authorities and AWAC, AIC equipped 450 young women working in the sex trade with life and livelihoods skills that will help them access economic support from both UNFPA and government programmes.

UNFPA supported the Uganda AIDS Commission to carry out rapid assessments of the impact of COVID-19 on the access to SRH/HIV/GBV services of adolescents and young people, and of key populations. UNFPA also supported psychosocial counselling for key populations on a toll free line.

LESSONS LEARNED

- Targeted service delivery nearer people requires additional investments in field teams in many locations for more days than needed for regular outreaches.
- Community engagement in planning and service delivery increases ownership.
- Prior strategic partnerships save time in re-programming and quick decision-making.
- Failure to act quickly may erode the gains made in key population programming.
- Crises are learning opportunities, for example, adopting new ways of communicating with female sex workers through digital platforms.

F. SOCIAL CONTRACTING FOR DELIVERY OF HEALTH SERVICES

A pandemic of the magnitude of COVID-19 calls for broad collaboration among all actors to find sustainable solutions. Partnerships between the public and private sectors, as well as between intergovernmental/NGO non-profit actors and for-profit operators, can leverage the strengths of each partner to improve health outcomes among underserved communities. In this case, the speed and reach of a motorcycle taxi (boda boda) company in Kampala was harnessed to ensure service continuity during lockdown.

UGANDA

Boda boda riders deliver condoms in Kampala

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© SafeBoda

Uganda has registered a significant decline in new HIV infections (53,000 new infections in 2018, down from 96,000 in 2000), but is unlikely to achieve the UN Fast Track for 2020 90-90-90 targets without an even bigger effort.

The HIV investment case prioritizes condoms as a proven core intervention and the MoH has estimated that increased condom use by key and priority populations could avert 9.4 per cent of new infections. Condoms are also a core family planning tool, critical in a context of low contraceptive prevalence rate (36 per cent) and high teenage pregnancy rate (25 per cent).

About 80 per cent of free public sector condoms are distributed through alternative distribution mechanisms and 20 per cent through the public health system. The alternative distribution mechanisms include community points, peer educators, pharmacies, recreational facilities and condom dispensers.

These mechanisms were disrupted on both the supply and demand sides by lockdown restrictions on movement, transport, shops and gatherings. The number of condoms distributed dropped from 16 million in February to four million in May 2020.

Boda boda services, however, were allowed to make deliveries. Seizing the opportunity, UNFPA expanded an existing partnership with the SafeBoda association to deliver free condoms to community health agents in poor neighbourhoods across the Kampala Metropolitan Region, where some seven million people live.

The process took one month from conception to action. Developing the concept note and reprogramming resources took two weeks. UNFPA's implementing partners compiled lists of their community health resource persons, and SafeBoda contacted them for agreement to participate.

AIC and Marie Stopes, picked up condoms in bulk from the national warehouse and brought them to the central SafeBoda office. Boda riders delivered condoms to community health agents, peer educators, and village health teams who, under NGO coordination, distributed the condoms to vulnerable people, truck drivers, local clinics, door to

door, organized pick-ups, and refilled condom dispensers.

Riders earned the normal fare – a bonus during the crisis – and learned about HIV and COVID-19 prevention. In so doing, UNFPA leveraged an established platform to sustain focus on planned results in a cost-efficient manner.

The initiative was supported by the Joint Programme on HIV/SRHR/GBV funded by Sweden, and by UNAIDS country funding. The total cost was US\$30,000.

RESULTS

- From May to July 2020, riders delivered 794,880 free condoms and were expected to deliver one million condoms by the end of August that year.

UNFPA is considering replicating the successful initiative in other cities. SafeBoda innovated too, setting up Personal Health, an E-shop app, where clients in Kampala and Wakiso districts can order condoms, pregnancy and HIV self-test kits.

LESSONS LEARNED

- Carefully crafted partnerships with non-traditional private sector actors can become win-win solutions to sustain service continuity during a crisis.
- Timely execution during a crisis requires concerted efforts, engaged leadership at the country office, and existing strong, strategic partnerships.
- Partner platforms can be leveraged to serve communities with minimal additional funding. Users appreciated obtaining SRH and HIV products with the convenience and privacy afforded by the new approaches to access, promotion and distribution.
- Buy-in from urban leaders will help build understanding and support for condom distribution and SRH messaging during a hunger and livelihoods crisis. Some people angrily objected to having condoms, and not food, distributed by the riders, especially during the early days of lockdown.
- Voluntary participation has its limits. Some community health agents refused to distribute condoms without an incentive. On the other hand, the sense of helping people remain healthy was a powerful motivator for many actors, especially the boda boda riders.



New challenges, new actors

“I found it strange because I was used to ferrying passengers, but if people need condoms, then it is my responsibility to help them get condoms.”

Moses Okanya, 25, boda boda rider.

“As I walk through the trading centre I sing a song in Luganda: “SafeBoda, SafeBoda, who needs a helmet? For those who are feeling cold, I have for you a coat.” (local slang for condoms). People call me “Musawo!” (Doctor). Many are shy to talk about condoms but when I sing my song, they approach me. I also do house visits.”

Betty Ngadaya works with the Village Health Team in Bukungulu village, Wakiso district, Kampala.





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6 KEY TAKE-AWAY MESSAGES

The real impact of COVID-19 on global health will not be fully known until many years after the pandemic. What is clear, however, is that those countries that were better prepared for such challenges are likely to suffer less.

Also clear is the fact that the emergence and re-emergence of epidemics will continue to define our lives. There is therefore a need to

learn from past experiences and to ready our health systems for any such adversity.

The early learnings from COVID-19 in ESA point to a number of important lessons that can help us minimize the loss of HIV prevention and SRHR gains of the past four decades. These lessons are also applicable in humanitarian settings.



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Firstly, we need to accept the reality of multiple simultaneous epidemics and find a strategic way of integrating their response without creating a competition for resources. The emergence of a pandemic should not mean the neglect of current health challenges. Integration needs to be strengthened in the context of our weaker health systems.

2

Secondly, in an emergency, it is easy to forget that HIV prevention matters. The AIDS response that first comes to mind is treatment, and space for HIV prevention, already tight, shrinks further, but that is self-defeating. We must champion HIV prevention to avoid straining the health system with new infections and additional demands for treatment.

3

Thirdly, strategic partnerships are necessary to achieve synergy and efficiencies at all levels. The benefit of working as One UN are clear for everyone to see. The partnership between UNFPA and WFP clearly proved the benefits that accrue to the communities we serve. Similarly, partnering with private sector, civil society and community members remains pivotal for universal coverage of health services. The boda boda experience in Uganda makes this very evident.

4

Fourthly, the impact of any pandemic will affect populations differently. It is critical to find solutions to mitigate the anticipated impact on marginalized and vulnerable communities. Some of those most affected by COVID-19 are sex workers, whose work remains illegal and criminalized in most countries in ESA. However, sex workers are a key linchpin to preventing new HIV infections. Empowered with adequate information and health care, sex workers can be strong agents for HIV prevention provided they are not marginalized and instead protected from the effects of COVID-19. The successful initiatives in Kenya and Lesotho can be consolidated for future programming for sex workers and other key populations. This will go a long way in ensuring that no one is left behind.

5

Fifthly, the challenges in accessing health facilities during lockdowns indicate that we should promote and invest in self-care. Opportunities such as HIV self-testing need to be expanded to empower individuals to have greater control of their health.

6

Lastly, there is a need to strengthen digital health-care services combined with robust online provision of information. The role of technology in public health care grew in leaps and bounds during lockdowns. We can do a lot more to maximize the utilization of cell phones, digital platforms and other technologies for HIV prevention and for SRHR. The youth, who are generally vulnerable to misinformation, will benefit from tailored information campaigns through social media.

The lessons learned during these difficult times will have value beyond the COVID-19 pandemic, even beyond HIV prevention. They can usefully be applied to the wider SRHR agenda, especially in humanitarian settings and in any adverse environment.



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