ACCELERATING INNOVATION

LEARNING FROM COMMUNITY-LED RESPONSES TO COVID-19 IN UGANDA AND INDIA

FRONTLINE AIDS

ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, 1.7 million people were infected with HIV in 2019 and 690,000 died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

ACKNOWLEDGMENTS

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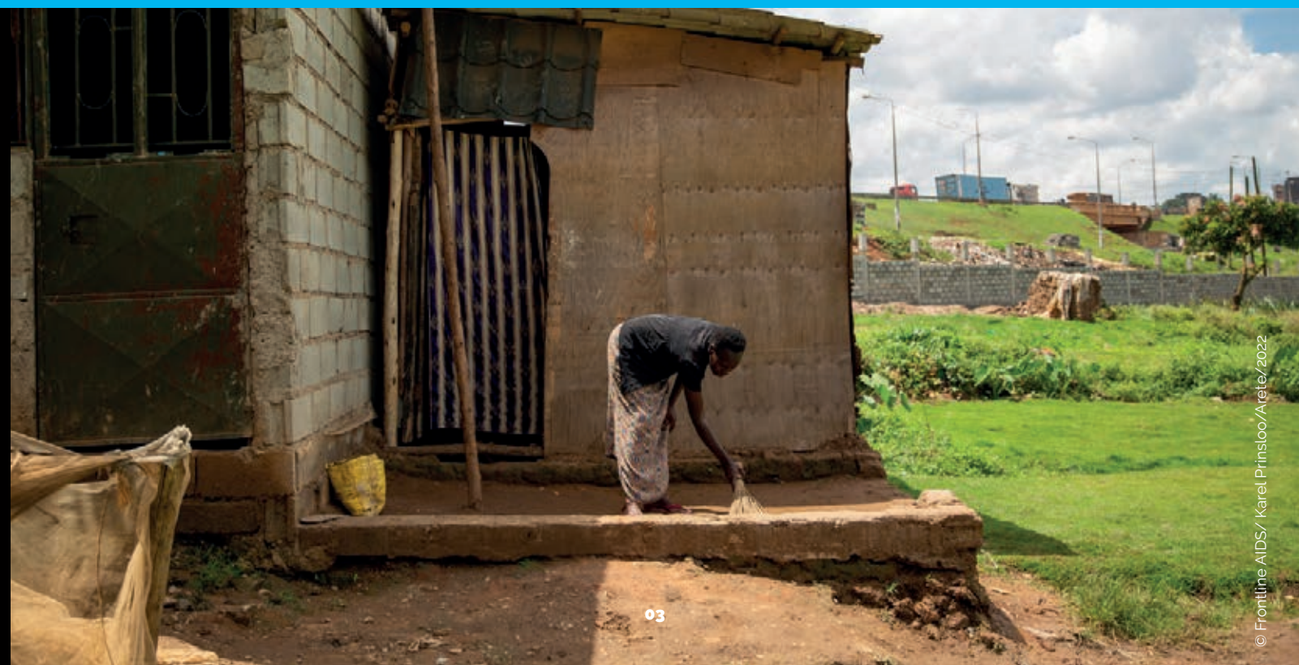

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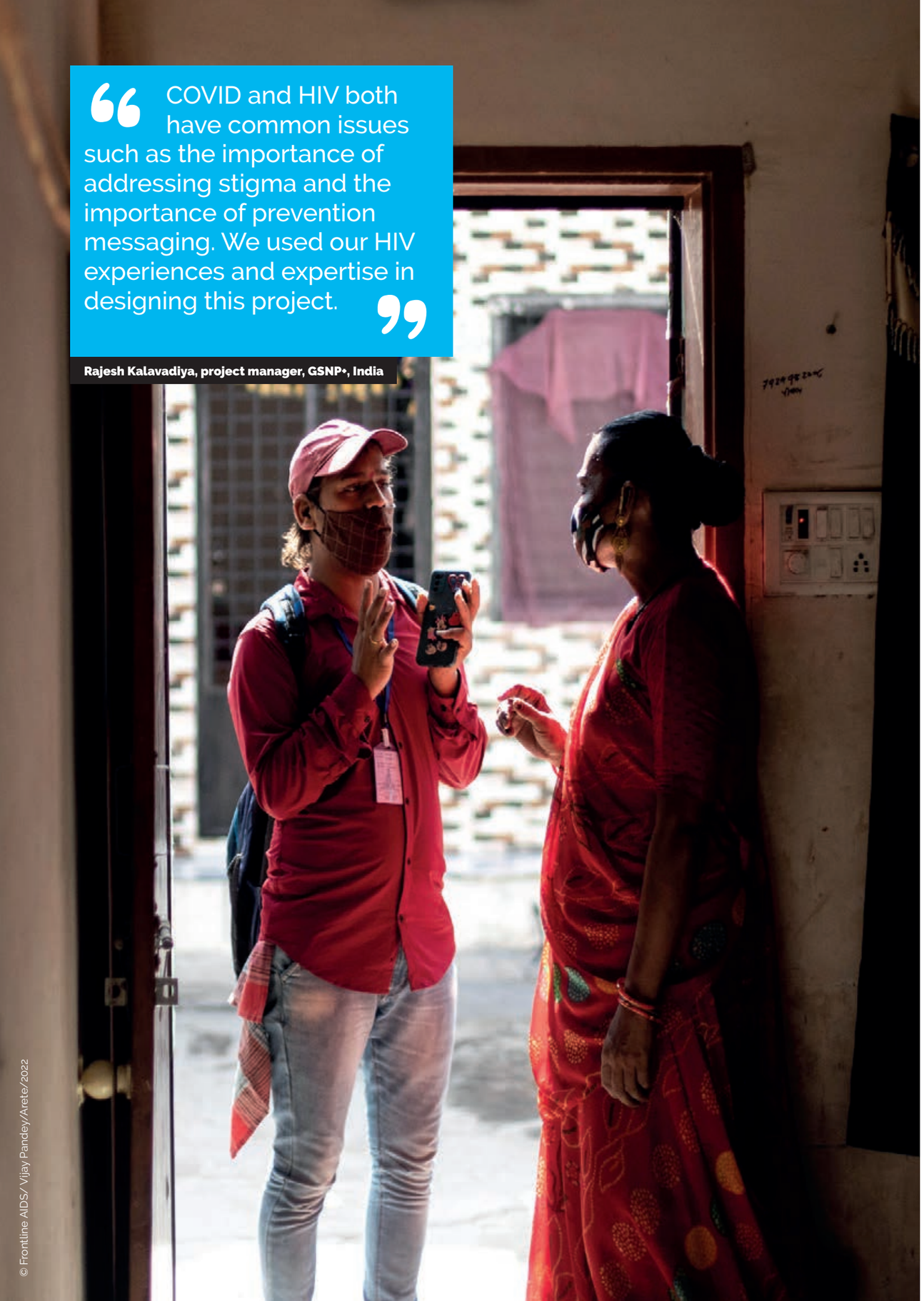

> COVID and HIV both have common issues such as the importance of addressing stigma and the importance of prevention messaging. We used our HIV experiences and expertise in designing this project.
>
> **Rajesh Kalavadiya, project manager, GSNP+, India**

INTRODUCTION

COVID-19 has caused devastation across the world with over **six million deaths** and more than **500 million confirmed cases**.

The indirect consequences have been equally devastating. Weak and underfunded health systems have been overwhelmed. There has been widespread disruption to services and supplies for people living with HIV and a rise in both new HIV infections and AIDS-related deaths. Beyond health care, the world's most marginalised communities have been hit hard by the economic and social impact of the pandemic.

In most countries, governments attempted to reduce transmission by imposing curfews, suspending public transport and closing workplaces, schools and shops. People living with HIV struggled to adhere to their treatment with restrictions on movement preventing them from accessing antiretrovirals (ARVs) or attending clinics or support groups. Other marginalised communities such as lesbian, gay, bisexual and transgender (LGBT+) people, sex workers, and people who use drugs also faced challenges accessing health care. Many lost their livelihoods and were unable to feed their families.

Many of the new problems seen during COVID-19 are similar to *historic* (and continuing) problems faced by communities most affected by HIV: unequal access to services for testing or treatment, high levels of stigma, and a lack of accurate and accessible information. Over many decades, civil society organisations (CSOs) and community groups (including networks of people living with HIV) have formed strong relationships with marginalised communities and developed agile community-level responses to meet ever-changing situations. Since COVID-19 emerged, communities have had to adapt rapidly to find innovative ways to mitigate the impact of the pandemic. Drawing on their experience of HIV, they have played a key role in the COVID-19 response, working with governments to ensure that people can continue to access information and services.

In this overview, we focus on learnings from the Accelerating Innovation project. The Elton John AIDS Foundation (EJAF) supported Frontline AIDS to work with partners in India and Uganda to increase the resilience of HIV responses to COVID-19 and other respiratory disease outbreaks, and to improve the continuity of HIV-related care.

- **Project duration:** **May 2021 to July 2022**
- **Overall impact:** **Over 10,827 people accessed community-based COVID-19 services including information, counselling, screening and vaccines. In addition, 19 non-governmental organisations (NGOs) were trained to include information on gender-based violence and COVID-19 in their programmes.**

In India, the health infrastructure was unable to cope with the size of the pandemic. Myths, misconceptions and high levels of stigma around COVID-19 further challenged public health efforts. The impact of the pandemic was particularly severe on marginalised communities and people working in the informal sector, including internal migrants who lost their homes and livelihoods.

The project was known as 'Parivartan' in India, meaning change or innovation. It focused on supporting people from marginalised communities to learn about the risks of COVID-19 and to access health care services free from stigma. The project evolved to also provide COVID-19 vaccines and address the social and economic impact of the pandemic. Frontline AIDS partnered with India HIV/AIDS Alliance (Alliance India) and the Gujarat State Network of People living with HIV (GSNP+) in the western part of India. The state of Gujarat was chosen because of a high number of reported COVID-19 cases; a high number of migrant workers; and the presence of a strong network of people living with HIV. The project also partnered with organisations including Lakshya Trust and PARAS PSM to reach LGBT+ people and sex workers.


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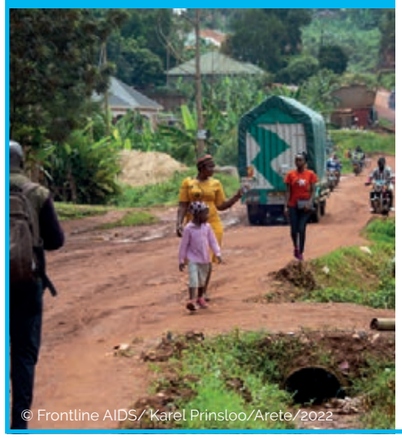
- **Project duration:** **March 2021 to April 2022**
- **Overall impact:** **The project reached 4,715 individuals with at least one prevention, testing, treatment, or support service. In addition, 177 healthcare workers and peer educators were trained and developed an understanding of self-care interventions.**

Having dealt with Ebola, the health system in Uganda was well-prepared for an emergency and clear public health guidance at the start of the COVID-19 epidemic helped to reduce transmission. Strict lockdowns and curfews had a severe impact on marginalised communities and informal workers such as market vendors, cleaners, construction workers and *boda boda* (motorbike taxi) riders.

In Uganda, the Accelerating Innovation project focused on expanding access to HIV prevention, testing and treatment services for people from marginalised communities through virtual and mobile delivery platforms and improving self-care for vulnerable people living with HIV. Frontline AIDS worked with Alive Medical Services (AMS) who offer free sexual and reproductive health and rights (SRHR) and HIV services through its network of outreach workers. The project mainly focused on Kampala and the surrounding areas. In order to reach LGBT+ communities, AMS partnered with other community-based organisations including Wave of Legacy Alliance Initiative (WALAI), Kuchu Shiners Uganda, Transgender Equality Uganda, Freedom and Roam Uganda (FARUG), Spectrum Uganda and Children of the Sun Foundation (COSF).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Section one below gives a snapshot of some innovations from each country and section two pulls together overall learning from this project.

COUNTRY FOCUS

UGANDA

> “As a peer educator, I was given the drugs to deliver to specific clients. I was giving people information about COVID prevention too. I spoke to people on the phone as well as doing home visits.”

George, peer educator

CASE STUDY 1

NAME

Accelerating Innovation – home delivery of ARVs and other commodities.

WHO

Marginalised communities including adolescent girls and women; men who have sex with men (MSM); orphans; and sex workers.

WHAT

Home delivery of ARVs and other commodities to support treatment and care for people who were unable to access health facilities.

WHERE

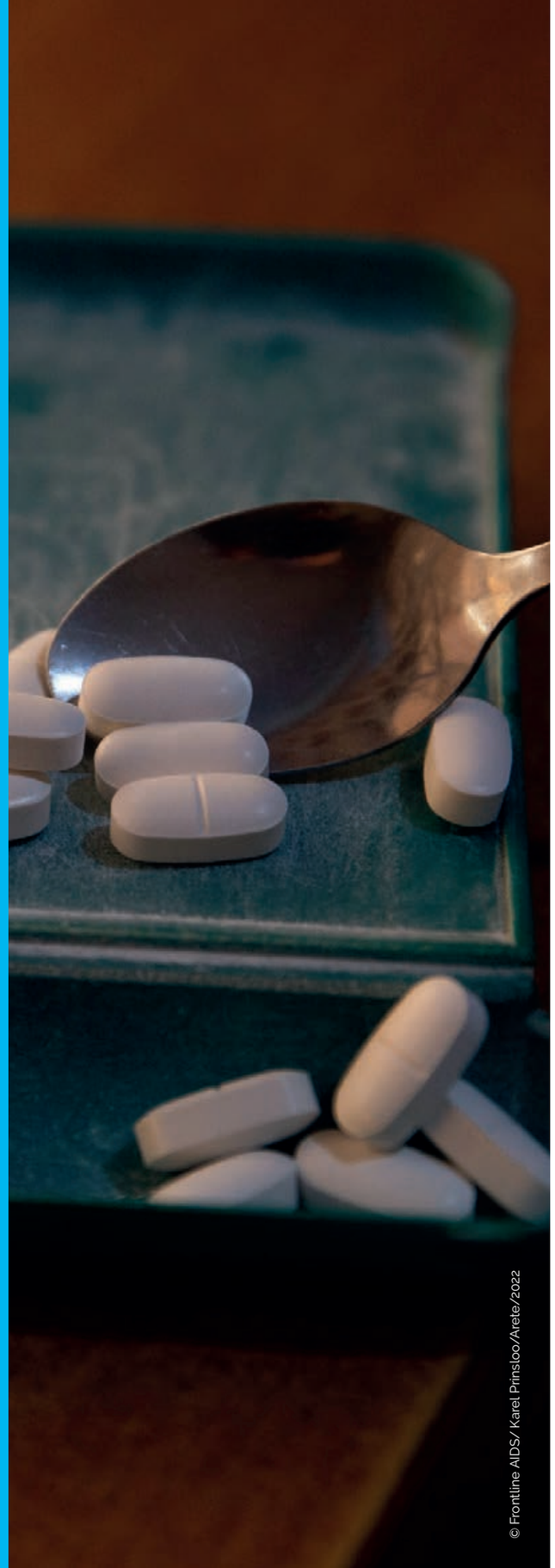
Uganda – Kampala and the surrounding areas.

WHEN

March 2021-April 2022

TYPE OF INNOVATION

New or different way of providing a service.



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WHAT DID IT ADDRESS?

During the COVID-19 pandemic, certain vehicles were not allowed on the roads in Uganda and the cost of public transport increased as buses could only travel at 50% capacity. Many people living with HIV could not afford transport and had to walk long distances to get their medication. At the same time, many people lost their income and some relocated to rural areas as the cost of living in urban areas became prohibitive. This intervention was introduced to support people to adhere to their HIV treatment in these difficult circumstances.

WHAT IS THE INNOVATION?

Before COVID-19, people collected their ARV refills from health facilities. Through this project, medication was delivered into communities and direct to people's homes instead. At first, medication packages were put on food trucks. Then, as lockdown rules eased and motorcycles were allowed on the roads, AMS began using *boda boda* drivers. Courier services were used for people who lived further away and peer educators played a vital role delivering medication to clients, especially those already receiving additional support.

WHAT WORKED WELL?

The treatment adherence rate among people who benefited from this intervention was high. Many of the people reached were from marginalised communities and had previously been reluctant to visit health facilities where they felt stigmatised. With this, they were able to receive medication in the privacy of their home or at a safe place of their choosing. The medication was wrapped to look like a small gift or package so that their privacy was maintained.

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

This was an expensive service to run; clients could have been asked to make a financial contribution towards the delivery. AMS believe this service could be useful across other parts of Uganda, including in more rural areas and among the wider population of people living with HIV not just among marginalised communities. But the funds were not available to extend it.

LESSONS FOR THE FUTURE

Keeping track of clients was difficult, particularly as COVID-19 led to greater migration and people moving more frequently. AMS found it helpful to ask clients to complete a locator form with their phone number, address and other contact details, plus the contact details of a friend or family member.

Many clients would like home deliveries to continue after the COVID-19 pandemic. It suits people who do not want to visit a health facility for any reason – work hours, migrant work, family commitments, cost of travel, fear of stigma etc. The best way to continue to meet the needs of these clients may involve a combination of home deliveries and community-based service provision. Some clients used to meet in hot spots and services were provided to them there. Many of these hot spots have disappeared so new mapping is needed to identify locations where marginalised populations are gathering now and where services can be provided.

> "I used to go to the hospital and pick up my medicine until I got introduced to the community peer educators who deliver my medicine home… We call ahead to explain our needs. If it concerns renewing a medication supply for example, someone is dispatched to deliver the drugs.
>
> **Margaret, sex worker, Uganda**

IMPACT

1257 beneficiaries received community multi-drug deliveries (and 222 beneficiaries were given transportation to the facility).

1257
BENEFICIARIES

CASE STUDY 2

NAME

Accelerating Innovation – peer educator-assisted HIV self-testing.

WHO

Marginalised communities including expectant mothers, sex workers, MSM, people who use drugs and truck drivers.

WHAT

People used HIV self-testing kits in their homes and communities. Depending on the result, peer educators supported clients to begin antiretroviral treatment (ART) or take prevention measures, including oral pre-exposure prophylaxis (PrEP).

WHERE

Uganda – mainly in Kampala, Wakiso and Mukono.

WHEN

March 2021-April 2022

TYPE OF INNOVATION

New or different way of providing a service.

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WHAT DID IT ADDRESS?

During COVID-19, the number of people attending walk-in centres and outpatient facilities dropped and there was concern that fewer people were taking HIV tests.

WHAT WAS THE INNOVATION?

Before COVID-19, most HIV testing took place at health facilities as the Ugandan government only allowed certain people to take HIV self-tests. During the pandemic, the rules were relaxed. AMS seized this opportunity to offer self-testing to a wider population. Through peer educators, they were able to reach people who would not normally consider taking an HIV test in a health facility. The peer educators worked with focal people, leaders within their communities, to identify who to offer a test.

WHAT WORKED WELL?

Initially this intervention was designed to prevent a drop in the number of people taking HIV tests during COVID-19. Once the service was established, peer educators offered follow-up after the test and, where relevant, connected clients to ART or PrEP.

They supported clients through the process and increased their level of care, mindful that many people were facing significant challenges during this time. Those who tested positive were accompanied to a health centre for a confirmatory test, helped to initiate treatment and given adherence support. Those who tested negative were given information about prevention methods and access to commodities from condoms to PrEP.

IMPACT

2586 HIV self-testing kits were issued – a total of 140 people tested positive for HIV and all were linked to care. 134 beneficiaries started and are continuing on PrEP.

2586
SELF-TESTING KITS ISSUED

> The outreach work we do has reduced the number of people getting HIV, as we hand out self-testing kits, provide condoms and pre-exposure prophylaxis. I feel good and humbled when I serve my community members through the work that I do.
>
> **Musa, peer educator and counsellor, Uganda**

As this intervention involved testing for HIV, confidentiality was particularly important and peer educators were given specific training on this. Many of the communities – especially the LGBT+ community – are small and everyone knows each other, so discretion is very important. This service was particularly useful for people experiencing self-stigma, who valued the privacy it gave them.

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

Currently, when someone receives a positive result from a self-test, they must visit a health facility for a confirmatory test. People who are reluctant to do so would benefit from being able to take a confirmatory test in or near their home with support from a peer educator.

The project was limited to urban areas but could be expanded to rural areas with additional funding.

LESSONS FOR THE FUTURE

This intervention depends on peer educators and covering all their costs. For example, this project gave them stipends and also covered their transport costs – whether it was to attend meetings or make deliveries.

This intervention shows the importance of not simply offering testing in isolation but also offering follow-up support including treatment and prevention services.

CASE STUDY 3

NAME

Accelerating Innovation – virtual intensive ART adherence counselling.

WHO

People living with HIV who are on treatment but do not have a suppressed viral load.

WHAT

To provide regular HIV treatment adherence counselling via phone calls and virtual meetings.

WHERE

Throughout Uganda.

WHEN

March 2021-April 2022

TYPE OF INNOVATION

New or improved service.

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WHAT DID IT ADDRESS?

AMS have monitoring systems that enable them to identify clients with a high viral load. These people are offered counselling once a month to support their treatment adherence. During COVID-19, the number of people attending counselling sessions dropped.

WHAT IS THE INNOVATION?

After an initial visit to a health facility to discuss their treatment, clients were given the option for their next two follow-up meetings to be virtual. These were either online (for those with access to the right technology) or by phone. People found this system very convenient as it prevented them from spending time and money visiting a health facility.

WHAT WORKED WELL?

AMS already had a home-based counselling and testing team. When COVID-19 measures were introduced in Uganda, they switched to working from home and continued providing adherence counselling virtually. The results were good; with support from virtual counselling, some people achieved a suppressed viral load. The service was relatively inexpensive to offer and AMS were able to reach clients wherever they lived.

IMPACT

1371 beneficiaries were reached with virtual or telephone counselling on adherence, gender-based violence, mental health and promoting health-seeking behaviours.

1371
BENEFICIARIES REACHED

> “Combining adherence counselling with home delivery of ART significantly changes how services and support are delivered, making it more client-focused. We want to continue this work, beyond COVID restrictions, as it allows people who can’t attend clinics to access these services.

Dr Elizabeth Kihika,
programme manager, AMS, Uganda

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

The main challenges centred around contacting the clients – people not answering their phones, connectivity issues, out of date contact details, lack of data etc. It became clear that contact details needed to be checked and updated at every opportunity – at the end of each counselling call and at each visit to the health facility.

LESSONS FOR THE FUTURE

This intervention is not just helpful during a pandemic – it makes it easier for people to adhere to their treatment when they do not wish to attend health facilities for any reason. It also combined well with home delivery of ART, offering a package of services to meet the multiple needs of clients.

CASE STUDY 4

NAME

Accelerating Innovation – integrated nutrition support and ART adherence counselling.

WHO

Vulnerable populations including the homeless, those in safe houses/shelters, those who do not have a suppressed viral load and the unemployed.

WHAT

To provide ART adherence support when people access food packages.

WHERE

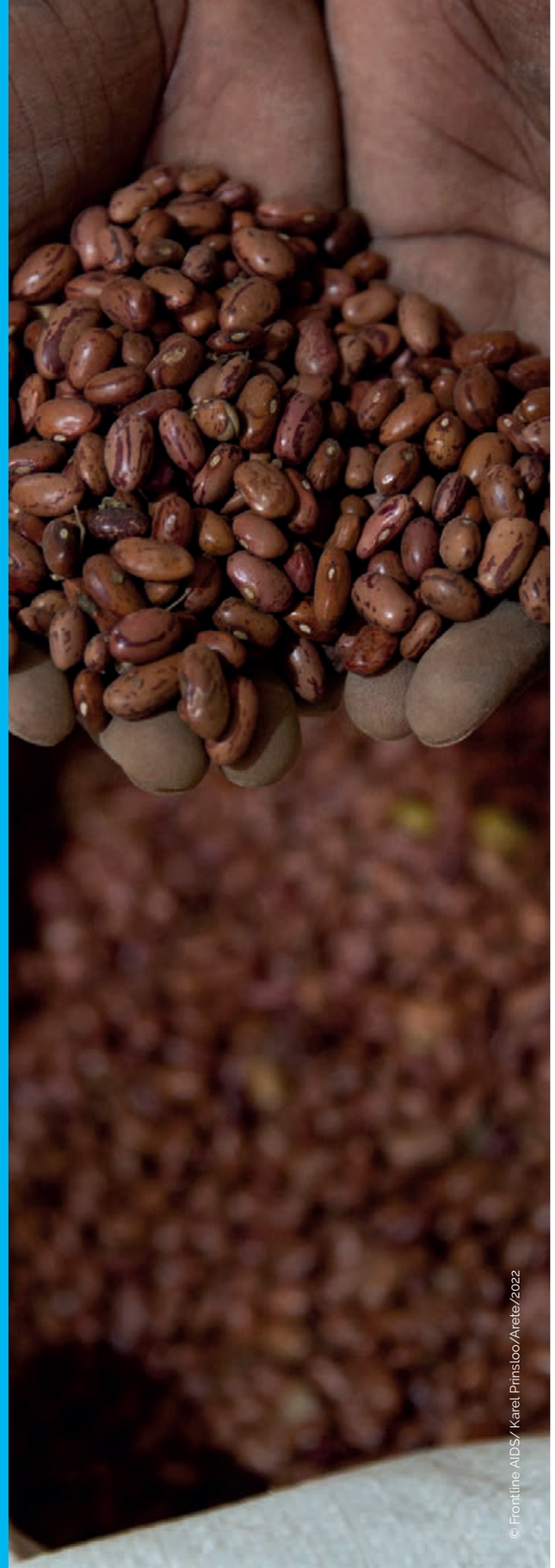
Kampala, Uganda.

WHEN

March 2021-April 2022

TYPE OF INNOVATION

New combination of existing services.



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WHAT DID IT ADDRESS?

During COVID-19, many people stopped gathering in their communities and attending health facilities. AMS were concerned that ART adherence levels could drop and they started to see people from marginalised communities with increasingly high viral loads. At the same time, many of their clients faced economic difficulties, struggling to meet their day-to-day needs, including providing enough food for themselves and their families.

WHAT IS THE INNOVATION?

AMS scheduled adherence counselling sessions for small groups and, at the end of each session, clients were given food packages. Clients could book clinical appointments at the same time and collect ARV refills if needed. One-on-one counselling sessions were also available.

WHAT WORKED WELL?

As the project offered a whole package of services in one place, there was an increased incentive for clients to attend. Food packages motivated people to join the counselling sessions whilst also helping to keep them healthy.

People from marginalised communities experience significant levels of stigma in Uganda. By bringing services closer to their homes and communities, clients felt safer accessing them.

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

The focus was on people living with HIV. People who are at risk of HIV could also benefit from some of these services. Groups of people with very specific needs (e.g. transgender people) would benefit if there were specialist staff to support them, with relevant additional training.

LESSONS FOR THE FUTURE

This intervention highlights the important role of peer educators who have detailed knowledge of the communities they serve. They identified hot spots where people gathered and the project provided a whole package of services in these places – adherence support, food, treatment refills, testing and screening services.

AMS have provided nutritional packages in the past and envisage a need for this service to continue into the future. Longer term, they are keen to promote income generation activities to address some of the underlying problems faced by their clients.

> “When you combine activities… it is an incentive for people to come – the food in particular. We are also trying to promote income generation activities. Many of our clients live below the poverty line – with or without COVID, these people were already struggling.

Martin Chebet,
nutritionist, AMS, Uganda

IMPACT

360 target beneficiaries received nutritional support and there were six adherence counselling sessions.

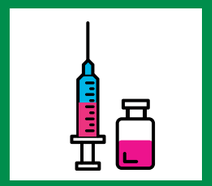
360
RECEIVED SUPPORT

INDIA

> “In any society, the groups which are most vulnerable healthwise or socially are the ones most affected by any epidemic or disaster. Special efforts are needed to reach them and are best undertaken by organisations which have prior experience of working with these groups.”

Dr Vikas Desai, public health professional, India

CASE STUDY 1



NAME

Parivartan – COVID-19 vaccination camps.

WHO

People living with HIV, female sex workers, MSM, transgender people, diamond factory workers, slum dwellers.

WHAT

To support marginalised communities to receive COVID-19 vaccinations in a dedicated and safe space.

WHERE

Surat city in the state of Gujarat.

WHEN

June-December 2021

TYPE OF INNOVATION

New or different way of providing a service.

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WHAT DID IT ADDRESS?

The Indian government rolled out a programme to offer COVID-19 vaccinations. Despite it being free of charge, many marginalised communities were reluctant to take up the service. Some feared the vaccine because of myths they had heard and others were concerned that they would face stigma and discrimination at the health facility. The online registration process for receiving the vaccine was challenging for people who were not sufficiently digitally literate and those without a phone number (which was a requirement). People living with HIV in particular were afraid of being exposed to COVID-19 in busy waiting rooms.

WHAT IS THE INNOVATION?

Vaccination camps provided a dedicated and safe space for people from marginalised communities. The camps were held at the offices of GSNP+ and offered a less crowded, stigma-free environment compared to health facilities. Outreach workers helped people to travel to the camps and overcome any registration hurdles.

WHAT WORKED WELL?

Alliance India and GSNP+ worked closely with community organisations such as Lakshya Trust (an LGBT+ group) and PARAS PSM (a sex worker organisation), to raise awareness and encourage people to attend the vaccination camps. Trusted outreach workers were recruited from the communities so that they could allay any fears and offer support as needed. GSNP+ also built a strong relationship with local government and key staff at the Surat Municipal Hospital who saw the value of involving community organisations and were willing to step in to provide extra vaccines when demand exceeded original expectations.

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

Closer coordination with the public health system and local authorities during the planning phase could have helped avoid some of the initial challenges. For example, staff at the camps would have benefitted from advance training on the online registration requirements. One lesson learnt from the first day of the camp was to provide different time slots to batches of people to avoid long queues.

LESSONS FOR THE FUTURE

The vaccination camps were devised in direct consultation with communities to address the challenges they faced. Having their own community members employed as outreach workers helped foster trust, reduce the fear around vaccines and encourage more people to come forward for the vaccination drive.

> “I heard from my friend that if I take the vaccine I might die. But in my heart, there was no fear. So, I came forward and I took the vaccine so that others are also encouraged to receive it.

Bhautik Zankhariya,
youth leader, GSNP+, India

IMPACT

1277 people received two doses of the COVID-19 vaccine at the camps.

1277
RECEIVED TWO DOSES

CASE STUDY 2

NAME

Parivartan – supporting livelihoods through vocational training.

WHO

Marginalised communities - female sex workers, transgender people.

WHAT

To provide livelihood options for individuals and families facing financial difficulties due to COVID-19 and lockdowns.

WHERE

Surat city in the state of Gujarat.

WHEN

January-May 2022

TYPE OF INNOVATION

New or improved service.

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WHAT NEED DID IT ADDRESS?

As the Parivartan project was implemented, most community members spoke about their loss of income due to COVID-19 and related restrictions. Some families were struggling because of the death of the breadwinner. Those who relied on sex work for their income were unable to work during the lockdowns while others started sex work for the first time during this period because of financial difficulties in their families.

WHAT IS THE INNOVATION?

The project addressed the lack of financial security by securing placements on vocational training courses for people affected by COVID-19. The project team worked with government-recognised institutes to provide short courses for community members to learn computer skills or train as beauticians.

WHAT WORKED WELL?

Community members were able to identify options that would help sustain them in the future. Although it took longer than expected, Alliance India and GSNP+ were able to identify suitable training providers and enrol people in short courses. One of the training providers, the Dr. Babasaheb Ambedkar Open University, saw the partnership as mutually beneficial and has set up a special initiative to work with community organisations to reach a range of marginalised communities with education and vocational courses.

IMPACT

42 people affected by COVID-19 enrolled in vocational courses.

42
ENROLLED

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

This kind of intervention needs more time at the planning stage, finding the right institute to partner with and contracting them is time consuming. More time is also needed to agree the courses that will be offered and recruit potential trainees, and it is important to consider the cost of travelling to the institute as some participants may need their expenses covered.

LESSONS FOR THE FUTURE

Many community organisations are seeking ways to improve opportunities and livelihoods for marginalised communities - providing vocational training is one way of expanding people's life choices. When selecting vocational course providers, Alliance India and GSNP+ shortlisted institutions that provide nationally recognised certificates. This was particularly important as many of the participants were migrants and any certificates that they obtained need to be valid across the country. It is also important to explore institutions that can offer a range of courses and link to work placements or bank loans for those enrolled in their courses.

> We want to work with heart, not just as a technical institute, with organisations like GSNP+ who are connected to the community. Learning skills together can help break taboos and reduce stigma among future generations.

Dr Nigam Pandya,
Atri centre coordinator, Dr. Babasaheb Ambedkar Open University, India

CASE STUDY 3

NAME

Parivartan - addressing mental health needs arising from COVID-19.

WHO

Marginalised communities.

WHAT

To identify individuals who reported mental health issues and refer them to services.

WHERE

Surat city in the state of Gujarat.

WHEN

January-May 2022

TYPE OF INNOVATION

New or improved service.

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WHAT NEED DID IT ADDRESS?

Many community members reported poor mental health and wellbeing because of COVID-19. People saw their family and friends die, lost their livelihoods and homes and were unable to feed themselves or their families. People living with HIV were also concerned about interruptions to their treatment. These problems compounded existing mental health challenges for people who are not accepted by their family or wider society due to their sexuality, gender identity or because they engage in sex work. High levels of taboo attached to mental illness meant that people were reluctant to talk about their mental health or seek support. There was also a lack of awareness of available services and how to access them.

WHAT IS THE INNOVATION?

This was the first time that Alliance India and GSNP+ explicitly tried to identify and support community members with mental health issues. They worked closely with mental health experts at the Urban Health and Climate Resilience Center of Excellence (UHCRCE) to design the intervention. UHCRCE also led a two-day residential training for outreach workers.

WHAT WORKED WELL?

The partnership with a local mental health hospital and other mental health organisations was critically important. The outreach workers received training on how to screen and identify mental health conditions as well as how to support people needing further services and make appropriate referrals. They were also given a guided visit of the health facility so that they could learn more about the services on offer. Outreach workers were community members themselves so were able to gain trust and, over time, encourage individuals to seek support despite their reluctance.

IMPACT

33 people affected by COVID-19 were referred to mental health services.
12 outreach workers were trained to screen and identify mental health issues among their communities.

12
OUTREACH WORKERS TRAINED

WHAT COULD HAVE BEEN DONE DIFFERENTLY?

While outreach workers and project coordinators were aware that taboos would make talking about mental health a challenge, they underestimated the level of shame and fear. Some community members talked at length about issues they were facing, such as depression and anxiety but were reluctant to be referred for support. The short time scale for the project was another challenge. The model could be adapted to include a period to sensitise communities and break down some of the stigma around mental health before offering referrals to those who need support.

> We need to allow more time and patience for mental health interventions. We need to raise awareness and help change the mindset of people as there is huge external and internal stigma.

Rashmi Rajak,
project coordinator, Alliance India, India

LESSONS FOR THE FUTURE

There is huge stigma and low awareness around mental health issues in India. However, there is increasing recognition of the need to address this and overcome the reluctance to seek mental health services. While networks like GSNP+ already provide counselling to people living with HIV to support greater emotional wellbeing and improved adherence, they need further training to identify conditions that may need referral to mental health professionals. Future efforts to integrate mental health services need a much longer time frame and greater use of social and behavioural change interventions to better prepare the community.

> The Parivartan project supported me both mentally and financially as I was utterly devastated when my husband died. The team provided me with food rations and essential items, including medicines. An outreach worker would visit me regularly to offer counselling.

Alka Bhuva, seamstress, India

LOOKING AHEAD

> “The core thing to replicate from this project is supporting communities, who are left out of the public health system, with the impact of an emergency and meeting all their needs - health, welfare, economic and social.”

Thota Maheshwari, project manager, Alliance India, India

WHAT CAN BE LEARNED FROM "ACCELERATING INNOVATION"?

This section looks at themes emerging from the interventions in Uganda and India and highlights what can be learned to strengthen the HIV response and improve pandemic preparedness.

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PERSON-CENTRED CARE

Each of the interventions showed flexibility. Well-established community-based structures were used to understand the changing needs of people living with HIV and marginalised communities and to adapt services for them.

Tailored services

In India, the project focused on designing COVID-19 responses that met the needs of marginalised communities, trying to address some of the reasons behind their vaccine hesitancy. By providing stigma-free spaces exclusively for them, alongside motivation from peer supporters, people felt safe and uptake of the vaccine was significantly increased among these communities.

In Uganda, as people found they had different needs during the COVID-19 pandemic, services were adapted to suit their changing circumstances and to prevent a drop in ART adherence. For example, the virtual counselling was deliberately flexible. People could have online meetings or counselling over the phone, and where possible in-person group counselling sessions were set up. These face-to-face sessions were tailored towards specific communities and run by known and trusted peer educators.

Integrated care

In Uganda, the integration of a range of services was particularly successful. These integrated services were on offer in locations like group counselling venues, where people could collect a food parcel as well as access adherence support, treatment refills, testing and screening services. The peer educators in Uganda were also able to offer an integrated package of services to their clients in the community.

In India, the project adapted to include a wider variety of services as the needs and priorities of marginalised communities changed. It started by raising awareness about how to prevent COVID-19 and providing masks and sanitisers. As vaccines were rolled out, dedicated stigma-free vaccine camps were set up. When it became clear that people were struggling financially and emotionally, the project adapted to offer mental health referral support and vocational training options.

> "As a peer educator, I was given the drugs to deliver to specific clients. I was giving people information about COVID prevention too. I spoke to people on the phone as well as doing home visits. And we delivered nutritional support, especially to young people who needed basic foods. We even got to know new clients who needed to begin ARVs through the self-testing.
>
> **George, peer educator and sex worker, Uganda**

Promoting self-care

Through necessity, people began to rely more on self-care interventions during the pandemic. There was also greater political support for differentiated service delivery (DSD) models that moved services away from clinics and into the hands of marginalised people in their communities.

> "The team had me vaccinated against COVID-19 and ensured that I had access to mental health services, including psychotherapy. I am now looking forward to earning a stable income thanks to the vocational training I am undertaking to become a beautician.
>
> **Sushma, sex worker and mother, India**

> "People are used to doing self-care [and] self-testing. We are going to continue with some of these things. It will help decongest the clinics … we will continue with mobile services through the phone, it helps us reach more people.
>
> **Martin Chebet, nutritionist, AMS, Uganda**

This can be seen in the work done to support HIV self-testing in Uganda. AMS seized the opportunity that arose from a relaxation of the rules around self-testing to use their network of peer educators to identify people at risk of HIV and offer them a test. Critically, clients were visited again after they had completed the test to encourage ongoing self-care. They were supported to take further steps to protect their health whether that was information and adherence support for ART or HIV prevention measures.

Addressing stigma

The high uptake of many of the services offered in Uganda and India was in part because they enabled people to avoid visits to health facilities and to protect their privacy. Even if interventions such as home deliveries and virtual counselling continue longer term, the concerns clients have about stigma and discrimination remain. Much more needs to be done to ensure that all facilities that offer health services are welcoming, safe spaces where people living with HIV and those from other marginalised communities can seek health care without the fear of stigma and discrimination.

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COMMUNITY LEADERSHIP

Communities have played an essential part delivering services for HIV prevention, treatment and support for many years. Community networks and organisations were among the first to respond to COVID-19, adapting and expanding their role and the services they provide.

Robust community structures

Alliance India and AMS have decades of experience running programmes to support people living with HIV. They have built community structures around peer educators and outreach workers. These structures play a vital role in providing essential services, alongside the more formal health system structures. During the COVID-19 pandemic, they were used to swiftly mobilise and reach communities with much needed services.

For example, AMS used their extensive network of peer educators to deliver ART and PrEP. Similarly, Alliance India used their expertise in communicating health information to marginalised communities to disseminate public health guidance and the latest science around COVID-19.

Both Alliance India and AMS also had the structures in place to be able to receive funds and, where needed, distribute funds to partner organisations – all within a short time frame. AMS also have a well-developed monitoring and evaluation system. By looking at the data gathered, they were able to identify areas where interventions were needed.

> “In any society, the groups which are most vulnerable healthwise or socially are the ones most affected by any epidemic or disaster. Special efforts are needed to reach them and are best undertaken by organisations which have prior experience of working with these groups. Donors must consider the importance of training and community participation in ensuring long-term success.

Dr Vikas Desai,
public health professional, India

Services led by peers

For this project, the Indian network GSNP+ expanded its remit beyond working with people living with HIV to other marginalised communities. Outreach workers from the Lakshya Trust and Paras PSM were included in the project which made it easier to build trust and reach LGBT+ and sex worker communities with services and support.

> “During the pandemic, when no one else was thinking about our welfare, the Parivartan team stood with us and supported us. A project outreach worker, who belongs to the transgender community, visits regularly to offer me counselling.

Tulsi, only income is from begging, India

Peer workers were also at the heart of all the interventions in Uganda. AMS have over 400 peer educators from different marginalised populations. They identified many of the services that were needed as well as the individual people who would benefit from them. The high uptake of services was in part due to the trusted relationship that they have with communities.

> “We worked hand in hand with our clients, we took much more care. We knew some of them were suffering with mental challenges. We increased the level of care.

Musa, peer educator, Uganda


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Designed by communities

A deep understanding of potential beneficiaries is one of the reasons why community organisations can deliver HIV services effectively and can also lead the way in promoting wider public health goals.

Alliance India and GSNP+ started the project with social mapping to understand the challenges and perspectives of the communities they were trying to reach. This informed the project at all stages of design, implementation and adaptation.

In Uganda, peer workers kept track of hot spots where members of marginalised communities gathered so that services could be delivered in these hot spots. Peer workers tracked changes in behaviours, such as how and where people were meeting to ensure that services were moved and delivered in the right ways and places.

> “COVID and HIV both have common issues such as the importance of addressing stigma and the importance of prevention messaging. We used our HIV experiences and expertise in designing this project.

Rajesh Kalavadiya,
project manager, GSNP+, India


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SUSTAINABILITY

Some of these interventions were, by their nature, short term. However, many of them could continue to bring significant benefits to communities of people living with HIV and marginalised populations. The sustainability of these interventions will depend on factors including the resilience, capacity and financial stability of organisations like AMS and Alliance India and the partnerships they build.

Cutting costs and raising funds

During this project, it became clear that many of the new interventions in Uganda may be useful beyond COVID-19. To continue home delivery of ARVs, AMS are looking to introduce an element of cost sharing by asking clients to make a contribution. For example, some people could pay the equivalent of their usual bus fare to the health facility. Other adaptations could reduce the costs of service provision. For example, AMS could save costs and offer counselling to a wider number of people across a larger geographical area if they continue to hold some virtual group counselling.

Building self-reliance

COVID-19 has pushed many people further into poverty. Although the food packages in Uganda were invaluable, AMS are keen to reduce the need for nutritional support in the long term by offering training and advice for income generation. Similarly, Alliance India and GSNP+ would like to build on their partnerships with vocational training institutes to provide skills and livelihood options for marginalised communities.

Close collaboration with local authorities

In India, the reputation of GSNP+ as a reliable partner and its relationship with bodies such as the State AIDS Commission, Surat Municipal Corporation and Surat Municipal Hospital were key to the success of the vaccination camps and the mental health referrals.

In Uganda, AMS also built on their existing relationships with government. In some areas, the district government helped to supply fuel for the vehicles that delivered ARVs to communities. There was a sense of partnership with government nationally and locally pulling together with communities to support each other's efforts.

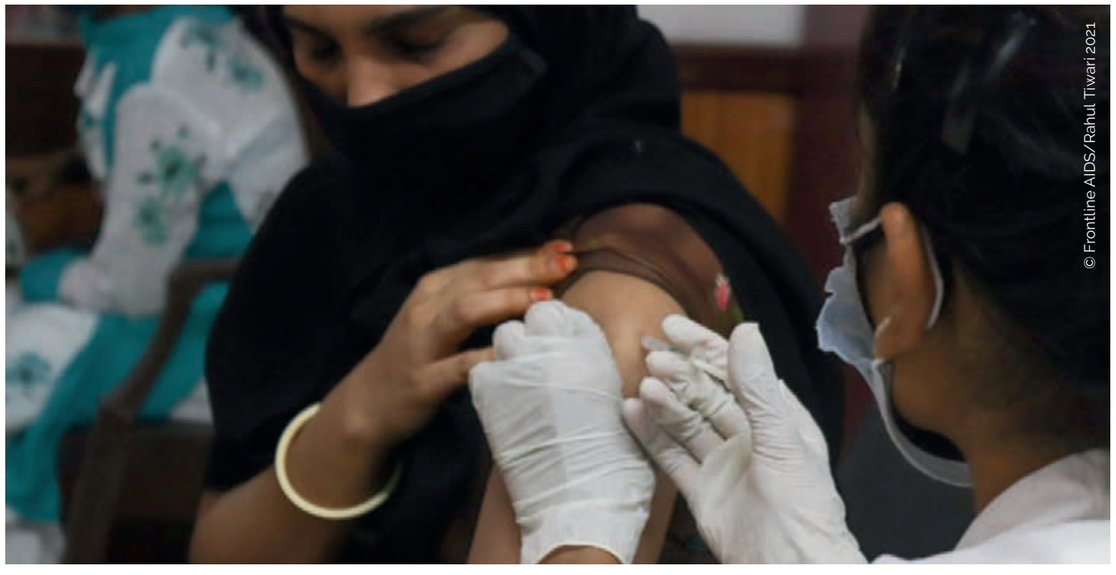
> “It would be good to include economic empowerment and livelihood training so that we can make an income and stand on our own feet. I would love to start my own business and open a clothes boutique.
>
> **Aisha, sex worker, Uganda**

PANDEMIC PREPAREDNESS

> “We expanded our work beyond HIV and are working with broader key population communities, not just those living with HIV. We have built up our reputation with government departments. We believe we can contribute more strongly to future pandemics because of this.
>
> **Daxa Patel, board member, GSNP+, India**

Alliance India and GSNP+ had the systems and structures in place to mobilise funds and volunteers rapidly to help marginalised people. Peer outreach workers raised awareness, delivered food rations, hygiene kits, and ARVs and also advocated to ensure that their communities were able to access SRHR and health care. Despite India's ability to manufacture a vaccine, it took months before the government started a vaccination programme and it was community networks that helped marginalised communities to overcome the bureaucratic registration process and access this life-saving intervention.

In Uganda, AMS adopted a combination of approaches, including health facility-based service delivery (through an AMS clinic), and community-based services delivered by peer educators and mobile clinics. Peer educators (themselves from different marginalised communities) provided HIV services to their networks in a variety of settings (safe spaces, hotspot and homes). They were able to adapt to the pandemic and provide a wider range of services.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The experiences in both India and Uganda show how quickly public health systems were overwhelmed by the pandemic. The national response in each country did not fully engage with those worst affected by COVID-19 and marginalised communities were not prioritised. Nonetheless, community-led organisations did reach marginalised communities, taking services to them and tailoring services to meet their differing needs. Alliance India, GSNP+, AMS and others working on HIV and TB demonstrated that they were able to quickly adapt and respond to emergencies such as COVID-19 and support public health goals. As governments invest more in pandemic preparedness, community organisations and their systems will need adequate funding if they are to be part of health systems.

The infrastructure and substantial expertise and experience that already exist in the HIV response are a strong base to build from to prepare for future pandemics. An opportunity exists to reimagine systems for health so that they work for and with people and include communities as essential partners.