SUMMARY BRIEF:

Rapid assessment on the impact of COVID-19 on community-led HIV responses in the SADC region

Key Findings

- The community-led aspect of the HIV response offers existing and well-established structures for health promotion and service provision and important building blocks with which to build community ownership and trust, share information and education on COVID-19 prevention, combat myths and stigma and empower communities in dealing with the ongoing COVID-19 pandemic;
- A disconnect occurred between government responses, including the National AIDS Councils, and civil society responses, which impeded civil society's ability to continue with community-led HIV responses and provide support to the COVID-19 relief efforts;
- Civil society was unprepared for the impacts of COVID-19 on their operations and displayed different levels of responsiveness in mitigating the impacts. Funder flexibility was a key enabler to this responsiveness;
- Programmatic targets were generally negatively affected but the extent of impact is unknown due to inconsistently applied levels of monitoring by civil society;
- For some civil society organisations, the crisis situation also served as a catalyst for acceleration and innovations in community-led HIV responses but the effectiveness and reach of these innovations still needs to be evaluated
- While it is still too early to assess the extent of the impact of the COVID-19 response on the current trajectory of the HIV and AIDS targets in the SADC region, there are early indications that HIV prevention and the 90-90-90 treatment targets have been negatively impacted.

Key Recommendations

- Civil society should develop risk mitigation strategies to increase levels of preparedness, resilience and ability to respond to health crises or emergencies. This will involve civil society strategically assessing previous modes of operation and possibilities of permanently adopting innovations that have been proven to work to increase productivity, innovation and ultimately competitiveness;
- Civil society should actively build cooperation between in-country sister organisations with a view to pooling resources to increase efficiencies and reach, and to buffer against shocks on grassroots organisations during health crises;
- Evaluation of the effectiveness and sustainability of civil society innovations as a response to COVID-19 needs to be carried out with a view to promoting learning and expanding their application in the SADC region;
- Broadening definitions of essential services through the inclusion of key aspects of community-led service delivery can reduce disruptions to existing services and leverage these existing structures for rapid deployment of relief efforts in emergencies affecting health;
- National AIDS Councils should be supported to play a stronger bridging role between government and civil society to ensure that resources reach the community and HIV-related service delivery remains uninterrupted during times of emergency.
- Further research is required to understand the health, economic and social impacts of the COVID-19 responses on HIV prevention, particularly for vulnerable and key populations in their diversity.

Introduction

After the first COVID-19 case was detected in the SADC region in early March 2020, countries imposed restrictions or lockdowns of differing intensity and duration as an urgent response in dealing with the health crisis posed by the pandemic. These measures disrupted social and economic life and access to health services, many of which were reconfigured to manage COVID-19 cases. In the SADC region, national responses to COVID-19 occurred in a context of systemically weak and under resourced health systems and high burden of HIV, and other chronic illnesses among the populace.

Community-led or outreach activities play a key role in mobilizing communities, combatting stigma, holding government accountable in policy and practice, and supporting health systems as well as have unique reach to populations who are disproportionately burdened by the HIV epidemic. Community-led HIV responses are the cornerstone to the HIV response in the region [3] but little is known about the impacts of the COVID-19 measures on the gains the region has made in the provision of HIV prevention, care and treatment. This brief presents the findings of a rapid assessment amongst 25 civil society organisations involved in the HIV response across the SADC region and provides recommendations for sustaining the community-led HIV response in the face of ongoing and future health crises.

Community-led HIV responses include a diversity of organisations (from coordinated communities, groups or structures, to CBOs, FBOs or NGOs) and programmes which has led to definitional challenges for monitoring and evaluation purposes [1].

These definitional complexities are deepened by the wide scope of activities involved in a comprehensive HIV response. As an overarching typology, UNAIDS identifies four key categories that constitute the collective of community-led activities in response to HIV:

1. **advocacy, campaigning and participating in accountability,**
2. **community-based service delivery,**
3. **participatory community-based research, and**
4. **community financing [2].**

Methodology

We conducted in depth interviews with representatives of 25 civil society organizations (CSOs) in the SADC region. Countries included were Madagascar, Mozambique, Angola, Democratic Republic of Congo, Zimbabwe, Zambia, Mauritius, Seychelles, South Africa, Botswana, Malawi, Republic of Tanzania, Lesotho, eSwatini, and Namibia. We included a spectrum of CSOs involved in the community-led HIV response, including networks, and grassroots organisations to larger, more established organisations with national reach. Constituencies of the participating organisations included people living with HIV, adolescent girls and young women, school going youth, lesbian, gay, bisexual and transgender people, sex workers of all genders, and people who use drugs. Programmatic focus areas of the organisations included advocacy, campaigning and participating in accountability; community-based service delivery (clinical, psychosocial, socioeconomic support, legal assistance, services or support, community outreach), education, training, sensitisation, adherence support, income generation) and community-based research.

Findings

COVID-19 resulted in a centralised, state of emergency, national response across the region that negatively impacted community outreach

Across the SADC region, member states issued a range of restrictions, that differed in duration and intensity at country level, in an effort to limit the spread of COVID-19. Where lockdown measures were instituted, people either returned to their homes (this included cross border and urban-rural movement), or limited their movements to the confines of their households, while health and other services which were not classed as essential became largely inaccessible. The adoption of a centralised crisis management approach was necessary for the containment of the pandemic and prevention of fatalities but also had the effect of displacing the critical function of community systems in the preparedness, coordination and infection prevention and control of COVID-19 and prevented community-led structures from reaching their communities for the HIV response.

"Sex workers went into hiding and were working clandestinely, completely hidden. This was very risky for them of course, but also very difficult for us as an organisation to go and find them and talk to them."

Democratic Republic of Congo

"Lockdown disrupted most of our operations. We couldn't do any outreach activities, we couldn't come to the office, our members also were not allowed to go and visit their clinics or hospitals for their clinical appointments. There was a disruption in terms of the services that were being provided. There was that shift."

Zambia

What were some of the community health needs during the COVID-19 emergency response?

While huge efforts were made to prepare and equip health facilities for an influx of (critically ill) COVID-19 patients, there were other important health needs still requiring attention. Firstly, the community at large needed health information on the new virus, including instructions on prevention and hygiene, testing and quarantine. And secondly, the treatment for chronic and other illnesses, including HIV, needed to continue as much as possible to maintain good health.

Civil society reported being faced with many questions about COVID-19, but that there was a general lack of information made available on the virus, which contributed to the rise of many myths and COVID-related stigma within communities.

General instructions to stay away from a health facility if not ill with COVID-19, further complicated by the restrictions in public movement, meant people with other health needs delayed seeking services or chose to stop their chronic treatment when they ran out of their medicine while at home. There were anecdotal reports from participants, from various SADC countries, of community members on their way to a health facility being turned away at checkpoints as they lacked the necessary travel permit or being turned away upon arrival at the facility as they did not have a face mask. Participants also reported community members being turned away if their health needs were classed as non-essential. There was a lack of information as to which facilities were still operational as some facilities were converted into COVID-response centres, or temporarily closed due to a rise of infections among health personnel or as a result of labour strikes following the lack of protective equipment. With a reported sharp increase in gender-based violence in many country contexts, the availability of shelter, protections, health and social care was also compromised as government and non-governmental institutions were limited in their ability to continue providing these services.

"We need to talk about stigma but the government's focus is on testing and isolating right now."

Namibia

"In the case of orphans and vulnerable children, some of them were subjected to GBV and this was not easily or detected quickly enough because our cadres are not on the ground. [Now] you find a case will be revealed after a week or two weeks whereas if COVID-19 was not there, if it happened last night, then the next morning we would have been able to pick it up and take appropriate action."

Lesotho

"While we intensified our community programmes, it was not easy to be cleared to go out into the community. It took us almost a month. We were only able to [go into the community] as from May. The bureaucracy, the red tape. Most of the offices were closed, and you reach out to contacts who then refer you to other people; people who didn't know the organization. We had to use our existing contacts to finally get some kind of clearance. We are not classified as an essential service... HIV testing, resupply of ART and PREP; those were our entry points."

Zimbabwe

What does a centralised COVID-19 response mean to the structures of the community-led HIV response?

Overall, the community-led HIV response was negatively impacted by the movement restrictions and lockdowns. While the duration and strictness of measures differed across countries, the majority of the HIV response activities at the community interface were suspended for months; from support groups for people living with HIV and AIDS, TB contact tracing, door-to-door HIV testing, to community dialogues and training. Clinical care for HIV and comorbidities as well as the provision of preventive commodities, such as condoms, PrEP, and clean needles and syringes, was not considered an immediate health priority under most national COVID-19 responses. Additionally, there was very limited evidence of concrete initiatives by governments to harness existing civil society structures and capacity, at least in the initial phases of the pandemic, as part of their risk mitigation strategy. In overlooking this capacity, the opportunity to capitalize on the presence and utility of community systems for reaching large numbers of people with health information, diagnostics and relief efforts was to a large extent missed by the central coordination centres. The assessment findings also suggest that the National AIDS Councils (NAC) in each member state missed the opportunity to play a stronger coordinating role in leveraging this multi-sectoral strength to support the respective COVID-19 national responses and in ensuring the continuation of activities contributing to the HIV response. The global scale of COVID-19 responses also resulted in interruptions in the supply chain of antiretroviral therapy (ART), and other essential medicine and commodities in the treatment and prevention of HIV.

"The government did not talk about HIV during this time. We were the only one so we had to do it!"

Seychelles

"The way the Ministry of Health is taking this is more a medical response than a community response, where they have left out civil society in most of these things. There are simple things that civil society can do. They can go and sensitise people, using public address systems. They can do quite a number of things, including contact tracing. It is these small things that civil society can do to respond to COVID-19. The other thing they can also do, for instance, the churches - the structures are still there and we have churches even where schools are not, even where government is not present so why don't we use these structures to provide basic health services? For instance contraceptives, for instance malaria treatment? We still have community agents who can provide these small services that were meant to decongest the health facilities. So civil society can still be very instrumental in providing some of these services as long as they are equipped with the informationand with the protective equipment. They can do this work."

Zambia

What was civil society's capacity to respond?

COVID-19 presented a new reality for the world, and civil society was no exception. Most CSOs were unprepared for the impact of the COVID-19 national responses on their strategic mandates and operations. Only two out of the twenty-five organisations that were interviewed had a response plan or task force in place at the beginning of the lockdown measures in March.

Civil society displayed different levels of resilience and flexibility in navigating their activities within a restricted working environment. Larger and more established CSOs, with direct links to government and donors, demonstrated the greatest agility and resilience, often intensifying their outreach efforts, while the smaller, less established, grassroots community-based organisations had almost no ability to absorb this shock while simultaneously facing the increased needs of their communities under the pandemic. The ability to adapt work plans and budgets and to rethink programme interventions relied heavily on the organisational capacity pre-COVID, the strength and size of the organisation's network, and on the flexibility of funders to accommodate the new reality. For example, the vast majority of CSOs were dependant on their funders for financing their work-from-home policy (e.g. modems and data bundles for internet connectivity and portable equipment such as laptops and smartphones) and for financing personal protection equipment (PPE) so that staff and volunteers could safely execute their community interventions, once permitted. The flexibility and support of funders was an important variable in the responsiveness of civil society to the impacts of COVID-19. This assessment found that most funders of HIV and key population programmes in the region have been responsive, supportive and accommodating towards the adaptation of work plans and reallocation of budgets in the current year. A number of funders mobilised additional funding and put aside a percentage or established special COVID relief funds for CSO partner responses to the most pressing needs among programme constituencies, such as food and PPE needs, and for the rapid digitalisation of services.

"I worry a lot because we have done so much in the past 4-5 years and the possibility of shut down or not having a space to operate from is one of the main concerns that we might have to revert to operating from our houses."

Namibia

However, organisations who were re-negotiating contracts or had less established relationships with funders found themselves in a more precarious situation. The grassroots community-based organisations, in particular, expressed most immediate concerns, such as looming evictions from rented office spaces and an inability to retain staff and outreach workers as salary costs or stipends were tied to project deliverables that could no longer be met. Unsuccessful requests with funders for no-cost extensions and the high competition in the region around COVID-19 related grants were seen to push an additional number of CSOs into uncertainty over their short term future.

None of the CSOs reported having received financial support from their government or NAC to continue their operations, and in kind contributions, such as disinfectant or masks, were said to have been minimal/negligible. A number of CSOs had been approached by the Ministry of Health or other government authorities, for example for seconding their vehicles in support of the national COVID-19 response. Without exception and in addition to their HIV mandate, all CSOs participating in the assessment had engaged in health promotion on COVID-19, both to and beyond their constituency. Some CSOs had also made provision for handwashing points with Tippy-Taps in the community and were supporting their Ministry of Health in the testing for COVID-19 at health facilities or at border posts (Lesotho, South Africa). In many countries, CSOs reported that the relief efforts, including the provision of PPEs, had not reached the community due to corruption or due to selective support for political constituencies of Parliamentarians instead of the mass. Further, unregulated prices for PPE in some countries meant that these resources were unaffordable to the most vulnerable populations. This has led to some CSOs taking up a more vigilant role and openly demanding transparency and accountability of the government-led COVID-19 response.

"What you will see, the ministers, the MPs, they will go to the business people and ask them to donate and then they themselves will take these parcels to the communities so that they are already preparing for the next election in 2022. So they want to be seen to be acting, to be helping the community. According to me, such donations could be taken to NAC and NAC could take them to the relevant people."

Lesotho

"We hear on a daily basis that government is receiving donations but we can't even monitor where these things are going, especially the food donations. […] Some of these food packs are given to MPs. You know MPs and their political will, they support those who are going to vote for them. So it seems difficult to say exactly how the food packs are being distributed in the country and the money with which they were going to support us, the relief funds. We hear that one or two people got the money but the majority of people don't get the money. We don't even know what is happening to those donations."

eSwatini

Solidarity among CSOs was most strongly observed on the Islands of Mauritius and Seychelles, where different organisations actively joined hands to mount relief efforts for key and other vulnerable populations and minimize service interruptions. On the mainland, CSOs were predominantly occupied with internal operations and conversations with funders, and tended to operate in silos especially in the first 2-3 months of the outbreak. This limited their ability to provide relief efforts as well as to continue carrying out their HIV-related mandates. More established organisations who had a history of networking with smaller sister organisations were more effective in sharing and distributing resources such as masks and food parcels.

"We did more outreach than in a normal situation."

Mauritius

"COVID was a catalyst to a process we were trying to put in place."

Zimbabwe

To what extent was civil society able to adapt and innovate?

While there were indications that the respective COVID-19 responses negatively impacted HIV targets and constituencies, it was also a catalyst for innovations and an accelerator for implementation of pre-COVID planned innovations. The effectiveness of these innovations remains to be determined but carry promise in efficiencies in staff productivity, travel and training costs, programme monitoring, and in various elements of service provision such as screening and contact tracing. CSOs also celebrated the successes of obtaining official government approval (at least temporarily) for differentiated ART approaches in which the COVID-19 pandemic had acted as a catalyst after years of lobbying.

In an effort to maintain programmatic gains and continue reaching beneficiary populations under the new circumstances, accelerations were seen in the use of digital platforms and roll out of differentiated HIV treatment models, in collaboration with governments. In at least seven countries (Mozambique, Lesotho, Mauritius, South Africa, Namibia, Zimbabwe and Seychelles), permission was either granted for multi-month ARV dispensing at the health facility or for CSO initiatives to establish community drug pick up points and/or dispense ARVs to peoples' homes.

"Sex workers themselves have indicated that with schools closed, with children out of school, while most of those who can afford and are privileged enough and can do online schooling, children of sex workers are not able to partake in online schooling because of limited resources and the costs around internet and things like that."

Zimbabwe

Multiple organisations expanded the use of their facebook page and whatsapp groups, as well as radio and television channels to provide HIV and COVID-19 related information. Direct telephonic contact was used to follow up on care and support arrangements with constituencies, and hotlines were reinvigorated or established to dispel myths and to provide psychological support from a distance. Several CSOs undertook to train their peer educators in communicating through digital media, facilitating small-size group sessions or in monitoring service availability and reporting on service gaps and violence against key populations (Malawi, Mozambique).

The digital revolution:

Much of the reported innovations consisted of digital platforms which offer opportunities and challenges that still need to be addressed. Most respondents agreed that digital communication could never replace face-to-face interactions and education activities with the community but that there were some clear strengths to a digital approach. For example, digital platforms offer anonymity to stigmatised groups and there was indication that the expansion of these platforms attracted a new group of constituencies who may have never accessed a static service or linked to a peer educator in the community. In countries where lockdowns have gradually been lifted, CSOs are experimenting with hybrid options. However, much work needs to be done in reducing the cost of data and strengthening the wireless networks. In addition, many constituencies either do not have a smartphone to support the applications for the various platforms required or have no mobile phone at all. The sharing of phones is common and this raises significant confidentiality concerns.

"The good point with digitalisation is we minimize costs. With face to face training we have transportation, training materials, we have to hire a trainer and so on. With digitalisation we have to create training support just for one time and then can publish it [online]."

Madagascar

"We also realised we are underutilising IT. We now know that we can have our staff working at a distance. We can have staff meetings virtually, and they are fruitful. There are tons of tools to our disposal that can help us optimize office work."

Mauritius

"We are reaching mostly young people in the age of 18-35 from the main cities in Mozambique. It has been challenging to reach individuals beyond these cities due to connectivity issues."

Mozambique

"Most of our activities are in-person community meetings, so we had to put these on hold. We couldn't sensitise community members on safety and security though we did come up with virtual meetings which I think were not as successful as in person meetings. Now we have zoom, skype and teams and people have really never used these things, so now you have to engage community membersand teach them to use zoom and skype and, for some of them, it was the issue of data. So you could start a zoom meeting and then have very few participants. Some will come with complaints that they really couldn't figure out how to use Zoom and then you can't reach the ones in the rural areas."

Zambia

How have the gains in the HIV prevention and the 90-90-90 targets been impacted by the COVID-19 response?

While it is still too early to assess the extent of the impact of the COVID-19 response on the trajectory of the HIV epidemic in the SADC region, there are early indications that prevention and the 90-90-90 targets have been negatively impacted. Firstly, while additional funds were made available for COVID-19 prevention activities, funding was also diverted from key HIV prevention activities such as health education, health care provider and other training, school-based interventions, as well as campaigns to promote PrEP. Secondly, funding has been reduced or diverted from funder budgets. As one participant succinctly said regarding the funding of the HIV response: "We have been robbed twice!"

90-90-90 targets:

Civil society organisations were unable to meet their programmatic targets during the country lockdowns. Fears over the reversal of gains made towards the 90-90-90 treatment targets were widely expressed by civil society. While some organisations innovated and sought to continue HIV testing, there were widespread indications that HIV testing was significantly reduced, with the halting of HIV testing in some facilities unless a person was very ill. Door to door HIV testing and TB symptom screening was also suspended. In addition, with people returning to their family homes during lockdown and with facility and community activities temporarily halted, there have been reports of increases in lost to follow up (LTFU). Additionally, the increased stigma experienced by LGBT people during the lockdowns has meant some have left their homes and the area where the community-led response was being carried out (Namibia, Botswana).

Despite efforts to take medication to the community, it is difficult to understand the full extent of LTFU from service delivery efforts and whether this will be temporary or more long lasting. Very little monitoring and follow up appears to have been carried out by civil society during the various lockdowns. Many systems, for example adherence clubs and support groups, have fallen apart. While these adherence clubs can be reconstituted, participants shared that many people took ART because it was made to be convenient to them. For those who have had a treatment holiday, there are fears that they won't come back and fears that if they do come back they will be chastised at facility level. Viral load monitoring was compromised during this period and shortages of reagents were reported (Lesotho, Seychelles). Due to the ARV drug shortages in several countries in the SADC region people living with HIV and AIDS had their regimens switched. In Seychelles, Lesotho, Zambia, concerns were expressed about the switching of regimens. According to participants, there had been much investment in messaging around a newer ARV. There were concerns around confusing people in switching regimens and worries around confidence levels around the older regimen and adherence. Concerns were raised about possible increases in ART and TB drug resistance.

"We gave out information to people to say this is a better drug than the one you are taking. Now we say there is shortage, now we will revert you to what you were taking. It is like we are sending mixed messages. If you see people doubting like that, you also start doubting they are taking their medication."

Zambia

"Key risks are in the numbers of people getting tested for HIV and TB lagging behind. There is a significant reduction since quarter two as clinics were less accessible and door to door testing was impacted for a while."

South Africa

HIV prevention concerns:

In some countries, availability of condoms was limited because they were either not distributed during lockdown or clinics (which supply condoms) were difficult to access, while implementation of PrEP initiatives were also disrupted. Concerns were also expressed over the disruption in manufacturing of condoms and the impact on supply in the next few years in the SADC region. Needle exchange programmes were reported to be negatively affected and continued access to methadone treatment for people who use drugs has been challenging (Mozambique, Tanzania). It remains to be seen how this period has affected the susceptibility to infections like HIV and Hepatitis B and C.

School closures as a result of the COVID-19 response:

Some civil society organisations were working in schools at the time of lockdown (Madagascar, South Africa) and indicated that they had entirely lost contact with their pool of learners, some of whom were from the most marginalised school communities with high teen pregnancy rates and high levels of sexual violence. Few learners had access to phones and without direct contact with learners in the school setting, civil society organisations expressed concern over the possible increases in sexual abuse during lockdown but, with loss of contact, less options for children to reach out for help. As one participant phrased it, the well-being of learner constituencies has been "a blindspot for us" (South Africa). Closure of schools also meant planned school-based interventions were not carried out and are unlikely to be carried out since funds have already been diverted to the COVID-19 response. Heightened risk behaviours of youth, now idle with school closures was a concern broadly expressed across the region.

What can we do better going forward?

The HIV response has taught us the importance of community ownership by putting communities at the centre of a health crisis response. The community-led aspect of the HIV response also offers existing and well established structures for health promotion and service provision. Both these lessons and structures offer important building blocks with which to build trust, share information and education on COVID-19 prevention, combat myths and stigma and empower communities in dealing with the ongoing COVID-19 pandemic.

1. **Civil society organisations** need to build cooperation between sister organisations to increase their effectiveness and reach as well as advocate for investments in community systems strengthening. At the organisational level, civil society organisations need to strengthen their risk mitigation strategies to increase levels of preparedness and resilience in the face of a rapidly evolving pandemic. This includes retooling and reskilling of staff to ensure productivity, innovation and competitiveness. Where innovations have been applied, careful review of programmatic indicators and targets is needed to determine the uptake of these innovations and whether target constituencies are being reached.

2. **Member States** should enhance the inclusion of civil society in government relief efforts by broadening definitions of essential services to include aspects of community led service delivery to allow rapid deployment in emergencies affecting health. Key questions to be posed are "what constitutes an essential service?" and "who is the best placed to provide the identified service in an emergency/health crisis setting?". In addition, government actors should put in place national mechanisms should be put in place to prevent price inflations of essential protective resources and ensure PPE distribution to all cadres of health care workers, including community-based and outreach care providers. NAC, as an coordinating and intermediary body, is well placed to ensure effective distribution of these resources. Lastly, codes of conduct for law enforcement need to be strictly monitored to ensure they do not pose additional barriers to people in accessing health services.

3. **Funders** should consider funding structures that strengthen cooperation between sister organizations or network members to increase sustainability, efficiencies and reach. Funding mechanisms which encourage the agility and responsiveness of civil society and buffer against disruptions and shocks could be further considered.

Future research needs

1. To evaluate the feasibility, acceptability and effectiveness of the emerging innovations amongst civil society organisations.

2. To better understand the health, economic and social impacts of the COVID-19 responses on vulnerable and key populations in their diversity.

"[We need] information. Most of the people just say it is coronavirus but they don't understand what it is and how it can be transmitted. So people have that fear. They don't know that if they were to come into contact with COVID if these are the signs. Hence, what we are seeing now in Zambia is that there are reduced deaths in health facilities because of that fear and we have seen an increase in the "brought in dead" cases. People don't have information so that they can take action."

Zambia

"If government is offering support to any organisations who are offering services, our organisations need to be included as well in the support or the relief. We have had to rely on reallocating some of the funds that we had for other activities."

Zimbabwe

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About ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) is a partnership of civil society organisations that seeks to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing for sustainable development in southern and east Africa. Through capacity strengthening of civil society, duty bearers and other decision makers as well as advocacy at regional and national levels, we work to contribute towards the creation of just, equal, productive and resilient societies in southern and east Africa, in which social justice and human dignity are at the centre of all development, policy and organising; and health and wellbeing are promoted for sustainable development.

About HEARD

HEARD is a leading applied research institute operating at the nexus of research, policy and advocacy, working to advance health equity in Africa. HEARD has a global reputation for its interdisciplinary research, education programmes, technical services, partnerships and networks aimed at informing policy and practice to more effectively address the broad health challenges of Africa. HEARD was established in 1998 and is based at the University of KwaZulu-Natal, South Africa.

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