



CYCLONE IDAI

Integration of HIV into the humanitarian response in Malawi, Mozambique and Zimbabwe

CASE STUDY

JANUARY 2020

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A child plays on a collapsed tree in the Praia Nova slum in Beira, Mozambique.

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1. SUMMARY

In March 2019, Cyclone Idai brought death and destruction to Malawi, Mozambique and Zimbabwe. Each of these countries has a high burden of HIV, which required a priority HIV response. Humanitarian crises can lead to increased vulnerability of people living with HIV, and of those at risk of acquiring HIV. Treatment services may be disrupted and negative coping strategies, such as transactional sex for income and food, may be adopted, increasing the risk of HIV exposure.

Through preparedness, coordination of key stakeholders, outreach to those at risk, and deployment of local expertise, HIV services were integrated into the cyclone response by the United Nations Children's Fund (UNICEF) and partners in new and effective ways. The experiences of the three countries in supporting people living with HIV in an emergency – particularly children, adolescents and pregnant women – offer valuable learning for preparedness and future humanitarian responses in high HIV prevalence settings.

This case study highlights important HIV-specific interventions which were successfully integrated into the emergency cyclone response. These sit within UNICEF's broader multisectoral interventions across the humanitarian development nexus.

2. BACKGROUND

The Tropical Cyclone Idai weather system affected nearly 3 million people and killed over 1,000 people, around half of them children (Figure 1). It proved to be one of the deadliest storms on record in the southern hemisphere. Aid workers spoke of a major humanitarian emergency, huge challenges in accessing populations in need and "inland oceans extending for miles and miles"¹.

In all three countries, there was extensive damage to crops, livestock and infrastructure including roads, bridges, water installations, power and communications, as well as to homes, schools, health facilities and community structures. Hundreds of thousands of people found themselves in desperate situations, fighting for their lives, sitting on rooftops, in trees and other elevated areas. Displaced families who were lucky enough to reach help, were forced to shelter in transit centers, having lost everything².

Impact of Tropical Cyclone Idai³

Malawi: About 868,900 people were impacted, with 59 deaths and 672 injuries recorded. Nearly 87,000 people were displaced but have since returned to their homes or resettled in new areas. Heavy rains caused by the cyclone led to severe flooding in the southern region of Malawi, which is prone to regular emergencies caused by floods, cholera outbreaks and lean seasons.

Mozambique: 1.85 million people were in need of humanitarian assistance, with more than 600 deaths and more than 1,600 injuries recorded. Nearly 161,000 people were sheltered in displacement sites. Just a few weeks after Cyclone Idai, the country was hit by Tropical Cyclone Kenneth – the strongest cyclone to ever hit the African continent – and the first time in recorded history that two strong tropical cyclones hit Mozambique in the same season⁴. It is estimated that at least 2.6 million people were affected by the two cyclones⁵ with 648 deaths in the central region⁶ (Cabo Delgado, Inhambane, Manica, Sofala, Tete, and Zambezia provinces).

Zimbabwe: More than 270,000 people were affected, with at least 299 deaths reported and more than 186 people injured. The cyclone came during a particularly challenging time for the country which is still experiencing drought as well as grappling with economic challenges that have exacerbated humanitarian needs across the country. Prior to the cyclone, the food security situation in affected provinces was already dire.

The full death toll from Tropical Cyclone Idai is not yet known. The storm impacted health and education facilities in all three countries.

1 UN News Cyclone Idai: emergency getting 'bigger by the hour', warns UN food agency 19 March 2019 <https://news.un.org/en/story/2019/03/1034951>

2 In Cyclone Idai's Wake, UNICEF Is Mobilizing in Mozambique and Malawi, March 17, 2019 <https://www.unicefusa.org/stories/cyclone-idais-wake-unicef-mobilizing-mozambique-and-malawi/35671>

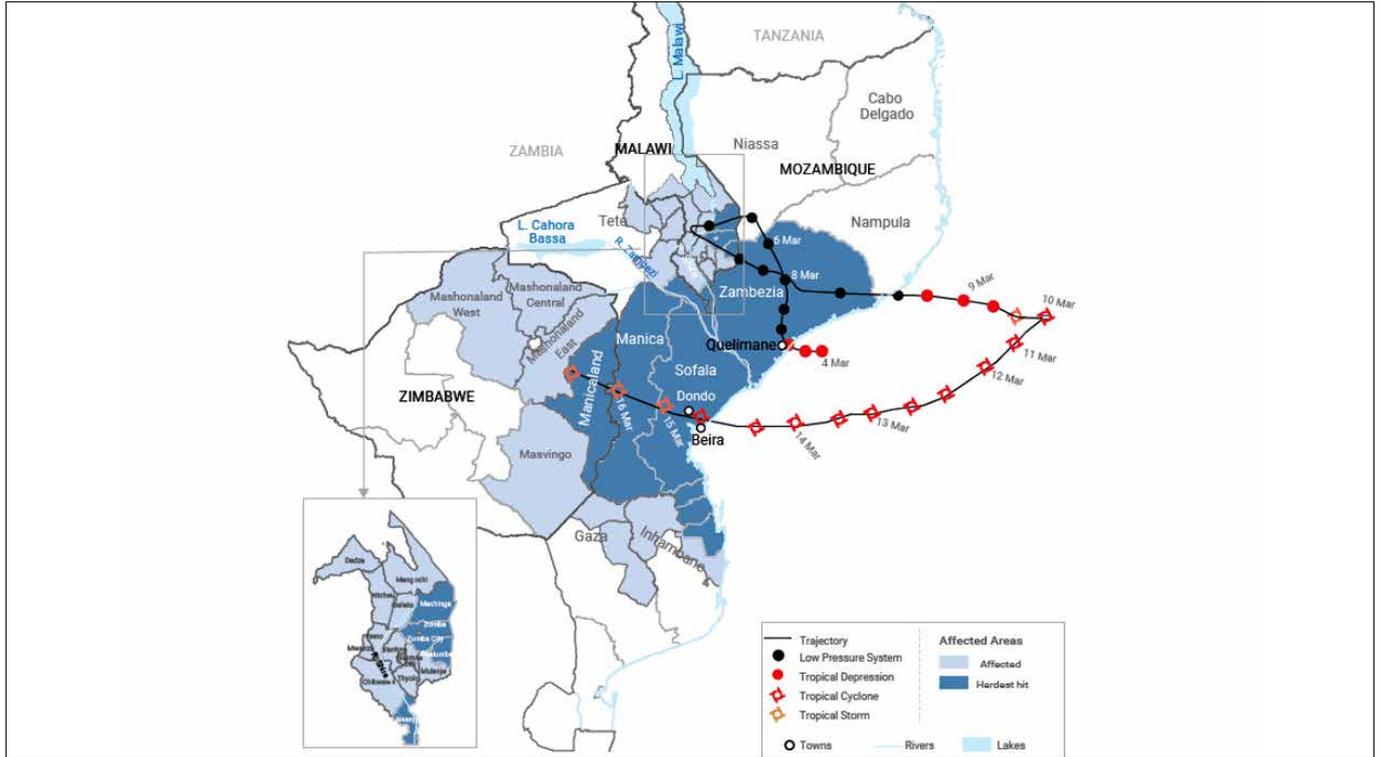
3 OCHA, Southern Africa Cyclone Idai Snapshot (as of 9 April 2019), unless otherwise stated.

4 OCHA, Cyclones Idai and Kenneth, <https://www.unocha.org/southern-and-eastern-africa-rosea/cyclones-idai-and-kenneth>

5 Sum of 2 million in Integrated Food Security Phase Classification (IPC) phase 3 and phase 4 levels of food insecurity, 500,000 people living in damaged or partially damaged houses, 60,000 people in resettlement sites and more than 59,000 displaced by insecurity in Cabo Delgado, National Institute for Disaster Management (INGC) and Humanitarian Community.

6 UNICEF Mozambique: 603 deaths from Cyclone Idai and 45 from Kenneth.

Figure 1: Tropical Cyclone Idai - Cyclone and food affected areas



Source: OCHA Southern Africa Cyclone Idai Snapshot (as of 9 April 2019)

Cyclone’s impact on adults and children living with HIV

Southern Africa is the global epicenter of the HIV epidemic. Malawi, Mozambique and Zimbabwe are countries with high HIV prevalence and priority HIV responses. The adult HIV prevalence rate⁷ is 9.2 per cent in Malawi, 12.6 per cent in Mozambique and 12.7 per cent in Zimbabwe⁸.

The cyclone-affected regions all had high HIV prevalence rates – sometimes above the national average. Southern Malawi has the highest burden of HIV, contributing to two thirds of HIV cases in the country. There are an estimated 660,000 people living with HIV including 63,000 children (0–14 years) in this region. In Mozambique’s central region, there are an estimated 847,000 people living with HIV including 54,000 children in the four provinces. In Zimbabwe, the nine affected districts are home to over 210,000 people living with HIV, including more than 14,000 children and at least 10,000 women who are pregnant or breastfeeding.⁹ More than 185,000 people living with HIV in affected districts of Zimbabwe were on ART and needed to maintain their supplies and daily adherence.

Continuous access to basic HIV services, including access to and retention on antiretroviral treatment (ART) was

seriously threatened during the emergency. In Mozambique, at least 112 health facilities were damaged or destroyed, meaning thousands of families and children could not access primary health services, including for HIV. In Malawi, most of the evacuation centres did not have health facilities in their immediate catchment areas; where they did, health facilities were overwhelmed by the high numbers in need. Basic critical services such as immunization, antenatal and postnatal care, screening and treatment of malnutrition, curative care, reproductive health, tuberculosis and HIV were all disrupted.

In Zimbabwe, an assessment conducted by the Ministry of Health and Child Care and UNICEF in the first week after the cyclone, found that five clinics (out of 28) in the affected areas had partial damage but were able to resume primary health service provision almost immediately. However, some clinics were only accessible by air, after roads, bridges and communications infrastructure were washed away. Helicopters were used to deliver essential medicines and commodities, and to ferry pregnant women and refer complicated cases to hospitals.

7 Adult HIV prevalence is the percentage of people living with HIV among adults 15–49 years

8 UNAIDS HIV Estimates, July 2019 <http://aidsinfo.unaids.org/>

9 Ibid

Challenges to HIV service provision during the emergency

The effects of a humanitarian crises on people living with or at risk of HIV infection can be particularly severe. At the individual level, disruption of essential health, HIV, and other social services, and loss of food stocks may lead to increased vulnerability. In addition, the inability to adhere to ART, risk of malnutrition, opportunistic infections and disease outbreaks may lead to increased morbidity and mortality. People living with HIV risk loss of medications and medical documents during crises. Among vulnerable groups, there may be an increased risk of new HIV infections due to disruption of prevention services and an increased proportion of virally unsuppressed people living with HIV due to reduction in adherence to ART; an increase in gender-based violence (GBV), especially sexual violence,

exploitation and abuse; and negative coping mechanisms such as transactional sex to survive, and school drop-outs.¹⁰

The emergency exacerbated existing bottlenecks and challenges in HIV prevention and care, and introduced new emergency-specific challenges, as summarized by UNICEF Zimbabwe (Box 1). UNICEF Zimbabwe conducted a U-report opinion poll on 30th March to determine access to medication and health facilities for Cyclone Idai victims (36 per cent of the 33,803 polled responded). Almost two thirds of the U-report respondents from Chimanimani and Chipinge (63 per cent) reported lost ARV drugs due to Cyclone Idai.

Box 1: Challenges faced in the HIV response to Cyclone Idai in Zimbabwe

Emergency-specific issues

- Challenges accessing antiretroviral treatment (ART) due to inaccessible roads, lack of transport, clinics / healthcare workers affected or lost Antiretroviral (ARV) drugs
- Challenges accessing essential medicines for other health conditions
- Accidental disclosure to children, adolescents, and young people living with HIV
- Lack of access to contraception
- Food insecurity led to poor adherence to ART
- Profound grief, depression, anxiety, trauma
- Exacerbation of pre-existing mental health conditions
- Increased violence and gender-based violence (GBV) due to shared housing and queues for food; transactional sex
- School attendance negatively affected
- Limited capacity of health care workers to respond to mental health issues among children and adolescents.
- HIV is not incorporated into the national emergency response

Note: Although outside of the HIV-specific response, some of the issues above are addressed with HIV-sensitive approaches through UNICEF's multisectoral response.

¹⁰ Overseas Development Institute, HIV and AIDS in Emergency Situations Synthesis Report, November 2008 <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/4277.pdf>

3. RESPONSE

During the cyclone response, the three UNICEF Country Offices and their partners achieved significant integration of HIV services into the humanitarian response. Each country approached the challenge according to their own context and needs, but with common threads, all implemented as the emergency unfolded and with a focus on hard-to-reach populations:

1. Support to mobile health teams and/or fixed health teams in accommodation centres with a focus on HIV service provision.
2. Efforts to locate pregnant adolescent girls and young women with health services, including prevention of mother-to-child transmission of HIV (PMTCT).
3. Outreach to locate HIV clients who were lost to follow-up and to re-engage them in treatment and care.
4. Information dissemination and engagement of vulnerable children, adolescents and young people, including through interactive digital platforms.
5. Multisectoral coordination through for example integration of HIV in clusters such as child protection, education, nutrition and water, sanitation and hygiene (WASH).

Malawi: Mobile clinic teams provide integrated health services, including for HIV

Immediately after the declaration of the emergency by the President of Malawi, UNICEF Malawi initiated a cross-sectoral response to support populations in need, initially targeting the six most affected districts and later expanding to nine districts in Southern Malawi.

Within three days of the declaration of the emergency, UNICEF Malawi established a sub-office in the city of Blantyre in the Southern Region. The team comprised experienced health personnel who conducted a rapid assessment of the health situation and needs, and immediately set up mobile clinics in the six most affected districts providing integrated health services. Within two weeks, the health team was expanded to include two international UNICEF staff with extensive experience in emergencies.

Mobile clinic teams were operated by District Health

Offices and funded in some districts through partnerships with the Malawi Red Cross and the Paediatric and Child Health Association (PACHA). A standard mobile medical team was made up of seven health workers comprising a clinical officer, nurse, midwife, a laboratory assistant, health surveillance assistant, HIV counsellor and data clerk. Occasionally, individual districts included other specialists, depending on trends in cases. The on-the-ground presence of skilled personnel was crucial in effectively responding to the emergency and reaching the most affected and vulnerable.

UNICEF identified urgent services related to HIV and broader sexual and reproductive health and rights (SRHR) that needed to be provided to affected populations. A minimum package was developed to guide the provision of health services within the accommodation camps (Table 1).

Area	Service package
Sexual and reproductive health	Family planning, gender-based violence (GBV) awareness and referral, sexually transmitted infection (STI) diagnosis and treatment.
Maternal, newborn and child health	Antenatal care, postnatal care, referral for deliveries, linkages to prevention of mother-to-child transmission of HIV (PMTCT) services, mosquito nets distribution.
General primary health care	Curative consultation, immunization, mosquito net distribution.
Nutrition	Nutrition screening and referrals.
HIV	Antiretroviral (ARV) drug refills for adults and children; counselling and testing; referrals; tracing of clients who drop out of care and linkages back into treatment; post-exposure prophylaxis, including for health workers; care for people with HIV-related illnesses, including a continual supply of cotrimoxazole (an antibiotic); early infant diagnosis and treatment for HIV-exposed infants, including paediatric prophylaxis.
Chronic conditions	Follow up and refills of medicines for chronic conditions (hypertension, diabetes and tuberculosis).

Source: UNICEF Malawi

The mobile teams travelled to the evacuation camps on a daily, rotational basis. Each camp was usually visited once or twice per week, primarily supervised by the District Environmental Health Officer with technical oversight from UNICEF and partners. At the camp locations, tents, empty classrooms or tree shades were utilized to provide work spaces for the various service points, with HIV and reproductive health services given the priority for privacy.

Mozambique: HIV teams located in accommodation centres with outreach to hard-to-reach areas

Shortly after the emergency and as a result of mobilization by the Joint United Nations Programme on HIV/AIDS (UNAIDS) country-level Joint UN Team on AIDS, the Ministry of Health activated the HIV cluster to design and execute a rapid needs assessment to evaluate the situation in affected areas. Preliminary findings from functional health centres revealed that patient records were destroyed, making it impossible to retrieve information on HIV clients; stocks of mainly paediatric formula and second-line ART drugs were disrupted; and HIV teams with ART were needed for deployment in accommodation centres.

It was the first time that all members of the Joint UN Team on AIDS participated in other clusters (such as child protection, education, nutrition and WASH) to ensure the needs of people living with HIV were included in each cluster's response plan.

UNICEF and partners played a crucial role in accompanying the Ministry of Health from the onset of the emergency response to support:

- Implementation of the minimum package of health services defined by the Ministry of Health, for displaced populations in accommodation centres (with an emphasis on HIV, malaria, tuberculosis, mental health and nutrition).
- Dissemination and introduction of HIV programme tools designed to return to care those HIV clients, particularly women and children, who were lost to follow-up as a result of the emergency.

Accommodation centres were provided with fixed health/HIV teams, to provide HIV testing, and ART services for

those who test positive. UNICEF supported Government to rehabilitate health facilities and (re-)establish maternal, newborn and child health services in accommodation centres and health facilities.

Mobile clinics and community health workers were sent to hard-to-reach areas to locate HIV clients lost to follow-up and return them to care. UNICEF placed health/HIV emergency specialists in two of the main affected provinces to support the response and enlisted key implementing partners for HIV outreach, testing, counselling and case management, with a focus on pregnant adolescent girls and young women.

To support pregnant women and children including adolescents, UNICEF – in collaboration with community radio and peer educators called “activistas” – disseminated preventive SRH messages and promoted youth friendly clinics, targeting adolescent girls and young women. UNICEF piloted the distribution of BP-5 biscuits (a high-calorie, vitamin fortified, dry food) to pregnant and breastfeeding women living with HIV through 56 Health Units, to improve their nutritional status and support ART adherence. Training on the BP-5 protocol was provided to 162 health technicians (HIV and nutrition focal points).

As part of the response, UNICEF Mozambique provided extensive training on Protection from Sexual Exploitation and Abuse (PSEA), including development of an inter-agency induction training package for the Mozambique PSEA Network and UNICEF implementing partners.

Zimbabwe: Cyclone relief team locates and supports majority of children, adolescents and young people living with HIV

In Zimbabwe, UNICEF supported the Ministry of Health and Child Care to conduct a rapid assessment, coordinated with the National AIDS Council and United Nations Development Programme (UNDP) to ensure availability of ART and other HIV-related prevention supplies (HIV testing kits, post exposure prophylaxis, condoms). Implementation in the affected districts was done in partnership with Africaid, a local non-governmental organization, through its Zvandiri

programme¹¹ for prevention, treatment, care and support for children, adolescents and young people living with HIV.

Three HIV interventions were prioritized in the response:

- The first was to **ensure access to medicines and continuation of treatment** for children, adolescents and young people living with HIV on ART.¹² Cyclone

¹¹ Africaid Zimbabwe <https://www.africaid-zvandiri.org/about>

¹² Implemented by the Ministry of Health and Childcare and Africaid with support from the 2gether 4 SRHR programme funded by the Government of Sweden.

relief teams were established in the two most affected districts comprising three Zvandiri programme mentors, two mental health specialists, two nurse counsellors, two strategic information officers, one income savings and lendings specialist, two drivers and 17 Community Adolescent Treatment Supporters (CATS). Within the first 48 hours of the cyclone, each relief team tracked the children, adolescents and young people registered in the Zvandiri programme to determine their safety and access to ARV drugs. Clients living with HIV were able to visit any accessible facility without any documentation to receive ARV medicines.

- The second intervention was to provide **psychosocial support, health care, mental health screening, risk and disability assessments and referral** to other social services (e.g., nutrition support and shelter). For broader reach to the affected population, Africaid broadcast an episode of the Zvandiri Radio Show focusing on the

impact of Cyclone Idai for children, adolescents, young people and their families to encourage return and retention into care.

- The third intervention involved the **dissemination of integrated multisectoral key messages on agriculture, child protection, HIV and AIDS, nutrition and WASH**. HIV prevention and treatment services were integrated into nutrition, protection and WASH interventions. UNICEF supported the National AIDS Council to train and mobilize community networks, village health workers and key stakeholders to raise awareness among community members using an integrated package of information which had previously been developed by UNICEF in responding to the 2016–2017 El Niño drought in the country. The package included cross-sectoral key messages, and messaging on HIV prevention and the importance of continuation and adherence to ART.

4. IMPACT

In all countries, the quantified results go beyond HIV, as services and outreach were cross-sectoral.

Reaching those in need after Cyclone Idai

Malawi: With UNICEF support, 249,695 individuals (134,835 females) were reached with emergency health services during the initial three months of the response, including consultations for common illnesses, reproductive health, immunization, family planning and HIV services (3,247 individuals) through the mobile strategy. Of these, 25 per cent were children under five years. Although services focused on displaced persons, others within those catchment areas also accessed services.

Mozambique: Consultations allowed 212,206 sick children to benefit from health care and treatment, and 1,760 pregnant women were reached in prenatal consultations. For pregnant and breastfeeding women living with HIV, 91 per cent (of 188) who were identified as lost to follow-up were found and returned to care and treatment; 1,011 benefited from nutritional support (i.e. BP-5 biscuits).

In addition, 110,404 people in transit centres, mainly adolescents and youth, were reached with essential health, HIV, nutrition and WASH messages; and UNICEF supported the birth registration of 26,924 people, of which 12,301 were children below 14 years of age.

Zimbabwe: Through mobilization of the cyclone relief team, it was established that 5,300 adolescents and young people living with HIV (3,180 females) were safe and had access to treatment – 71 per cent of those in the Zvandiri programme; 3,068 (1,841 females) had their safety and ART assessed; 1,152 (691 females) were provided with psychosocial support and referrals to other services.

In addition, 2,152 pregnant women living with HIV were receiving ARV drugs for PMTCT; six cases of violence including GBV were identified and assisted; 644 parents/caregivers of children (386 females) were reached with parenting support initiatives; 1,475 children and adults (885 females) were reached with awareness messages on child protection in emergencies including prevention of violence against children and GBV, and PSEA; and 37 children living with HIV and with a disability (22 girls) were assisted.

During screenings for mental health, at least 215 children and adolescents (129 girls) were identified with common mental health disorders. Counselling support was provided to 97 per cent, such as for trauma-related mental health disorders and grief/loss.

Support for a young mother living with HIV in Chimanimani, Zimbabwe



Pattie, watering her garden together with her little girl
© UNICEF Zimbabwe

Pattie*, aged 23, faced a string of heart-breaking losses at a young age and is the only survivor in her immediate family. Her two younger siblings died soon after birth, and when she was 9 years old her father died due to an HIV-related illness, followed three years later by her mother.

Like her parents, Pattie is living with HIV. When she became pregnant, the father refused to take any responsibility. Pattie was neglected by her paternal relatives after her parents' death and when she gave birth to her daughter (now aged 2 years), other maternal relatives rejected her and wanted Pattie and her daughter to leave the village. She is now living in Mutsvangwa village in Chimanimani District with her grandmother, who supports and encourages Pattie to adhere to her ARV medications.

Soon after Cyclone Idai, Pattie tried to commit suicide, as despite her grandmother's support, people in the community were discriminating against her due to her HIV status. *"My neighbours and some of my relatives used to*

say bad things about me and call me HIV. I thought being HIV positive means you are useless in life," explains Pattie. However, through several counselling sessions from the Africaid team, Pattie now adheres well to her ART, is more positive and is hoping to live a long life. *"A support group helped me to overcome stigma,"* she explains.

According to statistics from the clinic Pattie attends in Mutsvangwa, over 35 per cent of young mothers are living with HIV. Poverty and gender inequity continue to fuel the epidemic and adolescent girls and young women are particularly vulnerable. As a young woman living with HIV, Pattie was worried for her daughter. *"I was relieved when my baby girl tested HIV negative,"* she says with a big smile on her face. Efforts including timely initiation of ART for pregnant women, enrolment into the PMTCT programme, and adherence to ARV drugs, have empowered mothers living with HIV like Pattie, to stay healthy and keep their young children HIV free.

* Not her real name

5. LEARNING

Preparedness for an effective response

UNICEF Malawi, in partnership with the Ministry of Health, WHO and other stakeholders, played a key role in reviewing and updating critical documents at both national and subnational levels to guide better preparedness, response and coordination in the event of possible emergencies. These include guidelines for transporting laboratory samples for diagnosis of HIV, and the National Cholera Prevention and Control Plan 2017. Integrating HIV into key preparedness and response documents and tools is an important lesson learned.

Most displaced adults and children lost their health cards. Although UNICEF Malawi facilitated emergency printing of health cards, a key lesson is the need to keep extra stocks on hand for future emergencies.

Prior to the cyclone, UNICEF Malawi supported training in disease surveillance for laboratory technicians, health surveillance assistants and district level rapid response

teams. These staff were able to put their skills to use to prevent and treat disease outbreaks. Based on past emergencies, UNICEF Malawi prepositioned critical medical supplies, particularly for cholera, but also for HIV and common diseases. Capacity development prior to the onset of an emergency and prepositioning of needed supplies are key success factors in an effective response.

In Mozambique, the early integration of HIV in the rapid assessment was supported by a national workshop to develop an HIV in emergencies response plan for inclusion in the national emergency contingency plan. UNICEF played an instrumental role in the workshop, which was held only a few months before this recent emergency and was attended by health professionals and emergency focal points. In high prevalence settings, full integration across sectors is crucial to ensure the rights of people living with HIV are protected during an emergency.

Methodologies and tools to streamline and scale the response

In Malawi, the success of the mobile clinic strategy rested on the provision of the minimum package of services in an integrated manner. To reinforce integrated service delivery in all mobile clinics, several tools were developed that streamlined planning, supervision, tracking and monitoring of emergency health service delivery (example on right).¹³

In Zimbabwe, the existing Zvandiri programme in Chipinge district and its network of trained and mentored CATS enabled a rapid scale up of activities in response to the cyclone. In Chimanimani where psychosocial support services did not exist, the model was rapidly replicated through partnership with the Ministry of Health and Child Care and district stakeholders. Building on these existing proven models was key to the successful response in Zimbabwe.

UNICEF Malawi Mobile Team pre-travel checklist			
District:			
Camp:			
Estimated Population:			
Date of planned clinic session			
S/N	Curative consultation	Please tick	Quantity as appropriate
1	Antibiotics		
2	ORS/ZINC		
3	Antimalarials		
4	BP machine and stethoscope		
5	Thermometer		
6	Papers for writing medical notes for those who have lost health passports		
	ANC/PNC		
7	Ferrous folate		
8	Sulfadoxine/Pyrimethamine		
9	Albendazole		

¹³ The tools from UNICEF Malawi included: An excel data collection tool detailing emergency health issues and consultations with client populations; a mapping tool for people with chronic diseases including HIV within IDP camps; medicines and medical supplies usage and reporting forms; a mobile clinic supervision tool; and a mobile health team pre-travel checklist. These tools are available for sharing with other countries and for adapting and replicating in future emergencies.

Coordination to maximize impact

From the beginning of the emergency, UNICEF Malawi worked with national and district officials to identify needs and coordinate the response. UNICEF also coordinated with the joint South Africa and Malawi defence forces to provide emergency health services in hard-to-reach and inaccessible areas, using helicopter mobile clinics. Cross border coordination with districts adjacent to Mozambique was critically important for disease surveillance and service provision.

In Mozambique, the engagement and participation of members of the Joint UN Team on AIDS in all existing response clusters, led by UNAIDS, ensured coordinated inclusion of HIV at all levels of discussion, national to community, from the onset of the emergency.

In Zimbabwe, National AIDS Council structures at all levels and the presence of UNICEF implementing partners in affected districts facilitated the humanitarian response and coordination for both Cyclone Idai and the severe drought, also in 2019.

Dedicated and flexible funding to help those most in need

UNICEF Malawi employed a variety of methods to disburse funds for the mobile clinics, including disbursements directly to districts and through implementing partners, such as the Malawi Red Cross Society. The Country Office rapidly mobilized over \$2.5 million to support procurement of health supplies and service delivery, inclusive of HIV.

In Zimbabwe, the response had significant support from donors who were prioritizing an HIV-integrated emergency response.

Multisectoral strategies to maximize support for people living with HIV

A significant innovation in support of integrated service delivery in emergencies was the inclusion of BP-5 biscuits to incentivize pregnant women living with HIV/AIDS in affected areas of Mozambique to resume and remain on ART for their own health and that of their child. Collaboration between the HIV and nutrition programmes was key to the BP-5 pilot. While Mozambique enjoyed success with a multisectoral cluster response (as described above), UNICEF Mozambique notes the need to improve intersectoral collaboration between health, HIV, child protection, social protection and education to ensure the safety and well-being of adolescent girls and young women during emergencies.

In Zimbabwe, mainstreaming HIV information into communications for development, health, nutrition and WASH extended the reach of messaging and support to a particularly vulnerable group. This involved educating colleagues about HIV and the inclusion of HIV indicators in emergency nutrition surveys.

Adequate data vital for planning and response

UNICEF Mozambique acknowledged challenges related to data access and availability for better planning, as well as the urgent need for data disaggregation to identify and prioritize HIV services for adolescent girls and young women during emergencies.

In Zimbabwe, key HIV indicators were added to the UNICEF Cyclone Idai Response Dashboard to enhance monitoring and response.

Across the three countries and beyond in the region, more could be done to strengthen and link information systems for real-time monitoring and timely response.

6. NEXT STEPS

In Malawi, Cyclone Idai affected areas also have relatively high levels of poverty. UNICEF's role is not only to support the recovery, but also to harness the opportunity to "build back better" and raise standards in the affected communities. UNICEF and other humanitarian actors are supporting recovery efforts to help affected people and communities sustainably recover and reconstruct. Mechanisms remain in place to systematically incorporate resilience into the design of all interventions.

As part of the response, UNICEF Mozambique established a field presence in three hubs in the most affected provinces – Cabo Delgado (Pemba), Manica (Chimoio), and Sofala (Beira). The field presence will continue in Beira and Pemba to provide operational support, undertake higher frequency monitoring and quality assurance, and provide multisectoral support to the restoration of priority services. This includes the restoration of HIV services in all health centres, including in the resettlement areas via the medical mobile brigades.

Special attention will be provided to youth friendly clinics to promote adoption of the "One Stop" integrated model which facilitates uptake of comprehensive Health and HIV services by adolescent girls and young women. To improve preparedness and strengthen resilience, UNICEF

Mozambique will continue to partner with the International Organization for Migration (IOM) for the development of customized and updated provincial plans for HIV in emergencies, based on lessons learned in the cyclone response.

In Zimbabwe, UNICEF is also supporting transition from humanitarian response to recovery. Information continues to be disseminated among networks of people living with HIV by village health workers mobilized through the National AIDS Council. With UNICEF support, the Organization for Public Health Interventions and Development (OPHID) is strengthening the HIV testing and tuberculosis screening for malnourished children under 5 and referral to treatment and care, in 13 drought/cyclone affected districts. The Zvandiri model will be established in health facilities and an adolescent peer system in Chimanimani will strengthen the capacity of health workers to support children and adolescents living with HIV.

UNICEF Zimbabwe will focus on empowering adolescents on ART to remember which regimens they are on and to advocate for greater access to ART, viral load monitoring, SRH and other health services. UNICEF will advocate for a policy for age appropriate disclosure of HIV status to children and adolescents living with HIV.



Children play on a collapsed tree at an accommodation centre at John Segredo, Mozambique.

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JANUARY 2020

UNICEF Eastern and Southern Africa Regional Office
P.O. Box 44145 Nairobi, Kenya 00100

For enquiries, please contact Laurie Gulaid, lgulaid@unicef.org

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