Paediatric-Adolescent Treatment Africa

Health provider survey: voices from the frontline

#NothingForUsWithoutFronlineHealthProviders
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Rationale

PATA is an action network of health providers and health facilities in sub-Saharan Africa. This network offers a powerful platform for regional collaboration, capacity building and peer-to-peer exchange – closing gaps and building bridges for linking, learning and partnership in the paediatric-adolescent HIV response.

At the time the survey was initiated (April 2020), COVID-19 infections had already risen to over two million globally, and whilst the pandemic had not yet hit sub-Saharan Africa with the same intensity there were growing concerns of its impending impact. The COVID-19 pandemic presents a major threat to overstretched and under-resourced health systems and the delivery of vital primary health care in sub-Saharan Africa. Hard-earned gains already made in the AIDS response could also be compromised as HIV investments and resources are diverted to fight COVID-19, leaving many people living with HIV on the continent at great risk of treatment interruption and failure.

Intensifying pressure to urgently act on measures to mitigate a COVID-19 emergency and manage compounding health challenges will fall upon frontline health providers and first responders. PATA therefore reached out to its membership to better understand critical gaps and needs as were being experienced by health providers, and to ascertain health facility COVID-19 preparedness and possible impacts on HIV service delivery. The aim is to amplify the voices of health providers across sub-Saharan Africa, highlighting their reality and prioritising areas of support needed to fight the pandemic.

The survey was distributed to the PATA network, which consists of 454 frontline health facilities across 24 countries, in four languages: English, Swahili, French and Portuguese. Health providers had just under a month to complete the survey and had the option of filling it in anonymously if preferred. Health facilities were also encouraged to share the survey with other in-country colleagues. The health provider COVID-19 survey was developed internally and reviewed by a member of the Technical Advisory Panel (TAP) as well by some of PATA’s technical assistants in PATA network countries, who work with health providers every day.

We thank all of the contributors to this survey – every voice counts. #NothingForUsWithoutFrontlineHealthProviders
1. Demographic profile

Country and respondent breakdown:

The 188 respondents were from 17 countries across East, Southern, West, and Central Africa, with a large majority of responses from East and Southern African countries, where PATA has active projects.

Respondents’ roles were diverse, although all were connected in some way to the health system, with the vast majority (96%) involved with providing services, care, or programming for children, adolescents, and young people living with HIV.

93 respondents (49%)
Health Providers:
- doctors
- nurses
- midwives
- counsellors

95 respondents (51%)
Other roles:
- civil society representatives
- officers/managers
- data managers
- peer supporters
Respondents were employed at primary level facilities (n=73), secondary level facilities such as local or district hospitals (n=79), and tertiary facilities such as regional or provincial hospitals (n=36).

Half of all respondents work at urban-based facilities, while 25% work in peri-urban settings and 25% in rural settings.
2. Preparing for COVID-19

Information and training needs

Of all 188 respondents, 15% said that they did not have access to information that is reliable, helpful, and practical, and 70% cited needing more information. This figure was almost identical across health providers and non-health providers, as well as across levels of facilities (primary, secondary, and tertiary).

Respondents overwhelmingly cited the need for more information and training on COVID-19, including the need for information about how to identify and diagnose someone with COVID-19 (80%), how to treat and care for someone with COVID-19 (93%), and how to support colleagues and patients showing signs of distress and anxiety (84%).
I need more information about...

**Treating and caring for COVID-19 patients**
- Procedure on fumigation of an isolation room, following the discharge of a patient. The trainings should be ongoing, to allay anxiety. (Nurse, eSwatini)
- What impact COVID-19 has had on those who are living or personally affected with HIV/AIDS (Community worker, Zambia)

**Identifying and diagnosing someone with COVID-19**
- How to classify the risk of transmission of a person with COVID-19 (Nurse and manager, Zambia)
- How to track and trace people who may be linked to someone who has presented with COVID-19 (Project manager, Malawi)
- Any new emerging trends or discoveries of COVID-19 treatment (Clinician, Kenya)

**COVID-19’s effects on country and region**
- Rural areas and COVID-19 (Programme coordinator, Malawi)
- How effective is the use of various face masks in public? (Nurse, eSwatini)

**Supporting colleagues and patients showing signs of distress and anxiety**
- Psychosocial support for the healthy and those who test COVID-19 positive and their families. (Clinician, Kenya)
- Stress management (Clinician, Tanzania)
- How to tackle stigma targeting people diagnosed with COVID-19 (Nurse, Zimbabwe)

**Managing other routine services during COVID-19**
- How to support adolescent young adults on the continuation of ART and uptake of SRHR services and those who show signs of distress and anxiety (Project manager/coordinate, Zambia)
- What I should tell my peers to do when their appointment dates come, because there is no transport? (Peer supporter, Uganda)

**Keeping myself and my family safe from COVID-19**
- How to use personal protective equipment (Nurse, Zimbabwe)
- How to live with a person who recovered from the disease and came back to the family (Clinician, Tanzania)
Standard operating procedures and systems for managing COVID-19

When asked about protocols and standard operating procedures (SOPs), 24% of respondents reported that their facilities did not have any protocols or clinical SOPs related to COVID-19, with 55% needing more, 11% feeling that they had adequate SOPs, and 9% unsure if these SOPs existed.

Regarding protocols and clinical SOPs for infection prevention and control to ensure health safety, 22% of respondents reported having none at their facilities, 60% needing more, 12% having adequate SOPs, and 6% reporting they did not know.

22% of all respondents reported that their facilities had no systems for managing physical distancing in their facilities, and another 22% reported no systems to triage patients for general or emergency care, drug collection, to those displaying temperature and possible COVID-19 symptoms. The systems for triaging or screening would require the necessary equipment, which most respondents indicated not having, and noting them as a requirement.

These provisions are divided by level of care:
Working hours

32% of all respondents shared that they were planning to work longer hours than normal to manage COVID-19 cases. However, certain sub-groups of respondents were likelier to indicate that they were planning to work longer hours than normal: those in primary and secondary care facilities (35%), and those working in rural facilities (45%).

Overall, just over 40% of respondents reported working longer hours in the past week. However, 55% of all rural respondents reported longer past-week work hours, as well as 47% of primary care-based respondents.

Notably, only 11% of respondents, 20/188, indicated that they are compensated for extra time at work.
Longer hours

- Providing health education and counselling for children and young people living with HIV on COVID-19 and adherence. (Programme manager, Zimbabwe)

- I need to take extra precautions to prevent the spread of disease. (Nurse, Zambia)

- The prerequisite protection measures to fight propagation of COVID-19 are reinforced at all levels in our structures. Some of my colleagues are under strict containment. (Nurse, Republic of Congo)

- Planning work schedules for personnel in my department, encouraging pregnant women patients to show up at appointments and take the ARVs. (Midwife, Cote d’Ivoire)

- Responding to emergency plans for children focusing more on mental health issues and protection from abuse - higher probability in confined spaces during lockdown. (Mental health consultant, South Africa)

Did not work this past week:

- We’re working on a weekly rotational basis. (Nurse, Mozambique)

- There’s a ban on all public and private transportation. (HIV advocate, Uganda)

- I can’t reach out to young people when I am home because most of the people I deal with are young people with no access to phones. (Youth advocate, Uganda)

Summary: Preparing for COVID-19

- Overall, respondents felt that they did not have adequate information or training related to COVID-19. Identified needs were clinical as well as more broad-ranging, linked to community and individual concerns.

- Many facilities did not have SOPs or protocols in place for managing a "new normal", and this varied by level of care facility.

- Working hours and planning ahead were altered—both shorter and longer than usual—as a result of facility preparations for COVID-19, as well as respondents’ attempts to maintain routine services and restrictions from country-wide lockdowns.

- Reasons for these longer hours varied, with respondents reporting they were preparing their health facilities and communities for COVID-19, spending longer with patients to deliver important health and prevention information. In some cases, hours were shorter where lockdowns interfered with individuals’ ability to work.

Shorter hours

- I have to spare some time to walk back home. (Youth supporter, Uganda)

- I work from home then other days support supervision. (Nurse, Kenya)
3. Psychosocial support and experiences of stress

Over half of respondents reported being either extremely or very stressed about COVID-19 (52% collectively). The respondents who reported the highest levels of stress about COVID-19 represented a broad group across all health cadres and types of roles.

When asked to articulate specific reasons for stress, respondents spoke about both direct and indirect effects of the pandemic, at different scales—from the individual to systemic.

**Individual**

- **Risk of being infected with COVID-19 while caring for others.** (Nurse, Zimbabwe)
- **Transmitting the virus to my small children should I contract it because I am an essential worker.** (Project manager, South Africa)
- **As an individual I feel that I am poorly equipped to protect my family and ensure that their basic daily needs are met during lockdowns, should that happen.** (Project Manager, Malawi)
- **Many people are dying despite having adequate equipment.** (Clinician, Tanzania)

**Community**

- **My biggest worry is how we shall manage COVID-19 as infections spread to high density communities if our health system is already struggling with a few cases already.** (Programme Advisor, Zambia)
- **The number of people to gather during support groups has been limited due to social distance.** (Peer supporter, Cameroon)
- **If it strikes in our community, would people really survive?** (M&E Officer, Kenya)

**Systemic**

- **Many people have low risk perception.** (Nurse, Zimbabwe)
- **How COVID-19 is affecting the daily life of citizens.** (Clinician, Tanzania)
- **Not too sure of how to fight the virus especially when we can’t see it. Given Africa’s already economic challenges my biggest worry is how we can manage this disease if the numbers begin to escalate having witnessed how the West are grappling to deal with the virus.** (Civil society representative, Zambia)
Identifying support needed to help manage stress

When asked about what support they needed from their health facility, their health departments, and PATA to manage stress related to COVID-19, respondents shared a range of responses.

**Clinic**

“Protective materials and health education”

“Basic needs for COVID-19 prevention like gloves, masks and sanitizers”

“Psychosocial support”

“Provide flexible working hours”

“Devise ways to reach people at far distances”

“Awareness-raising at grassroot level”

“Guidance on how to support patients”

“Compensate for extra hours worked”

**Health departments**

Lockdown-related: “Clients to be allowed to use boda-boda or taxis to reach facilities”

Safety: “Could pregnant health providers be exempted from working on the frontline”

“Regular updates, support with transport, clear referral system for suspected cases”

“Additional supporting staff to ease pressure”

“Support the youth who are sensitizing the community, e.g. by providing fare for them to deliver medicine to homes”

**PATA**

“Supporting the peer supporters in this period”

“Provide online training on management of COVID 19”

“Advocacy for the provision of PPE”

“Resources to assist us procure and have our own protective clothing and materials since central government has done nothing in this regard”

“Financial support to reimburse transportation of deprived children requiring care”

“Guidance on how to conduct home visits to needy HIV patients”
Summary:

- Overall, respondents reported high levels of stress related to COVID-19.

- Because of the all-encompassing nature of the pandemic, these stresses related to individual, community, and systemic concerns, affecting the respondents in their spaces of working and living.

- When asked about specific needs to manage stress from their facilities, national Departments of Health, and PATA, respondents articulated diverse needs ranging from more immediate psychosocial support to more wide-reaching advocacy and training support to procure PPE and related resources, as absence of these was quite a significant source of stress.

- The wide range of sources of stress also raises an important point about the impact of public health and wellbeing on the economy. Also highlighted were some concerns about how COVID-19, having hit hardest in countries with better-off health systems and budgets, would cause more damage to African countries with already dire economic challenges.
4. Resource needs to tackle COVID-19

COVID-19-related resources were in short supply in many of the facilities where respondents were working. Overall, primary and secondary level facilities were, as might be expected, more likely to report not having any of the stated resources than were tertiary institutions. Similarly, rural facilities lacked more supplies than their urban and peri-urban counterparts.
## Resource needs, all respondents

<table>
<thead>
<tr>
<th>Resources to diagnose and care for COVID-19 patients</th>
<th>Table Label</th>
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<tbody>
<tr>
<td>COVID-19 test kits</td>
<td>COVID-19 test kits</td>
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<td>Drugs to treat COVID-19</td>
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<td>Respiratory support</td>
<td>Respiratory support (respirators)</td>
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<td>Supplies for supportive care (drips, IVs, oxygen)</td>
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<td>Sanitizer</td>
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<td>Handwashing supplies</td>
<td>Handwashing supplies (clean water and soap)</td>
<td></td>
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<td>PPE Gloves</td>
<td>Personal protective equipment: Gloves</td>
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<td>PPE Gowns</td>
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<td>Personal protective equipment: Masks</td>
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<td><strong>Systems and infrastructure</strong></td>
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<td>System: triage patients</td>
<td>System to triage patients for general or emergency care, drug collection, to those displaying temperature and possible COVID-19 symptoms</td>
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<tr>
<td>Protocols and infection prevention and control SOPs</td>
<td>Protocols and infection prevention and control SOPs on ensuring the health and safety of all health providers in the health facility and community</td>
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<tr>
<td>Protocols and clinical SOPs related to COVID-19</td>
<td>Protocols and clinical SOPs on diagnosing, treating or referring suspected or confirmed COVID-19 patients based on available supplies, drugs and equipment in my facility</td>
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<tr>
<td>Additional staff</td>
<td>Additional staff to replace those that have fallen ill or to support increased patient numbers</td>
<td></td>
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<tr>
<td>Space and/or beds</td>
<td>Space to manage increasing number of patients and/or patient beds</td>
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<tr>
<td><strong>Other resources for usual care</strong></td>
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<td>Chronic drug including ARVs</td>
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<tr>
<td>Essential drugs</td>
<td>Essential drugs</td>
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Drugs and tests:

- 63% reported having no COVID-19 test kits; this number jumped to 79% among rurally-based facilities.
- 52% reported having no drugs to treat COVID-19 symptoms. Again, in rural facilities, this number was 68%. Furthermore, there seemed to be lack of clarity from health providers as to the drugs they in fact would need to fight and treat COVID-19.

Systems and infrastructure:

- Nearly one-quarter of all facilities had no protocols nor clinical SOPs on diagnosing, treating or referring suspected or confirmed COVID-19 patients based on available supplies, drugs and equipment. Among primary care facilities and rurally-based facilities, this number was closer to 30%.
- Over half of respondents noted they need more systems for triaging patients presenting at their facilities for routine or emergency care (53%) as well as more systems for managing physical distancing (59%).
- 27% of respondents said their facility did not have adequate space to manage an increase in number of patients, although this number was lower for tertiary facilities (19%) and higher in primary facilities (34%).
- From a human resources perspective, nearly one-third of respondents (32%) said they had no additional staff to replace ill staff members or support increased patient numbers in their facilities. Another 49% reported needing more additional staff.

Caring for COVID patients:

- Regarding personal protective equipment (PPE), very few respondents felt they had adequate supply of gloves (7%), gowns (3%), and masks (2%). 50% reported having no gowns at all, and 32% reported having no masks at all.
- One-third of respondents said their facilities did not have supplies such as drips, IVs, or oxygen (51% in rural settings) and 57% of all respondents said they had no respiratory support at all.

Uncertainty about best practices:

For health providers only, most responses were in line with the larger sample. However, one notable area where respondents “did not know” was about drugs to treat COVID-19, and this uncertainty extended to health providers too. Many health providers, when prompted, shared a considerable amount of uncertainty regarding current best evidence and practice around which drugs were needed to treat patients with COVID-19. This is expected, considering that COVID-19 treatment guidelines at the time of this report do not suggest that there is a cure.

Other resources:

- More respondents felt they had adequate supply of chronic drugs (including ARVs, 33%) and systems to provide these drugs to patients (27%).
- Only 11 respondents (6%) said they did not have any handwashing supplies (clean water, soap) in their facilities, however, 10 of these respondents also noted having no sanitizer. The majority of other respondents indicated they had some, but not enough, supplies for personal hygiene and infection control.
### Resource needs, health providers

#### RESOURCES TO DIAGNOSE AND CARE FOR COVID-19 PATIENTS
- **COVID-19 test kits**
  - We have enough: 0%
  - We need more: 17%
  - We don’t have at all: 72%
  - Don’t know: 11%
- **Drugs to treat COVID-19**
  - We have enough: 3%
  - We need more: 19%
  - We don’t have at all: 57%
  - Don’t know: 22%
- **Respiratory support**
  - We have enough: 3%
  - We need more: 29%
  - We don’t have at all: 67%
  - Don’t know: 3%
- **Supplies for supportive care**
  - We have enough: 2%
  - We need more: 66%
  - We don’t have at all: 27%
  - Don’t know: 5%

#### RESOURCES TO PREVENT COVID-19 TRANSMISSION
- **Sanitizer**
  - We have enough: 3%
  - We need more: 76%
  - We don’t have at all: 18%
  - Don’t know: 2%
- **Handwashing supplies**
  - We have enough: 23%
  - We need more: 72%
  - We don’t have at all: 13%
  - Don’t know: 4%
- **PPE Gloves**
  - We have enough: 11%
  - We need more: 73%
  - We don’t have at all: 35%
  - Don’t know: 4%
- **PPE Gowns**
  - We have enough: 4%
  - We need more: 37%
  - We don’t have at all: 33%
  - Don’t know: 3%
- **PPE Masks**
  - We have enough: 4%
  - We need more: 61%
  - We don’t have at all: 33%
  - Don’t know: 3%

#### SYSTEMS AND INFRASTRUCTURE
- **Systems: physical distancing**
  - We have enough: 13%
  - We need more: 63%
  - We don’t have at all: 23%
  - Don’t know: 1%
- **Systems: triage patients**
  - We have enough: 17%
  - We need more: 57%
  - We don’t have at all: 20%
  - Don’t know: 5%
- **Protocols and infection prevention and control SOPs**
  - We have enough: 15%
  - We need more: 59%
  - We don’t have at all: 24%
  - Don’t know: 2%
- **Protocols and clinical SOPs related to COVID-19**
  - We have enough: 14%
  - We need more: 48%
  - We don’t have at all: 31%
  - Don’t know: 6%
- **Additional staff**
  - We have enough: 11%
  - We need more: 44%
  - We don’t have at all: 35%
  - Don’t know: 10%
- **Space and/or beds**
  - We have enough: 13%
  - We need more: 52%
  - We don’t have at all: 32%
  - Don’t know: 3%

#### OTHER RESOURCES FOR USUAL CARE
- **3-6 month ARVs or chronic meds**
  - We have enough: 28%
  - We need more: 65%
  - We don’t have at all: 5%
  - Don’t know: 2%
- **Chronic drug including ARVs**
  - We have enough: 37%
  - We need more: 57%
  - We don’t have at all: 2%
  - Don’t know: 4%
- **Essential drugs**
  - We have enough: 9%
  - We need more: 65%
  - We don’t have at all: 18%
  - Don’t know: 9%
What does your facility need most?

Respondents, prioritising the most pressing need for their clinics and hospitals, overwhelmingly named PPE (including gowns, masks, and gloves) as their foremost need. Additionally, 71% of respondents disagreed, or strongly disagreed, that their health facilities were prepared for COVID-19.
Identified needs from PATA:

Respondents highlighted their communities’ need for more information about COVID-19 and how to keep themselves safe and healthy. Rurally-based respondents in particular flagged the need for PATA to assist with working with local partners to share resources that explain COVID-19 to patients and communities (38%), while urban-based respondents were likelier to request PATA’s assistance in providing basic information for health providers themselves as well as larger-level advocacy work for emergency relief.

Summary:

- Very few respondents felt that they had adequate resources to combat COVID-19 in their facilities, yet these needs and lacking resources differed based on location of work as well as level of facility. This seems plausible as more resources will generally be allocated to those health facilities earmarked specifically for managing COVID-19 cases.
- It is also possible that the response to provide more of these resources is based on limited health budgets, which were already stretched, the response will be more reactive than active.
- PPE was by far the largest identified need across the spectrum of respondents.
- Respondents identified the need for PATA to continue working with local partners to share resources explaining COVID-19 to patients and communities.
- Findings from this segment brought out an important point in how PATA is viewed and further cement the role for PATA to curate health information and present it at grassroots level in a way that is simplified and practical.
Country profiles

KENYA

At the time the survey closed on 28 April, Kenya had 374 confirmed cases and 14 confirmed deaths from COVID-19.

Of the 32 respondents, 18 (56%) self-identified as clinical staff (doctors, nurses, or clinical officers).

Most respondents were based at primary and secondary level care facilities (81%), and more were based in urban or peri-urban settings (72%) versus rural settings.

Kenyan respondents were likelier to say that they worked shorter hours in the past week (31%) than the majority of respondents (18% in the main sample). When probed, some respondents shared that their hours were affected by policies in their countries restricting movement.

- “Curfew and calling clients to come and picks ARVs for at least 3 months.”
- “In the morning I give health talk to patients on COVID-19 and also measure the temperature of patients and non-patients and this takes a lot of time before I resume my normal duty.”

Kenyan respondents, compared to the main sample and the other 3 countries reviewed, were the least likely to report any compensation for overtime hours, with 1 of 32 respondents reporting compensation.

Resources: Kenyan respondents were less likely to report having no COVID-19 testing kits (13% compared to 22% for the larger sample). They were also more likely to report having adequate supply of handwashing supplies (38%, compared to 20% for the larger sample).

The most common identified need from PATA was advocating on a broader scale for national and global emergency relief – 38% of Kenyan respondents named this, as compared to 26% of the larger sample.
At the time the survey closed on 28 April, Zimbabwe had 32 confirmed cases and 4 confirmed deaths from COVID-19.

Of Zimbabwe’s 32 respondents, 17 were in clinical roles (53%). They also had a much greater number of rurally-based respondents than the main sample or other countries with higher contributing respondents (38% rural).

Identified needs for training included more focus on how to conduct contact tracing, as well as information to help their facilities prepare an appropriate response to the pandemic.

Stresses cited by Zimbabwean respondents included: the weakness of their country’s health system; children and adolescents living with HIV defaulting on treatment and having limited access to ART; community transmission and lack of information amongst community; low risk perception from general public; and not enough PPE.

Some respondents worked longer hours than normal, and reported reasons for this:

- “[I was] helping to develop material on COVID-19 and participating in Zoom sessions of HIV and COVID-19”
- “I had to work longer hours to ensure that we clear all clients who would require medication and provide supplies for a longer duration”

For one individual who reported working the same hours, they reported: “We have minimized the number of clients visiting the facility with minor conditions.”

Similarly, a COVID-related response to working shorter hours included the following experience: “Because of unavailability of PPE [we have] reduced working hours.”

While Zimbabwe had higher numbers of resources lacking than the main sample and other individual countries, respondents were also more likely to identify some degree of protocols and SOPs in place in their facilities.
At the time the survey closed on 28 April, Zambia had 95 confirmed cases and 7 confirmed deaths from COVID-19.

13 of the 31 respondents from Zambia were engaged in clinical roles.

There were also more respondents from Zambia based in primary level care facilities than the main sample (61%) and very few from tertiary-level hospitals (3%).

Zambian respondents identified a range of needs, from capacity building, to identifying COVID patients, to learning how to not become infected through their work. Across these respondents, almost all (97%) said that they needed more information on how to identify, diagnose, treat, and care for someone with COVID-19.

Among those who had worked longer hours, they gave reasons related to preparing for and mitigating the effect of COVID-19.

- “I was trying to triage every client at the reception ensuring they don’t infect each other in case one had COVID-19”
- “I need to take extra precautions to prevent the spread of disease”
- “I am coordinating the COVID-19 response within my clinic”

For a few other individuals whose movement was restricted, there were reports of not having worked in the past week:

- “My activities are mostly done in the community and at the health facility, there have been restrictions on the movements”

Zambian respondents identified needs on a broader level for extraordinary leadership, citing lack of training around COVID-19 at their facilities, along with lack of equipment: “we have nothing as a facility to face COVID.” Others noted the importance of strengthening communications to the public about using masks in public spaces.
At the time the survey closed on 28 April, Tanzania had 299 confirmed cases and 10 confirmed deaths from COVID-19.

Of the 19 respondents, 9 self-identified as clinical staff (doctors, nurses, or clinical officers).

With respect to place of work, Tanzanian respondents reflect a different cross-section than the main sample: 14 of the 19 respondents (74%) were urban-based, two peri-urban, and three rural. Only a handful of respondents were located at primary facilities (n=3), while 11 were based at secondary facilities and 5 at tertiary facilities.

Respondents from Tanzania were likelier than the total sample to report that they had worked longer hours in the past week, and were planning to work longer hours in the coming weeks and months.

- “It took longer hours because we took extra time to educate clients on how to conduct hand washing, screenings of clients for COVID-19”
- “There was a [support] club for adolescents, so I worked longer than expected hours to serve children and adolescents living with HIV”
- “I use more hours to give knowledge that I have about COVID-19 to my patients before I start my clinic”
- “Longer hours due to the preparation of the COVID-19 treatment centre”

The majority of the stressors named from Tanzanian respondents centered around becoming sick from caring for others, and also the overall anxiety about the spread of COVID-19.

Respondents from Tanzania also reported higher levels of resource scarcity than the main sample in select cases.
In Conclusion

It is important to note that while facilities represented in this survey may not be COVID-19-response sites, every frontline health provider is in urgent need of some level of preparation, in terms of awareness raising, prevention, accurate information dissemination, diagnosis of suspected cases and how to ensure infection control. The critical role that frontline health providers play in upholding our health systems – and therefore our societies – has never been more apparent. Thus, there has never been a more crucial time to advocate for their safety and protection as well as the resources and training to prepare them for the coming months. While the COVID-19 pandemic unfolds, essential HIV services must still be delivered to maintain the enormous gains made in recent years to increase access to care for children, adolescents, and young people living with HIV. It is imperative that we not only leave no child behind, but that we do not leave a health provider behind in our COVID-19 preparation and response.
It is time to recognise the critical contribution frontline health providers make to global health as agents of change. Let’s amplify their voices!

Frontline health providers need to have the tools, training, capacity-building, sensitization, resources and effective linkage to communities to deliver comprehensive and stigma-free child and youth friendly HIV services for all.

#NothingForUsWithoutFrontlineHealthProviders

Next steps

The results of this survey form part of PATA’s COVID-19 action plan, facilitating the support of frontline health providers during the global emergency and beyond. This forms the foundation for key advocacy messages that PATA can take forward to national, regional and global platforms:

- All frontline health providers need to be protected and provided the necessary PPE at all levels of health care
- All frontline health providers need to receive information, training and resources
- Supply chains need to be managed to keep essential medicine and PPE in stock and to ensure chronic medications remain available
- Multiple month dispensing needs to occur for ART and other chronic medication
- Vital primary health services (HIV testing and ART initiation and immunizations) needs to continue either at the clinic or in the community by supporting community cadres of health providers and peer supporters
- Community partners need to be utilized to promote education and awareness and provide much needed social protection and food security
- The mental well-being and safety of frontline health workers must be prioritised
- The voices of frontline health providers must be amplified in policymaking and decision making