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COVID-19 Emergency Response Fund (ERF) Case Study Report

Paediatric-Adolescent Treatment Africa (PATA)




Introduction

In the face of a global health crisis, frontline health providers, implementing partners, and funders around the world have spent most of 2020 in reaction mode: shifting and recalibrating their programmes and processes to ensure that the most vulnerable among us continue to receive the vital sexual reproductive health (SRH) and HIV treatment and the care they need. In April 2020, as part of its COVID Action Plan, PATA launched the Emergency Response Fund (ERF) to support local efforts and clinic-community collaboration in improving preparedness for addressing COVID-19 related setbacks in PATA focal countries with small, short-term grants.

Committed to clinic-community joint activities and supported by cohorts of peer supporters, 38 ERF grant partners used the small grants to do the essential work of continuing to provide health services for children and adolescents and young people living with HIV (AYPLHIV). Services supported included SRH services and preparing communities to manage COVID-19 in lockdown conditions. Most prominent activities included providing Personal Protective Equipment (PPE) to frontline health providers and delivering antiretrovirals (ARVs) directly to communities. A closer look at this work reveals how community-centred partnerships are particularly well positioned to provide uninterrupted HIV treatment, care, and support services that are effective and meaningful, not just in a crisis, but for improving the quality of care for vulnerable communities year-round.

In a series of seven case studies, PATA explores some of the key learnings from partners as they used their ERF grants to devise creative solutions, enhance partnerships, increase connection to communities, and elevate the role of adolescents and young people, as providers of essential care. Their work shows us that a little truly can go a long way.

Crisis mode

When the first cases of COVID-19 emerged in Africa in March 2020, governments across the continent responded swiftly, instituting strict lockdowns and containment measures. While the rapid action was commendable, the increased scarcity of information, time, and resources under lockdown conditions posed an existential threat to human well-being and placed the greatest strain on frontline health providers and the most vulnerable population, particularly children and AYPLHIV in low-to-middle income countries. Within the already over-stretched and under-resourced health systems, the restrictions on human movement, transportation, public gatherings, and availability of public facilities held dire consequences for the delivery of vital healthcare services. Furthermore, there was tremendous fear that the hard-earned gains made in the HIV response could be compromised as attention and resources were diverted away from HIV treatment and care to fight COVID-19, resulting in treatment interruption and failure.

Barriers to care

In the days following lockdown mandates, partners within the PATA network began experiencing critical disruptions that were resulting in increased ARV defaulting, sexual and reproductive health (SRH) risks, and psychosocial distress among vulnerable AYPLHIV.

Summary of causes of care disruptions and challenges reported by PATA partners

Access

Transportation

The suspension of transportation services meant that many were not able to access health facilities for ARV refills, receive counselling, and access vital SRH services. [Eswatini, Kenya, Uganda, Zambia, Zimbabwe]

Information

The lack of information about the effects of COVID-19 on PLH12IV created fear and anxiety among clients, driving many to stay home rather than risk infection by going to health facilities. [Uganda, Zambia, Zimbabwe]

Disruption

State mandated closures of certain care facilities meant that testing and education services were disrupted entirely for a period of time, increasing risks to patients. [Uganda, Zambia]

Connectivity

Access to internet, data, or computers were limiting factors in providing virtual services. [Kenya, Uganda, Zimbabwe]

Traceability

Many organisations were not prepared with the appropriate systems for tracking patients remotely to ensure continuity of care. [Kenya, Uganda]

Resources

PPE

Limited access to the correct PPE in both care facilities and communities made it difficult for health providers to safely provide services. [Eswatini, Mozambique, Zambia, Zimbabwe]

Food security

Food scarcity posed a fundamental health threat that further prevented clients from taking ARVs regularly. [Uganda]

Commodities

Without access to contraceptives, testing kits, menstruation products, and other SRH products, risk of pregnancy, HIV transmission, and STI infection increased. [Kenya]

Unemployment

Particularly for single mothers who were already struggling to provide for their families, loss of income due to lockdown closures strained their ability to access and purchase essential SRH products and medications for themselves and their children. Job loss also pushed some toward unsafe sex work where violence and sexual health risks increase. [Kenya, Uganda, Zambia]

Relationships

Disconnection

Social distancing and confinement mandates inhibited in-person support services. [Zimbabwe]

Isolation

The social isolation facing AYPLHIV threatens their emotional wellbeing and increases likelihood of engaging in unsafe sexual activity. [Eswatini, Kenya, Uganda, Zambia, Zimbabwe]

Violence

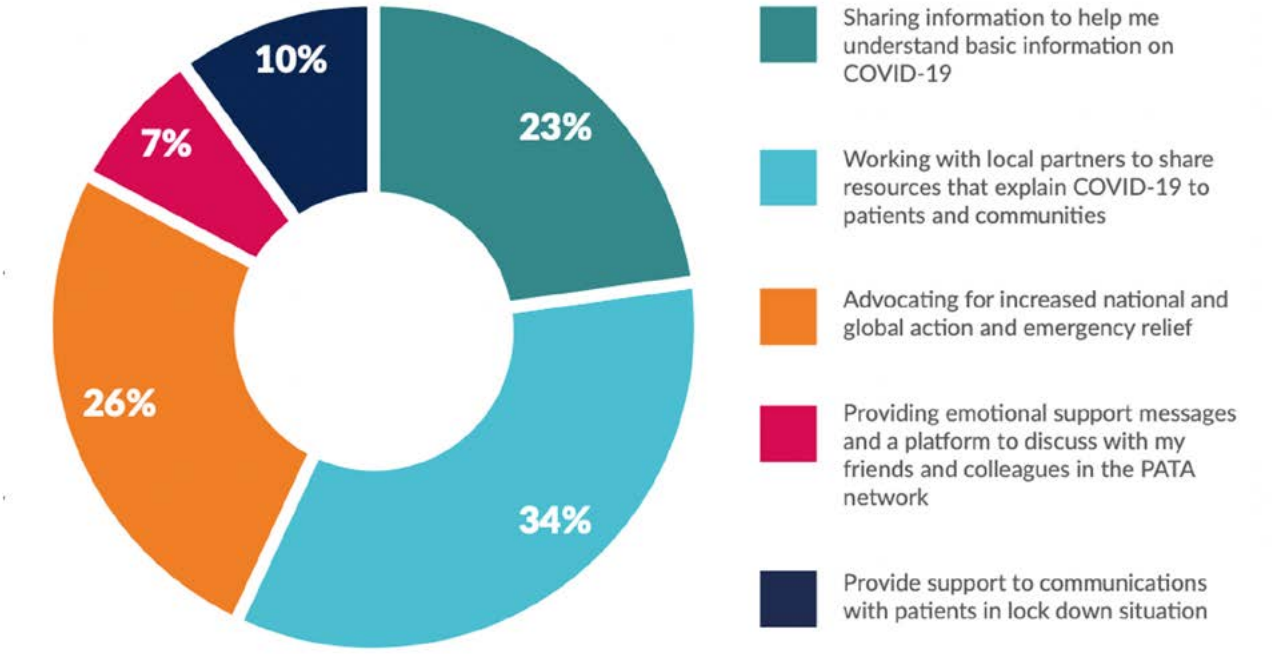
Home confinement mandates and job loss have led to a “shadow pandemic” of increased violence against women and children. [Kenya]

Burnout

The demands of addressing COVID-19 and providing essential services took an emotional toll on health providers. [Kenya, Uganda]

In April 2020, PATA developed the COVID-19 Survey which was conducted among its network of health providers to identify the most pressing needs for prioritising pandemic response activities within its network. Responses from 188 health providers, peer supporters, and civil society representatives across 17 countries pointed to five broad areas of need.

Identified needs from PATA COVID-19 survey



Two fronts of the pandemic

Access to care was further constrained by the precarious position of health providers. Frontline health providers faced the dual challenge of being the first responders in a public health crisis while continuing to provide the services that are so vital to the physical, emotional, and sexual health of AYPLHIV. In the process of coping with the new COVID-19 conditions, while trying to do their jobs, health providers also experienced the emotional and psychological toll of dealing with a crisis, with little or no provision made to support them.

The PATA COVID-19 survey showed that the need for personal protective equipment and training on COVID-19 for frontline health providers especially in the primary and secondary healthcare level was not everywhere seen as a priority let alone the psychosocial support for frontline health providers. In the words of Georgina Obonyo from the Nairobi Youth Advisory Council, "there's no care for the carer".

Faced with managing the pandemic on two fronts, many CBOs and their health facility partners began re-structuring programmes, re-allocating resources and implementing emergency interventions in order to overcome the barriers to care, reach vulnerable communities, and ensure that health providers were being supported. PATA's Emergency Response Fund represents one such effort.

Emergency Response Fund

By pooling funds from various funding partners (MAC, ViiV Healthcare Positive Action, Frontline AIDS, and ELMA Philanthropies) and programmes that were delayed or deprioritised by the pandemic, PATA designed the ERF with the aim of supporting CBOs and health facilities who have been part of PATA's REACH (Re-

Engaging Adolescents and Children living with HIV), C[3] (Clinic-Community Collaboration), and READY+ (Resilient and Empowered Adolescents and Young People) programmes. In order to support as many partners as possible, small, short-term grants of $1,000-5,000 were provided to 38 partner organisations across nine countries for the express purpose of complementing activities on the frontline toward one or more of the following goals:

Goal 1: Ensure primary health care and essential HIV services continue without treatment interruptions

Goal 2: Provide access to information and personal protective equipment and safe working conditions for frontline health care providers

Goal 3: Promote mental health and access to social safety nets and food security for frontline health care providers and children and young people in HIV affected households

Central to the ERF objectives was that CBOs, health facilities, and communities should work in close partnership to set their own emergency response agendas and develop joint action plans based on their unique needs, with PATA acting only in a supporting role. The ERF was able to build upon the PATA C3 (clinic-community collaboration) model.

On the frontline

This report takes a closer look at seven ERF partners whose work on the frontline represents the emergency response activities prioritised by most partners, but also holds valuable insights about the efficacy of community-centred approaches to SRH and HIV treatment and care for AYPLHIV. Faced with similar barriers to care, these partners prioritised many of the same emergency actions, layering a variety of health services and education activities to serve children, AYPLHIV and their communities.

Emergency response actions across a sample of ERF partners

Goal 1: Primary health care continuation activities

Goal 2: Pandemic response activities

Goal 3: Mental health and social safety net activities

	Associação Hixikanwe, Mozambique	Batani HIV/AIDS Support Group	Million Memory Project Zimbabwe	Nairobi Youth Advisory Council, Kenya	Ndola Nutrition Organization, Zambia	Peer to Peer Uganda	Nazarene Compassionate Ministries, Eswatini
Community ARV distribution and support services	■	■	■	■	■	■	■
Virtual psychosocial support services	■		■		■	■	■
Capacitating health providers (PPE, training)	■	■	■	■	■	■	■
COVID-19 and HIV IEC	■	■		■	■	■	■
Mental health campaigns and support	■		■	■			
Community safety nets (food, PPE, commodities)		■		■		■	■

Reflecting on their COVID-19 response activities, partners described common experiences and approaches. Many ERF recipients found themselves in a similar position of being the only support organisation still operational in their local community during lockdown. The emergency response activities were crucial for entire communities of children, adolescents, and caregivers to access essential HIV and SRH care as well as access to PPE for health providers. All worked closely with key government and health system stakeholders to coordinate and implement activities, with many actively using the PATA's C^3 model. All were empowered to deliver care by groups of adolescents and young people who served as peer supporters and representatives for children and AYPLHIV on the ground.

In a time of crisis, the impact of emergency response activities can most certainly be measured in numbers: of health providers trained, commodities delivered, households tested and informed, defaulters identified and reached, and young people supported. The case studies show that these impacts are underpinned by hidden work: small choices, actions, and ideas from people on the frontlines for solving problems, increasing efficiency, and enhancing quality of care. In this hidden work we find the resilience, creativity, innovation, expertise, commitment, and relationships that make community-based organisations and local health facilities uniquely positioned for emergency response funding strategies. Rather than provide a comprehensive overview of the ERF activities of each community-based organisation or health facility, this collection of case studies highlights and expands on one aspect of each ERF programme that speaks to the hidden work behind the impact. Their insights reflect the deeper, longer term impacts that are achieved by community-centred approaches: stronger partnerships within the health system, empowerment of frontline health providers, greater involvement of peer supporters, and enhanced SRH and HIV care for AYPLHIV.

Partner	Hidden Work	Key Learning	Deep Impact
Million Memory Project Zimbabwe (MMPZ)	MMPZ developed a new memory-work tool that provided psychosocial support to youth while also gathering information about the most urgent needs for them, their families, and their communities.	By being flexible and adaptable in their communication methods, MMPZ was able to reach and capture data from a large group of young people to broaden and enhance impact.	Their intervention process allowed them to layer a wide range of SRH and HIV support services onto their outreach programme to fill the gaps created by the pandemic for AYPLHIV.
Ndola Nutrition Organisation (NNO)	NNO collaborated with the health facility as C^3 partners and disseminated reliable information about COVID and HIV, which alleviated fear among frontline health providers and communities.	The trust community workers built with young people during the crisis by reaching out to them directly with reliable health information empowered AYPLHIV to become more proactive and make good health decisions for themselves.	As relatively new practitioners of the C^3 model, NNO found that the crisis drew them into closer collaboration, which also helped them form stronger relationships with the AYLPHIV they serve to provide a broader range of services in future.

Nairobi Youth Advisory Council (NYAC)	Youth activists proactively engaged government partners to undertake an emergency relief programme addressing the SRH needs of AYPLHIV. Their work filled a critical gap in providing healthcare to vulnerable communities during lockdown.	The strong relationship between NYAC and the government Adolescent Health unit made it possible to mobilise NYAC members to respond to the needs of their communities and provide ARVs and SRH services on site and in the community.	The work of NYAC members on the ground demonstrated to government bodies and health providers the value young volunteers can add to the broader health system and strengthened the relationship between these partners.
Associação Hixikanwe	In order to reach the most under-resourced and under-served AYPLHIV in their communities, the team moved their support groups and outreach activities online and employed a creative system for maximising the limited budget for data bundles.	The team was able to devise such creative approaches because they ensured the health and well-being of their team, who could lead by example knowing they had the right health information and PPE to work safely and educate others.	The youth in the community proved incredibly adaptable to using the online support services and the data bundle incentive system boosted engagement from AYPLHIV with the greatest need.
Peer to Peer Uganda (PEERU)	Due to the outstanding track record of their peer-to-peer model with AYPLHIV, PEERU earned a seat on the state COVID-19 Task Force, where they represented the needs of youth in the planning of emergency response actions.	Working closely with civil society to capacitate peer supporters for health work in communities revealed a remarkable level of commitment, strength, and efficacy among the peers to provide essential care services.	The work of peer supporters has moved government to take them more seriously as health providers and has encouraged PEERU to design more programmes that bring health services directly to communities through peer supporters.
Batanai HIV/AIDS Support Group (BHASO)	BHASO psychologically and emotionally empowered health providers and Peer Supporters/CATS to perform ARV refills and consulting activities in communities by capacitating them with the appropriate PPE and COVID-19 training.	Bringing SRH and HIV support services to communities increased fear of stigma from status disclosure among families, but also created an opportunity to educate communities about HIV and SRHR.	The additional outreach activities required to address stigma while working in communities allowed BHASO to strengthen its support and serve communities better than before the pandemic.
Nazarene Compassionate Ministries	When the lockdown lifted, leaving many AYPLHIV in economic desperation, the team prioritised continuing its community to ease the financial burden on clients and promote SRH.	During lockdown, the team realised that community needs and attitudes regarding HIV and SRHR had evolved, requiring new ways of working over the long-term, beyond the crisis.	As they collaborated for the ERF programme, the READY+ partners gained experience with valuable knowledge sharing and creative problem solving to improve efficiency and quality of care for AYPLHIV now and in the future.

Conclusion

The PATA COVID-19 Emergency Response Fund was initiated with a simple but urgent agenda: to ensure continuity of care for children and AYPLHIV during the pandemic by resourcing partnerships of health facilities, peer supporters, and CBOs who are closest to communities. Time after time, these partners prove that they are the most committed, most knowledgeable, and best positioned to design and implement programmes that will have the greatest impact on vulnerable AYPLHIV. The ERF grant recipients show that above and beyond this, clinic-community collaboration is essential to fill critical gaps in the health system, which they managed to do with small budgets during the greatest public health crisis in generations.

In the case studies of seven remarkable grant partners, we see how strong partnerships between different community-based health providers were the key to delivering care in a crisis. Working together, they rapidly adopted new ways of working, ensured the well-being of their teams, and provided vital, quality care directly to children and AYPLHIV in the community and in their homes. More impressive still, the innovation, commitment, and expertise they employed as a matter of short-term problem-solving for their communities also enhanced partnerships between health providers and CBOs, strengthened relationships with communities, and deepened understanding about HIV and SRH service delivery for the long-term benefit of their health systems. In the process, the grant partners have uncovered valuable learnings for their own future work, which they offer as helpful insights for others.

Funder insights

The case studies show how rapidly and effectively health providers and community partners who are immersed in the reality of a crisis can adapt and devise creative solutions when equipped with even modest financial resources. In many cases, funding to cover moderate stocks of one particular but inexpensive PPE was the only barrier to delivering ARVs in communities, which the ERF grant allowed them to easily do in a timely fashion. This was possible because ERF grants were disbursed directly to the operational decision-makers doing the work on the ground. By structuring grants so that programme agendas are set and controlled by practitioners who understand the context of AYPLHIV – because they live in it themselves – PATA ensured that funds were allocated more effectively to the right activities and deployed more efficiently, removing administrative hurdles, and ultimately broadening and enhancing impact.

Partner insights

All of the ERF grant partners were experienced in collaborative models or working in partnership with other key health system actors. However, almost all were under-utilising the knowledge- and resource-sharing power of these partnerships prior to launching their ERF work. By expanding communication and coordination on a more regular basis, not only were health providers able to be more effective in implementing their emergency response activities, but they were able to see the potential for improving standard processes, developing new ways of working, and delivering services directly to communities. This was largely enabled by the commitment, tenacity, and competence of peer supporters, who demonstrated a deep capacity for supporting their peers, more than partners thought possible.

Health facilities

Health providers proved incredibly resilient under the strain of the COVID-19 pandemic. In some cases, the only thing doctors and nurses needed to reduce their fear and anxiety and focus on patients, was the right equipment and training. Weekly team meetings where health providers could share concerns and feel supported were also useful for supporting their emotional well-being. More than anything, however, health providers in health facilities needed to know that they and their families were being protected by having access to the proper PPE and hygiene protocols. With that in place, they could do their jobs and ensure that more clients were served. Delivering services in the community, decongesting health facilities, and training peer supporters was critical to this work. As they saw on the ground, there is great demand for these community-based services, and they have a multitude of benefits. They mitigate the risk of AYPLHIV defaulting, ease the financial burden on already vulnerable people, and they create more opportunities to educate community members and thereby reduce the stigma of HIV and COVID-19.

CBOs

CBOs have an important role to play in facilitating the partnership between health providers and peer supporters through activity planning, communication, and resourcing. Many partner CBOs demonstrated how well-positioned they are to engage with government bodies on a strategic level to align their community health work with state health agendas, and more fully integrate peer networks into the health system. In an emergency, CBOs can play a similar role with health facilities, encouraging and facilitating coordination between them as they pursue shared programme goals and implement joint clinic-community action. CBOs can act faster and are effective first responders, providing a critical safety net in vulnerable communities. There are also opportunities for CBOs to expand their educational activities into the wider health and public services ecosystem to create greater understanding about the needs of the community and provide insight into how differentiated service delivery models will work best in the community.

Peer supporters

Peer supporters supported by the health providers proved to be critical to in-community health services, driven to take action by their commitment to their peers, families, and neighbours. Their work with CBOs and health facilities has ensured that they are well-informed about physical, psychosocial, sexual, and mental health issues when compared with many in the surrounding under-resourced communities. Their identities as AYPLHIV and trusted members of a community gives them unique access to people who are vulnerable, afraid, and left with few alternatives for receiving vital healthcare. This ability to reach vulnerable populations was even more critical during the COVID-19 crisis in bringing SRH services and certain HIV care services directly to communities.

ERF Recipients Contact Details

Partner	Learn more	Contact Person
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Million Memory Project Zimbabwe (MMPZ)	http://mmpztrust.org	Sandra Chiomvu, Programs and M&E Officer
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