Health providers' experiences and perceptions on the impact of COVID-19 on HIV services for children, adolescents and young people:

A 2021 cross-sectional survey in sub-Saharan Africa

#EndCovid-19
Acknowledgements

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#NothingForUsWithoutFrontlineHealthProviders

Acronyms

AIDS: Acquired immunodeficiency syndrome
ANC: Antenatal care
ART: Antiretroviral Therapy
CBO: Community-based organisation
COVID-19: Coronavirus disease 2019
HIV: Human immunodeficiency virus
IEC: Information, education, communication
MCH: Maternal and child health
PATA: Paediatric Adolescent Treatment Africa
PMTCT: Prevention of mother-to-child transmission
SRH: Sexual and reproductive health
WHO: World Health Organisation
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1.1. PATA

Paediatric Adolescent-Treatment Africa (PATA) is an action network of more than 4 000 health providers in 754 health facilities across 25 sub-Saharan African countries, whose goal is to effect positive change in paediatric and adolescent HIV policy and service delivery on the frontline. PATA provides a platform for regional collaboration, capacity-building and peer-to-peer learning among health providers involved in paediatric and adolescent HIV response.

When the COVID-19 pandemic began, PATA developed an action plan for COVID-19 to understand and respond to the needs of the paediatric and adolescent health providers in our network. The action plan comprised of a range of resources to support frontline health providers trying to deliver HIV services for children, adolescents and young people during the pandemic, including:

- Surveying the PATA network about its COVID-19 preparedness
- Creating a COVID-19 resource hub on the PATA website with guidelines and information, education, and communication (IEC) materials, and webinars to help overburdened health providers make sense of the latest evidence and guidelines
- Creating fora for health providers to engage with each other, share messaging, and facilitate peer support via social media, WhatsApp groups, and other online platforms
- Accelerate PPE access for health providers, report stockouts of PPE and ART, and advocate for differentiated care for children, adolescents and young people living with HIV
- Linking localised clinic-community initiatives with resource opportunities and relief funds
- Creating an online debriefing support programme for frontline health providers
- Building an online platform for individuals and communities to voice their appreciation of health workers
- Producing a ‘Voices from the Frontline’ media campaign that featured short videos and a three-part podcast series that amplified the stories of several frontline health providers from sub-Saharan Africa, offering inspiration and empowerment
- Mobilising support for vaccine equity campaigns
1.2. Background

The COVID-19 pandemic has stretched already under-resourced health systems and impacted the delivery of vital primary health care services across sub-Saharan Africa. The pressure to respond to the pandemic and manage compounding health challenges falls to frontline health care providers and first responders. Frontline healthcare workers across the globe have suffered disproportionately higher COVID-19 incidence compared to the general population and are the occupational category most threatened by COVID-19, with up to 180,000 having died from the disease between January 2020 and May 2021. Ensuring health providers’ health, safety, and wellbeing is thus essential to an effective COVID-19 response.

Research with African health providers at different stages in the COVID-19 pandemic indicated that many felt unprepared to respond to the health crisis and protect themselves from infection due to inadequate training and information, personal protective equipment (PPE), and resources to test for and treat COVID-19. For example, one study found just half of surveyed South African health providers felt adequately prepared to care for patients with COVID-19 and 40% hadn’t received training on the correct use of PPE. Only 14% of health providers from across Africa that participated in another survey had appropriate access to PPE.

The more knowledgeable health providers are about COVID-19, the likelier they are to perceive themselves as being at risk of infection and to comply with prevention control measures. Receiving adequate information and knowledge about COVID-19 lowers health providers’ risk of infection and increases their confidence and ability to provide optimum patient care, fight the pandemic, and have more positive attitudes. A survey of over 5,000 South African health workers found providers that were older, white, male, specialists, worked in urban formal areas and/or had degrees were more likely to express confidence in their knowledge about COVID-19, highlighting the critical need to capacitate all health care workers about infection prevention and control measures, regardless of their prior academic achievement.

A WHO-led analysis of surveillance data from 151 studies found that up to 65% of Africans have been exposed to the COVID-19 virus and that the true
number of SARS-CoV-2 infections on the continent is likely 97 times larger than the number of confirmed cases, due to limited and inconsistent testing and reporting and a high rate of asymptomatic cases. Rates of severe cases and deaths has been much lower than other parts of the world, due to Africa’s comparatively youthful population that has a smaller proportion of people with chronic disease; but that may change as more transmissible and potentially lethal variants circulate across the largely unvaccinated continent.

Africa’s COVID-19 vaccination rate severely lags other parts of the world as a result of global resource inequity, vaccine hesitancy, and distribution challenges, with just 15% of Africans having been fully vaccinated against COVID-19. The WHO reported that as of April 2022, just 457 million of the 816 vaccine doses African countries received had been administered; frontline health providers thus play a critical role in engaging communities and driving mass vaccination campaigns.

A survey of over 15,000 adults in fifteen African countries found over half of respondents felt the threat of COVID-19 was exaggerated and that willingness to accept a COVID-19 vaccine was highly variable across countries, with those who reported being unwilling to be vaccinated four times more likely to express concerns about vaccine safety than those who were willing. A systematic review of 21 studies found generally low acceptance of COVID-19 vaccines among healthcare workers across Africa, as well. The most common reasons for hesitancy were concerns about side effects, safety, effectiveness, duration of clinical trials, limited information, and social trust, highlighting the need to address health providers’ misconceptions and barriers to acceptance in order to boost vaccine rates in Africa. Despite calls by the WHO to accelerate efforts towards protecting health providers, only 27% of African healthcare workers were fully vaccinated by November 2021, compared to over 80% of health providers in most high-income countries.

Long work hours, isolation requirements, community stigma, grief, and a lack of workplace psychological support challenge health providers’ wellbeing. The African Hepatitis B Network found that by June of 2020, 49% of the 489 health workers surveyed across Africa reported a decrease in income and just 31% reported ‘never feeling depressed’ (compared to 61% before the pandemic), with 20% indicating that they experienced depressive symptoms on a daily basis. Health providers are commonly concerned about the safety of their loved ones, social stigma related to being a health provider, poor ventilation and overcrowding, lacking adequate PPE, and economic impact of the virus on their communities.

Psychological support programmes to help health providers debrief, make sense of the trauma they experience at the workplace, and cope with stress and loss are in short supply. Since feeling well-supported and competent is one of the most essential factors in making effective clinical decisions, the importance of supporting community- and facility-based frontline health providers, keeping them safe, and ensuring they have decent working conditions has never been greater.

### 1.3. Rationale

In April 2020, PATA surveyed its network to ascertain COVID-19 preparedness, information needs, and possible impacts on HIV service delivery (see results). The results shaped much of PATA’s activities with our network over the last year and advocacy messages at national, regional, and global platforms. When the 2020 survey was carried out, the pandemic hadn’t hit sub-Saharan Africa with nearly the same intensity as in other parts of the world.

That of course had changed by late 2021, so we decided to again survey frontline health workers that deliver HIV and sexual and reproductive health (SRH) services to children, adolescents, and young people, including clinical staff based at health facilities and community-based organisations. We wanted to do a ‘temperature check’ to find out how frontline health workers in sub-Saharan Africa were coping with COVID-19 and how the disease had impacted paediatric and adolescent HIV service delivery across the continuum of prevention, treatment care and support.
This activity was followed up by an ‘Africa Café’ session at the annual PATA summit (November 2021), in which preliminary survey results were presented alongside other research about the effects of the pandemic on frontline health providers on the continent. Findings from those presentations are summarised in this report as they offer further insight into health workers’ experiences.

Ultimately, the purpose of this report was to amplify the voices of health providers from across sub-Saharan Africa and highlight what support and resources are still needed to fight the COVID-19 pandemic and build resilience within this critical cohort, without compromising HIV and SRH services for children, adolescents, young people and their families.

Methods

The 2021 health provider COVID-19 survey, Voices from the Frontline, was developed by a consultant, drawing from the 2020 PATA survey, a desk review, and collaborating with PATA to clarify what additional information was desired. The survey sought to find out perceptions from health providers on how COVID-19 had impacted them, HIV and sexual health services to children and adolescents, what they’d found most challenging, their perceptions of COVID-19 vaccines, what support and resources they’d had access to, what can be done to improve service delivery at their facility, and what training and resource gaps persist.

The questionnaire was reviewed by senior members of PATA’s technical team, translated into Swahili, French and Portuguese and loaded onto Survey Monkey. The questionnaire was then distributed online to the PATA network of frontline health providers in 25 sub-Saharan African countries, by PATA’s in-country technical assistants, to PATA summit participants and was shared on PATA’s social media accounts. Respondents were encouraged to share the survey with health providers at other facilities.

Participation was voluntary and no financial incentives were provided. On average, the self-administered questionnaire took 25 minutes to complete; respondents could skip questions and complete it anonymously, if preferred. Health providers had three months to complete the survey, from September-November 2021. Responses were loaded onto a database and duplicate entries were deleted; data was then analysed using descriptive and inferential statistics. Qualitative data from open-ended questions were translated using Google Translate, rapid-coded and analysed thematically. Quotes were lightly edited to correct spelling and minor grammatical errors.

Data analysis was done at two levels: 1) at the individual level assessing perceptions of COVID-19 and 2) at the health facility level. The data presents a snapshot of health provider perceptions and their perceived impact of COVID-19 on their health facility. There may have been instances where more than one health provider responded from the same health facility, and their perceptions may have differed and this may vary according to profession and area of work.
3. Survey results

3.1. Respondents

206 individuals took part in the survey from 16 countries in Western, Southern, Eastern and Central Africa, where PATA has active projects.

51% of respondents were from West Africa, 39% were from East and Central Africa, and 10% were from Southern Africa.

The majority of respondents were female (55%) and between 18 and 39 years (68%).

58% of respondents worked at urban facilities, 19% at peri-urban and 23% at rural facilities or organisations.

Most respondents were frontline health providers (82%), reflecting a range of roles within the health system including nurses, doctors, social workers, and lay health workers. The other 18% held administrative or other positions, mostly in project coordination, research, data management, or organisational leadership.
Most respondents mainly provided services, care, or programming for children and/or adolescents and people living with HIV.

Almost all health providers indicated that they provided HIV prevention and/or treatment services (91%), followed by health education or community outreach (51%) and sexual and reproductive health services (49%) (including contraception and STI screening and treatment).

Half of our respondents (52%) reported providing direct care to clients that were suspected or diagnosed with COVID-19.
3.2. COVID-19 preparedness

Most respondents indicated their health facility or community-based organisation provides COVID-19 screening (91%) and testing (80%), with many facilities offering COVID-19 treatment (67%) or vaccination (72%) services as well.

Respondents that provide direct health services were asked about their and their facility’s level of preparedness to respond to COVID-19 and prevent transmission. A year and a half into the pandemic, only 46% of frontline health providers expressed they felt safe and sufficiently protected from COVID-19 at work, just 54% had access to enough personal protective equipment (PPE) to protect themselves, and 23% didn’t think their facility was adequately prepared to respond to COVID-19 (compared to 71% of our 2020 respondents).

75% were confident they can protect themselves from COVID-19 infection at work. 91% agreed that they always wear a mask around clients and 79% said COVID-19 testing was easy to access if they suspected exposure or infection.
Many basic resources to prevent COVID-19 transmission were in short supply at our respondents’ facilities, although some improvements were noted, when compared to our 2020 results.

COVID-19 resource levels

### RESOURCES TO PREVENT COVID-19 TRANSMISSION
- Designated space for COVID-19 testing and screening
  - We have enough: 22%
  - We need more: 47%
  - We do not have: 31%
- N95 masks
  - We have enough: 9%
  - We need more: 66%
  - We do not have: 25%
- Surgical masks
  - We have enough: 15%
  - We need more: 73%
  - We do not have: 12%
- Surgical gowns
  - We have enough: 9%
  - We need more: 67%
  - We do not have: 22%
- Gloves
  - We have enough: 17%
  - We need more: 73%
  - We do not have: 10%
- Handwashing supplies
  - We have enough: 33%
  - We need more: 58%
  - We do not have: 9%
- Alcohol-based hand sanitiser
  - We have enough: 23%
  - We need more: 68%
  - We do not have: 9%
- Posters and printed materials about how to prevent or manage COVID-19
  - We have enough: 21%
  - We need more: 64%
  - We do not have: 15%

### RESOURCES TO DIAGNOSE AND CARE FOR COVID-19 PATIENTS
- COVID-19 test kits
  - We have enough: 12%
  - We need more: 66%
  - We do not have: 22%
- Sufficient supply of oxygen and respiratory support equipment
  - We have enough: 4%
  - We need more: 59%
  - We do not have: 37%
- Mechanical ventilators
  - We have enough: 4%
  - We need more: 51%
  - We do not have: 45%
- Medication to treat COVID-19
  - We have enough: 7%
  - We need more: 65%
  - We do not have: 28%
- Enough space and beds to manage patient load
  - We have enough: 13%
  - We need more: 56%
  - We do not have: 31%
- Enough staffing to manage increasee patient numbers and cover staff that need to isolate
  - We have enough: 9%
  - We need more: 68%
  - We do not have: 23%

### SYSTEMS AND PROTOCOLS
- Guidelines on diagnosing, treating and referring suspected COVID-19 clients
  - We have enough: 25%
  - We need more: 58%
  - We do not have: 17%
- System to manage physical distancing
  - We have enough: 26%
  - We need more: 52%
  - We do not have: 22%
- System to triage clients for routine care vs. those displaying possible COVID-19 symptoms
  - We have enough: 14%
  - We need more: 60%
  - We do not have: 26%
Personal protective equipment
- 15% of respondents indicated they had enough surgical masks and just 9% had enough N95 masks. 12% didn't have access to any surgical masks and 25% didn't have access to any N95 masks. In 2020, 32% of participants reportedly didn't have access to any masks.
- 17% reported having sufficient surgical gloves and 9% had enough surgical gowns, while 10% lacked gloves and 22% lacked gowns. In 2020, 15% reportedly didn't have surgical gloves and 50% didn't have access to surgical gowns.
- 79% thought there should be more posters and printed materials about how to prevent and manage COVID-19 in their department.

COVID-19 testing and screening
- 22% of respondents indicated their facility had a designated space for COVID-19 testing and screening, 47% had inadequate space, and 31% lacked a dedicated area for COVID-19 screening and testing.
- 22% reported not having any COVID-19 test kits, an improvement over 2020, when 63% said their facilities lacked any testing kits. 79% of rural respondents in 2020 did not have access to COVID-19 test kits, compared to just 14% of our 2021 sample. Although resource levels have improved, 66% still said their facility needed more COVID-19 test kits.

Caring for COVID patients
- Medication to treat COVID-19 illness was also more available, with 28% of our sample reporting having no access compared to 52% in 2020. Still, only 7% reported their facilities had enough medication to treat COVID-19 patients.
- Most respondents indicated that their facilities lacked adequate supplies of patient beds (87%), oxygen and respiratory support equipment (96%), mechanical ventilators (96%), and staffing to manage patient load and cover for staff needing to isolate (91%).

Systems and infrastructure
- 25% of respondents thought their facilities had adequate guidelines on diagnosing, treating and referring suspected COVID-19 clients; 58% needed more and 17% had none at all. This is an improvement from 2020, where just 14% of respondents reported that their facility had sufficient COVID-19 protocols, 48% needed more and 31% had none at all.
- 60% thought more systems for triaging patients with possible COVID-19 symptoms that present at their facilities for routine care were needed; 26% did not have such protocols at all. Such systems require equipment that many respondents reportedly lacked.
- 74% did not have or needed more systems to manage physical distancing at their facility.
Information and training needs

69% of health providers reporting being satisfied or very satisfied with the level of training and information they had received about national COVID-19 guidelines. Similarly, 66% thought staff at their facility had received sufficient training on COVID-19.

Higher levels of basic training were reported than was found in the 2020 PATA survey, where participants expressed an overwhelming need for information about COVID-19. Nevertheless, most frontline health providers indicated they wanted additional information on nearly all of the topics we inquired about.

Respondents were most likely to have been trained on how to use personal protective equipment correctly (64%), infection prevention and control (61%), how to identify and diagnose someone with COVID-19 (49%), and how to educate patients and the community about COVID-19 (49%). Topics respondents wanted more information about unsurprisingly correlated with the topics they’d received the least training on, including: the effects of COVID-19 on children and adolescents (74%), COVID-19 vaccines (73%), triage and management of clients with COVID-19 (69%), and the effects of COVID-19 on people living with HIV (66%).

60% of respondents indicated they wanted more information on how to identify and diagnose someone with COVID-19 (vs. 80% in 2020); 59% wanted to learn more about how to safely manage routine health services (vs. 80% in 2020). 68% wanted more information about supporting colleagues and patients that show signs of distress and anxiety (vs. 84% in 2020).

When asked to select the two topics they wanted additional information on the most, 43% of respondents said they wanted to learn more about the effects of COVID-19 on people living with HIV and COVID-19 vaccines—including how they work, their effectiveness, side effects, and how to educate clients about them.
Health provider training and information received

- How to use PPE correctly
- Effects of COVID-19 on people living with HIV
- Occupational health and safety
- How to identify and diagnose someone with COVID-19
- How to safely manage other routine services during COVID-19
- Triage and clinical management of clients with suspected/confirmed COVID-19
- How to support co-workers and clients that show signs of distress and anxiety
- Effects of COVID-19 on children and adolescents
- Info about COVID-19 vaccines (how they work, effectiveness, side-effects, what to tell clients)

Health provider information and training requests

- Info about COVID-19 vaccines (how they work, effectiveness, side effects, what to tell clients)
- Effects of COVID-19 on people living with HIV
- How to educate clients and community members about COVID-19 (and address myths)
- Effects of COVID-19 on children and adolescents
- How to identify and diagnose someone with COVID-19
- Occupational health and safety
- COVID-19 infection prevention and control
- How to safely manage other routine services during COVID-19
- Triage and clinical management of clients with suspected/confirmed COVID-19
- How to support co-workers and clients that show signs of distress and anxiety
- How to use PPE correctly
I want more information about...

Caring for COVID-19 patients
- How to manage suspected cases of COVID-19 (Social worker, Cameroon)
- Detailed information about COVID-19 treatment (Nurse, Ethiopia)
- Treatment and nutrition for COVID-19 infected clients (Nurse, Cameroon)
- How to take care of infected COVID-19 clients (Nurse, Cameroon)
- How to provide home care for COVID-19 patients (Nurse, Zambia)
- Clinical treatment for COVID-19 clients that don’t want to be hospitalised (Nurse, South Africa)

How COVID-19 affects specific populations
- Challenges people living with HIV will face if infected with COVID-19 (Lay counsellor, Cameroon)
- Effects of COVID on adolescents and children (Programme director, Uganda)
- How to manage clients living with COVID-19 and tuberculosis or asthma (Volunteer health worker, Cameroon)
- Effects of COVID-19 on pregnancy (Nurse, Cameroon)
- How to manage COVID-19 in children (Lay counsellor, Uganda)

COVID-19 vaccines
- Effectiveness of vaccines (Lay counsellor, Kenya)
- How vaccines work (Clinical officer, Tanzania)
- COVID-19 vaccine hesitancy (Nurse, Cameroon)
- Effects of COVID-19 vaccines on reproductive health (Nurse, Cameroon)
- I would like to understand more about COVID vaccines, especially the protection period and how often one needs to be vaccinated (Doctor, Kenya)
- Whether genetics affect vaccine efficacy (Doctor, Nigeria)
- Side effects of COVID-19 vaccines on children and adolescents (Nurse, Uganda)

Impacts of COVID-19
- Long-term effects of COVID-19 on the general population (Nurse, Zambia)
- Post-COVID complications and management (Administrator, Uganda)

Community awareness
- To know the right information about COVID-19 in order to take away the stigma or myths in society (Clinical psychologist, Cameroon)
- How to reassure a psychologically-demoralised population of the necessity of the vaccine and prevention measures for them and their entourage (Community health worker, Cameroon)
- Community engagement and Human-Centred Design (Social worker, Malawi)

Programming considerations
- How to motivate staff and maintain high staff moral during [the pandemic] (Community health worker, Lesotho)
- Tele-medicine (Doctor, Nigeria)
- Sustainability of a CBO providing all the support services to a community; how can we lobby for better pay for our caregivers and frontline staff, rather than stipends (CBO manager, South Africa)
3.3. COVID-19 vaccine readiness

COVID-19 vaccine status

68% of our respondents had been vaccinated against COVID-19 and chose to do so to protect themselves, families, and friends (70%), to avoid infection (60%), and/or to set an example to others (56%). Just 17% said they got vaccinated because it was a job requirement.

Of the 32% of survey respondents that had not been vaccinated, 29% indicated they would be vaccinated as soon as it was available to them, 25% said they might agree, depending on which type became available in their area, and 2% said they would if it became an employment requirement. 38% were concerned about the safety profile of the various COVID-19 vaccines and preferred to wait until they were more confident of their safety and efficacy before being vaccinated themselves. Just 6% said they definitely would not get vaccinated against COVID-19.

Health providers’ own vaccine status was strongly linked to their likelihood to encourage vaccination: 88% of respondents that had been vaccinated against COVID-19 said it was ‘very likely’ they would recommend others get a COVID-19 vaccine as soon as possible, compared to just 30% of respondents who had not been vaccinated. 40% of unvaccinated respondents said they were ‘unsure’ or ‘not too likely’ to promote COVID-19 vaccine uptake, compared to just 2% of vaccinated respondents.
COVID-19 vaccine concerns

Health providers expressed a range of concerns about COVID-19 vaccines, including: side effects and adverse events (43%), the short turnaround time with which many vaccines were developed and approved (36%), inadequate information (18%), uncertainty about safety (15%) and efficacy (16%), and concerns that COVID-19 vaccines could negatively affect personal health issues (8%).

Additional concerns included uncertainty about the length of protection, the frequency with which boosters are needed, 'vaccine coercion', and a concern that vaccines don’t prevent COVID-19 infection altogether. A community health worker in Cameroon worried he might recommend someone get vaccinated, then experience serious side effects after. 19% of respondents indicated they didn’t have any major concerns about COVID-19 vaccines.

Respondents held a number of concerns about their country’s COVID-19 vaccine programmes. 63% were concerned that widespread misinformation discouraged vaccine uptake and 37% thought more should be done to encourage the public to get vaccinated. Concerns around vaccine access and equity were also expressed, with 37% concerned their country hadn’t secured enough vaccines and 30% concerned their country lacked the resources to make vaccines accessible to most people. 27% were concerned about the pace with which vaccines were being distributed in their country.

Concerns about national COVID-19 vaccine programmes

- 63% Misinformation has discouraged vaccine uptake
- 37% Not enough is being done to encourage the public to vaccinate themselves against COVID-19
- 37% We haven’t secured enough vaccines for our population
- 30% We lack the resource to make COVID-19 vaccines accessible to most people
- 27% We are not vaccinating our population quickly enough
3.4. Perceived impact of COVID-19 on HIV and SRH services

Service interruptions

36% of frontline health providers reported that their facilities experienced HIV and sexual and reproductive health (SRH) service interruptions during the pandemic.

When asked why they thought services were interrupted, 68% indicated clients avoided coming to facilities for fear of COVID-19 exposure. 45% said lockdown regulations impacted service delivery—including travel shutdowns that affected both health providers and clients’ ability to travel to health facilities.

Other factors included facilities limiting how many clients could be seen each day to ensure social distancing (58%), reducing routine care services (42%), or closing altogether (10%). Staffing shortages due to providers being infected with COVID-19 or needing to quarantine (39%) or being moved to other departments (19%) also reduced HIV and SRH service provision to children and adolescents.
Service delivery adaptations

To continue providing services during the pandemic, health providers adapted their paediatric and adolescent HIV and SRH service delivery models to different degrees. The respondent health providers shared service delivery adaptations made at their health facilities in response to the constraints imposed by COVID-19. There were more respondents who thought their facility should offer more of each type of community-based health service than there were providers who thought their facility provided it at a sufficient level. 39% of respondents' facilities offered sufficient multi-month dispensing of ART to allow clients to have fewer clinic visits, while 15% did not offer this at all. ART was much more likely to be provided via home or community delivery methods (31%) than contraception was (12%); 46% did not provide any home or community delivery of contraception. Tele-health services and virtual support groups were not extensively utilised; 41% of rural respondents said they did not offer any tele-health services. Additional innovations that were reported included radio talk shows, temporary outreach facilities, and streamlining visit procedures to reduce patient waiting time.

<table>
<thead>
<tr>
<th>Service Delivery Adaptation</th>
<th>We offered this service</th>
<th>We didn't offer this service</th>
<th>I'm not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home or community delivery of contraception</td>
<td>39%</td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td>Home or community delivery of ART</td>
<td>75%</td>
<td>22%</td>
<td>3%</td>
</tr>
<tr>
<td>Offering health services in the community (e.g. mobile clinics or community sites)</td>
<td>67%</td>
<td>25%</td>
<td>8%</td>
</tr>
<tr>
<td>Virtual support groups (via WhatsApp or video calls)</td>
<td>37%</td>
<td>47%</td>
<td>16%</td>
</tr>
<tr>
<td>Tele-health services</td>
<td>57%</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>Multi-month dispensing of ART to stable paediatric and adolescent clients</td>
<td>81%</td>
<td>15%</td>
<td>4%</td>
</tr>
<tr>
<td>Providing adequate supply of ARVs for HIV+ youth</td>
<td>90%</td>
<td>6%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Perceived impact of COVID-19 on HIV and SRH services for children, adolescents and young people

Client fears

Providers perceived a reduction in HIV services due to health system constraints and low demand, as many clients avoided going to health facilities. This was especially a concern for immunocompromised youth living with HIV, who are often ‘unwilling to come pick up their medications’, from fear of being infected with COVID-19. Respondents said many of their clients perceived health facilities to be unsafe or even anxiety-provoking and often missed their clinical care and ART appointments as a result; one nurse said ‘this has made physical assessment so difficult’.

• Many clients are missing appointments because they are scared of contracting COVID-19 at the health facility (Nurse, Zambia)

• COVID-19 has affected HIV services for children, adolescents and young people by instilling anxiety in the [clients]; they miss appointments because of the fear contracting COVID-19. We’ve seen an increase in the number of clients that are late for clinical and pharmacy appointments (Nurse, Zambia)

• Most clients don’t come for drug refills because of fear and stigma; some are afraid to be contaminated because of their weak immune system so they prefer to stay at home (Nurse, Cameroon)

• Clients miss their appointments because they’re scared of coming to the facility due to COVID. They believe we will transmit the virus to them and hence we have defaulters (Nurse, Cameroon)

84% of health providers were of the perception that COVID-19 impacted HIV and SRH services for children, adolescents and young people at their facility.

Several people cited caregiver concerns about COVID-19 as another factor that kept HIV-positive youth from accessing services.

• HIV services for children have been strongly affected because most of the parents and guardians that were supposed to accompany these adolescents to the clinics feared if they came to the clinic they will expose themselves to COVID-19 and expose the children as well (Social worker, Malawi)

• It has affected services in my facility in that sometimes clients don’t come to the facility at times in fear of being infected with the virus and that lowers service uptake and increases number of absences (Lay counsellor, Cameroon)
Mistrust and misinformation

Several respondents described how stigma around COVID-19 was another barrier to service uptake, with some young people fearing they would test positive for COVID-19 if they came to the clinic or even be tested for COVID-19 without their consent.

- Low patient turnout in the facility [due to the] fear of being diagnosed COVID-19 positive (Community health worker, Cameroon)

- Given the fact that the HIV services we offer are community-focused, children and adolescents are generally reluctant to do the HIV test, thinking we are trying to do the COVID-19 test or infect them with COVID-19. This point of view... is highly encouraged by their parents in our community (Community health worker, Cameroon)

Several other health providers from Cameroon mentioned mistrust and fears that kept community members from accessing health services, such as a belief that health providers will infect clients with COVID-19 while testing for HIV or vaccinate them in secret.

- Many clients are afraid to come to the hospital because they think that we inject COVID-19 to clients (Social worker, Cameroon)

- Where we work, people are afraid to do the HIV test because they think we want to give them COVID-19; it makes our work very difficult and stressful (Community health worker, Cameroon)

- Some would not want injections to be prescribed to them (Nurse, Cameroon)

- Most clients interrupted their treatment because of the fear of contracting COVID-19 if they visit health facilities. Parents don’t bring their children to the hospital for this same reason. The fear of being given the vaccine unaware scares adolescents and young people, too (Data clerk, Cameroon)

Lockdown restrictions

Lockdowns, curfews, transportation restrictions, and increased transportation costs were also said to reduce young people’s access to and uptake of HIV services.

- Government rules around COVID-19 affected HIV services because during lockdown there was no transport to reach health centres, curfew hours and other orders (CBO director, Uganda)

- Many services for children, adolescents, and young people have been affected at my facility due to COVID-19 regulations to stop assembly in a crowd... Since the effective way of learning for this age groups is in physical contact by meeting, playing together and sharing stories and testimonies, the ban due to COVID-19 was a challenge to achieve our objectives (Project coordinator, Zambia)

- Children with HIV are not able to access care as a result of limited movement and increased travel fare; they can’t afford to come to the facility (Project coordinator, Zambia)

- Since the COVID-19 pandemic occurred in my facility, many children and adolescents were unable to attend their follow-up appointments. It also has serious economic effects, which leaves them unable to pay transport fee. They also experienced anxiety (Nurse, Ethiopia)

Unemployment resulting from the pandemic was also said to impact continuity of care.

- Continuity of care has been affected by caregivers who have been transferred from one job to the other or who have been retrenched (Clinical officer, Kenya)
Health providers’ perceived impact of COVID-19 on the provision of HIV and SRH services for young people

Service reduction

Many health providers reported a perceived reduction in paediatric and adolescent HIV service provision as a result of COVID-19 lockdowns, social distancing, and/or health system staffing and resources being allocated to responding to the pandemic. Facilities decreased the number of routine services they offered, provided fewer and briefer consultations and counselling sessions or had staffing shortages that impacted HIV care and treatment services, including client tracing.

- During the lockdown, health workers were not all that free to provide HIV services and so clients could not access their treatment (Nurse, Nigeria)
- People just focus on COVID-19 more than other diseases like HIV/AIDS (Social worker, Malawi)
- COVID-19 clinical services have been prioritised over other health services like family planning, ANC, clinical care, STI treatment and children immunization. However, now things are a whole lot better (CBO manager, South Africa)
- Moonlight testing for key populations [was interrupted] (HIV index tracer, Cameroon)
- Clinics were closed for normal services for months. ANC, MCH and adolescent family planning services were not provided and many patients were scared to go to clinics. Many patients with HIV, TB, diabetes, and high blood pressure defaulted on treatment. Services are now restarting but there are many patients who missed appointments or defaulted, so we are now tracing and re-linking them to care. Clinics are also short-staffed due to some nurses doing outreach to vaccinate for COVID-19 in communities (Primary health care NGO manager, South Africa)

A few people mentioned that children struggle to adhere to COVID-19 protocols, like wearing masks or not touching surfaces unnecessarily. Inadequate infrastructure, personal protective equipment (for both clients and staff), and space to ensure social distancing were also said to impact how safely HIV-positive youth could access care services.

- Our clients find it difficult to wear the mask throughout their stay within the hospital premises (Volunteer health worker, Cameroon)
- Young people living with HIV at my facility face a lot of difficulties trying to manage their current situation and protect themselves from contracting COVID-19. Since our facility isn't well-equipped, we tend to have little or no space for keeping clients with COVID-19 and HIV [separated] and we have lost a lot of children, adolescents and young people living with HIV because we lack enough support system for their treatment and provision of COVID-19 protection tools (Lay counsellor, Cameroon)

A couple of health providers noted that pandemic-related supply chain issues resulted in treatment shortages.

- It reduced the supply, thus client’s having a one month [supply] instead of the normal three months for those who are virally suppressed (Lay counsellor, Kenya)
Quality of care

Providers also described how the pandemic negatively affected the quality of care they are able to provide clients, as when they are short-staffed or expected to shorten consultations to reduce contact time, which results in less discussion and support.

- COVID-19 has affected our services because we have been working in shifts, hence few staff work per shift which affects our quality of care—including adherence, psychosocial, intensive adherence counselling and viral load monitoring to our clients (Nurse, Malawi)

- Before COVID-19, children and adolescents living with HIV and orphans were easily assisted and came regularly for their treatment and respected their medical appointments; but [now] everything has changed (Lay counsellor, Democratic Republic of Congo)

- COVID-19 has affected my work as a [peer supporter] by not being able to do home visits as it is my duty to do (Peer supporter, Eswatini)

- [We’ve been limited in how much we can] see them face-to-face and interact with them. We no longer have group counselling meetings and counselling adolescents while wearing a mask seems not to work because they cannot see your whole face while you talk to them and you have to maintain distance from each other, which is not conducive for them (Doctor, South Africa)

Retention

Respondents overwhelmingly described the negative effects COVID-19 has had on the retention of HIV-positive children and adolescents, many of whom defaulted on their anti-retroviral treatment and lost the viral suppression they had previously achieved.

- Children, adolescents and young people could not come for refill and viral load uptake due to lockdown in the country (Nurse, Uganda)
  - It’s made many of them miss their appointments and prefer community dispensation (Lay counsellor, Cameroon)
  - It has affected me in that many clients refuse to come to the facility to collect medications because they are afraid (Social worker, Cameroon)
  - Infected children, adolescents and young people with HIV/AIDS didn’t come for their ARV appointment pick up for months due positive cases in our facility, thus poor viral load results for some clients (Facility manager, Cameroon)
  - Most of my clients lost or dropped from treatment (Lay counsellor, Ethiopia)

Following-up with clients was especially challenging for many of our respondents during this period who had difficulties locating and communicating with youth who’d missed their ART appointments.

- Appointment keeping and adherence was poor due the lockdown; some had moved to other places, which made it hard for facilities to monitor viral load (Nurse, Uganda)
  - Many children, adolescents and young people got lost and dropped out of treatment leading to most of them having unsuppressed viral load (Lay counsellor, Uganda)
  - There have been many who missed their appointments for HIV-related care and services which may in the long run lead to complications for their follow-up and health (Facility manager, Cameroon)

A nurse in Kenya described how disappointed she feels when her young HIV-positive clients miss their treatment appointments and how she uses her own resources to deliver their medication.

- Since they worry about being HIV positive, some of them are not coming for drug refills which poses many challenges to us nurses. [We try to send] drugs to them at our own cost since we care for them and are human beings. I feel so disappointed when I see my clients not coming for their routine check-ups due to COVID. They need help, like finance to cater for transportation for refills and other check-ups like viral loads, cancer screening TB screening, and more (Nurse, Kenya)
Discontinuation of support groups

Many respondents reported that their facilities and organisations discontinued teen clubs, support groups, ‘paediatric corners’ and other psychosocial activities as a COVID-19 prevention measure; sites that continued to run group programmes tended to report low attendance.

- [COVID-19] has reduced the number of children been called for support group activities to observe social distance (Clinical psychologist, Cameroon)
- Teen club sessions and support groups are no longer active like they used to be (NGO director, Eswatini)
- Many children are missing appointments because we stopped having other activities like food and games due to COVID (Nurse, Malawi)
- Due to the fear of COVID-19, psychosocial activities like the paediatric corner where children often come and play have been limited; this means we focus on dispensing ARVs with limited psychosocial activities (Doctor, Cameroon)
- We no longer have regular support group activities and only few people per day for [ART] pick up. Children are scarcely seen at the facility for their clinical checks to be carried out (Nurse, Cameroon)

Support groups provide health education and peer support, build motivation, keep clients engaged in care, and provide opportunities to dispense treatment; many respondents described negative treatment outcomes resulting from the discontinuation or poor attendance of these critical programmes.

- Adolescent support group meetings have been put on hold since March 2020. There is no more opportunity for education on health issues and to support each other (Counsellor, Lesotho)
- The facility no longer holds support groups for children, adolescent, clients with high viral load and PMTCT—forums meant to reenforce clients’ knowledge about their health (Nurse, Cameroon)
- Most young people and adolescents that were coming to the teen clubs to get their medication on their own would not show up because they feared they will contact COVID-19. This affected the services for all the adolescents and lessons that they get at the clinic. Because most of them missed these lessons, their viral load became high. It is very difficult to help them because we do not want them to spend much time in the clinic (Social worker, Malawi)

Multi-month dispensing

To continue providing services during the pandemic, health providers adapted their paediatric and adolescent HIV and SRH service delivery models to different degrees. The respondent health providers shared service delivery adaptations made at their health facilities in response to the constraints imposed by COVID-19 and these included providing more clients with a multiple month supply of chronic medications to reduce how often they needed to visit facilities. While this approach may work well with stable adult populations, our respondents indicated that reducing paediatric and adolescent client supervision negatively impacted treatment outcomes.

- We encouraged more multi-month prescribing and fast-tracked visits to minimise exposure time at clinic (Doctor, Tanzania)
- COVID-19 limited patient travel and therefore reduced time and frequency of clinician-patient interaction. We had to give longer refills to patients. Less monitoring of patient drug adherence and laboratory monitoring (Nurse, Eswatini)
- All group work had to stop. Stable patients were screened and given longer dates [between visits]. Routine screening for sexual health needs and mental health issues have taken a backseat (Doctor, South Africa)
- COVID-19 has affected HIV services on my side by not easily monitoring my adolescent and young people since we were refilling in every three months (Lay counsellor, Eswatini)

This population was seen to particularly need the psychosocial and adherence support afforded by more frequent contact with health providers and peer support groups.

- They were given up to three months’ ARVs and the time they spend at the facility has reduced, therefore they lack the opportunity of meeting with others and sharing life experiences (Social worker, Tanzania)
- Children and adolescents have missed appointments for medication collection and adherence counselling, [which reduces] viral load suppression because of this gap in psychosocial support (Social worker, South Africa)
- Due to social distancing, these children are not benefitting from the routine play activities during clinic visits (Nurse, Cameroon)
- [COVID-19] has led to poor adherence and low self-esteem (Lay counsellor, Uganda)
Sexual and reproductive health

Health providers perceived COVID-19 to negatively impact adolescent health-seeking behaviour and reported much lower demand for HIV counselling and testing, STI screening, family planning, and engagement in antenatal care. Respondents anecdotally perceived a marked increase in the number of new HIV and STI infections and early pregnancies among young people as a result.

- Access to treatment services has dropped. Patient turnout has seriously dropped leading to low HIV testing services (Community health worker, Cameroon)
- Adolescents they are not reporting to clinics for fear of getting COVID-19, which has led to a high default rate and teenage pregnancy (Nurse, Malawi)
- It is terrible; many adolescents and younger people, especially students, became pregnant in this time of lockdown. These adolescents had to hide until delivery (Facility manager, Uganda)
- Today, many of our young people cannot access SRH services, which has led to an increase in the spread of STIs in young people and also increased early pregnancies in adolescents and young girls in all communities of Uganda (Lay counsellor, Uganda)
- Few people are being tested for HIV they are scared of getting COVID-19 from the hospital. After the lockdown, there were a lot more cases of new HIV infection and pregnancy in young people (Clinical officer, Zambia)
- We need greater awareness that we are open and providing SRH services for youth regardless of any pandemic (Facility manager, Ghana)

Minimal impact

A few respondents reported that they did not perceive the pandemic to have much impact on HIV and SRH service delivery at their facilities, due to low levels of COVID-19 infection in their area, not having many HIV-positive youth test positive for COVID-19 or to community members’ general low concern about COVID-19.

- We have not had any COVID-19 cases among people living with HIV (Doctor, Democratic Republic of Congo)
- No obvious negative effects on services for this population (Nurse, Nigeria)
- Kept youth away from testing as frequently as they did pre-COVID-19. [But] on the whole, the majority of young people aren’t concerned about COVID-19 (Facility manager, Ghana)
- Most people in the community do not want to be tested for COVID-19 as they still don’t believe in the existence of the pandemic (Clinical officer, Malawi)
3.5. Impact of COVID-19 on frontline health workers’ physical and mental wellbeing

COVID-19 infection

29% of all respondents believed they had been infected with COVID-19, 72% of whom had this confirmed with a test. 44% reported experiencing mild or manageable symptoms, while 56% reported serious symptoms (with one person requiring hospitalisation). Respondents that had provided direct care to COVID-19 patients were more likely to have been infected with COVID-19 (40%) than respondents that had not (20%). Given that 67% of COVID-19 cases in Africa appear to be asymptomatic, it’s likely that a larger portion of our respondents had been infected by the time they were surveyed.

50% of respondents reported missing work because they were either infected with COVID-19 or had been exposed to someone who was. 30% had missed work because they didn’t feel safe or protected from COVID-19 at their workplace.

Concerns about COVID-19

When asked to indicate what their top two concerns about COVID-19 were, respondents shared they were most worried about their own health (55%) and the health of their family and friends (50%), followed by the health of their clients (19%) and the risk of transmitting the virus to a loved one (12%). When asked what other concerns they had, respondents expressed specific concerns at different levels:

- **Individual**
  - I’m afraid of getting infected (nurse, Tanzania)

- **Interpersonal**
  - [I’m concerned about] the community as a whole and my own health, including my family (community health worker, Cameroon)
  - The loss of close relatives and friends (nurse, Tanzania)

- **Community**
  - The health of our population (nurse, Ethiopia)
  - Feeling for those who die (nurse, Cameroon)
  - Feeling worried for our HIV-positive children (lay counsellor, Kenya)
  - My biggest concern is for the community in general because by being in the community, anyone in the family, colleagues, others, can become infected (CBO manager, Mozambique)

A manager also expressed concern over how the pandemic was threatening the economic viability of his community-based organisation (CBO):

- [COVID-19] threatens the existence of the centre with lockdowns, new ways of engagement and further financial strain in an already dwindling economy (CBO manager, South Africa)

A few respondents indicated they weren’t too concerned about the pandemic, saying things like ‘I don’t get stressed’ or ‘overly concerned about COVID-19’, ‘it’s not that bad’, or ‘I haven’t been impacted because the secret is protection [following infection protocols]’. A nurse from Cameroon said, ‘I haven’t had a patient or family member who died from it, so it hasn’t changed anything [for me]’

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COVID-19 concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having to work overtime</td>
<td>0%</td>
</tr>
<tr>
<td>Having extra workload</td>
<td>2%</td>
</tr>
<tr>
<td>Inadequate workplace protocols</td>
<td>3%</td>
</tr>
<tr>
<td>Access to vaccines</td>
<td>6%</td>
</tr>
<tr>
<td>Health of my co-workers</td>
<td>7%</td>
</tr>
<tr>
<td>Inadequate PPE</td>
<td>10%</td>
</tr>
<tr>
<td>Loved ones contracting the disease from me</td>
<td>12%</td>
</tr>
<tr>
<td>Health of my clients</td>
<td>19%</td>
</tr>
<tr>
<td>Health of my family and friends</td>
<td>50%</td>
</tr>
<tr>
<td>My own health</td>
<td>55%</td>
</tr>
</tbody>
</table>

23Lewis et al., 'SARS-CoV-2 Infection in Africa'.

24
Perceptions of COVID-19 and experiences of stress

Respondents were asked about their perceptions of COVID-19, stress levels, and how the disease had impacted them.

86% of respondents agreed that COVID-19 ‘felt close’ to them, with half strongly agreeing with the statement.

Most respondents (79%) indicated that they thought about COVID-19 ‘all the time’, with 48% strongly agreeing with the statement.

Most respondents (61%) agreed with the statement that COVID-19 makes them feel ‘extremely stressed’; just 19% disagreed or strongly disagreed with the statement.

The respondents that strongly agreed that COVID-19 made them feel extremely stressed consisted of a mix of cadres, including nurses, doctors, social workers, lay counsellors, and facility managers. Health providers that had provided direct care to COVID-19 patients were more likely to feel extremely stressed by the pandemic, with 29% strongly agreeing and 41% agreeing with the statement.

44% of respondents reported that many of their friends and family had been infected with COVID-19 and 60% knew people (excluding clients) that had died of COVID-19, the loss of whom likely impacted their work and mental wellbeing.

Respondents reported being negatively affected by COVID-19 in a number of ways, including experiencing increased levels of anxiety (60%), feelings of sadness (26%), difficulties concentrating (25%), difficulties sleeping (23%), absenteeism from work (19%), and changes in appetite (15%). 55% reported having experienced one of these negative impacts, 21% experienced two, and 26% experienced three or more.

Participants additionally reported that their stress about the pandemic made them feel more ‘withdrawn’, ‘tired’, ‘alert’ to the need to take precautions and ‘strictly abide to COVID-19 prevention measures’, and concerned for their colleagues. One person said the pandemic kept them from finishing a degree on time and three indicated their workload had increased due to co-workers needing to quarantine.

"I had to leave home when I started working because of my parent’s age, which was over 55 years old.”

Doctor, Mozambique

<table>
<thead>
<tr>
<th>COVID-19 effects</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased anxiety</td>
<td>60%</td>
</tr>
<tr>
<td>Increased feeling of sadness</td>
<td>26%</td>
</tr>
<tr>
<td>Struggle concentrating</td>
<td>25%</td>
</tr>
<tr>
<td>Changes in sleep patterns</td>
<td>23%</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>19%</td>
</tr>
<tr>
<td>Changes in appetite</td>
<td>15%</td>
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</tbody>
</table>
41% of respondents indicated they had experienced some form of COVID-19-related stigma or discrimination in their community as a result of their occupation. Health providers reported community members and sometimes even family members not wanting to associate with them, for fear of infection. 4-5% of providers had been insulted in public, moved residence, or had children that were stigmatised by association.

**COVID-19 stigma and discrimination**

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ve felt uncomfortable saying public transport due to what other people say (or behave)</td>
<td>12%</td>
</tr>
<tr>
<td>People in my community have avoided me</td>
<td>5%</td>
</tr>
<tr>
<td>I was told to find another place to live</td>
<td>5%</td>
</tr>
<tr>
<td>I’ve been insulted or harassed in public</td>
<td>4%</td>
</tr>
<tr>
<td>My children’s friends are less likely to play with my children (because of my work)</td>
<td>4%</td>
</tr>
</tbody>
</table>

- **People in the community tend to shy away when my team and I are out for HIV-VCT** (Community health worker, Cameroon)
- **At first, my family and other people were less likely to closely associate with me because I worked at the COVID centre** (Nurse, Zambia)
- **I lost three of my aunts within one month and we had no support from our community; they said all sorts of things like ‘COVID is at our gates’. They didn’t assist with funeral arrangements and [just] a handful came out for the burial** (CBO manager, South Africa)
- **My community does not care; it’s life as usual** (Community health worker, Lesotho)

90% of respondents either didn’t have (22%) or needed more (68%) opportunities for debriefing and supervision at their facility or organisation.

**System for regular debriefing and supervision**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have enough</td>
<td>10%</td>
</tr>
<tr>
<td>We need more</td>
<td>68%</td>
</tr>
<tr>
<td>We do not have</td>
<td>22%</td>
</tr>
</tbody>
</table>

### 3.6. Resource needs

**COVID-19 infection**

Respondents were invited to share what kind of resources and workplace support would make the biggest difference to their work and their ability to provide consistent HIV and SRH services during COVID-19. Providers overwhelmingly reported their most critical need was a regular supply of personal protective equipment (N95 masks, gloves, gowns, sanitiser) for both them and their clients.

- **[We need a] safe and secure environment which is free from contamination** (Doctor, Cameroon)
- **Adequate PPE to use during support group meetings and while offering client care** (Doctor, Cameroon)

A timely supply of other medical commodities was also mentioned, including COVID-19 testing kits, mechanical ventilators, oxygen, and bulk medication for COVID-19 treatment as well as more family planning commodities, STI treatment, condoms, lubricants, and HIV test kits.

- **We had a stock out of injectables especially the Depo Provera during the pandemic in public health service points** (Nurse, Eswatini)

Many providers said their facilities needed a buffer stock of ART in order to provide multi-month dispensation.

- **I think we need more ARTs so that multi-month scripting can be done and thus reduce patient turnout in the hospital** (Nurse, Cameroon)
- **We need a high availability of commodity so that when we go to provide these services even at the community, we should give for few months (like three months) before coming again so as to reduce the patient staff contact** (Doctor, Cameroon)
Respondents also mentioned needing greater access to COVID-19 vaccines, more efficient vaccination sites, and more training about COVID-19 vaccines and how to reduce vaccine hesitancy in the community.

Many of the respondents’ expressed needs concerned their limited capacity to provide community-based health services. While the importance of bringing ‘services closer to end-users’ was well understood, financial and logistical barriers limited their capacity to do so. Transportation resources (motorbikes, mobile clinics, funding for travel reimbursement) were widely requested to trace patients that missed appointments, deliver treatment, offer home visits, and provide health education and clinical services in communities. A need for more community access points, better linkage systems, and support to health workers who resist doing home visits for fear of COVID-19 exposure was also noted.

- **We need more pick-up community points to access ART, additional funding for adherence and support programs and extra mobilisers and counsellors to be able to cover and reach those in deep rural areas** (CBO manager, South Africa)

Communication resources including mobile phones, airtime and data bundles were also needed to help providers communicate with clients more easily and offer virtual support groups. A few people thought there should be more hotlines and call centres for community members to access.

- **Funds to cater for beneficiaries’ data bundles to have virtual meetings** (NGO director, Eswatini)

- The implementation of virtual support groups will help in continuous education and support for adolescents since most of them avoid the health facility (Data clerk, Cameroon)

Providers also asked for more training and capacity-building opportunities. They were eager to grow their knowledge and receive routine updates about COVID-19, vaccines, paediatric HIV treatment, and sexual and reproductive health. Best practices, approaches and success stories were also appreciated for enhancing their practice. A call for more health education materials and job aids to assist providers was also voiced, including brochures, posters, tools to use in demonstrations, guidelines, and videos.

- **I would love a patient-friendly, colourful pamphlet on why COVID-19 vaccines are safe** (Doctor, South Africa)

More community health workers and trained peer supporters would also make a difference to ease the workload of strained health workers by performing home visits, following-up with clients that defaulted on treatment, and health education. Having a full complement of health providers, including trained professionals that work with young people was expected to improve the quality and sustainability of service delivery. Lastly, several respondents said they needed psychological support and more opportunities to debrief with their colleagues.
3.7. Opportunities for PATA

How can PATA best support you?

<table>
<thead>
<tr>
<th>Support Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocating for funding for regular paediatric HIV and SRH services</td>
<td>52%</td>
</tr>
<tr>
<td>Giving a platform to share what is working well and discuss how to improve</td>
<td>50%</td>
</tr>
<tr>
<td>Advocating for funding for COVID-19 relief</td>
<td>23%</td>
</tr>
<tr>
<td>Providing up-to-date information about COVID-19 vaccines</td>
<td>23%</td>
</tr>
<tr>
<td>Providing basic information about COVID-19</td>
<td>23%</td>
</tr>
<tr>
<td>Working with local partners to share COVID-19 patient education materials</td>
<td>14%</td>
</tr>
<tr>
<td>Sharing information about the COVID-19 trends in my country</td>
<td>9%</td>
</tr>
<tr>
<td>Providing support to communicate with clients in lockdown situations</td>
<td>7%</td>
</tr>
</tbody>
</table>

Respondents were asked to share two types of support they most wanted from PATA.

- Just over half (52%) wanted PATA to advocate for greater funding of paediatric HIV and sexual and reproductive services and 34% hoped PATA would advocate for more COVID-19 funding relief.
- 50% desired a platform to network with other health providers, share ideas and best practices for how to improve service delivery.
- 23% requested PATA help them better understand basic COVID-19 information, 23% requested up-to-date information about COVID-19 vaccines, and 9% would like PATA to advise them about COVID-19 trends in their country.
- 14% would like PATA to create COVID-19 patient education materials with local partners and 7% would appreciate support in how to communicate with clients during lockdown situations.

When asked what other ideas they had for how PATA could support health providers, many respondents requested PPE and other medical resources to treat patients and keep themselves safe, highlighting how under-resourced many clinics, hospitals and community-based health programmes in sub-Saharan Africa are. Basic requests included COVID-19 support kits, face shields, hand sanitiser, medication, ‘face masks and other resources to limit the spread of COVID-19’.

- **PATA must help health service providers by donating PPE** (Lay counsellor, Eswatini)
- **Provide face masks and other resources to cope with the COVID-19 situation in the world, continent, country, region and district** (Community health worker, Cameroon)
- **Please, we need funds to promote this COVID issue** (Doctor, Cameroon)
- **If PATA would support us with finances during these hard times so that we can open up some adolescent sites in order to reach them at their community level** (Social worker, Malawi)
- **Advocate for better, comprehensive funding for CBOs on the ground who have been instrumental in creating achievements and gains in paediatric HIV programs. Funding for better pay for health care workers... overhead costs and admin costs... they are still needed in the fight against HIV and now in the new war against COVID-19. [Community] health care workers work hard and are dedicated for very little job security, not to speak of benefits** (CBO manager, South Africa)

It was clear that many respondents appreciate PATA for translating and disseminating current information and job aids. Respondents requested the organisation ‘continue to share best practices’ and keep them updated about new information about ‘what to do and not to do’ and ‘how to cope with COVID-19’ and especially about COVID-19 vaccines—including the rationale for using them, how they work, and current research about children and COVID-19 vaccines.

A call for more capacity-building trainings was often heard, with respondents variously asking PATA to ‘keep in touch regularly and involve me in trainings and meetings’, have ‘seminars with staff to update them on recent discoveries’, ‘workshops to better our skills’, ‘ongoing COVID-19 training for healthcare providers’ and ‘training programs related to paediatric and adolescents HIV
Respondents also hoped PATA would convene more in-person and virtual meetings that bring health providers together to network, exchange ideas and learn from each other:

- If PATA can do training and more workshops, we can gain more and connect to other partners (CBO director, Uganda)
- We could create more support groups for PATA members where we share ideas and resources (Lay counsellor, Cameroon)
- Training of all health providers, exchange experiences with other districts (medical assistant, Mozambique)
- Maybe increase follow-up to members in order to find out what each facility is doing (Counsellor, Lesotho)
- Network with teams providing adolescent and paediatric HIV services, to improve my gaps; this will help me provide a better service to my clients (Doctor, Cameroon)

A few health providers suggested PATA do more to ‘support the mental health component’ by providing counselling, ‘psychological care’, or incentives to motivate them:

- Give some incentives to health providers to motivate them for their hard work; they have continued working despite the pandemic (Clinical officer, Zambia)

4. Summary of survey results

Health providers still not fully prepared for or protected from COVID-19

- Frontline health providers are indispensable at reducing the burden of disease, creating a safe working environment, modelling preventative behaviours, and safeguarding communities. Yet a year and a half into the pandemic, nearly half of our respondents still did not feel safe and sufficiently protected from COVID-19 at work and a quarter thought their facilities weren’t adequately prepared to respond to the disease. Most thought their facilities needed better guidelines for triaging possible COVID-19 patients, managing social distancing, and preventing transmission.

- Many frontline health providers still lack enough PPE to protect themselves and their clients. Nearly half of our respondents reported inadequate levels of personal protective equipment including N95 face masks, surgical gloves and other protective materials at their facilities. Respondents also expressed lacking designated spaces to diagnose and treat COVID-19 patients and a timely supply of medical commodities, including COVID-19 testing kits, mechanical ventilators, oxygen, and bulk medication for COVID-19 treatment. When compared to the 2020 PATA survey, somewhat increased access to PPE, COVID-19 testing kits, COVID-19 medication, basic training, and protocols for treating and referring suspected COVID-19 cases were noted, but overall levels of each remain inadequate.

- While the majority of respondents felt satisfied with the information they had received about national COVID-19 guidelines, most had not received formal training about how the disease affects specific populations (including people living with HIV or children and adolescents), clinical management of COVID-19 patients, or COVID-19 vaccines (how they work, effectiveness, and side effects).

- Providers consistently requested more training and capacity-building opportunities and were eager to grow their knowledge and receive routine updates about COVID-19, vaccines, paediatric HIV treatment, and sexual and reproductive health. Many wished to receive more training, job aids and patient education materials to be better-informed and able to address misinformation in their communities. PATA’s role in disseminating up-to-date evidence in a simple and practical manner was well-appreciated.
Respondents repeatedly expressed concern over how under-resourced their HIV and SRH programmes and services are and requested more financial support for programmes for children, adolescents and young people, buffer stocks of ART for multi-month dispensation, and other SRH commodities including contraception, STI treatment, condoms, lubricants, and HIV test kits.

Many health providers want help translating current evidence about COVID-19 trends, prevention, treatment, vaccines, and HIV prevention and treatment evidence. They also requested capacitation to provide more adaptive, community-based health services, including how to optimise tele-health.

Networking opportunities to share innovative ideas and best practices for how to improve service delivery and patient health education materials and job aids are also needed.

Many health providers lack access to or are hesitant to be vaccinated for COVID-19

Frontline healthcare providers have a critical role to play in driving uptake of COVID-19 vaccines and advocating for more equitable access on the continent. Respondents reported needing greater access to COVID-19 vaccines, more efficient vaccination sites, and more training about COVID-19 vaccines and how to reduce vaccine hesitancy in the community.

A third of our respondents had not been vaccinated, despite the risks to their own health that COVID-19 poses. This group expressed concerns about side effects, safety, efficacy, and how the vaccines were developed. Respondents that had been vaccinated mostly had done so to protect others, themselves, and/or set an example to others.

Health providers’ own attitudes toward COVID-19 vaccines can be detrimental to vaccine acceptance and uptake. Providers that had been vaccinated were much more likely to encourage others to vaccinate as soon as possible than those that hadn’t done so themselves.

Community-based health services are critical, but under-resourced

Many of respondents’ expressed needs concerned their limited capacity to provide community-based health services. While the importance of bringing ‘services closer to end-users’ was well understood, financial and logistical barriers often limit their capacity to do so. Providers often expressed a need for transportation resources to enable them to deliver treatment, conduct home visits, trace clients, offer health education and provide clinical services in communities. Communication resources like mobile phones, airtime and data bundles are also needed to help locate and communicate with clients more easily and facilitate virtual support groups. Tele-health services and virtual support groups were not extensively utilised by our respondents, particularly those in rural areas.

Critical innovations and service-delivery adaptations transpired as frontline health providers adapted how they provide routine care during the COVID-19 pandemic, particularly around differentiated care and community-based health. Providers are hungry to build their capacity to bring services closer to the community, such as in learning how to provide tele-health services more effectively.

Additional human resources are needed to ease the workload on overstretched health workers, who said that having more community health workers, peer supporters, and trained professionals would help them follow-up with clients, provide health education, and improve the quality and sustainability of service delivery.
COVID-19 negatively affected HIV and SRH service provision and uptake

- A number of COVID-19-related barriers to HIV and SRH service provision and uptake were noted, including staff shortages and redeployments, national lockdowns, transport barriers, reductions in routine services and patient loads, and reduced consultation times. It was common for facilities to experience HIV and SRH service disruptions during the pandemic, with health education and outreach, HIV testing, client tracing, and psychosocial HIV care and support activities being the most common services that weren’t continuously provided.

- Providers perceived the pandemic to negatively impact adolescent health-seeking behaviour and reported much lower demand for HIV counselling and testing, STI screening, family planning, and engagement in antenatal care. Many respondents anecdotally perceived a marked increase in the number of new HIV and STI infections and early pregnancies among young people as a result. Many HIV-positive clients reportedly avoided going to health facilities for fear of COVID-19 exposure or involuntary COVID-19 testing.

- Most health providers reported that COVID-19 negatively impacted HIV services for children, adolescents and young people at their facility. Common adaptations to the constraints imposed by COVID-19 included the provision of multiple-month supplies of chronic medications (including ART) and stopping clubs and support groups that were deemed ‘non-essential’. Our respondents overwhelmingly agreed that reducing paediatric and adolescent client supervision negatively impacted retention and treatment outcomes and expressed that many of their youth clients defaulted on their anti-retroviral treatment and lost the viral suppression they had previously achieved. This population was seen to particularly need the psychosocial and adherence support afforded by more frequent contact with health providers and peer support groups.

Opportunities for health providers to access workplace mental health support are limited

- Frontline health workers experienced unrelenting pressure at work, stress, stigma, and other adverse effects on their physical and mental health as a result of the COVID-19 pandemic. Most reported thinking about the pandemic all the time and feeling ‘extremely stressed’ by COVID-19. Most reported knowing people (besides clients) that had died of COVID-19-related causes and many had been infected with COVID-19 themselves and missed work as a result (or from being exposed to someone who had).

- Providers were primarily concerned about their health, the health of their family and friends, their clients, transmitting COVID-19 to a loved one, and not feeling sufficiently safe or protected at their workplace—all of which contributed to increased levels of stress and anxiety.

- Opportunities for health providers to debrief and get mental health support at the workplace are limited; most respondents had not been trained on how to support distressed and anxious co-workers, but overwhelmingly wanted more information on how to address burnout, build motivation and provide peer psychological support.
The PATA 2021 Summit (1-3 November 2021) brought 1311 people working in paediatric and adolescent health from across sub-Saharan Africa together, including 850 frontline health providers, 155 peer supporters, and 306 other stakeholders from community-based organisations, ministries of health, and regional NGOs. 75% of summit participants attended in-person at one of 22 ‘satellite spokes’, with the remaining joining virtually. The event provided a platform for participants to share experiences, learn, interact with policymakers, offer peer support, and build the skills and motivation needed to continue responding to this unprecedented health challenge.

The three-day summit placed health providers at the centre of each conversation as they discussed innovations and adaptations around service delivery, the challenges they’ve faced translating policy into practice, and ideas for avoiding burnout while delivering frontline health services. On the last day of the summit, a session titled ‘Curbing the silent crisis: Strategies to mitigate burnout among health providers’ explored the impact of COVID-19 on frontline health providers, with a particular focus on mental health. Preliminary results of this survey were presented at the session, followed by three presentations that provided further context to how the pandemic has affected health workers and how best to support this priority group, summarised below.
5.1. Mzantsi Wakho: ‘You cannot be the nurse you used to be’: Reflections of public healthcare nurses during the first wave of the COVID-19 pandemic in the Eastern Cape, South Africa

To better understand the experiences of frontline health workers and identify strategies to assist them during the pandemic, researchers from the University of Cape Town’s Mzantsi Wakho and University of Oxford’s ‘Hey Baby’ team interviewed 13 frontline health workers from the Eastern Cape, South Africa, during the first wave of COVID-19. They found that nurses experienced a number of resource constraints that led nurses to reuse PPE, including shortages of basic resources and the rapid depletion and delayed restocking of COVID-19-related commodities. Their research also highlighted nurses’ adaptive responses and willingness to meet the needs of their young patients living with HIV. They described taking initiative in ensuring that young patients received their ART, sharing their personal contact information and being personally available to their patients, locating patients that had missed treatment appointments, and drawing on community health workers to deliver medication.

Healthcare workers have always experienced high stress levels, but they found COVID-19 made the stressors nurses ordinarily face more intense. Nurses reported feeling physically and emotionally drained, which affected their wellbeing and ability to care for their patients. Some compared themselves to ‘robots’ that didn’t have feelings and were just expected ‘to go on and on’. Nurses felt tension between fulfilling their work requirements and caring for patients and their fear of getting infected and bringing the virus home to their families. They reported not being given any psychological support and needing to find their own ways to cope.

The ‘Hey Baby’ team recommended that in addition to practical support from hospital management, healthcare workers be given holistic support, including continuous and sustainable forms of psychosocial support and encouragement to help them care for themselves, avoid burnout, and meet the needs of their patients. They also recommended greater task-shifting to community healthcare workers that can trace defaulting patients and deliver medication, thereby reducing workload and COVID-19 burden on healthcare facilities.

5.2. A model for collegial peer support from Groote Schuur Hospital

A psychiatrist from the University of Cape Town, Dr. Jackie Hoare, presented an innovative approach to supporting doctors during the pandemic at Groote Schuur Hospital in Cape Town. Initially, she and her colleague struggled to access clinicians working in the high- and intensive-care units; when they offered them mental health support, they would usually decline, saying things like ‘you’re a scarce resource, others need your help more, we’re fine’. That changed when they decided to work in the high-care wards themselves:

- The moment that I became part of the team, I was dealing with the same trauma and the same anxieties myself. I was bearing witness to the same suffering and deaths that they were... In effect, I had to witness the trauma that the doctors were facing daily and be unconsciously tested to see if I could survive this and manage their emotions. I came to see that the negative responses to our offers of help from a distance as opposed to them openly sharing their trauma with us on the wards, represented two sides of the same coin. Our colleagues were experiencing the unimaginable and the unspeakable—the only way they could begin to speak of what they were going through was through our having had an embodied experience of what they had experienced.

She came to realise that her initial offer (‘from a distance’) of training on resilience and coping strategies made providers feel blamed and pathologized for feeling overwhelmed:

- What’s problematic about this approach is that telling health care workers that ‘you need all of these skills’, unwittingly blames them for not managing themselves and their stress and pathologizes them, rather than acknowledging that their trauma was real and affecting an already traumatised healthcare system. What eventually became acceptable to the doctors was a contained space, a group where they were able to share their experiences and their anxieties... We know that to be vulnerable and admin feeling overwhelmed can be hugely stigmatising for doctors, in particular... Part of our job was to provide a space to allow that fear to be expressed safely; it was important to normalise these reactions as an appropriate response to real trauma, in order to dissipate the stigma to some degree.
By working side-by-side, she was able to create a space where colleagues could support each other and safely express their fears and anxieties, rather than bury them. Hoare noted that it was important not to try to ‘fix’ anything or tell them what to do; they were not incompetent, they were merely facing ‘an objectively novel and challenging situation’.

- My working on the frontline with the team made it possible to shift the model of helping our colleagues from a traditional group therapy model (which they rejected) to creating a collegial support space for sharing trauma. It became possible for them to safely express their emotions in the groups because I had been through the same trauma. They said a number of times, ‘we can only talk here, because no one can understand exactly what we’ve been through’ and ‘you understand because you are there with us, you are one of us’... The function of the groups was to create a space where people could feel safe and connected and not alone. The aim was not to provide a set of techniques for coping, but rather to provide a place where we could put these experiences into words and thereby address the isolation and the stigma that trauma inherently brings. It’s not just the sharing of the same trauma that makes a band of brothers and sisters; it’s processing it together.

The COVID-19 pandemic raised important questions about how clinicians cope with the on-going experience of working in very stressed and under-resourced health systems. Hoare concluded that integrating mental health professionals within COVID-19 teams creates trust by ‘flattening the medical hierarchy’ and helping clinicians normalise their appropriate reactions to workplace trauma. Peer support provides a valuable way for frontline health providers to express feelings of uncertainty and vulnerability, make sense of their experiences, feel less isolated, and avoid burnout as a result.

5.3. Panagora Group: Mental health of health workers

Graeme Hoddinott, a research psychologist at Stellenbosch University’s Desmond Tutu TB Centre, shared findings from the Panagora Group’s 2021 research exploring healthcare workers’ mental health. The team interviewed 92 health providers from USAID implementing partners working in seven high HIV and TB-burden districts in South Africa to find out how they were coping during the pandemic, what debriefing resources were available, and to identify additional support needs. They defined mental health as ‘a dynamic concept associated with the capacity to cope with increasing stressors and display healthy behaviour while performing roles at work, within families and communities’.

Health workers reported feeling a range of emotions that changed each day, including despair, despondency, hopelessness, fear of acquiring and transmitting COVID-19, and guilt for not being able to provide quality care to their clients. When asked how they coped with stress, very few said they spoke to others (including loved ones) about their difficult experiences, proactively sought out ways to manage their stresses, or accessed available mental health support services. Some enjoyed distractions like watching television or drinking heavily, but ‘overall, there was a sense that one just had to be strong as a health worker and maybe pray and hope it gets better’.

He discussed how everyday life was really stressful for frontline healthcare workers. Providers regularly witness violence in communities and experience stressor events—which was true before COVID-19 and will still be the case after. They found that both facility and community-based healthcare providers either weren’t aware of available mental health services, didn’t feel encouraged to access them, or didn’t consider that what they were experiencing justified using debriefing platforms.

- If you’re going to deliver quality care to clients, you have to be well yourself, which includes managing your mental wellness. The mental health of health workers shouldn’t be framed as a remedial thing that you only address if there’s an issue, but should rather be central to everything that is done so that the health workers are as optimum providers of health services as possible.

He concluded that mental health support should be integrated throughout the workplace, addressed during routine meetings, and that health workers should feel appreciated for their hard work and the burden they carry. The Panagora Group thus developed a toolkit with practical resources to implement and strengthen existing support platforms that mitigate burnout among health providers.
5.4. Key takeaways

The session emphasised how healthcare workers are the most valuable resource within healthcare systems and should be acknowledged and treated as such. Other session takeaways included:

- There’s a sense that the COVID-19 pandemic has bled into every element of health providers’ reality, making it difficult to separate their work from their home lives.
- Healthcare workers tend not to share that they are struggling with others or feel guilty doing so. They need safe spaces to share and make sense of their difficult experiences (virtually or in-person) with others that can relate to what they’ve been through.
- Frontline healthcare providers need to be recognised as the most valuable resource in the healthcare system and cared for as such.
- There is power in peer support; when teams gather to reflect on their experiences, it helps them normalise and make sense of their reactions with others that have shared the same traumatic experiences. This bonds them together, builds motivation, and ensures they don’t feel isolated.
- Healthcare worker mental health should be prioritised, integrated throughout the workplace, and recognised as an essential component of quality service delivery.

PATA debriefing platform

Noting how vital they are to ensuring that health systems operate effectively during the pandemic, PATA established an emergency debriefing platform to provide psychosocial support and online counselling services to frontline health providers experiencing heightened stress or anxiety as a result of the COVID-19 pandemic.

After completing an online booking form, health providers were given access to one to four hour-long debriefing sessions with an accredited counsellor within the PATA network. The confidential sessions offered lay and professional health workers a listening ear, a safe space to offload worries or concerns, and strategies for self-care and stress relief to help them feel stronger, healthier and supported.
6. Recommendations

Prioritise strengthening health systems

- The critical role that community-based health providers play in providing health care and education to communities has never been clearer, yet many organisations that mobilised to respond to the COVID-19 pandemic, provide differentiated HIV and chronic disease care to reduce facility visits, and support food security and the distribution of COVID-19 prevention information and commodities face on-going financial strain and uncertainty. Sustainable funding for organisations that provide critical community-based care should therefore be prioritised to prepare for possible future waves of more virulent strains of the coronavirus and to improve the overall health of communities.

- The COVID-19 pandemic highlighted the vast inequalities that exist within the global health system. Our health providers frequently raised concerns about barriers to good COVID-19 response including a lack of adequate PPE, designated spaces for triaging and treating COVID-19 patients, equipment, medication, ventilation, and even running water—fundamental challenges that affect public health systems more broadly. Financial support to address critical infrastructure, capacity, and commodity gaps within the sub-Saharan African public health sector is urgently needed to address the COVID-19 pandemic and respond to other urgent health crises including HIV, malaria and chronic disease affecting the continent.

Address global inequality within COVID-19 resource and vaccine distribution

- Donors and governments should address global inequality within COVID-19 vaccine distribution as a matter of urgency by focusing on densely populated urban areas in Eastern, Western, and Central African regions that are most impacted and ensuring that already-received doses are efficiently administered to the public.

- While there is extensive population exposure to COVID-19 in sub-Saharan Africa, vaccinating individuals with prior infection will result in higher levels of protection over infection-induced immunity alone, should more transmissible and/or lethal variants of COVID-19 emerge.

- Greater investment in health provider education and vaccine access is needed to address misinformation and reduce hesitancy, enhance trust in vaccine science, and encourage greater uptake among both health providers and the general public. It is essential to identify factors associated with vaccine resistance and tailor communication strategies to address health providers’ concerns in order to strengthen their role as committed partners and enhance public trust of COVID-19 vaccination programmes.

- Frontline health providers should be provided with the necessary information, training, and adequate PPE at all levels of health care.

- Supply chains need to be managed to keep essential medicine and PPE in stock and to ensure chronic medications remain available, including ART. Basic medical commodities, PPE, and ART should be closely tracked at facility and district levels to prevent avoidable stockouts.
Ensure continuous paediatric and adolescent HIV and SRH services

- The continuity of routine HIV and sexual and reproductive health services for children, adolescents and young people should be ensured at clinics and supported by well-resourced cadres of community-based health providers and peer supporters.

- Health facilities should be given greater access to transportation (including funds for travel reimbursement, motorbikes, and mobile clinics) and communication (including mobile phones, airtime, and data bundles) resources in order to deliver critical community-based health services and support adherence to HIV treatment.

- Locating and linking the substantial number of clients that defaulted from HIV treatment as a result of numerous barriers to care that arose during the pandemic back into care is essential to protect their health, prevent further HIV transmission in the community, and ensure the enormous progress to control HIV that was achieved in recent years isn’t lost.

- Psychosocial support to children, adolescents, and young people living with HIV should be prioritised and well-resourced. Adherence clubs and other programmes for HIV-positive youth that have been discontinued should be reinstated, given the critical role they play in building motivation and keeping youth engaged in care.

Prioritise the mental health and wellbeing of all frontline health providers

- Psychosocial support and regular individual and group debriefing opportunities should be made available to all health providers to process the routine stressors they experience, rather than regarded as for exceptional situations.

- Facilities should make time available for monthly or quarterly peer group debriefing sessions that provide time for frontline health providers to share, reflect and learn self-care strategies. Health facilities should integrate psychosocial support into regular meetings by allocating time for personal reflection, addressing workplace challenges and exploring ways to provide more mentorship and supportive supervision to employees.

- While referrals to external mental health professionals are necessary and appropriate for many scenarios, the value of bringing teams together to talk about the difficult experiences they’ve shared shouldn’t be underestimated. Health providers may find peer support more acceptable than other approaches that may leave them feeling pathologized and appreciate its capacity to normalise understandable feelings of vulnerability within medical culture and build resilience.

In-service trainings about mental health and coping with stress should be provided and information about mental health support widely circulated and referenced. Workplaces should create opportunities to acknowledge and celebrate the contributions of health providers and create regular opportunities for peer recognition and appreciation (e.g. monthly awards, staff teas, posters, team affirmation exercises, and so forth).
Invest in frontline healthcare providers

- Adequately resourcing public health systems and advocating for the safety, protection, and training of frontline health providers would go a long way in addressing the dual health crises of HIV and COVID-19. Comprehensive infection prevention and control training and universal access to appropriate PPE is needed for all health workers.

- Financial resources should address staffing shortages, reducing the burden placed on overworked health providers.

- Donors, governments, and regional networks should support the diffusion of innovations by finding networks that should support the safety, protection, and training of frontline health providers.

- The voices of frontline health providers should be heard and taken into account when policies are developed and assessed.

References


