Access to and utilisation of HIV and other essential health services amidst the COVID-19 partial Lock Down is Fundamental

Introduction

The Coronavirus disease (COVID-19) outbreak was declared a Public Health Emergency of International Concern on 30th Jan 2020 and a pandemic on 11th Mar 2020. Over a year into the response, COVID-19 continues to overwhelm health systems globally, with evidence showing that it is most likely to extend beyond 2021. Globally, the cumulative number of cases has surpassed the 100 million mark, with 141,754,944 million cases and 3,025,835 million deaths confirmed as of 21st April 2021.

The cumulative cases in Uganda stood at 72,679 confirmed cases including 680 confirmed deaths as of 22nd June, 2021. The outbreak in Uganda has been characterised by two waves. The country is currently experiencing the second wave which has proved to be deadlier than it was in the period March - Sept 2020. The surging numbers of new COVID-19 infections in Uganda and those that need critical care has drastically increased and surpassed the government health system capacity which has forced most Ugandans to seek care from private facilities across the country - which has also come along with associated challenges such as the exorbitant charges by private health facilities. Evidence from anecdotal information from some clients that have accessed services from private facilities and media reports show that the daily rate for patients that are critically ill and requiring Intensive Care Unit (ICU) admission ranges between UGX 2 – 5 million which is unaffordable by most Ugandans including the People living with HIV. Remember that most people in Uganda survive on hand-to-mouth and therefore cannot afford such expenditure yet they are most at risk of COVID-19 infection.

COVID-19 has almost reached all the districts of Uganda and people who migrated from urban centres to the rural setting (following partial lockdown announced by the president) are likely to export more cases to the villages/communities. COVID-19 testing and treatment facilities are more urban based than rural - yet community level cases are increasing. Community capacity to control and prevent the spread is lacking or very low. There is no well explained government plan to manage COVID-19 at community level other than directing people to stay home, wear masks, social distance and sanitize - these are preventive measures but now we have cases in the community.

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We appreciate the government of Uganda for the COVID 19 response measures that have been put in place under the stewardship of His Excellency the President of Uganda and the technical leadership of the Ministry of Health and the overall oversight of the Office of the Prime Minister. Health sector interventions have targeted coordination, surveillance, case management, risk communication and Strategic Information, Research and Innovation.

But with the previous wave and COVID-19 restrictions, we saw and or learnt lessons as far as the HIV response is concerned. There were unprecedented cases of human rights violations including gender-based violence, poor adherence to HIV treatment, high numbers of lost to follow, low viral load suppression, treatment breaks, loss of lives, increase in new infection, low uptake of HIV prevention measures (PrEP was more affected), forced HIV serostatus disclosure, irregular supply of HIV commodities and low uptake of HIV testing among others. One of such evidence was the high rate of sexual violence with PEPFAR performance records for FY20 (FY21Q1) showing 35,723 and only 5,442 received PEP for HIV prevention), between Quarter 1 FY2020 and Q1 FY2021, 62,871 people were lost to treatment. And this was just one source of evidence, we imagine a consolidation of the national picture-the situation is appalling.

The country wwitnessed how global lockdowns and travel restrictions threatened manufacturing and supply of ARVS, not forgetting at the onset of the lock down in 2020, Uganda had in stock for example 3 months stocks for Alluvia and Lopinavir and coincidentally during Community Led Monitoring (CLM) exercises between August and September, these were reported to have been stocked out for a period of over 3 months at the time of the assessment.

With these challenges, gaps and lessons, it is right to say to date, we have not yet fully recovered from the first wave of the pandemic and here we are once again, experiencing a more devastating wave from which we are already seeing issues and challenges, some spill overs and new occurrences.

From the current wave, key issues that have come up and need urgent attention include;

- COVID-19 testing and treatments for those found positive is very expensive. Testing and treatment services are not available in all parts of the country
- Access to emergency support for those in critical conditions is quite challenging in terms of getting admitted in a health facility and managing costs for those that are admitted. This includes the cost of accessing health services in private health facilities.

- Access to vaccines is limited or not there as fewer vaccines were imported into the country compared to the over 40 million Ugandans that need to be vaccinated.
- Access to oxygen in public and private health facilities is quite expensive - and or lacking in some places.
- The Director General's guidelines do not clearly state whether communities living with HIV, a critical group who have been at centre of addressing community challenges, as clients it is not clear whether only the Client's medical record or appointment card is sufficient permit to travel for treatment or whether they require additional permit from ministry of works and or local authorities.
- Current directives seem to define critical health workers as only clinical teams yet some strategies for this country define health workers otherwise to for example in the HIV response, the essential workers include; social workers and community health workers such as the expert clients, contact tracers, linkage facilitators and this limitation is likely to create a critical gap in health service provision. Additionally, there are populations in closed settings such as homes for persons with disability, DiCs for Ke populations, rehabilitation homes or centers for persons with various conditions like congenital disorders, stroke, drug addiction, GBV shelters for victims of violence all who are getting support from non health workers - and non prioritization of such community or social workers spells doom for the affected people.
- People in chronic care who either travelled upcountry or have to cross borders for HIV care and treatment are finding it challenging with this restricted transport. The ban on inter-district travels is already causing challenges to continuity of care for some clients who access ART from facilities beyond their places of current habitual residence. Recent CLM engagements for example reveal that some clients in Zombo, Nebbi, DR. Congo and South Sudan access ART in Arua, while some clients in Ntoroko receive ART from Kabarole.

- The cost of living is becoming quite high because people are confined in their homes and are no longer engaged in their routine chores and hence have no food yet its critical for those in chronic care to have proper diet and or nutrition. Experience from the previous lockdown shows that most vulnerable populations didn't get emergency support from Government; and the new lockdown was introduced without properly

defining mechanisms for providing emergency support - this creates more suffering to the already suffering populations

- A lot of infodemic information around COVID-19 is circulating which is subsequently causing a lot of panic, emotional and psychological distress yet little emphasis and attention is being paid to addressing this challenge. A lot of anxiety is growing among Ugandans especially among those at high risk of acquiring COVID-19 virus amidst lack of support - at the same time with limited online psychosocial services
- Plans to initiate stable clients living with HIV on multi month dispensing/refills hit a dead-end because of limited stocks in some facilities and the situation could get worth with the increasing cases amidst restricted transport system.
- Key and vulnerable populations risk being subject of human rights violations as they are now living in environments that they were not accustomed to; and there are no special programmes to cater for such people beyond the urban centres.
- Current trends show that the COVID-19 challenge/pandemic might be here for a long time compared to the anticipated period. There are no strong mechanisms that have been put in place to address the two issues at hand concurrently - managing the already existing chronic care cases (HIV, TB, cancer, diabetes among others) alongside the COVID-19 pandemic
- Community based approaches for managing chronic illnesses including home-to-home and moonlight approaches among others have not given due attention during the management of COVID-19 - yet they greatly contributed to the 90:90:90 UNAIDS targets.
- The uncensured exorbitant charges being imposed on COVID 19 patients by the private Health Service providers have proved to be a significant constraint in access to COVID-19 treatment as our communities are unable to afford the services. This has greatly compromised access to quality health care.
- The restrictions have created a situation where it is seemingly mandatory breach of the patient's fundamental right confidentiality. This has been brought about by the fact that PLHIV should be inclined to disclose their HIV status to their local council leaders in order to seek movement permits to allow them move to their health centers for refills. The subsequent impact of this is that, for fear, many PLHIV do not disclose which in the long run keeps them unable to move to their health facilities for refills.

- Lockdown restrictions have hindered access to TB services. Form the previous lockdown, many cases of multi- drug resistant TB are being registered as a result of poor adherence brought about by the restrictions at the time.
- There is little or no efforts being made to ensure that the elderly ably access treatment and vaccination services. This constituency especially those in the rural areas have not been helped to access.
- Communities at the boarder districts most especially those that harbor refugee camps have been put at a very high risk of acquiring COVID 19 considering the back-and-forth movement of refugees to and from their home countries.
- Children [OVC] have been left out of government interventions against COVID-19. Yet this is a group very vulnerable. The under 10 many are under care of care takers who in most cases are also elderly and cannot appropriately care for these children. The Teenager between 13-16 under the program are prone to pregnancies resulting from risky premature sexual engagement some of which are pre-conditioned by the COVID-19 restrictions and or conditions. This was also very rampant during the first wave and the spill overs to date are evidenced by the massive numbers of young girls who got pregnant and are speculated to drop out of schooling.
- Our communities are facing reduced and delayed service delivery due to shortage of health workers many of whom have contracted COVID-19 while others are focusing on managing it which leaves a gap in the service delivery to other clients including PLHIV.
- Some facilities have been closed due to the overwhelming cases of COVID-19 cases. This has rendered a stop to delivery of other essential services like ART refills, HIV Testing and other sexual reproductive health services
- Stigma against health workers evidenced by the fear by patients who fear going to the facility because health workers are looked at as carriers of the corona virus and also by health workers themselves depicted by the fear of going to and or avoidance of the facility when on duty to attend to clients for fear of contracting the virus has rendered human resource shortages
- Communities do not have information on where they can go for testing, this has led to misclassification of illnesses for instance TB being misclassified as COVID 19.

In light of the above issues, the constituency of People living with HIV, key and vulnerable populations make the following recommendations to avert the likely additional negative effects that might arise; bring back the HIV/TB response

- Each District COVID 19 task force should include a PLHIV, KVP representative, to identify vulnerable PLHIV, monitor COVID-19 response for PLHIV with continuity in HIV treatment and care.

- Government, PEPFAR, UNAIDS should engage scientists to see how to mitigate the effects of COVID 19 treatment and vaccination on PLHIV. This should be informed by a study into the specific effects of COVID- 19; COVID-19 treatments and vaccination on treatment. What are the short term and long-term effects of the science of COVID-19 on PLHIV? An early discovery of these will be key in preventing a future emergency for PLHIV.

- Government of Uganda should regulate the cost of COVID-19 testing and treatment in both public and private health facilities.

- Government should ensure uninterrupted access to HIV treatment and care services by ensuring that; i PLHIV with due appointments can ably move to any accessible health facilities (even if not parent health facility) and access ART refills; PLHIV should either be exempted acquiring movement permits and or it should be considered that ART clinic card should suffice as a permit as opposed to inclining clients to unwanted disclosure of their status to LCs in a bid to secure movement permits.

- Government and PEPFAR should take cognizance of the role of social workers in the HIV response, who ought to be prioritized supported and added to the list of essential workers for purposes of continuity in their service delivery.

- Government and the development partners ought to strengthen contact tracing mechanisms which will help in mitigating the spread of COVID 19.

- The government of Uganda through the Ministry of internal affairs-Uganda police should waive curfew for health workers considering the versatility of their operations, some being emergencies and others remote outreaches to rural communities which may cause delay in beating the curfew. Curfew puts health workers in harms way of law enforcement.

- Government, PEPFAR and other service delivery partners should consider community integration in service delivery. These include community refills, home deliveries, door to door visits so as to reach out to more clients, test them to avoid disease misclassification and loss of lives.
- This is the time and all development partners should be calling out the reserve forces of health workers to come in and cover the gap in service delivery caused by COVID-19.
- Government should look into the exploitation and extortion of money by the Private Health Facilities as a mechanism to reduces self medication and other concoctions
- Government of Uganda should avail alternative means of transport for people in chronic care other than boda-boda as not all people will ably use public means
- Service providers should strengthen and seriously implement multi-month dispensing programme mechanism to reduce on the cost of accessing HIV care during this difficult period
- Government and Development partners should allocate resources to provide emergency support to the vulnerable populations and intentionally include PLHIV and key population - with a well-defined approach
- The policy that requires people to get authorization from RDCs, DHOs and other security agencies should be relaxed because it causes human rights violations.
- Design psychosocial support messages that are electronic e.g., toll free line, food and any other support.
- Use of peer-to-peer approach. We need to see peers are supported to scale down health services to their members.
- Government and ADPs make resources available for aadministrative costs to enable the communities (linkage facilitators, mentor mothers, peer educators) to link clients to services.
- Immediately assess families/households that are likely to experience cases of violence as witnesses during the last lockdown and provide remedies.

- PEPFAR, UNWOMEN, should strengthen approaches to ably continue supporting adolescent girls and young women given the risks they face against their lives and health.
- Government of Uganda decentralise COVID-19 Testing and vaccination to the lowest levels as much as possible for easy access by the last user even at village level given the current travel restrictions which make even access more difficult for the elderly. Government and ADPs ensure that there is adequate and effective protection of the frontline workers against COVID-19 through ensuring that first of all, all are vaccinated, providing sufficient PPE,
- Government should ensure that all essential workers including the social workers can ably apply for and qualify to be among those in most need of the movement permits.

For and on behalf of people living with HIV and other high-risk populations

Signed

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