



Independent observer
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GLOBAL FUND-SUPPORTED PROGRAMS IN UGANDA FACE SIGNIFICANT CHALLENGES AMID THE COVID-19 PANDEMIC AND NATIONAL ELECTIONS

By the end of January 2021, Uganda had confirmed over 300,000 COVID-19 cases and more than 300 deaths. The country has introduced [various measures](#) to address the pandemic, including curfews, lockdowns, and physical distancing measures, since announcing its first case in March 2020. However, these measures, plus a rising number of cases, have disrupted health services, increased resource needs and shifted resources from other diseases. This has adversely affected the performance and outcomes of programs for the human immunodeficiency virus (HIV), tuberculosis (TB), malaria and other communicable and non-communicable diseases.

Recent national elections further exacerbated the situation as campaigns openly flouted COVID-19 guidelines, and the election period was marred by violence and violations of civil liberties.

Country context

Like other countries in the sub-Saharan African region, Uganda is particularly vulnerable to COVID-19 because of its relatively weak health systems infrastructure, comparatively [limited laboratory capacity](#), and [low clinician–population ratios](#), as well as lack of key equipment such as respiratory machines, oxygen supplies and personal protective equipment. The population also has a high number of underlying health conditions including malnutrition, anemia, HIV, and chronic respiratory conditions due to TB and air pollution. The country enforced strict lockdown measures to mitigate the spread and impact of COVID-19. The lockdown lasted until June 2020, and since then relaxed restrictions have remained in place but are not fully implemented.

Impact on the HIV program

COVID-19 has had a detrimental effect on hard-won gains in Uganda's HIV program

The Joint United Programme on HIV/AIDS (UNAIDS) and the World Health Organization WHO) estimated that a six-month disruption in antiretroviral treatment ART due to COVID-19 could lead to more than [500,000 extra deaths from AIDS-related opportunistic infections in sub-Saharan Africa and reverse gains made in preventing mother-to-child transmission of HIV](#). For Uganda alone, this translates into an increase in new child infections of up to 104%.

[Uganda has a population of almost 45 million people including 1.4 million people living with HIV \(PLHIV\)](#). The country has made excellent progress towards the [‘90-90-90’ targets](#). By 2019, 84% of PLHIV were aware of their HIV status and 87% of them were on ART; and of those on ART, 88% had achieved viral suppression. At its peak in the 1990s, Uganda's HIV prevalence was between 18 and 30%, which had reduced to 5.7% by 2019, largely due to the roll out of ART and extensive public health campaigns on the importance of HIV testing, initiating ART and [drug adherence counseling](#).

The COVID-19 lockdown measures have limited PLHIV's access to, and utilization of, HIV services and presented barriers to HIV testing, especially for the most vulnerable groups. Affected services include workplace testing, mobile mass testing campaigns and self-testing among fishermen, sex workers and male partners of women attending antenatal care. For those with a new HIV diagnosis, clinic closures and the practicalities of leaving the house during lockdown prohibited essential linkage to care.

Substantial interruption to ART availability and uptake

However, the gravest concern is the real possibility of significant ART interruption. While Uganda did not experience antiretroviral drug (ARV) supply chain disruptions, people could not leave home to obtain essential medications. Others relocated to villages away from their HIV clinics which may have affected their regular access to ARVs.

PLHIV were also significantly constrained in obtaining ARVs from private clinics. In early 2020, the Ministry of Health (MOH) stopped supplying ARVs to private clinics that had been providing care to an estimated 20,000 PLHIV. This change was due to the withdrawal of funds from these clinics by the US President's Emergency Fund for AIDS Relief (PEPFAR), as per PEPFAR's letter to the MOH in January 2020 concerning the [shift in its funding](#). The pandemic started just as PLHIV were transitioning from private clinics to public and non-government organization (NGO) facilities which considerably affected their access to ARVs.

Additionally, disruptions to economic livelihoods during lockdown worsened the poverty and hunger already faced by many individuals for whom mere survival, rather than maintaining HIV care, had become the priority. Interruptions to ART access have very real consequences on those who were previously ART-adherent and virally suppressed. Significant lapses in HIV virological suppression may result in increased morbidity, mortality and community transmission of HIV, which would be a catastrophic consequence of

COVID-19.

[Early data modelling](#) showed that new HIV case detection declined by 75% in the first two weeks of April 2020, while ART initiation declined by 55% in the entire month. Initiation of isoniazid-preventive therapy to prevent secondary TB among [TB/HIV co-infected patients](#) also reduced by 75% in the first two weeks of April. The model also estimated a 20% rate of lost-to-follow-up for six months among PLHIV and a consequent return to 1990 mortality levels (when no treatment had been available). Using standard assigned HIV disability-adjusted life years (DALYs), the model predicted that 41,757 excess cases would fail to commence ART over six months, with 12,151 DALYs lost. When all these data are combined, the model predicted a total of 475,319 DALYs lost.

Impact on the TB program

Disruption to the continuity of TB services

WHO classifies Uganda as a high TB burden country. The extra pressure on health services resulting from the pandemic, combined with its effects on health-seeking behavior, slowed or reversed progress towards TB treatment and prevention targets. The country reported [fewer monthly TB case notifications](#), possibly due to people with chronic conditions or mild symptoms being discouraged from seeking care at health facilities, reductions in the number of health facilities offering TB diagnostic and treatment services, and TB staff and molecular diagnostic platforms being reallocated to the COVID-19 response.

Other reasons include disruptions to accessing health facilities, especially with the curfew restrictions; the reduced number of health workers leading to an increased workload for the remainder; the failure to conduct TB outreach, door-to-door services and contact tracing; and COVID-19 related stigma preventing people from accessing TB services.

Results from modelling studies indicated an immediate 43% decrease in TB notifications during the lockdown period that persisted and remained relatively stable for several weeks. This decrease was expected to result in a 14% increase in TB related mortality. Similarly, among all presumptive TB cases in children, only 61% were detected and notified out of the annual planned output of notifying 88% of expected paediatric new and relapsed TB patients; and 39% were missed (not notified), demonstrating a low pediatric TB case finding.

Impact on the malaria program

COVID-19 has resulted in delayed and insufficient implementation of malaria interventions

In Uganda, as in many malaria endemic countries, the COVID-19 pandemic has caused major disruptions in essential malaria services. Early messaging advised the public to stay at home if they had fever, potentially disrupting treatment-seeking for febrile diseases such as malaria. In 2020, Uganda had planned to implement large prevention campaigns before the peak malaria transmission season of September to December. This included distributing long-lasting insecticidal nets, indoor residual spraying and seasonal malaria chemoprevention. The pandemic threatened the safe and effective delivery of these interventions, resulting in late and inadequate implementation.

[New malaria cases](#) dropped in the first quarter of 2020; this was consistent with a seasonal decline but more persistent and of greater magnitude than in 2019 (1,206,606, 1,010,524, and 678,176 cases in January, February, and March 2020, respectively, compared with 832,499, 666,493, and 722,370 in 2019).

Hospital admissions and in-patient deaths declined by similar proportions, as many people ? especially children and vulnerable groups ? may have died from malaria.

Impact on maternal and child health (MCH) and non-communicable diseases

Scarce resources were diverted from priority health programs to the COVID-19 response

The travel bans and reduction in public transportation restricted access to MCH services. Fear of contracting the virus at health facilities dissuaded attendance whereas activities considered 'non-urgent', such as antenatal care, [were postponed](#). [Data](#) show a 29% reduction in facility birth deliveries in March compared with January 2020, 28% less than the 12-month average for 2019. Alarming, over the same period the country recorded an 82% increase in maternal mortality, up by 87% to 170 maternal deaths over the 12-months compared with the 2019 average of 90 maternal deaths.

The government necessarily had to divert health personnel and resources from other diseases. Patients with cancer, hypertension and other cardiac conditions, diabetes, epilepsy, sickle cell, as well as mental health, maternal or childhood conditions, faced an increased risk of complications and death due to their inability to access healthcare services. The situation was exacerbated by already existing healthcare system challenges, including inadequate human and financial resources, poor infrastructure, and supply chain and logistical challenges.

Anecdotal data show that access to medication has been a major problem for patients with chronic conditions who rely on drugs for their survival and improved quality of life, as they were unable to obtain repeat prescriptions, while others could not afford medication due to [lack of income](#). On the other hand, self-purchasing and stockpiling of antibiotics and other medicines for those who could afford to do so presented another challenge of medication safety, including antimicrobial resistance. Patients who had been newly diagnosed with cancer were not able to start treatment while others missed their three-month refills for hormonal treatment. These delayed initiations and interruption of treatment cycles resulted in increased stress, anxiety, disease progression, recurrence and premature death.

Impact on the health system

COVID-19 has redirected health system focus and prioritization. Public health responses have been dominated by [enforced social distancing and stay-at-home rules](#). Health service delivery has become more difficult and riskier. [Clinicians and the direct care-givers of COVID-19 patients](#) have a disproportionately higher mortality than the general age-adjusted population. With low per capita physician/population and hospital bed ratios, Uganda has a relatively fragile health system with limited capacity to expand critical care services. Restricted access to intensive care, particularly to oxygen, has reduced the recovery rates for severe COVID-19 cases resulting in mortality and DALYs lost. Closure of logistics-related workplaces and transport services have interrupted supply chain lines. And the increased pressure on health service personnel has caused problems in collecting and submitting timely data reports.

Impact on civil society and civil liberties

Slow recognition of the importance of existing community health structures

Uganda was slow to leverage the expertise and know-how of communities in the COVID-19 response until well into the pandemic.

Community health workers are usually the first point of contact for healthcare services and sources of health information. They are trusted, well connected and use appropriate community engagement approaches to mobilize and sensitize the community. They are best placed to demystify the myths and perceptions regarding COVID-19 and address complacency. Involving them in community-based surveillance, case management and contact tracing is a winning strategy. Realizing this, the MOH launched a national COVID-19 community engagement strategy in September 2020 to strengthen existing

community health systems for integrated people-centered primary health care. These include strengthening the roles of community leaders, including political, religious, cultural leaders and community extension health workers in mobilizing and engaging community members to respond effectively to COVID-19.

Potential effect of the political elections on civil society's health response

The government launched the election period in October 2020 with guidelines informing political candidates that campaign meetings should not exceed 200 people who should observe social-distancing and practice frequent hand-washing. There was additional guidance for candidates to rely more on TV, radio and social media to reach potential voters rather than face-to-face rallies. However, candidates held open campaigns that did not follow the COVID-19 safety rules, exposing attendees to infection. Many opposition candidates were not allowed to use the existing nationwide private and government-owned TV and radio channels. There was reported election-related violence while attempting to enforce COVID-19 rules that resulted in over 50 deaths and many people sustaining injuries. The government shut down the internet between 13 and 18 January 2021 to mitigate pre-and post-election protests about the elections held on 14 January; and social media only reopened on 10 February ?before this, people were using Virtual Private Networks (VPN) to access social media.

The political upheaval also has the potential to affect donor support to Uganda and in some cases already has. The government froze the bank accounts of several civil society organizations (CSOs) for alleged support of opposition candidates. On 3 February 2021, the government also suspended the operations of a major donor, the [Democratic Governance Facility \(DGF\)](#), a €100 million European Union funding mechanism to support equitable growth, poverty eradication, the rule of law and long-term stability in Uganda. The DGF supports at least 74 institutions, both state and non-state actors, including a number of CSOs.

PEPFAR gives Uganda around \$400 million each year, the US President's Malaria Initiative about \$150 million and the Global Fund grants comprise \$579 million in the allocation period 2020-2022, an annual amount of around \$743 million provided by these three donors. To date, this financial support has not been threatened by political events. However, the United Kingdom has cut off its aid to the police and prisons; and the European Union parliament passed a 19-point resolution condemning Uganda's abuse of civil liberties.

All these developments have adversely affected national and CSO responses to both COVID-19 and other communicable diseases.

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