COMMUNITY-LED MONITORING IN INDONESIA, UGANDA, UKRAINE AND VIETNAM

ASSESSING THE IMPACT OF COVID-19 ON PEOPLE LIVING WITH HIV

SEPTEMBER 2021
ABOUT ITPC
The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- **Treatment education and demand creation** (#BuildingResilientCommunities)
- **Intellectual property and access to medicines** (#MakeMedicinesAffordable)
- **Community monitoring and accountability** (#WatchWhatMatters).

To learn more about ITPC and our work, visit www.itpcglobal.org.

This publication is available to read and download from the ITPC website here.

ACKNOWLEDGEMENTS
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## Abbreviations and Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>CLM</td>
<td>Community-led monitoring</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus disease – 2019</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>ITPC</td>
<td>International Treatment Preparedness Coalition</td>
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<tr>
<td>NAFOPHANU</td>
<td>National Forum of People Living with HIV and AIDS Network in Uganda</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>OI</td>
<td>Opportunistic infection</td>
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<td>PITCH</td>
<td>Partnership to Inspire, Transform and Connect the HIV Response</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
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<td>SARS-CoV-2</td>
<td>Severe acute respiratory syndrome coronavirus 2</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>VNP+</td>
<td>Vietnam National Network of People Living with HIV</td>
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<td>WHO</td>
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EXECUTIVE SUMMARY

This document describes a pioneering rapid assessment by people living with HIV of the impacts of the COVID-19 pandemic on people in four countries: Indonesia, Uganda, Ukraine and Vietnam.

From October 2020 to February 2021, the International Treatment Preparedness Coalition (ITPC) partnered with four community-based organizations to rapidly document and assess impacts of COVID-19 on health and human rights among people living with HIV and key populations. The implementing organizations were Yayasan Peduli Hati Bangsa in Indonesia, the National Forum of People Living with HIV and AIDS Network in Uganda (NAFOPHANU), 100% Life in Ukraine (formerly known as the All-Ukrainian Network of PLHIV), and the Vietnam National Network of People Living with HIV (VNP+).

Funded by the Partnership to Inspire, Transform and Connect the HIV Response (PITCH), the principal aim of this four-country rapid assessment was for community-based organizations to gather information about impacts of COVID-19 on the health and human rights of people living with HIV and key populations to inform community-level action and advocacy, and to build an evidence base informed by the perspectives of key populations in sites across Africa, Europe and Asia. The rapid assessment had four key components:

1. **Treatment literacy training and information sharing on HIV and COVID-19** among key populations of people living with HIV, including a desktop review of national and local policy documents and COVID-19 directives.

2. **Involvement of people living with HIV** in participatory tool design and adaptation to document impacts of COVID-19.

3. **Primary data collection and co-analysis**

4. **Early dissemination of findings** by advocacy organizations to local and national partner networks, government ministries, bilateral agencies and global agencies.

In all countries, negative effects of the COVID-19 pandemic were documented on access, availability and affordability of HIV testing and treatment across steps of the HIV treatment cascade:

- COVID-19 disrupted medicine procurement and supply chains, causing stockouts and reducing consistent availability of essential medicines and diagnostics.
- Due to COVID-19, health facilities were closed, the numbers of recipients of care allowed within facilities were restricted, non-essential healthcare...
services (defined broadly and enacted differently within every location in this project) were suspended, and curfews and lockdown restrictions limited access to HIV prevention and treatment services, although they were needed to curb the spread of SARS-CoV-2.

Furthermore, across all sites in the rapid assessment, participants recounted their fears of acquiring COVID-19 if they went to health facilities or accessed health services. This meant that they refrained from accessing a broad range of routine health screenings and testing services, medical care and treatment, and prevention and support services.

As a result, people living with HIV delayed treatment initiation, experienced HIV treatment interruptions, and were forced to switch HIV treatment regimens. Examples from different sites include: limited access to sexual and reproductive health and opioid substitution therapy in Ukraine; difficulties in accessing antenatal and postnatal care in Uganda (with new, out-of-pocket charges levied within public health facilities for antenatal examinations); and stockouts of ART (in Vietnam) and of viral load diagnostics and reagents (in multiple sites).

This report documents the methods and findings of this work, focusing on the impacts of COVID-19 on healthcare and human rights from the perspectives of people living with HIV and on their urgent advocacy priorities for health and human rights in the era of the COVID-19 pandemic. The report contributes to global evidence about the power of community-led monitoring to strengthen evidence based advocacy for health and human rights by people living with HIV and their organizations.
In 2020, a new pandemic emerged in the form of SARS-CoV-2, the virus that causes COVID-19, adding to the burden of premature deaths and disability caused by HIV, tuberculosis (TB), malaria, viral hepatitis and other infectious diseases. Much remains uncertain about global health in 2022 and beyond, but the HIV and TB responses will be permanently changed by this newest pandemic of COVID-19. Namely:

- Public health measures taken to control COVID-19, such as curfews and lockdowns, have disrupted and widened gaps in access to HIV and TB testing, prevention, treatment and support.

- COVID-19 created economic hardships and adverse effects on mental health, substance use and violence, all of which are impacting the health of people living with HIV and TB.

- COVID-19 has deepened global disparities in health, having the largest negative economic impacts on lower-income countries and groups of marginalized populations that have had the least resources and power to address those impacts.

- The fragmented global distribution of COVID-19 vaccines, the lack of available and affordable supplies for many countries, and the lack of trust in many communities about COVID-19 prevention efforts is causing a serious examination of the global architecture and funding for pandemic response and health security.

Despite these major impacts of the COVID-19 pandemic, there have been limited systematic data collected about its effects on people living with HIV in resource-constrained settings. Without this data, policymakers cannot design and tailor HIV-related programmes to target emerging needs of people living with HIV and effectively maintain progress towards meeting Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 HIV targets and other Sustainable Development Goals (SDGs) related to people living with HIV.

For the epidemics of HIV, TB and COVID-19, the world has effective low-cost medicines for treatment and prevention, evidence-informed and effective interventions, and other tools to control widespread transmission and prevent premature deaths and disability. But these products and programmes must be made available, accessible and affordable, and people at greatest risk must perceive these services as relevant to them and responsive to their immediate needs.
Recipients of care and their communities are a first and central resource for addressing this public health challenge:

- Recipients of care and their community-based organizations are often the first to recognize and document new and emerging health issues and impacts and the first to respond immediately and innovatively to people’s survival needs.

- Recipients of care and their community-based organizations are also uniquely placed to describe and confront gaps in access to essential health services – including routine health screenings and testing services, medical care and treatment, and prevention and support services – and to showcase disparities in health and human rights.

- Through community-led monitoring (CLM) and related advocacy, recipients of care can provide valuable support to health providers and government health authorities to “build back better” in a post-COVID-19 landscape by advancing greater differentiation of service delivery, increasing use of communications technology in health services, and improving supply chain management and multi-month dispensing.

Ultimately, community involvement in documenting the quality of local health service delivery can help country health programmes better tailor prevention and treatment services to population needs, achieve higher rates of utilization and retention, and produce better population-level health outcomes with more effective and efficient use of resources. Improvements in the quality and effectiveness of health programmes in ensuring positive health outcomes will, in turn, hasten the achievement of global SDGs.

**ABOUT THIS PROJECT AND REPORT**

From October 2020 to February 2021, International Treatment Preparedness Coalition (ITPC) partnered with four community-based organizations to rapidly document and assess impacts of COVID-19 on health and human rights among people living with HIV and key populations to inform community-level action and advocacy. The implementing organizations were Yayasan Peduli Hati Bangsa in Indonesia, the National Forum of People Living with HIV and AIDS Network in Uganda (NAFOPHANU), 100% Life in Ukraine (formerly known as the All-Ukrainian Network of PLHIV), and the Vietnam National Network of People Living with HIV (VNP+). The project was funded by the Partnership to Inspire, Transform and Connect the HIV Response (PITCH).

Through this initiative, networks of HIV activists mobilized rapidly and effectively to document the impacts of the COVID-19 pandemic on people living with HIV and to build an evidence base informed by the perspectives of key populations in sites across Africa, Europe and Asia.

The rapid assessment had four key components:
Treatment literacy training and information sharing on HIV and COVID-19 among key populations of people living with HIV, including a desktop review of national and local policy documents and COVID-19 directives.

Involvement of people living with HIV in participatory tool design and adaptation to document impacts of COVID-19.

Primary data collection and co-analysis.

Early dissemination of findings by advocacy organizations to local and national partner networks, government ministries, bilateral agencies and global agencies.

This report documents the methods and findings of the rapid assessment. It focuses on the impacts of COVID-19 on healthcare and human rights from the perspectives of people living with HIV and on their urgent advocacy priorities for health and human rights in the era of the COVID-19 pandemic. By doing so, this report contributes to global evidence about the power of community-led monitoring to strengthen evidence-based advocacy for health and human rights by people living with HIV and their organizations.¹,²
ASSESSMENT METHODOLOGY
This rapid assessment project had four key components, described above and summarized in Figure 1.

**PARTNER AND COMMUNITY ENGAGEMENT AND ORIENTATION**

The rapid assessment project started with each of the four community organizations conducting desktop reviews of national and local policy documents on COVID-19, HIV and infectious diseases, and then contacting key populations for information sharing and treatment literacy training.

Partner organizations selected participant populations for the rapid assessment based on the key populations with whom they work. For example, VNP+ in Vietnam chose to conduct the assessment among people living with HIV who use drugs or sell sex in two cities: Ho Chi Minh and Hanoi. Meanwhile, 100% Life in Ukraine chose to focus on women living with HIV. NAFOPHANU in Uganda chose to include women who had moved to rural areas during lockdowns to wait out restrictions with their families (Table 1).

**TABLE 1: Selected organizations and communities engaged**

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>ORGANIZATIONS</th>
<th>COMMUNITIES ENGAGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine</td>
<td>100% Life</td>
<td>Women living with HIV who are sex workers or use drugs</td>
</tr>
<tr>
<td>Uganda</td>
<td>National Forum of People Living with HIV and AIDS Network in Uganda (NAFOPHANU)</td>
<td>Women living with HIV who had moved to rural areas</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Vietnam National Network of People Living with HIV (VNP+)</td>
<td>Men living with HIV who use drugs and sell sex</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Yayasan Peduli Hati Bangsa</td>
<td>People living with HIV and key populations, including those who use drugs, sell sex and live with viral hepatitis</td>
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</tbody>
</table>
TREATMENT LITERACY TRAININGS, LITERATURE REVIEW AND SITUATION ANALYSIS

Alongside COVID-19 treatment literacy and training on community-led monitoring and data, each of the four country-based partners conducted a rapid situation analysis about the local impacts of COVID-19 on key populations, scanning for the types of impacts of the COVID-19 pandemic that have been documented globally. For the rapid situation analysis, partners collated the following sources:

- Documents and communications related to the organization’s current advocacy projects
- Recent national plans and policies, including HIV, TB, hepatitis and key population plans issued by the World Health Organization (WHO), UNAIDS and ministries of health
- New COVID-19 programmes and policies instituted by national governments
- Media articles, social media posts and other communications that reflect local governmental and local organizational responses to COVID-19.

PARTICIPATORY TOOL DESIGN

Equipped with the situation analysis and trained through COVID-19 and HIV treatment literacy sessions, community-based organizations then designed a participatory assessment tool in the local languages to document and relate the impacts of COVID-19 on people living with HIV.

The tool combined the formats of a citizen’s report card, a community assessment, a qualitative survey and, in the case of Ukraine, a Likert scale. It used images and emoticons to encourage participants, regardless of literacy, to relate their experiences of healthcare and human rights for people with HIV during the COVID pandemic, and to rank their government’s performance on health and human rights before and during the pandemic. Every component of the tool’s development and implementation was collaborative, from the design of indicators to the selection of images, the organization and completion of the assessment with participants, and the analysis of findings.
INDICATOR SELECTION

Within each assessment tool, indicators were designed according to each country’s commitments to managing the COVID-19 pandemic (as stated in national policy documents), alongside the specific needs of key populations and their health objectives. Indicators were adapted according to the HIV epidemiological profiles of each country, with a focus on the advocacy objectives of partner organizations.

The tool included two fields that elicited information about participants’ experiences both before and during the COVID-19 pandemic. Participants therefore described how healthcare services, social support and economic circumstances had changed during the pandemic. The final section of the tool encouraged participants to describe the strengths and weaknesses of their governments’ responses and to articulate their priorities for health and social services and advocacy initiatives in the future.

Indicator images were also adapted for each country, ensuring that these images resonated with the experiences and understandings of participants locally. For example, the image for the indicator “Antiretroviral treatment”, was customized by each partner organization to encourage recognition of local regimens.

FIGURE 2: Example of the first and second pages from the rapid assessment conducted among people living with HIV (men who have sex with men, people who use drugs, and sex workers) in Vietnam. It is translated here into English; the original responses were written in Vietnamese.
While structured according to a small number of indicators (a maximum of 10), the assessment tool was designed to encourage a variety of response forms, including emoticons, written text and oral responses transcribed by facilitators to ensure that participants could speak in their own languages and vernacular. To seek to counter social desirability bias, participants were encouraged to describe their own authentic experiences about the impacts of COVID-19 on people living with HIV. For example, as stated in the introduction to 100% Life Ukraine’s assessment:

“This is the first global project we know about that aims to document the experiences of people within community-based populations, rather than engaging with high-ranking medical officials from the World Health Organization and the Ministry of Health. The aim of this work is to document your own real, direct experiences, as truthfully as you can.”

The four community organizations then trained their own staff to implement the rapid assessment within their local contexts and piloted the assessment with a minimum of 15 recipients of care. In the case of Ukraine, the assessment was implemented virtually. In Indonesia, Vietnam and Uganda, HIV activists chose to conduct the rapid assessment directly with recipients of care. As organizational staff engaged with recipients of care, they not only piloted the rapid COVID-19 assessment, but also heard from individuals about their health, social and economic needs and did their best to provide information, counselling, referrals and other services and resources to meet those needs. Partners facilitating the assessment used personal protective equipment, together with stringent infection control measures, and every
participant took part in a COVID-protection discussion about the imperatives of physical distance, mask wearing and hand washing.

PARTICIPANT SAMPLING, RECRUITMENT AND CONSENT

Participant identification and sampling methods included purposive, convenience and snowball sampling, with an objective sample size of 15 participants per country.

Participants in all four countries were living with HIV (except for a small number of men who have sex with men in Vietnam), and each belonged to a region-specific key population. Otherwise, eligibility for participation in the rapid assessment was defined according to the advocacy and key population focus of each partner following their national and local epidemiological target populations. These local populations were: pregnant women and mothers in Uganda; men who have sex with men and use drugs in Vietnam; sex workers and people who use drugs in Ukraine; and people who use drugs, sell sex and live with viral hepatitis in Indonesia.

Partner organizations also aimed for diversity within their sampling of key populations, rather than focusing merely on a single population group in one area. For example, 100% Life in Ukraine recruited ex-prisoners, sex workers and people who use drugs. NAFOPHANU in Uganda targeted sex workers and young mothers (aged 18-24 years), recruiting participants from different districts to ensure that results were more comparative and inclusive, incorporating both urban and rural participants.

Potential participants were identified from the internal lists of contacts of collaborating organizations. Contact by lead partners was then made via phone and social media applications, based on the availability of participants’ contact information and their interest in the project. The informed consent of participants was formally procured at rapid assessment sessions and recorded on each assessment. Facilitators explained that participation in the assessment was entirely voluntary, and every participant gave formal consent before data collection commenced. To protect participants’ confidentiality, pseudonyms and locations have been anonymized throughout this report.

Each partner organization met the sampling aim of 15 participants; the Uganda partner exceeded its sampling target with 18 participants.

DATA COLLECTION

In response to local restrictions on travel, weighed against the urgency of meeting directly with people living with HIV to reconnect them with care (both medical and psychosocial), three of the four organizations in this rapid assessment chose to conduct it in person with participants. Partners decided to conduct the assessment offline because many participants lacked mobile phones, rendering virtual engagements impossible, and ensuring that the experiences of less affluent people would not be ignored or dismissed.
As Caroline Thomas, Programme Manager from Peduli Hati Bangsa in Indonesia, explained:

“We decided that it was better to do one in-person meeting. Some of our participants don’t have mobile phones, so it’s impossible to do this using an online platform such as Zoom or Skype. We decided to conduct the rapid assessment face-to-face. With the correct protocols, the risk of transmission was quite low. We checked with the hotel before to make sure that the ceiling was high and that there was an open door to allow for the circulation of air, and that the room was large enough to maintain a space of two metres between each participant.”

(Co-analysis session, 3 December 2020)

Throughout the data collection, participants were positioned not as the subjects of research, but as experts and partners in describing and relaying the impacts of the COVID-19 pandemic on people living with HIV.

As Caroline Thomas explained to participants:

“There is no right or wrong answer; there is just your experience.”

(Co-analysis session, 3 December 2020)

Participants were encouraged to ask questions at any time and to talk to each other if they wished in the style of a focus group discussion, as well as encouraged to enjoy the process of the assessment.

FIGURE 4: Temperature screening of participants in Indonesia. Peduli Hati Bangsa colleagues ensured screening and safety before entering the conference room.

FIGURE 5: Participants were physically distanced and masked with free flow of air from an open door behind the conference table (off-camera, to the far left).
FIGURE 6: VNP+ colleagues completing the assessment in a small group. Both VNP+ (Vietnam) and Yayasan Peduli Hati Bangsa (Indonesia) arranged numerous sessions to conduct the rapid assessment in different locations to uphold physical distancing while ensuring a diverse sample of participants.

FIGURE 7: A VNP+ activist completing the rapid assessment in her bathroom at home.

FIGURE 8: Screengrab from a co-analysis session of findings from the rapid assessment, with Yaroslav Zelinskyi and Anastasia Homukiu from 100% Life Ukraine and Helen Etya’ale from ITPC (4 December 2020).

FIGURE 9: Screengrab from a co-analysis session of findings from the rapid assessment, with Caroline Thomas from Peduli Hati Bangsa and Rebecca Hodes from ITPC (3 December 2020).

DATA ANALYSIS

Data collected in Indonesia, Ukraine and Vietnam were translated and transcribed into English. The leading partners were gathered for consultation and reflection about the combined data, reviewing several sources of information, including rapid assessment transcripts, photographs, interim reports capturing partners’ analyses and findings from the assessment, and primary interviews with the facilitators of the rapid assessment.

Data were analysed inductively, with a focus on partners and participants’ key experiences and findings. The consultation and reflection among leading partners strengthened the quality of data analysis across multiple sources and media. Partners then read and reviewed this report and their revisions were incorporated into the final version.

ASSESSMENT METHODOLOGY
HIV TESTING

HIV testing services were disrupted or halted due to limited lab capacity. Access to HIV testing was hampered by restricted transport and movement and fear of COVID-19 acquisition among recipients of care. Overworked and stretched healthcare workers were unable to fully counsel recipients of care.

Since December 2013, the global HIV response has worked to meet the UNAIDS 90-90-90 targets by 2020:

- 90% of all people living with HIV know their status
- 90% of all people diagnosed with HIV receive sustained access to ART
- 90% of all people receiving ART achieve viral suppression.5

This has required provision of widescale public access to HIV testing. But the COVID-19 pandemic has had a profoundly negative impact on access to HIV testing. All partners in the rapid assessment reported reductions or suspensions of HIV testing programmes.

Neira, a 23-year-old pregnant woman living in rural Uganda, explained that healthcare workers had provided community-based HIV testing before the COVID-19 pandemic. But during the pandemic, “Community testing is not done. HIV testing awareness stopped.” (See Figure 11.)

Also in rural Uganda, 23-year-old Afiya echoed Neira’s response. She wrote: “[Before COVID] HIV testing facilities were good and treatment ... and free services were given and hospitals were free and caring. During COVID-19, hospitals are hard to access. Services [including HIV testing] were not given in time since [the start of the] COVID-19 period.”

![FIGURE 10: HIV testing before and during COVID-19 in rural Uganda – Neira's response (November 2020).](image)

![FIGURE 11: HIV testing before and during COVID-19 in rural Uganda – Afiya's response (November 2020).](image)
People living with HIV in Vietnam related similar experiences. Tran explained (Figure 13): “Before the COVID epidemic, HIV testing services were available. There were many public places to test and public HIV testing campaigns, so many people with risky behaviours had access to services.”

In stark contrast, Van stated: “During the period with COVID, all activities of the HIV testing campaign stopped. People wishing to have an HIV test when going to a medical facility have to do more procedures, such as having to make a medical declaration.”

Hoang described similar experiences: “[Before COVID-19] many medical facilities provided services. Many types of tests were convenient, fast and suitable. Many activities of medical facilities were being implemented.”

During COVID, Phuong stated: “Because I am isolated, I cannot go to a medical examination and get treatment or have an HIV test. Laboratory activities are limited. Customers feel unsafe when going to the medical facility for fear of COVID-19 infection.”

In the course of Vietnam’s COVID-19 response, certain areas identified as disease “hotspots” were quarantined and inhabitants were unable to leave. Phuong’s “isolation” was due to this “containment” strategy.

Do Dang Dong, the National Coordinator of VNP+, praised Vietnam’s “easy access to testing at health facilities and counselling community groups” before the COVID-19 pandemic. Vietnam’s rapid desktop review captured the successes of VNP+ in collaborating with other civil society organizations and government partners in responding quickly and effectively to the healthcare challenges posed by the emerging COVID-19 pandemic, in particular for people living with HIV. Dong’s participation in the Vietnam Administration of HIV and AIDS, affiliated with the national
Ministry of Health, meant that VNP+ was able to draw on extensive organizational networks, as well as capitalize on its government partnerships, to support a national response to COVID-19 that also protected the healthcare and human rights needs of people living with HIV. Moreover, at the beginning of the COVID-19 pandemic, VNP+ leveraged its experience with health and human rights advocacy and its symbiotic working relations with community-based organizations and state authorities to rapidly establish Vietnam’s HIV COVID Working Group. This group has 120 members from diverse civil society organizations, including activists representing key populations and people living with HIV based in every province in Vietnam. It has worked consistently alongside the state to identify and address healthcare and human rights challenges arising from the COVID-19 pandemic.

Yet even within countries with strong, enduring and effective partnerships between HIV advocacy groups and state authorities, the COVID-19 pandemic interrupted access to HIV testing and treatment. Hui from Vietnam recounted the difficulties of accessing healthcare services during COVID-19, explaining that VNP+ and other advocacy groups had helped transfer HIV self-tests and deliver ART via motorbike taxi when government restrictions precluded their access. As Do Dang Dong and partners working with VNP+ in Vietnam explained, despite continued demand for HIV testing during COVID-19, peer educators “ran out of testing tools because the test kits were not timely allocated”.6

As partners working with Yayasan Peduli Hati Bangsa in Indonesia explained:


Prior to COVID-19, HIV testing was easy and education about HIV testing was done routinely among key populations. There were frequent HIV tests at the Puskesmas (public health centres) or mobile clinic, and there was no limitation to the working days of services. Hours of service ranged from 7am until 4pm. Doctors were not in a hurry to examine the patient and doctors didn’t keep their distance with patients. Services were considered simple and affordable.

With COVID-19, routine tests among all the population were not done (either through mobile or facility-based health services). The number of people accessing HIV testing decreased. [When] the HIV test result was available, healthcare providers were in a hurry and did not explain the result or educate the patients. Service hours were limited, ranging from 8am to 1pm, and only for two working days per week. Some transgender people were told that they could only bring a maximum of two other people to a healthcare facility to be tested for HIV. And everything had to be done by appointment.”7

(November 2020)
From the beginning of the COVID-19 pandemic, ITPC partners mobilized rapidly to secure access to HIV treatment for people, including through direct deliveries of ART to people who had relocated to different areas to wait out quarantine restrictions (such as in their family villages),\(^8\) as well as for those who were quarantined in neighbourhoods “sealed off” by government officials as “COVID-19 hotspots.”\(^9\) All partners confirmed that recipients of care in their networks experienced stockouts of ART at healthcare facilities, and all reported declines in ART adherence. In all of the countries in this assessment, medicine procurement and distribution networks were severely strained by COVID-19. In Ukraine, where ITPC partners worked closely on pharmacovigilance, 100% Life reported that dolutegravir regimens were most severely affected by stockouts and healthcare facility closures, due in part to the relatively recent introduction of the drug and to countries’ reliance on international imports and trade flows to replenish national stocks.

Participants described their terror of running out of essential medicines, having to pay out of their pockets for services that recipients of care would not be able to afford, and having to queue in healthcare facilities with poor infection control. Participants reported a loss of confidence in healthcare facilities, accompanied by a greater reliance on NGOs and donor organizations.

There is a big problem with ART drugs in Odessa and the region. Everyone is provided with the same regimen regardless of liver and kidney condition, or opioid substitution therapy. And if they used to provide it for three months, now they provide it for one month, which means that you need to visit the clinic twice as often during the quarantine. The fact that a general blood test and a general urine test, as well as liver tests, are available only as paid services is depressing. Not every [person who injects drugs] can afford to pay 500 hryvnia each time for regular tests. Also, there were great difficulties with CD4 and viral load testing. People who have just started their therapy cannot check if it works or not and it only...
takes a year to find out. I’ve been hearing a lot from infectious disease doctors: ‘Drink what you’re given because soon even these won’t be available.’ This is very frightening.”

(Yu.O., woman, 54 years old, Odessa)

Due to mobility restrictions and increases in transport costs, people living with HIV trying to travel to healthcare facilities to refill their ART prescriptions faced additional, out-of-pocket expenses. In Indonesia, Vietnam and Ukraine, people living with HIV tried to avoid defaulting on their ART regimens by purchasing “substitution” drugs. In Vietnam, for example, Le Thang reported “buying missing ingredients” to sustain his regimen. Peduli Bansa in Jakarta also reported that participants were purchasing “regimen substitutions”.

To access facilities, people living with HIV had to skirt a multitude of new bureaucratic hurdles, including reporting to local police (in Indonesia), registering with district health authorities (in Vietnam), and attempting to comply with complex COVID-19 “standard operating procedures” (in Uganda), which bundled transport and mobility restrictions with health facility closures and restricted operating hours. A 20-year-old pregnant woman in a city in Uganda summarized the correlation of transport limitations and limited ART provision: “COVID-19 standard operating procedures affected my access to ART because transport was restricted.”

In many locations under lockdown, new permissions had to be sought from local authorities, like police, to travel to healthcare facilities. These new requirements threatened the confidentiality of people living with HIV who had returned to their family homes for lockdown and those who feared being expelled from their rented accommodation if their HIV status was revealed. The prospects of disclosing living with HIV to strange government officials and healthcare workers in different urban locations – or conversely, to family acquaintances working in government or healthcare in participants’ home districts – deterred many from seeking care. In all locations in this project, those who braved new restrictions, working around stay-at-home orders to seek essential healthcare, were fearful of violence and shame from being identified as living with HIV.

The fear of undesired and unintended disclosure combined with the perceived threat of acquiring COVID-19 from public transport, as well as from queueing in crowded government offices, were further obstructions to ART access. The dread of stigmatization by threatening officials was a further deterrent to ART access.

The evidence base on access and adherence to HIV treatment has shown that multi-month scripting for stable recipients of care, which limits the fiscal and opportunity costs of monthly clinic appointments, optimizes HIV service delivery and improves the retention of people living with HIV in care. Emerging studies of ART provision during the COVID-19 pandemic suggested that multi-month dispensing may have, in fact, improved as a result of more widespread attempts to provide longer-term scripts for stable recipients of care. However, the only partner reporting incremental
improvements in multi-month dispensing during this rapid assessment was in Indonesia, where one virologically stable recipient of care reported that she had been given a three-month supply of her ART regimen and that ART had been made available to other experienced people living with HIV via courier. However, her “home facility”, at which she had accessed ART for several previous years, had been closed after a COVID-19 outbreak and she had been transferred out to another facility where her medical history was unknown.

All other participants in the rapid assessment reported greater difficulties in accessing and adhering to ART during the COVID-19 pandemic. In Vietnam, border closures with India had curtailed supplies of medicines, and ART provisions had been rolled back from multi-month dispensing to a single month. In parts of Vietnam and Indonesia, healthcare facilities were closed after outbreaks of COVID-19. People living with HIV dependent on those sites for ART had to seek treatment from other healthcare facilities, where they were given “only a few days of supply”.

In particular, 100% Life in Ukraine emphasized the negative impacts of COVID-19 on multi-month dispensing. Before the COVID-19 pandemic, people living with HIV who were stable on treatment had received between three and six months of ART, including dolutegravir (which was dispensed for three months to “stable” recipients). To their frustration and disappointment, ART provision was reduced to a one-month supply in Ukraine during the pandemic.

"[During COVID-19] … access to ART has worsened. Prior to the introduction of quarantine, it was possible to get therapy for three months, and during the quarantine, it is usually provided only for one month. This is inconvenient, especially for those people who go to work (usually ART is provided after 10am, due to the routine test material collection). For example, one of the reasons for this is the inability to perform routine X-ray diagnosis (most X-ray machines are redirected to coronavirus infection treatment units, so firstly you need to look for a hospital where an X-ray machine is available for common use). Of course, you can make an X-ray of your lungs at private clinics, but it’s not affordable for everyone.

There was a case when a person who had just been diagnosed with an infection could not get his first ART for two weeks because there was no therapy available. If [he has] less than 100 cells/mm3, in my opinion, it is very dangerous. This person had to wait for two weeks before his first ART prescription. This also has a very negative effect on a person’s psychological state. Because while this news of his diagnosis needs to be accepted, his chance to take the first steps to improve his health condition was being postponed."
I also noticed that in most newly diagnosed cases, Atripla/Trastiva was prescribed for patients, while dolutegravir regimens were prescribed in a very small number of cases. Atripla/Trastiva is a good therapy, but it is not suitable for everyone. Many people experience the side effects of one component included in this regimen. Prior to the introduction of quarantine, Atripla/Trastiva used to be prescribed less often. But due to stockouts of dolutegravir (which is less harmful; its side effects are reported more rarely), the prescription choice is made depending on drug availability.”

(O.A., woman, 34 years old, Donetsk)

In Uganda, participants emphasized the negative effects of limited consultation times and highlighted associations between growing food insecurity, increased transport costs and greater difficulties in accessing and adhering to ART.

Participants also connected ART access issues with issues of confidentiality and stigma and discrimination.

Quarantine measures and increases in transport costs significantly increased the expense of filling ART prescriptions.

“...As in situations with ART, the lack of public transport was the main problem. My medical institution is located in another city because in my city I have faced stigma and disrespect for me as a...”
patient, and witnessed some cases of other people’s status disclosure. But after establishment of strict quarantine restrictions, it has become impossible to get to the medical facility, except by taxi. The price of a taxi in both directions is about UAH 1,000 (about US $40) … Other patients have faced the same problem.”

(Valeria, woman, 39 years old, Kyiv)

**VIRAL LOAD TESTING**

HIV viral load testing services were slowed or stopped because of stockouts of lab reagents, as well as the repurposing of viral load machines for COVID-19 testing. The additional costs associated with viral load testing, notably out of pocket, acted as a deterrent for recipients of care.

As with all other healthcare services, access to viral load testing for people living with HIV decreased during the COVID-19 pandemic. A lack of chemical reagents and the repurposing of viral load machines for COVID-19 testing led to drastic reductions or, indeed, total suspension of viral load testing for people with HIV. In certain locations, such as Vietnam, viral load testing for people living with HIV returned to “normal” relatively quickly. But even in sites where suspensions of viral load testing for people living with HIV were in place only during peaks of the COVID-19 pandemic, this assessment highlighted the perennial, out-of-pocket costs of viral load testing – essentially a violation of UNAIDS’ commitments to free, universal access to the medical mechanisms to reach the 90-90-90 targets. Recipients of care in Indonesia, Vietnam and Ukraine related how viral load testing for people living with HIV was charged for “out of pocket”. In Indonesia, viral load testing was described as “really costly” and “a luxury”. In parts of Ukraine, suspensions of viral load testing for people living with HIV were in place throughout 2020.

“… There were long queues for viral load testing. It was necessary to stand on the street waiting in line. I received my results from a social worker, but other patients did not have the opportunity to get more detailed information about their health condition and their adherence. It was impossible to take the test in some regions due to lack of reagents.”

(N.B., man, 42 years old, Kyiv)
SEXUAL HEALTH SERVICES

COVID-19 disrupted access to testing for sexually transmitted infections and reduced access to condoms and lubricants.

The quarantine has severely limited access to treatment of sexually transmitted infections (STIs). Most of the STI dispensaries did not work during the strict quarantine. Also, access to sexually transmitted infection diagnosis was limited. Some members of the [men who have sex with men living with HIV] community had to look for doctors through personal contacts and arrange for the treatment of gonorrhoea and syphilis. There were also problems with the diagnosis and treatment of viral hepatitis.”

(Petro, male, 38 years old, Kyiv)

People are newly diagnosed with HIV each day and they may need condoms and lubricants. But these supplies are limited and this creates a risk of HIV infection spread.”

(O.A., woman, 34 years old, Donetsk)

Unfortunately, there is no access to such services as condoms, lubricants, pregnancy tests dispensing, medical examinations and ... testing.

Condoms can be received only from social workers of the NGO, 100% Life.”

(Natalia, woman, 44 years old, Kharkiv)

During the period from 2019 to October 2020, the doctors of the AIDS centre never offered a gynaecologist examination and cervical cancer screening (according to the protocol, it should be done every six months). And there are no contraception or family planning consultations offered for HIV-positive people who are not members of vulnerable groups. Sex workers say there is lack of transport and the inability to get to places of sexually transmitted infection testing and condom distribution. The HIV-positive girls I know said that access to abortion was a big problem during the quarantine period because all the planned surgeries were cancelled, and abortions were classified as planned interventions. Also, the lack of transport was a big problem as regards getting to hospitals.”

(Valeria, woman, 39 years old, Kyiv)

Tests for sexually transmitted infections are not provided at all or are out of stock. It was impossible to get a gynaecologist examination during quarantine unless it was an emergency.”

(N.B., man, 42 years old, Kyiv)
FIGURE 20: Reporting of reduced access to STI treatment. Naminda, a 23 year old living in Mityana in rural Uganda, captured a significant decline in the quality of and accessibility to medicines for STIs in her facilities.

REPRODUCTIVE HEALTH, POSTNATAL AND ANTENATAL CARE

Women faced barriers in accessing pregnancy testing and other reproductive health services and perinatal care during the height of the COVID-19 pandemic.

Participants reported that before COVID-19, they were able to get good antenatal and postnatal care, including immunizations (tetanus for mothers and other basic vaccines for newborns). However, during COVID-19, health facilities limited their hours of operation and limited the number of recipients of care inside clinics. Further, people were unable to get to perinatal health services because of limited public transportation and curfews and lockdowns prohibiting travel.

“[A woman living with HIV] gave birth to a child about three weeks ago and was at a maternity ward. According to the rules, the baby must take the drops for some time after being born [to a mother living with HIV]. At this time, it turned out that the maternity ward workers were not fully provided with personal protection equipment: special suits, masks, shoe covers, etc. As a result, some of the medical staff refused to work until the issue was resolved. This woman had to go back home with the baby earlier and look for the necessary medicines she previously hadn’t planned to buy in pharmacies on her own. She asked if she could take home some medicines, which her baby was provided with while staying at the maternity ward; she was ready to pay for them. However, the woman was refused in an inappropriate form, being told that it’s impossible to have enough treatment for all [mothers with HIV]. (‘We shall never have enough for AIDS mamas’). I want to emphasize that she doesn’t have the AIDS stage.”

(O.A., woman, 34 years old, Donetsk)

“The big difficulty is that we’ve often heard has been that women don’t have access to pregnancy testing or perinatal consultations during quarantine. Women were advised to go to their
family doctor. And another problem has been for women who [live with HIV] or who have addiction issues. There is stigma, condemnation, and women are dissuaded from giving birth as they are considered to be bad mothers.”

(Yu.O., woman, 54 years old, Odessa)

POOR OR BLOCKED ACCESS TO HEALTHCARE SERVICES

Recipients of care faced bureaucratic, financial and logistic hurdles in accessing HIV services and health services in general as the focus of health resources were redirected to managing COVID-19.

During the pandemic, health services, including HIV services, were redirected to managing COVID-19, which created bureaucratic, financial and logistic hurdles to accessing care. For those who found their way through these hurdles and succeeded in procuring clinical consultations, the hostile treatment received from healthcare workers was a final deterrent to future, persistent access to HIV care as long as COVID-19 restrictions were in place.

Participants in Vietnam and Indonesia reported that healthcare workers refused to touch them physically and appointments lasted for just minutes. In Ukraine, people living with HIV turned to the private sector for medical care, while those who were unable to afford this simply went without medical check-ups.

In Uganda, out-of-pocket charges for healthcare increased drastically during COVID-19, with illegal charges made even for antenatal care. As an HIV activist explained: “COVID has become the survival of the fittest, and healthcare workers are taking advantage, asking for money for services that are meant to be free.”

(Personal correspondence, 7 December 2020)

FIGURE 22: A Ugandan woman describes the impacts on other healthcare services when the prioritization of solely COVID-19 has closed or reduced access to other medical services.

Unfortunately, there are cases when a person with a fever was not allowed to enter the hospital. On the one hand, this security measure can be understood. However, if a person cannot wait for a family doctor, the ambulance is not available, there are no clear instructions on how to take medication without a doctor’s examination, the condition only worsens – where shall he go to? Self-treatment is harmful, but there is no way out. People buy what they
consider might be helpful, thus leaving those really in need of specific treatment without necessary medications.”

(O.A., woman, 34 years old, Donetsk)

“... My response to this question just hurts. It was impossible to receive a consultation with a medical specialist during quarantine. The polyclinic registry was saying that the doctors weren’t working, that it was only family doctors who were working. And the worst thing is that now it is simply impossible to get a house-call medical consultation. After the quarantine was lifted, medical specialists were back to work, but there is a very high degree of stigma in polyclinics and in hospitals, and therefore [people who inject drugs and people living with HIV] go to doctors in urgent cases only. And now it has become impossible to take tests. It used to be free of charge. Now there are price lists specifying the cost of each test in the offices of family doctors. And it’s not a small sum!”

(Yu.O., woman, 54 years old, Odessa)

“... Termination of public transport became an obstacle in receiving services. And when the quarantine was introduced, nobody cared about transgender people at all. A special hostility towards ... transgender people was observed. Trans sex workers who are practising chemsex do not have access to quality sexual and reproductive health services in Kyiv. Amidst the COVID-19 pandemic, an outbreak of syphilis was detected and new cases of HIV were diagnosed in Kyiv and the Kyiv region. Those trans sex workers who were in crisis situations had no opportunity to get to healthcare facilities to get syphilis and HIV treatment due to the COVID-19 quarantine and public transport termination.”

(I.O., 36 years old, transgender/non-binary, Kyiv)

ACCESS TO MENTAL HEALTH AND SUBSTANCE USE SERVICES

COVID-19 increased needs for mental health services among people living with HIV, but services to address mental health and addiction issues were severely curtailed during the pandemic.

The quarantine conditions in orange and red zones across Ukraine, social distancing and self-isolation are intensifying the negative effects of COVID-19 on the mental health of sex workers. Community representatives have reported an increased frequency of depression and suicidal thoughts.
And at the same time, such mental conditions create a situation in which people don’t care about health at all, thereby increasing the potential transmission of HIV. In these difficult circumstances, chemsex workers take drugs more frequently than usual.”

(I.O., 36 years old, transgender/non-binary, Kyiv)

FIGURE 21: Reported reduced support for mental health in Uganda.

In settings of injection drug use and harm reduction services (in particular, Ukraine), participants reported precipitous challenges to the continuity of harm reduction services, in particular opioid substitution therapy.

On 1 April 2020, the city’s TB service, where many patients received opioid substitution therapy (near home), was shut down. Redirection to new sites and the lack of public transport at the time have significantly worsened the quality of life of those patients who are receiving opioid substitution therapy.”

(Alla, woman, 42 years old, Odessa)

What happened when strict quarantine measures were introduced was that the [opioid substitution] drugs were provided to everyone for 10 days, and people met only once every 10 days, which was great. But the clients of the programme who live outside the city were not able to get to the site. Many suburban minibuses and buses did not run, the only possible way to get to the site was by taxi, which was financially burdensome. The worst thing is when they get sick with COVID-19. And if a person gets hospitalized, no one will bring him opioid substitution therapy. Therefore, they come with a high temperature, keep silent and are afraid to confess [if they have COVID-19 symptoms].”

(Yu.O., woman, 54 years old, Odessa)

Many patients who are taking opioid substitution therapy were forced to spend money, which is not always available, on taxis because public transport either did not run at all or was under restrictions for passengers. Some patients walked a long distance from home to the sites, for example, from the left bank of Kyiv to their site on the right bank. Medicines were provided for five days, the dosage was reduced for some patients, and medical workers tried to manipulate patients using intimidation.”

(N.B., man, 42 years old, Kyiv)
The situation with drugs, especially antibiotics, has deteriorated significantly during the introduction of quarantine limitations. Sometimes there are even no antipyretics available at the pharmacy. People are massively buying ibuprofen, paracetamol, etc., not being even sure that it will help them. I also want to point out that there is an acute problem with drugs that are used for coronavirus treatment. They are not available in adequate quantity; for a few days, they were lacking. Patients with COVID-19 were left without medication. The number of patients who needed mechanical ventilation has increased, as well as the number of lethal cases.”

(Alla, woman, 42 years old, Odessa)

During the quarantine period, prices for personal protective equipment have risen sharply. Many patients have purchased one mask and wear it for months until it tears apart. Medical facilities are provided with them mainly by volunteers who are purchasing personal protective equipment. To date, there are no free places in hospitals (even for patients with oxygen saturation levels lower than 90 per cent). Patients in serious conditions who are staying at home and whose PCR COVID-19 test will be taken by a mobile clinic are waiting more than two weeks for diagnosis to be conducted, and then two weeks for the results (there is only one laboratory where PCR analysis can be made). During this time, their relatives are not staying in self-isolation. Patients in hospitals are waiting at least seven days for test results. There is no oxygen in hospitals.”

(Alla, woman, 42 years old, Odessa)

Job and food security was negatively impacted by COVID-19; income loss from widespread unemployment led to growing hunger among participants. The added stress also led to increased incidents of violence and abuse.

HARDSHIP

For many participants, concerns about continued access to HIV medicines and other healthcare services were eclipsed by
worries about food scarcity, job losses and precipitous increases in the cost of living. The experiences of participants in Uganda, whose incomes were the lowest among partners, were the most extreme. NAFOPHANU’s age range for participants was 17-24 years and it chose to focus on young women who were pregnant or had recently given birth, representing a key population for people living with HIV in Uganda. As NAFOPHANU colleagues lacked the capacity to translate the rapid assessment from Baganda to English in the short period available for the rapid analysis (six weeks for primary data collection), they chose to sample only participants who could communicate in English. NAFOPHANU’s 18 participants therefore represented young, educated Ugandan women. But every one of these participants had lost her job and income during the COVID-19 lockdown. The result was growing hunger, coerced resettlement with families who were abusive and, in one case, a forced marriage to a violent boyfriend as the participant’s family could not afford to support her and her child.

"During COVID, it has been very difficult since we are no longer working, yet our residences are far ... apart from that, we are no longer working to sustain ourselves with transport and meals."

(Jesus, woman, 22 years old, rural Uganda)

"During COVID, it’s not easy to get money to buy food and stock it at home; hence we miss food for lunch so that we get supper some days."

(Woman, 24 years old, with baby, currently lactating, urban Uganda)

**FIGURE 18:** Reporting of food insecurity. “Before COVID, we were able to get food in time because we were working and we eat three meals a day. In COVID, to look for food was difficult, to even to get just one meal.”

**FIGURE 19:** Reporting of food insecurity. This response draws a direct connection between a reduced income, food insecurity and challenges in accessing health services. It states: “Our businesses were locked down, so we moved on foot to the hospital, which was tiresome with no food.”

In all locations in the rapid assessment, participants drew direct links between COVID-19, income reductions and violence. As stated bluntly by V.S., a 41-year-old man from Kyiv: “Quarantine = borders closures = discontinuance of work = earnings are suspended.”
Due to insufficient income, my husband became violent ... COVID-19 worsened the abusive situation I am under because of the mistreatment from my husband.”

(Woman, 20 years old, Kampala)

Many of my acquaintances have lost their jobs. Many cannot afford to buy food. One mother of many children (who is single), living with HIV, was compelled to sell the refrigerator because there was nothing left to feed her kids with.”

(Alla, woman, 42 years old, Odessa)

Many were simply ... kicked out from work. People were grabbing any part-time jobs. When there is nothing to eat, the problems and worries about the coronavirus are left aside. Many were simply trying to survive.”

(Yu.O., woman, 54 years old, Odessa)
RECOMMENDATIONS

The following are the core priorities and recommendations developed collectively by the project partners and team across the four countries:

**TREATMENT EDUCATION**
- Government public health authorities should ensure that communities have access to basic, accessible health information on how to prevent acquiring COVID-19 and what actions to take in case of acquisition so that they can make informed decisions about their health.

**COMMUNITY ENGAGEMENT**
- Ministries of health should promote meaningful community engagement in national COVID-19 responses, particularly in decision-making forums to ensure that the needs of people living with HIV, key populations and disenfranchised populations are adequately taken into account in policy decisions.

**COMMUNITY-LED SERVICES**
- Community-led and community-based organizations have demonstrated resilience and adaptability in filling service delivery gaps. Governments should expand social contracting to equip community organizations to provide tailored, inclusive, acceptable, stigma-free services that cater to the specific needs of people living with HIV, key populations and disenfranchised sub-populations.
- Governmental social contracting to community organizations to support people living with HIV with their healthcare-related needs should include flexible funding to address social and economic needs resulting from COVID-19, such as food insecurity, joblessness, and increased substance use and physical violence.
- When governments implement population-wide public health measures, such as curfews and lockdowns related to COVID-19, they should take into consideration people who are on long-term medication and build structures to ensure continued supply of medication and access to needed commodities. This could take the form of community ART delivery for selected individuals living with HIV.

**QUALITY, COMPETENCY AND CONTINUITY IN TAILORED, HOLISTIC AND INTEGRATED HEALTH SERVICES**
- Governments should ensure reliable supply chains for test kits, laboratory supplies and medicines to prevent disruptions of routine health screenings and testing services, medical care and treatment, and prevention services.
- Multi-month dispensing, community adherence groups and other
differentiated service delivery models should be encouraged to support adherence and prevent disruption in ART access for people living with HIV.

- Prioritization of access to COVID-19 tests and care should not come at the expense of other vital health services. The continuity of prevention, treatment and care for HIV and related conditions should be maintained.

- Governments can and should maintain principles of infection control while maintaining standards of care in healthcare provision, such as person-centred approaches to care.

- Governments should prioritize a person-centred, integrated, non-siloed model of care for HIV, co-infections and sexual and reproductive health services to minimize the burden on people living with HIV in accessing the healthcare they need without engendering additional costs.
CONCLUSION

The COVID-19 pandemic is an unprecedented challenge. Many of the health and development gains of the past two decades, realized through sustained advocacy and commitments to public health and human rights, have been threatened by the impacts of this new disease. Much of the ground that had been claimed for global initiatives to tackle health inequities has been lost, at least temporarily, either directly through COVID-19’s effects on morbidity and mortality or indirectly through its economic fallout.

This rapid assessment documented negative effects of COVID-19 on access, availability and affordability of HIV testing, prevention and treatment. Although multiple locations initiated multi-month dispensing of HIV treatments and of HIV pre-exposure prophylaxis (PrEP), the documented challenges included the following:

- COVID-19 disrupted medicine procurement and supply chains, causing stockouts and reducing consistent availability of essential medicines and diagnostics.
- Due to COVID-19, health facilities were closed, the number of recipients of care allowed inside facilities were restricted, non-essential healthcare services (defined broadly and enacted differently within every location in this project) were suspended, and curfews and lockdown restrictions, while needed to curb the spread of SARS-CoV-2, limited access to HIV prevention and treatment services.

Across all sites in the rapid assessment, participants recounted their fears of acquiring COVID-19 if they went to health facilities or accessed health services, meaning that they refrained from accessing a broad range of routine health screenings and testing services, medical care and treatment, and prevention and support services.

As a result, people living with HIV delayed treatment initiation, experienced treatment interruptions, and were forced to switch treatment regimens. Key populations were unable to access prevention services, such as testing and treatment for STIs and opioid substitution therapy. Women in need of pregnancy testing and perinatal care, including medicines to prevent HIV acquisition among newborns, were unable to access these services.

For the epidemics of HIV, TB and COVID-19, the world has effective low-cost medicines for treatment and prevention, evidence-informed and effective interventions, and other tools to control widespread transmission and prevent premature deaths and disability. But these products and programmes must be made available, accessible and affordable, and people most vulnerable must understand these services as relevant to them and responsive to their immediate needs.
Recipients of care and their communities are a first and central resource to address this public health challenge. This rapid assessment has shown that recipients of care can usefully describe gaps in access to essential health services – including routine health screenings and testing services, medical care and treatment, and prevention and support services – and can showcase disparities in health and human rights.

Through community-led monitoring and related advocacy, recipients of care can also provide valuable support to health providers and government health authorities to “build back better” in a post-pandemic landscape and better tailor prevention and treatment services to population needs, achieve higher rates of utilization and retention, and produce better population-level health outcomes with more effective and efficient use of resources.

Improvements in the quality and effectiveness of health programmes in ensuring positive health outcomes would hasten achievement of the Sustainable Development Goals. A major push to finally end the HIV and TB epidemics is needed to deliver humanitarian and health security benefits for the world.


9 Personal correspondence, Do Dang Dong (Vietnam) (21 November 2020).


This rapid assessment and report was managed by ITPC through Watch What Matters, a community-led monitoring and research initiative to gather data on access to and quality of HIV treatment globally.