AFRICAN CONSTITUENCY BUREAU
FOR THE GLOBAL FUND

Foreign, Commonwealth & Development Office

A VIEW FROM WITHIN: IMPACT OF COVID-19 ON **HIV, TB, MALARIA** PROGRAMMING IN AFRICA

1 SERIES

SHARING OF EXPERIENCES, CHALLENGES AND LESSONS LEARNT IN MAINTAINING HIV, TB AND MALARIA SERVICE DELIVERY IN THE FACE OF THE COVID-19 PANDEMIC

BACKGROUND

In Africa, **the first case of COVID-19 was reported in Egypt on 14th of February, 2020.**[1] By March 2020, several countries had started implementing stricter control measures that include lockdowns, curfews, schools closure, ban on large gatherings (e.g. religious, sports, funerals, and other social events), systematic quarantines, and strict infection control measures.[2] **On 11th of March, 2020 the World Health Organization declared COVID-19 as a global pandemic.**[3] By 2nd July, 2021 09:00 GMT, 182,101,209 cumulative cases had been recorded worldwide with 3,950,876 cumulative deaths. Of these cumulative figures, Africa accounted only 2.2% of the cases and 2.4% of the global deaths.[4] In the midst of the COVID-19 pandemic, Africa makes **'a special case'** in that the continent has a fragile health system and globally, it bears the most of the HIV and malaria burden. In response, **the Global Fund introduced the COVID-19 Response Mechanism (C19RM) to help mitigate the impact of the pandemic on HIV, TB and malaria (HTM) programs.**[5] This write-up shares country experiences, lessons learnt and best practices in maintaining HTM service delivery in the face of the COVID-19 pandemic.

APPROACH

With funding support from the **Foreign, Commonwealth & Development Office,** the African Constituency Bureau for the Global Fund conducted a series of virtual sessions with countries in the East and Southern Africa and the West and Central Africa constituencies. This was between November 2020 and June 2021 in order to document experiences, share lessons learned and best practices in accessing the C19RM support and maintaining HTM services while mitigating the adverse impact of COVID-19. Topics for discussion were diagnostics and treatment, supply chain management, health financing, human resources for health (HRH), adolescents girls and young women (AGYW), and COVID-19 vaccination. During each session, three pre-selected countries presented their experiences on a given topic, then this was followed by plenary discussions. An in-depth analysis of each of the above topics is currently being shared separately through a series of factsheets.

COUNTRY EXPERIENCES

Access to the C19RM during the first phase of the country application was flexible and less bureaucratic than it is in the second application. The funds were used to support procurement of personal protective equipment (PPEs) for health workers (HWs), capacity building, COVID-19 diagnostic tools, strengthening laboratory networks, supply chain management, mentorship and addressing critical gaps in community health systems. Country priorities for 2021 however fast changed to a surging demand for oxygen supplies and other related accessories. Additionally, countries faced challenges with the lengthy procurement processes, with some resorting to wambo.org while others turned to international or local procurement mechanisms. Countries that went for external tendering experienced delays in obtaining tax waivers/exemptions for COVID-19 commodities, while local tendering attracted lengthy and bureaucratic processes (such as, issues of quality standards, limited number of potential suppliers, available quantities, etc.).

The moratorium on restricted movements brought in challenges related to accessing transport to travel to health facilities for routine medicine pick-up. Specifically for the HTM, community outreaches were suspended and the effect cascaded down to almost a 50% drop in TB notifications rates, HIV testing, access to antiretroviral, and the distribution of mosquito nets among others. Sample transportation and lab capacity were massively disrupted, and it led to long-turnaround time to churn out viral load, EID or TB results. The capacity of the health system to deal with the pandemic was further weakened as some countries experienced closure of accreditation schools such as those that offer quality control HTM trainings. The low ratio of HW to patient in most countries resulted in burnout to the already overburdened HW, thereby further affecting the quality of health services.

[1]The WHO Regional Office for Africa. (2021). COVID-19 cases top 10 000 in Africa. Available from https://www.afro.who.int/news/covid-19-cases-top-10-000-africa

[2] International Monetary Fund. (202). Policy responses to COVID-19. Available from: https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19

[3]World Health Organisation. (2020). WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020. Available from https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

[4] World Health Organisation. (2021). WHO Coronavirus (COVID-19) dashboard. Available from https://covid19.who.int/table

[5]The Global Fund. (2020). COVID-19. Available from https://www.theglobalfund.org/en/covid-19/response-mechanism/

Despite these challenges, COVID-19 presented opportunities to countries to strengthen infection prevention and control measures, particularly for TB. The moratorium forced governments to hire additional HWs and other related personnel (laboratory and pharmacy technicians, nurses, data clerks) to sustain service delivery, while in other instances, nursing and medical students, and other volunteers were deployed to strengthen service provision. A call for service integration became apparent and even grew louder for countries to efficiently use the available limited resources.

Key lessons learnt

- Timely disbursement of funding is critical as priorities articulated now during the funding request may change by the time funds are disbursed. For example, towards the end of the first phase, there was a surge in demand for oxygen as opposed to PPEs which COVID-19 started;
- Carefully assigning duties and responsibilities within the health facility is key to ensuring seamless delivery of service. The delivery of COVID-19 vaccines itself was a mitigation measure for it ensured HTM services remain on course; however, the delivery of the vaccine led to the assigning of the already understaffed and overworked HWs to also support the vaccination programme hence introduced service delivery gaps;
- COVID-related stigma and reluctance for HWs to attend to people suspected of having TB or malaria was rife since the symptoms at the onset of the infections are almost similar. Capacity building is therefore required for staff not only to prioritise one diseases condition at the expense of the other. For example, community screening for presumptive TB was affected because COVID-19, also a respiratory-related health condition, received the most attention. Continuous capacity building is therefore key;
- COVID-19 exacerbated gaps in availability, distribution and quality of HRH, a wake-up call for countries to recruit, expand and retain multi-skilled staff who can better manage an array of health care services. Shifting around of HTM officers to cover other service points such as immunisation did harm to the program as some officers were not adequately trained to document the many registers that come with the programs;
- Anecdotal evidence suggests that out-of-pocket-expenditures increased drastically among patients on chronic conditions such as those on HIV or TB treatment, mostly arising from additional measures to procure PPEs to protect self and the family. There are compelling reason to undertake studies to determine the level of catastrophic costs that may be associated with the TB programme;
- Outreach services such as voluntary medical male circumcision and interventions for AGYW were suspended and this led to low uptake of HIV services. Yet in Sub-Saharan Africa, close to 59% of HIV infections occurs among the AGYW. It is important therefore to use existing evidence to guide programming even when faced with a dire programmatic situation;
- Repurposing of laboratory equipment can ensure testing of HTM, COVID-19 and other health conditions continue to happen at the facility; and
- Partnerships are an effective tool for continued services. In some countries, partnerships were created with institutions of higher learning to help strengthen in-service training for improved coverage while in other countries,

telecommunication companies provided data relief to facilitate online communication across health facilities and labs.

Some best practices

- Establishment of a solidarity fund entirely set up and supported through public-private partnerships, and also wholly owned by the country provides relief to the most vulnerable as the fund can take care of the quick gains such as user-fees (consultations, diagnostics and treatment);
- Proactive registration of priority groups, including people living with HIV, those with TB or living in malaria endemic zones well ahead of the COVID-19 vaccination helps to reduce disruption of services;
- Differentiated service delivery such as multi-months prescribing of HIV/TB medicines, say for 3-6 months in advance, decongests health facilities and in the process the likelihood of patient exposure to COVID-19 is greatly reduced;
- Equipment repurposing could potentially better manage future outbreaks. For example, the Gene Xpert machines for TB testing can be used for COVID-19 testing thereby reduce idle time; and Instead of using couriers, the use of activated electronic systems speeds up results notification to peripheral health facilities, thereby improving clinical management of the patient.

IMPLICATIONS FOR POLICY

Experiences from the COVID-19 pandemic underscore the importance of decentralisation of health services to decongest patients at health facilities and promote equitable access to services. Advocating for domestic resource mobilisation and establishing resilient and sustainable systems for health make a stronger case for sustainability. The C19RM has made the case for effective coordination to promote technical efficiency and even a louder call for integration of services.

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