COVID affected access to HIV treatment: The stories of migrant women in South Africa show how

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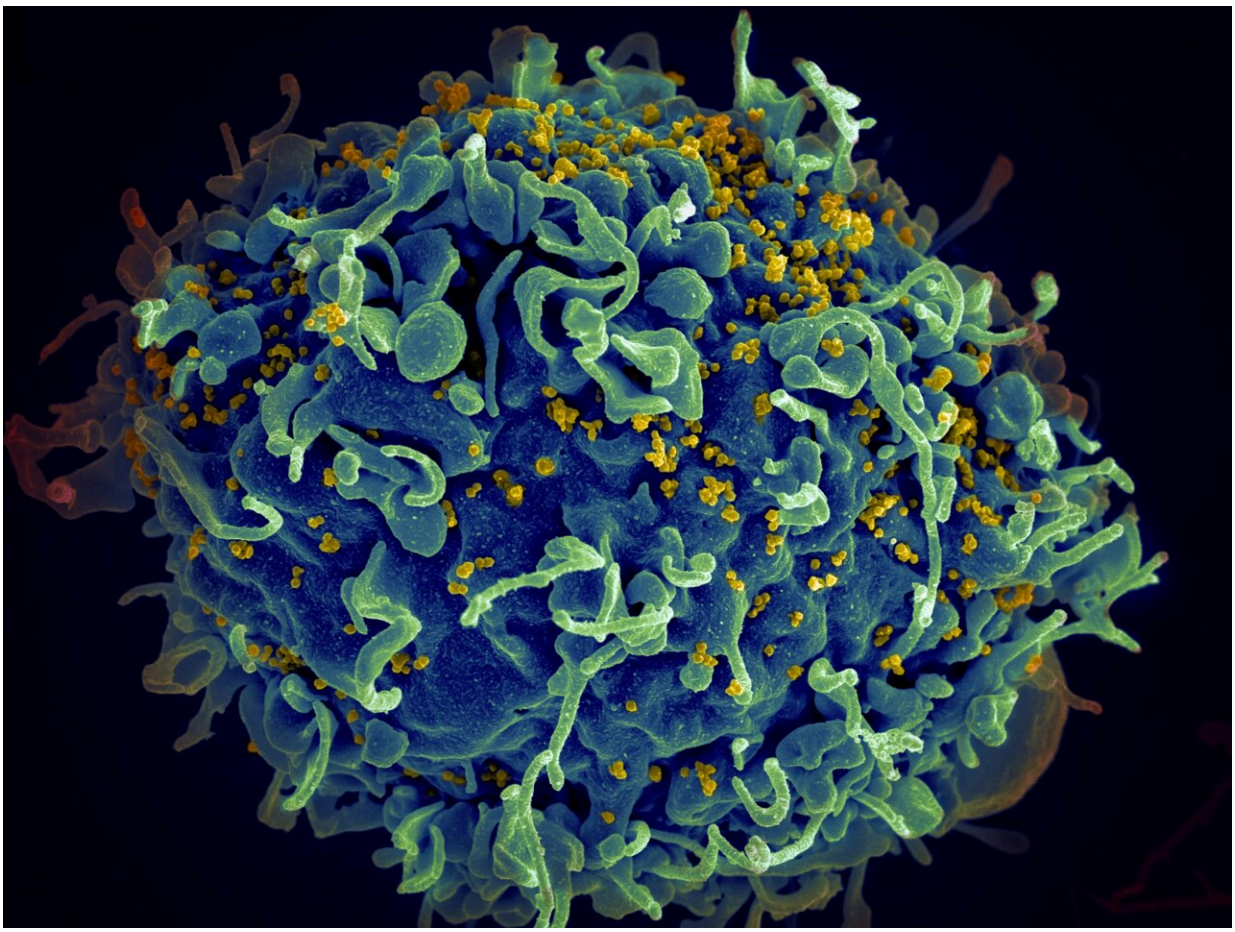

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South Africa has made massive strides in the fight against HIV. One of the country's flagship interventions has been the prevention of mother-to-child transmission (PMTCT) of HIV. Nevertheless, South Africa still has the world's largest HIV epidemic. It's estimated that 7.5 million people in the country have HIV. Women of reproductive age account for more than half of this number—4.8 million.

Prevention of mother-to-child transmission of HIV requires pregnant women to take life-long antiretroviral therapy (ART) to prevent the onward transmission of the virus to their babies during pregnancy, birth or breastfeeding.

But one of the challenges is ensuring that women stay on treatment. When life gets in the way, it can cause an individual to temporarily disrupt taking ART routinely. Treatment interruptions can occur due to many reasons. These include mobility, side effects, stigma, disclosure and not being able to get time off work to visit the clinic. Treatment interruptions can lead to the risk of HIV transmission, and poorer health outcomes for both the mother and baby.

Women with different mobility patterns who move across country borders and within a country found it difficult to stick to treatment regimens during the COVID-19 pandemic. This risk was highlighted in March 2020 when the South African government introduced lockdowns to control the spread of COVID-19. Research suggests that the lockdowns significantly reduced access to and the provision of antiretroviral treatment services. One paper put the reduction at 46% in 65 South African primary care clinics.

To understand the impact of the lockdown, we conducted research among 40 women at a public hospital in Johannesburg. All were HIV positive and migrant women on the move—crossing country/provincial borders and/or moving within the city of Johannesburg.

The aim was to find out what their experiences had been in the COVID lockdowns. We found that all had encountered serious problems accessing and adhering to treatment. They also were ill-informed about the importance of maintaining treatment regimes.

There were, however, differences between these women on the move. For women who crossed country borders, the biggest challenges included border closures and bureaucracy in accessing healthcare. Twelve women had taken ART for less than one year and were already four to eight months pregnant. This remains an alarming concern for many cross-border migrants who are newly diagnosed only when accessing available PMTCT care at a state hospital for the first time. For some internal migrants (moving within the country) the biggest challenge was the fear of being infected with COVID, which kept them away from healthcare facilities.

The stories of these women need to be shared as countries put in place plans for future pandemics. Their views are important in helping policy makers understand how to strengthen support for patients on the move.

What the women had to say

A common thread in the accounts of treatment was that most women didn't understand the need to continue treatment after they'd given birth. Most (38) of the women said they chose to take the medication to protect the health of the baby but they felt they could stop after delivery, unaware of the risk and long-term benefits of staying on treatment—for them and their baby.

This lack of knowledge pointed to the fact that with the COVID-19 pandemic and its increased burden placed on the healthcare system, the women hadn't been given the support and counseling needed after diagnosis. Some women reported they would have liked comprehensive

counseling immediately after diagnosis, especially when they started taking antiretrovirals. But often there wasn't enough space and time for thorough counseling to be done.

Most of these women knew that they had to take antiretrovirals, but could not tell us why. Although there were similarities with women on the move, some differences stood out. In the experiences of women with internal migration patterns, the big issues were interruption of treatment and missed appointments due to fears of contracting COVID-19 at health facilities; public transport to health facilities being unavailable during the lockdown; and separation of patients by HIV status, which led to indirect disclosure.

Restrictions on travel due to the lockdown affected women with cross-border migration patterns. The alarming concerns that were raised included mistreatment by staff at health facilities; discrimination and longer waiting times in queues; running out of ARVs; language barriers and not understanding dosages and side effects; lack of education and counseling; and documentation. All acted as barriers for mother-infant pairs to access care.

As one woman described it:

It was very hard. We would travel on one bus and then step off to take another one. This occurred several times. Before we arrived at the border, we were arrested. When we arrived at the border we got arrested again. Even when we had passed through the border we still got arrested … My sister had identification, but I didn't. They thought she had kidnapped me.

What can be done?

Healthcare systems must include different services that cater to the individual needs of women who are on the move.

Multi-month dispensing and the long-term supply of antiretrovirals can significantly reduce the number of clinic visits required.

Health education talks should be conducted both in person and virtually, taking advantage of long waiting times at clinics. Key messages must be conveyed in various languages and at a primary education level that patients will understand—empowering patients through information.

Online virtual educational care platforms made available in different languages can help keep women on treatment to prevent mother-to-child transmission of HIV. They can provide 24-hour services that meet the individual needs of patients on the move. This also addresses the financial and documentation challenges of receiving care.

Patients need more time for counseling, especially individuals who start treatment on the day they find out they are HIV positive. Often, it is a lot to cope with and people need time and support to process the news.

Service providers need more support in their work environments, which can help them learn how to be more language sensitive and helpful towards migrants.

Migration and health are not static. Healthcare policies that work towards inclusion and sustainability for migrants are needed to improve prevention of mother-to-child transmission.

The individual stories of patients are essential in understanding whether HIV healthcare strategies and programs are working. It's therefore important for government and policy makers to provide spaces to listen and engage with individual women, no matter what their migration journey may be.