



HIV patients torn over Uganda's shift in healthcare

As Uganda faces a sharp decline in donor funding that has long underpinned its HIV response, the government is shifting treatment from specialised clinics into general public health facilities, a move affecting more than 1.4 million people on antiretroviral therapy. While officials present integration as a necessary and more sustainable approach, patients, activists, and health experts warn that the transition is happening too quickly and without adequate preparation, raising fears of increased stigma, loss of privacy, strained health systems, and potential treatment dropouts that could reverse decades of progress in the fight against HIV.

BY ELVIS BASUDE KYEYUNE

For 26 years, Maxensia Nakibuuka has known the rhythm of survival. Every month, she makes her way to a familiar place, a clinic where the nurses know her name, where the waiting room is filled with faces like hers, and where she can collect the medication that keeps her alive without explanation or embarrassment.

But that rhythm is about to change. And for Nakibuuka, who uses a wheelchair and has lived with HIV since 1998, the uncertainty is terrifying.

"They are taking me from what I would call a family facility, a centralised place where I have been getting my medicine, and putting me in line with other peo-

ple," she says, her voice edged with apprehension. "It is inconceivable."

Nakibuuka is not alone in her fear. Across Uganda, a quiet but profound transformation is underway. Faced with a sudden funding crisis following the American government's aid freeze and reduced contributions from other international donors, the government has begun integrating HIV services into general healthcare, dismantling the standalone clinic model that has been the backbone of the country's celebrated Aids response for decades.

The move affects approximately 1.4 million Ugandans living with HIV who depend on antiretroviral treatment.

For years, the country has relied on foreign donors for more than 90 percent of its HIV response funding, with PEPFAR

alone providing an estimated \$400 million annually. That support is no longer guaranteed, and policymakers are scrambling for alternatives.

But what appears to be a necessary fiscal adjustment to some looks to others like a dangerous gamble, one that could unravel hard-won gains, resurrect stigma, and cost lives.

'We stand to lose the gains'

Prof Vinand Nantulya, a prominent Ugandan medical professional and former chairperson of the Uganda Country Coordinating Mechanism overseeing Global Fund-supported projects, issues a stark warning.

"If we go in a rush and integrate the HIV and Aids programmes into the general health sector overnight without taking caution, we shall be in trouble. We most likely stand to lose the gains we have made over the years because we do not know what the repercussions are going to be."

Nantulya notes that the health system has not been adequately prepared to absorb integrated services, nor the patients who depend on them, including healthcare workers themselves. Without sufficient planning, he fears infection rates could rise.

The former chairman of the Uganda Aids Commission sees the integration as "sentimental, wrong and misguided," arguing it could accelerate stigma if people living with HIV receive services alongside others.

Privacy is another critical concern. "In

professional ethics, you are not allowed to reveal information acquired through interaction with a patient. The Hippocratic Oath binds us," he says.

In crowded public facilities, however, disclosure can become unavoidable. Patients risk being identified by the services they seek, exposing them to stigma and discrimination.

Nantulya also draws parallels to earlier decentralisation debates, arguing that specialised care requires coordination and focus.

"The number of people living with HIV is still increasing and will continue to do so. We have to ensure they receive the services they need and maintain life expectancy. But are we able to do that without the necessary funding? No."

His solution is direct: "It is not the question of integration, it is money. The government should replace donor funding at the same level if services are to continue."

'They would rather drop medication'

As both a person with a disability and someone living with HIV for more than 26 years, Nakibuuka speaks from experience. She is also the founder and executive director of Lungujja Community Health Caring Organisation, which provides medical care and advocacy for people living with HIV, particularly women and children.

"Relocating to a facility without improving the structure, provision of transport and so on is a serious concern," she

People participate in a HIV/AIDS awareness marathon in Kampala. PHOTO/TO/FILE



Peace Anne Baguma, an HIV activist living with the virus, admits she would not have chosen integration. But with the policy already being rolled out, she feels she has little option. PHOTO/COURTESY



says, recalling how delayed diagnosis once left her with a disability caused by osteoporosis, a side effect of earlier treatment regimes.

Integration, she insists, must be matched with capacity.

"You cannot just tell me today to adjust to integration where the health workers you are bringing for me, I am not sure they have been trained in HIV and Aids issues, chronic illnesses, and women ageing with HIV. That is a very big burden to me as an individual."

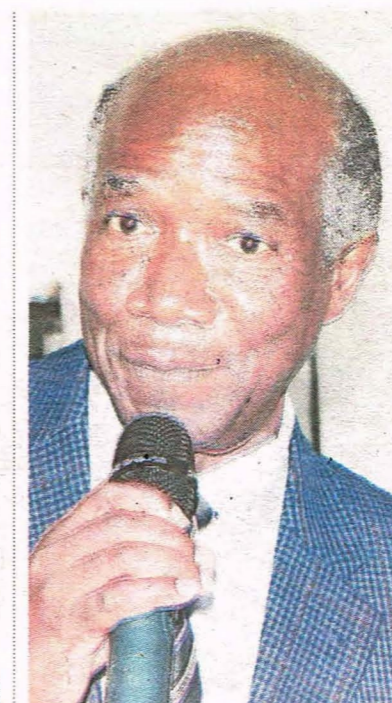
Nakibuuka has engaged communities across the country, and the message she hears is deeply troubling.

"People are saying they cannot mix with others in general facilities — they would rather drop medication."

If that happens, she warns, Uganda's ambition of ending Aids by 2030 could be derailed.

"Many are going to be lost to follow-up. Such programmes must involve us because we are the final consumers. Otherwise, this model may hit a deadlock be-

Milly Katana believes the health system has evolved enough to manage HIV as a routine condition.



Prof Vinand Nantulya says the health system has not been adequately prepared to absorb integrated services.

fore it even begins."

'I have to appreciate it'

Peace Anne Baguma, an HIV activist living with the virus, admits she would not have chosen integration. But with the policy already being rolled out, she feels she has little option.

"I inevitably have to appreciate it and see how best we improve access, utilisation and availability. I have to go to the general facility, pick my medicine and take it for my benefit."

Even so, she worries about others who may not adjust as easily.

"Some are shy and nervous. They may get lost because of stigma and discrimination," she says, predicting that some patients could drop out of care.

She also highlights existing system pressures.

"Manpower is already very low in most facilities, and that alone can hinder access. Government needs to expand infrastructure and build more space to accommodate all these patients."

'Integration is good, but it must be funded'

Dr Stephen Watiti, a prominent Ugandan medical doctor and HIV activist, acknowledges both the promise and the risk.

When standalone clinics were established, he says, they were well funded, health workers were motivated, and essential tools were available.

But with integration, realities have shifted.

"Today, you may go to a facility and be told the doctor is not there or the medicine is out of stock," he says.

He recalls working at Mildmay Hospital, where adequate funding ensured consistent, high-quality care.

"Integration is good, I must say. But it must be funded. We must accept that funding today is limited."

He notes that treatment costs have fallen significantly — to about \$200 per patient annually — and that many general health workers now understand HIV. Still, without sustained investment, service quality may suffer.

'Integration is the best way to go'

Rev Canon Gideon Byamugisha, the first Anglican priest to publicly disclose his HIV status, sees integration as both logical and necessary.

Healthcare is already integrated in

THE ROAD AHEAD

Uganda now stands at a delicate crossroads. With 1.4 million people relying on antiretroviral treatment, even a small drop in adherence could affect tens of thousands, a setback that would ripple through families, communities, and the health system.

The divide is clear. On one side are those who see integration as inevitable and sustainable. On the other are patients and advocates who fear stigma, longer queues, and the erosion of trusted systems built over decades.

Nakibuuka captures that uncertainty in stark terms: "You do not just wake up one day and bring in such a project without consulting us. This model may demotivate people from seeking treatment. Watch the space."

Whether Uganda can manage this transition carefully will determine if it protects its hard-won gains, or risks losing them at a critical moment.

'It is the right thing to do'

Dr Alex Riolexus Ario presents the government's position.

"HIV was managed separately because it was new. Now we can treat it like any other chronic illness," he says.

He argues that integration reflects changing global funding realities.

"You cannot run a standalone programme without funding. It does not make sense."

He adds that health workers are already trained to manage HIV and that integration could strengthen care for chronic diseases overall.

practice, he argues. Patients routinely access multiple services at the same facility. "The hesitation comes from stigma," he says.

"If government can address stigma, both external and internal, integration is the best way to go. It is sustainable, time-saving, and makes efficient use of resources."

He regrets that stigma remains deeply rooted decades into the HIV response and calls for renewed efforts to eliminate it.

'We cannot afford standalone clinics'

Milly Katana offers a pragmatic view shaped by years in public health advocacy.

"We cannot afford standalone clinics. They are expensive," she says.

She believes the health system has evolved enough to manage HIV as a routine condition.

"We need to build competence within communities and balance privacy with access, because specialised clinics at every level are simply not feasible."

With Uganda's population approaching 50 million, she argues, disease-specific facilities are unsustainable.

"You cannot have a health facility for each illness. Integration, with proper referral systems is the only realistic path."

No room for preparedness

Flavia Kyomukama supports the principle of integration but criticises how it has been introduced.

"It did not give room for communities to prepare. It came abruptly after the funding crisis, and people did not have a choice," she says.

She points to long waiting times and growing challenges with adherence, especially among younger patients.

"We are already seeing more people needing follow-up and more with high viral loads due to poor adherence."

She warns that the consequences could be far-reaching if gaps are not addressed quickly.

'HIV was isolated'

Jane Mwirumubi believes integration could correct past over-specialisation.

"HIV was isolated, and some health workers became too focused on it alone. Integration makes services more accessible," she says.

However, she acknowledges persistent concerns — long queues, staff shortages, and issues of privacy, equity, and continuity of care.

'This is not something new'

Dr Bernard Micheal Etukoit notes that many facilities have long managed multiple conditions alongside HIV.

"What is happening now is scale-up driven by funding constraints," he says.

He adds that the primary healthcare model supports integrated services, enabling comprehensive care at lower-level facilities.

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