

PATIENT EXPERIENCES ON CHRONIC DISEASE CARE DURING COVID-19 PANDEMIC. A QUALITATIVE CROSS-SECTIONAL STUDY DESIGN STUDY IN TWO SELECTED HEALTH FACILITIES IN MBARARA REGION.

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Abstract

Background:

Living with chronic conditions during the COVID-19 pandemic has forced a rapid and dramatic change in where, when, and how care is sought to reduce the risk of virus transmission. Several reports have confirmed that COVID-19 patients with pre-existing chronic conditions experience severe disease, worsened health outcomes, and higher mortality than those without. Lack of access to healthcare, poor treatment adherence and lack of self-care due to physical/social distancing, lock downs, and disruption in outpatient services were among the hindrances in the healthcare system despite patients living with chronic diseases requiring maximum attention and easy access to health care for proper monitoring. Therefore, important to explore the patient experiences of chronic disease care during the COVID-19 pandemic in Mbarara region.

Methods:

This was an exploratory descriptive study with a qualitative approach conducted in randomly selected health centers in Mbarara Region, Southwestern Uganda. People living with chronic diseases receiving care in health facilities around Mbarara Region were purposively sampled for an in-depth interview using an interview guide. Interviews were recorded and transcribed using verbatim in MSWord. The descriptive data analysis was done using Creswell's six-step model and transcribed by the researcher manually and keywords were identified to represent the codes.

Results:

Participant experiences during the COVID-19 pandemic were categorized into four themes: lifestyle changes, challenges faced during the lock down, experiences of the participants diagnosed with COVID-19, preventive measures taken, and lessons learnt during the COVID-19 pandemic.

Conclusions:

People with chronic conditions experienced a confluence of the COVID-19 pandemic and chronic diseases in the context of difficulty in accessing healthcare and in recommendation more research should be done to quantify the factors associated with these patient experiences

Keywords: COVID-19 pandemic, Chronic disease care, Health facilities, Social distancing, Lock down., Submitted: 2023-07-16 Accepted: 2023-07-21

1. INTRODUCTION.

Living with chronic conditions during the COVID-19 pandemic has forced a rapid and dramatic change in where, when, and how care is sought to reduce the risk of virus transmission. As of 3rd April 2022, there have been more than 514 million confirmed cases and 6.2 million deaths due to COVID-19 worldwide (WHO, 2022). In Uganda, 164000 cases and 3597 deaths (MOH Uganda, 2022). Several reports have confirmed that COVID-19 patients with pre-existing Chronic conditions experience severe disease, worsened health outcomes, and higher mortality than those without (Yadav et.al, 2020, Thakur, et.al., 2019). Hypertension and diabetes are the most prevalent comorbidities among patients infected with COVID-19 (Yadav et.al., 2020; Thakuret.al., 2020).

Even though having a chronic illness makes one more susceptible to COVID-19, patients' worsening health outcomes throughout the pandemic may be attributed to unintentional effects of precautionary measures (including lock downs) to combat the pandemic (K Singh et al., 2021). Lack of access to healthcare, poor treatment adherence, and lack of self-care due to physical social distancing, lock downs, and disruption in outpatient services, may increase exposure to chronic disease factors (Yadav et.al., 2020)

Uganda went into a nationwide lockdown on 18th May 2020 with most districts having extended the lockdown until June 2021. Later on, some districts remained in lockdown or enforced night curfews mostly those with high COVID-19 patients and those at the borderlines (WHO, 2021).

Limited socialization, panic buying, disruption in essential services, and rising fear of the unknown were a few ways in which the pandemic has had unintended adverse social, economic, and psychological consequences. Heavy disruption in outpatient services in many medical centers due to the relocation of medical personnel had im-

acted access to healthcare, particularly for vulnerable populations such as the elderly and those with chronic conditions (Yadav et.al., 2020). People living in rural areas, for whom social distancing was difficult, have experienced barriers to getting tested or receiving treatment, including stigma, anxiety, fear, panic, denial, and sleep disturbances (Friese et.al., 2020). Health services providers were at risk in the COVID-19 outbreak through various mechanisms. Clinicians and direct caregivers of COVID-19 patients have disproportionately higher mortality than the general age-adjusted population (Friese et.al., 2020). The closure of logistics-related workplaces and transport services interrupts supply lines (Chintalapudi et.al., 2020). Travel bans and reduction in public transportation limited access, and public perceptions of increased risk of SARS-CoV-2 infection near health facilities dissuade attendance, whereas clinic activities considered "non-urgent," such as antenatal care and other medical conditions were postponed (Chen et.al., 2020)

There was some effort to give attention to those with emergencies like being allowed to go to the facilities though this was still delayed by bureaucracies seeking permission from the RDCs and political influence as well as limited staffing and overwhelming numbers of COVID-19 patients at the facilities to attend to them due to the focus on the deadly pandemic. This affected the whole of Uganda and Mbarara as well yet there is scarce information regarding how patients were handled and their experiences.

During pandemics, such as COVID-19, qualitative research allows us to better understand the underlying psychological effects and changes in health-seeking behaviors and lifestyle and can provide insights into aspects of behavior and perceptions often missed in epidemiological and clinical research (Vindrola et.al., 2020). Hence, given the high burden of chronic conditions in Uganda, which are sub-optimally controlled, and the cases of COVID-19, it is crucial to use qualitative research techniques to examine how the COVID-19 pandemic has affected people with chronic illnesses. Living with chronic conditions during the COVID-19 pandemic has forced

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a rapid and dramatic change in where, when, and how care is sought to reduce the risk of virus transmission (Yadav et.al, 2020). Even though having a chronic illness makes one more susceptible to COVID-19, patients' worsening health outcomes throughout the pandemic may be attributed to unintentional effects of precautionary measures (including lockdowns) like limited access to healthcare, poor treatment adherence, total lockdown and disruption in outpatient services even though patients living with chronic diseases requiring maximum attention and easy access to health care. Several reports have confirmed that COVID-19 patients with pre-existing Chronic conditions experience severe disease-worsened health outcomes and higher mortality than those without (Shabir Ahmad Lone & Aijaz Ahmad, 2020).

Despite, the special consideration for people with severe diseases and conditions getting clearance from the Resident District Commissioner and offering transport to reach the hospital, there were still increased emergencies related to hypertension and diabetes-like cardiac attacks, hypoglycemia, and hyperglycemia respectively. Some of these contributed to increased mortality and significant morbidities in the emergency department MMRH (verbal report March 2020).

In this paper, we aim at exploring the patients' lived experiences of chronic disease care during the COVID-19-related lockdowns with the main objective of helping us better understand the challenges faced by people with chronic conditions, their coping strategies, and the social and economic impacts the COVID-19 pandemic has had on their lives. Interviews with patients living with chronic conditions in different parts of Mbarara will focus on the key challenges that were faced and the mitigators/lessons learned during the COVID-19-related lockdowns.

Although several studies have highlighted the effects and the implications of the COVID-19 pandemic on the general population mostly the economy and social well-being of the people, few studies have focused on the experiences people living with chronic diseases had during the pandemic, especially during the time of total lockdown where

accessibility to the health facility was too difficult due to limitations of transport and relaxed health workers on these patients. Further, there may be challenges unique to the context of the Mbarara Region in Southwestern, Uganda. Concerning the above discussion, it is therefore important to explore the Patient Experiences of Chronic Disease Care specifically the positive and negative experiences during the COVID-19 Pandemic in Mbarara Region to improve in health care delivery system in case of such circumstances.

2. METHODS.

2.1. Study Design.

The study used a cross-sectional exploratory qualitative approach with a phenomenological descriptive design which allowed the researcher to appropriately explore the participant's experiences of care during the COVID-19 pandemic.

2.2. Study Setting.

The study was conducted in Mbarara city council health Centre IV and Bwizibwera Health Centre IV in August and June. The HCIV provided care to people living with chronic diseases who live in the Mbarara region (city, and district), in southwestern Uganda. Mbarara district is located in southwestern Uganda with its largest being Mbarara Region. This is about 290 kilometers (180 miles) by road, southwest of Kampala, the capital and largest Region in Uganda. Mbarara is neighbored by the Ibanda district to the north, the Kiruhura district to the east, the Isingiro district to the southeast, Sheema district to the west, and the Buhweju district to the northwest. The health facilities were selected because they are the main health centers within Mbarara. Mbarara city council health Centre IV

is located in Mbarara city town near the Bank of Uganda and Mbarara city council offices and Bwizibwera Health Centre IV is located 7.9 km along the Mbarara-Ibanda highway from Mbarara city town.

2.3. Study Population.

All people living with hypertension and diabetes receiving care from the randomly selected health facilities around the Mbarara region at the time of the study were involved in the research.

2.4. Selection Criteria.

2.4.1. Inclusion Criteria.

The study included all people who lived with hypertension, diabetes, or both 6 months before the COVID-19 pandemic outbreak and receiving care from the randomly selected health facilities around Mbarara Region who consented to the study.

2.4.2. Exclusion Criteria.

The study excluded all people living who had other chronic diseases receiving care from randomly selected health facilities around Mbarara Region, those who were diagnosed with chronic illnesses less than 6 months before the COVID-19 outbreak, post-COVID season patients, and those who did not consent to the study.

2.5. Sample Size Determination.

We sampled 15 participants. The size of the sample was determined by the principle of saturation whereby the researcher stopped collecting data when the categories (themes) are saturated. (Creswell, 2014).

2.6. Sampling method.

The study used a purposive sampling method to enroll all people living with hypertension and diabetes in receiving care from randomly selected health facilities in Mbarara, southwestern Uganda. The study included 8 participants from Bwizibwera and 7 participants from Mbarara city health Centre IV with each equal probability of participation of hypertensive and diabetic clients. The purposive sampling method was used because it is the best sampling method suitable for such explorative studies.

2.7. Study variables.

2.7.1. Dependent variable.

Patient Experiences on Chronic Disease Care during the COVID Pandemic. These are encounters that patients with chronic noncommunicable diseases particularly during the COVID-19 pandemic.

2.7.2. Independent variables.

Social demographics (Income levels, address, age, Education level, Occupation). When the income levels of the patient are high accessibility to services becomes easy due to the high cost of transport involved during the pandemic. Similarly, education level directly influences experiences because a high level of education is directly associated with high health literacy which would influence positively the patient's experiences

Availability of care means that patients would easily access health services and care like home nursing.

Health facility accessibility means patients would easily access their care in the facilities

Partner involvement support involves the partners aiding in the care like reminding their spouses about taking drugs and assessing their disease status like measuring BPs and sugar levels .

- Primary outcome
- Lived experiences
- Secondary outcome
- Access to care utilization of the care
- Factors associated with the care
- Challenges faced by patients living with chronic diseases.

2.8. Data collection.

2.8.1. Data collection tool.

Data was collected through exhaustive dialogues using an interview guide which allowed probing of views from the participants. An interview guide used was adopted from a similar study in India (Johnson et al., 2020) and was

modified and validated to suit the context of our study setting by translating the interview guide into Runyankole. The questions in the interview guide were linked to the purpose of the study. As interviews continue, new questions would arise from the answers that were provided by the participants.

2.9. Pretest interviews.

A pretest interview was conducted to refine the interview guide questions and the interviewing skills of the researchers such as listening, reflecting, probing, paraphrasing, and summarizing (Grove et al., 2013). One participant was interviewed in the pretest study who met the inclusion criteria. No changes were made to the validated interview guide and the data collected was included in the analysis.

2.10. Data Collection Procedure.

The researchers engaged the relevant Unit personnel together with the professional nurses and departmental chargers that provided care to these patients to identify and request permission from participants before referring them to the researcher. The study participants were people who had lived with chronic diseases and received care from elected health facilities around Mbarara Region in southwestern Uganda. A neutral venue for participant interviews was carefully selected before the onset of interviews by the researcher. This room was separate from where other care was provided. The researchers ensured that the recorder was in good working order before the interviews with a spare one in case of a technical emergency. Extra care was taken by inviting participants in advance so that they would not disturb them in terms of missing their appointments or losing their place in the queue. Data was collected by the researcher within an anticipated time of about 30 minutes in a private room with each participant using semi-structured Individual interviews. The researchers collected data for two weeks, 8 participants from one health Centre and 7 participants from another health facility making a total of 15 participants.

2.11. The interviews.

An introduction of the study topic would be given and the objectives explained to the participant to gain permission. Upon agreement, the participant would be requested to sign the informed consent form indicating a willingness to participate in the study. To ensure participant confidentiality, the researcher applied participant codes on each participant's interview guide form instead of their names. In-depth individual interviews were used which enabled the researcher to explore all the information needed. Data were collected by conducting one-on-one interviews with the researcher in the venue that was organized by the researchers in the health facilities. The researchers built rapport with the respondents when collecting data. The interview was recorded using a digital voice recorder and the open-ended questions were asked in an informal, conversational manner which allowed the participant to talk freely about her experiences. Participants were interviewed in either English or Runyankole according to their language of preference in the two languages.

2.12. Validity of the study (Trustworthiness).

Trustworthiness was ensured by following the four principles of trustworthiness described by Lincoln and Guba (1985) in Brink, et al., (2012). Guba's model was used for trustworthiness to establish and maintain overall trustworthiness.

2.13. Credibility.

Trustworthiness was ensured by selecting only those participants who met the inclusion criteria and by following the interview guide. The researcher ensured that the participants accurately understood the questions and the research that was being conducted. Applying the strategy of credibility ensured truth value. Assurance of the truth of the data collected was established through the techniques of peer debriefing and member checks. Member checking was done during the interviews by asking the participants whether she understands correctly by rephrasing and summarizing. Peer debriefing was done by

reviewing the interview transcripts with the mentor.

2.14. Transferability.

Generalization was not the aim of this qualitative research, but a detailed understanding of the participants' experiences. To improve transferability, a purposive sample was used. Purposive sampling enabled researchers to maximize the range of information by a conscious selection of participants in terms of their attachment to the phenomenon under investigation and other background characteristics.

2.15. Dependability.

The researchers ensured in the methods were described in sufficient detail by maintaining a step-by-step "audit trail". The supervisor was function as an auditor to make sure that the information given by the participants is accurately captured. The details of the interviews were recorded using a recorder, documented, and sent to the supervisor for verification.

2.16. Confirmability.

Confirmability was ensured by representing the information provided by the participants in code form and interpretations of the data was not influenced by the researcher's imagination (Brink, et al., 2012). The researcher kept all data safe for further analysis and provide enough substantiation that the findings and their interpretation are grounded in the data by making use of verbatim participant quotations.

2.17. Data Management and Analysis.

The interviews were recorded using a digital recorder and the researcher would listen and relisten to each recording before making transcriptions. The Interviews were transcribed verbatim in MS Word. A wide margin was left on the transcript for coding and categorizing. The descriptive data analysis was done using Creswell's six-step model (Creswell, 2014) which included data logging, anecdotes, vignettes, data coding, and a thematic network to ensure proper data management and analysis. All information that was

collected from the participants through interviews was analyzed by way of gathering and generating the collected data into themes.

2.18. Ethics Considerations.

The study protocol was reviewed and approved by the research ethics committee of Bishop Stuart University. District clearance was sought from the district DHO and the City health officer.

During data collection, the participant was requested to sign the informed consent form indicating a willingness to participate in the study and they were free to withdraw from the study at any time without altering their relationship with the researcher.

3. RESULTS.

Interview participants (n =15; 9 females, 6 males) were aged between 34 and 60 years. The interviews were conducted in two health centers (Mbarara City health center IV and Bwizibwera Health Centre IV) with 7 participants from MCHC IV and 8 participants from BHC IV revealing variations in their experiences in the care (both negative and positive) they received during COVID 19 Pandemic. The participants would be living with Hypertension, Diabetes, or Both for 6 months before the COVID-19 outbreak.

3.1. Theme 1: Lifestyle Changes.

The majority of the participants highlighted that the COVID-19 pandemic brought many changes in their lives in terms of earnings, feeding habits, working time, and personal schedules. One of the participants highlighted that the pandemic made her understand the importance of having a home outside town as in the covid time she came to know that one must have at least some he/she can do outside town not primarily living in town for good.

"During the COVID-19 lock down I got to know that even when we are living in town, we must be having some agricultural land somewhere in the village. because, during the time of total lock down, you would find me and my children all in

the small house. (Female participant, 36years old)”

However, COVID-19 affected them negatively where one participant said that COVID-19 lead them to live in poor situations even up to now because of its associated effects like loss of earnings, limited working time, and strict restrictions yet they had to have money to buy drugs for their conditions

“During the lock down, you would find that blood pressure has increased and the only money you are remaining with you have to use it to buy the medications so generally COVID-19 has let us down in all forms let it be earnings and agriculture at large (male participant, 34years)”

3.2. Theme 2: Challenges faced and impacts of the COVID-19 pandemic.

3.2.1. Feelings of fear, anxiety, and stress associated with COVID-19.

The majority of participants reported fear of contracting COVID-19. However, the fear associated with COVID-19 or feelings of stress/anxiety were more commonly experienced by women than men from Bwizibwera health center IV. In Mbarara city health center IV, more men experienced fear, stress, and anxiety associated with COVID-19 than women.

“We had fear about death. When we would hear about things that are happening, we also had tension and anxiety. (female participant, 47 years old)”

Some participants were afraid of visiting the hospitals and doctors as they may contract the infection from there. Participants also reported having pre-existing chronic diseases and/or being in an older age bracket as concerning factors as they felt they may have a higher risk of getting infected.

“I was afraid of the corona, in the neighbor’s house, there was a corona. They said it will spread through the air, we have small kids in the home so, we didn’t allow the kids to play outside. As soon as we saw (them) we got fear. (female participant, 42 years old)”

In addition, most participants reported feeling stressed and having difficulty sleeping due to a loss in income. Some participants reported that they were positive for COVID-19, but there was no need to worry since they were taking all necessary precautions.

3.2.2. Impact on self-care behaviors (diet and exercise).

A few of the participants reported positive changes to their diets such as increasing their intake of vegetables and eggs. Some participants expressed that they consumed fewer non-vegetarian food items, either out of safety concerns or due to lack of availability during the lockdown.

One participant expressed that being at home during the lockdown enabled him to have regular meals on time because he used not to have daily meals due to work. Positive changes to diet were commonly reported. Participants reported finding alternatives to their exercise routines such as walking; however, no significant change was reported in terms of improving self-care and activities/hobbies undertaken during the lockdown in fear to contract covid.

“I used to go for a walk daily earlier but now I’m unable to go. Now I used to walk on our compound and sometimes on the farm. (male participant, 58 years old)”

However, most refused to indulge in any exercise during the lock down. Particularly, participants with diabetes feared going for a walk due to their underlying conditions.

“Me, I wouldn’t go for exercise because every time I make exercise, I feel like eating which is always accompanied by an injection. (female participant, 38years old).”

3.2.3. Impact on access to healthcare.

Most participants reported they did not feel the need to visit a hospital; however, those who did avoid it. There were no major striking differences observed across gender, age, or site for the following themes: access to healthcare/medicines, worsening of hypertension or diabetes symptoms during the pandemic, and CO and VID-19 diagnosis and care. Among those who accessed healthcare

reported major complaints during the lock down as doctors feared to touch them or come close to them in fear of the spread of covid.

“Even when you would get a chance to come to the hospital via many procedures, the doctors would fear to touch you or come near you, so sometimes I would get a chance to come and leave it because they seemed the same. (female participant, 48years old)”

Some of the participants expressed difficulty in accessing health facilities due to covid -19 restrictions that were put during the lock down. Others avoided visiting health facilities due to fear of contracting the infection. The few participants who tried to visit a hospital were advised against doing so by the hospital staff unless it was an emergency. Further, medicines remained out of stock at government pharmacies, particularly in Bwizibwera health center IV.

“But they say that they would give medicine only if doctors say so. But we feel afraid of going to the hospital. If we go to the hospital, then they (hospital staff) would touch us. We are afraid of this.” (male participant, 54 years old)

One participant reported that they had difficulty getting medicines from the health center, stating:

“They are saying that the medicine (stock) has not come yet. So, I asked them to write down the medicines so that I can buy from a medical shop.” (male participant, 56 years old).

Those who were unable to buy medicines themselves asked others to buy them. Unlike in other sites, participants in Mbarara city council health center IV reported getting their blood sugar tested during the lockdown by themselves or in the nearby clinics.

“For example, I would give my check myself because I was advised by the doctor to buy the machine so that I keep on checking myself but sometimes I would get challenged and go to a private clinic nearby. (male participant, 48years)”

3.2.4. Impact on employment and income.

Almost all of the participants reported that the lock down impacted their employment status and income. The self-employed participants expressed

concerns regarding their incomes as they had to shut down shops during the lock down and are experiencing fewer buyers post-lock down.

Lack of transportation to go to work was another barrier for a few participants. No such differences were observed in participants interviewed from Mbarara city council health center IV and Bwizibwera health center IV.

Others reported a reduction in income or salary despite having a job. One participant who was a bus driver reported having no work during the lockdown period, while a participant who was a carpenter reported not going to work even if there were upcoming jobs, due to fear of the difficult measures that were put in place to combat the pandemic.

“I used to have jobs to work on but because of the difficult measures that were put in, I could not even allow my customers to trust me that I will do their work because I had no access to my workshop. (male participant, 36years)”

Another participant expressed that she had to sell some ‘items’ for her family’s survival, as she was not earning an income and her son provided the only source of income from selling matooke, which too was insufficient.

3.2.5. Impact on lifestyle and Socializing.

Almost all participants reported that they reduced outdoor activities and socializing. They either avoided or were unable to attend social gatherings, such as weddings, due to the restrictions imposed by the government, lack of transport, and fear. Some participants reported that they were unable to attend to the deaths of their immediate family members.

“The rates (of essential supplies) were high (during the pandemic). Grocery shops, fish shops, vegetable shops were all charging high.” (female participant, 52 years).

3.3. Theme 3: Experience of the participants diagnosed with COVID-19.

Participants who were diagnosed with COVID-19 mostly had mild symptoms—cough and fever. The common mode of treatment was hospital admission with medication before returning home or

self-quarantining elsewhere. When asked about their treatment by doctors or hospital staff, one participant responded;

“ Doctor used to come in the morning and ask everyone personally if we are having any problem. Whether we have any headaches or body pains. Also, ask everyone personally if we are feeling dizzy or had any other problems, and he used to give medicines to everyone separately according to their problems. Covid-related medicines were given in the morning for taking 2 times a day.” (male participant: age: 63 years)

Another participant reported that she stayed in a separate room at her home and took all necessary precautions to avoid spreading her infection to other family members.

A few of the participants reported that they faced discrimination after they were cured and that neighbors stopped talking to them or behaved strangely toward them.

Everyone in the family had Corona, and I and auntie were safe. Both my son, their wives, and even my grandchildren. Only our reports were negative.

“You cannot stop someone, they might have said something, that corona has spread in the family and they should stay away from our family. (male participant, age: 63 years)”

Death was also experienced first-hand by participants whose families became infected. One participant reported that there were three deaths in their family due to the infection.

“Whoever got infected, expired. My uncle's son got infected. My aunt got infected, she expired and later my sister-in-law was infected, she too died.” (female participant, age: 48 years).

3.3.1. Theme 4: Preventive measures taken during lock down or mitigators.

Almost all participants reported undertaking the three main preventive measures: using face masks and maintaining social distancing, keeping personal hygiene, and cleaning vegetables, fruits, and other grocery items. Some participants also reported using gloves or face shields to protect themselves when they went out. An increase in frequent hand washing and the use of sanitizers

was reported. Some participants emphasized that they practiced taking a bath as soon as they returned home.

“When going out then it is like washing hands with soap and wearing a mask also. I have to be away from people while talking to anyone and keep a distance of 2–3 feet. I had stopped doing handshake and then it is like when I come from outside, I will wash the hands and face with soap and water.” (Male participant, age: 45 years)

Most participants reported that they avoided leaving their homes unless necessary. A few participants mentioned taking other measures such as steam inhalations and drinking herbal juices, and hot water. One participant, a driver, reported that he always kept a mask on while driving and asked his passengers to do the same.

3.3.2. Theme 5: lessons learnt from the pandemic.

Almost all participants stressed the continued importance of wearing masks, washings hands, or using sanitizers in case of any other pandemic in the future. While some participants expressed not having given any thought to how things would be post-pandemic, most participants expressed that they considered the changes brought by the pandemic positively and that they embraced the improved practice of cleanliness.

When asked if anything positive happened because of the pandemic, one participant responded,

“For me through this pandemic, I have learnt that all we need is work hard and have some that you are sure of that can cater for you and your family for some good time .” (female participant, age: 53 years)

Some participants reported that they experienced less pressure due to the COVID-19 pandemic and were able to spend more time with their families. Almost all participants said they would continue having time with family their members even post-pandemic.

“During this pandemic, I learnt that family is a beautiful thing to spend time with, for example, I had never spent a whole full week with my whole family, but during covid, I was forced to stay home for more than 6months and during that time, I got

a chance to understand my 2 beautiful kids and the Mum. (Male participant, 34 years)”

4. Discussion of the Research Findings.

To the best of our knowledge, this study is among the first studies to investigate the lived experiences of patients with chronic conditions during the COVID-19 pandemic in southwestern Uganda and the impact it had on their health, social and economic well-being using qualitative research methods. We summarized our findings into five themes: Life lifestyles, Challenges faced during the COVID-19 pandemic, experiences of participants diagnosed with COVID-19, preventive measures taken, and lessons learnt from the pandemic.

The underlying feeling of fear, anxiety, and stress associated with Covid 19; the impact on self-care, impact on income, employment, and lifestyle; and the threat of contracting the virus contributed to unfavorable emotions like dread, worry, denial, tension, and rage. These findings were in line with previous studies (Roy et al., 2020; Nilima et al., 2021). In this study, participants reported fear, anxiety, and other mental health implications could be attributed to loneliness due to a lack of social interaction, misinformation, and information overload through media/social media platforms (Yadav et al., 2020).

In the present study, It was found that participants from the rural area experienced difficulties in accessing healthcare or medicines, which is consistent with previous studies that suggest rural areas face more severe impacts during the pandemic in comparison to urban areas due to a lack of healthcare facilities, as well as a low physician-patient ratio (Kundu et al., 2020). The pandemic economically impacted most participants, whether it was due to a lack of employment, reduction in salary, or market inflation, and the impact was found to be similar across the two study sites. The impact on the lifestyle of participants was explicit as well, with most participants reducing socializing, especially in outdoor settings.

Participants infected with COVID-19 reported experiencing discrimination from neighbors af-

ter they recovered and this sheds a light on the issue of stigma related to the disease. This study though did not quantify the number of participants that were affected. Such behaviors of stigmatization have also been previously reported-‘The increasing frequency of the negative social trend of stigma is causing a significant barrier to social inclusion and treatment delivery. When a person is reported as positive for COVID-19, he/she is sometimes singled out, blamed, and can be asked to leave the locality; but how stigmatization and negative behaviors affect the mental health of those infected needs further exploration (Kundu et al., 2020).

In the current study, a significant difficulty of the pandemic was a rise in indoor time, which was responsible for the growth in prevalent risk factors for long-term illnesses such as lack of exercise, stress, increased use of alcohol/substance abuse, or inadequate access to medicines (Thakaur et al., 2020). This study reports only an increase in sedentary lifestyles. Negative feelings such as stress, anxiety, and lack of sleep were reported. Recent studies highlight that the largest percentage increase in excess deaths was noted in vulnerable and marginalized populations, particularly among those with mental health problems. Negative health consequences are frequently attributed to factors like isolation or confinement, social exclusion, economic closures, and increased stress from dealing with a pandemic. (K Singh et al., 2021) People living with chronic conditions are experiencing a syndemic in which the COVID-19 pandemic exacerbates their pre-existing chronic condition, already occurring alongside other potentially marginalizing sociopolitical and ecological factors, which contribute to poor health outcomes. This syndemic phenomenon has been reported further countries like Brazil, Italy, Spain, Pakistan, and the USA. (Thakaur et al., 2020; Mendenhall et al., 2020; Islam et al., 2021) .

To better aid people with chronic conditions in overcoming impacts of the pandemic, particularly for the elderly, basic interventions like providing more time and attention to people living with chronic diseases can be applied using innovative digital healthcare solutions such as mHealth,

education/training on self-monitoring of blood pressure and blood glucose at home involving trained non-physician health workers. Further, those at high risk should be actively encouraged to monitor their symptoms, and practice self-care, adhere to medication. When receiving health-care is hampered by mobility issues as well as a deep dread of catching the virus, it may be helpful to provide details about self-managing of long-term illnesses and COVID-19 through short messages and social media channels. (Yadav et.al, 2020). Recovered patients with COVID-19 should be encouraged to spread information on health and self-care management and help lessen the stigma around the disease. Encouraging people to spend more time with the elderly and children as well as learning to avoid misinformation related to COVID-19 circulating on social media platforms can be effective on how to stop feeling lonely, stressed out, or anxious.. Initiatives for interventions regarding mental health awareness during the pandemic have been pursued by various state governments in India. Broadcasting these on regional news channels or through text messages can be effective strategies and improve outreach (Roy et al., 2020). Recognizing the 'syndemic' and 'reciprocal effect' COVID-19 and chronic conditions have on each other, there is a need to address misinformation and fake news, especially on social media, as it fuels fear and panic.

In the present study, participants reported having had difficulty accessing health services and that even when they would get a chance to reach out to the hospital, the doctors would distance themselves from them. This may be because of the restrictive regulations that were put in place by the Government to combat the spread of the disease and the fact that even most health workers were fearing to contract the disease from patients. This finding is different from a study that was done by Singh et. al., 2021 where participants reported having access to healthcare services from healthcare providers via social media like WhatsApp and Telegram.

From the present study's results, participants reported having changed their lifestyle positively

spending more time with their families, getting time off work, and concentrating on agricultural work. This is because most of the participants traveled to their home villages during the lockdown where they got more time to practice the theory they could not afford on normal days. These results are in line with a study that was done in Delhi and Sonipat by Yadav et.al, 2020.

Lastly, as indicated by previous studies, low socioeconomic status is a major underlying factor for psychosocial distress and response to the pandemic (Singh et.al., 2020) Therefore, further research is warranted to shed light on the long-term psychological, health, and socioeconomic impacts of COVID-19 pandemic among the vulnerable or marginalized population (Rehman et.al., 2020; Maturehure et.al., 2020)

5. Conclusion.

In conclusion, the implementation of COVID-19-related lock downs positively and negatively affected the health, psychosocial, and economic well-being of people living with chronic conditions. Health systems have an opportunity not to only adapt workflows but also to leverage new forms of service delivery such as virtual or teleconsultations involving trained and supervised non-physician health workers, to safely support patients with chronic conditions at a time when traditional in-person care increases the risk of transmission.

6. Recommendations.

6.1. To nursing research.

The research provided a qualitative view of participants, therefore more research should be done to quantify the factors associated with these patient experiences.

6.2. To the health workers and health facility administration.

Health workers should always provide more time to people living with chronic diseases to cater to most of their expectations mostly during pandemics and epidemics.

6.3. To the Nursing Education.

The results from the qualitative study provide an overview of the patient who experiences chronic disease care in different health facilities these experiences are contributed mostly by health workers thereby equipping the nursing education department to train students in response to patient care.

7. Strength.

Through the analysis and interpretation of in-depth interviews, we have provided insights into the lives of those with pre-existing chronic conditions during the COVID-19 pandemic and shed light on how the interaction of these conditions introduced additional challenges to accessing care while also providing an impetus for some positive lifestyle changes. In particular, the findings of this study describe the impact of COVID-19 on access to healthcare as well as on individuals' psychosocial and Economic well-being. A unique strength of this study is that it does not focus on the reporting of solely negative feelings experienced during the pandemic.

Bias was eliminated by allowing the participants enough time to express themselves and the interviews were conducted in the participant's local language to ensure comprehension in an isolated environment to avoid bias of the data given. The recordings were transcribed verbatim into Microsoft Word to avoid altering information.

8. Limitations.

This study also has important limitations. First, the study findings are based on self-reported impacts of COVID-19 (i.e., job loss or income loss), and the authors could not verify these with objective measures or ethnographic observations.

Lastly, only a few participants in our study sample had confirmed diagnosis of COVID-19, so we could not explore the direct psychological and economic effects of COVID-19 across subgroups and the potential role of public and private health facilities to cater to the healthcare needs of other

population during a pandemic, which merits further evaluation.

9. Generalizability.

The findings of this study may be specific to the people in the mentioned health centers but may not be generalized to other health centers.

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11. List of abbreviations.

COVID 19- Corona Virus 19
WHO- World Health Organization
MOH- Ministry Of Health
HTN- Hypertension
DM- Diabetes
NCDs- Non-Communicable Diseases
HIV- Human Immunodeficiency Virus
BP- Blood pressure
OPD- Out Patient Department
HC IV- Health Center IV
DHO- District Health Officer
RDC -Resident District Commissioner
MMRH- Mbarara Regional Referral Hospital
BSU- Bishop Stuart University
MCHC IV-Mbarara City health Centre IV
BHC IV- Bwizibwera Health Centre IV
SARS-CoV-2-Severe Acute Respiratory syndrome corona virus 2

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