

The Uganda Society For Health Scientists

7th ANNUAL SCIENTIFIC CONFERENCE

22ND & 23RD JUNE 2006, KABIRA COUNTRY CLUB,
KAMPALA

MULTI-DISCIPLINARY APPROACH TO MANAGING THE
HIV/AIDS PANDEMIC IN THE ERA OF HAART

Conference Group Photo

TABLE OF CONTENTS

SESSION 1: PMTCT AND PREVENTION.....	Error! Bookmark not defined.
Welcome Remarks: By Ms Jayne Byakika.....	Error! Bookmark not defined.
Welcome Remarks: By Dr Chris Whalen – Technical Advisor USHSE.....	Error! Bookmark not defined.
Official opening: Speech by the guest of honour- WHO Country representative.....	Error! Bookmark not defined.
Consistent condom use among couples in primary sexual relations in Uganda.....	Error! Bookmark not defined.
The uptake of HIV and syphilis testing by mothers and their male partners in a program for PMTCT.....	Error! Bookmark not defined.
Traditional healer’s Practices and risk of spread of HIV/AIDS in Unyama Camp, Gulu District.....	Error! Bookmark not defined.
Pediatric antiretroviral Treatment Program characteristics in Sub-Saharan Africa: The KIDS-ART-LINC collaboration.....	Error! Bookmark not defined.
Session 11: Official opening	Error! Bookmark not defined.
Treatment of AIDS in Africa: The Promises and Perils of Anti retroviral in Africa.....	Error! Bookmark not defined.
HIV/AIDS in the last two Decades, The Uganda Experience.....	Error! Bookmark not defined.
SESSION 111: ART AND ADHERENCE.....	Error! Bookmark not defined.
Nucleoside-associated lactic acidosis in HIV-1 Infected African patients.....	Error! Bookmark not defined.
Adherence to Antiretroviral Therapy Among Children in Mulago Hospital in Uganda.....	Error! Bookmark not defined.
Adherence to HAART in a cohort of HIV infected clients in a resource-poor setting in Uganda.....	Error! Bookmark not defined.
Routine HIV testing for children: Challenges and Lessons Learned.....	Error! Bookmark not defined.
OCCURRENCE AND OUTCOMES OF PREGNANCY AMONG HIV POSITIVE WOMEN RECEIVING ART- DART EXPERIENCE.....	Error! Bookmark not defined.
EXPERIENCE OF PROVIDING ART TO CHILDREN OF TRIAL PARTICIPANTS :DART Trial – MRC Entebbe.....	Error! Bookmark not defined.

SESSION IV: SPECIAL GROUPSError! Bookmark not defined.

Accepting of Routine HIV testing and burden of HIV/AIDS in a medical emergency setting at Mulago Hospital.**Error! Bookmark not defined.**

Impact of Routine HIV Testing and Counselling on access to care at Mbarara Hospital.**Error! Bookmark not defined.**

Patients duplicating ART between ISS clinic and TASO Mbarara clinic.**Error! Bookmark not defined.**

Effects of antiretroviral therapy on bone age in perinatally-infected HIV-positive adolescents in Sub-Saharan Africa.....**Error! Bookmark not defined.**

Ensuring successful TB treatment in a resource-limited urban setting through a community based approach.**Error! Bookmark not defined.**

Adherence to ART-Reach Out Mbuya HIV/AIDS Initiative.**Error! Bookmark not defined.**

SESSION V: PLENARY ON HIV/AIDS.....Error! Bookmark not defined.

KEY NOTE ADDRESS: Evolving Humans: Genomes, Institutions and Aspirations.**Error! Bookmark not defined.**

Rakai Health Sciences Program (RHSP), Uganda: HIV, Infectious Disease and Reproductive Health Research.**Error! Bookmark not defined.**

Update on HIV Vaccine Research.**Error! Bookmark not defined.**

The Aids Support Organisation (TASO)**Error! Bookmark not defined.**

Effectiveness of repeat single-dose Nevirapine in subsequent pregnancies among Ugandan women.**Error! Bookmark not defined.**

POSTER DISCUSSION.....Error! Bookmark not defined.

Discontinuation and Modification of Highly Active Antiretroviral Therapy among HIV Positive People in Kampala.**Error! Bookmark not defined.**

Prevalence & Factors associated with Tuberculosis Infection among Primary School Children in Kampala.**Error! Bookmark not defined.**

Speech by Chairperson- Ms. Jayne Byakika Tusiime ...**Error! Bookmark not defined.**

Fogarty alumni association meeting.**Error! Bookmark not defined.**

LIST OF ACRONYMS

USHS: Uganda Society for health scientists

HAART: Highly Active Antiretroviral therapy

ARV: Antiretroviral

ART: Antiretroviral therapy

WHO: World Health Organization.

UNAIDS: Joint United Nations Programme on HIV/AIDS.

PLWHA: People Living with HIV and AIDS

PMTCT: Prevention of Mother to Child transmission

IDP: Internally Displaced Persons

NRTI: Nucleoside Reverse Transcriptase Inhibitors.

NNRTI: Non Nucleoside reverse transcriptase inhibitors.

RNA : Ribonucleic acid

DNA: Deoxyribonucleic acid.

PCR: Polymerase Chain reaction.

IEC: Information educational Communication

BCC: Behavioral Change Communication.

VCT: Voluntary Counseling and Testing.

RCT: Routine Counseling and Testing

STI: Sexually Transmitted infections.

TASO: The AIDS Support Organisation.

JCRC: Joint Clinical Research Center.

ISS: Immunosuppressive Syndrome.

MOH: Ministry of Health.

MRC: Medical Research Council.

UVRI: Uganda Virus Research Council.

TB: Tuberculosis

TBI: Tuberculosis Infection.

DOTS: Directly Observed Therapies.

sdNVP: Single dose Nevirapine.

1.0. OPENING REMARKS

1.1 Welcome Remarks: By Ms Jayne Byakika – USHS Chairperson

The chairperson welcomed participants to the 7th Annual Scientific conference and introduced the current theme “Multi-disciplinary approach to managing the HIV/AIDS pandemic in the era of HAART”.

She thanked the organizing committee for having organised the conference and the selection of the current theme, noting that HIV/AIDS is a multifaceted problem hence needs multidisciplinary approach.

She also emphasized the need for doctors to work hand in hand with nurses, counselors and pharmacists in managing HIV/AIDS.

Ms Byakika then introduced Dr Chris Whalen, the technical advisor to the society, and invited him to give welcome remarks to the conference participants.

1.2 Welcome Remarks: By Dr Chris Whalen – Technical Advisor, USHS

Dr Chris Whalen welcomed participants to the 7th Annual Scientific conference. He gave the brief history of the Uganda Society for Health Scientists.

He noted that in late 1990s, a critical mass of Uganda young scientists didn't have a forum to meet and share their findings locally. Some alumni and others working with Case Western Reserve University such as Dr. Paul Tumusiime, Dr. Moses Kanya, Dr. Paul Waibale and others drafted the 1st constitution and registered USHS as Non Governmental Organization. 30-40 members were first registered at the time.

Main objectives of the Society:

- Health Research.
- To disseminate new findings within field of HIV/AIDS.
- To offer opportunity of networking within members and generate collaborations.

The society introduced pay for membership. It conducts education, journal clubs and workshops.

Dr Chris Whalen encouraged members to join and get involved with the working of the society. He reminded participants that the society had taken on a scientific focus.

On the conference theme, he noted that in the early days of the epidemic, management of HIV/AIDS was focused at the management of opportunistic infections. However with the introduction of ARVs, there is need to know and monitor the impact of rolling out ARVs in Uganda.

He finally thanked the workshop organizers and the participants for attending the 7th Annual Conference of the Uganda Society for Health Scientists.

1.3 Official opening: Speech by the guest of honour- WHO Country representative Dr. Juliet Bataringaya

The Chairperson of the Uganda Society for Health Scientists, Ms Jayne Tusiime Byakika,

The Technical Advisor to the Society, Dr Chris Whalen

Dear Participants, Ladies and Gentlemen.

All Protocol observed.

I am honoured to be here as Guest of Honour at the 7th Annual Scientific Conference of the Uganda Society for Health Scientists, under the theme “A multi disciplinary approach to managing the HIV/AIDS pandemic in the era of Highly Active Antiretroviral therapy (HAART)”

It is gratifying to note that significant progress has been made in treatment and care of HIV infected patients in Uganda and that Uganda is ahead of many countries in the Region. The provision of Antiretroviral therapy in Uganda (ART) as part and parcel of comprehensive HIV/AIDS care and support services, including counseling and testing, prevention of mother to child transmission, chemoprophylaxis and management of opportunistic infections as well as home based and palliative care is exemplary. There are currently an estimated 76,000 people on Antiretroviral therapy (ART) in Uganda, up from 42,000 at the end of 2004, when the “3 by 5” target by WHO/UNAIDS and other partners was set. Uganda had achieved its 3 by 5 target of having 60,000 people on ART by June 2005. The factors that helped the country achieve this include the high level of political commitment, the concerted efforts made by various partners, including those represented here, and the financial support from the Multilateral AIDS Project, Global Fund to fight AIDS, Malaria, and Tuberculosis, President’s Emergency Fund for AIDS Relief and Government of Uganda own resources. Civil society, including People Living with HIV and AIDS (PLWHA), have also been actively involved in the treatment scale up process.

Despite the tremendous gains made in the fight against HIV/AIDS in Uganda, the current HIV prevalence of 6.4% among adults aged 15-49 and 0.7% among children under 5 remains unacceptably high. Almost half the women and a third of the men who participated in the Uganda HIV/AIDS Sero-behavioural survey 2004/05 have the Herpes Simplex type 2 virus. Many of them are not even aware that they have a Sexually Transmitted Infection. In addition, the interaction of HIV and Tuberculosis is increasing the burden of both diseases in Uganda and presents a massive challenge to tuberculosis control.

The theme for this conference: A multi disciplinary approach to managing the HIV/AIDS pandemic in the era of Highly Active Antiretroviral therapy (HAART) is indeed timely. Efforts to scale up access to treatment programmes must overcome the human resource crisis in low and middle-income countries, such as ours, which is particularly pronounced in the health sector. Traditional initiatives, although critically important to scaling up treatment access, are not enough to remedy the acute shortage and mal-distribution of health workers. In addition to providing training programmes, it is important for governments, donors and other partners to explore innovative solutions. Countries should maximize the use of existing community health workers and other community based resource persons to scale up treatment. This combined with the careful examination of optimal roles and responsibilities of physicians, nurses, counselors and other staff, can help stretch health care resources further. WHO promotes such task shifting in the Integrated Management of Adult and Adolescent Illnesses approach, which was adopted by the Ministry of Health in Uganda in 2004 and is in use for training first level health workers, at district level, in comprehensive HIV care including Antiretroviral therapy.

The identification and rapid application of new knowledge is vital in the area of HIV/AIDS treatment and care. Scientific evidence is required to provide clinicians and patients with a stronger basis on which to make important treatment decisions. Further research is also needed in the area of prevention and treatment of opportunistic infections, among many other priority areas. The Uganda Society for Health Scientists is thus a vital partner in the response to this pandemic both locally and internationally.

We take this opportunity also to re-emphasize the need to integrate HIV care with other health services, the need to use treatment and care as an opportunity for strengthened HIV prevention services, the importance of patient monitoring and the need to ensure equity and quality in our HIV/AIDS programmes.

With these remarks, I wish you fruitful deliberations and a successful outcome of this conference.
Thank You.

1.4 Keynote address

1.4.1 Treatment of AIDS in Africa: The Promises and Perils. By Dr Chris Whalen

Background:

There is an estimated 36.7 – 45.3 million adults and children living with HIV as of the end 2005. Another 4.3-6.6 million adults and children were estimated to have been infected with HIV during 2005. About 2.8-3.6 million adults and children died from AIDS during 2005.

Content:

Epidemics are caused by the transmission of an infectious agent from an infectious person to a susceptible person.

Determinants of epidemics include: frequency of adequate contacts, likelihood of transmission when there is adequate contact and duration of infectiousness.

The major routes of HIV transmission are mother to child transmission, blood products and sex.

Strategies for prevention include, abstinence, faithfulness, partner awareness for discordant couples, quarantine, these limit the frequency of contact. Strategies that reduce the likelihood of transmission with contact are; condoms, circumcision, low HIV viral load and vaccination.

Perils in Treating AIDS in Africa

Serious Toxicity include liver toxicity, lactic acidosis, Stevens-Johnson syndrome,

and hypersensitivity reactions. Challenges in resource-limited setting are surveillance for and treatment of adverse events.

Drug-Drug Interaction- the challenges are measure of drug levels and safe drug combinations. Most are expensive and unavailable.

Drug Resistance- selection of resistant strains resulting from poor adherence of the ARVs hence mutations and loss of treatment choices. Later there is transmission of drug resistant viruses.

Sustainability- a problem resulting from infrastructure, clinical expertise, expanded access to antiretroviral medication, funding for care and distraction of treatment.

Distraction of Treatment- treatment is directed to patients with advanced disease, late in the course of infection (AIDS & Low CD4+ T cell count). Transmission of HIV occurs before AIDS develops. Early in the course of infection, treatment may have little impact on transmission and may promote the spread of resistant viruses.

Conclusion:

Due to distraction of treatment and population effect of therapy there is need for development of effective interventions. These may include behavioral interventions, community-based counseling and testing, public education and vaccine development.

1.4.2 HIV/AIDS in the last two Decades- The Uganda Experience.

By Prof. Fred Wabwire-Mangen

Background:

A total of 980,000 adults and children live with HIV/AIDS in Uganda. One and a half million children have been orphaned by AIDS. Sero-prevalence is estimated at 10.1% in urban areas and 5.7% in rural areas, with the national average at 6.4%.

HIV prevalence increased between 1988-94, declined between 1994-2002, and stabilized between 2002-date. HIV prevalence has stabilized at an unacceptably high level of 6.4%. There is need to investigate further factors responsible for the current trend.

There has been an observed increase in age at first sex from 17.6 year in 1995 to 18.3 years for men and 16.5 years in 1989 to 17.3 years for women in 2000. Premarital sex and extramarital partnerships

decreased between 1995 and 2000. Ever use of condoms increased from 16% to 40% for men and 1% to 16% for women between 1995 and 2000. Condoms use with non-regular partner increased from 35% to 59% for men and 20% to 39% for women.

Factors influencing risky sexual behaviour include; normalization of the of epidemic, promoting secrecy about sex, alcohol and drug use, domestic violence, negative perceptions about HIV testing, disclosure, peer influence and peer communication networks among others.

Trends in key HIV interventions.

1. IEC/BCC: Actors in IEC for behaviour change have decreased. Agencies with IEC have reduced from 78%to 17%. There has been a shift from BCC to service access messages.
2. Condom promotion: most populations are reached with freely distributed condoms. There is difficulty in achieving consistent and correct use in many relationships. Condom use is low despite high knowledge.
3. VCT: There has been progress in expansion of coverage.
4. PMTCT: There is lack of postnatal care service for PMTCT clients. Delivery of the program is project-based and sustainability may not be assured.
5. STI Treatment: Low health care seeking behaviour and stock out of STI drugs is common at lower level health units.

History of Uganda's HIV/AIDS care and treatment program begins in 1987 with TASO providing counseling, medical and nursing care, providing material assistance to PLWHA and their families. The same year the ISS clinic was established in Mulago hospital to provide care to TASO clients and other patients as outpatients.

In 1990 the JCRC was formed to conduct clinical research on HIV/ADS but later in 1992 care and treatment as well.

In 1998 Uganda piloted ARVs under the UNAIDS drug Access Initiative. In 2001 the Academic Alliance for AIDS care and prevention in Africa was formed. It increased the capacity and improved the scope of service of the ISS clinic. In this same year ART was integrated in the national comprehensive program for HIV/AIDS care & support in MOH. To date 78,000 are on ARVs.

The future:

New approaches to HIV counseling and testing e.g. RCT & home-based counseling and testing are needed. Scaling up proven interventions is essential.

New technologies in the horizon include microbicides, vaccines and herpes simplex virus suppression.

1.4.3. Evolving Humans: Genomes, Institutions and Aspirations.

By Prof: Keith PWJ McAdam Director Infectious Diseases Institute

The infectious disease institute in Kampala has a mission to build capacity in Africa for the delivery of sustainable, high quality HIV/AIDS care and prevention through training and research.

Content

Human genomes and indeed institutions and aspirations are evolving driven by several factors. As Charles Darwin concluded in the Origin of species; ‘...the evolution of higher animals directly follows from the war of nature, from famine and death...’

Factors responsible for the evolution of human genomes include, famine, infection, leading to death. The key problems are; malnutrition and infectious diseases like tuberculosis, leprosy and HIV. The principle selection factor responsible for maintenance of genetic polymorphism within a population is infection with pathogens (Haldane 1949). Other studies have shown genetics and environmental influences on premature death in adult adoptees (Sorenson *et al.* 1988)

Malaria is a leading cause of death in Africa (1 million deaths per year) and is responsible for causing disability and poverty. Malaria susceptibility and resistance genes have been identified and these include: sickle cell, alpha thalassemia, ovalocytosis, duffy blood group, G6PD, HLA Class I: B53, HLA Class IIDRB1*1302, TNF promoter polymorphisms (-238, -308), -308 RR 7.7 for death and neurological sequelae, -238 RR 2.5

Similarly, genes and regions in the genome have been found to be associated or linked with susceptibility to tuberculosis and leprosy. Tuberculosis susceptibility is highly polygenic. In Africans susceptibility loci have been mapped to chromosomes Xq27 and 15q11-13. Several candidate genes show significant associations: (HLA-DR2, VDR, NRAMP1, IL-1b, P2X7, and IL10). Over 30 other candidate genes studied showed no association.

Genetic susceptibility to HIV has also been exhibited through; discordant pairs, persistently negative sex workers, long term non-progressors, CCR5 Δ 32, CCR2-621, CCL3L1 (MIP-1 α P), SDF1 α -3'A
HLA Class I: B17, B27, B57, B35, A2, A3, II: DR6; DR7, ? APOBEC 3G

2.0 CONFERENCE PRESENTATIONS

THEMATIC AREA: PMTCT AND PREVENTION

SESSION CHAIR: Dr. Phillipa Musoke

2.1 Consistent condom use among couples in primary sexual relations in Uganda.

By Ms. Flavia Nakayima.

Background:

Worldwide millions are infected with HIV by their primary sexual partners. For these individuals, marriage is their main risk factor for HIV infection.

Should condom use therefore be promoted within stable relationships in area with high HIV prevalence?

Is it a 'lost cause' for HIV and family planning programs to promote condom use in stable heterosexual relationships?

Uganda has a population of 27 million with a total fertility rate of 6.9 children. Contraceptive use is at 18% while annual population growth rate is 3.3%.

HIV prevalence ranges from 4.1% to 7.1%. Percentage of men/women reporting condom use in cohabiting/stable relationship 3.8%/2.2% vs non-cohabiting relationship 59.7%/24.2%.

Objective:

To inform HIV and family planning programs, the condom use study explored the dynamics of consistent condom use among steady partners in Uganda through qualitative methods.

Methods

This was part of a larger study, the Hormonal Contraception and HIV Acquisition Study.

Thirty-nine stable couples who reported 100% use of condoms in the last three months and 10 stable couples who reported less than 100% condom use in the last three months were selected. In-depth interviews and focus group discussions were employed.

Findings:

Male partners were dominant in these relationships but females were more likely to demand condom use due to fear of infection from infidelity and unintended pregnancy. Some women used threats others used persuasion, persistence or reason. Men were more cooperative than woman expected.

Men in this study accepted condoms mainly because of; unsure of partner 's fidelity , family planning, wanted to protect wife/ stable partner and children from infection, wanted to keep peace in the relationship and did not want to give up other sexual partners. It sometime took courage to introduce condoms into a stable relationship. Female respondents felt empowered by knowledge from the clinical trial, community education and mass media. Most couples had some problems using condoms as it affected their sex life.

Conclusion:

Introducing condom into a stable relationship is awkward at best and scary at worst. Condom users need supportive environment. Source of support included clinical trials, community education mass media and HIV testing.

Recommendation:

1. Exploit the dual-purpose nature of condoms.
2. Identify new opportunities to promote condoms among stable couples.
3. Involve couples who have successfully used condoms to plan condom promotion programs.

2.2. The uptake of HIV and syphilis testing by mothers and their male partners in a program for PMTCT. By Mr. Dennison Kizito.**Objectives:**

1. To determine the effect of a mother's HIV and syphilis status on the probability of the male partner attending.
2. To find whether the time until a male partner came later was affected by the mother's HIV status.
3. To look for the discordant couples who tested within 30 days of one another.

Contents:

From May 2002 to January 2006, 20,738 mothers registered at the antenatal clinic, 17,210 received counseling, out of which 12,946 (75.2%) accepted an HIV test and 16,971 (98.6) were tested for syphilis. However only 236 brought male partner for HIV and syphilis counseling of whom 232 (98.3%) accepted an HIV test and 191(82.6%) syphilis test.

Findings

There was an association between the test results of the mothers and whether they later brought their partners.0.8% of those who were HIV-positive later brought their partner for HIV test and 0.4% of those who were HIV-negative ($p=0.01$).

1.1% of those who were syphilis-positive later brought their partner for syphilis –testing and 0.3% of those who were syphilis-negative ($p=0.01$). No evidence was found for a difference in the time until a partner came for testing. Among those tested, the HIV prevalence was 12.6% for mothers and 10.4% for male partners, and the syphilis prevalence was 4.0% for mothers and 6.3% for male partners. Nineteen of 199 couples tested within 30days of each other were HIV discordant, 10 were concordant positive and 170 concordant negative.

Conclusion:

The data highlight the challenge of promoting couple HIV-testing within a PMTCT programme, since only 1.8% of mothers tested had partners who accepted HIV tests.

HIV or Syphilis positive mothers are more likely to bring their partner for testing after discovering their disease status.

2.3 Traditional healer's Practices and risk of spread of HIV/AIDS in Unyama Camp, Gulu District. By Dr Odong Patrick Olwedo.**Objective:**

To assess the knowledge, practice and occupational risk of human immunodeficiency virus (HIV) among traditional healers in Unyama IDP Camp.

Background

The practice of canine tooth bud extraction is a common phenomenon among the Acholi people of northern Uganda. Traditional healers among the Acholi also practice other forms 'treatment' for ill-health, common among which is the making of incisions on the chest and then rubbing herbs therein.

Methodology

In-depth interviews were held with twelve traditional healers and 8 key informants. Traditional practices of canine tooth bud extractions and therapeutic cuttings on the chest are very common in Unyama IDP camp.

Findings

All the traditional healers have heard of HIV/AIDS.

For extraction of the canine tooth buds, the healers use locally designed arrow or bicycle spokes. In the case of the therapeutic chest cuttings the traditional healers use razor blades.

One of the traditional healers reported boiling her instruments and storing them in paraffin to prevent rusting. But the key informants reported that sterilization does not take place. However, the traditional practices are done without anaesthesia, in an –sterile environment using bare hands. Some of the traditional healers suggested need to be supplied with gloves and surgical blades.

Conclusion:

The risk of acquiring HIV by traditional healers in their course of their duties is therefore high. The traditional practices expose the children and the traditional healers to risk of HIV transmission. Basic education on HIV/AIDS must be given to all traditional healers including their patients and the general public. The Ministry of Health, World Health Organization and other agencies involved in the fight against HIV infection should focus on the safety of traditional practices as a possible mode of HIV infection in the IDP camps of Northern Uganda.

Recommendation

Continuous community education is a key factor to behavioural change and reduction in the practices.

2.4. Paediatric antiretroviral Treatment Program characteristics in Sub-Saharan Africa: The KIDS-ART-LINC collaboration. By Daniel Kyabayinza

Background:

The Paediatric Antiretroviral Treatment Programs in Lower-Income Countries (KIDS-ART-LINC) collaboration is an international network whose goal is to inform on paediatric ART treatment programs in Africa.

Objectives:

1. To gain a direct understanding of the organization and operating rules of paediatric HIV treatment centers.
2. To assess the level of data management.
3. Create direct links between clinic staff and members of the KIDS-ART-LINC Central Coordinating Team (CCT)

Content:

155 children receive HAART in each of the 21 clinics, 17 of which are based in public health facilities. Fives programs exclusively treat children .The minimum care package offered by all programs includes medical consultation, co-trimoxazole prophylaxis, HAART, CD4 monitoring and a complete blood count.

All programs but two provided free ARVs. Seven programs perform viral load estimates and 12 offer early infant HIV diagnosis at clinic sites. In the nine sites where age breakdown was available, only 6.8% of children on ART were less than 2 years old. On average, each physician and nurse cares for 20 children. Eighteen of 21 sites reported employing counselors. Standardized record forms are used in the 18 sites, but only 12 have a computerized and functional data management system. Clinical criteria for starting HAART essentially correspond to WHO guidelines. Lack of paediatric formulation delayed HAART initiation in 9 programs. There is active follow-up of children on treatment who miss appointments in 13 programs. In nineteen programs, the first-line HAART regimens are NNRTI-based (11-nevirapine, 8 efavirenz) while 2 provided ritonavir-boosted lopinavir and either zidovudine or stavudine.

Conclusion:

There is good standardization of clinical practices in the paediatric treatment programs surveyed across sub-Saharan Africa but monitoring and patient information systems that are needed to accurately estimate and document impact of ART in children are commonly lacking.

In most sites, access to DNA/RNA PCR technology for early infant HIV diagnosis has not yet been operationalized and the number of young infants identified through PMTCT services receiving ART is still limited.

Theme: ART & Adherence**Chairperson: Dr. Peter Mugenyi****2.4 Nucleoside-associated lactic acidosis in HIV-1 Infected African patients**

By. Dr. Mwebaze Patricia Songa,

Background:

As of January 2006, fifteen thousand patients had been registered at the Infectious Diseases Institute (IDI), Kampala, Uganda. Currently over 4200 patients have started on ART.

The most commonly prescribed first line regimens are:

Zidovudine (AZT), lamivudine and efavirenz, and fixed generic combination of stavudine (D4T 30mg or D4T 40mg), lamivudine and nevirapine i.e. (Triomune). Whereas D4T and AZT are linked to nucleoside associated lactic acidosis (NALA) in the west, there are few data from Africa. Approximately 24.8% are on AZT, 24.6% on D4T 40mg and 50.6% on D4T 30mg. ART is free, but patients with clinically suspected NALA pay for serum lactate and bicarbonate tests.

Methods:

Retrospective chart review of patients with confirmed symptomatic lactic acidosis was carried out between November 2005 and April 2006. Patients were suspected for NALA when they had: a prolonged history of NRTI use, non-specific symptoms of vomiting, fatigue, myalgia, nausea, vomiting, diarrhea, abdominal distension, weight loss or dyspnea, with no other apparent cause e.g. opportunistic infection and when medical history ruled out other causes of metabolic acidosis. Patients who can afford then pay for serum lactate (~US\$7) and Bicarbonate (~US\$5) done at Joint Clinical Research Centre.

Results:

There are 8 patients with confirmed hyperlactemia (> 2 mmol/L). All patients were on Triomune. Four patients on D4T 30mg and the other 4 on D4T 40mg.. Seven patients were female. The median age was 38 years (range 28-50years), median baseline CD4 90 cells/mm³ (range 1-149). Median duration on ART to laboratory confirmation of Hyperlactemia was 14.5 months (range 7-36 months). All had non-specific symptoms of fatigue and abdominal discomfort with severe peripheral neuropathy and either protracted vomiting or shortness of breathe. Five patients had ultra sonographic features of fatty liver infiltration (Hepatic Steatosis). Median serum lactate was 7.68 mmol/L (range 3.33-12.0). Although ART was stopped for all patients, 2 died and 4 remain off ART while 2 switched to alternative ART.

Conclusions:

These cases highlight NALA as an important complication of ART in Uganda and Africa, where D4T remains an important first line agent.

These cases underscore the importance of a high index of clinical suspicion especially in settings where laboratory monitoring is limited.

NALA may be an important cause of mortality in ART experienced patients in Uganda. This reinforces the need for alternate ART such as tenofovir and abacavir.

2.5 Adherence to Antiretroviral Therapy among Children in Mulago Hospital in Uganda.

By Dr. Nicolette B. Nabukeera¹

Background: Non-adherence reduces efficacy of antiretroviral therapy (ART) and also may lead to emergence of drug resistance. The objective of this study was to determine the levels of adherence to Highly Active Antiretroviral Therapy (HAART) and identify factors associated with it in children attending Paediatric HIV/ AIDS clinic at Mulago Hospital.

Methods

This was a cross sectional study of 170 children attending the Paediatric HIV clinic. Adherence to HAART was defined as taking $\geq 95\%$ of prescribed medication. It was determined using three

measures; 24 hour, 3 day and 7 day self report from the caregivers or children ≥ 12 years, clinic based pill counts and unannounced pill counts were carried out in their homes 2 to 3 weeks later.

Results

The children that reported $\geq 95\%$ adherence the previous day, previous 3 days and 7 days were 92.4%, 89.4% and 88.8% respectively (n=170). Using clinic based pill counts, 94.1% had $\geq 95\%$ adherence to treatment. Of the 164 children successfully followed up in their homes, 72% were found to have $\geq 95\%$ adherence using unannounced pill counts. When the primary caregivers were the only one who knew the children's serostatus, they were three times more likely to be nonadherent [p=0.02, odds ratio [OR]=3.34, 95% confidence interval [CI] (1.14 – 9.82)]. Based on unannounced pill counts, having a grandmother as a primary caregiver was associated with $\leq 70\%$ adherence (p value=0.001, OR=0.141) Those who had been hospitalized 2 or more times before starting HAART were more likely to have $\geq 95\%$ adherence [p=0.02, OR=0.44, 95% CI (0.20 – 0.92)].

Conclusion

About three quarters of the children had $\geq 95\%$ adherence using Unannounced Pill Counts. Self report and pill counts in the clinic over estimated adherence to HAART when compared to unannounced pill counts at home. When only the primary caregiver was aware of the child's HIV serostatus, the children were three times more likely to be non-adherent to HAART. Two or more hospitalizations before HAART was associated with better adherence.

Recommendation

Home visits should be incorporated in the care program, counseling and health education should emphasize disclosure of the child's status to at least one other person and promote peer counseling among the children. A prospective study to determine association between different levels of adherence with virologic outcome and resistance would be helpful.

2.6 Adherence to HAART in a cohort of HIV infected clients in a resource-poor setting in Uganda. Author:

Dr. Alamo Stella Talisuna (Fellow IPH/CDC Fellowship Programme/Reach Out Mbuya)

Introduction

Good adherence to HAART is critical for HIV treatment, but difficult to achieve. Although there is demand for programmes that enhance HAART adherence, there is scanty evidence about the extent to which community-based programmes have been able to achieve this. Reach Out, a faith based HIV/AIDS initiative with a strong network of community volunteers many of whom are people living with HIV/AIDS, provides holistic care to 2000 clients, 45% of whom are on HAART. Reach out provides medical care including ARVs, spiritual, HIV and treatment adherence counseling and education, school fees support, income generating activities, disclosure and family support, treatment support through community volunteers, health education, and adult literacy among others. With more people receiving HAART, it is important to have an integrated adherence component, which involves more than merely instructing patients to take medication.

Methods

Adherence to HAART over a 12-month period was determined for an open cohort of 405 clients by counting pill-returns at each clinic visit. Models including gender, residence as a proxy for strength of the community/support network, regimen type and change were fitted to determine predictors of incomplete adherence. Good adherence was defined as having taken 95% of the pills prescribed.

Results

Of the 405 records retrieved over the study period, 64% were female. The median duration on therapy was 26.4 weeks. Analysis showed that on average, the patients had taken 99.3% of the pills during the study period. 126 (41.7%) had 100% adherence (range = 90.4% - 100%). Five clients had an adherence of less than 95%. Gender, residence, regimen type and regimen change were not predictors of adherence. Adherence improved with time over the 12 months. The main reason for missed pills was forgetfulness (67%)

Conclusion

Levels of adherence to HAART in resource-poor settings can be comparable to those achieved in resource-rich countries, provided that sufficient support is made available to those on therapy, and should not be used as a limitation to ART access. Community-based models may achieve better adherence and may be more cost effective in delivery of HAART.

Recommendations

Community participation is a recipe for successful adherence, but needs to be empowered. Strict adherence should be emphasized at every interaction between a patient and health care workers. Holistic approach is the way forward in sustaining adherence.

Treatment literacy should be an integral part of IEC activities relating to HIV/AIDS

Empathy, respect and trust between service provider and client are crucial for good adherence.

2.7 Routine HIV testing for children: Challenges and Lessons Learned

By Dr. Cecilia Nawavvu

Issues

One third of children infected with HIV through vertical transmission die within two years. Routine HIV Testing and Counseling (RTC) in health care settings has been proposed to increase access to care. However, RTC for children presents unique challenges as caregivers must be involved. We evaluated pediatric RTC in four wards of Mulago hospital, Kampala, Uganda.

Description

Between March and December 2005, RTC was offered on an opt-out basis to all hospitalized children and their caregivers. The program was designed to test children aged 6 weeks to 12 years only if the biological mother was HIV positive. Practically this was difficult due to the limited hospitalization time. Additionally, for 20% of children the mothers were not available at the time of testing. In order to ensure that HIV positive children are not missed, mothers and children pairs are now tested concurrently. Children below 18 months are tested using DNA PCR, HIV-infected persons receive Co-trimoxazole prophylaxis and are referred for HIV/AIDS care upon discharge.

Findings

Overall, 3,178 children were offered RTC; 3,017 (95%) caregivers consented to have their children tested. Of these, 19% were HIV-positive; 99% had never been tested before. There was no variation in HIV prevalence by age group. A total of 1,649 caregivers underwent RTC; HIV prevalence among mothers, fathers, and caregivers was 29%, 17% and 18%, respectively. RTC is acceptable (and identifies many HIV-infected children and parents). The optimal cut-off age for counseling children separately from the parent remains unclear.

Recommendations

RTC for children and their caregivers should be expanded at hospitals with high prevalence of HIV among hospitalized children. Counselors should be equipped with skills to assess the readiness of children to receive counseling separately.

2.8 OCCURRENCE AND OUTCOMES OF PREGNANCY AMONG HIV POSITIVE WOMEN RECEIVING ART- DART EXPERIENCE. :

By Dr. Ben Kikaire)

BACKGROUND:

The DART (The Development of Antiretroviral Therapy for Africa) is randomized trial evaluating two strategic approaches for management of antiretroviral therapy (ART) in symptomatic HIV infected adults in Africa at Entebbe, Joint clinical research center in Kampala and another site in Harare. The first strategy compares clinical monitoring only (CMO) with laboratory plus clinical monitoring (LCM). The second approach compares structured treatment interruptions (STIs: 12 weeks on, 12 weeks off ART) with continuous ART in patients who achieve CD4 cell counts ≥ 300 cells/mm³ after 48 or 72 weeks on continuous ART. Within this trial a sub-study of participants at Entebbe site was conducted to evaluate the occurrence and outcome of pregnancies as they occur.

METHODS

Descriptive study design. Before enrollment in the DART trial a urine pregnancy test is done to exclude pregnant women and thereafter it is repeated every 6 months while in the study. Participants with positive tests are done a confirmatory repeat test, if positive an obstetric ultrasound scan is done

at 12 weeks, mother counseled for PMTCT, withdrawn from STI randomization until 6 months postpartum and HAART adjusted as necessary and referred for antenatal care at a center of their choice. The mothers are followed up in the study clinic for any acute events and scheduled visits.

A pregnancy outcome form is filled at end of the pregnancy.

RESULTS:

Six hundred and eighty out of 1020 DART participants at the site were women with 82.5% below 45 years of age. Total number of pregnancies was 85 with 35 abortions (26 induced, 7 spontaneous and 2 missed). Live births were 31 (36.5%), ongoing pregnancies were 13 (15.3%), and 6 (7.1%) stillbirths/IUFD. All mothers were clinically stable except one who died in immediate post partum period. Twenty (68.97%) mothers have not breast fed while the others have done exclusive breastfeeding for the first 3 months. Of the 33 babies delivered, 2 missed prophylactic ART and were delivered at home and reported 2/52 weeks postpartum, 1 was an early neonatal death, all received Cotrimoxazole prophylaxis, 20 have been tested for HIV, 18 are negative and 2 are pending results.

CONCLUSION

Pregnancies will occur as women improve on ART, but most of them may be unwanted and will end in abortion. It is important that participants are given contraception and prevention for positives skills.

Recommendation

Qualitative research on factors that determine decision to become pregnant and outcomes is needed. Secondly follow-up sub-study of babies born to women in DART for long-term outcomes is necessary.

2.9 EXPERIENCE OF PROVIDING ART TO CHILDREN OF TRIAL PARTICIPANTS.

By Dr. Martha Nakazibwe

Introduction/Background:

Over three million children under 15yrs are infected with HIV worldwide, 90% of these are in sub-saharan Africa. In Uganda an estimated 100,000 children are infected with HIV. There is increasing access to ART, however the majority of treatment programmes are focusing on adult patients. DART

is a multi-center study of ART strategies in HIV infected adults in Africa including Entebbe site. Nine hundred and twenty five adults are currently being followed up at the MRC - Entebbe research clinic and receive ART. Several parents expressed anxiety that their children were also infected with HIV and required ART. The MRC/UVRI unit on AIDS signed an agreement with Joint Clinical research Centre to provide ART children of study participants that needed treatment.

Methods and Description

The objective of this article is to share experiences of treating children at study premises used by their parents. Parents were asked to register their biological children. Talks about children's clinic were given on clinic days. Study participants were invited to bring the children whom they thought were infected for VCT. Sero-positive children were further evaluated for ART eligibility using WHO criteria for commencement of ART. Ineligible children undergo periodical evaluation. The children and parents were scheduled on the same drug refill dates and adherence measured by self-report and pill counts. Meetings between the medical team and parents are held to discuss their concerns about disclosure, ART adherence, effects of ART on child's quality of life and welfare, opportunistic infections, nutrition and review of child's clinic history and notes.

Results

Eighty-five children were screened of whom 61 and 21(24.7%) were HIV negative and positive respectively. Among the 21 infected children; 2 were referred to the Mildmay center, 10 were ineligible for ART and 9 started on HAART depending on WHO criteria. Their age range is 2.5 to 13 years, 6 were 5 years and below.

The most common reported opportunistic infection was TB (4 out of 9 had a history of TB). One child had LIP. Three out of 9 started co-trimoxazole prophylaxis at this evaluation for ART; the rest had either started earlier from TASO or through parent's initiative. Adherence to ART was up to 98%. Response to treatment is also very good as evidenced by CD4 response.

Conclusion

The parents' experience of the benefits of ART was a positive factor in child's adherence. The children have benefited from return of health and normal activity such as regular school attendance.

Challenges

Parents fear to disclose to their children and ask question such as: when and how do I tell the child about the disease, what if they ask me how I got it, what and how do I tell siblings, the school, having HIV means one is going to die. Disclosure is particularly difficult with ‘older’ children and most parents requested assisted disclosure from clinical staff.

Recommendations

A multi-disciplinary approach is required to ensure adherence to treatment.

Parents disclosure helps with compliance to treatment.

Parents need Guidance on disclosure to children.

A family approach to treatment is beneficial for overall effectiveness of parents’ and children’s therapy

DAY TWO

Theme: Special Groups, Chairperson: Dr. Jackson Amone

3.0 Accepting of Routine HIV testing and burden of HIV/AIDS in a medical emergency setting at Mulago Hospital. By Dr. Damalie Nakanjako

Objectives:

1. To determine acceptability level of RTC among patients at the medical emergency unit Mulago Hospital.
2. To determine the burden of HIV infection in the medical emergency unit at Mulago hospital.
3. To estimate the demand for ART among patients attending the medical emergency unit at Mulago Hospital.

Contents:

In Uganda over 1million people are living with HIV. Despite the global movement to scale up access to antiretroviral therapy in the developing countries, only 11% of those requiring ART are able to access it. HIV testing and ART are not widely offered as part of routine medical care in acute care settings and demand for these services in this setting is unknown. The study enrolled 233 patients for RTC. Of these, 25 (11%) knew their HIV status. Two hundred and eight patients were eligible for testing, 198 (95%) accepted to test, and of these 86 (43%) were diagnosed HIV positive. Seventy one percent of those testing positive were in WHO clinical stages III and IV.

Conclusion:

1. There is high demand for RTC in the medical emergency unit, and this shows that the majority of patients attending the unit are unaware of their HIV sero-status.
2. Without RTC in emergency units, there are missed opportunities for HIV prevention, diagnosis and treatment in most curative health units in Uganda.
3. The burden of HIV infection is still very high in the emergency unit at Mulago hospital with the advanced HIV burden also being high. This was depicted in the 71% of those HIV positive being in WHO stages III and IV.

Recommendations:

HIV testing and provision of ART should be scaled up in the medical emergency unit at Mulago Hospital in order to increase access to HIV/AIDS care and ART in Uganda

Discussion:

The study excluded patients with altered mental state. This creates a missed opportunity for HIV prevention, diagnosis and treatment in these vulnerable groups.

3.1 Impact of Routine HIV Testing and Counseling on access to care at Mbarara Hospital. By Dr. Bosco Bwana Mwebasa**Objective:**

To compare clinical characteristics of patients at initiation of RTC program and approximately one year after implementation

Contents:

Early testing and linkage to care is an important strategy for successful HIV prevention and treatment programs. Through the Mulago-Mbarara Joint AIDS Program (MJAP), RTC, basic HIV care, ART and training of health workers are offered. The study used two comparison groups; group one with patients who joined the clinic at initiation of RTC, and group one year after RTC was initiated. Observations were carried out at the Mbarara Immune Suppression (ISS) clinic. The study showed that prior to the institution of RTC, more patients joined the ISS clinic at a late WHO stage and with CD4 counts less than 200. Changes in clinical presentation were seen in both WHO stage and CD4 after one year of RTC implementation.

The identification of patients with early WHO clinical stages and higher CD4 counts has implications to care. Most of the patients simply require basic HIV care. This therefore reduces the urgency for starting ART as seen in patients presenting with the advanced disease.

Conclusion:

1. Routine HIV testing and diagnosis links patients to care earlier than symptomatology based diagnosis.
2. Early linkage to care reduces the urgency of starting ART and improves the patients' quality of life.

3. With early linkage to care, patients are maintained on basic HIV care for longer periods, which is more cost effective and sustainable in care programs in resource limited countries.

Recommendations:

There is a need to further evaluate trends with time to find out if the distributions will change with time.

4.3 Patients duplicating ART between ISS clinic and TASO Mbarara clinic

By Dr. Moses Katafiire

Objectives:

1. To obtain and compare the names and demographic details of all patients registered for ART in Mbarara at both TASO and ISS clinics
2. To verify and quantify any duplication of ART by patients at both clinics

Contents:

The study aimed at investigating any duplication of ART between patients at the ISS clinic and at the TASO Mbarara clinic. Electronic records of all clients registered or booked for ART at the ISS clinic were compiled into a confidential list. This was also done at TASO Mbarara. Clients were compared by full names, gender, age and residential address. Case definitions were grouped into definite, probable, possible, and false-duplicates. As of April 2006, the ISS clinic had registered 2428 clients, while the TASO clinic had a total of 990 registered for ART, out the 1000 slots available for ART at TASO. Total matches (duplicates) were 89 (3.7%), while the non-duplicates were 2339 (96.3%). Although the percentage of duplicates was very small, it could rise with time.

Discussion

Duplication has significant cost implications and poses potential toxicities for patients. A qualitative study is being carried out to find out reasons as to why patients duplicate ART services. Are they trying to access better services? The problem of how to deal with a client confirmed to be duplicating ART still remains a challenge.

Recommendations:

1. There is need to instigate regional and national mechanisms of identifying all ART clients in order to prevent duplication
2. Similar audits of non ART services could be carried out to compare levels of duplication within health service providers
3. Mechanisms should be instituted to avoid this ‘shopping’ by clients through close collaboration with all service providers
4. A national database for all ART clients and an ART Health Management Information system should be started by the MOH
5. The adoption of national IDs could also remove this problem of duplication

4.4. Effects of antiretroviral therapy on bone age in perinatally-infected HIV-positive adolescents in Sub-Saharan Africa.**By Dr. Sabrina Bakeera-Kitaka****Objectives:**

1. Determine the discrepancy between chronological age and trueborn age.
2. Assess the rate of bone maturation during 12 months of ARV in drug-naïve adolescents.
3. Describe the impact of growth and sexual maturity development in HIV perinatally infected adolescents.

Contents:

In Sub-Saharan Africa there are growing numbers of perinatally-infected children entering adolescence. One common manifestation seen in the perinatally infected is skeletal and pubertal growth failure. Various studies have shown that perinatally infected HIV+ adolescents present with delayed bone age when compared to chronological age. This study was carried out on 92 patients who were antiretroviral-naïve at enrolment, considered to have contracted HIV by perinatal transmission, and were followed up after 12 months. Patients underwent left hand/wrist radiographs prior to starting ART and a repeat at 12 months while on ART. The mean chronological age was 14.56 years at time of enrolment, with 58% of the adolescents having bone maturation delay. The mean delay was 3.8 years when compared to mean chronological age. After 12 months of HAART, this delay was reduced to

3.5 years ($p > 0.0005$). Physical growth which was measured using the HAZ and WAZ scores improved significantly by 12 months, from -3.31 to -2.07, and -2.6 to -1.7 respectively. Pubertal growth measured using the tanner stage showed that 78% of those with bone delay had tanner stage 1, and there was a significant catch up in the pubertal growth compared with bone age.

Conclusions:

1. HIV-positive adolescents of both sexes presented with delayed skeletal age when compared to chronological age.
2. Even though there was no significant change in bone age after one year of HAART, it appeared that there was room for bone growth in this cohort.
3. Pubertal maturation appears to be more affected by ART intervention when started during adolescence.

Recommendations:

Early initiation of ART should be advocated for to prevent growth failure of HIV infected children.

Note

Tenofovir should not be given to patients in the pre-pubertal age group as it affects bone maturation.

4.5 Ensuring successful TB treatment in a resource-limited urban setting through a community based approach. By Dr. Alamo Stella-Talisuna

Contents:

Reach Out Mbuya is a community based programme with a goal to provide free holistic care to poor people living with HIV/AIDS in Mbuya Parish. It uses a nurse based approach with intensive monitoring of all clients especially those on ARV and TB treatment. It uses community volunteers as the core staff, and about 63% of the volunteers are clients. It cares for over 2000 clients, with 930 on ART.

TB is highly prevalent and is the commonest cause of death in PHA at Reach Out. In other high areas of co-infection, autopsy studies confirmed TB as the cause of death in more than 60% of the deaths.

Untreated TB and defaulters lead to high mortality rate amongst the clients. Client monitoring is the centre of ensuring treatment success and preventing defaulters

The TB program which started with community work developed a program using trained “expert clients” as treatment supporters, as well as trained family members as family treatment supporters to ensure DOTS.

RO through the CATTs (Community ARV, TB Treatment Support) ensures that work is done where the clients live, and in so doing helps clients take their ARV drugs, helps clients take their TB medicine, and helps clients in all aspects of care, including social and spiritual care. The CATTs group uses clients who have been on TB or ARV treatment, and have been given a 3 week training course on home-based care, TB, ARV and counseling. Each CATTs, under close collaboration with the community supervisor, is assigned 10 clients living in their area. Weekly meetings are held to review clients and problem cases.

Conclusions:

Community approach leads to

- Better understanding of TB in the communities.
- Reduced stigma.
- Strong prevention tool as more people are motivated to access care.
- Helps supporters gain self esteem as well as provide employment.

Community involvement in TB management gives good outcomes, but training of staff involved is very important and support to patients should be supervised until the patient is completely cured.

4.6 Adherence to ART-Reach Out Mbuya HIV/AIDS Initiative.

By Dr. Alamo Stella-Talisuna

Contents

The program aims to provide access to good quality care for people with limited resources and employs the following strategies:

- Faith based HIV/AIDS initiative
- Holistic approach to health care
- Network of community volunteers many of whom are HIV+

The ARV program was initiated in 2003 with participation in the JCRC DART study and currently has three sub-programs in which clients are enrolled

- JCRC-DART study: 74 active clients
- PEPFAR Project: 437 active clients
- Goodwill Private Sponsorships: 69 active clients
- GFATM: 470 clients

The forms of non-adherence commonly seen include; missing one or more doses of one or more prescribed drugs, missing whole days of treatment, not observing intervals between doses and not observing dietary or other instructions. The program aims to restore an acceptable level of physical health through provision of medical care, nutrition and basic care package and uses support groups, continuous individual counseling and spiritual support. It also works to enhance family and community support through disclosure, home visits, school fees support, IGAs, treatment support (CATTS) and health education and information. The program has led to improvement of client's quality of life, reducing clinic visits and waiting time.

Recommendations

- Community participation is a recipe for successful adherence, but they need to be empowered
- Strict adherence should be emphasized at every interaction between a patient and health care workers
- Holistic approach is the way forward in sustaining adherence
- Treatment literacy should be an integral part of IEC activities relating to HIV/AIDS
- Empathy, respect and trust between service provider and client is crucial

Discussion

The Mbuya Reach Out Programme appears well coordinated, funded and is a truly community based programme. There is need to replicate such services elsewhere while addressing issues of sustainability of these community based interventions

SESSION V. PLENARY ON HIV/AIDS. CHAIR DR. MOSES KAMYA

5.1 Rakai Health Sciences Program (RHSP), Uganda: HIV, Infectious Disease and Reproductive Health Research. By Dr. Tom Lutalo.

Background

Rakai Project was established in 1987 and has conducted annual cohort surveillance since 1989, reaching over 56 communities and interviewing 12,000 respondents. The activities are mainly:

- Hypothesis testing intervention trials
- Hypothesis generating observational studies
- Service provision and operations research

Randomized trials of male circumcision for HIV prevention in men

Contents

Three trials are being conducted in South Africa (ANRS Bertran Auvert), Kenya (NIH BOB Bailey) and Uganda (NIH Ron Gray). The studies are of similar designs and involve enrollment of uncircumcised men who were randomized to: 1, Immediate circumcision (Intervention), 2, Circumcision delayed 21-24 months (control) to be evaluated after one year. The Rakai trial has two arms, a) NIH sponsored trial which has recruited 5000 HIV negative men and examines male circumcision for HIV prevention among HIV men, b) the Gates sponsored trial which has recruited 800 HIV +ve men and 7000 women and examines male circumcision for STD prevention in men and women. The trials will all be completed by September 2007. The HIV incidence in the circumcised in Uganda, South Africa and Kenya was 1.1-2.1, 2.7-5.2, and 2.5 respectively in the trial site community. Other observational studies (Gray et al AIDS 2000) have shown reduced male-to-female transmission if HIV+ male was circumcised: IRR~0.41 and if HIV+ male viral load<50,000cps/ml, male circumcised: no transmission, male uncircumcised: transmission 9.6/100 py (p=0.02)

Conclusions

- Male circumcision could have a major impact on the HIV epidemic and can be cost-effective, especially if protective in both sexes and over a prolonged period.

- There is a possibility of reduced penile and cervical cancer, STIs and HIV in both sexes.
- Behavioral disinhibition could offset benefits, and intensive risk reduction and integration with other prevention programs will be required.

Discussion

If all three trials show benefit for men, and if Rakai shows benefit for women, then there is need to provide programmatic services on a large scale. It is important to establish possible confounding between reasons for circumcision, use of other protective measures like condoms and potential HIV effects.

Update on HIV Vaccine Research.

By Dr Hannah Kibuuka, Director, Clinical Programs. Makerere University-Walter Reed Project

Content

Phase I trial to evaluate the safety and Immunogenicity of a multiclade HIV I DNA plasmid vaccine in adult uninfected Ugandans started in late November 2004. The Vaccine is provided by VRC and trial sponsored by DAIDS, NIH, USA. The trail has enrolled 31 volunteers aged 18-40 years. First vaccination was in January 2005 and all vaccinations were completed by June 2005. Volunteers were followed up for 1 year subsequent to enrollment with 100% follow up rate. So far the vaccine has been safe. Immunogenicity results are not yet available.

Phase I/II trial to evaluate the safety and immunogenicity of 2 vaccines, a multiclade HIV I DNA plasmid vaccine and a multiclade HIV I recombinant adenovirus 5 vectored vaccine as single agents or in a prime boost strategy is a multi-center study with sites in Uganda, Kenya and Tanzania. The study will enroll a total of 324 volunteers (108 per site) 18-50 years. Both Uganda and Kenya are currently enrolling. The activities started late march and first vaccination in Uganda was on 3rd May.

Cohort development for phase III vaccine testing is currently underway in Kayunga district. The study will enroll 2000 volunteers (15-49years) who will be followed up at 6 monthly intervals for 3 years. Activities initiated in mid-march 2006 and almost 65% enrollment.

Objectives.

- Determine HIV prevalence and incidence and risk factors
- Determine circulating HIV subtypes
- Evaluate population stability and willingness to participate in vaccine trials

The Study is done in collaboration with Nakasero blood bank using Laboratory reference range, HIV rapid tests algorithm, HIV subtypes circulating and Antibody profile of viruses used as vectors in HIV vaccine design

Planned studies

1. RV 156 A- Volunteers for RV 156 (First phase I trial) will receive Adeno 5 vectored vaccine as a boost.
2. PAVE 100 – Phase II B with a number of Research Networks participating.

5.3 The Aids Support Organisation (TASO). By Dick Muhwezi, Programme Officer, PEPFAR

Content

The organisation was started in 1987 by Noerine Kaleeba and 16 others and the mission is ‘To contribute to the process of restoring hope and improving the quality of life of people infected and affected by HIV/AIDS. Services offered include:

Counselling: positive living, prevention and adherence.

Testing: At registration, during recruitment onto ART, during home based HIV counselling and testing (HBHCT)

Sensitization: drama group performances and health talks

Medical: diagnosis and management of opportunistic infections and STDs, ART

Offer basic care package-Septrin prophylaxis, safe water vessels, water guard, +/- condoms and bed nets, social support, training

Lessons learnt

- Proper and timely accountability-financial and programmatic-is important.
- Proper Information management is key to success

- Meaningful involvement of clients in care is necessary
- Quality services create demand
- Productive collaboration is inevitable
- Effective advocacy is important
- Staff turnover causes programmatic disruptions
- Its necessary to integrate ART into core services

Recommendations

- Improve collaborations and networking
- Invest more in information management systems-infrastructure and personnel
- Institute systemic solutions to combat effects of staff turnover
- Integrate ART into our core services
- Intensify efforts to prevent transmission of HIV

5.4 Effectiveness of repeat single-dose Nevirapine in subsequent pregnancies among Ugandan women. By Dr. Flavia Matovu from MUJHU

Objectives:

- 1.To determine if the risk of HIV transmission among NVP experienced mothers who receive sdNVP again in a subsequent pregnancy is the same or greater than for NVP naïve women who receive sdNVP for the first time at labor/delivery for PMTCT
- 2.To determine the proportion of NVP-experienced and NVP-naïve women with NVP-resistant mutations following repeat or initial sdNVP

Contents:

Single-dose Nevirapine (sdNVP) is widely used for prevention of Mother-to-Child Transmission of HIV in resource limited settings. The study, which was of a cohort design, used two groups, the prospective and retrospective group. The primary outcome was to compare the HIV transmission rates for NVP experienced versus NVP naïve mothers based on infant DNA PCR results. The retrospective group included women who had either sdNVP or short course Zidovudine (ZDV) in HIVNET 012; followed by sdNVP in a subsequent pregnancy. Prospective group included women from the PMTCT

program at Mulago Hospital who either had prior NVP exposure or were NVP naïve; and then received sdNVP peripartum in the study pregnancy and were followed for 12 months post partum.

For the retrospective group, the percentage of infected infants in the NVP experienced was 11.8%, and 17.1% in the NVP naïve. In the prospective group followed up at 6-9 months, the percentage of infected infants was 18.4% in the NVP experienced, and 17.5% in the NVP naïve. These findings from a total of 201 infants born to HIV infected Ugandan women indicate there were no significant differences in infant infection rates for NVP experienced versus NVP naïve women

Resistance testing on the prospective group has not yet been completed.

Conclusions:

The results are reassuring and provide evidence that use of sdNVP in subsequent pregnancies remains an effective option for PMTCT in resource limited settings where more complex regimens are not yet feasible.

Discussion

It is important to ascertain whether the NVP-resistant mutations do remain dormant for years and can get re-activated later in one's life.

SESSION VI, CHAIRMAN: DR ANDREW KAMBUGU

6.1 Discontinuation and Modification of Highly Active Antiretroviral Therapy among HIV Positive People in Kampala. By Mr. Ronald Kiguba

Objectives:

1. To determine the prevalence of HAART discontinuation among HIV+ people in Kampala
2. To identify the factors associated with HAART discontinuation among HIV+ people in Kampala.
3. To determine the prevalence of HAART modification among HIV+ people in Kampala
4. To identify the factors associated with HAART modification among HIV+ people in Kampala.

Content:

There is concern that antiretroviral therapy discontinuation and modification are recent phenomena challenging the roll-out of ARVs in Uganda. This cross-sectional study was conducted at Joint

Clinical Research Centre and Mulago Hospital between December 2005 and March 2006. In all, 686 respondents were interviewed.

- **HAART Discontinuation:** The simultaneous stopping of all antiretroviral drugs used in a HAART regimen for a period of at least 1 month in patients who have been on treatment for at least 14 days.

- **HAART modification:** The changing or switching of at least one of the antiretrovirals used as part of an initial HAART regimen for patients who have been on treatment for at least 14 days. More than one changes for an individual were registered as a single modification in this study. Dosage adjustments were not considered as modifications.

Findings:

1. Prevalence of HAART discontinuation (13.7%) and of HAART modification (25.5%) were higher than those observed in Asia and in Europe
2. Risk of discontinuation of HAART was high among the hospitalized, ART-experienced, users of alternative medicines, those on therapy for less than 1 year & those who started treatment after 2004
3. Risk of modification of HAART was high among the unmarried, those on therapy for more than 3 months, those who started ART in 2004 or earlier and individuals taking more than 2 pills of regimen

Recommendations

1. National estimates of the extent of discontinuation and modification of ART need to be established in countrywide longitudinal studies of ART utilization.
2. The components of patient counselling should be updated regularly with emerging patient risk factors for discontinuation and modification of antiretroviral therapy.
3. MOH should develop IEC materials on the dangers of voluntary discontinuation of ART. More public awareness campaigns involving even patients successful on ART should be developed and implemented.
4. Training programmes targeting more health care providers should be scaled up to equip them with the ability to make finesse decisions on when to change or not to change antiretroviral therapy.
5. MOH should harmonize the practice and roles of traditional and complimentary medicines with the ART programmes

Discussion

It was observed that 60% of individuals discontinuing antiretroviral therapy were defaulters and this is a big challenge.

Spiritual healing and use of alternative medicines need to be harmonized with ART.

6.1 Prevalence & Factors associated with Tuberculosis Infection among Primary School Children in Kampala. By Dr Charles Namisi.

Objectives:

1. To determine the prevalence of TBI among primary school children in Kawempe Division
2. To identify factors associated with TBI among primary school children in Kawempe Division

Study design

This was a cross sectional study carried out among primary schools in Kawempe Division, Kampala District. A total of 768 pupils were recruited into study.

Findings:

1. The prevalence of TB among primary school children in Kawempe Division, Kampala District was high (25.1%).
2. The factors associated with TBI among primary school children in Kawempe Division were;
 - Social demographic (male sex, adolescent age, children from households headed by a non prof parent/ guardian & children in schools located in commercial areas)
 - Clinical features (haemoptysis, and BCG scar seen).

Discussion:

1. It was noted that the prevalence in Kawempe was twice as high as the national estimate. Similarly Guwatudde and others obtained rates that were five times those in the WHO report.
2. TB infection and disease are a continuum. Expertise is needed to set up a cut-off level for the Ugandan setting.
3. It was noted that its unwise to give BCG vaccine since its only useful in prevention of severe disease.

Proceedings of the Special General Meeting

Speech by Chairperson- Ms. Jayne Byakika Tusiime

At the close of the scientific meeting, the paid-up members of the USHS were requested to stay behind for a special general meeting.

The society chairperson, Ms. Jayne B Tusiime, highlighted that various study findings had been disseminated in the conference and encouraged members to use the opportunity offered by the USHS to disseminate their research findings. She thanked members for their active participation and also acknowledged the USHS secretariat for their tireless commitment. Members were also encouraged to pay their subscription fees for the current year.

She brought to the attention of members that this was not an annual general meeting but rather an ad hoc meeting. Members were informed that the treasurer of the society had resigned and left the country and this position had been vacant for some time. A board meeting had earlier been convened and Dr Carol Onyango elected as the acting treasurer. It was therefore necessary to have her confirmed and have a new board member elected to replace her.

The formal conference was closed at 3:34 PM.

FOGARTY ALUMNI ASSOCIATION MEETING

Dr. Kenneth Kintu gave a brief background, present status and way forward for the association.

Background

- The Fogarty Alumni- any body who has received training with funding from Fogarty International.
- The idea had been conceived by Dr. Kanya and Dr Whalen who sourced for funding to kick start the activities of the alumni association. The alumni association among various activities is to bring together alumni from any Fogarty sponsored program for networking and establishing links.
- USHS had earlier tasked two board members (Dr. Kenneth Kintu and Dr. Denise Meya) to carry out preliminary work leading to the launch of the Alumni association. The activities

included: Generate list of former fogarty grantees, setting a data base and launching the association among others.

- The association was officially launched on the 2nd of June 2006 at Grand Imperial hotel where 37 members attended.

Fogarty Programs in Uganda

- AIDS International Training and Research Program (AITRP) at Case Western Reserve University
- International Clinical Operational and Health Services Research on TB and AIDS (ICOHRTA)
- AITRP at university of California, Berkeley
- AITRP at Johns Hopkins
- Malaria and other infectious Diseases training

Possible activities of the Alumni Association

- Participate in presenting at scientific workshops and journal clubs
- Proposal writing
- Participate in service projects to raise awareness of diseases and fundraise money.
- Participate in health related Radio talks
- Poster session.

Fogarty subcommittee

- Its consists of four members: Drs. Mose Joloba, Jim Aizire, Fred Nakwagala and Damalie Nakanjako. They will work in collaboration with the Program Officer and two board members of the USHS. Their roles are to formulate Alumni objectives, activities and pave the way forward.

Fogarty Committee Position

- Strategy: To integrate the Fogarty alumni in the USHS
- Specific:

1. Actively involve the Alumni in the USHS activities e.g. presentations
2. Mobilize the alumni into post-training activities e.g. research
3. Promote net working and social interaction among the alumni.

Resolutions

- The alumni should be an interest group within the USHS
- The USHS secretariat to carry out alumni activities
- The alumni to have permanent representation on the USHS board.
- Subcommittee to oversee the alumni activities

Other

suggestions

- Counsel and guide new Fogarty members
- Grant sourcing
- Mentoring
- Help new graduates to publish
- Ensure USHS Constitutional changes to involve the alumni.
- Encourage presentation of their work.

Discussion

- Members were requested to register and provide their contacts so that they can easily be accessed
- It was stressed that apart from Case Western, other alumni such as those from University of Alabama, Berkeley, UCSF, and Johns Hopkins should be brought on board.
- A database of all alumni should be maintained
- A member requested to know about the origin of the Fogarty. Dr. Whalen informed members that the founder, John Fogarty was a congressman who founded the international programme in 1964. Concern then was population explosion. As a centre, Fogarty, obtains money through the various departments of the National Institutes of Health.

- A member updated the meeting that a USHS newsletter was to be released the week of the conference. Members were encouraged to prepare articles that can be published in the special editions of the newsletter.
- An aspiring member sought information about how one can become a beneficiary of Fogarty. A recipient thereafter highlighted that there is a need to tell others about the available opportunities of the international programme.
- Dr. Whalen informed members that the selection process is competitive and recruitment is not always sure deal. He also stated that there is a move to emphasize postgraduate training locally here and focus on only PhDs abroad.
- A member suggested that a presentation be made at medical school to attract people to obtain similar training.

Dr. Kenneth Kintu passed a vote of thanks to Dr. Whalen on behalf of all Fogarty recipients and the session ended at 4:36 PM.

7th Annual conference rappouters:

Dr. Kenneth Kintu

Dr. Fred Sewankambo

Dr. Dithan Kiragga

Mr. Ronald Kiguba.

EVALUATION OF THE ANNUAL CONFERENCE.

A total of 159 participants attended the meeting. The list of participants and their contacts has been attached. For purposes of improving future organization and conduct of scientific meetings, the USHS requested the participants to fill out an evaluation form that had been provided.

Below is the summary of the participants' evaluation of the scientific meeting.

PARTICIPANTS' EVALUATION OF THE WORKSHOP

Activity /item	Average or below (%)	Good or Excellent (%)
Venue	10.6	89.4
Meals	11.6	88.4
Responsiveness from the secretariat	3.5	96.5
General conference organization	3.4	96.6
Oral presentations	6.8	93.2
Poster presentations	18.5	81.5

Comments made participants

1. Venue

'Accessible and appropriate'. 'Places of convenience were far from the conference hall'. 'Good climate and sound'. 'Exclusively quiet environment'. 'The venue was so conducive and it is just good'. 'Good but very cold at times'. 'Toilets too far'

2. Meals

'Great food, thanks'. 'Except for so many flies'. 'Good quality'. Quick service and good food' 'Very good and appetizing'. 'Very delicious'.

3. Responsiveness from the secretariat

Some presentations were not available in hard copy.

Each time a participant asked for some assistance it was give. They worked very hard. Thank you. 'please reply quickly if the abstracts are accepted for better preparation'. Cissy and the friends have good public relations'.

4. Overall Conference Organization

The best in a long time. Keep it up. Well organized, though few male organizers were involved'. More time was needed for more detailed discussions'. Good venue, excellent time keeping'. 'I was happy to be given hand-outs, it gave me time to concentrate on the presentations'. 'Congratulations! High quality conference'.

A very well organized place'. 'Appropriate venue, good and varied presentations

Every thing was on time'. 'Could have been better with more advertisement'.

5. Oral presentations

'More research on ART still needed. We don't make a balance between HIV and TB. No studies done among the youth of Uganda.' Well arranged and good time enforcement'.

'Great presentations, Dr. McAdam was amazing'. 'Morning presentations are rushed up a lot'.

'Very good work done.' 'All very good, some were excellent, and some sounded like they love what they do, like Dr. Alamo.

Presentations were audible and all questions were well explained.

5. Poster presentations

'Posters should have had their owners standing by them at all times' Words on posters could hardly be read from behind'. The display room was small, an open place would have been preferable'. 'Poor venue choice'.

'Were well done'. More time should be given to them and not just break time'.

Most information was well displayed'. 'Were well written but few'. Poster quite a distance from the conference room'.

List of Conference Participants

S.no	Names	Organization	Tel Contact	E-mail
01	Dr.Awor Phyllis	Medical Research Council	0712-651573	Phyllis.nsereko@gmail.com
02	Ms. Owacha Immaculate	I.U.I.U		owachaalli@yahoo.com
03	Ms.Olweny Angella	Volunteer		0772-847761
04	Dr. Andrew Kiboneka	TASO	0712-685780	akiboneka@yahoo.com
05	Dr. Nansubuga Emma Jane	STD Clinic	0782-109122	
06	Dr. Amuron Barbara	MRC		b_amuron@yahoo.co.uk
07	Ms. Nakalanzi Sarah	Faculty of Medicine		snakalanzi@med.mak.ac.ug
08	Ms. Namugunya Rosette	Faculty of Medicine	0782-847772	r_narosen@yahoo.co.uk
09	Dr. Fred Ssewankambo	IDC	0782-463412	ssewaf@yahoo.com
10	Dr. Pauline Byakika	IDI		pbyakika@gmail.com
11	Mr. Arinaitwe Innocent	Kabubbu Dev. Project	0782-862728	
12	Dr. Nakazibwe Martarine	MRC	0772-609161	kawoovarene@yahoo.co.uk
13	Dr. Christine Watera	MRC		Christine.watera@mrcuganda.org
14	Dr. Mpendo Juliet	MRC	0782-481045	mpendoj@yahoo.com
15	Ms. Mercedes Mock	Private participant		mercedesmock@hotmail.com
16	Ms. Lakomekeen Nancy	Private participant	0772-601197	
17	Mr. Dennison Kizito	MRC/UVRI	0772-445920	Denison.kizito@mrcuganda.org
18	Ms. Tumwekwase Grace	MRC/UVRI	0782-481894	Grace.tumukwase@mrcuganda.org
19	Ms. Adoch Stella	M/Bay Hospital	0772-677099	Adoch_stella@yahoo.com
20	Ms. Melissa Cunningham	IPH-Makerere	0774110313	melissamecunningham@yahoo.com
21	Dr. Freddie Kibenge	MRC-Masaka	072-435251	fkibenge@yahoo.com
22	Dr. Kimeze J Mbalira	STD Clinic- Mulago	0782-881978	joshuakimeze@yahoo.com
23	Dr. Apollo Basenero	IDI	0782-580-611	Apobase77@yahoo.com
24	Dr. Nkalubo ML	UMMB	0772886374	
25	Dr. Irene Andia	Mbarara University	0772-483289	andiaodanga@yahoo.com
26	Ms. Byamukama Sam	Mengo Hospital	0772634156	
27	Dr. Sekiziyivu Denis	Makerere University Hospital	0772834883	

28	Dr. Fiona Kalinda	UVRI-IAVI	0772443751	
29	Ms. Olubunmi Ogundadegbe	MUIPH		oogundadegbe@wesleyan.edu
30	Ms. Anita Sarathi	MUIPH		aaasarati@yahoo.uk.com
31	Ms. Manyangwa Grace	PIDC		gsegobe@yahoo.com
32	Dr. Philippa Musoke	Pead Dept, Makerere	041531875	pmusoke@mujhu.org
33	Ms. Nakayima Flavia	IPH-CDC		flatmiiro@yahoo.com
34	Dr. Sheila Baingana	Mildmay		sbainga@yahoo.co.uk
35	Dr. Carol K. Pool	UVRI/IAVI		cpookonde@yahoo.com
36	Dr. Ekoku Yuventine	Mulago Hospital Med.Sch.	0772668747	ekokuy@med.mak.ac.ug
37	Ms. Bridget Nanteza	UVRI		Bridget.nantenza@mrcuganda.org
38	Dr. Ssemganda Aloysious	UVRI/IAVI	0772334633	assemaganda@iavi.or.ug
39	Dr. Sebatta Elias	Mulago Hospital	0772500571	eliasmse@hotmail.com
40	Dr. Aloyo Judith	TASO		Judithaloyo2000@yahoo.com
41	Dr. Odong P. Olwedo	Gulu University	0772840732	p_odong@yahoo.com
42	Mr. Simon Kasasa	MUIPH		
43	Dr. Nabaggala Catherine	TASO	0712735330	kattinamercy@yahoo.com
44	Dr. David Meya	IDI		David.meya@gmail.com
45	Dr. Malinga Stephen	TASO		stunmalinga@yahoo.com
46	Dr. Buwule Grace	Pead Dept Mulago		bbuwule@yahoo.co.uk
47	Dr. Jacky Nyiracyiza	MRC/UVRI		J4cyiza@yahoo.co.uk
48	Dr. Emmanuel Mupisha	IAVI/UVRI		emugisha@iavi.org
49	Mr. Omongot Samson	Makerere Med Sch.	0712-865247	omongotsam@yahoo.com
50	Dr. Paula Munderi	MRC	0772-728715	Paula.munderi@mrcuganda.org
51	Ms. Kyeyagali Robert	IPH	0712-352115	Rchair2000@yahoo.com
52	Ms. Muwanga Farida	UPDF	0772-570277	
53	Dr. Shevin Jacob	IDI		sjacob@post.harvard.edu
54	Mr. Amana John	ADAPT		adaptconsults@yahoo.co.uk
55	Dr. Stephen Schrantz	IDI		Stephen.schrantz@uchospitals.edu
56	Ms. Omeera Mildred	EBB Hospital	0712367132	
57	Dr. Chris Moore	IDI		
58	Dr. Daniel Kyabayinze	RCQHC		dkyabayinze@rcqhc.org
59	Dr. Damalie Nakanjako	Mulago Hosp		drdamalie@yahoo.com
60	Ms. Margaret Winchester	CWRU		Mxw103@case.edu
61	Dr. Ajay Sethi	CWRU		Aks26@case.edu
62	Ms. Joseph Kasaija	Girimbabazi	0752423514	ngerojoseph@yahoo.com

63	Dr. Kenneth Kintu	MUJHU	0782571450	kkintu@mujhu.org
64	Ms. Sarah Nakamanya	MRC	0772514990	nakamanyasarah@yahoo.com
65	Dr. Fred Lyagoba	MRC	0752534345	Fred.lyagoba@mrcuganda.org
66	Dr. Deo Ssemwanga	MRC	0752655177	Deogractius.ssemwanga@mrcuganda.org
67	Ms. Adong L Judith	Makerere University	0772957772	adongjudith@yahoo.co.uk
68	Ms. Nabatanzi Rose	UVRI/IAVI	0772603646	rosemagala@yahoo.com
69	Mr. Lutangira J Reeves	MRC	0782027342	Esiyabj04@gmail.com
70	Mr. Sendaula A Charles		0782265943	asseysend@yahoo.com
71	Ms. Nicole Gatoni	NEC Health World Pharm		ngatoni@gmail.com
72	Ms. Ameka Christine	MRC		
73	Dr. Sarah Coutinho	UVRI/IAVI		scoutinho@iavi.org.ug
74	Dr. Monica N Balyeku	UVRI/IAVI	0772842025	mbalyeku@iavi.or.ug
75	Mr. Moses F Nsibambi	YHO	0782859822	youthhealthorgan@yahoo.com
76	Mr. Kukeera James	YHO	0782205044	youthhealthorgan@yahoo.com
77	Ms. Christine Tusaba	Mulago Hosp		tusabk@yahoo.com
78	Dr. Moses Kanya	Makerere University		mskanya@infocom.co.ug
79	Mr. Mulindwa Hannington	Mulago hospital		hmulindwa@hotmail.com
80	Dr. Habyara Emmy	Jinja Hospital		habyaraemmy@yahoo.com
81	Dr. Doris mwesigire	MJAP		dorismutabazi@yahoo.com
82	Dr. Namagembe Imelda	Mulago Hospital		namagime@yahoo.com
83	Ms. Unia Nalugya	UEEF		uniagya@yahoo.co.uk
84	Dr. Musinguzi Patrick	MUK		musingtri@yahoo.com
85	Dr. Wesonga Irene	EBB Hosp		wesongaim@yahoo.com
86	Ms. Cissy K Nabahubi	Ebb Hosp		
87	Ms. Nakitende A J	MUK		janakitex@yahoo.com
88	Mr. Norbert Anyama	MUK		nanyama@med.mak.ac.ug
89	Dr. Muwanga Moses	EBB Hosp	0772-455619	
90	Dr. Sabrina. B Kitaka	Dept, Pead Mulago	0772401790	sabrinakitaka@yahoo.co.uk
91	Ms. Rwagata Alphosine	RRP Rwanda		00378435321
92	Ms. Isabelle Nizeyimana	RRP Rwanda		nizisabelle@yahoo.fz
93	Dr. Andrew Kambugu	IDI		akambugu@idi.co.ug
94	Mr. Mubiru Joseph	COWESER-Rakai		mubjosey@yahoo.co.uk
95	Dr. Muramuzi Emmy	IPH-CDC	0772450967	muramuzi@yahoo.com
96	Dr. Kikare Ben	MRC/UVRI	0772669396	Ben.kikaire@mrcuganda.org
97	Dr. Nakwagala Fred	Mulago	0772325869	nakwagala@yahoo.com

98	Dr. Ayebare Richard	TASO-Mulago	0772614895	
99	Dr Tweheyo Raymond	Gulu Hosp	0772466695	ratweheyo@yahoo.co.uk
100	Ms. Jayne B Tusiime			
101	Dr. Bwire Godfrey	USHS	0712451329	sgbwire@yahoo.com
102	Dr. Nicolette Nabukeera		0772435166	nicbarungi@yahoo.com
103	Dr Ekiria Kikule	Mildmay		Ekie.kikule@mildmay.or.ug
104	Dr. Christine Rugasira		0752647776	
105	Mr. Nabali Joseph	Mulago Hosp	071803841	
106	Mr. Wossita S	Daily Monitor		swossita@monitor.co.ug
107	Mr. Evelyn Liri	Daily Monitor		eliri@monitor.co.ug
108	Dr. Stella A Talisuna	Reach Out		mastalisuna@yahoo.com
109	Dr. Flavia Matovu	MUJHU		fmatovu@mujhu.org
110	Dr. Patricia Nahirya	Kabale Hosp		pnahirya@yahoo.com
111	Dr. Olwenyi Obbo	Mbale Hosp		jsoobbo@yahoo.co.uk
112	Ms. Sarah Mumia	Mulago Hosp	0774019456	
113	Mr. Richard Obedi	TPF-Uganda	0774-114474	richobedie@yahoo.com
114	Mr. Anguzu Rashid	Adjumani Hosp	0772-697292	
115	Dr. Sylvia Kusemererwa	TASO	0772-568682	
116	Prof. Fred Wabwire Mangeni	MUIPH	0772-732206	fwabwire@imul.com
117	Mr. Kalanzi F	TASO	0772899417	kalanis@yahoo.com
118	Dr. Rhoda Wanyenze	MJAP	0772419762	rwanyenze@hotmail.com
119	Mr. Jim Kalyesubula	TV Reporter	0772-992992	Jkalyesubula2008@yahoo.com
120	Mr. Kiguba Ronald	Makerere University		kiguba@yahoo.co.uk
121	Dr. Cecilia Nawavuu	MJAP		cnawavuu@yahoo.com
122	Ms. Cissy Namakula	USHS		Cinam40@yahoo.co.uk
123	Ms. Doreen Kakembo	Volunteer		dkakembo@yahoo.co.uk
124	Ms. Isabella Achokotho	USHS		bellaus@yahoo.com
125	Ms. Janet M Butera	CARE-Rwanda		janetb@care.org.rw
126	Dr. Okia Simon	Gulu Ind. Hosp		angurasp@yahoo.co.uk
127	Dr. JH Obol	Gulu University	0772972991	obolh@yahoo.com
128	Dr. Harriet Mayanja kizza	Makerere University	041-541188	hmk@mucwru.or.ug
129	Dr. Juliet Bataringaya	WHO-Uganda	031262071/6	whouganda@ug.afro.who.int
130	Ms. Namayanja E Kamugisha	Straight Talk Foundation	0772402060	namayanjaem@yahoo.com
131	Dr. Kukkiriza Benjamin	TASO	0782056268	kukkirizaben@yahoo.com
132	Prof. Roy Mugerwa	Dept of Med MUK	041-540718	

133	Dr. Mukulu Cecilia	CWRU	0772640753	Celia.mukulu@case.edu
134	David Mafigiri	CWRU	0782-027085	mafigidk@yahoo.com
135	Dr. Patricia Mwebaze Songa	IDI		Mwebsie76@yahoo.com
136	Dr. Lydia Kiryabwire	COU	0772651252	afaayo@hotmail.com
137	Dr. Peter Kawanguzi	Bugolobi Hospital	0772-436228	kawangunzi@hotmail.com
138	Dr. Wabulya Elizabeth	UWESO	0772-525001	kristekli@yahoo.com
139	Dr. Okwera Alphonse	Mulago Hosp		A-okwera@mucwru.org.ug
140	Dr. Henry Luzze	Mulago Hospital		hluzze@mucwru.or.ug
141	Dr. Noeline Nakasujja	Mulago Hospital	0772419700	drnoeline@yahoo.com
142	Dr. Kiragga Dithan	Plan International		Dithan.kiragga@plan-international.org
143	Dr. Tom Lutalo	Rakai Health Sci. Prog		tlutalo@rhsp.org
144	Dr. Innocent Nuwagira	Uganda AIDS Com		nuwagirabi@yahoo.co.uk
145	Dr. Kamy Ivan	St. Athony Hosp. Tororo		ivankamya@yahoo.com
146	Ms. Gwoyita Loi	CEU MUK		lgwoyita@yahoo.com
147	Mr. Emmy Mayanja	Video & Photography	0772911418	
148	Dr. Katafiire moses	MJAP	0772-654645	katafiiremoze@yahoo.co.uk
149	Ms. Elise Min	MUIPH		elisemin@gmail.com
150	Ms. Mwebesa B Bwana	MJAP		Mwebesa_bwana@yahoo.com
151	Ms. Namugumya Rosette	MUK		N_rosen@yahoo.co.uk
152	Dr. Joan Nankya Mutyaba	CWRU	0772324309	
153	Dr. Galina Boyarinoa	Univ. of Virginia		Gsb7b@virginia.edu
154	Prof F A mmiro	MUJHU	041-541044	
155	Ms. Serufusa Visantos	Media	0782-339259	
156	Dr. Kibuuka Hannah	MUWRP	0772437554	hkibuuka@muwrp.org
157	Dr. Mary Glenn Fowler	MJHU	0782-972080	
158	Ms. Beatrice Orisinga	Fine Health Products		fine@fineservicesltd.com
159	Mr. Martin K Asimwe	Fine Health Products		akyammartin@yahoo.com