

## Briefs of a Scientific Lecture held on 9<sup>th</sup> February 2006

Topic	National Roll – out of HIV Care and Treatment
Presenter	Dr. Elizabeth Namagala
Rapporteur	Mr. Turyahebwa Anthony
Chair	Dr. Fred Nuwaha
Audience	90 people attended; 47 males, 43 females
Main point	<p><b>Background:</b> Antiretroviral Therapy (ART) started in Uganda in 1992 at Joint Clinical Research Center (JCRC) as a study of AZT. In 1996, triple therapy was introduced at the Center. In 1998, the Drug Access Initiative in collaboration with UNAIDS was launched. The initiative later demonstrated that it was possible to provide ARVs in low resource settings. In 2001, ART was integrated as part of the Ministry of Health National Program for Comprehensive HIV/AIDS Care and Support.</p> <p><b>Current situation of HIV/AIDS care activities:</b> There has been tremendous progress in increasing access to ART. About 69,000 Ugandan chiefs were on ART by December 2005. Over 182 sites have been accredited of which 170 are providing ART. Recruitment of children into care has been however slow.; only 6000 children &lt; 15yeras (8.67%) have accessed ART. There has been reduction of patients paying for ARVs for over 85% in 2002 to about 24% (Dec. 2005). In general, there has been countrywide scale up of HIV care activities: HCT, PMTCT and home based care.</p> <p><b>National Scale up plan for ART services in Uganda:</b> Phase 1 covered all the regional referral hospitals. This was completed by Dec. 2003. Phase 2 covered all the district and other hospitals. This was completed in Dec.2004. Phase 3 will be completed by Dec.2006 and will cover health centers IV. Phase 4 is not yet not yet started but intends to cover lower level facilities / communities.</p> <p><b>Preparatory steps for ART Roll – Out:</b> The 1<sup>st</sup> step was to develop policy and guidelines. This involved standardizing the delivery of ART and providing guidance to implementers and partners. The next step was capacity building that involved countrywide trainings of health workers in Comprehensive HIV/AIDS Care including ART management. Resources were managed from donor agencies for ART roll out. Because ART succeeds in an environment of comprehensive care, there were scaling up of the HIV services like HCT, provision of I.E.C, treatment of opportunistic infectitious diseases. Lastly, sites were accredited. This was after they had satisfied the required accreditation criteria. These criteria include human resource i.e. the site must have a doctor, counseling support, laboratory capacity, adequate security and ability to manage data bank.</p>

**Key policy recommendations:**

These include accreditation of all health facilities before provision of ART services, use of simple but effective ARVs drug regimens, use of both generic and branded drugs, procurement of ARVs from WHO pre qualified companies which are registered in Uganda by National Drug Authority, free ARVs for HIV prevention i.e. PMTCT, post posure prophylaxis and integration into existing services.

**Coordination of ART activities:**

Ministry of Health is responsible for over all coordination. The National ART Committee is responsible for guiding policy, guideline development and evaluation of ART program. At the district level a coordinating team for ART is recommended. At the ART center level, the health unit based care team provides and coordinates ART services.

**Capacity building for HIV care**

- Strengthening regional referral hospitals capacity to train, mentor and supervise lower health facilities
- Training and establishment of clinical teams in each facility
- Over 1663 health workers have so far been trained (sept. 2005); 1 medical, 1 clinical officer, 2-3 nurses, 2-3 counselors, 1 pharmacist / dispenser, 1 lab person.
- Strengthening referral network across a continuum
- HIV algorithm was incorporated in IMCI for identification of children with possible with possible HIV
- Ministry training materials have integrated the pediatric component of HIV care.

**Recommendations for starting ART:**

Adults and adolescents with documented HIV infection and:

- WHO stage IV disease with any CD4 cell count
- Advanced WHO stage III disease with any CD4 count or total TLC (persistent or recurrent oral thrush and invasive bacterial infections
- WHO stage I, II, or III with CD4 cell counts = or < 200/mm<sup>3</sup>.
- T.B and CD4 200 – 350mm<sup>3</sup>

**Recommendations for starting ART in Children**

< 18 months

- WHO pediatric stage III with irrespective of CD4 count
- Advanced pediatric stage II
- WHO stage I disease or stage II with CD4 cell percentage < 20%

< 18 months

- WHO pediatric stage III with irrespective of CD4 cell count
- Advance pediatric stage II
- WHO Stage I disease or stage II
- WHO Stage I stage I disease or stage II with CD4 cell percentage <15%.

Adherence to ART

	<p><b>Adherence to ART:</b></p> <ul style="list-style-type: none"> <li>- Adherence counseling is emphasized before ART initiation</li> <li>- Assessment for adherence and ongoing counseling after initiation after initiation of ART</li> <li>- Training of adherence counselors / educators</li> <li>- Use of simple regimens (triple combinations)</li> <li>- Use of treatment supporters (family or community)</li> <li>- Involvement of PLWAs in treatment education and adherence support.</li> </ul> <p><b>Available resources</b>  Available funds for the public sector (US\$ 50millions) can support 35,000 – 40,000 patients for 3 years. The PEPFAR (Presidential Emergency Plan for AIDS Relief) is targeting 70,000 patients over 5 years. Other partners and providers of free ART services include: AIDS Healthcare Foundation, MS – France, CDC Tororo, GTZ Clinical Trials.</p>
<p><b>Questions</b></p>	<p><b>Qn. 1.</b> Many innovations are going on. Is there operational research being done to find out whether everything is going on well?  <b>Ans.</b> There are plans for that and some initial studies are going on.</p> <p><b>Qn.2.</b> What do you intend to do after the funders have pulled out?  <b>Ans.</b> There are plans to that effect but it is still on paper. We are encouraging cost recovery for patients who are able. We are also thinking about the possibility of levying a special tax. We are also involved in more resource mobilization.</p> <p><b>Qn 3.</b> Are you making enough plans to scale up pediatric roll – out for ART?  <b>Ans.</b> We are beginning a program to do pediatric testing. This will be through PMTCT program.</p> <p><b>Qn 4:</b> What are you doing for universal access to ART?  <b>Ans.</b> There are enough ARVs currently. In fact at one time, ART providers were competing for clients.</p> <p><b>Qn 5:</b> Given the problem of sustainability, what is the view of the Ministry of Health in regard to the use of herbs?  <b>Ans.</b> Ministry of Health promotes herbal medicine. Ministry has established a National chemotherapy Laboratory.</p>