Experience with Decentralization of Lifelong ART for Pregnant & Lactating Women (Option B+) in Uganda:

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## Uganda Demographics

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<tbody>
<tr>
<td>Population</td>
<td>37 Million</td>
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<tr>
<td>Fertility Rate</td>
<td>6.2 children/woman</td>
</tr>
<tr>
<td>CPR</td>
<td>30%</td>
</tr>
<tr>
<td>HIV Prevalence in adults</td>
<td>7.3%</td>
</tr>
<tr>
<td>Prevalence in Children 5 yrs. and below</td>
<td>0.6%</td>
</tr>
<tr>
<td>HIV Prevalence in Pregnancy</td>
<td>5.5% down from 6.5% in 2004/5</td>
</tr>
<tr>
<td>HIV+ pregnancies in FY 2013</td>
<td>107,000 from 101,000 in 2013</td>
</tr>
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</table>
HIV Prevalence by Region

Percent HIV-positive women and men age 15-49 who are HIV-positive

Uganda
7.3%

West Nile
4.9%

Mid Northern
8.3%

North East
5.3%

Mid Eastern
4.1%

East Central
5.8%

Central 1
10.6%

Central 2
9.0%

Mid Western
8.2%

South Western
8.0%

Kampala
7.1%
Country Context-1

• The response to HIV/AIDS in Uganda has been guided by the Decentralized Policy since 1992, in recognition of the effects and the impact of HIV/AIDS at community level.

• The decentralization Policy has been a key vehicle for improving service provision, promoting democratization and ensuring good governance and to empower local communities to take control of their own development strategies.

• Under this policy, coordination structures and partnerships were developed at the national & Sub national levels with strong participation of CSOs and PLHA networks.
Country Context-2

• Health Service Delivery was also decentralized to the district level since 1994.
• The Ministry of Health provides Oversight Function
• Levels Health of Health Facilities
  ➢ 2 National Referral Hospital
  ➢ 13 Regional Referral Hospitals
  ➢ 114 General/District Hospitals
  ➢ 187 Health Centers IV’s
  ➢ 1114 Health Centers III’s
  ➢ 55 Centers of Excellence

**Altogether 1430 Health Facilities targeted for ART service by Policy**

➢ 3008 Health Centers II’s
➢ Health Centers Is (VHT- No infrastructure)
Implementation of Decentralised Response -1

• Preceded by Policy revisions to;
  – Accommodate rational use of Human resources for Health (Task Sharing) which provided for Nurse-led initiation of ART
  – Allow for Decentralization of ART to lower HC III level

• Development of training package
  – 6 day for rolling out the new EMTCT Guidelines in line with option B+
  – 13 day package for training new Sites for accreditation

• Tailored Mentorship guide and schedule lead by MOH in collaboration with IPs.

• Resource Mobilization; $25m from USG, buy in from GOU & Various ADPs
Implementation of Decentralised Response -2

- Was guided by revised accreditation criteria and tools developed to cater for the changing landscape in HIV prevention, care and treatment.

- Required Harmonization of the PMTCT & ART order forms & Master lists, shared with all warehouses. Master List updated each quarter to include new sites.

- Development and rolling out of the Web Based ART ordering system.

- Supply Chain Rationalization “one site one source”
Flow for ARVs in SCR

One site one supply (69% NMS, 20% JMS & 11% MAUL)

Buffering at National Level

NMS

Stock trading

All Public ART sites

Stock trading

MAUL

CDC supported PNFP

USAID supported PNFP & PFP

JMS

IPs provided Technical assistance and not buffer stocks
ROAD MAP FOR DECENTRALIZATION OF GUIDELINES (Phased Roll Out)

April-Aug 2014
• Policy revisions
• Preparation of training materials and medicines procurements

Sep - Dec’12
• Phase 1 roll out
• Training of Trainers and HW & pushing drugs to HF

Dec ‘12 – Jan ‘13
Phase 1: Roll out evaluation and tools update

Feb ’12-Mar ‘13 2014
Phase 2: Roll out

April to Aug 13-
Phase 3 Roll out
Evaluation of roll out in Oct’13

Evaluation Oct- Nov 2013
Why Phased Rollout: Determined by the HIV prevalence rates.

- Reduced risk of Option B+ stock-outs and Option A expiries
- Consistent treatment at lower-level and referral facilities in same region
- Experience from initial Phases could be used to improve the other Phases

- Sept 12 – Dec 2012
  - Kampala, Central I and II

- February – Mar 2013
  - South West, Mid Northern and Mid Western

- April – Sept 2013
  - East Central, Mid-Eastern, Northeast West Nile & Karamoja

- Oct- Nov 2013
  - Fully transitioned in 12 months
  - End of roll out Evaluation
## Main components of the Decentralization process

<table>
<thead>
<tr>
<th></th>
<th><strong>Regional Sensitization and Coordination meetings</strong></th>
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<tbody>
<tr>
<td>1</td>
<td>• 1-day orientation meetings by MOH</td>
</tr>
<tr>
<td></td>
<td>• With the IPs, DHOs and PMTCT FP</td>
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<td></td>
<td>• Includes 8-10 districts</td>
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<table>
<thead>
<tr>
<th></th>
<th><strong>Districts Entry Meetings</strong></th>
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<tbody>
<tr>
<td>2</td>
<td>• 1-day orientation meetings by MOH and IPs</td>
</tr>
<tr>
<td></td>
<td>• Involves extended DHT (Technical and Political arms)</td>
</tr>
<tr>
<td></td>
<td>• Agreeing on roles and responsibilities and training plans</td>
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<thead>
<tr>
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<th><strong>B-Plus training Workshops for Health Workers</strong></th>
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<tr>
<td>3</td>
<td>• 6-day and 13-day training, preferably residential</td>
</tr>
<tr>
<td></td>
<td>• Includes 5-7 facilities</td>
</tr>
<tr>
<td></td>
<td>• Mix of didactic modules and practical exercises</td>
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<table>
<thead>
<tr>
<th></th>
<th><strong>Scheduled Mentorships</strong></th>
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<tr>
<td>4</td>
<td>• Continuous mentorship visits to ensure program is functioning effectively</td>
</tr>
<tr>
<td></td>
<td>• 4 visits per year— at 2 wks, 1.5 months, &amp; then quarterly</td>
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</table>
B-Plus implementation components...

5. Provision & orientation on Data tools
   - Many new data tools, job aids, posters, and brochures were made and sites needed to access them to implement

6. Provision of medical equipment
   - Weighing scale, height board, head circumference tapes, etc
   - Med equipment essential for integration of care into EID

7. Follow-up for lost mother/infants
   - Sites either receive airtime for phone calling, or support for home visiting, this is happening in various modes in different places.
Roles and Responsibilities for key stakeholders

**MOH responsibilities:**
- Creation of training curriculum
- Executing a National Training of Trainers
- Monitoring and reporting on the implementation of Option B+
- Organizing stocks to be used in the trainings and provided immediately after the trainings to the facilities

**IP responsibilities:**
- Printing of all tools (ART register, HIV/ART card, Appointment books etc)
- Executing trainings and mentorships
- Reporting to MoH on progress

**Facility responsibilities:**
- Attend trainings and start implementation at their facilities
HW Capacity Building Sept. 2013

- Roll out package (5 & 13 Day)
- Training of trainers – 400
- HW Trainings Over 3000
- Scheduled Mentorship
- Monitoring

5 day Workshop
5 day Workshop
2 days ongoing per site
Overcoming Challenges 1: Ensuring Adequate Stock Management

- **Integrating new order forms into central stock management**
  - With Option B+, a new form which integrates ordering of ARVs for eMTCT and for Adult treatment, was created and is now in use.
  - All warehouses that supply ARVs were required to integrate this form into their systems.

- **Creation of procurement forecasts for new regimen**
  - MOH created a forecasts of ARVs required to serve current and future patients on Option B+
  - Warehouses have integrated the forecasts into their procurement plans.
  - Creation of the QPPU Unit within Pharmacy to ensure adequate stock monitoring and management was needed throughout the implementation of Option B+, especially as the regimen was also the recommended 1st line for Adult patients.

- **Ensuring ARVs are present during and immediately after trainings**
  - Trainings are most effective when there are the tools available to implement the knowledge health workers have gained. As a result, having the commodities available to implement Option B+ immediately was imperative to the success of the program.
  - For all the phases of implementation, the Central Warehouses had to provide commodities directly to the Implementing Partners, to supply to the facilities immediately following the trainings.
## Overcoming Challenges 2: Ensuring appropriate integration of Option B+ into facility infrastructure

### Encourage Greater Coordination between ANC and ART

**Linkages and Referrals**
The clinicians working in the ART clinic to interact more frequently with ANC to link mothers immediately after delivery to the ART clinic then (now after 18 months)

**Use of tools**
Such as the triplicate referral form, which informs the ART that they are passing a mother from ANC to ART

**Dispensing of ARVs within the MNCH platform**
ART and ANC clinics need to coordinate to ensure both areas are stocked with ARVs

### Larger emphasis on adherence

**Adherence counseling –**
Was stressed in the training curriculum since non-adherence could result in multi-class resistance

**Ensuring mothers enroll in chronic care**
Linkages and referrals is more important than ever to ensure adherence so that widespread resistance does not develop

### Rapid Decentralization

**Rapid accreditation of facilities**
Only a fraction of facilities were ART accredited, but many were offering PMTCT.

To provide chronic care to mothers, many facilities were being prepared to become ART accredited facilities.

Designed on line accreditation tools that was used by IPs to accredit the HF
Overcoming Challenges 3: Strengthen EID lab Services; Regional Hubs for CD4 & DBS specimen collection from 19 to 79; & include Viral load & TB MDR specimens from

The hubs include:

- Aber Hospital
- Arua R R Hospital
- CPHL
- Hoima RR Hospital
- Jinja RR Hospital
- Gulu RR Hospital
- Kabale RR Hospital
- Kagando RR Hospital
- Kamuli Hospital
- Kitgum Hospital
GSM printers, placed at the sample transport hubs, helped to cut further the delay in returning results to facilities, and increased pediatric initiation.

Facility feedback to reduce loss to follow up and reduce TAT of results:
This intervention provides facilities with a list of positive infants that require follow up and a report on their performance on following up children.
M & E: Option B+ reporting thru DHIS2

At a facility
- Aggregate data on 9 indicators
- Enter data - phone (sms)
- Send to DHIS2 central server
- Receive Automatic feedback

At a District
- Validate report
- Approve reports (Completeness)
- Follow-up on missing report

At a National
- League tables
- Follow-up on missing report and query data
- Further aggregation and analysis
### EID Results Turn Around Time (TAT)

<table>
<thead>
<tr>
<th>Facility Level</th>
<th>One Week</th>
<th>Two Weeks</th>
<th>Three Weeks</th>
<th>Four Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>14 %</td>
<td>67 %</td>
<td>5 %</td>
<td>14 %</td>
</tr>
<tr>
<td>HC 4</td>
<td>10 %</td>
<td>65 %</td>
<td>6 %</td>
<td>19 %</td>
</tr>
<tr>
<td>HC 3</td>
<td>12 %</td>
<td>57 %</td>
<td>12 %</td>
<td>19 %</td>
</tr>
<tr>
<td>Overall</td>
<td>12 %</td>
<td>60 %</td>
<td>10 %</td>
<td>18 %</td>
</tr>
</tbody>
</table>

Overall, 72% of health facilities have an EID results TAT of two weeks or less.

The majority of facilities report no positive EID test for mothers on Option B+.
92% of targeted Health facilities were trained and transitioned to option B+ within 12 months.

In addition 360/3008 (12%) of HCIIs were brought on board. It took the concerted effort of all stakeholders [IPS, HWs, District leaderships and national level teams].
### Major Achievements for the eMTCT Programme

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Achievement</th>
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<tbody>
<tr>
<td>Increase in no. of HF offering life long ART</td>
<td>from 1800 to 2,130</td>
</tr>
<tr>
<td>Increase in Pregnant and Lactating women with known HIV sero-status</td>
<td>From 65% in 2009 to 90.4% in FY 2012/13</td>
</tr>
<tr>
<td>Increase in proportion of HIV + preg &amp; lact women on ARVs</td>
<td>~52% in 2009 to 72% in 2012/13</td>
</tr>
<tr>
<td>Reducing number HIV+ infants born in FY 2012/2013 - Up to 1000 new infections averted in 2012 year alone</td>
<td>22,000 in 2009, 16,000 in 2011, 15,000 in 2012, ~8000 in 2013</td>
</tr>
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# Achievements for the ART programme

<table>
<thead>
<tr>
<th>Uganda ART Program Context</th>
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<tbody>
<tr>
<td>Increase in no. of HF offering ART</td>
<td>From 600 to 1,500</td>
</tr>
<tr>
<td>Number in Chronic Care</td>
<td>~800,000 form 450,000</td>
</tr>
<tr>
<td>Number on ART (June 2013)</td>
<td>566,000 (192,000 new clients enrolled in 2012 alone), &gt; 590,000 sept. 13</td>
</tr>
<tr>
<td>Number in Need of ART (CD4 350)</td>
<td>733,127 (CD4&lt;350), &amp; about 1.3m (CD4&lt;500)</td>
</tr>
<tr>
<td>ART coverage</td>
<td>72% (June, 13)</td>
</tr>
<tr>
<td>Pediatric Coverage (&lt;15yrs)</td>
<td>38% (Mar 13),</td>
</tr>
<tr>
<td>12 &amp; 60 month retention</td>
<td>86% &amp; 67%</td>
</tr>
<tr>
<td>12 &amp; 60 month mortality</td>
<td>3.7% &amp; 8.5%</td>
</tr>
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63,000 AIDS related death in 2012 down from over 100,000 in 2009

Coverage drops from 72% to 43% with CD4<500
### Linkage to Care in the Decentralized Response

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>20/12</th>
<th>2013</th>
<th>Target 2013</th>
<th>Linkage Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT –Care</td>
<td>45%</td>
<td>72%</td>
<td>80%</td>
<td>VHT, Expert Clients, HCT Volunteers</td>
</tr>
<tr>
<td>Care – Treatments</td>
<td>60%</td>
<td>73%</td>
<td>80%</td>
<td>Nurse, Counselors</td>
</tr>
<tr>
<td>TB/HIV- ART</td>
<td>32%</td>
<td>58%</td>
<td>80%</td>
<td>Facility TB Focal persons</td>
</tr>
<tr>
<td>PMTCT- ART</td>
<td>20%</td>
<td>80%</td>
<td>100%</td>
<td>VHT, peer/mentor mothers</td>
</tr>
<tr>
<td>EID - ART</td>
<td>22%</td>
<td>??</td>
<td>100%</td>
<td>EID focal persons</td>
</tr>
</tbody>
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Linkage Facilitators are individuals that actively escort/walk patients or samples from one service point to the next appropriate point.
Approaches for Demand Generation & Retention in care in the Decentralised response

- Working with Champions & support agents/PLWHIV
- Utilising the VHTs
- Utilising expert clients who are beneficiaries of the ART program to provide support to fellow clients
- Using Mobile Phones
Major Challenges

- Low Paediatric Coverage
- Slow progress of mentorships and accreditation
- Demand out weighing supply especially of HIV test kits
- Web based ARV Ordering System not universal
- Monitoring adherence and retention to care a key challenge
- Poor documentation coupled with a big number of tools needed to monitor the HIV Response overwhelming the poorly motivated work force
- Poor infrastructure at lower HC IIIs
Conclusions

• Decentralization of Lifelong ART for pregnant and Lactating women HIV services is feasible in resource constraint settings.

• It is a cornerstone for rapidly achieving universal ART access in low income settings.

• However, it should be preceded by a favorable policy framework especially in the rational use of HRH, coupled with close mentorships and routine technical support supervision to ensure quality of services and for confidence building.
Acknowledgment

✓ Government of Uganda (GoU)
✓ Ministry of Health-Uganda (MoH)
✓ USG through PEPFAR
✓ ADPs
✓ Event Organizers
✓ Women and Children Living with HIV who keep our desire burning