

# FIELD PERSPECTIVES ON BRINGING STRONG PROGRAMS TO SCALE

by

**Hon. Dr. Elioda Tumwesigye**

Member HIV/AIDS Committee, Parliament of Uganda

Executive Director , Integrated Community Based Initiatives (ICOB)

*E-mail contact: [elioda@parliament.go.ug](mailto:elioda@parliament.go.ug), [telioda@yahoo.co.uk](mailto:telioda@yahoo.co.uk)*

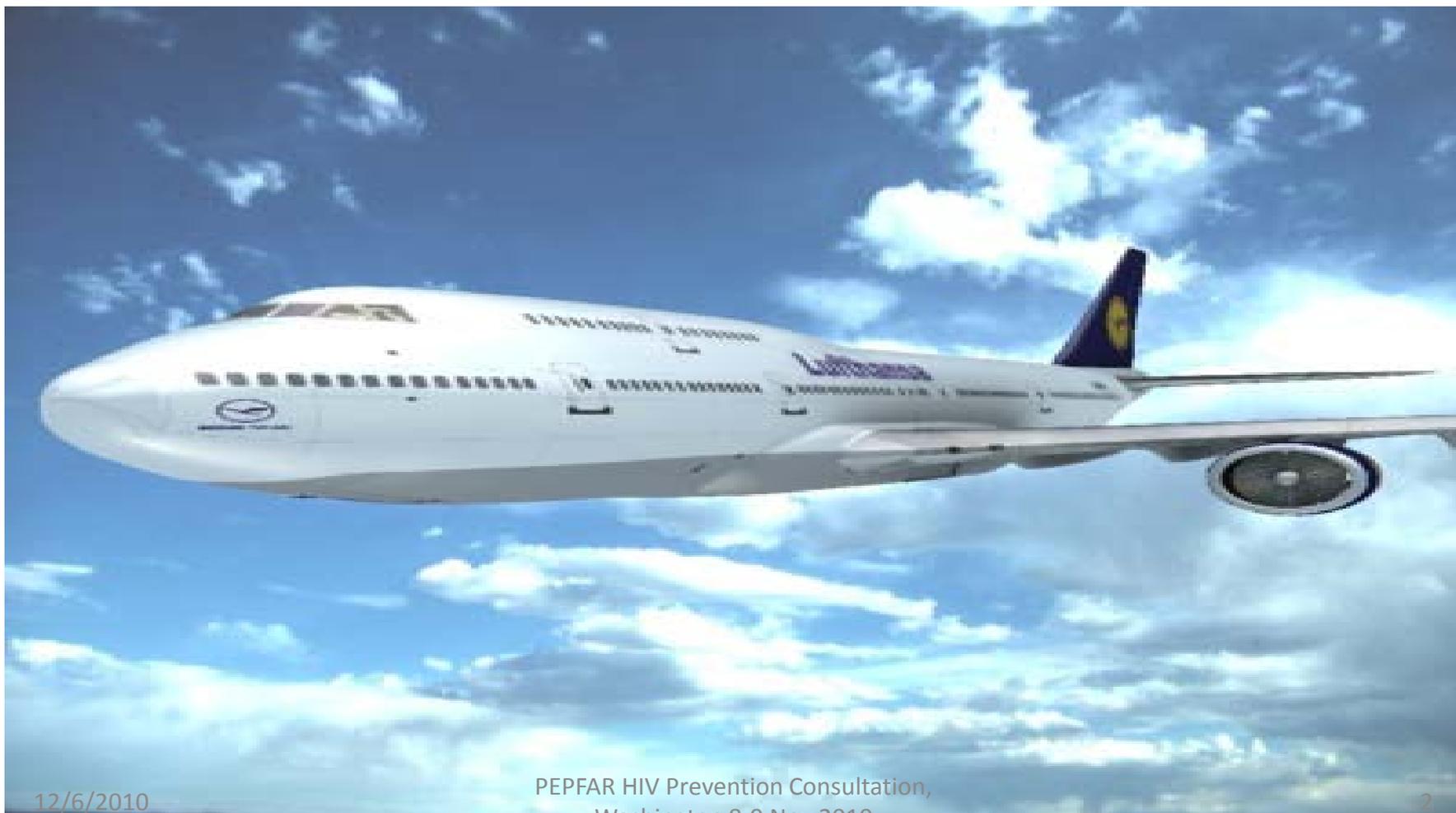


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**“Saving a Life is the Highest Ethical Act one  
can ever do to Fellow Mankind”**

*Full Load of such a plane ~ 400 Passengers*



**2,100,000 Annual AIDS deaths =  
5250 Annual plane crashes @400  
passengers, or 14 Daily plane crashes**



**For every 2 who start ART, 5 new infections occur. How best to turn off the tap water as we mop up the floor**



# HIV Prevention in 2010

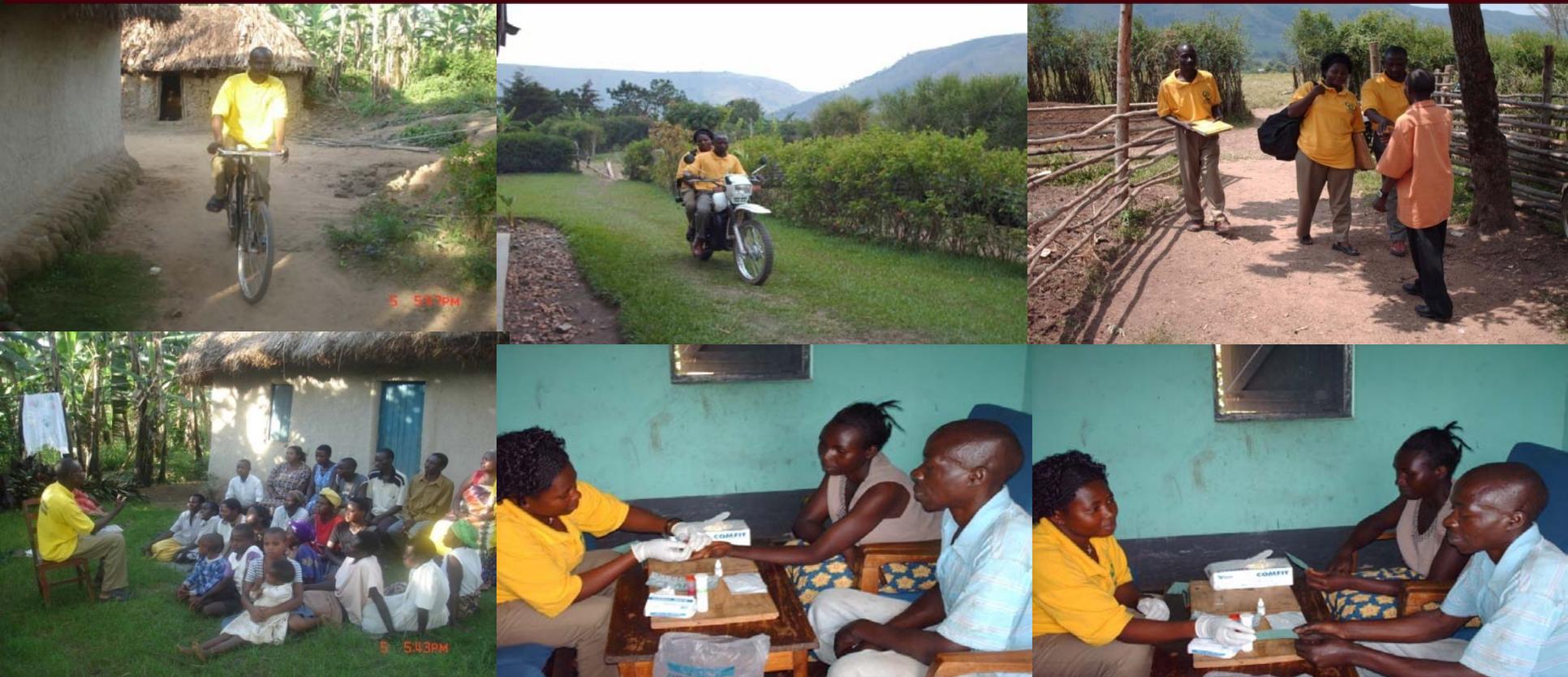
- Critically need evidence-based prevention strategies
- Behavior Approaches that seek positive behavioral and normative changes in individuals, families and communities thru mutually reinforcing multi-level communication efforts
  - Increased condom use esp. among discordant couples
  - Better understand role of & interventions for multiple, concurrent partnerships
- Biomedical Approaches to block infection, reduce infectiousness, and reduce infection risk. Those that have partial efficacy include:
  - PMTCT
  - Male circumcision of HIV-negative heterosexual men (clinical trial data)
  - ART (observational & ecologic data)
  - Tenofovir gel (need confirmatory data)
- New biologic interventions being tested for efficacy:
  - PrEP, microbicides (tenofovir gel daily use), HIV vaccines, ART for prevention
- No single strategy will work alone; need multiple integrated, partially effective biomedical , behavioral and structural interventions
- HIV Counseling & testing – critical entry point to prevention, treatment and care.

# Bringing Strong Programs to scale:

## An example of Home-based Door-Door HCT

- HIV/AIDS in Africa first identified in Rakai Uganda in 1982. Country soon became epicentre of the epidemic. HIV rapidly spread in through out the country resulting into a severe generalized epidemic. By late 1980s/early 90s the virus had spread to all parts of Uganda, affecting different population groups – prevalence 18%
- 2004-05 National HIV Sero-behavioural Survey - only about 11% of men and 13% of women in Uganda knew their HIV status! 80% of those infected (77% F, 85% M) did not know their HIV status.
- Lack of knowledge of one's HIV status and that of one's partners is a key driver of the African HIV epidemic and is associated with 50-66% decreased likelihood of condom use
- Between 2005-2007, we piloted a district-wide door-door home-based HIV Counseling and Testing in Bushenyi district, South western Uganda which showed that one can achieve near universal access to HCT without making it compulsory.

# HBCT in Uganda: Achieving near universal testing without making it compulsory



**Integrated Community Based Intervention, ICOBI:**  
Rural district in southwestern Uganda (~700,000 population)  
**264,966 (94% uptake) tested and received HIV results, identifying**  
**11,300 HIV+ persons**  
**1,700 persons in known HIV discordant partnership**

# High Uptake of Home-based, District-Wide, HIV Counseling & Testing in Bushenyi, Uganda

- Programmatic evaluation of HBCT in rural southwestern Uganda district, 2005 -07
- Successes:
  - Reached 63% of all homes in the district.
  - Of 323,621 people eligible for HCT, 282,857 (87% - coverage) were present at home and offered pre-test counselling.
  - 264,966 (94% -uptake) accepted testing and received HIV results
  - 90% of those tested were previously not tested
  - ~50% of those married or with a sexual partner received results as a couple
  - Reached and tested a majority of adult men
  - Cost of testing = \$7.83 per previously untested client
  - No social harm reported

# HIV+ Persons Identified by HBCT in Bushenyi, Uganda: Linkages to HIV Care

- All 11,359 HIV positive were referred for services
- 110 post test clubs initiated at parish level
- 7,957 basic care kits distributed to HIV+ families
- 10,851 referred HIV+ assessed, initiated on septrin
- Identified HIV+ persons earlier in HIV disease course: coupled with effective linkage to ART maximized both benefits of HBCT & ART.
  - 2085 CD4 samples collected at home, tested at KCRC and results delivered to HIV+.
  - Of these 607 identified ART eligible (CD<200).
  - Mean CD4 – 492.9, Median CD4 -432 (IQR 223.5 -591.5)
- **Key Lessons:** Plan for post test services, can use lay persons for testing, address supply chain management, involve PHAs and local leaders and have multiple strategies for community mobilization

# Examples of Successful Program Scale up of HBCT in East Africa and South Africa

- After Bushenyi ICOBI scaled up HBCT to 6 central districts of Uganda ( Btn Feb 2009 – Oct 2010 – Out of 227,968 eligible, 199,447 found at home and counseled, 193,486 accepted testing – 87.5% coverage and 97% uptake).
- Kumi district, northeastern Uganda
- Kalangala district and areas surrounding Lake Victoria, Uganda
- Apac district, Northern Uganda
- Kisumu and Nyanza district, western Kenya
- Sisonke district, KwaZulu Natal, South Africa

# HBCT – Now a ‘platform’ for evaluation of multi-component, combination HIV prevention & care

- Massively increase knowledge of HIV serostatus
  - Home-based VCT
- Electronic data capture for risk & tailored prevention prescription
  - HIV seropositive individuals & HIV concordant + couples
  - Pregnant HIV+ women
  - HIV serodiscordant couples (DCs)
  - High-risk HIV- uncircumcised men
- **‘PreventionRx’**: 1) Knowledge of HIV serostatus, 2) Triage and target to increase coverage, 3) Measure population effect
  - *Example of ‘PreventionRx’ for a Discordant Couple*:
    - 1) Deliver couples counseling,
    - 2) HIV+ female: Evaluate eligibility for ART and refer for care, deliver Basic Care Package
    - 3) Refer HIV- male for MC
  - Facilitated referral to ART for HIV+ and HIV- to prevention services
  - Pilots in Uganda and South Africa underway

# Challenges "from research to program implementation"

- **PMTCT**

- Use of single dose nevirapine – proven in Uganda 1996/97 – To-date 20% of new infections –MTCT! - Challenges of roll out, - long debate on how to package nevirapine syrup in amber colored syringes and administered to babies not delivered in health facilities!
- Knowledge of the dangers of infected breast milk and how long it took to advise on HAART or how to make breast milk sterile in developing countries

- **Safe Male Circumcision**

- Efficacy shown in Rakai in Uganda
- A policy has just been made and national roll out yet to start
- Political resistance to its nationwide implementation
- Cultural and religious challenges

- Challenge of research planning, research implementation and results dissemination with no significant local involvement and buy in.

# Key strategies for scaling up programs – Challenges in program implementation

1. Country ownership-Governments with key stakeholders (private sector and civil society) in program planning and implementation – *challenge of delivery system - competition b/n govt /non govt actors, local/foreign NGOs*
2. Sustained partnerships with international, national, Civil society, networks to achieve common goals and targets. – *How can PEPFAR assist Civil society to implement sustainable programs?*
3. Aiming for both impact and equity
4. Structural factors including policies and frameworks
5. Socio-economic, political or cultural factors contributing to risk behaviour or affect program scale up – *ABC debate – ideological – Zero-grazing or B vs MCP interventions - faithful house training – Role of religion. Languages.*
6. Systems strengthening (health /non-health systems) – *Accountability and transparency, government staff motivation and capacity, construction and infrastructural developments to cater for increased patient load.*
7. Country priorities – *Young countries, cold war- neo colonialism-political instability, WB Structural Adjustment policies, HIV/AIDS, Climatic changes, World economic crisis – affect resource envelope.*

# Key Questions in programming

- **Coverage:** reaching a critical mass of affected populations
- **Reach:** reaching the right populations
- **Quality:** doing the right thing well
- **Intensity:** doing enough of the right thing to make a real difference

## Level of implementation: Individual, family, community, health facility?

- Facility based programs have low coverage & popn denominator is unknown
- Facility based services accessible only to those who can easily travel to facilities (challenge in rural Africa), requires knowing of existence of services at the facility and availability of service inputs and human resource
- Home-based services easily increase coverage and can be cost effective
- Households are the primary producers of health & home-based / family centred approaches increase access to care and improve health outcomes.
- “Health is made in the home and only repaired in hospitals”

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- Ministry of Health Uganda
- Parliament of Uganda

# Thanks and Welcome to Uganda

- The Pearl of Africa is in the East with neighbours Kenya, Tanzania, Rwanda, Sudan, DRC
- At the roof of Africa where R. Nile starts a 7000 Km journey to the Mediterranean sea
- The best climate with snow on the equator
- Home to the rare mountain golliras, water rafting
- Good homely hotels, Connected to major Airlines
- Fresh organic delicious food & hospitable people
- Good investment opportunities. All welcome

*Contact: [elioda@parliament.go.ug](mailto:elioda@parliament.go.ug)*