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HIV

From a Visitor's Eye

The aim of my elective was to understand health service provision in a less economically privileged country and compare it to that of our own. Having worked in a National Referral Centre for four weeks, where most essential treatments and investigations were largely available, and a Health Centre IV at the county level, where there was only one doctor and limited resources, I have learnt to understand that the difference in health provision between the two countries is not only in funding and availability, but stems much deeper. By using HIV/AIDS, one of the leading causes of morbidity and mortality in Uganda, as one example, I aim to illustrate the success, shortcomings and challenges of health provision in Uganda.

The Ugandan National Health System

Funding is no doubt a large barrier to health care provision. However, it became evident to me soon into my elective that the biggest challenge facing equal health provision has been in reaching into the rural community; the extent to which this is influenced by finance is debateable.

At face value, the population of Uganda is half that of the UK. The Ugandan National Health System includes hospitals (2 Referral, 11 Regional, and 109 General); and Health Sub-District facilities at the county level (Health Centre IV), the subcounty level (Health Centre III), and the parish level (Health Centre II). These are intended to build and strengthen the capacity of health facilities to improve health service provision by reaching deeper into the community.[1] Despite a similar size, the number of hospitals in Uganda compares with over 1100 in the UK. The Health Sub-District facilities may help reduce this extraordinary gap, however the limited number of doctors working in these centres, as well as inadequate resources and investigations, limits their potential. There is a referral system so that patients with "danger signs" are referred to the next health centre level, though these referral letters are carried by patients, who often do not appreciate the need for referral, and are often lost in the system.

Furthermore, statistics seem to support my feelings of inadequate use of the health facilities available. Out Patient Department (OPD) utilisation is a measure of usage of health services and is used as a proxy measure for both the quality and quantity of services and the health seeking behaviour of the population. The target of the Health Sector Strategic Plan (HSSPII) is 0.9 by 2009/10, but the Out Patient Department Per capita attendance (visits to a health unit per person per year) has stagnated at 0.8 at national level for the years 2008 and 2009.[1] One potential reason for this is that there is an alternative to using such health facilities. Traditional medicine tends to replace health centres for many people, especially in rural areas. These are more widely accessible, are recommended by friends and family, and gain a greater trust amongst the

community than modern medicine, in spite of the fact that the service they provide is more expensive than the free service provided by the National Health System. Thus, traditional medicine is most often the first place for health seeking, and patients present much later to conventional health facilities.

The value of traditional medicine in the community deserves research in its own right; though the influence it has on health provision cannot be denied. Having spent some time with 'Bone Setters' who have been treating fractures for generations, I learnt that despite the myths used as principles, they in essence, reduce and immobilize fractures as modern medicine would advocate; the difference is the herbs they use to "soften bone", and the lack of understanding of complications. It was reassuring to me that x-rays were required before the bone could be "set", and that a doctor visited the centre frequently. Despite my own prejudices, I realized that they provided physiotherapy and rehabilitation, something hospital medicine would not provide, and the outcomes were generally positive. This being said, I am not sure this is true of all traditional medicine. By offering an alternative, which is not controlled, traditional medicine interferes with modern medicine by delaying presentation to clinics, interfering with health education and adherence to prescribed medicines.

I was, however, fortunate enough to visit a Village Health Team (VHT) in the county of Kinoni. The VHT is trained by Health Unit Staff, and immobilizes people from the community and serves an applaudable link between the village and the health unit. The VHT are trained in promoting health by recognizing 'danger signs', reporting village sickness and referring sick people to health workers, providing assistance with prescribed medicines, ensuring child immunization, encouraging antenatal and postnatal checks and providing first aid. Training manuals are provided by the government, but training sessions are self funded, such that not all areas are fortunate enough to receive the good VHT training that I witnessed. Furthermore, VHT members work voluntarily, and are driven by the desire to improve their own understanding of health and that of their families. It seemed to me that the VHTs were the missing link between people and the health service, and further recognition and funding to extend this success across Uganda may offer a footstep in developing health service utilization.

HIV/AIDS

Combating HIV/AIDS, malaria and other disease is one of the eight Millenium Development Goals. AIDS has had a devastating impact on Uganda, having killed approximately one million people, and significantly lowered life expectancy. Nevertheless, Uganda is often held as a model for Africa in the fight against HIV/AIDS. The campaign against HIV has seen a huge reduction in the prevalence since the early nineties. Uganda's first AIDS control programme was set up in 1987 to educate the public about how to prevent infection with HIV, by promoting the ABC approach (abstain, be faithful, use condoms), ensuring safe blood supply and starting HIV

surveillance. The HIV prevalence fell dramatically over the coming years from 15% amongst adults in 1992 to 5% in 2001.[2] However, between 2000 and 2005 there has been a stabilisation of prevalence; there are speculations that this may be due to complacency about HIV/AIDS no longer being a life-threatening disease since the introduction of free anti-retrovirals in 2004, and the shift in the prevention campaign away from the ABC approach towards a US-backed abstinence-only programme. The number of new infections (an estimated 120,000 in 2009) exceeds the number of annual AIDS deaths (64,000 in 2009), and it is feared HIV prevalence in Uganda may be rising again.[2]

The HIV prevention drive is noticeable as one walks through the streets of Kampala. There are enormous billboards across the city, some campaigning for testing: "It's Never Too Early to Get a HIV Test- Free HIV Testing and Counselling"; while others encourage abstinence, the more controversial area of the campaign: "Take interest in your partner's passion and spend more time together to avoid the sexual network". Indeed, condom use is often discouraged by some billboards and abstinence-only campaigns are more likely to receive funding from PEPFAR (the largest HIV-related donor to the country).

Furthermore, ninety five percent of the antiretroviral (ARV) programme is donor funded, mainly by PEPFAR. This support is under threat, as the US government plans to cap funds to Uganda. The increasing demand and reduced donor funding is already having an impact on the provision of HIV treatment. According to the World Health Organisation guidelines, an estimated 39% of those who need it are receiving ARVs, and patients are turned away due to funding shortages. Uganda aimed to relieve the drug supply problem by supplying its own generic drugs; the Luziria factory in Kampala had the capacity to produce at least 2 million tablets per day and reduce costs of drugs and stock-outs. Unfortunately, due to lack of government funding, this factory was recently closed down.

Another challenge in the HIV campaign is reaching the rural community. The number of health facilities, which offer HIV testing and counseling has increased from 554 to 1,215 between 2007 and 2009. Similarly, prevention of mother-to-child transmission (PMTCT) services expanded in recent years with emphasis on providing service to rural areas. Furthermore, there are promising outreach programmes led by volunteers, as well as follow-up of ARV treatment and counseling to take medication by the VHT.

Thus, better education that encorporates abstinence, fidelity and condom use, more widespread HIV testing and counseling as well as of prevention of mother-to-child-transmission may offer hope of reversing the trends in the battle against HIV. But this is only possible with more promising drug availability.

Conclusion

Using HIV as just one example, it is clear that funding is no doubt a large barrier to health care provision. Donor funding is currently heavily relied upon, which offers no self-sustainability or obligation to work within the means. Funding can also be blamed for the inadequate number of hospitals to cover rural Uganda, and limited resources in health facilities. However, the problem in health service provision is deeper and extends to an inadequate usage by people of the facilities that are available. Health provision needs to extend deeper into the heart of community through health education. The trends in fall and rise of HIV in Uganda illustrate the importance of working with the people: in offering advise irrespective of religious or personal views, such as in condom use, and in reaching rural people through services such as the VHTs and outreach programmes. Only when the people feel empowered by what they have and what they can do individually and collectively, will the Ugandan Health System develop without the need for donor funding.