

ART IN UGANDA CATHOLIC CHURCH HEALTH FACILITIES: OPPORTUNITIES AND CHALLENGES

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Abstract

Uganda Government plans to scale up access to antiretroviral therapy (ART) through the involvement of all stakeholders including public, private, Non-governmental organizations, Private-not-for-profit providers etc. based on the use of the existing institutional framework. Like other stakeholders, health facilities of the Catholic Church stand some opportunities to participate in this process. However, it is already clear that the rollout process is overstressing both the implementing health facilities and the Ministry of Health. The human and infrastructure resource demand is fast proving overwhelming. This is worse for the private-not-for-profit facilities. Salary enhancement for government staff alone will further weaken the PNFPP partners from contributing effectively in the rollout. Integration of the ART programme into the comprehensive function of the hospitals faces difficulty from its "project" or vertical nature. There is concern over the visible drain of resources from other activities of health facilities providing ART and possible weakening of these facilities. The future sustainability is progressively being questioned. It is proposed that government assists the Church and other implementing partners in strengthening the existing framework as a composite part of the rollout package. It is also suggested that strengthening of the Public Health approach that Uganda is already partially practicing could offer some relief. Strengthening of the community-based approach is particularly advocated for.

Introduction

The national HIV average prevalence in Uganda, according to the first (and so far only completed) seroprevalence survey of 1987/88 was 6-8% (UAC, 2004a). The Uganda AIDS Commission also reports that the average prevalence, based on antenatal tests of expectant mothers, had risen to 18.5% by 1995. Although prevalence of HIV has since dropped, it still remains high at 6.2% among antenatal clinic mothers in 2004 and 5% among the general population (UAC, 2004a). Underreporting of HIV / AIDS cases in Uganda is well acknowledged (UAC, 2004b). A HIV sero-behavioural survey is currently going on and it is expected to give up to date figures. It is estimated that there are about 1,000,000 people currently living with HIV in Uganda, of who between 100,000 to 150,000 need antiretroviral treatment. Uganda had a national target of providing antiretroviral treatment (ARVs) to 30,000 clients by the end of 2004, rolling out to 60,000 clients by end of 2005 and 90,000 by end of 2006.

The Ministry of Health believes that by end of January 2005 there were some 35,000 clients on ARVs. These were either provided free (trionimmune) or subsidized by the employers or fully self-paid by the individuals who are free to choose their drugs with the guidance of their physicians.

The institutional framework for providing or rolling out ART in Uganda makes use of the existing health system in terms of infrastructure and human resources right from the National Referral Hospital down to community-based structures. This service is to be integrated in the system, thus involving both public as well as private providers (private-not-for-profit and private-for-profit). Data at the AIDS Control Programme (ACP) of the Ministry of Health indicate that by end of January 2005 there were 118 centers identified for provision of ART and selected across the country, of which 63 were functional in 25 districts.

Although the process of rendering the identified centres functional and identifying more is still going on, the government has already recognized a number of challenges to rolling out the plan for ART in the country.

This paper looks at the opportunities available to the health facilities of the Roman Catholic Church (RCC) in Uganda to enable provision of ARTs as well as the challenges to be faced, keeping in mind that these are likely to apply to other not-for-profit and faith-based providers as well. It gives proposals on the way forward, which may require reconfiguring the policy implementation framework.

Opportunities for RCC Health Facilities

The need for ART exists and, for now, overwhelms the capacity of Government infrastructure and personnel. There exists a Government policy to scale up the provision of ART, Prevention of Mother to Child Transmission (PMTCT), Voluntary Counseling and Testing (VCT) etc. There is a supportive policy for public-private partnership for providing health care in Uganda.

Cognizant of that high need for services and the policy to scale up to meet the need, the Uganda National AIDS Control Policy spells out partnership between government, civil society organizations (CSO), Faith-based organizations (FBOs), PHA networks, the private sector (including community-based structures) and development partners (UAC, 2004b). Table 1 below shows the distribution of accredited ART centers as at end of January 2005.

Overall, it can be seen that 33 (28%) of the accredited facilities belonged to the private-not-for-profit (PNFP) sub-sector. Out of the 33 accredited centres, 16 (48.5%) were affiliated to the Uganda Catholic Medical Bureau at the time. This meant that 13.6% of all the accredited health facilities were affiliated to the Bureau. Seven of these 16 were already providing ART (or 11.1%).

The minimum criteria for a health facility to be accredited for provision of ART include setting and achieving targets for the comprehensive basic health care services as outlined in the minimum health care package. Others are the presence of basic physical infrastructure (space for HIV counseling and testing clinical assessment, drug storage and laboratory), minimum numbers of qualified personnel with experience in HIV/AIDS management and the ability to ensure the provision of follow-up care and support for families and communities with people living with HIV/AIDS, (WHO, 2003a). On February 7th 2005 the Ugandan Ministry of Health's Management Unit of the Global Fund to fight AIDS, TB and Malaria (GFATM), published a list of health facilities selected /accredited to provide antiretroviral treatment, in The New Vision newspaper. However, this list contained many new names that were not on the Ministry of Health list by January 31st 2005. Also, among the new names were some health facilities affiliated to the Uganda Catholic Medical Bureau. It was realized that some of the listed units did not have the necessary preparations for provision of ART e.g. personnel training, laboratory equipment, a well-organized AIDS clinic etc. Staff of some of the newly listed units saw their names in the newspaper without having been contacted or assessed by the Ministry of Health. On the other hand, there were

Table 1: Health Facilities selected for the provision of ART in Uganda as of January 31st 2005

Level	TOTAL ACCREDITED	Already Providing ART	Not yet providing ART
National Referral Hospitals	2	1	1
Regional Referral Hospitals	11	11	0
District Govt. Hospitals	28	11	17
PNFP Facilities (Hosp, HC etc)	33	14	19
Private For-Profit	18	14	4
Centres of Excellence/Research	7	7	0
Health Centres IV	19	5	14
TOTAL	118	63	55

Source: AIDS Control Programme, Ministry of Health, Uganda, 2005

other facilities that had already been assessed and prepared but which were not short-listed for the supply of the drugs. Despite these and other anomalies, it further reflected the willingness of government to involve all stakeholders in the partnership.

Free antiretroviral drugs and other input

The government is also committed to provide free antiretroviral drugs and drugs for treating opportunistic infections to those who are clinically eligible. These are to become part of the Ministry of Health Essential Drug List (UAC, 2003b). The capacity building component also includes training the health workers (doctors, clinical Officers, nurses / midwives, counselors and laboratory personnel) who may use some of the skills acquired to manage other clinical conditions as well e.g. the counseling skills. It also includes provision of laboratory equipment. In a rapid assessment carried out by the Global Initiatives Fund management Unit (GIFMU) of the Uganda Catholic Secretariat in February 2005, hospitals providing or preparing to provide ART stated the following as government input so far: free ARV, laboratory Testing Kits, anti-fungal drugs, registers / record forms, staff training and supply of test kits. One health unit also registered the promise for further support to the laboratory.

The experience and network of the Catholic Church

Roman Catholic Church has provided health care in Uganda for many years and it has the advantage or opportunity of having health infrastructure distributed across the country, more in number than of any other single civil society organization. These are more often than not in difficult or hard to reach areas. This is because most of the health facilities sprang up where Catholic Missions had been set up, mainly in the rural areas. The Church is, thus, well placed to improve access to ARV to people in rural areas and other difficult areas like those with conflict. In 2004 health facilities accredited to the Uganda Catholic Medical Bureau included 27 hospitals, 5 Health Centers IV, 164 Health Centers III and 64 Health Centers II (UCMB, 2004).

Supply Chain Management System

The Catholic Church and the Church of Uganda jointly own the Joint Medical Stores that has built a lot of experience and capacity to manage the supply chain for drugs and other essential health commodities over many years. It is perhaps comparable or only second to the National Medical Stores. While facilities of the

RCC do receive ARV supplies through government, they could as well receive through the Joint Medical Stores if the JMS was capitalized to do so. Currently the JMS only provides storage of ARV procured by the Catholic Relief Services (CRS), and a few other organizations. Managing the procurement and supply chain without additional and sufficient capitation would greatly affect the already on-going functions of JMS.

Availability of Funds

The main sources of funds for the procurement of Antiretroviral drugs in Uganda are currently the GFATM and the President's (Bush) Emergency Plan for AIDS Relief (PEPFAR) funds. The PEPFAR Country Plan for Uganda is to provide treatment to about 60,000 people, provide care to 300,000 people and avert 164,194 new infections within 5 years (PEPFAR, 2003). The Catholic-founded health facilities providing ART have done so with PEPFAR funds channeled through the US organization, CRS. Lately some have benefited from direct input by the government through Ministry of Health. Other smaller sources of funds are from other donors and employers who offer to provide either full cost or subsidy to the cost of treatment of their staff having AIDS.

Challenges for the Roman Catholic Church Health Facilities

Some of these challenges apply to government facilities as well and some affect other PNFP facilities in the same way they affect those of the RCC. The overall risk is to give in unduly to public demand for ART provision without regard to the challenges ahead. This may relate to the fact that the facilities are located where they are seen as the main source of hope to the rural or difficult areas. The health workers then tend to answer more to conscience than to practical logic. Local political pressures may aggravate this further.

As of now, no matter which part of Uganda a health facility is located, it is bound to face one or more of the following challenges in the provision of ART. These were expressed by almost all the 17 Catholic hospitals that answered the rapid assessment questionnaire in February 2005 and during the annual meeting of the senior hospital managers on March 2nd 2005.

Demand for extra resources

In order to start a single person on antiretroviral treatment, a facility will have sensitized many people in antenatal clinics, at the VCT facility and in the community. Many of these will have been counseled

before and after testing. Those found positive and willing to go on treatment will have undergone a period, often months, of follow up as an adherence exercise, even when these become eligible by their CD4 count or clinical staging. All these steps require a lot of time, human resources, space and other inputs.

Managers of all the facilities of RCC providing ART have expressed the need for more space for counseling and more staff-time for the HIV or VCT clinics that cause much strain on staff who are already strained by other "ordinary" or "routine" activities.

Shortage of staff in health facilities, both government and private-not-for-profit (PNFP) is an issue well known to the public as well as to the government (MOH, 2003; MOH 2004). Even before the introduction of ARVs, government had started to provide some funds to the PNFP facilities to be used to support their activities. Some were being used to top up staff salaries but in almost all of the PNFP facilities, salaries have not yet reached the level of government employees, except for doctors in some cases. However, since then, in the face of an impending strike by health workers, the government has pledged to further increase the salaries of its own staff, without a matching increment in funds allocated to PNFP facilities. In fact there has been a slight reduction. As the government gets on with salary enhancement for civil servants it is feared that even more staff will be drawn from the PNFP to government facilities, further aggravating the strain on the remaining staff especially with the introduction ART services in the facilities.

Effects of project approach

In almost all facilities implementing ART, the provision is operated as a vertical programme. There are specific staff attached to the programme, where some NGOs are supporting the programme. Allowances are paid to these staff members from outside the regular integrated budget of the hospital. The AIDS clinics also have separate rooms. The effect of this is multiple. First, it is drawing the staff away from other services of the hospital. Secondly, it also tends to alienate the ART-providing staff from other staff that do not receive these allowances. The result is that when the "ART staff" are not there for any reason, other staff are unwilling to step in, partly because ART training has been provided to very few staff. Some hospitals have reported having only 1 to 10 staff having undergone this training by the Ministry of Health.

In some hospitals, the HIV/AIDS programmes operate autonomously from the hospital management. For example, the Nsambya Home Care programme that does good work operates within Nsambya hospital area but almost as an autonomous body.

The worry is that by the time attempts are made to integrate the programme in terms of budget and management into existing systems of the hospitals it may be too late and it will have greatly affected other services.

Coping with increasing demand

Related to the strain on personnel and infrastructure is the increasing difficulty to cope with increasing demand or clients. While the inputs from government for ART programme do not include expanding the human and infrastructure capacities in terms of number and space, most of the inputs increase the loads or tasks to be shouldered. Availability of ARVs in health facilities has increased turn up for VCT and PMTCT. Some funds are spent on community sensitization about available services. Government is, therefore contributing to increasing the load on the health facilities without equivalently increasing the strengths of those facilities to cope with the tasks. Moreover, much is being done to sensitise communities to make use of available services and access ARVs. Not only health workers but also politicians and other stakeholders are doing this. However, but not surprisingly, the politicians particularly do not sensitise enough on the restrictions to the use of ARV. Consequently, some persons living with HIV in rural communities especially seem to think that health workers are denying them drugs that should be provided to all HIV positive persons. This gives additional and unnecessary pressure apart from having to cope with the estimated 100,000 to 150,000 people needing ARVs now.

As mentioned earlier, where training has been provided it has been to a few staff making the few trained too few to effectively or professionally handle the increasing demand.

Laboratory equipment is equally inadequate. CD4 count machines exist in only 12 regional centers. The rest depend on clinical judgments. However, patients on ART also need other general haematological assessments. The increasing numbers of clients have to compete with other patients for the same old laboratory which is already, in many cases inadequate.

Lack of other support services

For many of the hospitals now providing or about to start providing ARVs they are yet to figure out how to provide other care and support services to these clients. There are in many of these cases no staff trained yet to plan and provide home care services, for example and palliative care.

Low capacity of the Supply Chain Management

If JMS is provided additional capital to provide ARVs, this may strengthen it further for the future. If it is not provided with capitation and instead foreign firms are used, JMS will not be able to compete. Instead, it might get relatively weakened.

Use of branded drugs

Most of the PLWAs receiving ARVs through the PNFPs are currently on the branded expensive drugs. These are essentially drugs procured from the United States using PEPFAR grants. Of course, where supporting organizations pay for these costs, they are not a problem. However, there is a problem with branded drugs: the pill burden. PLWAs on generic drugs take all three combination-drugs in a pill while those on branded drugs have to take them in three separate pills each time. This requires more staff time to explain and monitor and even affects adherence.

Apart from having inadequate number of trained personnel, some of the rural hospitals have expressed concern over their lacking of the standard WHO guideline or eligibility criteria for starting PLWAs on ARVs. It might have been assumed that all the doctors in the hospitals are fully aware of these guidelines.

Possible negative effect of ART on Prevention

Fears have been expressed that the availability, access to and benefits of antiretroviral therapy, may have a negative effect on the uptake of behaviour change communications, especially regarding sexual transmission. It is also feared that as more PLWAs get onto ARVs, drugs that are to be taken for life, the sustainability cost may affect government expenditure and lead to a reallocation of resources with direct negative effects on preventive services.

Financial restrictions by the Ministry of Finance

The Ministry of Finance, Planning and Economic Development (MoFPED) has drawn a mid-term expenditure framework (MTEF) for the country, to

guide the limits to which government may spend to avoid macroeconomic instability. This inevitably limits the inflow of expendable funds into the country beyond accepted limits for the period. The demand to scale up and even sustain the ART programme and other HIV/AIDS related services requires a lot more money that government could get through the GFATM, the PEPFAR and other sources. However, these would need to be additional to current funding to the sectors. If the MoFPED does not yield to the plea to allow these funds to be additional, then these scaling up programmes whether in government or Catholic hospitals or indeed other facilities are likely to either stagnate or collapse.

Poor access to funds by faith-based organizations

Churches do a lot of good work but are in general not well placed to compete for grants with the other civil society organizations that make money or that employ the services of consultants to write very competitive proposals. Many of their health institutions are rural and have limited access to information about funds. Even when these funds are channeled through the Inter-Religious Council, access by the rural dioceses or hospitals is still poor. In addition, the Church has traditionally not been in the business of market competition for grants and is ill-equipped to do so. In addition, many of the intermediary NGOs work through local government structures that are, in principle, supposed to integrate and bring all stakeholders in the districts on board. However, in many dioceses, it is reported that churches (especially the Catholic Church) are viewed as "having too much already". This misconception stems from the fact that during the previous governments when donors lost confidence in government systems, many of them preferred to and did channel funds for development activities through the churches. As a result, church institutions had relatively more funds than government structures for the implementation of social services. However, even after government credibility was restored and resources shifted to government structures, this view of Church facilities as competitive or parallel to government is still common at district and lower levels.

Discussion

With the scaling up of ARVs, the need for government to respond to the call by PNFP to enhance the PHC grant to NGOs is greater than ever before. This requires increasing the grants to a level that will allow the PNFPs to both recruit additional staff and also enhance the salaries of their staff to that or near that

of government staff. Training in the management of ARVs in health facilities needs to be extended to more than a handful of staff to enable integration and rotation of staff. Government (Ministry of Finance) needs to reconsider its stand on the MTEF ceiling with regards to funds for the global initiatives. The bureaucratic channels also need to be modified to increase access to funds by faith-based organizations. For instance, one recommended approach is the establishment of a separate principle recipient to receive and channel funds from the Global Fund to faith-based organizations. The Public Health approach to the provision of ARVs needs to be used even more. It is expected that this will reduce demands on the human resources and infrastructures of the health facilities. This may involve the following:

Delegation of functions

The use of standardized regimens in Uganda and some other countries has made it possible to scale up ARV provision to many health facilities that do not have CD4 count machines, thus relying on WHO recommended clinical guidelines. Under this arrangement prescription is easy. Also, nurses, clinical officers, other health care workers and some community members can easily be delegated to follow up PLWAs who are on treatment. This reduces some cost of providing ARVs. It therefore requires that training of health workers in both government and the faith-based health facilities including those of the Catholic Church should be extended to more than just the current handful. It is also important that ART programme is not started where only one or two staff have been trained, as is currently the case in some of the selected hospitals.

Involvement of PLWAs

The importance of involving PLWAs or their families and communities in which they live in the provision or follow up has been observed to be very important (WHO,2003b). In Uganda one of the typical examples is the experience of Reach Out Mbuya programme.

Reach Out Mbuya's Community AIDS TB Treatment Support (CATTs) programme involves PLWAs who are on ARVs (ART peers) to carry out community sensitization, community-based counseling, follow up of clients for adherence, and arranging for review and testing of new cases. Anecdotal data show that their involvement gives them more satisfaction, provides greater confidence building in new clients and has improved adherence. Each client can be followed up at least once a week. Some of these clients are on anti-TB treatment. The follow for both ART and anti-

TB treatment is carried out concurrently. This is in line with the new draft policy of WHO on HIV/AIDS and TB control which is also being adapted for Uganda (WHO, 2004).

In Haiti a strategy similar to the TB CB-DOTs was used, known as DOT-HAART. In this strategy community health workers known as *accompagneurs* visit people receiving ARV therapy at home daily. It is, however reported that such an approach was disliked by people receiving ARVs in Trinidad and Tobago because they did not want a health care worker to visit them at home to give the therapy. The approach is also labour-intensive. A similar approach is being used for the CRS-sponsored programme in Lacor hospital in Gulu. They have, however not yet documented similar feelings as reported in the Trinidad and Tobago experience. Other anecdotal reports, however, say that there are people in Uganda, especially among the middle and upper class who exhibit the Trinidad and Tobago response.

Probably, a combination of the Reach Out Mbuya's CATTs experience and the TB CB-DOTs may prove better than the DOT-HAART of Haiti, Trinidad and Tobago. In what could be call a "Modified CATTs" approach, the community health worker who may or may not be someone on ART (ART peer) visits the client only once a week or fortnightly to avoid discomfort about the supervision. A "treatment supporter" or "treatment buddy" who is chosen by the client (mother, brother, father, or any other close confidant) in addition to the community health worker / volunteer carried out the daily observation of treatment. The important thing is that the client and not the health workers or community leaders or other relatives must choose this person. This requires proper counseling of the client before starting the treatment programme. For those who are already on the TB CB-DOTS programme it is easy. This experience needs to be studied more with the possibility of including it into the HIV/TB collaboration policy in future.

Another lesson that can be drawn from the Reach Out Mbuya experience is the use of existing non-health facilities. The organization is under the leadership of Mbuya Catholic parish. It has no health center building. On days when clients have clinical assessment, part of the church is used for clinical examinations while some of the classrooms or rooms within the nearby primary school are used for counseling. Blood for CD4 count and other examinations is taken to Mulago hospital. The organization has only one doctor and a number of volunteers, mostly PLWAs who have got trained on the job. Reach Out Mbuya plans

to decentralize clinical assessments to the church buildings of the sub-parishes to reduce distance both for the clients and the CATTs volunteers. The doctor and nurses will then conduct outreach visits once a month to each of the outreach centers.

Proper sensitization of the community

Community involvement should not only target increase in demand of services and adherence but also sensitization on the risks of using ARVs and the benefit of delayed use of ARV if possible.

Just as government involved various stakeholders in agreeing on the national strategic framework for HIV/AIDS control in the country, at the implementation level government needs to involve the health facilities and their umbrella organizations e.g Uganda Catholic Medical Bureau in this case, in the decision on how and where to scale up ART programme. For example it may be useful to have a combination of "vertical" and "horizontal" scale up. The vertical scale up means scaling up of number of clients in health facilities that have already built capacity and are already providing ART. Horizontal scale up would mean increasing access through expansion to include new health facilities into the programme. A combination of the two would mean that while scaling up in health facilities already providing the services and have build up capacity, step-wise capacity should be built in other strategically chosen facilities until they are able to start also. This includes increasing on personnel number and training, infrastructure expansion, laboratory equipment procurement etc. At this stage when PNFs are faced with the challenge of salary enhancement and inability to recruit, it would not be advisable for health facilities to accept horizontal scale up without caution.

Just like it applies to government, it is advisable that any donor agency or NGO that is willing to support scale up of ART to or at a given health facility should include the infrastructure and human resource support in the scale up package.

Conclusion

In conclusion, the need for scaling up of ART in Uganda is appreciated. The policy to involve all stakeholders is a great one. However, the scale up faces a lot of challenges especially for the Catholic Church and other faith-based organizations that are faced with low level of human resources, difficulty of staff retention in the wake of salary enhancement by government, over loaded infrastructure. The vertical or project approach to the provision of ART seems to undermine the capacity to integrate the service and prospect of eventual sustainability.

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