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Why small health facilities matter in getting treatment to all Ugandans with HIV

Over the past three years, there have been 'game changers' on the global scene regarding HIV treatment eligibility. In 2014, UNAIDS unveiled the ambitious 90-90-90 targets a part of which aim at enrolling 90% of those with HIV on sustained anti-retroviral treatment (ART) by 2020.

In November 2015, the World Health Organisation(WHO) announced new treatment guidelines recommending that all diagnosed with HIV be enrolled on ART regardless of disease stage. Even prior to this 'test and treat' policy, Uganda had already dramatically increased ART coverage through expanding the network of facilities providing HIV treatment beyond large government hospitals with PEPFAR and Global Fund support. This expanded service delivery programme was also implemented in private-for-profit facilities.

Recent study findings drawn from a nationally-representative sample of 195 health facilities across Uganda, which participated in the first phase of ART roll-out demonstrate that lower-level health facilities and small private clinics are relatively constrained in sustaining HIV treatment services. The study examined the sustainability of HIV treatment programmes in health facilities in Uganda. Several smaller health facilities were found to have since discontinued HIV treatment services despite the availability of free antiretrovirals (ARVs), medical equipment support and health worker training.

> *Uganda depends highly on external donors for HIV services*

It was found that the current HIV treatment funding architecture in Uganda favours larger, well-established hospitals. Our findings show that large hospitals have been able to attract multiple donor grants for HIV treatment while several smaller health facilities are hard-pressed to maintain even a single funder given the associated performance requirements. Specifically, it was found that smaller, rural and especially for-profit health facilities were constrained in sustaining HIV treatment services. The barriers identified were numerous but the major ones included shortage and attrition of ART-proficient personnel, inability to keep up with ART programme reporting mandates by funders and irregular and insufficient supply of ARVs.

The findings suggest that the organisational goals of for-profit facilities are not well aligned with the public health goal of mass access to HIV treatment. There was evidence in some for-profit providers, where donor-supported HIV treatment services attracted long patient queues and a broader socio-economic class of patients, which was at odds with the goal of catering to high-end patients, who sought privacy. A number of providers discontinued services based on this mismatch alone.

Demand factors were also at play. Patients often bypassed nearer smaller health facilities and sought care in larger hospitals because they had a broader 'menu' of HIV services, more staff and, therefore, shorter waiting times and less frequent ARV stock-outs. These findings suggest that unless interventions are devised, smaller, rural and for-profit providers are bound to fail and hence HIV treatment coverage is bound not to expand beyond well-established hospitals. This defeats the very essence of HIV treatment scale-up of increasing service delivery platforms including in small for-profit health facilities which constitute half of all health facilities in Uganda.

So, how do we grow smaller health facilities to ensure they 'take-off' and thrive?

Mentoring programmes involving the twinning of large hospitals and smaller health facilities could be helpful. Service purchase agreements between the Government and for-profit providers are worthy of consideration. Salary support to select for-profit facilities with large patient volumes or in hard-to-reach areas are worth a thought. This study reveals high levels of dependence on external donors for HIV services delivery.

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