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Uganda and the Current HIV Treatment Crisis – A Perspective

According to UNAIDS (the Joint United Nations Programme on HIV/AIDS), 33.3 million people worldwide are infected with HIV. Of these, 10 million require treatment with anti-retroviral therapy (ART).[1] Currently, it is estimated that for every 100 people who receive treatment, there are 250 more people who become infected daily. This past October, the Global Fund to Fight AIDS, Tuberculosis and Malaria, an organization that provides treatment to roughly half of the world's poor population, failed to meet its minimum fundraising target of $13 million, which is the minimum necessary to continue distributing anti-retroviral drugs to patients that have already started treatment.[2] This failure only serves to force us to recognize the reality that some HIV-positive individuals will be fortunate enough to be treated with life-extending medications and some will not.

Uganda provides a good example of the controversy surrounding global HIV/AIDS care and ART in resource-poor settings. During the 1990s, Uganda was viewed as a model for HIV/AIDS research, prevention, and public health education, and was one of the first countries in Africa to see a dramatic decrease in HIV prevalence. Now, Uganda is once again in the global spotlight, but as an example of one of the first countries in which clinics are routinely turning people away from care.[3]

In order to better understand the medical and public health principles of HIV/AIDS care and how treatment decisions are being made in resource-poor settings, I traveled to Uganda recently to complete a month-long medical student clinical elective. I visited Makerere University's Infectious Disease Institute (IDI) in Kampala, one of the country's state-of-the-art HIV research and treatment facilities. This was my ninth trip to Uganda; the first was during the mid-1990s, when HIV prevalence was around 15% and coffin shops lined the roads out of the capital city. Today, the HIV prevalence in Uganda is 5.7% and Kampala has the chaotic, palpable energy inherent in all cities undergoing tremendous development and growth.[4] According to 2009 data, the number of Ugandans living with HIV in was 1 million, with only 11% receiving anti-retroviral treatment.[5,6]

A non-governmental organization (NGO), the IDI was established in 2004. It focuses on strengthening the care and treatment of HIV and related infectious diseases for people living with HIV across Africa by offering professional training for health workers, conducting research on best practices related to HIV in low resource settings, and advancing clinical services that support the development of new models of HIV/AIDS care. The IDI started at a time when ART was becoming more widely available in countries where there were not enough clinicians to implement treatment programs.[7]

Approximately 9,000 people currently receive care at the IDI clinic, and an additional 6,000 receive care through outreach activities.[7] These patients, who often travel from great distances, wait for hours with hundreds of other patients, many of them quite sick, to be monitored during routine visits. Due to sheer volume, physicians and providers at the IDI see an average of 60 patients per day. Many patients that receive care at IDI do not qualify for treatment with ART based on their T-cell count. According to the World Health Organization's clinical guidelines, patients with T-cell counts below 350 should receive ART.[8] However, in Uganda, like most resource-poor countries that cannot afford to treat patients based on this guideline, the T-cell count cut off is 250 for initiation of ART. Financial circumstances are forcing physicians to apply sub-optimal criteria of care for patients, including denying medications to those who actually do clinically qualify for treatment. During my rotation, I watched clinicians turn away patients and make the sometimes impossible decisions regarding who should be treated and why. Importantly, these funding shortages also force patients to watch loved ones suffer and make the difficult decision to share or sell medications, which can ultimately lead to treatment resistance.

Although my clinical rotation at the IDI was, in part, about learning how to provide appropriate medical care to persons with HIV/AIDS in Uganda, it was also about re-examining a country that I care deeply about at this specific point in history. As always, I am inspired and impressed by Uganda's dedication to extraordinary research in the field of HIV/AIDS. It is a country that, through research and example, continues to provide the scientific foundation for HIV treatment in resource-poor settings. At the same time, I am angry and deeply saddened that the current level of global commitment to HIV/AIDS prevents clinicians from successfully translating this research into a model of clinical care that minimizes suffering and emphasizes principles of health equity. When I read about the Global Fund's fundraising failure, the faces of the many HIV-positive patients I saw in Uganda flashed through my mind. What will happen to them? The difficult reality is that, almost thirty years into the global HIV/AIDS pandemic, most of these patients with HIV, and those who will become infected, will die without ever accessing life-saving treatment. ■

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