BHIVA - AbbVie - SSAT
(BASS)
Exchange Scholarships
2015

Evaluation report

Dr Tafara Moga
Care & Treatment Technical
Advisor
EGPAF Zimbabwe
BHIVA - AbbVie - SSAT (BASS) Exchange Scholarships 2015
Evaluation report

I travelled to London, UK on 11 April 2015 for the exchange scholarship programme. I was to be hosted by Dr Lakshmi Jain, a Specialist Registrar at Mortimer Market Centre (MMC). At Heathrow airport I was welcomed by Dr Jain before travelling to Morland Mews, Islington where accommodation had been arranged for me.

On the first day of the program I met with Dr Erica Allason Jones who is a consultant and Training Program Director at MMC. I then went for registration as an honorary clinical observer at Central and North West London (CNWL) with no challenges. Dr Jain provided an overview of health service provision (including HIV) in the UK. She then took me on a familiarization tour of MMC and University College London Hospital (UCLH) where I was going to be attached for the greater part of the program.

HIV disease burden in the UK
The prevalence of HIV in the UK is 2.8 per 1,000 of the population aged 15–59 years with an estimated 107,800 people living with HIV (PLWH). The HIV epidemic is largely concentrated among gay men, bisexual men, men who have sex with men (MSM) and black African heterosexual men and women. Vertical transmission of HIV has been very well controlled (<1%) through implementation of numerous strategies that include cART for the mother, infant ARV prophylaxis and replacement feeding for the baby. Most of the children enrolled in the program are in the adolescent age group as new infections among children are that rare.

During the first week of the program I managed to sit in as a clinical observer in the walk-in clinic at Bloomsbury, inpatient round at T8 UCLH, HIV meeting and paediatric clinic at North Middlesex Hospital as well as Great Ormond Street Hospital. I also participated during a teaching session for medical students at UCLH and attended the HIV MDT meeting at MMC. During the MDT meeting, I had an opportunity to present on the Zimbabwe HIV program. My presentation was entitled: ‘HIV Care & Treatment in Zimbabwe: Towards Universal Access using a Decentralized Approach.’ The major highlights of this presentation included the following:

- HIV/AIDS remains a major public health concern in Zimbabwe with an estimated 1.42 million PLWH (including 156,718 children aged less than 15 years of age)
- The HIV prevalence in Zimbabwe among people aged 15–49 years is 15%, with a mother-to-child transmission (MTCT) rate of about 9%, making Zimbabwe one of the 22 high-burden countries
- The strategies within the national response focus on four thematic areas:
  - HIV prevention (including HIV testing & counselling, PMTCT, male circumcision, PEP, condom programming, treatment of STIs)
  - Care and treatment (ART according to WHO 2013 guidelines, TB management)
  - Enabling environment
  - Management and coordination of the national response
• Decentralized, public health approach to management with nurses initiating and managing ART
• Successes in the program include reduction in MTCT from 30% in 2009 to about 9% in 2014, improved coverage and access to ART, roll out of VMMC
• Use of generic ARVs preferably as FDC
• Clinical and immunological monitoring are key (due to poor access to viral load).

This was well received and generated some interesting discussion as people appreciated the significant differences between the Zimbabwe and UK programs.

**Provision of HIV services in the UK**

Healthcare is delivered largely via government institutions (the National Health Service). HIV care and treatment is provided by a multi-disciplinary team led by an HIV specialist physician. All patients have access to specialist treatment as well as monitoring. HIV treatment is guided by the BHIVA and London council guidelines although there is room for individualised care based on patient’s option. The majority of patients are on a home delivery model for resupply of their ARVs and they only come for scheduled clinic appointments after every 3–4 months for their routine blood tests for monitoring. This has proved to be cheaper for the NHS and also helps to decongest the hospitals. Integrated with HIV treatment is provision of sexual and reproductive health services including screening and treatment of STIs, family planning and counselling. Psychosocial support services are provided onsite through the patient representatives and health advisors. The annual retention rate and treatment coverage among all adults seen for HIV care remained high at 95%. Of the 73,290 adults receiving ART in 2013, 90% were virally suppressed (VL <200 copies/ml).

A key component of this multi-disciplinary care is the multi-disciplinary team meetings. These are meetings led by the HIV specialist physicians where patients’ management is discussed with input from other professionals. This helps in bringing all members of the MDT on board with clinical management as well as other relevant programmatic issues. Closely related to this are board rounds, which are done for inpatients and team meetings for the outpatient clinics.

During the second week of my program, I had the opportunity to meet with AbbVie representatives at AbbVie House, Vanwall Business Park in Maidenhead. Even though this was a short meeting, it was quite successful in that I managed to appreciate the other scholars’ experiences in this program including some similarities between the Malawi and Zimbabwe programs. After this meeting, I then travelled to Brighton to attend the 21st BHIVA Spring Conference.

As a pre-conference activity, on Tuesday, I attended the HIV Trainees’ Club meeting at Jury’s Inn. This meeting was packed with interesting presentations and discussions on management of hepatitis C co-infection (including clinical trials) as well as HIV prevention including PrEP. This was quite enlightening to me because in Zimbabwe we haven’t started offering PrEP in the public health sector and there isn’t much data on the burden of hepatitis C (including its management). I also attended the scholars’ dinner at Little Bay Restaurant organized by BHIVA and AbbVie. This really
provided an opportunity to interact with the other two scholars (Dr Banda and Dr Crofts) as well as Dr Melinda Tenant-Flowers (BHIVA Education dept) and the two medical advisors from AbbVie.

The BHIVA conference was a great opportunity where HIV clinicians, researchers, programmers, the academia and civil society met to discuss topics of mutual interest, raise issues of concern and share updates and experiences. It was well lit with interesting discussions and presentations during the oral research sessions, satellite symposia, plenary sessions and lunchtime workshops as well as the poster presentations. Even though currently my area of work is more of PMTCT and paediatric HIV programming, presentations on the topic on cardiovascular disease and HIV as well as oral research presentations were very informative and stimulating. I also attended the BHIVA Prizes and Awards Ceremony and was very much delighted to be one of the recipients of the BHIVA scholars’ award and participate in the photo opportunity.

Despite the high-quality presentations and discussions, the conference could have been better had it not been for the unexpected passing on of Professor Martin Fisher (may his soul rest in eternal peace).

After the conference closure, I travelled back to London for the final week of the program.

During the third week of my program I had the opportunity to sit in during consultations with the patient representative and health advisors at MMC. I was also a clinical observer during the walk in clinic and the TEAM (adolescent) clinic at Bloomsbury. In addition, I attended the Wednesday morning meetings (HTD, HIV, MDT, research meetings) at MMC before joining Dr Laura Waters and her team in the hepatitis C co-infection clinic at Bloomsbury. Furthermore, in order to get a better appreciation of sexual and reproductive health services in the UK, I was attached as a clinical observer to the GUM clinic at Archway. It was quite interesting to note the investigations that are done to diagnose specific STIs (as opposed to syndromic management of STIs in Zimbabwe).

To complement my clinical experience in the UK, I also had the opportunity to meet with Professor Diana Gibb and Dr Sarah Pett from the MRC CTU who gave me an overview of the many clinical trials they are involved in. To conclude my program, I had a meeting with Dr John Saunders who is the NCSP Clinical Champion from Public Health England (PHE). It was a privilege discussing with him as I gained a valuable overview of the role of PHE in the UK health system as a significant part of my current job involves programming as well as monitoring and evaluation of the PMTCT and paediatric HIV program in Zimbabwe.

Lessons learnt
My experience in the clinical setting in the UK made me appreciate the following:
- The multi-disciplinary team approach to care with all members of the team sitting at the same platform to discuss patient care leads to more comprehensive patient care
• The art of active management in the transition of adolescents from the pediatric to adult clinic
• Better monitoring of patients on ART (through viral load and resistance testing)
• Management of hepatitis C co-infection
• Integration of HIV and SRH services
• Screening and diagnosis of STIs through NAATs
• Strategies to provide better psychosocial support such as involvement of patient representatives
• Strategies to decongest the clinics such as home/community deliveries of ARVs
• Better engagement of the patients through phone and email and not just relying on patient visits.

All these have made me review my practice and encouraged me to have some insight with regard to improving the quality of care patients on ART are getting in Zimbabwe, especially having managed to improve access to ART through decentralization. In the same way it was encouraging to note that within the NHS, discussions have already begun on rationalising services especially considering the evidence coming in from several trials and a possibility of dwindling health budgets in the UK.

In conclusion, this exchange program was a huge success as I had the privilege to meet and learn from many experienced specialists and consultants in the field of HIV. I look forward to the opportunity to disseminate this information further through the HIV partnership forum meetings, technical meetings at EGPAF as well as HIV management trainings of health workers in Zimbabwe.

I would like to express my sincere gratitude and appreciation to BHIVA/AbbVie/SSAT for this wonderful opportunity, which has certainly resulted in an increase in my understanding of the treatment and management of HIV both in the developing and the developed world. In addition, my acknowledgements also go to Professor Frances Cowan for all the support and contributions in making this visit a success.