



Providing Treatment,
Restoring Hope

AIDS  **RELIEF**™

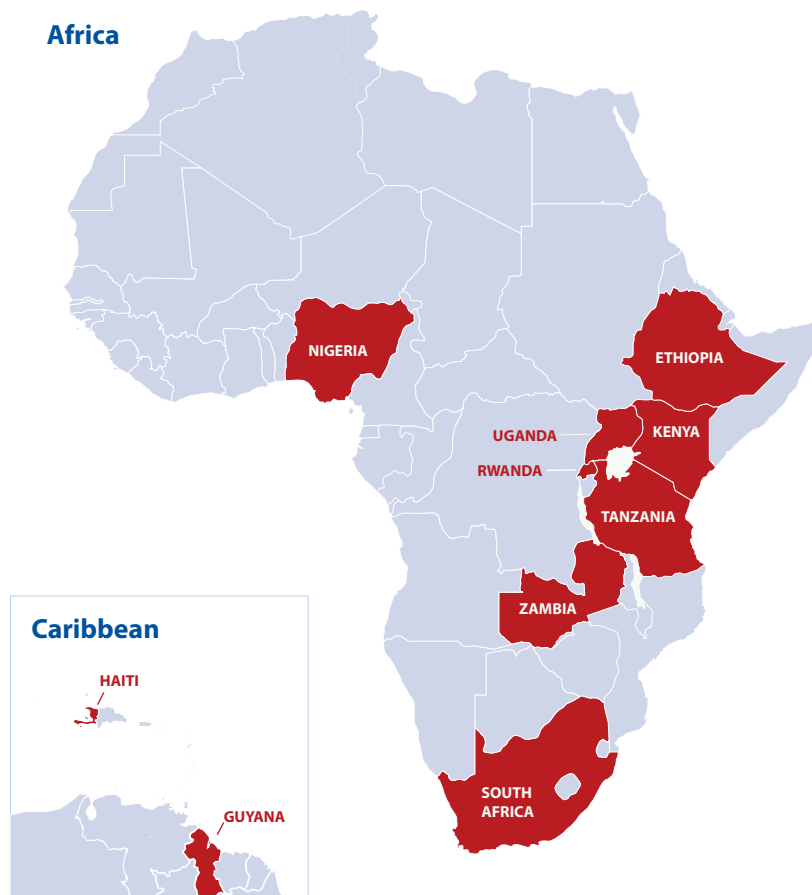
SOUTH AFRICA

FINAL REPORT 2004-2010

AIDSRelief, a five-member consortium funded through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), supported rapid scale up of HIV care and treatment services for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. Over nine years, the program served more than 700,000 people, including more than 390,000 who enrolled on antiretroviral therapy through 276 treatment centers.

AIDSRelief countries

Africa



AIDSRelief worked largely through rural facilities and established basic packages of care and treatment that exceeded what many thought possible in a resource-constrained environment. Instead of merely offering HIV tests and dispensing medicine, AIDSRelief helped broad cadres of health workers to identify and manage treatment failure or other adverse drug events; to diagnose, treat, and prevent opportunistic infections such as tuberculosis or pneumonia; and to provide patients with adherence counseling and support, empowering them to effectively manage their own treatment.

AIDSRelief consortium partners included Catholic Relief Services as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children’s AIDS Fund as a key sub-grantee, operating sites in three countries.

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The project described was supported by grant number U51HA02521 from the Health Resources and Services administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, the Centers for Disease Control and Prevention (CDC), or the United States government.





From 2004 to 2010, AIDSRelief South Africa provided HIV care and treatment to more than 73,000 patients, including 35,000 who enrolled on lifesaving antiretroviral therapy (ART) at 28 treatment sites. A deep commitment to partnership underscored AIDSRelief's relationships and capacity strengthening activities, which culminated in late 2009 when AIDSRelief South Africa became the first PEPFAR Track 1.0 program to transfer management responsibility to its local partners.

This report outlines key outcomes and lessons learned during the six-year program. It also describes approaches and methods that contributed to the program's success.

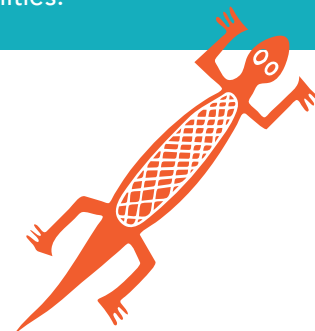
“The AIDSRelief program came at a time when the government hospital couldn't cope with the number of patients. It came at a right time, and reduced the pressure on the hospital. The Church's caregivers were helping sick people. It is a lot easier now, because the caregivers refer to the Catholic treatment site nearest to them.”

—Silindile Mhlongo, Administrator,
Mtubatuba SACBC treatment site



HIGHLIGHTS INCLUDE:

- » Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (8.6%) and mortality (9.8%).
- » Sustainability plans involved a variety of public-private partnership arrangements where the South African government covered the costs for certain services, including laboratory services, antiretroviral medications, and even, in several cases, staff salaries.
- » A focus on strategic information prioritized comprehensive and timely access to clean, complete, and accurate data. Teams used data to make informed decisions and address gaps in program operations and services.
- » AIDSRelief South Africa recognized the in-country capabilities and used all local clinical experts as consultants and advisors. As a result the local partners established good working relationships with the local universities, laboratories, government officials and clinical societies.
- » Moving forward, treatment facilities are working to align clinical services with the South African Department of Health. As a result, some patients are being transferred to government facilities and government is increasingly providing drugs, laboratory tests, and, in a few cases, staff salaries for church facilities.



OUR CALL TO ACTION

When PEPFAR launched in 2004, South Africa's HIV burden was already among the highest in the world: adult prevalence was around 16%¹ and more than 5.6 million people were living with HIV. As in other countries, poor people were disproportionately affected, and in some areas local prevalence spiked as high as 40%. The epidemic was rapidly decimating South Africa's adult population, while treatment was either unavailable or prohibitively expensive. Nationally only 55,000 people were on ART, just 4% of the total in need².

Catholic Relief Services had opened a small office in South Africa in 2000 at the invitation of the Southern

African Catholic Bishops Conference (SACBC). Together the two organizations supported many small HIV programs, most of which had no buildings or other infrastructure. Most focused on home-based care, including bathing and feeding the sick, caring for children, supporting families, and, inevitably, helping infected people to die with dignity.

With the advent of PEPFAR came tremendous resources, and the SACBC AIDS Office set about developing a program for providing ART in needy communities. When CRS secured PEPFAR funding through AIDSRelief, the stage was set for a remarkable collaboration.



1 South Africa Global AIDS Response Progress Report, 2012

2 UNAIDS, 2008 Report on the Global AIDS Epidemic; Annex 2, Country Progress Indicators

The AIDSRelief consortium operated in ten countries³ in the hardest hit areas of Africa and Latin America. In most countries, the five U.S.-based consortium partners worked together to implement a care and treatment model that emphasized clinical care, strategic information, and site management. However, South Africa's large HIV epidemic meant that the country was home to many skilled clinicians and other experts with significant experience managing HIV patients. Therefore, CRS was the only consortium member active in South Africa.

Program implementation was managed by two local organizations: the SACBC and the Institute for Youth Development in South Africa (IYDSA). The two local partners were responsible for selection and management of the care and treatment facilities. CRS was the prime grantee and provided technical assistance for financial management, monitoring and evaluation, and other grant management issues.

Twenty-eight program facilities, located in areas of need throughout South Africa's provinces, were supported by AIDSRelief. Most had experience with pre-existing HIV programs operating within the Catholic health network. These included two hospitals, four primary care clinics, and six hospices. Nine of the programs offered clinical outreach services in a variety of community settings; eighteen provided home-based care.

Rapid Expansion

Working hand-in-hand with local experts, the AIDSRelief team provided technical assistance and capacity strengthening to and improved infrastructure and equipment at a total of 28 treatment sites linking dozens of satellite health facilities across the country. Each facility participated in a dynamic assessment

process to determine what the site needed in terms of material and capacity to begin delivering quality ART services. Treatment facilities were expanded and equipped. Financial systems were strengthened and health facilities were prepared to implement a new >>

AIDSRelief Supported Health Facilities 2004-2010

Siyathokoza
Father Balink Therapy and Counselling Centre
St Francis Care Centre
Sizanani Village, St Joseph Care Centre
Nazareth House
Inkanywezi
Holy Cross Home
Hope for Life
Centocow Mission, St Appolinaris
Blessed Gerard Care Centre
St Mary's Hospital
Mtubatuba Catholic Church, Mkulukulu Unati
Newcastle ART Program
Kurisanani
Tapologo
Great Kei Treatment Centre
Wesley & Nora Clinics
Masibambisane
Sophumelela
Siyangqoba
Good Shepherd
Good Samaritan
Sinosizo ART Project
Sinosizo Home-Based Care Program
Sisters of Mercy
Shongwe Mission, Thembaletu
Bela Bela
Diocese AIDS Ministry

³ Globally, the AIDSRelief consortium included CRS, the University of Maryland School of Medicine Institute of Human Virology, Futures Group, IMA World Health and Catholic Medical Mission Board. The program operated in Ethiopia, Guyana, Haiti, Kenya, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia

“By working together we learned from one another and, over time, built a strong team characterized by trust and mutual respect. It was not always smooth sailing. We did not always agree. But our commitment to the work we were doing together got us through the rough seas.”

—Ruth Stark, CRS South Africa

electronic database to assist with patient management. Hundreds of health workers were trained, and links were established with local clinical experts as well as with health institutions and organizations. Relationships with government health and social services agencies were strengthened.

Training the staff of the selected sites began even before the outcome of the proposal was known. Using funding from CRS, CORDAID (Caritas Netherlands) and other church-related donors, the SACBC AIDS office

trained 100 staff members on ART in a government-accredited program. Then, using funds from CORDAID, the eight sites most prepared to begin treatment were readied to accept patients. Doctors and nurses were hired, laboratory services were secured, and arrangements were made for the delivery of the life-saving medications. By the time the AIDSRelief program officially began, the SACBC treatment program was already in full swing.



Long-term efficacy and sustainability of HIV treatment, care, and support depend on using evidence-based strategies to guide expansion of services and continual improvement of patient care. As HIV programs continue shifting from an emergency response to long-term care, it is imperative to assess treatment outcomes and provide technical support so that scale-up does not come at the expense of service quality. With this goal at the forefront, AIDSRelief worked to ensure that providers faced the epidemic with the necessary material resources, skills and knowledge.

Early on, the SACBC, IYDSA and the AIDSRelief South Africa team concluded that there was ample expertise available in-country and that the assistance of local experts was more appropriate, more helpful, and far less costly than using external clinical experts. Accordingly,

AIDSRelief engaged local expert clinicians, institutes, and universities in the treatment program. Linkages were established with the clinical and research arms of four South African universities and with the Southern African HIV Clinicians Societies. These entities provided training, clinical advice and supervision, and data evaluation at no cost to AIDSRelief.

The local experts, in turn, trained project doctors and nurses, evaluated the clinical outcomes of the treatment, and served in an advisory capacity on a broad range of issues. The strong and productive relationships established between the treatment sites and these local experts has contributed immeasurably to the sustainability and affordability of the treatment program, and has been a major contributing factor in preparing the way for transition to local leadership.



WRAP-AROUND SERVICES AND STRATEGIC LINKAGES FOR COMPREHENSIVE CARE

In South Africa, AIDSRelief operated alongside dozens of other implementers offering HIV-related services, including government clinics. To minimize duplication and leverage each project's focus, AIDS-Relief provided patients with formal referrals and less formal links to complementary services that support HIV counseling, testing, and prevention, including the following:

Tuberculosis and HIV

In addition to its generalized HIV epidemic, South Africa bears a significant burden of tuberculosis (TB). Given the dramatic comorbidity of TB and HIV throughout the country, AIDSRelief sites screened all HIV patients for symptoms of TB. Laboratory specimens were collected and patients were referred to government clinics for treatment as needed. All health workers received training on TB infection control and low cost, basic renovations were made to reduce transmission, such as outdoor waiting areas and improved ventilation.⁴

Maternal-Child HIV Care

AIDSRelief's treatment sites were stand-alone HIV care and treatment centers. Most did not offer primary health care services and, therefore, referred HIV-positive women to maternal-child health centers located within full-service clinics.

"St. Mary's Hospital and its patients and their families have benefitted immeasurably from the AIDSRelief program. Thousands of patients who would otherwise have died are living productive lives with their families because of this program... The Hospital and AIDSRelief have learned a lot during this five year journey together."

—Dr. Douglas Ross, CEO St. Mary's Hospital



⁴ For more information, see *Room to Breathe: Four Steps to Reducing the Spread of Airborne Tuberculosis Infection*. Catholic Relief Services, 2012

Each AIDSRelief country program was designed to transition management of the program to a local partner, but the South Africa program was unique in its commitment to transition, which began in the earliest stages. The program was characterized by a team approach from day one of the project: staff from CRS and the local partners planned activities collaboratively and made decisions jointly, and all activities were implemented with the agreement of all partners. By working together staff learned from one another and, over time, built a strong team characterized by trust and mutual respect.

In preparation for the transition to South African ownership, in 2006 each local partner was awarded a separate, small PEPFAR grant to administer independently. All the local partners demonstrated the ability to manage these grants successfully, earning the trust and respect of the donor, the local government, and the communities they serve.

Throughout, AIDSRelief accompanied partner staff and management in a continuous process of capacity strengthening and program quality improvement. By working side-by-side in all of these areas, AIDSRelief put its partners in the “driver’s seat” and gradually decreased program involvement while simultaneously increasing partner responsibility.⁵

Strengthening capacity

AIDSRelief placed strong emphasis on strengthening the capacity of the individual church service programs within each umbrella organization—SACBC and IYDSA. The individual treatment sites were encouraged to partner with other local organizations, to attend training programs and conferences, to develop sound financial systems, and to engage with local government

departments. As a result, some of the treatment sites now receive services and benefits from the South African government including medications, laboratory, staff salaries, and even government subsidies. Some have been accredited as government treatment sites; others have established public-private partnerships of various types. Still others have developed collaborative relationships with other PEPFAR-funded partners.

Each of these linkages has the potential to contribute to long-term sustainability of the program. Linkages with government will be a source of continued funding. Linkages with local clinical experts and educational institutions will provide continued technical support. Linkages with other local treatment organizations will provide opportunities to share information and resources.

Long-term Sustainability

As transition moved to the forefront, the program’s scope of work became clearer: strengthen health facilities for sustainable provision of care and treatment services, while gradually reducing the role of CRS and increasing the local partners’ responsibilities.

Sustainability plans for some facilities involved public-private partnership arrangements where government would cover certain costs including laboratory services, antiretroviral drugs, and even, in several cases, staff salaries. For other programs, sustainability involved the transfer of ART patients to the South African government health services as they became available and accessible. Over five years, 6,764 patients were transferred to accredited government facilities where they continue to receive life-long HIV treatment. The strong partnership with the local church, the commitment to collaborate with the local government, and the encouragement and support of the U.S. government mission in South Africa made the transfers possible. >>

⁵ For a full examination of transition in South Africa, see. *The AIDSRelief South Africa Partnership*, Catholic Relief Services, 2010.

“From the beginning of the program, we were told that the ultimate goal was to transition the program to local partners, and to this end AIDSRelief South Africa worked with IYDSA to make this possible. To say that all went well would not be true. However, differences never got in the way of doing the job to the best of our ability.”

—Darren Gough, Director, IYDSA

Local Ownership

As the project moved toward transition, AIDSRelief continued to support the provision of quality care at health facilities while also considering their organizational capacity (e.g., management of human and material resources, governance, planning and budgeting). Furthermore, AIDSRelief and its local partners came together to determine how best to ensure a smooth transition of responsibility for AIDSRelief-supported sites and maintaining quality of care.

This gradual shift from international management to local ownership culminated in 2009, AIDSRelief South Africa became the first PEPFAR treatment program to transition to local ownership. SACBC, IYDSA and St. Mary’s Hospital demonstrated their leadership by

developing competitive funding applications that won new grants from the U.S. Centers for Disease Control and Prevention (CDC). They now receive PEPFAR grant funds directly and are responsible for managing the program. CRS continues to work in partnership by providing ongoing support in the areas of clinical coordination, monitoring and evaluation, and to a lesser and decreasing degree in financial management

In the second phase of transition, some patients have been transferred to government clinics, while others are receiving antiretroviral medication provided by the Department of Health at Church sites. By the end of 2011, the SACBC/CRS program had initiated more than 40,000 patients on ARV treatment. Former AIDSRelief facilities are also expanding services to include TB treatment and increased services for affected children.



For six years, AIDSRelief leveraged the strengths of South Africa's faith-based health network to expand high-quality HIV care to those most in need. Facilities that once could offer only rudimentary palliative care to patients in the last throes of an incurable disease now manage thousands of healthy, HIV-positive patients who raise families, participate in their communities, and contribute to their economies.

AIDSRelief helped local health systems absorb and grow stronger with the influx of financial, human,

and material resources; helped local partners greatly expand their capacity to provide clinical oversight, effectively use data, and manage sites and direct funding from the U.S. government; and helped individual health facilities provide high quality care and treatment services to tens of thousands of people who once faced certain death. Committed partnership and capacity strengthening were key to the program's excellent outcomes and its substantial progress toward a wholly locally-owned HIV response.



ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief South Africa received from our donor, our local partners, staff and management at health facilities, as well as from the South African clinical experts who have given of their time and expertise to ensure that those most in need received quality HIV care and treatment.

We would like to express special appreciation to F. Gray Handley, who was the health attaché at the US Embassy when we first started the ART program. Now the Associate Director for International Research Affairs at the United States National Institutes of Health, Mr. Handley gave expert advice and unfailing support.

We are grateful for the financial and technical support from the program's donor, HRSA, through funding from PEPFAR. We are particularly grateful to the staff of HRSA for their technical support in planning and implementing this transition to local leadership.

The U.S. Centers for Disease Control and Prevention (CDC) in Atlanta provided excellent technical

support and the CDC country mission in South Africa provided on-the-ground guidance for the HIV care and treatment activities. We would particularly like to acknowledge the CDC treatment liaison specialist, Celicia Serenata, who provided outstanding support over the six years of the project.

Transition to the local partners would not have been possible without the South African clinical experts who participated in the training, implementation and evaluation of the program. Their engagement with the local partners will contribute to the sustainability of quality care for poor communities and is much appreciated.

Finally, we also want to acknowledge the health workers and managers in treatment sites and communities across South Africa. These often-unsung heroes and heroines of the epidemic work under challenging circumstances and directly serve those in need. It has been an honor to work in partnership with them.

Patients Served by AIDSRelief in Ten Countries

Country	# Sites	Cumulative ever in care and treatment at transition	Cumulative ever on ART at transition	Current on ART at transition (incl. adults and pediatrics)	Current pediatrics on ART at transition
Ethiopia	5	4,125	2,179	1,062	144 (13.6%)
Guyana	3	2,443	1,519	1,083	74 (6.8%)
Haiti	11	14,644	6,473	4,469	306 (6.8%)
Kenya	31	141,734	88,615	60,549	6,320 (10.4%)
Nigeria	34	109,872	64,564	52,559	3,301 (6.3%)
Rwanda	20	11,928	6,698	4,850	670 (13.8%)
South Africa	28	73,293	35,038	21,204	1,518 (7.2%)
Tanzania	102	165,488	85,673	44,924	3,414 (7.6%)
Uganda	23	87,943	45,221	35,047	3,263 (9.3%)
Zambia	19	96,247	60,041	42,783	3,197 (7.5%)
Total	276	707,717	396,021	268,530	22,207 (8.3%)



For more information, contact aidsrelief@crs.org