

Providing Treatment,
Restoring Hope

AIDS  **RELIEF**[™]

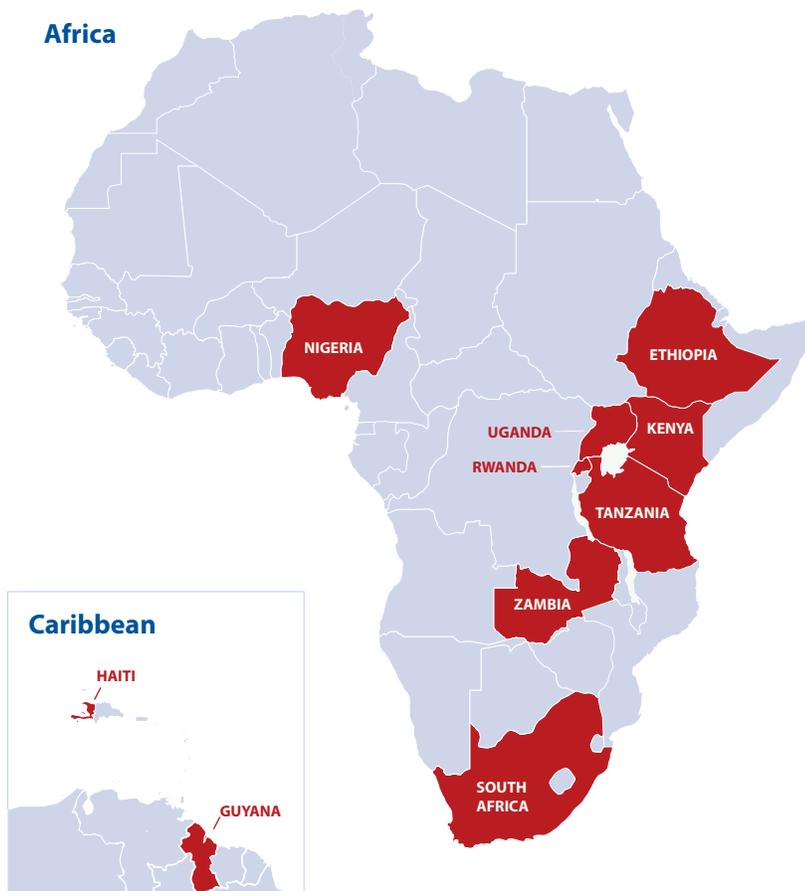
UGANDA

FINAL REPORT 2004-2012

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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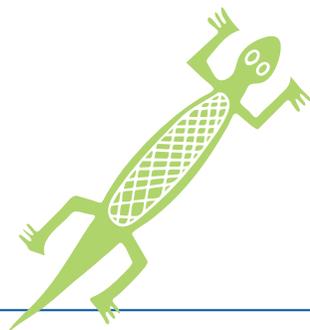


From 2004 to 2012, AIDSRelief Uganda provided HIV care and treatment to nearly 88,000 patients, including 45,000 who enrolled on lifesaving antiretroviral therapy (ART) at 23 treatment sites. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, Futures Group, and Children's AIDS Fund worked hand in hand with local partners to build the skills and systems needed to support high-quality care. A deep commitment to partnership underscored AIDSRelief's relationships and capacity strengthening activities, which culminated in late 2011 when two local partners—the Uganda Episcopal Conference and the Uganda Protestant Medical Bureau—won new grants to receive PEPFAR funds directly and assume full responsibility for managing the program.

Average viral suppression for AIDSRelief Uganda patients exceeded 88%

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

In the process, AIDSRelief has provided hope and has afforded longer and higher-quality lives to thousands of people affected by HIV, particularly the poor and those in rural areas. At the height of the program in 2009, about 15% of Ugandans on ART were receiving treatment through AIDSRelief-supported facilities. In the last nine years, rapid upscaling efforts have meant that ART has now become common and patients no longer have to travel long distances to access care and treatment.



HIGHLIGHTS INCLUDE:

- » Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (4.8%), high retention (88.5%)¹, and cross-directional linkages to other community-based programs supporting people living with HIV.
- » At the height of the program in 2009, about 15% of Ugandans on ART were receiving treatment through AIDSRelief-supported facilities.
- » As part of program monitoring and quality improvement, three patient-level outcome evaluations were conducted over the eight years of the program. Each time, average viral suppression—the gold standard for measuring treatment success—exceeded 88%.²
- » Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management. From 2008 to 2012, more than 5,200 participants attended off- and on-site training sessions.
- » AIDSRelief worked to build and strengthen the health supply chain, resulting in zero stock outs and an uninterrupted supply of ARVs throughout the eight years of the program.

1 Rates are derived from survival (time to event) analysis. At each time period, the probability of 'survival' is calculated. These 'survival probabilities' are then cumulated (multiplied) over several time periods. For instance, 12-month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.

2 Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys. Analysis in 2006 and 2008 indicated viral suppression rates of 88.1% and 89.2%, respectively.

OUR CALL TO ACTION

At the advent of the new millennium, Uganda became the first African country to bring a major HIV epidemic to relative stability. An aggressive response reduced adult HIV prevalence from a high of approximately 18% in 1992 to just over 6% by 2004.³ However, one of the more significant challenges that emerged was access to HIV treatment and care. The initial high price of antiretroviral medications seriously limited the country's capacity to expand treatment services. Even after the Government of Uganda successfully negotiated with drug companies to lower the price of treatment, the lack of government subsidies and the purely out-of-pocket purchasing arrangement ensured that ART remained a privilege of relatively well-to-do patients.

In Uganda, AIDSRelief supported 23 health facilities and 37 satellite clinics that brought brought services to more patients, enhanced adherence and reduced loss to follow-up.

AIDSRelief—one of the first non-government, large-scale ART interventions—entered the scene at a time of government desire for expansion in a reality of severe access constraints. Creating a high-quality, sustainable care delivery system meant developing the full range of adult and pediatric care and treatment services

along with community-based treatment support, laboratory infrastructure, supply chain management for medicines and health commodities, and strong data management and quality improvement activities. The program also established links with the Uganda Ministry of Health and other organizations such as the Clinton Foundation and Program for Accessible Health Communication and Education (PACE) in order to increase the number of services available to HIV patients and their families.

AIDSRelief Supported Health Facilities 2004-2012

Amai Community Hospital
Dr. Ambrosoli Memorial
Hospital, Kalongo
Bethlehem Medical Center
Bushenyi Medical Center
Comboni Hospital Kyamuhunga
Family Hope Center Jinja
Family Hope Center Kampala
Holy Family Virika Hospital
Kabwohe Clinical Research Center
Kabarole Missionary Hospital
Kamwokya Christian
Caring Community
Kasanga Health Centre
Kololo Workers Treatment Center
Nile Treatment Center
Nkozi Hospital
Nyenga Hospital
Pope John's Hospital Aber
St. Francis Hospital Nsambya Home
Based Care
St. Francis Hospital Nsambya MTCT+
St. Francis Hospital Nsambya
Private Clinic
St. Joseph Hospital Kitgum
St. Mary's Hospital, Lacor
Villa Maria Hospital



³ Uganda 2004-05 Sero-Behavioural Health Survey. Retrieved from http://pdf.usaid.gov/pdf_docs/PNADG508.pdf



AIDSRelief Uganda included three of the five AIDSRelief global consortium members: Catholic Relief Services (CRS), Futures Group, and the University of Maryland School of Medicine Institute of Human Virology (IHV). In Uganda, the program also partnered with Children's AIDS Fund (CAF). The consortium partners worked together to implement a care and treatment model that emphasized its core components equally: clinical care, strategic information, and site management. This model was supported by a foundation of health systems strengthening activities designed to ensure excellent patient outcomes that can be sustained over time by local partners, a goal that is wholly dependent on a functional health system.

CRS was the prime grantee and provided overall program coordination and oversight for grant

administration and compliance, in addition to coordinating representation of the grant to the United States government donor agencies; local government, particularly the Ministry of Health; and other stakeholders. IHV served as the clinical lead for AIDSRelief in developing and implementing activities that built local partners' capacity to provide comprehensive, high-quality HIV care and treatment within the framework of national policies and guidelines. Futures managed strategic information through data collection and analysis; monitoring; and generation of reports for donors, government, and other key stakeholders, and development and implementation of electronic health records and other health informatics applications. CAF provided site management and capacity strengthening assistance for selected health facilities.



A NETWORK OF TREATMENT SITES

Strengthening care delivery systems is strongly linked to sustainability and was a priority from the onset of AIDSRelief. Therefore, the project's initial scale-up phase included two interrelated processes: selecting individual treatment sites and strengthening existing health networks to ensure sustainability of the treatment programs.

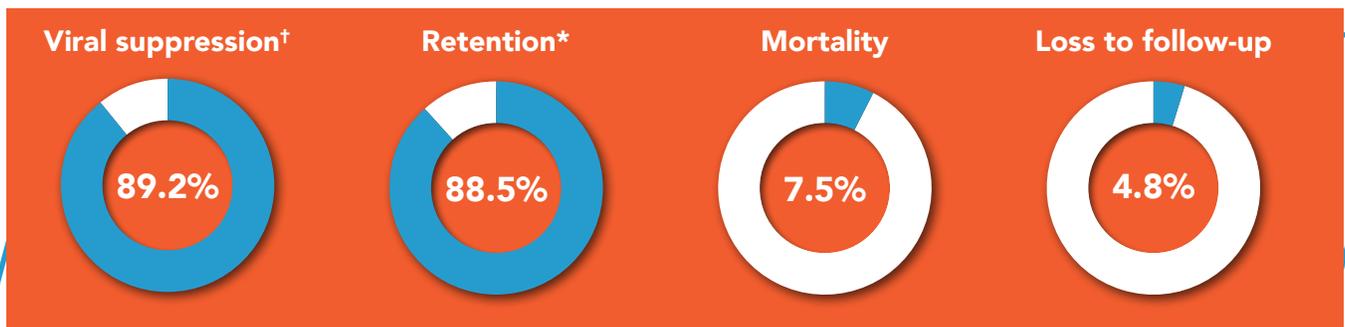


First, AIDSRelief focused on developing sustainable capacity at individual health facilities. Second, AIDSRelief fostered long-term partnerships and targeted capacity strengthening with health networks. Treatment facilities were expanded and equipped. Financial systems and an electronic patient management system were put in place. 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.

AIDSRelief provided care to more than 87,000 patients, with priority given to pregnant mothers and TB-infected clients.

Initially, AIDSRelief focused on hospitals in the Catholic health network because an existing close relationship with CRS facilitated new initiatives. Early on, the program developed a strong partnership with the Uganda Episcopal Conference, with its Uganda Catholic Medical Bureau acting as the lead technical department for the care and treatment program. >>

AIDSRelief by the Numbers



[†] Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys. Analysis in 2006 and 2008 indicated viral suppression rates of 88.1% and 89.2%, respectively.

* Rates are derived from survival (time to event) analysis. At each time period, the probability of 'survival' is calculated. These 'survival probabilities' are then cumulated (multiplied) over several time periods. For instance, 12 month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.

Later, the Uganda Protestant Medical Bureau also became a local partner. Over time, AIDSRelief supported a total of 23 health facilities in Northern, Western, and Central Uganda.

A key component of AIDSRelief Uganda's approach was improving inter- and intra-facility integration of services. In addition to the 23 health facilities, AIDSRelief worked through 37 satellite clinics that refilled ARVs and other drugs, obtained patient blood samples for laboratory investigation, provided basic patient counseling, and linked clients to other health facilities, such as antenatal clinics for pregnant mothers. Satellite clinics have brought AIDSRelief's services to more patients, which has enhanced adherence and reduced loss to follow-up.

Through these health facilities and their satellites, the program provided care to more than 87,000 patients, with priority given to pregnant mothers and TB-infected clients.



From the clinic to the community

A key element of AIDSRelief's success was community based treatment support, a cross-cutting program at all treatment sites. The comprehensive program emphasized strong links between people living with HIV, their families, and their communities and health facilities. AIDSRelief Uganda developed an extensive network of support and services through partnerships with the Ministry of Health and HIV support organizations and provided extensive training of patients and volunteers who serve as peer counselors, supporters, and trainers.

AIDSRelief trained staff and designated a focal person at each health facility to coordinate the activities of a network of more than 500 local community health volunteers, many of whom were themselves living with HIV. These volunteers addressed adherence issues by preparing patients for treatment and linking them to service providers or support groups. Community health volunteers were also a core component of AIDSRelief Uganda's family approach, whereby they visited the homes of people living with HIV and encouraged family members to get tested, urged pregnant women to access services to prevent transmission of HIV to their babies, educated mothers on infant feeding practices, and worked to integrate HIV and TB care for patients. Through these and other activities, volunteers eased the burden on the strained health systems by doing tasks that would otherwise be done by medical personnel, if at all.

EXCEPTIONAL TREATMENT

In the early years of ART, there were simply not enough drugs to go around and healthcare providers were under pressure to serve those most in need. Severe resource constraints meant that most developing countries initiated treatment only for patients with very low CD4 counts using less potent regimens, despite evidence that certain drug regimens might be less effective when initiated late in disease progression. Moreover, late initiation of treatment and a lack of early infant diagnosis and services for pregnant women meant that HIV-infected children were experiencing symptoms of AIDS.

From the outset, AIDSRelief advocated for maximizing the initial ART regimen in an effort to ensure

durable treatment outcomes and long-term cost control. This is especially important in low-resource settings where extensive laboratory monitoring and multiple treatment options are not available.

In fact, AIDSRelief was the first PEPFAR-supported implementer in Uganda to use and advocate for the inclusion of the antiretroviral drug tenofovir in the national treatment guidelines as a preferred first-line regimen. The consortium demonstrated that a durable first-line regimen saved money and lives in the long run because of improved patient outcomes and the ability to minimize costly second-line drugs.



AIDSRelief established an integrated approach to services, which helped reduce overlap and create better opportunities for positive outcomes. In so doing, AIDSRelief moved from treating a disease to treating a family, to treating a community, to strengthening an entire health system.

In addition, the AIDSRelief model treated adherence as a therapeutic intervention. A patient's treatment experience included structured treatment preparation, adherence counseling, home visits by peer counselors, and community involvement. This emphasis on support networks helped patients adhere to their treatment plans and reduced the number of patients lost to follow-up.

The AIDSRelief model also ensured that all ART clinicians were well-trained and regularly mentored. Treatment sites were assessed prior to activation to identify gaps that required immediate attention. For example, laboratories were outfitted with all equipment necessary for high-quality ART management. AIDSRelief also ensured availability of ARVs and other medications through a well-coordinated supply chain system, which recorded zero ARV stock outs over the eight years of the program and supported government sites with ARVs when their medical stores ran low.

A Complete Package

Beginning in 2006, additional funding allowed AIDSRelief Uganda to provide a more comprehensive treatment package including testing and counseling, TB services, prevention of mother-to-child transmission, and services for orphans and vulnerable children. AIDSRelief established an integrated approach to services, which helped reduce overlap and create better opportunities for positive outcomes. In so doing, AIDSRelief moved from treating a disease to treating a family, to treating a community, to strengthening an entire health system.

Maternal-Child HIV Care (MCHC)

AIDSRelief approached prevention of mother-to-child-transmission of HIV from a perspective of maternal-child HIV care. Interventions strengthened links between antenatal care and HIV clinics so that all HIV-infected pregnant women identified at the antenatal clinics were linked to treatment that same day.

Clinicians were trained to ensure that all HIV-positive babies under 2 years of age were started on ART irrespective of CD4 count or clinical stage⁴. In addition, more than 100 midwives and nurses were trained in maternal-child health, ART, and clinical staging of HIV-infected pregnant women. All health facilities established early infant diagnosis systems that included staff overseeing activities.

Community follow-up of exposed babies through phone calls, home visits, and outreach visits has improved retention of these children in care. The number of children receiving cotrimoxazole (an antibiotic used to treat opportunistic infections) by 2 months of age increased from about 23% in 2009 to 75% in 2011.

To increase male support for HIV-infected women and improve antenatal care and treatment, AIDSRelief linked to a Catholic Relief Services program known as The Faithful House, a values-based curriculum focused on couple communication, family strengthening, behavior change, and couples testing. AIDSRelief enhanced the program by linking pregnant women to MCHC services. Six months after attending a Faithful House workshop, 91% of men reported willingness to attend antenatal visits with their partners.

Encouraged by the health facilities' technical capacity and strong patient level outcomes, AIDSRelief lobbied the Ministry of Health to consider introducing Option B, which includes a full ART regimen for the mother until breastfeeding is completed along with treating the baby until 6 weeks of age. In October 2011, the Ministry invited AIDSRelief to launch Uganda's first Option B program. Information from this pilot program (which includes 12 >>

⁴ For HIV-infected patients, a CD4 test is the best way to determine a patient's degree of immunosuppression. Where such tests are not available, doctors must rely on other methods to support treatment decisions. The World Health Organization (WHO) system classifies the degree of HIV disease based on symptoms that can be recognized and treated in diverse settings. See WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Disease in Adults and Children.

facilities and 572 pregnant women on prophylaxis)⁵ will inform nationwide implementation plans.

Tuberculosis (TB)

Tuberculosis is the most common opportunistic infection and a leading cause of death among people living with HIV in sub-Saharan Africa. Treatment of TB depends on proper identification of the disease, although prior to AIDSRelief health facilities largely relied on relatively inaccurate sputum samples for diagnostic purposes. AIDSRelief provided comprehensive TB/HIV care with a focus on introducing and implementing the 2004 WHO-recommended 3Is strategy.⁶

Because no standard protocols existed, AIDSRelief trained health facility staff and spearheaded teams that conducted TB transmission risk assessments at their facilities and for the first time documented an infection control plan. To improve diagnosis, more than 360 clinicians, nurses, counselors, and laboratory staff were trained in TB/HIV co-management, recording and reporting, and TB infection control.

AIDSRelief provided all facilities with fluorescent microscopes, which are easier to use and provide a more accurate diagnosis, and trained laboratory staff to use the equipment. All patients who presented with TB were tested for HIV, and vice versa. A cumulative total of more than 24,000 clients were treated for TB.

AIDSRelief also began gradual, cautious expansion of isoniazid preventive therapy. The most significant obstacle to TB prevention was the sporadic availability of isoniazid. AIDSRelief overcame this barrier by facilitating access to free isoniazid from the National TB and Leprosy Program Office.

Orphans and Vulnerable Children (OVC)

After AIDSRelief launched counseling and psychosocial support groups, the donor asked if the program

could add education, food security, and protection services for orphans and vulnerable children. AIDSRelief adjusted budgets and streamlined OVC support to ensure that the comprehensive OVC package included psychosocial counseling, protection, food security, and education support. These programs not only helped meet the needs of vulnerable children but also served as an entry point for pediatric ART. Training children in the maintenance of kitchen gardens improved their nutrition and created the opportunity to generate income. Additionally, in a project partially supported by the Clinton Health Access Initiative, children who exhibited evidence of malnutrition were provided with food, tested, and enrolled in care if needed.

Because many HIV-infected OVC—particularly those not residing with any parent—suffer abuse at the hands of caregivers, AIDSRelief offered training to help health workers recognize and report abuse, assisted abused children in finding safer homes, and sensitized communities in protection topics. With AIDSRelief support, each health facility sponsored at least five adolescents to participate in apprenticeships which improved their livelihoods. The program also linked some of the other children to additional apprenticeships.



⁵ As of February 29, 2012

⁶ The three I's include intensified case finding, isoniazid preventive therapy, and infection control. The Uganda National TB and Leprosy Program had adopted the 3Is but implementation was slow up to 2008. For more information on the 3Is, visit <http://www.who.int/hiv/topics/tb/3is/en/index.html>

Because HIV care and treatment programs depend on strong, well-managed health systems that can provide comprehensive care, health systems strengthening was a key component of the AIDSRelief Uganda program. This meant not only improving the leadership and management of health facilities, but also strengthening the capacity of laboratory staff, the supply chain system, and human resources.

Leadership and Capacity Building

At the health facility level, AIDSRelief focused on building the capacity of its partners to manage an HIV care program; this entailed developing and implementing work plans, budgeting and managing expenditures, and strengthening internal financial control systems.

Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management.

AIDSRelief complemented its training with mentoring activities that assisted program coordinators in implementing the program at the health facility level.

As part of its capacity strengthening endeavor, AIDSRelief trained its local partners' boards of directors on governance and leadership; provided technical assistance to develop manuals, policies, procedures, and internal controls; and hired staff to aid managers in improving site performance.

Laboratory

Most of the AIDSRelief sites in Uganda did not have the sophisticated laboratory capacity required for high-level management of ART, such as CD4 counts,

viral loads, and genotypic resistance tracking. In fact, many had no reliable electricity or running water. Because poor laboratory services can compromise the quality of care, AIDSRelief made laboratory capacity development a major programmatic area in Uganda.

At many sites, AIDSRelief rehabilitated the infrastructure by providing critical equipment and power backup systems, a necessity in areas where an unreliable power supply could cripple laboratory services. Several of these facilities are now equipped with modern solar generating systems. All 18 laboratories were furnished with CD4 platforms, chemistry equipment and other supplies necessary for proper monitoring of patients. >>



In addition, AIDSRelief created standard operating procedures for all tests performed by these laboratories, and more than 75 laboratory personnel were trained in services and procedures including infection control and quality control.

These improvements resulted in dramatic improvements in laboratory indications. Over 80% of patients initiating ART had a baseline CD4 count to evaluate eligibility and overall CD4 repeat rates were above 69%, which ensured close monitoring of patients on treatment. The turnaround time for infant test results was reduced from 2-3 months to only one month by strengthening links between PMTCT programs and testing labs. As a result, more than 5,000 HIV-exposed babies have been identified and tested for HIV since December 2009.

AIDSRelief created easy-to-use tools that assisted facilities in tracking drugs from the time they entered the country, through transport and distribution, to the point at which they were dispensed to patients.

Finally, all laboratories have been integrated into external quality assurance schemes such as the United Kingdom National External Quality Assessment Service and the Uganda National Tuberculosis and Reference Laboratory External Quality Assurance scheme.

Supply Chain

All efforts to provide care and treatment would be rendered moot if medicines, reagents, and other commodities were not available; however, stock-outs of ARVs were frequent when AIDSRelief entered the scene. Healthcare staff had attributed this to the fact that drugs were sent to facilities based on a push system, rather than using forecasts derived from facility-based data on usage trends (a pull system). Moreover, AIDSRelief found that many health facilities were not storing the drugs according to accepted standards.

AIDSRelief created easy-to-use tools that assisted facilities in tracking drugs from the time they entered

the country, through transport and distribution, to the point at which they were dispensed to patients. In addition, AIDSRelief placed a strong emphasis on sustainability of the supply chain by fostering therapeutic drug committees to effectively oversee and manage the clinical and supply chain aspects of the program. Within facilities, therapeutic drug committees enhance communication between the various departments involved in providing care, such as clinicians, laboratory staff, and supply chain managers.

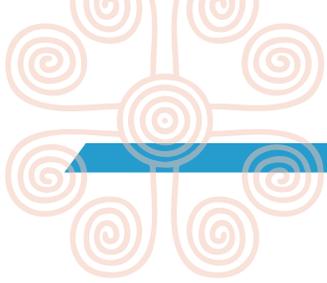
Accurate consumption-based forecasts, quantification of drug needs, and a three-month buffer stock at the central level (two months at the facility level) resulted in zero stock outs and an uninterrupted supply of ARVs throughout the eight years of the program.

Human Resources

One of Uganda's primary health challenges has been a severe shortage of health care workers. For instance, in 2004 fewer than 1,400 doctors provided services to its population of 27 million people⁷. Due to this shortage of doctors, nurses, and other health care professionals, staff turnover is high and health facility staff members are sometimes stretched thin and unable to perform the multiple duties expected of them.

Because compensation emerged as a notable issue linked to staff turnover, AIDSRelief helped facilities to devise a salary structure that was both fair and sustainable. AIDSRelief also worked to ensure that health workers at facilities have the knowledge base, guidelines, skills and support necessary to perform their jobs well. Due to the limited health workforce, especially in hard-to-reach areas, the program encouraged task shifting and, in some cases, trained lower worker cadres to carry out tasks that would otherwise be done by the senior staff. In evidence of the success of the program's human resources strategy, many of the ART clinics supported by AIDSRelief retained core staff present since the program started.

7 Samba, B., Celletti, F., et al. (2007). Rapid Expansion of the Health Workforce in Response to the HIV Epidemic. *New England Journal of Medicine* 357; 24. 2510-2514



Prior to AIDSRelief, medical records were kept in paper form, making it difficult for health staff to locate records and properly follow patient progress. This practice also made it difficult to generate useful statistical information that could drive evidence-based

decision making. The impact reached beyond the patient level to affect the health supply chain, as the lack of data on consumption and forecasting contributed to frequent stock-outs. The lack of data use was not only an issue of inadequate systems and technology, but also one of capacity: In some facilities, AIDSRelief encountered health care staff members who were unable to use computers.

AIDSRelief was a pioneer of electronic data management systems in Uganda.

AIDSRelief set about to first increase efficiencies in existing patient record management practices, subsequently introducing an electronic data management system⁸ designed to link laboratory, planning, budget, and patient-level data collection and analysis. AIDSRelief also deployed customizable and enhanced shareware tools that can be used widely and in resource-limited settings, thus becoming one of the pioneers of electronic data management systems in Uganda. Using in-country networks and innovative technology, AIDSRelief built a strong, sustainable system for clinical records and program information that meets standards established by local governments and that can be uniformly used to collect and track data. The system manages records for more than 87,000 patients across 18 facilities.

More than 300 strategic information officers, data clerks, and other staff were trained to use these tools, which allowed health facilities to do the following:

- » Identify potential defaulters by monitoring patients' monthly ARV pickup
- » Manage the clinic schedule and schedule appointments to reduce waiting time



⁸ AIDSRelief's data management system is called IQSolutions. For more information, visit <http://www.iqstrategy.net/>

- » Examine trends such as mortality and loss to follow-up and provide information to treatment teams and address gaps in program and services
- » Improve feedback and analysis of routine government and donor reports

Perhaps the greatest challenge was that, initially, facility staff did not see the need for data, regarding data management as an added burden. However, AIDSRelief appealed to the staff members' desire to understand progress in their work, demonstrating how data could provide answers. AIDSRelief has had significant impact in shaping the facilities' approach to and enthusiasm for data use; health facilities now collect, review, analyze, and disseminate the data

themselves. Clinics are better able to follow patients and assess treatment outcomes, determine budgets, plan for human resource needs, and inform supply chain decisions. In fact, facilities have begun performing operations research on the data they obtain and manage, rather than depending on third parties for such activities.

In addition, a comprehensive monitoring and evaluation curriculum, a rarity among Ugandan treatment programs, strengthened patient monitoring and management. AIDSRelief integrated its monitoring and evaluation systems with national systems as a way to promote the highest quality of service and care, as well to help track and prevent loss to follow up.





AIDSRelief was designed with transition to local partners in mind and all program planning supported that goal. A shared vision—among the donor, local partners, and within the AIDSRelief consortium—was challenging to develop but also essential to successful transition. In Uganda, the consortium was committed to ensuring that the systems and capacities of the transition partners were enhanced to maintain high quality treatment outcomes.

During the early stages of transition planning, AIDSRelief engaged in dialogue with potential local partners as well as with the Ministry of Health and shared the proposed transition strategy. Key considerations for identifying a local partner for transition included being a preexisting and viable health organization; established by the owners of the faith based health facilities; demonstrated effective health programming; efficient management systems; links with the other health institutions, and recognition as an effective health organization by treatment facilities, U.S. donor agencies and the Ministry of Health.

Through this process, AIDSRelief collaborated with two transition partners: the Uganda Episcopal Conference (UEC) including its Uganda Catholic Medical Bureau (UCMB), and the Uganda Protestant Medical Bureau (UPMB). In 2007, AIDSRelief began planning to transition responsibilities including financial management, non-technical site support, supply chain, ancillary services, and representation. Activities intensified in 2008 when the donor re-emphasized local ownership and program sustainability by allowing funding to prepare local partners for transition.

Transition was an exercise in partnership and capacity strengthening in which AIDSRelief incrementally reversed roles with the local partners, culminating with the partners taking on full leadership and overall responsibility for management of the ART program. AIDSRelief worked with UEC and UPMB to recruit key



staff to lead the transition, including a project coordinator with HIV programming and PEPFAR experience, a finance and compliance officer, and a strategic information officer. With support from AIDSRelief, each partner implemented capacity strengthening plans that led to their increasing responsibility and eventually managing the entire program.

This gradual shift from international management to local ownership culminated in 2011, when UPMB and UEC demonstrated their readiness for local leadership, management and ownership, by developing competitive funding applications that won new grants from the U.S. Centers for Disease Control and Prevention (CDC). They now receive their PEPFAR grant funds directly and are responsible for managing all aspects of the program⁹. In their new roles as prime grantees, UEC and UPMB are also responsible for oversight of clinical support and strategic information.

⁹ The supply chain transitioned to the Ugandan organization Medical Access, which received a separate award for the health commodities and logistics component of the transitioned program.

ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Uganda received from our donor, our local partners, staff and management at local health facilities, and the Ugandan clinical experts who gave their time and expertise to ensure that those most in need received—and will continue to receive—quality HIV care and treatment.

We are grateful for the financial and technical support from the program’s donor, the Health Resources and Services Administration (HRSA), through funding from PEPFAR. We also appreciate the CDC team in Uganda for their on-the-ground program oversight, guidance, and support. The program’s impact would not have been possible without the tremendous dedication from all levels within the Uganda Ministry of Health and with our local partners, the Uganda Episcopal Conference including its Uganda Catholic Medical Bureau, and the Uganda Protestant Medical Bureau. Each and all were essential

to AIDSRelief’s success and are helping make sustained country ownership possible in Uganda.

We also wish to acknowledge the health workers and managers in treatment sites and communities across Uganda. 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.

Thank you to the past and present staff of AIDSRelief, the Uganda Episcopal Conference, Uganda Catholic Medical Bureau, and the Uganda Protestant Medical Bureau, as well as staff at individual health facilities who agreed to be interviewed and share their experiences for this report. Lastly, thank you to the author of this document, Paul Perin, and to the reviewers whose thoughtful comments on early drafts were invaluable.

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%)

