

Providing Treatment,  
Restoring Hope

**AIDS**  **RELIEF**™

**ZAMBIA**

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 Zambia provided HIV care and treatment to more than 96,000 patients, including more than 60,000 who enrolled on life-saving antiretroviral therapy (ART) at 19 treatment sites linking 111 satellite health facilities. 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 Churches Health Association of Zambia and Chreso Ministries—won new grants to receive PEPFAR funds directly and assume responsibility for managing the program.

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.



## HIGHLIGHTS INCLUDE:

- » Patients on treatment in AIDSRelief-supported facilities maintained a viral suppression rate as high as 91.5%, indicating excellent adherence to treatment<sup>1</sup>.
- » Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (16.8%), high retention (79.8%), and very low mortality (6.5%)<sup>2</sup>.
- » 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, nearly 8,000 participants attended off- and on-site training sessions.
- » More than 226,000 people underwent HIV testing and counseling and received their results.
- » 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.

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. In the last decade, ART has become common and patients no longer have to travel long distances to access care and treatment.

- 1 Based on an analysis of summaries for 43,547 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, 2007 and 2008 indicated viral suppression rates of 80%, 91.5% and 90.5%, respectively.
- 2 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.

## OUR CALL TO ACTION

Prior to PEPFAR's launch and the national expansion of ART in 2004, Zambia's HIV burden was among the highest in sub-Saharan Africa. Adult prevalence was 15.6%,<sup>3</sup> and more than 66,000 adults died of AIDS-related causes in 2003 alone. AIDS was rapidly decimating Zambia's adult population, while treatment was either unavailable or prohibitively expensive.

Though the context in each AIDSRelief country varied, most programs launched in 2004 facing health systems struggling under the burden of HIV. At best, treatment was prohibitively expensive and inconsistent; more commonly it was virtually nonexistent. 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.

With the help of bilateral and multilateral partners, Zambia—now categorized as a middle-income country by the World Bank—has achieved impressive growth in HIV care, support, and treatment services in public and private settings. By 2011, 90% of Zambians aged 15 and older who needed treatment received it, and AIDS-related mortality among infants plummeted thanks to prevention of mother-to-child transmission services.



3 Zambia Demographic and Health Survey 2001/2002

AIDSRelief Zambia was comprised of 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), working in partnership 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

- » **226,605 people underwent testing and counseling for HIV and received their results**
- » **96,247 adults received care and treatment, including 60,041 who received ART**
- » **10,461 children were enrolled in care and treatment, including 3,197 on treatment (7.5% pediatric enrollment on ART).**

development and implementation electronic health records and other health informatics applications. CAF provided site management and capacity strengthening assistance for selected health facilities.

### Impact

AIDSRelief brought life-saving medicine and high-quality HIV care to Zambia at an unprecedented scale and pace. Working hand-in-hand with local partners, the team provided technical assistance and capacity strengthening and improved infrastructure and equipment at 19 >>

### AIDSRelief's Local Partners

**The Churches Health Association of Zambia (CHAZ)** was formed in 1970 by church mother bodies as an interdenominational, indigenous, locally registered umbrella organization. CHAZ member institutions provide about 50% of the formal health services in Zambia's rural areas and more than 30% nationwide. CHAZ has a memorandum of understanding with the Ministry of Health that ensures government support for human resources, essential drugs, and about 75% of running costs for mission hospitals.

**Chreso Ministries** is a Zambian organization registered as a nonprofit faith-based organization that operates three stand-alone ART sites based in Kabwe, Lusaka, and Livingstone. Chreso contributes a strong model of treatment and is a training ground for clinicians in HIV medicine.

treatment sites linking 111 satellite health facilities across all 72 districts in Zambia to ensure high-quality HIV services. For every patient, there also are partners, children, and friends who face a future more hopeful than they could have imagined just a decade ago.

Each of these patients received exceptional care from AIDSRelief-supported facilities, a claim rooted in evidence from patient-level outcome surveys and survival analyses that demonstrated the following:

### Strengthened Systems

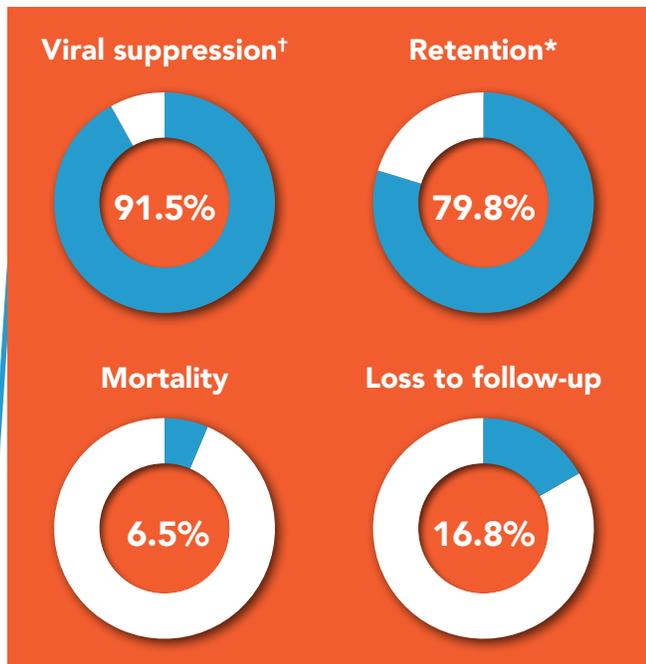
The advent of PEPFAR and national roll-out of ART in 2004 brought tremendous resources to Zambia. However, indigenous organizations did not have adequate systems, structures, and staff to manage these new resources. A program the size and scope of AIDSRelief

would have been very challenging to implement in Zambia's resource-constrained environment in 2004.

Inherent to the project's design was intensive health-systems strengthening. Because such an approach is a fundamental shift for many health institutions in resource-poor settings, AIDSRelief provided direct assistance for technical skill building among individuals (particularly with regard to HIV treatment, strategic information, and U.S. government grant management), organizational development among institutions at all levels, and systems strengthening within organizations and within the larger context of Zambia's health system.

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.

## AIDSRelief by the Numbers



† Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review.  
\* 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.





## RAPID EXPANSION: A NETWORK OF TREATMENT FACILITIES

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. With a focus on reaching rural, underserved Zambians, AIDSRelief turned to the Churches Health Association of Zambia to identify health facilities in which to roll out treatment.

Each facility participated in a dynamic assessment process to determine what the site needed in terms of material and capacity to begin delivering quality

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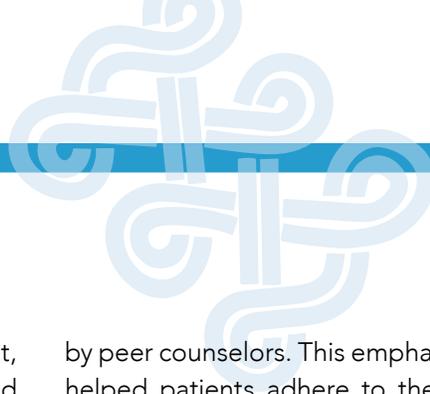
ART services. Treatment facilities were expanded and equipped. Financial systems and an electronic patient management system were put in place. Hundreds of health workers were trained, and links were established with local clinical experts as well as with health institutions and organizations. Relationships with government health and social services agencies were strengthened.

A key component of AIDSRelief's approach was improving the inter- and intra-facility integration of services. In addition to the 19 health facilities, AIDSRelief worked through 111 satellite clinics linked to the facilities 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.

### AIDSRelief Supported Health Facilities 2004-2012

Chikuni Mission Hospital  
Chilonga Mission Hospital  
Chreso Ministries Kabwe  
Chreso Ministries Livingstone  
Chreso Ministries Lusaka  
Circle of Hope Family Care Clinic  
Itezhi-Tezhi Hospital  
Kamoto Mission Hospital  
Katondwe Mission Hospital  
Macha Mission Hospital  
Mukinge Mission Hospital  
Mtendere Mission Hospital  
Mwandi Mission Hospital  
Siavonga District Hospital  
Sichili Mission Hospital  
St. Theresa's Mission Hospital  
St. Francis Mission Hospital  
Wusakile Hospital  
Macolm Watson Hospital





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, up-to-date skills and knowledge, and an enabling policy environment.

In addition, the AIDSRelief model treated adherence as a therapeutic intervention. Each patient's treatment experience included structured treatment preparation, adherence counseling, community involvement, and highly supported treatment initiation with home visits

by peer counselors. This emphasis on support networks helped patients adhere to their treatment plans and reduced the number of patients lost to follow-up.

### Tuberculosis (TB) and HIV

Given the dramatic comorbidity of TB and HIV in Zambia, AIDSRelief implemented the WHO-recommended "Three Is": intensified case finding, infection prevention, and isoniazid prophylaxis<sup>4</sup>. Every AIDSRelief-supported patient was screened for tuberculosis, and screening was available to exposed family members. Just over 3% of HIV patients were also TB-positive and began treatment for that disease. More than 70,000 AIDSRelief patients (73%) received cotrimoxazole prophylaxis. AIDSRelief also strengthened diagnostic strategies and capacity among laboratory staff so that they could better detect TB; training was offered in conjunction with the Ministry of Health. >>

### Advocacy for Supportive Policies: Enabling Success

To ensure lasting change, capacity strengthening should include efforts to make the external environment more supportive of the desired change or end goals. In the AIDSRelief context, this included development of innovative education programs in concert with Zambian health and education institutions. AIDSRelief consortium members and CHAZ representatives participated in all HIV-related national technical working groups convened by the Zambian government. Representatives also advocated that the government institutionalize the highest-quality evidence-based treatment guidelines and best practices. Chreso members are expected to join the technical working groups soon as well. AIDSRelief helped influence the following Zambian decisions:

- » Adopting concepts such as treatment preparation and adherence counseling standards (2010 national guidelines) in order to improve adherence and retention
- » Replacing stavudine with tenofovir for first-line therapy (2007 national guidelines) in order to maximize the initial regimen and minimize the need for more expensive and less well-tolerated regimens
- » Providing ART to HIV-positive partners in discordant couples, regardless of the patient's CD4 count or clinical stage, in order to minimize transmission risk (2010 national guidelines)

<sup>4</sup> For more information on the 3Is, visit <http://www.who.int/hiv/topics/tb/3is/en/index.html>

## Expanding the Infrastructure of Clinical Education in Zambia

AIDSRelief worked with Zambian institutions to establish locally-run educational programs designed to close skill gaps and address obstacles such as shortages of clinicians qualified to initiate and manage patients on ART. Set to continue long after AIDSRelief's closing, these programs and their impact on health outcomes include the following:

- » A one-year diploma program for nurse practitioners established with the Ministry of Health and General Nursing Council. Twenty of the 60 program graduates are now working with AIDSRelief (as of June 2011). This has expanded the role of nurses in ART care and has been implemented in all provinces
- » An 18-month Masters of Science program in HIV medicine, developed with the University of Zambia, University Teaching Hospital, and the Ministry of Health. Twelve medical officers have completed their coursework, working throughout the country in public- and private-sector capacities, including as the National ART Coordinator, in provincial health offices, and for other implementing partners. These clinicians play a crucial role in managing complex patients, leading national HIV strategies, and collectively training nearly 1,000 health care providers since June of 2010 (an aggregate calculation).



## Wrap-Around Services and Strategic Linkages for Comprehensive Care

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

- » Links to home-based care through projects such as World Vision's RAPIDS grant and to male circumcision services
- » Collaboration with Zambia Serenity House and Chinama Hospital (a national mental health facility) to support patients struggling with alcohol and/or substance abuse
- » Links to HIV testing and treatment for survivors of gender-based violence



- » Close coordination with Integrated Support for ART and PMTCT (ISAP), a sister project implemented by AIDSRelief consortium members to ensure access to maternal-child HIV services
- » Full implementation of post-exposure prophylaxis national guidelines for health workers in all supported sites

## Infrastructure & Equipment

AIDSRelief helped ensure that providers had the tools required for their jobs, ranging from blood chemistry machines used to monitor patients for adverse drug reactions to bicycles for community treatment supporters to visit patients in their homes. Depending on a facility's needs, AIDSRelief funded and managed refittings and equipment purchases at all facilities. Improvements included creating adequate laboratory space, providing benches and tables to make workspaces more functional, installing generators to provide reliable power sources, and providing CD4 machines to monitor patients.

**“We owe it to the millions worldwide on treatment who once had no hope.”**

— Karen Sichinga, CHAZ Executive Director

## Clinical Skills & Knowledge

In the first years of AIDSRelief, technical assistance to supported facilities was intense. Staff worked side-by-side for weeks at a time, and AIDSRelief technical teams were available for consultations around the clock. As facilities reached certain benchmarks, AIDSRelief reduced technical support from quarterly visits, lasting three to four weeks, to less frequent technical assistance focused on specific needs. Overall, the program provided on-site clinical training to more than 200 medical and clinical officers per year.

As the program's focus expanded to emphasize transition, AIDSRelief and CHAZ staff jointly conducted supervision, mentoring, and technical assistance at



facilities. This accompaniment approach concurrently reinforced technical skills among facility staff and training and oversight skills among CHAZ staff. Similarly, as CHAZ teams demonstrated technical and supervisory capacity, they began to lead provision of technical assistance to facilities identified for transition. CHAZ technical teams also continued to provide technical assistance to their Global Fund-supported sites.

The AIDSRelief model of capacity strengthening and technical support is highly effective, but resource intensive. This is a sustainability concern, given that CHAZ and Chreso maintain more sites than AIDSRelief did, with far fewer oversight personnel available. However, staff and facilities that have developed the capacity to provide high-quality care and can maintain this quality with less-intensive, targeted technical assistance.

## Treatment Preparation & Counseling

Prior to initiating treatment, all AIDSRelief clients attended a minimum of three intense, structured counseling sessions to prepare them for the life-long commitment. Treatment preparation helps patients better understand the importance of adherence and the dedication required of and resources available to them as they embark on the therapeutic regimen. Patients were strongly encouraged to have a “treatment buddy”—a friend, family member, or other confidante who may or may not be HIV-positive—attend treatment preparation sessions.



After initiating treatment, patients participated in adherence counseling as a standard part of their monthly visits to refill ART prescriptions. Adherence sessions provided the opportunity for counselors to answer patient questions, identify potential adherence challenges, and reinforce messages about effective treatment. Adherence counselors are often on ART themselves and can provide a unique perspective to other patients. The model was so effective and well-received that the government of Zambia incorporated it into the 2010 national treatment guidelines.



## Paging Dr. Haloka: More HIV Care for Zambians

Dr. John Haloka was among the first students to graduate (in 2009) from Zambia's first medical residency program for advanced HIV care and treatment.

"Our clinic is running far better since Dr. John's return," says Fredrick Chitangala, programs director for Chreso Ministries. "He's able to handle the more complicated cases."

While completing his medical internship in 2003, Dr. Haloka began working at Chreso Ministries because of its affiliation with his local church and his interest in HIV care. At the time, ART was inaccessible to most Zambians and Chreso could only offer basic nutritional advice and emotional support to clients when informing them of their HIV status.

As Chreso entered into partnership with AIDSRelief and its ART program grew over the years, so did Dr. Haloka's expertise. However, he still lacked the advanced knowledge needed to treat complicated cases. When AIDSRelief staff encouraged Dr. Haloka to apply for a space in the HIV residency program, he jumped at the chance.

AIDSRelief collaborated with Zambia's Ministry of Health, the University of Zambia, and the U.S. Centers for Disease Control (CDC) to create the



one-year HIV residency, which has now been certified as a master's degree. The program is now taught mostly by local University of Zambia staff, with University of Maryland staff shifting from serving as the primary instructors to becoming program advisors and guest lecturers.

"The residency program staff really mentored me, particularly stressing the need to document every action taken with patients and the reasoning behind it," Dr. Haloka adds, explaining that this documentation provides clear explanations for subsequent visits. "The training really changed my work. I feel so excited about how I look at my patients now."



Patients receiving any sort of treatment are far from passive recipients of care, and myriad social factors influence their health-related behaviors and decisions. This is certainly true of people living with HIV—a complicated disease that requires life-long care and treatment. Furthermore, many HIV patients face multiple clinical and social challenges, including comorbidity, substance abuse, stigma, and violence. Through AIDSRelief’s unique treatment model, the program prepared and informed patients so that they could make sound decisions for their health, bolstered support for those decisions through care and support at the family and community levels, and helped link patients with complementary services.

### Family-Centered Care & Support

The family is the central unit of an individual’s social support and can dramatically influence HIV-related health decisions ranging from ART adherence to breastfeeding. Additionally, most HIV transmission in Zambia occurs between married or cohabiting partners or from infected mothers to their infants. AIDSRelief-supported counselors brought as many family members as possible into counseling and testing in order to determine their HIV status and to foster a supportive home environment for patients.

The family-centered approach helped increase pediatric ART uptake by promoting counseling and testing throughout each client’s household and by engaging fathers and other family members, such as mothers-in-law, who might influence such decisions.

When multiple family members are found to be infected, facilities strive to provide comprehensive care for affected family members together in order to facilitate participation in care and treatment programs. This has proven particularly important in treating children and caregivers who are both living with HIV.



### Engaged Communities

Community-based treatment support was a cornerstone of AIDSRelief’s highly effective treatment model and an important contributor to the project’s high retention and adherence rates. Interventions included home visits during which trained counselors answered questions from family members and assessed the challenges and opportunities each patient faced at home. For example, a counselor might notice that the family is struggling financially and refer them to supplemental nutrition programs. Counselors also offered HIV testing to all family members.

Outside of patient homes, AIDSRelief community supporters engaged opinion leaders such as chiefs, headmen, and religious leaders to combat stigma and misinformation (such as harmful myths about HIV transmission or treatment risks), raise awareness about HIV and available services, offer mobile counseling and testing services, and help cultivate an environment that is enabling and supportive to HIV-infected community members. AIDSRelief also supported more than 600 community-based support groups (all linked to facilities) that provided services including home care, adherence support, and income generating activities; engaged target populations such as mothers and men; and used drama to disseminate messages and raise awareness.

## STRATEGIC INFORMATION: TRANSFORMING HEALTH SYSTEMS AND PATIENT CARE

To evaluate the successes and struggles of patients, facilities, and programs, comprehensive and timely access to clean, complete, and accurate data is a top priority. This focus on strategic information provides decision makers at the country management and clinic levels with quality data to make informed decisions. In keeping with AIDSRelief's commitment to excellent patient outcomes, informed decisions, and continuous quality improvement, strategic information was a technical pillar from the earliest stages of program design.

### Creating a Culture of Data Use

While data collection and reporting can easily be perceived as an administrative burden, AIDSRelief's approach to strategic information emphasized the application of that data to all facets of patient care and site management. AIDSRelief helped ensure access to good data through training in monitoring and evaluation, data demand and information use, and SmartCare. (AIDSRelief trained 618 people who have physical access to SmartCare, Zambia's national electronic medical records system). In collaboration with Zambian government officials and U.S. donor agencies, the project also provided all 19 sites with computers and strengthened staff capacity to plan, document, and implement problem-solving approaches using data. Through these efforts, AIDSRelief sparked a paradigm shift.



Staff members at CHAZ, Chreso, and the health facilities now understand data as a tool to provide quality patient care and identify gaps in capacity strengthening. For example, a quarterly chart review might reveal a facility-wide gap in cotrimoxazole prophylaxis among pre-ART patients. Further investigation could then determine possible explanations and responses, such as pharmacy stock-out (resolved by supply chain management) or a provider unfamiliar with national guidelines (indicating a need for refresher training or mentoring).

### Evidence-Based Quality Improvement

AIDSRelief worked with facility staff to establish continuous quality assurance and improvement teams at all health facilities, training staff to identify and address quality-related issues. AIDSRelief supported facilities to establish quality improvement committees that meet monthly and discuss challenges in different areas. With electronic and paper tools for data collection and by applying the "small test of change" problem-solving process, facilities maintained and improved service quality and took ownership of the process.

#### A Small Test of Change

After identifying challenges, facility staff discussed possible remedies that could be implemented quickly on a small scale. By making and observing incremental modifications to a process or system—a "small test of change"—teams isolated simple variations to the status quo before implementing more extensive changes. This method has led to significant improvement in patient waiting time, CD4 monitoring and patient flow. For example, in 2010 Circle of Hope Family Care Clinic used this method to reduce patient waiting time from three hours to just one hour.



“[That AIDSRelief was] 100 percent committed to transition was very motivating. We saw in our partner total commitment.”

— Karen Sichinga, CHAZ Executive Director

Each AIDSRelief country program was designed to transition management of the program to a local partner, but the early project years were necessarily focused on initiating patients on treatment. As transition moved to the forefront, the program’s scope of work became clearer: 1) strengthen health facilities for sustainable provision of care and treatment services, and 2) strengthen and reinforce the capacity of CHAZ and Chreso to oversee and maintain the quality of services.

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 CHAZ came together to determine how best to ensure CHAZ’s success in absorbing responsibility for AIDSRelief-supported sites and maintaining quality of care. The resulting transition framework became the basis of the program’s transition plan.

To become a local partner for transition or a direct recipient of PEPFAR funding, CHAZ and Chreso had to come into compliance with stringent regulations and meet criteria set forth by the U.S. government. AIDSRelief provided relevant computer hardware, software, and training (e.g., for central computerized accounting and payroll systems) to site staff and helped them strengthen financial management, compliance, and reporting functions in their facilities. All sites saw a decrease in findings by both internal CRS auditors and external audits. Additionally, by establishing and reinforcing *systems*, improvements were not dependent on individuals who might move on to other opportunities.

This gradual shift from international management to local ownership<sup>5</sup> culminated in 2011, when CHAZ and Chreso 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 PEPFAR grant funds directly and are responsible for managing many aspects of the program. The new grants, known as CHAZ AIDSRelief Transition and Chreso AIDSRelief Transition, continue to work in partnership with former AIDSRelief consortium members to ensure a complete and lasting transition of HIV care and treatment efforts without compromising patient care.



5 For a full examination of transition in Zambia, see The AIDSRelief Zambia Partnership: Transitioning to the Churches Health Association of Zambia.

“[We have] given life where people were supposed to die.... Patients in our community can look after their families, participate in community development.”

—Sister Beatrice Chanshi, St. Theresa Mission Hospital

Working closely under three complementary grants issued by CDC in September 2011, CHAZ, Chreso, CRS, IHV, Futures, and CAF are reinforcing and expanding capacity in grants management, strategic information, and clinical areas. Through the course of the three projects, local partners CHAZ and Chreso will gradually assume the remaining responsibilities for managing the care and treatment program from their international counterparts.

The AIDSRelief experience in Zambia was not uncomplicated; however, the program accomplished what many said could not be done: It partnered with local institutions to provide high-quality care and treatment for HIV-infected men, women, and children in a resource-constrained setting. It leveraged the influence of faith-based organizations and has strengthened the capacity of local partners to continue the program’s life-saving work.

Through dramatic expansion of HIV care, treatment, and support through projects like AIDSRelief, Zambia is approaching its goal of universal access, including to preventive services and counseling and testing. Nevertheless, treatment targets could increase by as much as 40% given the rate of new infections and the country’s revised 2010 National ART Guidelines.<sup>6</sup> Continued and controlled expansion of sustainable and high-quality HIV services is imperative.

AIDSRelief’s commitments to meaningful capacity strengthening, clinical excellence, data-driven quality improvement, and responsive management made an unprecedented expansion of HIV treatment possible. AIDSRelief’s commitment to a truly Zambian-owned response to the disease has helped prepare the nation to deftly manage this virus that once threatened to debilitate a continent.



<sup>6</sup> In accordance with WHO guidelines, Zambia now recommends adult ART initiation to all patients with a CD4 count less than 350 and all discordant couples, as well as pediatric initiation of ART to all HIV-positive children younger than two years old, regardless of clinical or immunologic criteria.

## ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Zambia received from our donor, our local partners, staff and management at health facilities, and the Zambian 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, HRSA, through funding from PEPFAR. We also appreciate the CDC team in Zambia 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 Zambia Ministry of Health and with our local partners CHAZ and Chreso. Each and all were essential to AIDSRelief's success and are helping make sustained country ownership possible in Zambia.

We also want to acknowledge the health workers and managers in treatment sites and communities across Zambia. 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.

Lastly, thank you to the author of this document, Rebecca Bennett, 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%)
<b>Zambia</b>	<b>19</b>	<b>96,247</b>	<b>60,041</b>	<b>42,783</b>	<b>3,197 (7.5%)</b>
<b>Total</b>	<b>276</b>	<b>707,717</b>	<b>396,021</b>	<b>268,530</b>	<b>22,207 (8.3%)</b>

