Providing Treatment,
Restoring Hope

AIDS RELIEF℠

HAITI

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

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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COVER PHOTO: BENJAMIN DEPP FOR CRS; AFRICAN ART ILLUSTRATIONS (THROUGHOUT): STANISLAV/ALL-SILHOUETTES.COM

EXECUTIVE SUMMARY

From 2004 to 2012, AIDSRelief Haiti expanded HIV care and treatment to 14,644 clients, including 6,473 who enrolled on ART. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, Futures Group, and Catholic Medical Mission Board worked hand in hand with local partners to build the skills and systems needed to support high-quality care. Interventions focused on providing technical assistance and capacity building, including clinical mentorship, comprehensive training on HIV care and health systems strengthening.

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

HIGHLIGHTS INCLUDE:

- Community-based treatment support expanded services from clinic to community and contributed to high retention (75.9%) and low mortality (9.2%) and loss to follow-up (18.9%)[1].
- Due to major gaps in service linkages between health facilities and the communities, AIDSRelief introduced community-based interventions including patient preparation, adherence and psychosocial support, and strengthened service linkages.
- AIDSRelief used community members (such as traditional birth attendants) as promoters and case managers. By the end of the program, all pregnant women obtaining services at an AIDSRelief-supported sites were tested for HIV and syphilis, with prophylaxis provided to all exposed infants. Only 10% of exposed infants tested positive for HIV.
- Responding to the critical need to develop human resources, AIDSRelief, in collaboration with the Haitian Ministry of Health, the Université Notre Dame d'Haiti, and St. François de Sales Hospital, established a specialty training program in HIV medicine. The program addresses the sustainability of HIV care and treatment programs and ensures Haitian ownership of the process.
- A focus on strategic information prioritized comprehensive and timely access to clean, complete, and accurate data. Teams used data to make informed decisions to address gaps in program operations and services.

AIDSRelief achieved these results despite political and economic instabilities as well as the 2010 earthquake that overwhelmed the already-weak health system and shifted resources to other lifesaving priorities. Despite these challenges, the program built capacity in HIV care and treatment and established strong foundations to meet human resources needs and ensure a culture of data-driven interventions in HIV care.

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.

PHOTO: RICK D'ELIA FOR CRS

OUR CALL TO ACTION

High population density, severe deforestation, and decaying infrastructure make Haiti, the poorest country in the Western Hemisphere, particularly vulnerable to disease and disaster. Indeed, Haiti was among the first countries in the region to experience AIDS cases, which were first recognized in the country in 1979. HIV infections continued to increase throughout the next two decades, eventually leading to the highest adult prevalence in the Latin America/Caribbean region. When AIDSRelief Haiti began in 2004, estimated adult prevalence was 5.6%[2], and today the country's generalized epidemic continues to be the greatest burden of HIV in the Western Hemisphere.

Initially the weak health system, high HIV-related stigma, widespread poverty, and extremely low availability of essential medications meant that Haitian communities were ill-equipped to cope with the spread of the disease. Subsequently, an aggressive international response targeted behavior change, contributing to a gradual reduction in prevalence, particularly in urban areas. Even with this progress, treatment remained a privilege of the wealthy, and for much of the affected population a diagnosis of HIV infection was tantamount to a death sentence.

Over eight years, AIDSRelief Haiti provided durable, comprehensive quality care and treatment using a comprehensive, family-centered approach that included prevention, treatment and community support. Target populations included HIV-exposed and infected >>

2 UNAIDS Epidemiological Fact Sheet. Retrieved from http://data.unaids.org/Publications/Fact-Sheets01/haiti_en.pdf

PHOTO: BENJAMIN DEPP FOR CRS

children, HIV infected adults, pregnant women, and victims of sexual violence.

AIDSRelief in Haiti

AIDSRelief Haiti comprised four of the five global consortium members: Catholic Relief Services (CRS), Futures Group, the University of Maryland School of Medicine Institute of Human Virology (IHV), and Catholic Medical Mission Board (CMMB). The consortium partners worked together to implement a care and treatment model 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, 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

AIDSRelief Supported Health Facilities 2004-2012

- Armee du Salut Béthel
- Hôpital Albert Schweitzer
- Hôpital Alma Mater
- Hôpital Espérance Pilate
- Hôpital Foyer Saint Camille
- Hôpital La Providence, Gonaïves
- Hôpital Sacré Coeur Milot
- Hôpital Saint Boniface
- Hôpital Saint Jean de Limbé
- Hôpital Saint François de Sales
- Hôpital Sainte Croix Léogâne

Over eight years, AIDSRelief Haiti provided durable, comprehensive quality care and treatment using a comprehensive, family-centered approach that included prevention, treatment and community support.

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. CMMB provided site management and intensive capacity strengthening assistance for 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 program's initial scale-up phase included two interrelated processes: selecting individual treatment sites and strengthening care delivery to ensure sustainability of the treatment programs.

In most cases, AIDSRelief teams discovered that Haitian providers had limited experience with HIV care. Therefore, 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. Next, treatment facilities were expanded and equipped. Financial and patient management systems 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 agencies were strengthened. The ultimate goal at each site was to maintain good patient flow while providing quality services.

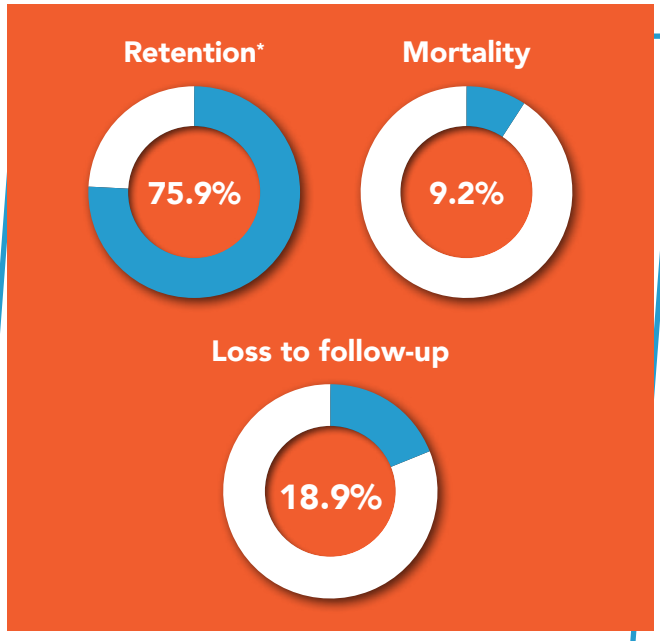
Through these facilities, the program provided HIV care to 14,644 patients, including 6,473 who enrolled on ART.

EXCEPTIONAL TREATMENT

In 2004, antiretroviral medications were a rare commodity in Haiti and few health facilities offered treatment. HIV-related services were predominantly limited to prevention programs or end-of-life care. Therefore, the prognosis for people living with HIV was poor and many were bedridden, unable to work and support their families, with little hope for the future. The advent of AIDSRelief brought new opportunities and hope to Haitians living with HIV.

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.

AIDSRelief by the Numbers



* 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.

In addition, the AIDSRelief model treated adherence as a therapeutic intervention. A patient's treatment experience included structured treatment preparation, adherence counseling, highly supported treatment initiation with 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.

AIDSRelief 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 necessary equipment required for high-quality ART management. AIDSRelief also ensured availability of medications and other supplies through a well-coordinated supply chain system and worked to meet the unique needs of pregnant women, new mothers, infants, and children.

A Complete Package

AIDSRelief staff worked with the Ministry of Health and with clinic staff to implement a family-centered approach that included prevention, treatment and community support. Efforts to provide quality care and treatment began by routinely targeting patients at highest risk for HIV infection through expanded voluntary counseling and testing services along with provider-initiated testing and counseling. Throughout the eight-year program, more than 212,000 people underwent HIV testing and received their results. AIDSRelief worked to reinforce the internal referral system between testing points and ART clinics, as well as external links with neighboring institutions. When clients tested positive, clinical teams prepared patients for treatment, including referring to support groups and underlining the importance of the caregiver.

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All patients enrolled in AIDSRelief's program were entitled to psychosocial support, laboratory exams, and medical treatment for opportunistic infections. To improve physical and mental health outcomes, AIDSRelief worked to expand support groups to create a supportive environment for treatment adherence, disclosure counseling, and stigma reduction. Beneficiaries also often received services from mobile clinics or in their communities through community health workers.

AIDSRelief reinforced health facilities' ability to adequately manage common infections among people living with HIV, particularly tuberculosis (TB). Low penetration of TB screening and poor diagnostic capacity drove under-detection of TB in Haiti. At health facilities, AIDSRelief achieved almost universal coverage of testing and counseling for TB patients, who were assured a referral to HIV care and treatment if they tested positive for the virus. Conversely, AIDSRelief highlighted increased TB case finding in ART and HIV care settings through referrals for TB diagnosis and treatment. Fluorescent microscopes and other specialized equipment were installed at each health facility to improve diagnosis of TB.

Maternal-Child HIV Care

AIDSRelief approached vertical transmission within the broader context of maternal-child HIV care, working to identify HIV-positive mothers and provide them and their infants with prophylactic ARVs. This approach involved not only ART for the mother during pregnancy and delivery, but a continuum of care that included community-based efforts to increase access to services for all pregnant women and their families.

AIDSRelief worked to implement strategies for increasing the uptake of counseling and testing among pregnant women, male partners, and exposed infants. To accomplish this, district mentor teams were formed, trained, and supported. AIDSRelief also disseminated World Health Organization (WHO) guidelines for pediatric ART to all partners. A tracking protocol was created for follow up of mothers and exposed infants.

Encouraging HIV-positive mothers to give birth in a health facility posed a significant challenge; due to the high cost of transportation and hospitalization fees, many women rely instead on a traditional birth attendant. Therefore, all treatment facilities worked with and supported the use of the traditional birth attendants.

In addition, AIDSRelief expanded testing among pregnant women obtaining antenatal care services, while simultaneously providing community-based testing among pregnant women who were not seeking antenatal care. AIDSRelief's community-based treatment support efforts allowed staff to link women to HIV care and community follow-up.

Because of this focus on mothers and children, more than 57,000 pregnant women who presented at AIDSRelief-supported sites were tested for HIV and syphilis. In addition, 100% of AIDSRelief sites employed case managers trained in prevention of mother-to-child transmission, who played a crucial role in improving the tracking and follow-up of HIV-infected pregnant women.

AIDSRelief Haiti also provided a comprehensive care approach to children exposed to and living with HIV. All facilities now have the capacity to carry out early infant diagnosis through blood spot polymerase chain reaction (PCR) testing; cotrimoxazole and ART prophylaxis also became routine treatment for all exposed infants. AIDSRelief worked with the Ministry of Health to improve guidelines and sample transport networks. By the end of the program, 80% of HIV-exposed infants received PCR testing and only around 10% of exposed infants tested positive for HIV. The program also provided immunization for HIV-positive and exposed children according to WHO guidelines for integrated management of childhood illness[3].

Orphans and Vulnerable Children

The hundreds of thousands of orphans and vulnerable children (OVC) in Haiti face a number of challenges, including socioeconomic difficulty, poor sanitation, limited >>

3 Manuel sur la PCIME : La prise en charge intégrée des maladies de l'enfant. World Health Organization, 2005.

Rising to the Challenge: How CRS protected ART patients

The greatest challenge of all arose on January 12, 2010, when a magnitude 7.0 earthquake devastated Haiti's capital city, Port-au-Prince, along with much of the surrounding area. An estimated 230,000 people died and more than 2 million people were displaced; health and political systems that were already weak prior to the earthquake were both literally and figuratively reduced to rubble overnight. At the time, AIDSRelief was providing ART to 2,985 people—12% of the national total.

An estimated 50 health facilities were completely destroyed, including St. François de Sales, an AIDSRelief partner hospital. While the other AIDSRelief facilities sustained limited damage, most saw increases in patients as displaced people moved from Port-au-Prince to the surrounding areas. The emergency care demands of more than 300,000 injured people stretched the limits of the health system, while routine needs, such as prescription refills or access to labor and delivery services, continued unabated.

AIDSRelief's robust community patient follow-up system helped staff to locate all ART patients within days of the quake and prevent a disruption of services. AIDSRelief staff worked with the hospitals to review their care and treatment plans and make adjustments to maintain treatment goals. That AIDSRelief was able to retain all its ART patients in such a demanding environment is a testament to the strength of the model and the dedication of staff and partners.

A new state-of-art facility

Thanks to its presence at St François de Sales, one of the country's oldest and most respected hospitals, CRS was able to mobilize trauma teams immediately after the disaster, in collaboration with the University of Maryland School of Medicine. The teams consulted 71,000 patients at hospitals and camps and performed more than 1,000 emergency surgeries. CRS then rebuilt the St. François de Sales facility into a state-of-the-art university teaching hospital with 120 beds. The new hospital—a joint project between the Catholic Health Association, the Archdiocese of Port-au-Prince, Sur Futuro foundation, the University of Notre Dame Haiti and CRS—is training the doctors and nurses of Haiti's future as well as serving the poorest citizens of Port-au-Prince and beyond.

"This project at St. François de Sales is not only about what we're doing today," said AIDSRelief physician Herby Derenoncourt. "It's also about creating a model for providing quality care to the poor that we can use around the country, in the north and south. If this works in a country where the health care system is failing, it will become a model."

An architect's rendering of St. François de Sales hospital. Illustration courtesy of CRS Haiti

Rebuilding St. François de Sales hospital was a central element in the efforts by CRS and its partners to create an integrated system of care among the seven Catholic health care facilities in Haiti. By supporting the establishment of a faith-based health care network in Haiti, with centralized supply chain management, a solid foundation is being laid for a better coordinated and more sustainable system nationwide.

PHOTO: LANE HARTILL FOR CRS

access to health care, poor adherence to treatment regimens, and the risk of sexual and economic exploitation. In response to these challenges, AIDSRelief provided a comprehensive care approach by better identifying orphans and vulnerable children, reducing stigma, and providing them with economic and physical relief.

To better identify vulnerable children, AIDSRelief supported prenatal clinics, community field workers, and pediatric clinics to follow up with pregnant women or mothers who tested positive for HIV. Education sessions were organized to raise awareness, reduce stigma, promote testing and counseling, and encourage psychosocial support for OVC in schools, churches, and community groups. For caregivers, training emphasized the importance of good adherence, a healthy environment, and referrals for management of psychosocial disorders. AIDSRelief provided life skills training and formed a monthly club for infected adolescents aged 15 to 17. AIDSRelief also provided economic and material support through a partnership with Catholic Relief Services' Community Health and AIDS Mitigation Project (CHAMP), which provided assistance to meet >>

Matrones Expand Coverage

Alma Mater Hospital is a difficult-to-reach site in the rural Artibonite region. Many pregnant women in the hospital's catchment area tended to opt for home delivery for financial and logistical reasons. With AIDSRelief support, Alma Mater trained and deployed traditional birth attendants called *matrones* to administer life-saving HIV prophylaxis to babies whose mothers declined hospital delivery. Alma Mater's efforts to provide all pregnant women with services, including those who were not easily reached, had a positive impact on their children. In a survey conducted between December 2009 and June 2010, 100% of newborns supported through the project had negative HIV tests.

PHOTO: BENJAMIN DEPP FOR CRS

school and other household expenses, in addition to legal advice, food aid, and psychosocial support to more than 20,000 OVC through a network of local partners.

A key success was the integration of community-based OVC services with clinic-based ART services. This approach required a strong referral and monitoring system, beginning when a person presented at the clinic for testing. After sharing test results, counselors would record the names and ages of all family members and encourage them to also be tested. Children who tested positive were enrolled in the ART program. Each family was assigned a community nurse to coordinate and follow up with clinic care. For children testing positive, a field animator was assigned to conduct regular home visits, assess needs and prioritize essential services.

From Clinic to Community

In most countries, AIDSRelief worked through strong, local faith-based organizations and health facilities. However, because Haiti's health system is highly centralized—administered at the highest levels of the Ministry of Health—the experience in Haiti was in many ways distinct from that in other countries. Haiti's regional health departments oversee specific geographic areas, and AIDSRelief sought to work within this system to reinforce and strengthen linkages between facilities. Haiti had seen successful

community outreach programs for malaria, TB control and childhood vaccination campaigns and AIDSRelief worked to integrate a similar approach into all HIV care and treatment programs.

Community-based treatment support (CBTS) was a cornerstone of AIDSRelief's highly effective treatment model, contributing to patient retention and adherence by fostering formal links between hospitals, health centers, and their respective communities. Healthcare providers at all sites routinely discussed adherence and conducted continuous health education throughout the treatment process. All sites also carried out robust patient treatment preparation counseling and have received support in community mapping and identifying their catchment areas.

Health facilities linked with community outreach organizations conducting voluntary counseling and testing events to ensure prompt linkages to care. AIDSRelief supported the training and networking off community health workers, who worked together to bridge the service gaps between clinic and community. CBTS teams and community health workers were provided with tools to better ensure patient progress, including a patient priority list to track patients who missed their appointments; a list of red-flag indicators to determine the risk of poor adherence and treatment failure; and treatment preparation plans. Teams also emphasized community outreach activities in schools, at youth associations, and during home visits.

LEFT PHOTO: BENJAMIN DEPP FOR CRS / RIGHT PHOTO: BENJAMIN DEPP FOR CRS

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 program in all countries. 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.

In Haiti, the primary focus of strengthening activities was capacity building and institutional strengthening of health facilities, improving laboratory services, supporting pharmacy and supply chain management efforts, and fostering a culture of data use. AIDSRelief's activities were a collective effort of each of the consortium members and local Haitian partners. Working together, the program endowed local partners with the knowledge, competencies, tools, and systems necessary to successfully implement the AIDSRelief model for uninterrupted, high-quality HIV care and treatment.

Pharmacy and Supply Chain

Access to medicines and commodities such as lab reagents or clean needles for drawing blood is critical to successful HIV care and requires a dependable supply chain and competent, trained pharmacy staff. All of AIDSRelief's efforts to build a sustainable treatment program would be rendered moot if medications were not available, yet stock-outs of ARVs and other essential commodities were frequent in Haiti when AIDSRelief first entered the scene. Assessments revealed critical deficiencies in pharmaceutical and supply chain management that often resulted in stock-outs of necessary drugs and supplies, hampering the continuity of care.

One of the most significant contributors to stock-outs in Haiti was poor forecasting and quantification of commodities at the site level. Pharmacy staff, though trained in providing and prescribing medication, did not generally have the skills or tools to ensure an uninterrupted supply of drugs. In collaboration with the Supply Chain Management System (SCMS)[4] Haiti office, the AIDSRelief supply chain team ensured that the necessary infrastructure, systems, and skills were >>

4 Pooled procurement streamlines the purchase and distribution of bulk commodities such as ARVs by bundling orders from multiple pharmacies, projects, and even countries. SCMS coordinates pooled procurement across 19 PEPFAR-supported countries. It was established under PEPFAR in 2005 to ensure the availability of essential products (notably, HIV-related medicines) for programs in developing countries, and to strengthen national supply chain management systems.

PHOTO: RICK D'ELIA FOR CRS

AIDSRelief strengthened laboratory diagnostics by installing and providing onsite training for both manual and automated chemistry equipment. All sites now have state-of-the art equipment that supports basic laboratory services for HIV care.

in place for efficient forecasting, storage, distribution and dispensing of ARVs. AIDSRelief and SCMS also collaborated on providing health facilities with training and technical assistance in stock management, data management tools and reporting.

To complement the human resource capacity building efforts, AIDSRelief also strengthened the physical capacity of partner sites: seven supply depots were renovated, all of which now meet international standards and are air-conditioned to mitigate spoilage. In addition, AIDSRelief established computer-based systems and mechanisms for the acquisition and delivery of drugs for opportunistic infections.

Laboratory

Optimal patient outcomes rely on accurate testing and diagnoses, which in turn depend on the capacity of laboratory services.

However, in 2004 most of the laboratory sites in Haiti did not have the capacity to support high-level management of ART, including CD4 counts, viral load, and genotypic resistance tracking. This led to missed opportunities to provide care and treatment to Haitians living with HIV.

Eight years later, facilities had improvements such as infection control measures in laboratories and clinics, >>

PHOTO: BENJAMIN DEPP FOR CRS

Institutional Strengthening for Sustainability

One of the notable gaps at AIDSRelief-supported sites was a lack of specialized training in HIV care that could ultimately hamper the sustainability of the program in Haiti. Therefore, the AIDSRelief consortium developed an institutional strengthening program in coordination with the Ministry of Health, the Université Notre Dame d'Haiti, and St. François de Sales Hospital to establish specialty training programs in HIV medicine.

To facilitate the transfer of clinical and technical skills to local institutions, physicians and nurses were trained in infectious diseases through a "training of trainers" concept. These trainers would provide post-graduate medical and nursing education in select specialties, while also building capacity of training sites to provide quality specialty care in infectious diseases. Originally conceived for strengthening Haitian providers' skills in treating infectious disease, the program expanded after the 2010 earthquake and now includes two components: a one-year post-graduate diploma in HIV medicine and infectious disease nursing; and Centers of Excellence in HIV medicine. By fostering the current and future capacity of Haiti's practitioners to understand and cope with the needs of patients living with HIV, AIDSRelief and its partners are helping to lay the groundwork for continued progress against the disease.

private areas for patients receiving HIV test results or adherence counseling, and adequate space for co-located HIV and TB services. AIDSRelief funded and managed refitting of the laboratory at each health facility, purchased essential equipment, and encouraged integration of HIV and non-HIV services when appropriate so that facilities could leverage the improvements for all patients. All treatment sites were equipped to carry out HIV testing, chemistry and hematology analysis, and automated and manual CD4 tests.

Technical assistance focused on practical training for new technology and improved diagnostic techniques including HIV testing, CD4 counts, and CrAG tests for Cryptococcal disease. AIDSRelief strengthened laboratory diagnostics by installing and providing onsite training for both manual and automated chemistry equipment. All sites now have state-of-the art equipment that supports basic laboratory services for HIV care. In recognition of its high achievement, the laboratory at Hôpital Sacré Coeur (in Milot) has been designated as laboratory center of excellence and is involved in training laboratory staff at other facilities.

PHOTO: RICK D'ELIA FOR CRS

STRATEGIC INFORMATION: TRANSFORMING 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. 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.

Prior to AIDSRelief, Haiti's health facilities kept medical records in paper form, making it difficult for staff to locate records and properly follow each patient. This practice also made it difficult to generate useful statistical information that could drive decision-making based on evidence derived from patient experiences. The impact of this reality went beyond the patient level, also affecting the health supply chains, as the lack of data on consumption and forecasting contributed to frequent stock-outs. A lack of standardized monitoring tools also meant that data was not always comparable across sites.

One of the most significant undertakings involved readying sites for point-of-care data entry and paperless records. Many hospitals did not have the equipment necessary for direct data entry into Haiti's national electronic medical records system, but digitizing existing paper records wasn't simply an exercise in introducing new technology. To help mitigate the serious backlog of paper forms, AIDSRelief—in close collaboration with the International Training & Education Center for Health (I-TECH) and the CDC's Haiti office—organized a number of data entry task forces. By 2012, most of the AIDSRelief facilities were operating backlog-free and adept at using patient monitoring and management systems. This has created a tremendous opportunities for sites to access, analyze, and use the information linked to the program.

In addition to the transition to electronic systems, AIDSRelief has also enhanced its commitment to creating a culture of data use.

In addition to the transition to electronic systems, AIDSRelief has also enhanced its commitment to creating a culture of data use. While data collection and reporting can easily be perceived as an administrative burden, AIDSRelief's approach emphasized the application of that data to all facets of patient care and site management. For example, AIDSRelief supported a chart study to identify patterns of mortality and opportunistic infections that could be addressed through targeted interventions. Continuous quality improvement efforts focused on improving quality and integration of prevention, maternal health and pediatric services, as well as reducing mortality and loss to follow-up, both of which represented significant challenges to the Haiti program.

PHOTO: RICK D'ELIA FOR CRS

LOOKING AHEAD

From the earliest stages of program planning, long-term sustainability and transition to local ownership have been central to AIDSRelief. In Haiti there was no national health association that could provide the faith-based facilities with support for long term sustainability. Therefore, in 2009, CRS assisted AIDS-Relief-supported facilities to organize as a local faith-based health network. As AIDSRelief began to plan for an incremental transition of responsibility to the network, a key activity was creation of an institutional strengthening program that would enable sustainable training of health professionals.

Most AIDSRelief country programs transitioned management responsibility to local partners in 2011. At the time, the local faith-based health network was still in its early stages and in need of continued capacity strengthening. Therefore, the health facilities continue to work with AIDSRelief consortium members under a number of new grants, with an eye towards long-term sustainability of the care and treatment program.

One example is an institutional strengthening program designed as a partnership between the Université Notre-Dame d'Haiti Schools of Medicine and Nursing, Hopital St. François de Sales, the Institute of Human Virology, the University of Maryland School of Nursing, and CRS. The project was originally conceived for strengthening St. François as a center of excellence in infectious disease and offers a post-graduate diploma in HIV medicine. Additional activities will be implemented across the local health network, to strengthen the entire health system and create an environment in which all patients can receive high quality medical care.

PHOTO: BENJAMIN DEPP FOR CRS

ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Haiti received from our donor, our local partners, staff and management at health facilities, and the Haitian 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 Haiti 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 Haiti Ministry of Health.

We also want to acknowledge the health workers and managers in treatment sites and communities across Haiti. 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, Paul Perrin, 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%)**

CRS CATHOLIC RELIEF SERVICES

AIDSRELIEF

For more information, contact aidsrelief@crs.org