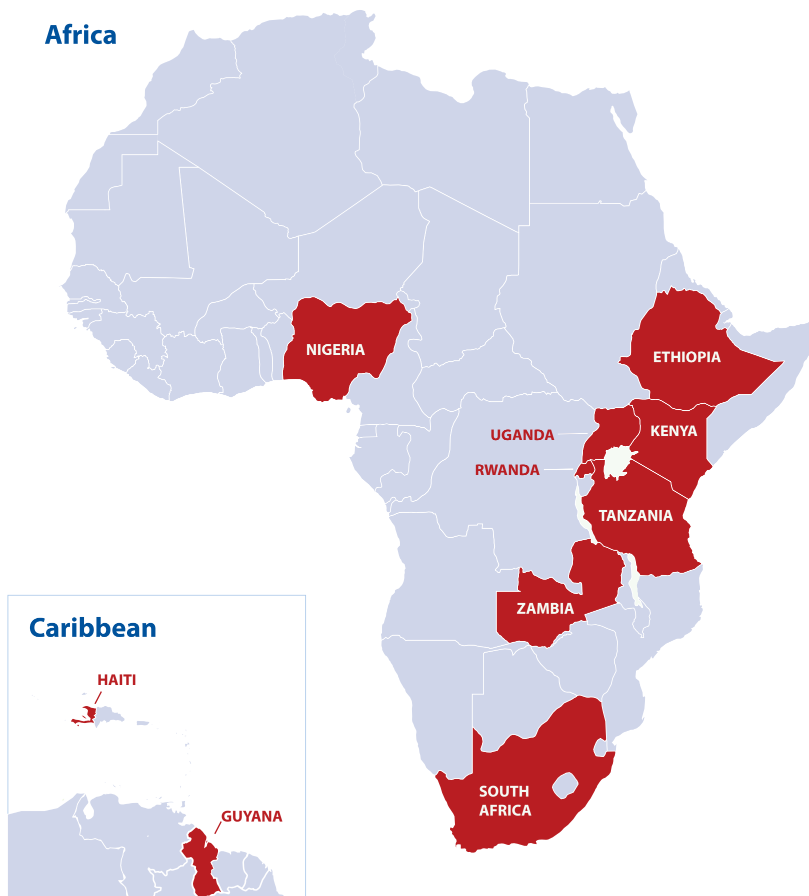
ETHIOPIA

FINAL REPORT 2009-2012

AIDSRelief

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.

© 2013 Catholic Relief Services—United States Conference of Catholic Bishops

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

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

The photographs in this publication are used for illustrative purposes only; they do not imply any particular health status (such as HIV or AIDS) on the part of the people who appear in them.

EXECUTIVE SUMMARY

From 2009 to 2012, AIDSRelief Ethiopia provided HIV care and treatment to more than 4,000 patients, including 2,179 who enrolled on lifesaving antiretroviral therapy (ART) at five treatment sites. Three members of the global AIDSRelief consortium—Catholic Relief Services, the University of Maryland School of Medicine Institute of Human Virology, and Futures Group—provided technical and program support based on their core capacities. The care and treatment program was implemented through a local partner, the Ethiopian Catholic Secretariat.

Although the program commenced much later than the nine other AIDSRelief programs (all of which began by 2004), it was able to demonstrate essential service delivery approaches and key accomplishments in a very short period of time. This report outlines key outcomes and lessons learned during the four-year program. It also describes approaches and methods that contributed to the program's success.

HIGHLIGHTS INCLUDE:

- More than 88,000 people underwent testing and received their results. Of these, 12,600 were pregnant women.
- Remarkably, 13.6% of patients receiving treatment at AIDSRelief-supported facilities were pediatric patients, compared to the national figure of 6%. Across the ten AIDSRelief country programs, only Rwanda enrolled a comparable percentage of pediatric patients.
- Through AIDSRelief's continuous quality improvement approach, malaria and tuberculosis diagnostic scores at supported laboratories improved from "unsatisfactory" (below 65%) to "excellent" (above 85%) by the sixth quarter of the project. Each laboratory maintained that score through the end of the program, indicating sustainability.
- AIDSRelief's community-based treatment support program addressed the national challenge of limited facility-based service delivery and expanded services from clinic to community by reorganizing existing healthcare staff to extend HIV services to the community. These activities contributed to a reduction in loss to follow up, which declined rapidly from 2010 to 2011.
- Moving beyond a basic approach to monitoring and evaluation, AIDSRelief enabled health facilities to analyze, share, and use data to drive decisions and quality improvement initiatives. This strengthened the capacity of health facilities to improve operations and guide continuous quality improvement initiatives.

OUR CALL TO ACTION

Although Ethiopia's national adult HIV prevalence is lower than in many of the hardest-hit African countries and its epidemic has shown evidence of stabilization over the past decade, the country has a significant population of HIV-infected people. In 2009, the year AIDSRelief launched its Ethiopia program, approximately 1.1 million people were living with the virus, representing an adult prevalence of 2.3%. Ethiopia's epidemic is considered generalized and heterogeneous, although there are notable variations in prevalence: as in many countries, urban areas are more prone to the epidemic than rural areas and women are disproportionately affected.

By 2009, antiretroviral therapy coverage increased to 53% of people in need of treatment. However, interventions largely focused at the facility level, leading to fragmentation of services and access difficulties at the community level, compounded by a lack of community-based support systems for patients on treatment. As a result, the national program experienced high loss to follow-up, with rates as high as 28% in 2009[1], as along with high mortality.

The overarching goal of AIDSRelief's Ethiopia program was to create a comprehensive HIV care model that provided quality services extending from the hospital into the community. The hospital-health center-community linkages have not only contributed to the success of the project, but have made AIDSRelief's approach exceptional in Ethiopia. The formal link between health facilities and the community through mentorship and community outreach interventions resulted in increased retention, decreased loss to follow up, and strengthened service linkages. AIDSRelief also demonstrated effective program implementation through functional infrastructure, proactive leadership, skilled human resources, and effective use of data.

1 Federal HAPCO Report on Progress Towards Implementation of the UN Declaration of Commitment on HIV/AIDS, 2010

PHOTO: DAVID SNYDER FOR CRS

The AIDSRelief Consortium

AIDSRelief Ethiopia 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). 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.

As the prime grantee, CRS managed project implementation, provided oversight for grant administration and compliance, and coordinated overall representation of the program to the United States government, local government and other stakeholders. CRS also supported health systems strengthening and pharmaceutical management activities. IHV served as the technical lead for clinical activities and provided technical support in HIV testing and counseling, adult and pediatric HIV care and treatment, prevention of mother-to-child transmission, tuberculosis (TB) and HIV services, adherence and community-based services, and other clinical areas. Futures built and strengthened local capacity in capturing, managing, and using strategic information. Using training modules, technical assistance, and a continuous quality improvement model, Futures worked to strengthen data use at the sites and to support the government rollout of the national health management information system.

AIDSRelief Supported Health Facilities 2009-2012

- Chitu Health Center
- Dilela Health Center
- Gurura Health Center
- St. Luke Hospital
- Tole Health Center

Local Partner: The Ethiopian Catholic Secretariat

CRS identified the Ethiopian Catholic Secretariat (ECS)—which has maintained a partnership with CRS Ethiopia for fifty-plus years—as the local partner for transition. ECS is a nonprofit organization that acts as a national coordination, facilitation, and representation office for the pastoral, social and development activities of the country's eleven Catholic dioceses. ECS' Health and HIV/AIDS Unit coordinates all health services provided by the Catholic Church in Ethiopia through its national network of 78 health facilities. In order to meet program goals, AIDSRelief established within ECS an ART unit of 10 staff members comprising a program manager, clinical specialists, a supply chain specialist, a strategic information advisor, and finance officers.

A NETWORK OF TREATMENT SITES

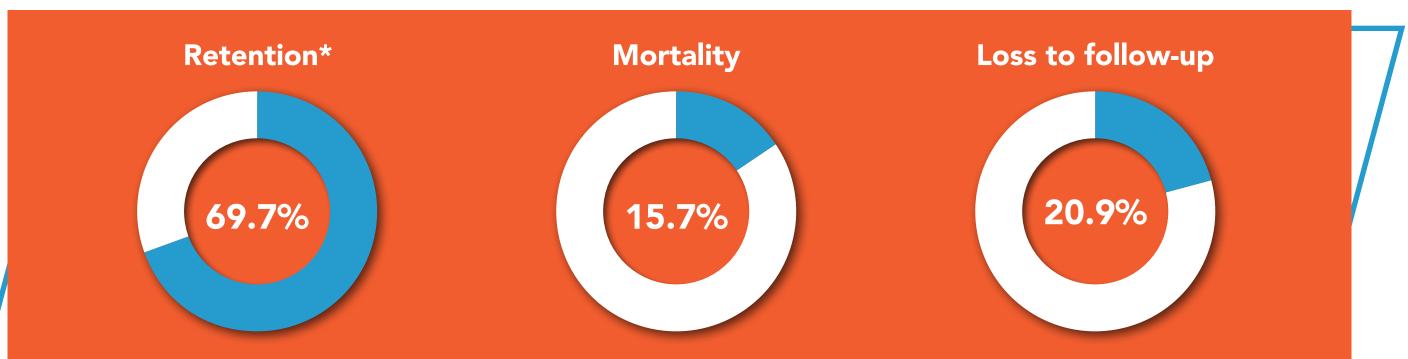
The AIDSRelief approach in Ethiopia was designed to establish a formal link between hospitals, health centers, and the community through mentorship and community outreach interventions. Following a number of visits to potential treatment sites and in consultation with ECS, AIDSRelief selected St. Luke Catholic Hospital and College of Nursing and Midwifery in South West Shoa Zone, Oromia region, to implement the program. AIDSRelief chose the facility, which serves a rural population, due to the need for scale-up at the facility and the excellent existing working relationships it maintained with both ECS and the South West Shoa zonal health department.

In addition, five government health centers in the same area were selected to begin providing ART services. In Ethiopia, health centers are generally a patient's first point of contact with the health system. Therefore, strong community and hospital linkages cannot be achieved without addressing health center capacity gaps, which AIDSRelief made a priority. Initial site capacity assessment at all six selected sites were conducted by AIDSRelief, and HIV care and treatment interventions were based on the findings.

"Now that we have all the services available here in Dilela, it is much better for the patients. They can come here now and receive the care that they couldn't get before since Dilela did not offer HIV care and treatment services before."

—Adherence Manager, Dilela Health Center

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.

PHOTO: LAURA ELIZABETH POHL FOR CRS

EXCEPTIONAL CARE AND TREATMENT

When AIDSRelief began, only St. Luke Hospital was providing HIV care and treatment services. AIDSRelief supported St. Luke and the five other health facilities with training, materials, development of a care and treatment plan including standard operating procedures for linkages and referrals, expanding testing units both at the facility and community level, and laboratory and supply chain systems. As a result, all health facilities now provide comprehensive care and treatment services.

One area of focus was setting up optimal patient flow at the St. Luke Hospital. To this end, the ART clinic was renovated, patient flow was mapped and additional staff hired and trained to ensure effective patient flow and facilitate communication among the clinical team. After the renovation, patient records were moved to a designated room with locked cabinets, ensuring confidentiality.

By the end of the program in December 2011, 4,125 patients had enrolled in care. Of these, 2,179 began treatment, 1,062 of whom were on ART at program close. The survival rate of patients after six months of ART improved from 68% in 2009 to 82% by the end of 2010; additionally, 90% of patients received a baseline CD4 count.

PHOTO: DAVID SNYDER FOR CRS

A COMPLETE PACKAGE

High-quality HIV care and treatment services cannot function independently and must be strongly integrated with other services. Therefore, AIDSRelief's package of medical services was designed to foster treatment uptake and disclosure through HIV counseling and testing and prevention of mother-to-child transmission services. TB/HIV services and community-based treatment support were also provided to patients both in care and on treatment.

HIV Counseling and Testing (HCT)

Counseling and testing was a key point of intervention due in part to weak links with ART clinics and a shortage of trained staff.In addition, AIDSRelief experience showed that inviting patients to a health facility for a non-HIV related appointment could be a point of entry for pre-ART services. As a result of AIDSRelief's support, point-of-service HIV testing is now routinely practiced and health facilities are including HCT in continuous quality improvement activities. To improve inter-facility linkages, AIDSRelief designed a mechanism by which all clients testing positive for HIV saw a case manager for registration and counseling to ensure follow-up.

Throughout the program, 88,148 people underwent HIV testing and received their results.

Maternal-Child HIV Care

AIDSRelief approached prevention of mother-to-child transmission (PMTCT) from a perspective of maternal-child HIV care. AIDSRelief's technical team worked closely with St. Luke's PMTCT coordinator to oversee the provision of comprehensive services at all five health facilities. Technical assistance focused mainly on building staff knowledge and confidence in the provision of comprehensive, high quality services using the WHO four-pronged approach[2] and in line with national guidelines. Due emphasis was given to increasing uptake and coverage during visits to antenatal care clinics and labor and delivery units.

Increasing Partner Testing Rates

In September 2010, partner testing was low: just 26% at antenatal clinics and zero at labor and delivery units in AIDSRelief-supported health facilities. Focus group discussions revealed that the main causes of low partner testing were the fact that women came to seek antenatal care services alone, without their partners, and moreover providers thought of male partners testing as an added burden. Based on these findings, strategies implemented included the following:

- Educating providers on the importance of male partner involvement and its impact on a mother's wellbeing and a baby's outcomes
- Using partners "invitation cards"
- Suggesting male partner testing at each health providers' encounter with the mother
- To complement these interventions, a community sensitization workshop was conducted to encourage women to bring their partners to the health facilities for testing.

As a result of these steps, male partner notification and couple counseling and testing has increased to 57% in labor and delivery and 46% at antenatal clinics.

2 The UN four-pronged strategy addresses a broad range of HIV-related prevention, care, and treatment and support needs of pregnant women, mothers, their children and families. See World Health Organization PMTCT Briefing Note, October 2007, p. 5

One of the key components of AIDSRelief's maternal-child HIV care program was fostering partner involvement in an effort to increase disclosure, facilitate support for women receiving test results, and encourage adherence to healthcare providers' recommendations. This approach also provided an opportunity for male partners to learn their HIV status and access treatment and for health providers to identify and manage discordant couples. AIDSRelief emphasized couple HIV counseling and testing, which is now routinely practiced at all six facilities. Intensive community-based campaigns promoting uptake of PMTCT services were crucial in increased service utilization.

Overall, 12,611 pregnant women were tested for HIV and 198 received prophylaxis to protect their babies.

Pediatric Treatment

Remarkably, 13.6% of patients receiving treatment at AIDSRelief-supported facilities were pediatric patients, compared to the national figure of 6%[3]. Across the ten AIDSRelief country programs, only Rwanda enrolled a comparable percentage of pediatric patients.

To support continuity of services, AIDSRelief introduced innovative approaches such as implementing a disclosure program designed for children. Initial assessment showed a small number of HIV-infected children knew their status and that providers and caregivers had misconceptions about disclosure. Ongoing disclosure sensitization was provided to health care workers and caregivers and pediatric psychosocial care training was organized for staff from all health facilities.

About 50% of HIV-infected infants will die before their second birthday[4] without access to effective treatment, a fact that could be mitigated with timely diagnosis and early initiation of pediatric patients. Therefore, emphasis was given to detection and follow up of pediatric clients and addressing treatment failure. Through training and monitoring it was possible to improve the capacity and confidence of pediatric care providers.

TB/HIV services

Tuberculosis is one of the leading causes of death among people living with HIV and was a new area of focus for the health facilities, particularly St. Luke hospital. AIDSRelief supported screening, diagnosis and treatment of TB among HIV patients and provision of isoniazid preventive therapy through training for HIV staff, mentoring and development of TB management protocols. The program ensured universal provision of HIV testing to TB clients in all sites and provision of cotrimoxazole preventive therapy for all co-infected clients. Moreover, AIDSRelief >>

3 Ethiopia's 2012 Country Progress Report on HIV/AIDS Response states that there were 249,174 adults (86% of eligible) and 16,000 children (20% of eligible) currently on treatment by the end of 2011.

4 *Antiretroviral therapy for HIV infection in infants and children: Towards universal access.* World Health Organization, 2010.

PHOTO: DEBBIE DEVOE/CRS

"Before the AIDSRelief treatment preparation began, I was enrolled in the treatment program at the hospital, but I did not believe in taking the drugs. I would carry the drugs home, but I wouldn't take them. The people in the clinic were very surprised to see that I was not getting any better. Then after talking with the Adherence Manager, I was convinced about the need for the drugs. I have now joined a mothers' support group to support other women to take their medicines, because it helps us to remain strong for ourselves and our families. It worked for me and I want it to work for them too."

—AIDSRelief Beneficiary

initiated contact screening at the TB clinic, preventive therapy for children with contact history, and TB infection control with encouraging results. In total, 1,239 HIV patients were screened for TB and 175 received treatment.

Community-Based Treatment Support

In each country program, AIDSRelief emphasized strong links among people living with HIV and their families, their communities, support groups, and health institutions. Community-based treatment supporters worked closely with providers to assist patients to achieve optimal adherence and adequate viral suppression, and to maintain low loss to follow up by tracking patients who missed appointments or were at risk for dropping out of treatment.

Community-based support was embedded in the AIDSRelief program from the beginning, with some later modifications. Activities provided support to HIV patients through the efforts of adherence case managers, adherence supporters, and community volunteers, most of whom were living with HIV themselves. In addition, working with organizations of people living with HIV was essential to the success of the program.

Community-based treatment support contributed to reduced loss to follow-up, increased patient retention, strengthened service linkages with other existing services, and higher likelihood of testing among partners and families. AIDSRelief's experience demonstrated that optimal patient outcomes can be attained when patients and their families are continuously engaged in their care through a structured program. Moreover, the level of community stigma and self-stigma among people living with HIV could be reduced by engaging the community and creating a comfortable environment for patients to take responsibility for their own health.

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 AIDSRelief. The program did not focus solely on its capacity-building efforts with direct partners, but also included the regional and zonal levels. AIDSRelief participated in monthly regional partner meetings with the Oromia Regional Health Bureau staff and all implementing partners working in the region, and conducted joint supervision of health facilities in conjunction with health bureau staff. AIDSRelief also worked to strengthen the South West Shoa Zonal Health Department and district health offices by regularly consulting with them on activities; jointly assessing and selecting treatment sites; encouraging their participation in program review meetings and in training sessions, both as trainers and trainees; conducting a zonal and district assessment; and providing some material and infrastructure support. AIDSRelief also supported linkages between its supported sites and existing national training systems.

Small Tests of Change

One of the pioneering activities of AIDSRelief Ethiopia was applying the model of "small test of change" (STOC) interventions to HIV care in the country. The process tests small structural or systemic changes aimed at improving the quality of patient care in the work setting, by **S**eeing it, **T**rying it, **O**bserving the results, and **C**ontinuing with what is learned. Areas for potential intervention were identified through site-generated data indicating low performance. In Ethiopia, activities included monitoring partner testing for increasing PMTCT uptake and tracking patients lost to follow up. The teams developed an annual quality improvement work plan to track and document the impact of various STOCs and were therefore able to generate evidence supporting this approach in improving the quality of care.

> "Our mentors in the zonal health department have really become empowered. They know how to mentor, how to support. I can assure you that our mentors can stand on their two legs now, and this is a great thing for us. We have absorbed [AIDSRelief's] skills."
>
> —Ato Wagari Edossa,
> Head of the South West Shoa Zonal Health Department

At the treatment sites, AIDSRelief introduced tools that assessed, strengthened, and measured service delivery, including program operations systems, while identifying gaps requiring technical assistance. With the findings of these site capacity assessments, AIDSRelief developed a clearer picture of each site's programmatic, technical, and administrative capacities, enabling the AIDSRelief team to prioritize the focus of technical assistance.

A Culture of Data Use

Most ART facilities in Ethiopia generate numerous reports for submission to various government offices and donors, which are then aggregated for use at zonal, regional, and national levels. However, these facilities largely fail to analyze and use the data they generate to guide their own subsequent decisions and to improve quality. To address these gaps, AIDSRelief supported a culture of data demand and information use and encouraged continuous quality improvement activities to assist facilities in analyzing, sharing, and

>>

using their data to drive decisions and quality improvement initiatives in all program areas.

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. This initiative has shown great promise in improving information utilization and addressing key quality gaps at the facility level in Ethiopia.

Laboratory

The Ethiopian Ministry of Health has been working to leverage improvements in HIV-related diagnostic services to enhance the quality of all services provided by the medical laboratory. In line with this approach, AIDSRelief's laboratory support reflected the belief that improving the quality of laboratory operations at primary health facilities is essential for strengthening the entire health system. The program's multi-faceted strategy to improve laboratory performance led to a number of notable successes, including improved laboratory performance and improved work environment.

Trends over the course of the AIDSRelief program show an improvement in both HIV-specific and general laboratory services on a number of benchmarks. For example, prior to AIDSRelief, patients did not receive their HIV test results until their next appointment, which could be up to a month after the test; patients now receive test results the same day.

The effectiveness of laboratory services at health facilities had been hampered by a lack of sufficient equipment and reagents. To help fill this gap, AIDSRelief supported renovation and refurnishing of the laboratories at all the health facilities. The renovation at St. Luke hospital has allowed initiation of independent microbiology, immunology, clinical chemistry,

>>

An Integrated Approach to External Quality Assurance

AIDSRelief established a protocol whereby from among all the samples collected onsite, each health center lab sent to St. Luke hospital on a weekly basis two TB slides, two malaria slides, and two blood samples for a comparative analysis. Similarly, the hospital laboratory preserved the same number and type of specimens to send to each health center for retesting. This approach was devised to assess the diagnostic performance of the facilities. Results have demonstrated a relatively high test-retest performance. For example, during a one-month period in late 2011—after several quarters of AIDSRelief support to laboratories—a total of 192 specimens were rechecked. The analyses demonstrated greater than 95% agreement between the test and the retest, indicating a high level of accuracy. The AIDSRelief results have proved that secondary laboratories can play a vital role in assuring laboratory quality at primary health centers.

PHOTO: DAVID SNYDER FOR CRS

parasitology, and hematology departments that are equipped with emerging technologies. AIDSRelief also procured and distributed reagents and crucial laboratory equipment.

By providing systems, material and infrastructure, and human resources support to six laboratories, AIDS-Relief worked to ensure timely access to diagnostic services, adequate quality of blood specimens, and a reasonable balance of quality and turn-around time. The results were seen during a WHO-African Office accreditation process, when an AIDSRelief-supported lab received the second-highest baseline score in the country.

Through AIDSRelief's continuous quality improvement approach, malaria and tuberculosis diagnostic scores at supported laboratories improved from "unsatisfactory" (below 65%) to "excellent" (above 85%) by the sixth quarter of the project. Each laboratory maintained that score through the end of the program, indicating sustainability.

Pharmacy and Supply Chain

One of the most significant bottlenecks in providing ART services has been poor supply chain management for ARVs and related health supplies. Challenges involving drugs for opportunistic infections and laboratory supplies are even more evident. Therefore, AIDSRelief's pharmaceutical and supply chain team prioritized capacity development of staff providing pharmaceutical services in HIV care and treatment centers. This was accomplished through formal training, on-site continuous technical assistance, sharing of best practices, and provision of materials and infrastructure support.

The development and introduction of standard operating procedures proved very useful in avoiding stock outs, minimizing the rate of expiry of medicines, ensuring the efficient and effective use of limited resources, and maintaining an uninterrupted supply of health commodities. Moreover, AIDSRelief extended a number of these services to other health centers in the zone, district health offices, and the zonal health

department. Strategic partnerships with key supply chain stakeholders, including the government-supported Pharmaceuticals Fund and Supply Agency, the Oromia Regional Health Bureau, and other implementing organizations allowed treatment sites to better leverage resources and become acquainted with the latest guidelines, work procedures, and technologies.

The long-term sustainability of supply chain systems will largely depend on the strength of institutional systems for managing these commodities in the hospitals and health centers. Realizing this gap, AIDSRelief invested more effort and resources with the expectation that experiences and lessons learned from managing ART-related commodities at the facility level will have an effect across the entire spectrum of health commodities management. At the AIDSRelief sites, ARV and other HIV-related supplies are now managed using the same infrastructure >>

PHOTO: DAVID SNYDER FOR CRS

"The trainings and support … have helped me to improve my skills on how to systematically process and use data. Before the training, I assumed reports were simply submitted to facility managers and were of no significance to me. After the trainings and assistance from AIDSRelief, I have come to understand the value of data and [how] to use it to support our team [and] improve our services."

—Muleta Ali, Chitu Health Center Data Clerk

and standard operating procedures as non-ARV commodities. This accomplishment will continue to contribute to the sustainability of the care, treatment, and support of HIV patients after the end of AIDSRelief support.

Local Partner Capacity Strengthening

AIDSRelief's capacity building efforts extended not only to treatment sites but also to the local implementing partner, the Ethiopian Catholic Secretariat. Following an organizational capacity assessment of ECS in 2009, program and operations-focused action plans were developed in close collaboration with ECS managers. In addition to the initial capacity assessment, efforts included a review of ECS' human resources, procurement, and financial accounting policies; leadership and governance training for ECS and diocesan leadership; training on proposal development; a salary scale and organizational structure review for improved staff management; a cost allocation system; and support in program management. These interventions have contributed significantly to ECS' operational capacity.

PHOTO: DAVID SNYDER FOR CRS

Sustainability and transition strategies have been central to the implementation of the AIDSRelief program. With that vision in mind, from the very onset of the program ECS implemented AIDSRelief's day-to-day technical and programmatic activities and maintained a close working relationship with the Ministry of Health and its regional offices.

In addition to building ECS' capacity with effective and efficient management systems, AIDSRelief coordinated activities with the zonal health department, ensuring its staff were involved in the implementation process and understood the commitment required to provide appropriate HIV care and treatment. Zonal staff also participated in joint mentoring with AIDSRelief and took part in linkage exercises involving the hospital and health centers.

While the Ethiopia program was small relative to other AIDSRelief country programs, its impact was not limited to the individual patients who received care. The integration of zonal-level mentors strengthened the relationship between the hospital, the health centers and the communities. This model is replicable, and indeed, the Oromia Regional Health Bureau has adopted the AIDSRelief linkage approach. AIDSRelief envisions a culture of care in Ethiopia wherein implementing partners target efforts on building technical mentorship packages and extension of services to the community in collaboration with government health departments as a means to build local capacity, to transfer necessary technical skills, and ensure ownership of the HIV care and treatment program by government counterparts.

PHOTO: DAVID SNYDER FOR CRS

ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Ethiopia received from our donor, our local partners, staff and management at local health facilities, and the Ethiopian 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 Ethiopia 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 Ethiopia Ministry of Health—including the Oromia Regional Health Bureau, the South West Shoa Zonal Health Department and district health offices—and our local partner, the Ethiopian Catholic Secretariat. Each and all were essential to AIDSRelief's success and are helping make sustained HIV care and treatment possible in Ethiopia.

We also wish to acknowledge the health workers and managers in treatment sites and communities across Ethiopia. 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, 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 authors of this document, Paul Perrin and Misrak Makonnen, 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%)**

For more information, contact aidsrelief@crs.org