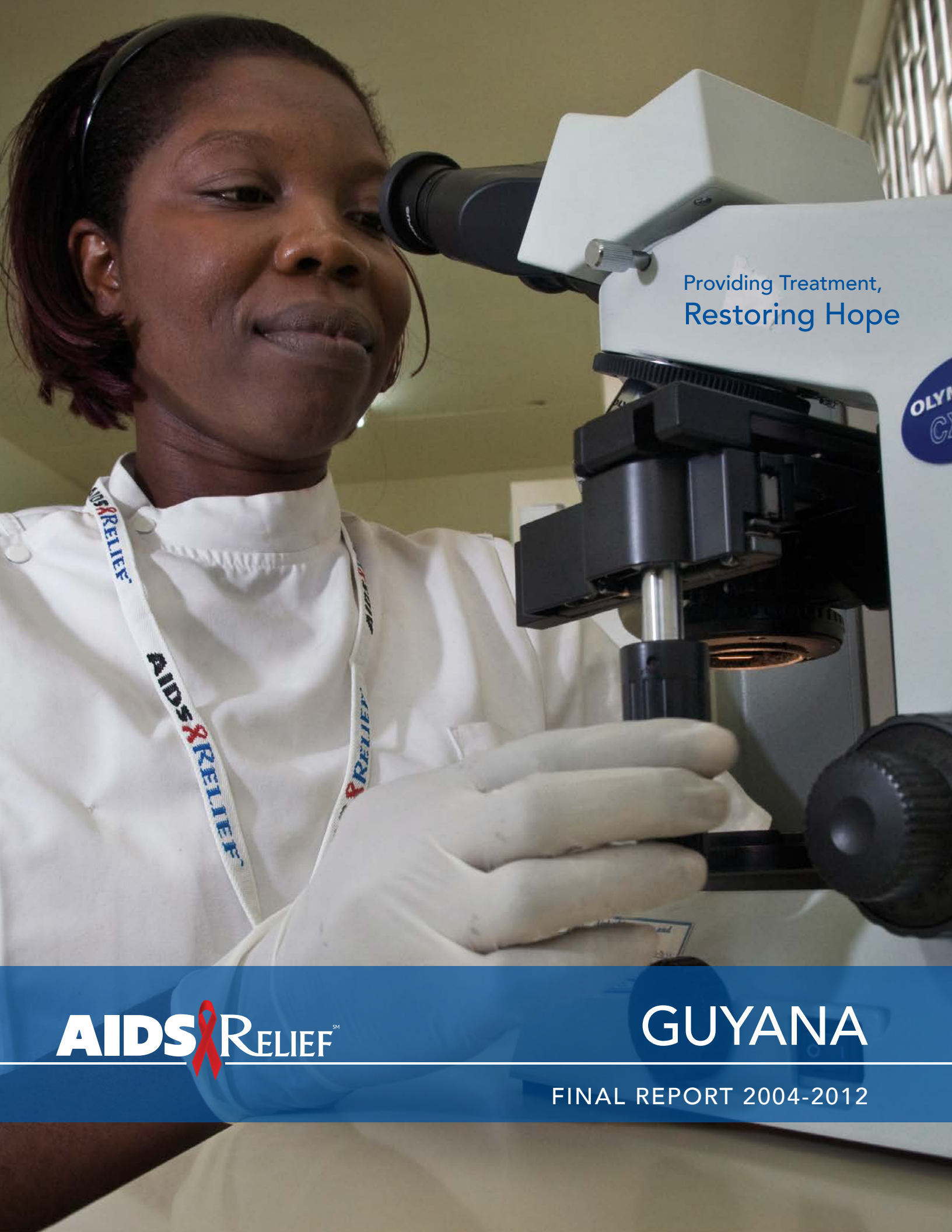


AIDS RELIEF[SM]

GUYANA

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.

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, CDC, or the United States government.

CRS CATHOLIC RELIEF SERVICES · INSTITUTE OF HUMAN VIROLOGY · Futures GROUP · IMA WORLD HEALTH · CMMB CATHOLIC MEDICAL MISSION BOARD

COVER PHOTO: RICK D'ELIA 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 2004 to 2012, AIDSRelief Guyana provided HIV care and treatment to more than 2,400 patients, including more than 1,500 who enrolled on lifesaving antiretroviral therapy (ART) at three treatment sites. In this small country, AIDSRelief's patient load represented approximately 30% of adults enrolled in care and treatment programs in all of Guyana. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, and Futures Group 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 three local partners—Davis Memorial Hospital, St. Joseph Mercy Hospital, and the Society of St. Vincent DePaul—formed a consortium and won a new grant to receive PEPFAR funds directly and assume full 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.

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.

HIGHLIGHTS INCLUDE:

- Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (5.4%), high retention (86.2%)[1], and cross-directional linkages to other community-based programs supporting people living with HIV.
- Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management. From 2008 to 2012, more than 5,200 participants attended off- and on-site training sessions.
- AIDSRelief's patient load represented approximately 30% of all adults enrolled in care and treatment programs in all of Guyana.
- A focus on strategic information prioritized comprehensive and timely access to clean, complete, and accurate data. Teams used data to make informed decisions and address gaps in program operations and services.
- AIDSRelief Guyana collaborated with the Catholic Church to set up a hospice care center managed by the St. Vincent de Paul Society of Guyana. The 17-bed inpatient facility provides palliative, rehabilitative, and end-of-life care and is the only such facility currently operating in Guyana.

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.

OUR CALL TO ACTION

When AIDSRelief began operating in Guyana in 2004, adult HIV prevalence was estimated to be at 2.5%, the second highest prevalence in the Latin America/Caribbean region. HIV has spread to all ten regions of the Guyana, predominantly affecting the 20-49 age group, in which it has become one of the leading causes of death. As a consequence, the country experienced a drop in productivity arising from illnesses and deaths, an increase in government health expenditure, and a drop in income for families of people living with HIV. Moreover, HIV led to a rise in the number of Guyanese orphans and vulnerable children, who numbered 4,200 when AIDSRelief began programming.

Throughout its eight years of programming in Guyana, AIDSRelief provided durable, comprehensive quality HIV care and treatment while building sustainability and local ownership. AIDSRelief also helped establish the first hospice care facility in Guyana, improving the transition of care from the hospital to the home. Working through three health facilities, AIDSRelief provided targeted on-site technical assistance to build the capacity of the local partners to deliver quality care. Through its program package, AIDSRelief made significant contributions to local government priorities in HIV response by increasing access to HIV care and treatment, voluntary counseling and testing, and prevention of mother-to-child transmission services; promoting improved laboratory capacity for screening and testing including expanding early infant diagnosis opportunities; and providing services to orphans and vulnerable children. The work of AIDSRelief, the government of Guyana, and the many international and local service providers has contributed not only to reducing adult prevalence to around 1.2% by the end of the program, but also to improving the lives of infected and affected people.

PHOTO: RICK D'ELIA FOR CRS

THE AIDSRELIEF CONSORTIUM AND ITS KEY PARTNERS

AIDSRelief Guyana comprised three of the five global AIDSRelief consortium members: Catholic Relief Services (CRS), Futures Group (Futures), 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.

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 in developing and implementing activities that built local partners' capacity to provide comprehensive, high-quality HIV care and treatment in accordance with national guidelines. Futures managed strategic information through data collection, analysis, monitoring, and generation of reports for donors, government and other key stakeholders.

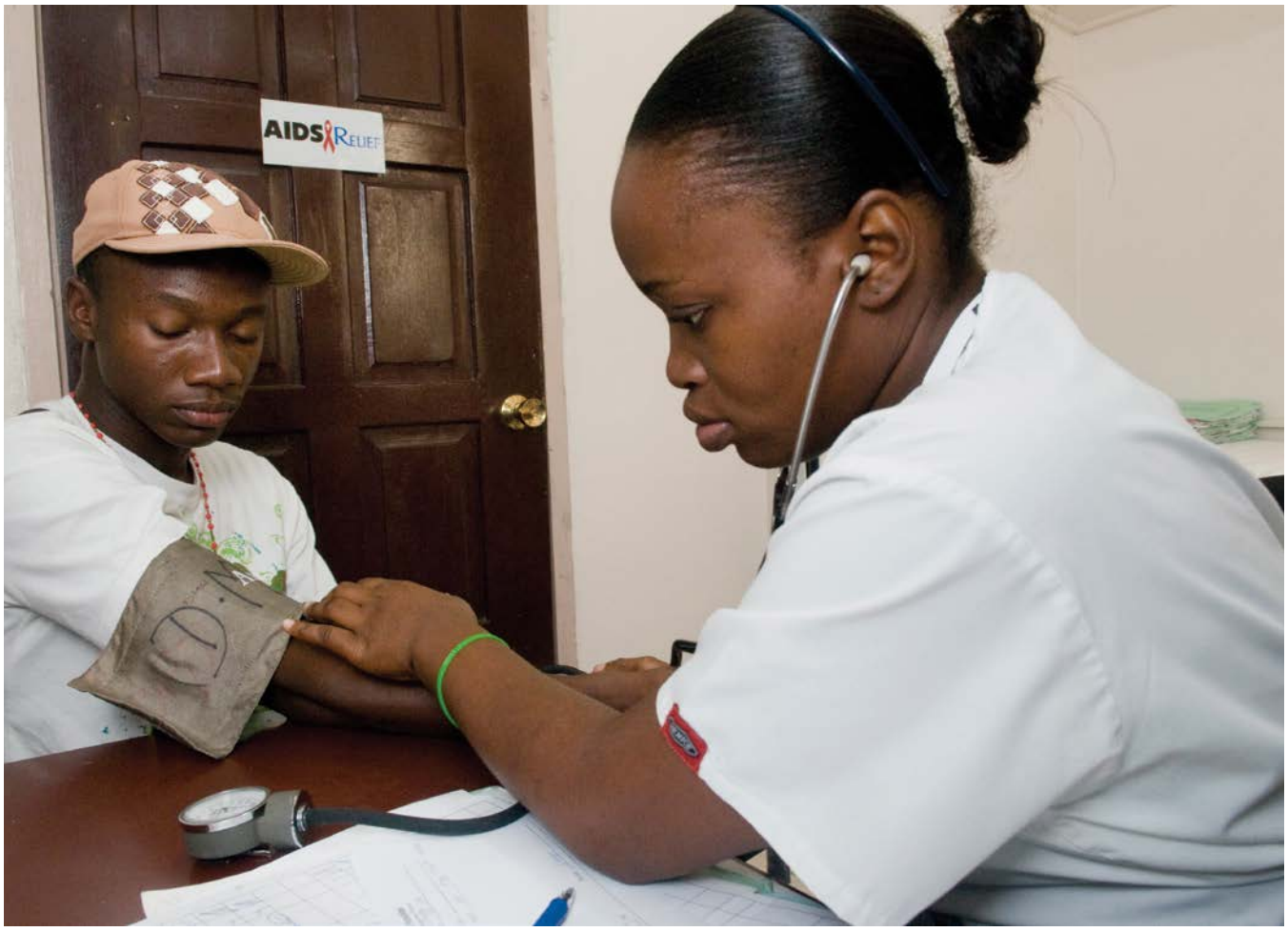
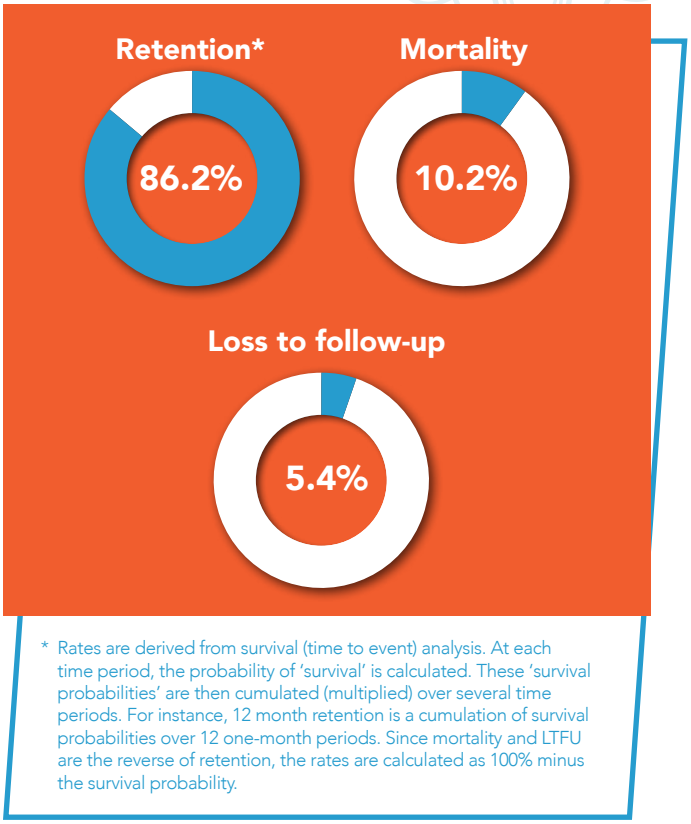


PHOTO: RICK D'ELIA FOR CRS

A NETWORK OF TREATMENT SITES

AIDSRelief Guyana initially provided antiretroviral therapy and care for people living with HIV by supporting the St. Joseph Mercy Hospital, a faith-based hospital in the capital city, Georgetown. As outcomes began to demonstrate the strength of the approach, in 2005 the government of Guyana invited AIDSRelief to a second site, the government-run Bartica Hospital, which would serve as a gateway to treatment for a high-risk mining community outside of Georgetown. As the program scaled up and patient load increased, AIDSRelief expanded in 2006 to a third facility, the Davis Memorial Hospital—a private faith-based hospital operated by the Seventh

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.

Day Adventist Church. AIDSRelief also established links with other organizations in order to increase the services available—such as drug abuse treatment, nutrition, and home-based care—to AIDSRelief patients and their families. Beginning in the spring of 2007, AIDSRelief Guyana collaborated with the Catholic Church to set up a hospice care center managed by the St. Vincent de Paul Society of Guyana. Rather than focusing on treatment, the 17-bed inpatient SSVP Care Center was established to provide palliative, rehabilitative, and end-of-life care; it is the only such facility currently operating in Guyana.

Through these facilities, the program provided HIV care to 2,443 patients, including 1,519 who enrolled on lifesaving ART. Priority was given to pregnant mothers and TB-infected clients.

PHOTO: RICK D'ELIA FOR CRS

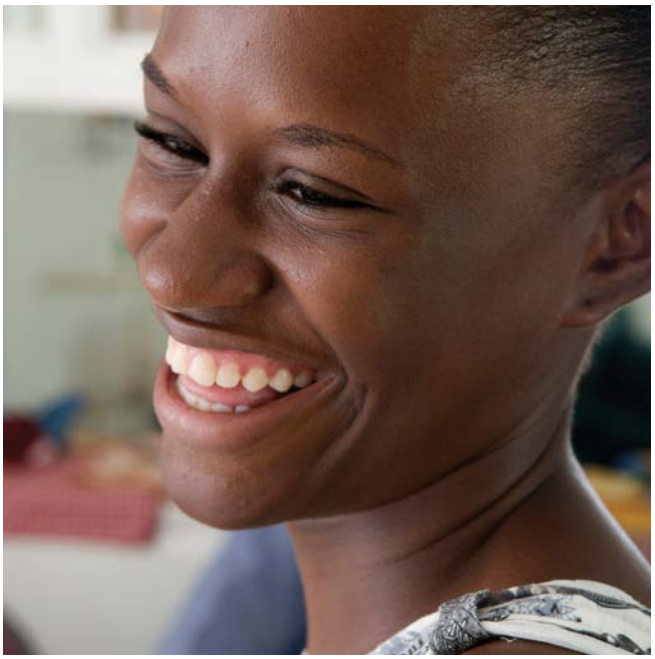
FROM CLINIC TO COMMUNITY

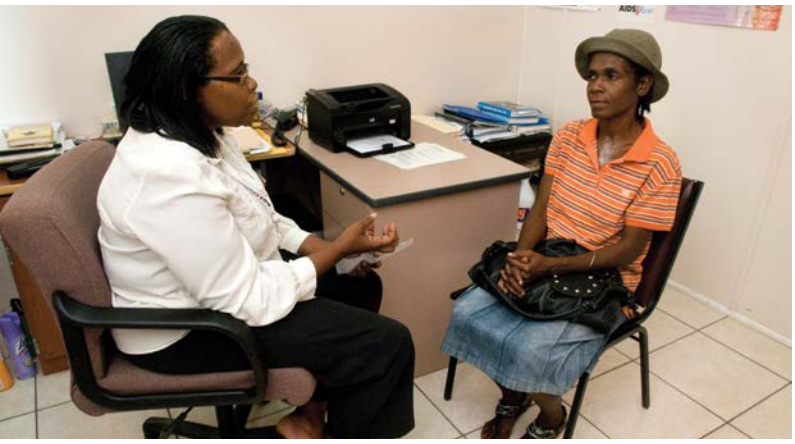
"To date we have had no negative reaction to the [SSVP] Center's presence. Clients and staff from the Center utilize the services of a neighboring taxi service for transportation. Clients are allowed to use community services such as Internet cafés without any difficulty."

—Emily Cumberbatch, SSVP Care Center Manager

A key aspect of AIDSRelief in Guyana was promotion of community involvement and behavior change not only at health facilities but also at the community level. Integrating ART services into treatment networks and community activities allowed treatment sites to take a more holistic approach to addressing HIV. Both hospitals promoted community mobilization through mobile clinics that provided services within communities. AIDSRelief also initiated a community outreach strategy that facilitated links to existing home-based care and community adherence support services. AIDSRelief mainstreamed gender-focused activities in its programming by training health care and home-based care workers on gender-based violence, and by training young peer educators in addressing gender norms.

AIDSRelief capitalized on existing community networks in order to increase access to services and promote community awareness, HIV testing, counseling, and community follow-up. Strong referral and reporting mechanisms ensured that people testing positive could access the care they needed. All patients were offered and referred to home-cased care.





To facilitate these community efforts, Davis Memorial Hospital maintained treatment support officers whose primary focus was to prevent loss to follow-up among patients, along with a home-based care nurse who followed up with HIV-infected clients on ART adherence. The SSVP Care Center also supported greater community care through links with home based care services and community support structures, a stigma awareness campaign, and training of family caregivers. Indeed, prior to the SSVP Care Center's opening, AIDSRelief took several steps to minimize community stigma by launching a community-awareness campaign in nearby churches, schools, and health centers.

LEFT PHOTO: RICK D'ELIA FOR CRS / RIGHT PHOTO: RICK D'ELIA FOR CRS

EXCEPTIONAL TREATMENT

At the core of AIDSRelief's services was antiretroviral therapy. Between July 2004 and the end of the program in February 2012, AIDSRelief Guyana enrolled into care a total of 2,443 adults and children, of which 1,519 (6% of whom were children) were enrolled on ART. AIDSRelief's patient load represented approximately 30% of all adults enrolled in care and treatment programs in all of Guyana. In 2009, an adolescent clinic was opened at St. Joseph Mercy Hospital to meet the special needs of patients aged 16 to 24. The adolescent clinic not only offered the same services as the adult clinic, but also provided adolescent counseling, support groups, and patient education services through youth-friendly staff. In addition, AIDSRelief expanded HIV care and treatment services to the Mazaruni Prison, where the program supported fixed HIV testing services.

AIDSRelief's patient load represented approximately 30% of adults enrolled in care and treatment programs in all of Guyana.

AIDSRelief's family-centered care model promoted comprehensive adherence support, which included treatment preparation, ongoing counseling, support groups, and community follow-up. The team included a dedicated adherence specialist who worked with and trained counselors on adherence and promoting disclosure. Prior to initiating ART, new clients were required to attend patient education classes that stressed the importance of adherence and encouraged the habit of keeping appointments. To assess adherence, doctors monitored CD4 counts and counselors counted pills during clinic visits. In cases of poor adherence, the home-based care nurse visited patients' residences to discuss compliance.

Although many care and treatment programs begin and end with the provision of ART, AIDSRelief adopted a comprehensive approach to care by offering screening and treatment for opportunistic infections and sexually transmitted infections that commonly afflict HIV patients. Cervical cancer screening and viral load testing were also initiated in 2009 and 2010, respectively. To address one of the more common and detrimental infections, AIDSRelief expanded TB diagnosis services to ensure timely treatment and consistent follow-up for co-infected patients. Health facilities established mechanisms to integrate co-infected patients into the National TB program. Upon diagnosis, AIDSRelief clients were referred to the National TB clinic for treatment. Overall, 97.5% of AIDSRelief patients were screened for TB; 34% of those screened were referred for treatment.

Cervical Cancer Screening for Women with HIV

In 2009, St. Joseph Mercy Hospital integrated a cervical cancer screening intervention for women living with HIV, performed through visual inspection with acetic acid (VIA). Technical assistance for the intervention was provided by JHPIEGO; financial support was later provided by AIDSRelief to perform the test as part of baseline testing for HIV-infected patients and in annual follow-ups. As part of the intervention, five staff members were trained on the VIA methodology. In cases of positive tests, cryotherapy was provided for precancerous cells, while large lesions were referred for treatment. By the end of AIDSRelief, nurses had screened 379 HIV-positive patients for cervical cancer.

"We know that people with HIV are at higher risk of getting cervical cancer," said Ollin George, a nurse working in the program. "This is a great program to prevent patients from [succumbing to] cervical cancer. A pap smear wastes time and also increases fear of people who are then referred for the VIA. By doing the VIA immediately, treatment is available immediately."

A COMPLETE PACKAGE

In recognition of the fact that treatment is essential to reducing the risk of transmission, prolonging productivity, and improving quality of life for people living with HIV, Guyana's Ministry of Health introduced an ART regimen to the country in 2002. While treatment itself was made available free of charge, costs associated with testing and HIV care were the patient's responsibility. Therefore, many people in need of treatment did not have the means to undergo testing, let alone initiate and maintain treatment. In addition, HIV-related stigma was high in Guyana and patients were reluctant to visit the few government ART clinics for fear that others would learn their HIV status.

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.

Nearly 29,000 people were tested for HIV

At all its treatment sites, AIDSRelief supported an integrated service delivery model that ensured that clients received complete, confidential, and high-quality care. AIDSRelief staff provided targeted on-site technical assistance and mentoring while overseeing the integration of HIV care and treatment with other services. AIDSRelief Guyana helped healthcare staff analyze problems and identify solutions, from diagnosing complex medical cases to improving patient flow and increasing clinic efficiency. Additionally, the program not only collaborated with the Ministry of Health National AIDS Program Secretariat to ensure that care and treatment adhered to national guidelines for ART, but also provided clinical feedback where appropriate to continually improve standards of care.

Voluntary Counseling and Testing (VCT)

Government of Guyana surveys from the mid-2000s revealed the persistence of HIV-related stigma and discrimination, leading to a corresponding reluctance to undergo testing. To address this issue, AIDSRelief Guyana trained staff and auxiliary organizations in stigma reduction to improve treatment and to educate their peers and community about the effects of HIV. Counseling staff at each of the facilities offered psychosocial support to clients, helping them to identify and overcome adherence barriers and to manage the myriad social ramifications associated with HIV. >>

PHOTO: RICK D'ELIA FOR CRS

Beginning in 2004, the AIDSRelief sites pursued an aggressive VCT campaign, in line with national guidelines, that helped individuals to assess their own behaviors and level of risk for acquiring or transmitting HIV. During the course of the program, nearly 29,000 HIV tests were performed. The three treatment sites also organized outreach activities such as going to concerts, attending health fairs, and participating in the annual National Week of Testing. In addition, AIDS-Relief advocated that all physicians offer HIV testing as part of their routine screening.

"God places a port in the middle of every storm; this place is that port for me."

—SSVP hospice client

Palliative Care

Although AIDSRelief's ART regimen visibly improved the lives of its patients, there were no palliative and step-down care services for more seriously ill patients. Many of these patients noted that they did not have access to the types of food and clean water necessary to support successful ART. AIDSRelief responded to this unmet need by converting a former youth hostel in southern Georgetown District into a 17-bed hospice, which was not only the first of its kind in the country of Guyana but also the only hospice funded by AIDS-Relief in any of its ten country programs. A regular

flow of patients has been referred to the center by the ART facilities as well as by a number of other health center referral sites. Once at the live-in center, patients

Reducing Patient Waiting Time

Information collected on-site demonstrated that one of the primary patient complaints at Davis Memorial Hospital was a long waiting time, generally over an hour, before seeing a physician. Hospital management set a goal to reduce average waiting time to less than 40 minutes and set about to determine the best course of action to accomplish this goal. While understaffing and lack of skill among the attendant nurses was determined to be the root causes of delays, management monitored patient flow for one month to discover other bottlenecks, which included delays in patient chart flow and a crowded waiting room that made it difficult for patients to hear their names being called. Management developed a plan to address these issues. Through this "challenge model" exercise, six months later, the goal for a reduced patient waiting time was met.

PHOTO: RICK D'ELIA FOR CRS

receive medical treatment, extensive adherence counseling, and the overall care and support needed to regain their strength and lead healthy lives.

The Care Center expressed two end-goals for its services, depending on the prognosis of the patient: 1) transition of the client's care from the facility to the home and community; or 2) end-of-life care that created an atmosphere wherein clients spend their remaining days in comfort and with dignity and where family members are always treated fairly and with respect. Regardless of client type, patients had access to 24-hour nursing care and regular visits by a physician. Patients in need of urgent care were referred and transported to a hospital. Mental health was fostered through regular recreational activities, patient and family support groups, and counseling provided by an on-site social worker and a partnership with the Social Work Unit of the University of Guyana, which allowed for one-on-one support to clients. To help meet the clients' nutritional needs, AIDSRelief received material support from additional partners including the government of Guyana, the Bernice Nansell Foundation, and Food for the Poor. Finally, staff worked to ensure income-generating opportunities and vocational training to improve future prospects for rehabilitative patients.

Maternal-Child HIV Care

By the year 2000, HIV prevalence among pregnant women was about 7%, prompting the government of Guyana to make prevention of mother-to-child transmission (PMTCT) a priority. Since then, the government has sought to provide universal coverage of testing and PMTCT services across the country. Monitoring and surveillance demonstrated not only the need for such services, but also the desire, as more than 90% of pregnant women took advantage of testing and other services when offered.

AIDSRelief approached PMTCT from a perspective of maternal-child HIV care. Prior to AIDSRelief, treatment regimens consisted of a single dose of nevirapine. Now, all AIDSRelief facilities provide highly active antiretroviral therapy (HAART) to all HIV-positive pregnant women who attend maternal and child health clinics. Women taking antiretrovirals as prophylaxis discontinued their therapy after delivery or after breastfeeding ceased, while those taking ARVs for their own health continued their treatment. Exposed infants received a series of drugs and were provided with cotrimoxazole prophylaxis from 4–6 weeks. Infants were also tested at six weeks, given vaccines according to the national vaccine schedule, provided with breast milk substitute until 18 months of age, and underwent clinical check-ups until age five. AIDSRelief Guyana provided care to 223 HIV-exposed infants, only seven of whom ultimately tested positive.

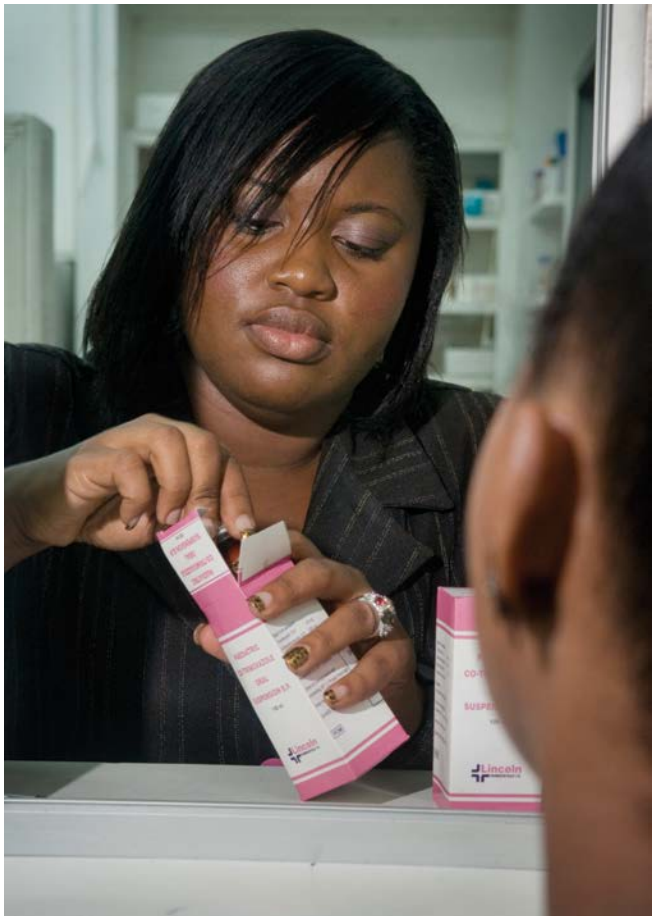
PHOTO: RICK D'ELIA FOR CRS

THE HEALTH SYSTEMS FOUNDATION

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 Guyana program. This meant not only improving the leadership and management of health facilities, but also strengthening the capacity of laboratory staff, the supply chain system, and human resources.

Pharmacy and Supply Chain

Thousands of patients, along with the clinicians and pharmacists who treat them, depend on Guyana's supply chains to deliver essential medicines and supplies. However, the country's basic infrastructure has often presented serious challenges. For instance, until early 2006, the Ministry of Health maintained a single central warehouse for health commodities which was often saturated with expired medicines and unnecessary medical supplies. The Ministry recognized the need for improvement and, with the support of the U.S. government, opened a warehouse annex, allowing storage and distribution of medication, test kits, and lab supplies in a secure and optimal environment.



Recognizing that local supply distributions depend on national systems, AIDSRelief worked closely with national counterparts in a mutually beneficial relationship. As government supply chain capacity increased, AIDSRelief Guyana successfully transitioned all procurement of its ARVs to the national system. AIDSRelief also worked closely with national partners in harmonizing standards and tools for supply chain management.

AIDSRelief Guyana provided the three treatment sites with technical assistance to improve drug utilization, forecasting, procurement, adherence counseling, recognition of adverse reactions, and pharmacovigilance. Recognizing the usefulness of technology in improving outcomes in these arenas, at Bartica and Davis Memorial hospitals AIDSRelief supported the roll out of an electronic ART dispensing tool. In addition, the two private-sector sites benefitted from establishing and maintaining drug and therapeutic committees, which empowered pharmacies to play a more proactive role in the delivery of ART services.

Laboratory

As in any other country affected by HIV, treatment and care in Guyana depended upon timely and accurate diagnosis, which demands functional laboratory capacity, infrastructure, and supplies. However, Guyana's laboratory infrastructure in 2004 was limited in its ability to meet the needs of an effective, large-scale HIV care and treatment program. AIDSRelief

>>

PHOTO: RICK D'ELIA FOR CRS

was called upon to help build laboratory capacity while working with local and national counterparts to better ensure sustainability.

AIDSRelief equipped sites with the tools and infrastructure necessary to meet program goals and international standards. All supported facilities also benefited from AIDSRelief-provided lab equipment, reference manuals, and reagents. Additionally, AIDSRelief promoted inter-laboratory collaboration for procurement, quality assurance, and equipment calibration.

Adequate infrastructure and equipment alone cannot ensure timely and accurate testing; therefore, in-country training ensured that staff could safely and accurately run critical diagnostic tests. Training covered a broad array of laboratory topics and techniques including specimen collection; basic immunology; epidemiology of HIV and HIV-related infections; good laboratory practices; microbiology; equipment maintenance, calibration, and repair; forecasting and procurement; and quality control. AIDSRelief also supported lab supervisors and hospital administrators in improving the management of their laboratories, communication with clinicians, delineation of roles and responsibilities, and integration of lab services within the ART program.

With AIDSRelief's support, Bartica Hospital became the first treatment site outside of Georgetown with the capacity to conduct CD4 testing and to offer pediatric ART services. In 2009, AIDSRelief worked with the U.S. Centers for Disease Control (CDC) and Guyana's National Public Health Reference Laboratory to centralize CD4 testing. Mechanisms were put into place to transfer blood samples and results from AIDSRelief to the national laboratory. In 2010, the same mechanism was used for viral load testing. These steps built national capacity and increased cooperation between private health facilities and the Ministry of Health.

PHOTO: SARA A. FAJARDO/CRS

STRATEGIC INFORMATION

Prior to AIDSRelief, medical records were not managed in a systematic fashion; while records were kept at sites, they tended to be disorganized and were rarely, if ever, used to support evidence-based decision making. AIDSRelief viewed this situation as an opportunity to effect meaningful and lasting change at supported facilities. At the site level, AIDSRelief Guyana developed tools and provided capacity-building activities to help physicians and other staff manage clinical data while addressing barriers and challenges in the program and services.

AIDSRelief first worked to enhance use of the national paper system, which was based on government registers. Next, AIDSRelief gradually introduced an electronic record system, IQChart[2], which was first deployed at Davis Memorial Hospital before expanding to the remaining sites. The system was designed not only to align with national requirements, but also to allow for site-specific programmatic and organizational data needs. IQChart allowed staff to easily generate routine programmatic reports on key indicators such as loss to follow up, mortality, and ARV pick-up.

The AIDSRelief team worked with clinicians, administrators, and other health care workers to use information to enhance patient care and tracking. Best practices and lessons learned were shared across the network to promote ownership and use of data. In November 2010, Davis Memorial and St. Joseph hospitals established continuous quality improvement committees, which adopted an interdisciplinary approach. Through small tests of change, the committees addressed issues such as loss to follow up, patient waiting time, and repeat CD4 testing. Through all these efforts, the AIDSRelief Guyana team improved capacity to effectively and efficiently collect, manage, and use data at all levels.

2 IQChart is part of the IQStrategy suite of patient management and monitoring systems and data reporting tools developed by Futures Group. For more information, visit http://www.iqstrategy.net/index.shtml.

PHOTO: RICK D'ELIA FOR CRS

AIDSRelief was designed with transition to local partners in mind and all program planning supported that goal. A shared vision—among the donor, local partners, and within the AIDSRelief consortium—was sometimes challenging to develop but also essential to successful transition. In Guyana, AIDSRelief undertook a consultative transition planning process that involved representatives from the three treatment facilities, Guyana's government, and other stakeholders.

AIDSRelief and its partners developed a transition strategy that laid out objectives for each aspect of transition in areas of program management, site management, supply chain, and finance and compliance. In 2011 the Bartica care and treatment program transferred to the Ministry of Health while the remaining sites formed a consortium and began developing a competitive funding application that won a new grant from CDC. They now receive their PEPFAR grant funds directly and are responsible for managing all aspects of the transitioned program (known as Positively United to Support Humanity, or PUSH) which provides long-term support to the former AIDSRelief sites in terms.

In transitioning to the PUSH program, AIDSRelief experienced a number of implementation challenges. Clinical transition was smooth because nearly all of the AIDSRelief clinical personnel were hired by the PUSH project, ensuring continuity of technical expertise. But one significant issue was beyond the immediate ability of AIDSRelief and the transition partner to control:

reduced budget support for the PUSH program led to a smaller remuneration package for program staff and some subsequent staff attrition. Funding constraints have also limited the ability to maintain the same level of program monitoring and evaluation.

The key lesson learned in addressing these and other transition challenges is the primary importance of advance preparation. AIDSRelief staff felt that the timeline for preparation and transition was not optimal and they recommend that future projects should start planning for transition at the beginning of the project. This would allow country ownership to be gradually built in phases, rather than handing responsibility over in a sizeable load. Transition partners should have a clear role and input into the transition plan.

PHOTO: SARA A. FAJARDO/CRS

ACKNOWLEDGEMENTS

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

We are grateful for the financial and technical support from the program's donor, the Health Resources and Services Administration (HRSA), through funding from PEPFAR. We also appreciate the CDC team in Uganda for their on-the-ground program oversight, guidance, and support. The program's impact would not have been possible without the tremendous dedication from all levels within the Guyana Ministry of Health and with our local partners: Davis Memorial Hospital, Saint Joseph Mercy Hospital, and the SSVP Care Center. Each and all were essential to AIDSRelief's success and are helping make sustained country ownership possible in Guyana.

We also want to acknowledge the health workers and managers in health facilities and communities across Guyana. 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, our local partners, and individual health facilities who agreed to be interviewed and share their experiences for this report. Lastly, thank you to the author of this document, Paul 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