Providing Treatment,
Restoring Hope

AIDS RELIEF℠

TANZANIA

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, supporting sites in three countries.

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

EXECUTIVE SUMMARY

From 2004 to 2012, AIDSRelief Tanzania provided HIV care and treatment to 165,488 patients, including 85,673 who enrolled on lifesaving antiretroviral therapy (ART) at 102 treatment sites. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, Futures Group, and IMA World Health provided technical and program support based on their core capacities. A deep commitment to partnership underscored AIDSRelief's relationships and capacity strengthening activities, which culminated in late 2011 when the US government issued simultaneous follow on awards to AIDSRelief and its local partner, the Christian Social Services Commission (CSSC). Through the five-year LEAD project, AIDSRelief consortium members will incrementally transfer responsibility for the care and treatment program to CSSC.

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

HIGHLIGHTS INCLUDE:

- Patients on treatment in AIDSRelief-supported facilities maintained very high viral suppression rates—as high as 89%[1], indicating excellent adherence to treatment.
- Community-based treatment support expanded services from clinic to community and contributed to low loss to follow-up (16.4%), high retention (74.7%), and low mortality (13%).
- Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management. From 2008 to 2012, nearly 6,000 clinicians, nurses, pharmacy and laboratory staff, community volunteers, and other key health care workers were trained.[2]
- By 2012, AIDSRelief Tanzania was also managing 698 prevention of mother-to-child transmission (PMTCT) programs. During the eight years of the program, more than 587,000 pregnant women were counseled, tested and received their results. In addition, 15,000 HIV-infected pregnant women received ARV prophylaxis to prevent transmission of HIV to their babies.
- 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.

1 Based on a 2008 analysis of summaries of patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys.

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

OUR CALL TO ACTION

From the time that HIV was first recognized in Tanzania in 1983, the infection quickly evolved from a new and relatively unknown condition into a common household affliction. The toll has been significant: at the advent of AIDSRelief in 2004, an estimated 1.1 million people aged 15 and older, or just over 5% of Tanzania's adult population, were living with HIV. Although this number has recently stabilized, in some areas of the country AIDS has become the leading cause of adult morbidity and mortality. As a result, the number of orphans has been increasing, placing strain on extended families, communities, and government services. Beyond the significant human costs, the Tanzanian HIV epidemic has also hindered the country's economic development, not only through medical costs associated with HIV care but also by diminishing the active workforce, particularly in the agricultural and industrial sectors of the economy.

Early in the epidemic, the government of Tanzania recognized the threat and has taken many steps to slow the spread of HIV and minimize its impact. But prevalence continued to rise, prompting the President of Tanzania in 1999 to declare HIV a national disaster, which triggered the development of a national HIV policy that continues to serve as a framework for all entities involved in the response. Even into the new millennium, however, treatment remained a privilege of the wealthy, and for most Tanzanians a diagnosis of HIV infection was tantamount to a death sentence.

AIDSRelief was a timely program in Tanzania, entering the scene at a time of government desire for universal treatment in a reality of severe access constraints. Creating a high-quality, sustainable care delivery system meant developing the full range of adult and pediatric care and treatment services along with community-based treatment support, laboratory infrastructure, supply chain management for medicines and health commodities, and strong data management and quality improvement activities. The program also established links with the Ministry of Health and Social Work and other organizations in order to increase the services available to patients and their families. In the process, the program has provided hope and has afforded longer and higher-quality lives to many people affected by HIV.

PHOTO: DEBBIE DEVOE/CRS

AIDSRELIEF IN TANZANIA

AIDSRelief Tanzania comprised four of the five global AIDSRelief consortium members: Catholic Relief Services (CRS), Futures Group International (Futures), and the University of Maryland School of Medicine Institute of Human Virology (IHV), and IMA World Health (IMA). 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, compliance, and pharmacy and supply chain management, in addition to coordinating overall representation of the grant to United States government donor agencies; local government, particularly the Ministry of Health and Social Work; and other stakeholders. IHV served as the clinical lead for AIDSRelief in developing and implementing activities that built local partners' capacity to provide comprehensive, high-quality HIV care and treatment within the framework of national policies and guidelines. Futures managed strategic information through data collection, analysis, monitoring, and generation of reports for donors, government and other key stakeholders. IMA provided site management for 32 treatment sites, and both IMA and CRS ensured that the health facilities received the strengthening and support they needed to provide high quality care and treatment services.

PHOTO: DAVID SNYDER FOR CRS

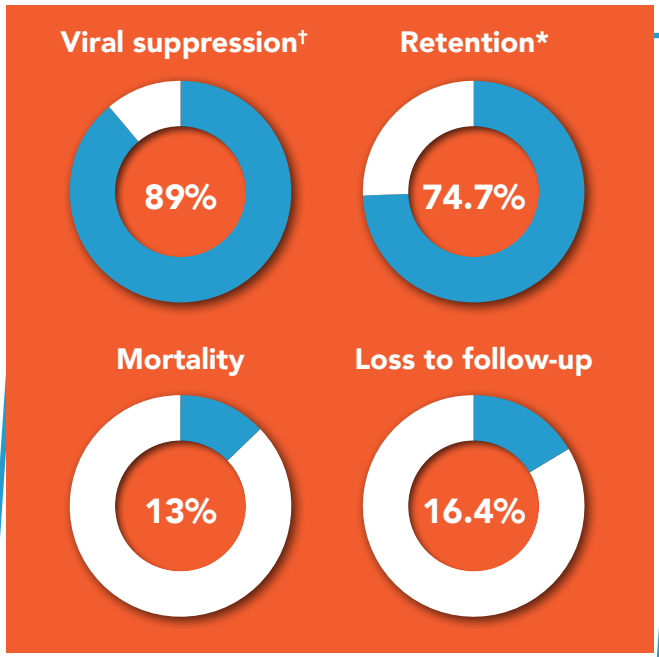
A NETWORK OF TREATMENT SITES

AIDSRelief initially worked through faith-based health facility networks, including seven hospitals, to provide HIV care and treatment services. However, the Government of Tanzania encountered difficulty in coordinating the efforts of AIDSRelief and the five other PEPFAR-funded programs operating in the country, prompting a 2006 mandate for a new "regionalization" approach which appointed a single implementing partner with responsibility for supporting all of the designated treatment sites in a given region. The approach was meant to minimize overlap and duplication in service provision while simultaneously fostering nationwide coverage of treatment services. While this approach posed a significant implementation challenge, AIDSRelief was able to adapt and rapidly scale up in its four assigned regions: Mwanza, Mara, Manyara, and Tanga.

AIDSRelief worked in close partnership with the National AIDS Control Program, regional and council health management teams (RHMTs and CHMTs), and faith-based organizations to increase access to comprehensive HIV care and treatment through a network of government, faith-based, and private health facilities in the four regions. AIDSRelief provided programmatic, clinical, and strategic information technical assistance to 102 sites in total, of which 69 received direct financial support.

Through these health facilities and their satellites, the program provided care to more than 165,000 patients, with priority given to pregnant mothers and TB-infected clients.

AIDSRelief by the Numbers



† Based on a 2008 analysis of summaries of patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys.

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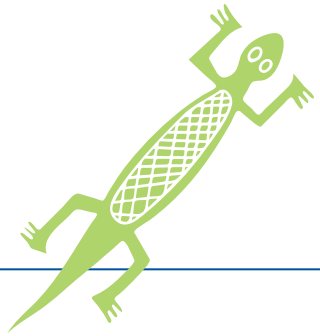
PHOTO: DAVID SNYDER FOR CRS



EXCEPTIONAL TREATMENT

In 2004, antiretroviral medications were a rare commodity in Tanzania, with only approximately 2,000 people on ART (although more than 300,000 were eligible for treatment). Severe resource constraints meant that, as in most developing countries, the few facilities offering ART initiated treatment only for patients with very low CD4 counts using less potent regimens, despite evidence that certain drugs might be less effective when initiated late in disease progression. Moreover, late initiation of treatment and a lack of maternal-child HIV services meant that infected children were experiencing symptoms of AIDS. Services were predominantly limited to counseling and testing, behavior change interventions, and end-of-life care. As such, the prognosis for people living with HIV was poor, many were bedridden and unable to work and take care of their families.

From the outset, AIDSRelief advocated for maximizing the initial ART regimen in an effort to ensure durable treatment outcomes and long-term cost control. This is especially important in low-resource settings where extensive laboratory monitoring and multiple treatment options are not available. In addition, the AIDSRelief model treated adherence as a therapeutic intervention. A patient's treatment experience included structured treatment preparation, adherence counseling, home visits by peer counselors, and community involvement. This emphasis on support networks helped patients >>

PHOTO: DEBBIE DEVOE/CRS

adhere to their treatment plans and reduced the number of patients lost to follow-up.

Beginning in 2006, additional funding secured by the Tanzania program allowed AIDSRelief to provide an integrated approach to services, most notably through the introduction of TB/HIV and maternal-child HIV care services. This full package dramatically improved the quality of care, reducing overlap and creating new opportunities for positive outcomes.

Treatment Preparation and Counseling

A key element of AIDSRelief's success was community-based treatment support, a cross-cutting program at all facilities. The comprehensive program emphasized strong links between people living with HIV, their families, and their communities and health facilities. Each patient's experience included structured treatment preparation, adherence counseling, highly supported treatment initiation with home visits by peer counselors, and community-based treatment support. This emphasis on support networks helped patients adhere to their treatment plans and reduced the number of patients lost to follow up.

Before starting treatment, all patients participated in at least three structured counseling sessions to help them better understand the importance of adherence and the dedication required of and resources available to them as they embarked on the life-long therapeutic regimen. Patients were strongly encouraged to have a "treatment buddy"—a friend, family member, or other confidant—to join them at these sessions. After initiating treatment, patients attended adherence counseling as part of their monthly prescription-refill visits and were further supported by home visits from community supporters. These sessions presented an opportunity for counselors to answer questions, identify potential adherence challenges and opportunities, and reinforce messages about effective treatment.

Maternal-Child HIV Care

AIDSRelief approached mother-to-child transmission (PMTCT) from a broader perspective of maternal-child HIV care (MCHC). After an assessment revealed >>

From Clinic to Community

AIDSRelief Tanzania's community-based treatment services (CBTS) approach was designed to encourage better retention and follow-up by fostering formal links between hospitals, health centers, and communities.

AIDSRelief trained and supported a network of community health volunteers with support from development partners, local stakeholders, and support groups. To improve access to services, AIDSRelief also worked with district councils, departments of community development, and networks of people living with HIV. AIDSRelief put forth considerable effort to change attitudes and address challenges before it could fully accomplish CBTS goals. For instance, clinic staff did not always readily accept that community services were necessary or that optimal patient outcomes required more time and persistence with the patient.

Within two years, more than 500 support groups had been formed, some of which were supported financially by district authorities. These groups have taken a major role in supporting the follow-up of patients on treatment. Furthermore, the community-based treatment support program has helped relieve staff shortages in the local and national health system by introducing task-shifting concepts through community-based volunteers, lay counselors, and peer educators, especially in rural areas. Finally, new national guidelines introduced in 2010 included many components of the program, such as increased involvement of people living with HIV.

Mobile Technology for Timely Reporting

Rapid scale-up of maternal-child HIV services posed a number of reporting challenges, as these sites often employed few staff and depended on paper-based reporting. Moreover, the remote locations and poor infrastructure at many locations meant that reports took up to four months to reach the national level and often contained errors and inaccuracies. District and regional coordinators often had to travel to these remote sites on a quarterly basis to facilitate report submission.

In response, AIDSRelief Tanzania developed IQSMS, a data quality and validation system used by 265 facilities to support quick reporting of data to various stakeholders. The system sends a reminder to all users to submit the reports by a particular date. Data are submitted via mobile phone SMS in a predetermined format. Messages are received by a modem connected to a central server. One of the advantages of the system is instantaneous validation and feedback; in the case of inaccurate reports rejected by software, the user is notified and asked to resubmit. After data verification, reports are automatically entered into a database and can be retrieved from the server for further analysis. This system is unique to AIDSRelief Tanzania, although it would have broad applicability in other remote settings.

In addition, AIDSRelief collaborated with the Clinton Foundation to train 37 staff from Manyara and Tanga regions on the utilization of printers to transmit infant test results from the zonal laboratory back to health facilities using SMS. This initiative has helped to decrease turn-around time for communication of results by more than 50%.

numerous missed opportunities for implementing services, AIDSRelief began offering MCHC services at six sites. AIDSRelief subsequently responded to an ambitious national mandate that every health facility offer PMTCT services by rapidly scaling up to 689 facilities in 2012.

AIDSRelief adopted several approaches to strengthen HIV care for mothers and children, including early infant diagnosis and pediatric care and support services. A key success was fully integrating MCHC within the clinics, allowing all services to be performed under one roof and thereby minimizing loss to follow up. Special focus was directed at improving testing, diagnosis, enrollment, tracking and management of HIV-exposed and infected children through integration of pediatric inpatient wards, pediatric outpatient clinics, government maternal and child health clinics, and labor and delivery.

AIDSRelief also promoted male partner involvement through invitation letters, community sensitization, and prioritizing pregnant women accompanied by their partners. Health care workers received continuous training and mentorship on the importance of involving partners, and documentation procedures were improved to ensure that male partners were captured in the data. As a result, male partner uptake of services improved from 1,791 clients in 2008 to 24,431 in 2010, an increase of 1,300%. >>

PHOTO: DEBBIE DEVOE/CRS

As a result, a total of 587,340 pregnant women were counseled, tested and received their results during the eight years of the program. In addition, 15,140 HIV-infected pregnant women received ARV prophylaxis to prevent transmission of HIV to their babies. AIDSRelief reduced the use of single-dose nevirapine (an older regimen) during labor and delivery from 92% in 2008 to just 3.3% in 2011.

Tuberculosis

Tuberculosis is the most common opportunistic infection and a leading cause of death among people living with HIV in sub-Saharan Africa. In Tanzania, the two infections traditionally had been vertically managed in separate clinics specific to each disease, an approach that failed to recognize the frequent co-occurrence of the two diseases and led to missed opportunities for treatment. In addition, low penetration of TB screening and poor diagnostic capacity drove under-detection of TB in Tanzania.

AIDSRelief introduced a TB component in 2006, beginning with the development of a special TB screening questionnaire which significantly reduced the paperwork associated with previous tools and was later adapted by the Ministry of Health and Social Work to screen all HIV patients. Through this tool, TB screening in care and treatment clinics has steadily increased, reaching more than 90% of HIV patients by 2010. AIDSRelief also trained community health workers to screen patients at their homes, a practice that increased the number of successful TB diagnoses by 10%.

The AIDSRelief team worked to improve collaborative TB/HIV activities. Specifically, AIDSRelief spearheaded the integration of services between ART clinics, TB clinics, and inpatient wards by offering voluntary HIV counseling and testing at TB clinics, sputum collection at HIV clinics, and advocated for cotrimoxazole administration at TB clinics. At 36 facilities, AIDSRelief integrated TB treatment services into the HIV care and treatment package and also targeted TB screening to HIV-positive pregnant women.

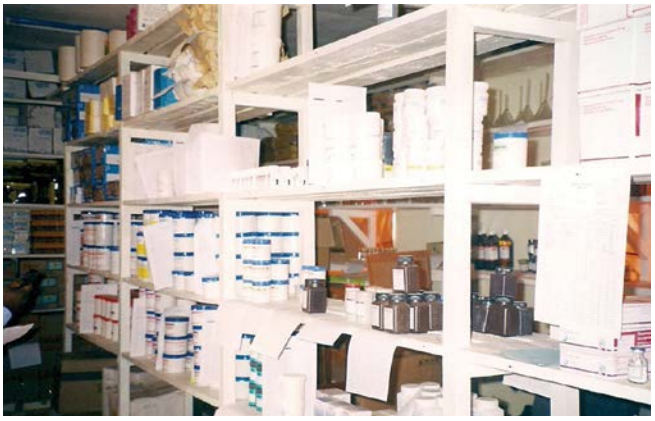
PHOTO: DAVID SNYDER FOR CRS

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. 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.

Throughout the eight years of the program, AIDSRelief Tanzania trained nearly 6,000 clinicians, nurses, pharmacy and laboratory staff, community volunteers, and other key health care workers. The centralized trainings were complemented with onsite mentorship and supportive supervision. Comprehensive AIDSRelief clinical teams—including clinicians, nurses, laboratory technologists, and other program support specialists—visited care and treatment centers to provide one-on-one mentorship to facility staff. Regional teams also encouraged providers to contact them directly if issues or questions arose. Mentorship has contributed to strong levels of accountability and a sense of ownership of program activities.

Pharmacy and Supply Chain

All efforts to provide HIV care and treatment would be rendered moot if medicines were not available, yet stock-outs of ARVs and other essential commodities were frequent when AIDSRelief first entered the scene. The practice of each individual site procuring drugs for its own facility led to variations in drug prices from site to site, making budgeting difficult. Medicines were shipped to facilities based on unrealistic forecasts and budgets that were not derived from data on usage trends, resulting in frequent stock-outs of essential commodities. Moreover, AIDSRelief found that many care and treatment centers were not storing or cycling through the drugs according to accepted standards, resulting in frequent drug expirations.



Initially, AIDSRelief supported physical renovation of pharmacy storage areas and equipped many with essential storage and dispensing equipment and tools such as refrigerators, wooden pallets, air conditioners, dispensing trays and storage shelves. Technical assistance focused on forecasting and ordering, documentation, reporting, pharmacy practice, and inventory management. Over time, it became clear that greater effort would be necessary in order to ensure a continuous, cost-effective, and quality supply of drugs and other commodities. AIDSRelief began procuring items to ensure there would be no interruption of services, complementing the national pipeline by supplying more than 60 different drugs for management of opportunistic infections.

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PHOTOS: CRS STAFF

Laboratory

One of the important aspects of AIDSRelief's work was leveraging the power of networks to expand laboratory services while simultaneously containing costs. Because it would not be economically feasible to introduce all tests at all sites, AIDSRelief worked with the Ministry of Health and Social Work to foster a laboratory networking system whereby higher-level health facilities, such as zonal and regional hospitals, would be equipped with all tests. Lower-level facilities, such as health centers and dispensaries, were linked to higher-level facilities, enabling them to transport samples for prompt, high-quality laboratory testing.

To this end, AIDSRelief procured and installed 18 biochemistry machines, 16 hematology machines, 16 CD4 machines and 3 bio-safety cabinets to support laboratory services at selected health facilities. In addition, the program complemented the national pipeline by procuring and distributing CD4, hematology and biochemistry reagents, HIV test kits, and essential supplies. AIDSRelief also renovated laboratories at selected facilities in order to improve the working environment.

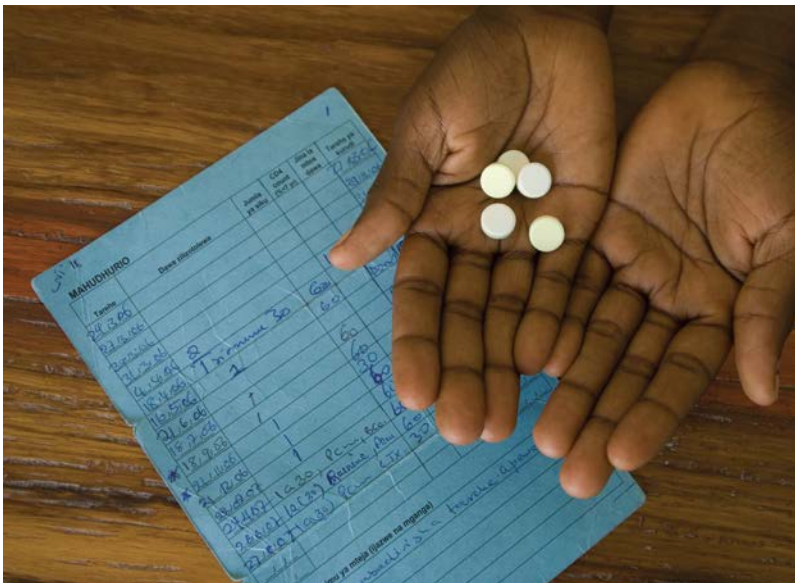
In another effort to promote cost-effectiveness and sustainability, a step-down approach was adopted for training on laboratory quality systems management, equipment maintenance, and introduction of new tests and technologies: AIDSRelief trained a single laboratory staff member who would in turn train colleagues at the facility with follow up by AIDSRelief to ensure uptake of the peer training. Likewise, AIDSRelief formed laboratory network email groups in Mwanza and Arusha that allowed constant information sharing with regional laboratory technologists and created an avenue for connecting needs and filling gaps.

PHOTO: KAREN KASMAUSKI FOR CRS

A CULTURE OF DATA USE

In Tanzania, health facilities were collecting data in accordance with government guidelines, but lacked the will, capacity, and equipment to use this data to drive decision-making. Many health personnel didn't even realize that data was being collected. AIDSRelief also encountered an initial reluctance to change data habits, because there was a sense that these facilities were doing fine and didn't need evaluation, or there was a fear that collecting data would be a time-consuming burden. Indeed, across the facilities, continuous quality improvement received the lowest marks of all assessed areas, indicating a significant opportunity for impact.

Because the majority of staff lacked basic computer skills, AIDSRelief provided training on how to use a computer prior to introducing electronic records. Other training taught staff how to use the national database (known as CTC2) and increased their understanding of monitoring, evaluation and how to retrieve and use data for program management. Through these sessions and continuous technical assistance, the information culture improved over time as sites gradually embraced strategic information for planning and clinical management.



Furthermore, prior to AIDSRelief, the Ministry of Health and Social Work did not include monitoring and evaluation personnel in national guidelines. AIDSRelief introduced these personnel and integrated them into facility operations, a practice that has been so successful that the Ministry has not only recognized the importance of such staff, but also taken steps to absorb them into the national health system.

IQTools

In Tanzania, AIDSRelief has created and deployed a patient management and monitoring query system called IQTools. This system works in coordination with Tanzania's CTC2 database to provide a comprehensive health management information system where users can enter, manage, and analyze HIV patients' clinical and demographic data. IQTools facilitates data validation and automated reporting both at the facility and central levels, as well as across multiple databases, thereby improving data quality. Through extensive training and technical assistance provided by Futures Group, IQTools was implemented at 66 facilities, allowing data clerks to enter and analyze HIV patients' data. At these locations, a total of 80 data workers have been hired and trained in monitoring and evaluation.

PHOTO: DAVID SNYDER FOR CRS

LOOKING AHEAD

AIDSRelief was designed with transition to local partners in mind and all program planning supported that goal. A shared vision—among the donor, local partners, and within the AIDSRelief consortium—was challenging to develop but also essential to successful transition. In Tanzania, the consortium was committed to strengthening the local partners' capacity to maintain high quality treatment outcomes.

AIDSRelief's transition model was unique in Tanzania; all other PEPFAR-funded programs opted to form new local organizations under their management, whereas AIDSRelief chose to work with an established local partner, the Christian Social Services Commission (CSSC), which had longstanding ties with the faith-based health facilities. While in some ways, this required extensive work on AIDSRelief's end to assess and strengthen capacity, the reward has been an uninterrupted flow of quality services for the patients.

A deep commitment to partnership underscored AIDSRelief's relationships and capacity strengthening activities, which formed the foundation of a systematic, planned, and transparent transition process. AIDSRelief worked closely with CSSC and the health facilities to better enable them to assume financial and project oversight responsibility for a large and complex program. Capacity strengthening activities included formal training; joint site visits to districts, communities, and health facilities; study tours and visits; seconding staff; and workshops and conferences.

Activities culminated in late 2011 when the US government issued simultaneous follow on awards for the five-year LEAD project, through which AIDSRelief consortium members will transfer management of the care and treatment program to CSSC in an incremental process commensurate with CSSC's gradually strengthened capacity. This gradual transition has allowed AIDSRelief and CSSC to identify potential challenges and areas for improvement. In addition, AIDSRelief supported two RHMTs—Tanga and Mwanza— in winning a US-funded grant focused on building their leadership, organizational, and financial management capacity.

PHOTOS: DAVID SNYDER FOR CRS

AIDSRelief Supported Health Facilities 2004-2012

Amani Bulwa Health Centre
Babati District Hospital
Bombo Regional Hospital
Bugando Medical Centre
Bukima Health Centre
Bukumbi Mission Hospital
Bumbuli Mission Hospital
Bunda Designated District Hospital
Bungu Health Centre
Bweri Health Centre
Butiama Hospital
Buzuruga Health Centre
Bwisya Health Centre
Coptic Medical Center
Dareda Mission Hospital
Dongo Dispensary
Emboreti Hospital
Endasak Dispensary
Engusero Dispensary
Geita District Hospital
Hale Health Centre
Handeni District Hospital
Haydom Lutheran Hospital
Hindu Union Hospital
Ikizu Health Centre
Kabuku Health Centre
Katoro Health Centre
Katunguru Health Centre
Kharumwa Health Centre
Kiagata Health Centre
Kibara Mission Hospital
Kijungu Dispensary
Kilindi District Hospital
Kilombero Health Centre
Kinesi Health Centre
Kisesa Health Centre
Kisorya Health Centre
Kiteto District Hospital
Korogwe District Hospital
Kowak Health Centre
Kwangwa Dispensary
Kwediboma Health Centre
Lushoto District Hospital
Magoma Health Center
Magu District Hospital
Magugu Health Centre
Makongoro Health Center
Makorora Health Center
Manyamanya Heath Centre
Maramba Health Centre
Matui Dispensary
Mbulu District Hospital
Mererani Health Centre
Misasi Health Centre
Misungwi District Hospital
Mkata Health Centre
Mkinga Health Centre
Mkula Hospital
Mkuzi Health Centre
Mombo Health Centre
Msitu wa tembo Dispensary
Muheza Designated District Hospital
Murangi Health Centre
Musoma Regional Hospital
Mvumi Hospital
Mwananchi Hospital
Mwangika Health Centre
Mwera Health Centre
Naberera Health Centre
Nasa Health Centre
Ngamiani Health Centre
Ngorika Dispensary
Ngudu District Hospital
Nyakahoja Dispensary
Nyakaliro Health Centre
Nyamagana District Hospital
Nyamongo Health Centre
Nyasho Health Centre
Nyerere Designated District Hospital
Nyumba ya Mungu Dispensary
Nzera Health Centre
Orkesument KKT Hospital
Orkesument Urbun Hospital
Pangani District Hospital
PASADA
Pongwe Health Centre
RAO Hospital
Safi Medics Health Centre
Sekou-Toure regional Hospital
Selian Lutheran Hospital
Sengerema Designated District Hospital
Shirati Mission Hospital
Sirari Health Centre
St. Elizabeth Hospital
St. Raphael Health Centre
Sumve Mission Hospital
Tanga Central Health Centre
Tarime District Hospital
Tumaini Hanang District Hospital
Tumaini Health Centre
Tunguli Health Centre
Ukerewe District Hospital

ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Tanzania received from our donor, our local partners, staff and management at local health facilities, and the Tanzanian 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 Tanzania 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 Tanzania Ministry of Health and Social Work and with our local partner, the Christian Social Service Commission. We are additionally grateful for our close collaboration with Weill Bugando University College of Health Sciences. Each and all were essential to AIDSRelief's success and are helping make sustained country ownership possible in Tanzania.

We also wish to acknowledge the health workers and managers in treatment sites and communities across Tanzania. 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 and CSSC, as well as staff at individual health facilities who agreed to be interviewed and share their experiences for this report. Lastly, thank you to the author of this document, Paul 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