



The AIDSRelief Zambia Partnership: Transitioning to the Churches Health Association of Zambia

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Cover photo: AIDS Relief volunteer Astrida Kambadika talks with patients during a monthly check up at the AIDSRelief-supported Chamboli Clinic in Kitwe, Zambia. Photo by Jake Lyell for CRS.

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List of Acronyms

| | |
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| ART | Antiretroviral therapy |
| CAF | Children's AIDS Fund |
| CDC | U.S. Centers for Disease Control and Prevention |
| CHAZ | Churches Health Association of Zambia |
| CIDRZ | Centre for Infectious Disease Research in Zambia |
| CRS | Catholic Relief Services |
| CORAT | The Christian Organizations Research and Advisory Trust for Africa |
| DH | District hospital |
| FBO | Faith-based organization |
| FOA | Funding opportunity announcement |
| GNC | General Nursing Council (Zambia) |
| GRZ | Government of the Republic of Zambia |
| HRSA | Health Resources and Services Administration (U.S.) |
| HSS | Health systems strengthening |
| IHV | University of Maryland School of Medicine Institute of Human Virology |
| IT | Information technology |
| LPTF | Local partner treatment facility |
| LTFU | Lost to follow-up |
| MOH | Ministry of Health |
| NGO | Nongovernmental organization |
| OGAC | Office of the Global AIDS Coordinator (U.S.) |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PMTCT | Prevention of mother-to-child transmission |
| SCA | Site Capacity Assessment (tool) |
| SI | Strategic information |
| TA | Technical assistance |
| TWG | Technical Working Group |
| UNZA | University of Zambia |
| USG | United States Government |
| UTH | University Teaching Hospital (Zambia) |

Introduction

In 2004, the United States President's Emergency Plan for AIDS Relief (PEPFAR) funded AIDSRelief, a global project implemented by a five member consortium, to rapidly scale up HIV care and treatment for the poor and underserved through nine country programs (adding a tenth, Ethiopia, in 2009), including Zambia. AIDSRelief is a Track 1.0 grant – a centrally-funded, centrally-managed program supporting rapid scale-up of prevention, care and treatment programs in focus countries. Each AIDSRelief country program was built upon the AIDSRelief model of care, adapted to each country's unique context and needs. Sustainability was a key component of the original project design, which incorporated a vision for eventual local ownership of the care and treatment programs.

The AIDSRelief Zambia consortium, comprised of Catholic Relief Services (CRS), Futures Group, the University of Maryland School of Medicine Institute of Human Virology (IHV), and Children's AIDS Fund (CAF), provided technical assistance and capacity strengthening to 19 local partner treatment facilities (LPTFs) linking 111 satellite health facilities across all 72 districts in Zambia to ensure high-quality clinical HIV services. Churches Health Association of Zambia (CHAZ), Chreso Ministries, the Zambian government, or private mining companies manage the sites that were supported by AIDSRelief.

As of September 2011, AIDSRelief-supported sites in Zambia had provided antiretroviral therapy (ART) to 60,041 adults and children, care and support (including management of sexually transmitted infections and tuberculosis, and links to psychosocial services) to 96,247 clients, and HIV testing to 226,605 people.

The Partnership and Capacity Strengthening unit at CRS developed this learning document with representatives from AIDSRelief Zambia, CHAZ, and selected health facilities to highlight project lessons and successes—particularly in the

areas of capacity strengthening, partnership, and transition—and to make relevant information available to others seeking adaptable or replicable strategies. This document focuses on how AIDSRelief and one partner, CHAZ, developed a powerful partnership and worked through a well-established transition framework to enhance CHAZ's capacity to support treatment sites without additional support.

PEPFAR: From Emergency Response to Sustainable Development

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2004 as a \$15-billion response to the global AIDS epidemic implemented through the Office of the Global AIDS Coordinator (OGAC). PEPFAR provided funding and technical expertise through agencies such as CRS to make antiretroviral therapy available throughout the world, with emphasis on 15 focus countries including Zambia. With the U.S. Congress's reauthorization of PEPFAR in 2008, programming shifted from externally led emergency relief to strengthening health systems and building a sustainable response wholly owned by each host country.

AIDSRelief transition timeline

This timeline notes key events in the transition from AIDSRelief to CHAZ over the course of an eight-year period.

2004: AIDSRelief Global Project awarded to CRS-led consortium by the Health Resources and Services Administration (HRSA)

2004: AIDSRelief Zambia country program launched

2004: CHAZ becomes Global Fund Principal Recipient, rolls out ART at sites not supported under AIDSRelief by the Health Resources and Services Administration (HRSA)

2006: AIDSRelief Zambia Sustainability Plan results framework developed (basis for the AIDSRelief Zambia Transition Work Plan)

2007: Noncompetitive follow-on project award issued to AIDSRelief

2008: U.S. Congress reauthorizes PEPFAR

2008: The AIDSRelief Zambia Transition Plan (including work plan) developed to guide transition activities from March 2009 through February 2012.

2009: CORAT assessment and report

2010: HRSA Clinical Assessment for Systems Strengthening (CIASS) assessment and report

2010: Supply chain management responsibilities and funding transferred from AIDSRelief to CHAZ

2010: Five LPTFs transition from AIDSRelief to CHAZ

2011: Follow-on awards issued to AIDSRelief, CHAZ, and Chreso to maintain services and complete transition from international to local partner

2012: AIDSRelief closeout

The HIV Epidemic in Zambia

Prior to PEPFAR's launch and the national scale-up of ART in 2004, Zambia's HIV burden was among the highest in sub-Saharan Africa. Adult prevalence was 15.6 percent, and more than 66,000 adults died of AIDS-related causes in 2003 alone. AIDS was rapidly decimating Zambia's adult population, while treatment was either unavailable or prohibitively expensive. With the help of bilateral and multilateral partners, Zambia has achieved unprecedented growth in HIV care, support, and treatment services in public and private settings—by 2009, 79 percent of Zambians who needed treatment received it. AIDS-related mortality among children under 14 years was halved between 2003 and 2009 (from 14,681 to 7,282) due to prevention of mother-to-child transmission (PMTCT) of HIV, pediatric ART, and lower fertility.

The Health System in Zambia

Zambia's health system struggled with limited resources before the HIV epidemic overwhelmed existing health care workers and facilities. As in many African countries, the faith-based health network serves an essential role in meeting the health needs of the public and works closely with the Ministry of Health (MOH) to reach underserved populations, particularly those in rural areas.

Formed in 1970 by church mother bodies as an interdenominational, indigenous faith-based organization (FBO), CHAZ's 146 member sites provide approximately 50 percent of the formal health services in rural areas and 30 percent countrywide. CHAZ has a memorandum of understanding with the Zambian government that ensures support for human resources, essential drugs, and about 75 percent of running costs for mission hospitals. Most facilities that were supported by AIDSRelief in Zambia are faith-based and belong to the CHAZ network.

AIDSRelief: Country Programs for a Global Response

The AIDSRelief model of care has three pillars (see Figure 1) and relies on health systems strengthening to provide comprehensive and high-quality HIV care and treatment. The model posits that a strong system depends on the strength of each facility, its network, and its links with the public health sector and the community.

Figure 1: The AIDSRelief Model of Care

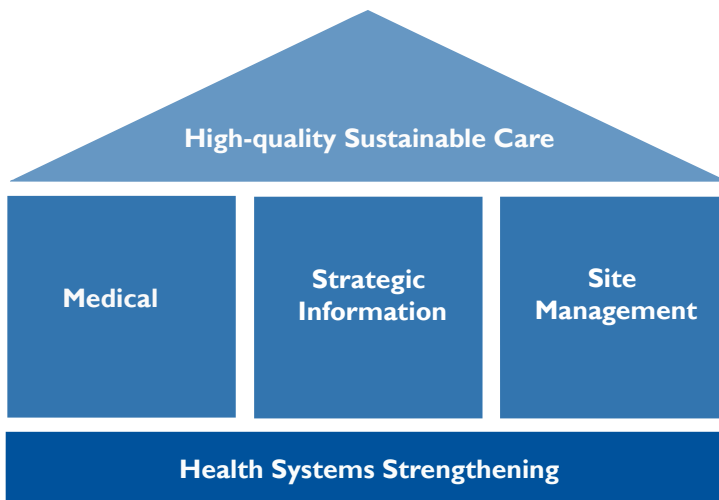


Figure 1. Health systems strengthening is the foundation that supports the three pillars of the AIDSRelief model: medical, strategic information, and site management.

The three pillars include the following:

- **Medical.** Long-term efficacy and sustainability of HIV treatment, care, and support depend on using evidence-based strategies to guide scale-up of services and continual improvement of patient care. HIV treatment delivery must be medically driven. As HIV programs continue shifting from an emergency response to long-term care, it is imperative to assess treatment outcomes and provide technical support so that program scale-up does not come at the expense of service quality.

- **Strategic information.** To evaluate the successes or struggles of patients, facilities, and the program, comprehensive and timely access to clean, complete, and accurate data is a top priority. This focus on strategic information (SI) provides decision-makers at the country management and clinic level with quality data to make informed decisions.
- **Site management.** HIV care and treatment programs are most effective as part of well-managed facilities. The development of strong, facility-level administrative and management practices—including human resources, finance, work plan and timeline development, and stakeholder coordination—helps ensure that each site’s efficient day-to-day operations further support excellent service delivery and patient outcomes.

Because such a systems-strengthening approach is a fundamental shift for many health institutions in resource-poor settings, AIDSRelief provided direct assistance to partners in the development of financial, material, technical, and human resources. AIDSRelief staff accompanied partner staff and management through a continuous process of capacity strengthening and program quality improvement.

A Sustainable Response to HIV: CHAZ and AIDSRelief

With the shared mission of bringing HIV services to Zambia’s most disadvantaged people, CHAZ and AIDSRelief were natural partners and each brought complementary assets to the partnership. AIDSRelief’s staff offered cutting-edge technical expertise, particularly with regard to HIV treatment, strategic information, site management, and U.S. government (USG) funding compliance. CHAZ offered a countrywide network of facilities, creative and culturally appropriate responses to HIV, a deep knowledge of Zambian communities, strong supply chain management skills and systems, and a decades-long relationship with the Zambian government.

AIDSRelief Zambia began by rolling out ART at health facilities recommended to the consortium by CHAZ during the project's design. During the same timeframe, CHAZ became a Global Fund Principal Recipient in Zambia, receiving grants to establish HIV treatment programs at CHAZ facilities not supported by AIDSRelief. CHAZ and AIDSRelief programs each focused on building and sustaining care and treatment services, particularly at the facility level. In general, CHAZ and AIDSRelief worked independently, though CHAZ provided supply chain services to AIDSRelief-supported sites through a memorandum of understanding, and the two programs shared PMTCT training curricula.

In 2008, the U.S. government (USG) mandated that all Track 1.0 programs transition their programs to local ownership by February 29, 2012, shifting the focus of the programs from scale-up to transition and long-term sustainability (see box). Transition was consistent with the new emphasis in the 2008 reauthorization of PEPFAR, was rooted in AIDSRelief's existing sustainability plan, and made clear the program's two-pronged scope of work to 1) strengthen health facilities for sustainability, and 2) strengthen and reinforce CHAZ's capacity to oversee and maintain service quality at treatment sites.

Under the new mandate, AIDSRelief continued to provide quality care through program-supported health facilities, strengthening clinical and strategic information skills among facility staff, while also considering their organizational capacity (e.g., management of human and material resources, governance, planning and budgeting for implementation). Furthermore, AIDSRelief and CHAZ came together to determine how best to ensure CHAZ's success in absorbing responsibility for AIDSRelief sites and maintaining quality of care. The resulting transition framework became the basis of the program's transition plan.

By the end of 2011, AIDSRelief Zambia had leveraged effective partnerships and needs-based capacity strengthening to transfer clinical, grants management, strategic information, and supply

chain staff to CHAZ and facilitate the transition of site management for five health facilities. In addition, a project oversight structure was designed for Chreso Ministries, a CHAZ member organization which owns three health facilities in Zambia. Working closely under complementary grants issued by USG in September 2011, CHAZ, Chreso, CRS, IHV, Futures Group, and CAF will reinforce and expand capacity among health facilities and local partner staff in grants management, strategic information, and medical-clinical areas, gradually transitioning remaining responsibilities and site management to local partners CHAZ and Chreso.

“[That AIDSRelief was] 100 percent committed to transition was very motivating. We saw in our partner total commitment.”
— Karen Sichinga,
CHAZ Executive Director

In support of country ownership of development programs across the world, PEPFAR mandated that all Track 1.0 grants eventually transition program efforts to a local partner. Early in the project, each AIDSRelief country program identified local partners for future transition. These partners were existing organizations with a track record demonstrating their viability and potential to sustain the program. In addition, they were either the owners of supported health facilities, or organizations that represented facility owners and were committed to providing facilities with long-term support. Both CHAZ and Chreso met these fundamental criteria and have a long history caring for underserved Zambians and working closely with the MOH.

Partnership and Capacity Strengthening for Transition

All AIDSRelief country programs were designed to transition management of the program to a local partner or partners; this approach is rooted in CRS's recognition that people and organizations in their own context are best suited to identify and address their own development needs. CRS has spent more than 60 years developing sound programs with an array of local partnerships marked by mutual respect and equity. This experience has revealed that all organizations can improve their ability to function as institutions, and healthy local institutions help ensure that positive changes outlast project funding, staffing, and material or technical support. Partnership, capacity strengthening, sustainability, and transition are critical to a successful transition of expertise or responsibility. They are also often complex, mutually reinforcing, concurrent and overlapping processes.

CRS regards **capacity strengthening** as essential to any organization's health. It includes **capacity building**, which focuses on individuals or teams, enhancing or developing new knowledge, skills, and attitudes in order for people or teams to function better; **institutional strengthening**, focusing on an organization, enhancing or developing its systems and structures to function more effectively, work towards sustainability, and achieve goals; and **accompaniment**, consistent coaching and mentoring that allows new skills to be mastered or new organizational systems to become standard operating procedures.

These tenets inspired AIDSRelief's program design and commitment to change: a transition from externally driven, vertical, HIV treatment activities to locally owned, high-quality, integrated ART services delivered within a strengthened health system.

Shared Vision and Leadership

Without a shared understanding of success, no partnership—however simple or complex—can achieve its goals. Everyone must know where they’re going in order to get there. In order to muster internal support and commitment, stakeholders must agree what success “looks like” and how that success benefits them or their goals. Strong leaders can help persuade and align stakeholders, rallying them around a common purpose or motivating them to stay committed during trying times. AIDSRelief faced challenges in developing and maintaining that shared vision and commitment both externally with CHAZ and internally among consortium members.

“The primary goal of AIDSRelief is to offer access to quality medical care for all patients through the supported LPTFs. Core to this program objective is sustainability. For the patients, sustainable programs mean access to high quality uninterrupted care beyond the project duration; for the local partners it means management and technical capacity to ensure that the level of health care is maintained. AIDSRelief’s approach to transition and sustainability is driven by the concept of universal right to access to treatment and quality medical care.” — Excerpt from AIDSRelief Transition Plan

Defining “Local Partner” and “Transition”

Each AIDSRelief country program was designed with the intent to transition to a local partner, but the early project years were necessarily focused on initiating patients on treatment. As treatment systems were put into place, transition moved to the forefront and different understandings of transition and a local partner’s role in that transition emerged among donor representatives, local partners, and within the consortium.

Bringing these different perspectives into a unified vision—and beginning to make that vision a reality—was an enormous challenge.



Laboratory Technician Panji Nkhoma analyzes samples for signs of tuberculosis at St. Theresa Mission Hospital in Ibenga, Zambia. Photo by Jake Lyell for CRS.

From project inception in 2004, CHAZ and AIDSRelief officials had a relationship and saw a long-term role for CHAZ in sustaining AIDSRelief’s impact in Zambia. CHAZ was written into the AIDSRelief sustainability plan, but the “how” was not clear. Was transition a singular event—a ceremonial hand-off of trained staff and records—or a process of learning, staffing, and capacity strengthening? How would individual sites, functions, or the local partner be deemed “ready” to transition? Could transition of responsibilities be meaningful while AIDSRelief consortium partners remained accountable to the donor for technical targets and financial management?

Furthermore, some consortium members envisioned that AIDSRelief’s legacy would be a new local partner providing technical support for clinical functions—a nongovernmental organization (NGO) registered in Zambia with local and expatriate staff, similar to the Centre for Infectious Disease Research in Zambia (CIDRZ) founded by the University of Alabama. These different visions fed existing and created new tensions that strained both internal consortium relationships and the AIDSRelief-CHAZ relationship. (In 2010, CHAZ met the OGAC criteria for a local partner and in 2011 was approved as a primary recipient of a USG grant.)

To create a clear vision of transition and a local partner’s role in that transition—and to unite stakeholders around that vision—

AIDSRelief facilitated an intensive, consensus-building phase for stakeholders. At the core was the Leadership Forum, a quarterly meeting of senior managers and technical leads from AIDSRelief, CHAZ, and Chreso Ministries, which began meeting at the onset of the transition planning process. Responsibility for chairing each meeting rotated among the three organizations, and technical subcommittees convened monthly around four technical areas or functions: clinical, strategic information, grants management and compliance, and supply chain management. Issues raised in technical subcommittee meetings were the basis for each Leadership Forum meeting's agenda.

These regular meetings encouraged open discussion; allowed the technical subcommittees to improve ongoing work and plan for transition; and remain as a forum for addressing organizational, transitional, and technical challenges. The frequent communication and collaboration also helped to ease anxiety and keep everyone focused on the partnership and its goals, with tangible results. It was through these technical subcommittees that partners developed AIDSRelief's detailed transition plan.

“Will There Be a Job for Me?”

While most would agree that program ownership by local partners is desirable, at its simplest, transition also meant that AIDSRelief staff were working themselves out of a job. As the vision for transition became clear and implementation began, some local and international consortium staff were uncertain about their employment options. Some started job-hunting outside of the AIDSRelief network, others tried to position themselves for future positions with CHAZ. Sensing this possible influx of new staff, some CHAZ employees worried that outside candidates would be perceived as more desirable and would replace long-time CHAZ staff. Reinforcing this perception was the reality that AIDSRelief, CHAZ, and the donor were rightly concerned about retaining the tremendous human

resource capacity that was developed and reinforced through the project. The specialized skills were and remain critical to maintaining program quality and patient outcomes.



Volunteers like Pauline Mwamba and Jane Nanyangwe make sure that patients adhere to their ARV regimen and make house calls for those who miss their check-ups appointments.

Photo by Jake Lyell for CRS.

Individual managers from each organization took

the initiative to reassure their staff and communicated frequently with them, sharing information about the transition process as it became available. Eight AIDSRelief staff voluntarily resigned from AIDSRelief and became permanent CHAZ employees in 2010 as part of the transition plan. Funding for their salaries was transferred from AIDSRelief to CHAZ and no CHAZ employees were released as a result of the staffing changes. Most former AIDSRelief staff who joined CHAZ performed functions that previously did not exist at CHAZ and had been handled by AIDSRelief. Others had skills and expertise that were either new to CHAZ or complemented internal talent. The new staff found a balance between assimilating into and serving CHAZ, and brought new energy and expertise to the existing teams at CHAZ. As the transition began and staff joined CHAZ, concerns began to abate in spite of challenges that arose around availability of office space and computer equipment. Several staff commented that they could see, in retrospect, that their managers acted transparently, although at the time they were unsure.

Relationships, Buy-in, and Communication

An organization will not be successful if it forces its staff into supporting a mission or task they do not believe in. Similarly, one

partner cannot force another to participate and expect the collaboration to be successful. Healthy relationships—marked by open communication, defined rights and responsibilities, fairness, and mutual respect—facilitate buy-in from partners and often can

improve plans by engaging those most affected. AIDSRelief’s model for right relationships is drawn from CRS’ dedication to a culture of equity, respect, and subsidiarity. AIDSRelief, CHAZ, and LPTF staff worked together on program design, implementation, evaluation, and reporting, ensuring that successes were locally owned. This mutuality helped joint teams to:

- Quickly identify populations in need and address their most urgent problems;
- Leverage and complement existing networks, relationships, and supply chains, and avoid redundancies;
- Lay a firm foundation to sustain and expand the program’s impact.

“There were good times and bad times, but there was always a relationship.”
— John Donahue,
Deputy Global Chief of Party
for Transition

Hands-on Technical Support

In the first years of AIDSRelief, technical assistance to health facilities was intense. AIDSRelief strengthened staff and institutional capacity in grants management, strategic information, and clinical services by jointly identifying needs and providing direct, hands-on support to facility staff. Staff worked side-by-side for weeks at a time, and AIDSRelief technical teams were available around the clock. This model was highly successful and appropriate for rolling out high-quality ART services in under-resourced facilities largely lacking experience with treatment, and it remains relevant, to

varying degrees, in facilities facing high staff turnover, a common problem in health facilities throughout sub-Saharan Africa.

As the program's focus expanded to emphasize transition, AIDSRelief staff and CHAZ staff newly responsible for

facility oversight jointly conducted supervision, mentoring, and technical assistance visits at facilities. This accompaniment approach concurrently reinforced technical skills among facility staff and training and oversight skills among CHAZ staff that now mentor and supervise facility staff in transitioned sites.

This model of technical support is highly effective, but resource intensive. However, staff and facilities that have developed the capacity to provide high-quality care and site management can usually maintain this capacity with less-intensive, targeted technical assistance. As facilities reached certain levels of achievement (see page 34 for institutionalized tools and approaches for assessing capacity and identifying needs), AIDSRelief reduced technical support from weeks-long visits each quarter, to less-frequent technical assistance focused on specific needs identified by the sites. Similarly, as CHAZ technical teams demonstrated technical and supervisory capacity, they began to lead (with minimal support from AIDSRelief) provision of technical assistance to facilities identified for transition to CHAZ. CHAZ technical teams continued to provide technical assistance to their Global Fund-supported sites as well. Members of these teams included some staff that had transitioned from AIDSRelief in 2010.



Laboratory technicians Panji Nkhoma (r) and Mabin Phiri (l) test blood samples at St. Theresa Mission Hospital in Ibenga, Copperbelt Province, Zambia, where nearly 3,000 patients are enrolled in the AIDSRelief-supported ART program. Photo by Jake Lyell for CRS.

Clinical Outcomes as a Measure of Success

Based on a patient line listing in 2011, an analysis of summaries for 43,547 patients in Zambia who had started ART a mean of 12 months prior to review in each quarter revealed that AIDSRelief Zambia was able to attain dramatic treatment success even in very remote areas and despite limited access to laboratory monitoring tools.

- Of AIDSRelief patients surveyed, 92 percent had undetectable viral loads. Patients with low viral loads are healthier, suffering fewer opportunistic infections and reduced mortality; they are also less infectious and thus present a reduced risk of onward transmission, embodying “treatment as prevention” efforts in Zambia.
- Only 6.2 percent of AIDSRelief patients were lost to follow-up as of July 2011, rivaling rates in industrialized countries with robust health systems. This set an excellent retention rate of 82 percent, suggesting patient satisfaction and demonstrating excellent adherence and treatment management.

Changing the nature and pace of these close relationships among technical staff was challenging, as behavior change can be. In spite of reassurances to the CHAZ technical staff that they were capable and that less-intensive technical support reflected well on site capacity, some facility staff felt abandoned by the AIDSRelief staff they had learned to rely upon. Over time, facilities increasingly began to look to each other for answers, and transitioned facilities grew to trust CHAZ and view the organization’s technical staff as an important resource for information and assistance.

Through this experience, AIDSRelief learned to encourage confidence among facility staff, to communicate that changes

in the level of support were appropriate, and to emphasize that CHAZ has expanded and continues to expand its capacity to provide technical assistance.

Facing Uncertainty and Worry

In working toward transition of program responsibilities from AIDSRelief to CHAZ, the organizations were breaking new ground. The challenges inherent in



Sister Doreen Maluva is a pharmacist at St. Theresa Mission Hospital in Ibenga, Copperbelt Province, Zambia, where she distributes ARVs to patients and consults with them on proper adherence to the medication. Photo by Jake Lyell for CRS.

development work (i.e., development funding is usually issued in contracts or grants with specific scopes of work and finite timetables) created additional uncertainty. Based on the donor's focus on host-country ownership and the understanding that CHAZ and facility staff would need ongoing, limited external technical assistance (for clinical updates, etc.), both CHAZ and AIDSRelief expected the USG to issue a new grant designed to directly fund a local partner. In anticipation of such a grant, consortium partners and CHAZ discussed the possibility of CHAZ submitting a bid with AIDSRelief consortium members as sub-grantees. With this in mind, CRS facilitated in-depth capacity building on USG proposal development and a strategic visioning workshop in late 2010 (see box on following page).

“[AIDSRelief consortium members] were magnificent during the proposal process.” — Senior CHAZ official

USG proposal development is relatively specialized and the application process is unfamiliar to many local entities that usually fund their work through government allocations or charitable donations. CRS sponsored a privately funded workshop on USG proposal development for AIDSRelief country teams. The workshop was held in Zambia in October 2010, and regional partners including CHAZ and Chreso attended. Attendees widely praised the workshop and CHAZ created from workshop materials a proposal development manual for CHAZ staff who couldn't attend.

In anticipation of a new, CHAZ-led project to follow AIDSRelief, CRS and CHAZ jointly led a daylong strategic visioning workshop in December 2010, establishing a project design relationship that put CHAZ “in the driver's seat” while also ensuring they had adequate support. The funding opportunity announcements (FOAs) that USG released in February 2011 took a different approach than expected, but the workshops proved to have been valuable as CHAZ and Chreso both submitted their own winning proposals (with proposal development support, respectively, from CRS and CAF). In addition to cultivating critical skills (namely an ability to secure funding), the proposal development and visioning workshops were another sign of CRS's commitment to its local partners, and helped all parties weather the uncertainty surrounding the FOAs and their eventual award.

When USG released a single grant for an international organization in February 2011, CHAZ members were deeply

disappointed and taken aback. A complementary grant was issued a few weeks later for a local organization or organizations that would incrementally take on responsibility for supporting more sites and increasing levels of funding; this was reassuring, but still a shock for CHAZ as well as for AIDSRelief consortium members. These grants are the AIDSRelief-Transition projects being implemented in concert by the previously existing AIDSRelief consortium, CHAZ, and Chreso. While the donor unequivocally stated that care and treatment services would continue without disruption for the tens of thousands of Zambians served by AIDSRelief, the months between grant submission and award were still nerve wracking for many people who were unsure of the future for AIDSRelief-supported facilities, their patients, and their future employment. Although there was often little news to share, AIDSRelief, CHAZ, and facilities communicated frequently and regularly throughout this period to reassure all partners that everyone was fully transparent and, essentially, in the same situation.

The grant awards were met with great relief and teams are working toward a seamless start-up in December 2011. At the time of writing, CHAZ was in the process of formally announcing receipt of the award to its constituents and partners; CHAZ, Chreso, and AIDSRelief consortium members have met (with CDC Zambia at the first meeting) to map out areas of focus in order to avoid gaps and duplication of effort among the three awards; sites are continuing to deliver services; and funds are due to flow directly to these sites.

Planning, Evaluation, Realignment, and Resource Allocation

The process of planning—*how* to reach the shared vision—is iterative and challenging in even the best of circumstances. The context or environment of a project may change based on factors

including donor or host-government priorities, staffing changes, or newly identified needs; plans must be evaluated against these factors and a project's own targets, and revised accordingly. Accurate and nimble planning helps ensure appropriate allocation of human and material resources, manage expectations, and keep a project or organization on track to meet its goals.

Developing the Plan

In a truly ground-up effort, each technical subcommittee of the previously mentioned Leadership Forum developed a transition plan specific to its technical area; these plans were then rolled up into a single plan and harmonized into a



Febby Siamulina sits with some of her children at her house in Ibenga, Zambia. A widow, Mrs. Siamulina lives a healthy life and supports 15 children thanks to the care and treatment she receives at St. Theresa Mission Hospital. Photo by Jake Lyell for CRS.

system-wide approach. The aggregated plan also set out a gradual transition of discrete responsibilities and individual facilities, easing the shock of transition and allowing AIDSRelief and CHAZ teams to assess in detail the effectiveness and impact of each facet of the transition. These subgroups were vital to developing clear requirements for the transfer of site management from AIDSRelief to CHAZ, and to paving the way for the transition of key staff from AIDSRelief to become permanent CHAZ employees.

Health facilities did not participate in road-mapping transition from the outset. In hindsight, most Leadership Forum or subcommittee participants agreed that earlier engagement would have helped engage health facilities rather than making them feel as if transition were happening to them. The first five sites to transition to CHAZ admittedly served as a de facto pilot and lessons learned informed the program design of both the CHAZ and Chreso transition projects.

The transition plan was constantly evaluated and realigned through Leadership Forums and technical subgroup meetings to accommodate changing circumstances such as areas for

“AIDSRelief has been fantastic...we’ve benefitted as an institution.”

— Kuwema, staff member at Mukinge health facility

improvement highlighted by the HRSA assessment, but the end-result was successful and recognized. For example, the donor invited AIDSRelief to present the transition plan to CDC Zambia staff and AIDSRelief asked the executive director of CHAZ to do a joint presentation at the annual Track 1.0 partners meeting in Maputo, Mozambique in 2010.

Value of Participatory Evaluations

Neutral, third-party assessments can provide extremely valuable observations and perspectives to organizations and the change process, but criticism is often difficult to hear. Learning to see opportunity in even critical assessments can be important to organizational growth. CHAZ and AIDSRelief shared the experience of two evaluations.

To become a local partner for transition under AIDSRelief or a direct recipient of USG funding, organizations must comply with stringent regulations and meet criteria set forth by OGAC. In anticipation of the USG’s assessment of CHAZ (planned to formalize CHAZ’s status as a local partner of the USG), AIDSRelief contracted with CORAT, an organizational development agency, in February 2009. The purpose of the assessment was to familiarize CHAZ with the evaluation process and to identify areas in which CHAZ could improve its systems to ensure USG compliance. Results of this assessment informed capacity strengthening plans, for example, by recommending additional human resources (in terms of both number of staff and their technical skills and experience) and by proposing

the gradual transfer of functions from AIDSRelief to CHAZ. The year after the CORAT assessment, CHAZ and AIDSRelief underwent a USG assessment conducted by HRSA. The CORAT assessment helped CHAZ and AIDSRelief identify concerns that were likely to be raised (and were, in fact, raised) by HRSA, such as the need to build CHAZ capacity to manage and comply with the terms of USG grants.

The learning from these experiences was twofold: how to prepare for and go through evaluation, but also how to accept criticism and leverage it for organizational advantage. In one valuable example, HRSA provided technical assistance to CHAZ (distinct from that provided through AIDSRelief) to help address evaluation findings. The recent award of FOA 1120 to CHAZ confirms that the organization is now considered eligible for receipt of USG funds—a great accomplishment and step toward program sustainability.

Budgeting and Legal Logistics

Initially, transition was not budgeted under AIDSRelief because it was perceived as cross-cutting and a part of everyday work. Upon examination and through transition planning and implementation, everyone came to understand that transition is closely related to but distinct from implementation and even capacity strengthening. The efforts must be closely linked, but transition requires discrete planning, monitoring, and implementation. It's an ambitious task and warrants up-front attention and investments to ensure longer-term success. Two critical actualizations of this were 1) budgeting for transition activities such as capacity assessments of facilities and local partners to identify gaps, development and implementation of action plans to address those gaps, monitoring action plan progress, and coordination of technical subcommittees and stakeholders, and 2) removing transition responsibilities from the AIDSRelief Chief of Party and creating—and funding—a

dedicated, senior position to manage and oversee transition with the full-time focus it required.

In implementation, AIDSRelief management also came to realize that some of CRS' organizational policies and procedures—at country, regional, and headquarters offices—were at odds with AIDSRelief's transition plan. In



Mwale Kataba Ngandu, a pharmacist at the Mindolo Clinic in Kitwe, Zambia, prescribes medication to ART patient Winfrida Soko. The clinic is owned by the Mopani Copper Mine and is used by its employees and their families. Photo by Jake Lyell for CRS.

order for staff from AIDSRelief to become employed with CHAZ, AIDSRelief needed to transfer funds to cover those employee salaries. Because CHAZ was not part of the active AIDSRelief grant there was not an obvious subgranting mechanism to transfer the funding. By working closely with CRS headquarters, AIDSRelief staff found a contracting solution that was amenable to all, but a great deal of time and effort could have been saved by engaging CRS' headquarters office earlier in the transition planning process and anticipating policies or structures that could impact transition efforts.

Health Systems Strengthening

A program the size and scope of AIDSRelief could easily have disintegrated in the type of resource-constrained environment Zambia had in 2004. Inherent to the project's design was intensive health systems strengthening: technical skill building among individuals (particularly with regard to HIV treatment, strategic information, and USG grants management),

organizational development among institutions at all levels, and systems strengthening within organizations (e.g., CHAZ or health facilities) and within the larger



Pharmacist William Mwiinde fills prescriptions of lifesaving anti-retroviral drugs at the Chamboli Clinic in Kitwe, Zambia. The clinic is owned by the Mopani Copper Mine and is used by its employees and their families. Photo by Jake Lyell for CRS.

context of Zambia's health system. In part because CHAZ and AIDSRelief were working independently on ART programs, both organizations had to learn to recognize and appreciate the value of each other's experiences and skills managing ART programs, and be honest about gaps in knowledge or understanding. At times this was challenging, but frequent communication and strong relationships helped make it possible.

Institutionalizing Capacity through Technical Assistance

At its height, AIDSRelief provided extremely intensive technical assistance to health facilities and made tremendous inroads clinically. As ART program scale-up gave way to program maintenance, this side-by-side method gave way to refresher trainings or need-based technical assistance. Local staff who gained specialized knowledge shared it with their colleagues. In harmony with the Zambian government's guidelines, staff provided health facilities with technical expertise, MOH-approved equipment, and maintenance for that equipment. AIDSRelief also worked with technical working groups convened by the Zambian government, and supported publication of national guidelines related to HIV care and support. In particular, the

Zambian government adopted concepts from the AIDSRelief model of care (including treatment preparation and adherence counseling standards) into the 2010 guidelines. This technical assistance has been extremely successful as measured by clinical outcomes as well as anecdotal information from the health facilities.

With the implementation of SmartCare, a health management information system (HMIS), AIDSRelief's strategic information staff managed the system from central to site level while concurrently building site-level capacity to manage the system locally and analyze data effectively. To meet the health information needs of care providers and managers throughout Zambia, SmartCare required frequent upgrades and the addition of new modules. While invaluable to strategic information goals and quality improvement, this complicated capacity building because staff needed additional support learning to use new software features and to analyze new datasets. The pace of change slowed as the system came to accommodate most HMIS needs and staff became increasingly independent, requiring less frequent, need-based technical assistance to manage the system and analyze data from their facilities.

Staff retention remains a concern as highly trained staff from AIDSRelief-supported facilities can often earn more money and live in more desirable areas if they take jobs in the private health care or information sectors. Some programs are in place to retain staff, for example, by requiring a two-year commitment to an underserved area in exchange for advanced training like the nurse practitioner program discussed later in this document. Members of the AIDSRelief team also hoped that even staff who move on will share the approaches and knowledge they have gained and mentor other colleagues, ultimately serving the people living with HIV who were at the heart of this program and strengthening Zambia's entire health system.

Institutionalizing Tools and Approaches

Through eight years of AIDSRelief implementation, partner organizations and staff have become acquainted with several tools and approaches. While initially part of AIDSRelief project design, many have proven valuable to Zambian staff and institutions, and were assimilated into operations.

Developed by AIDSRelief and used in nine country programs, the Site Capacity Assessment (SCA) tool helps program managers to assess a health facility's overall capacity of program operations to deliver quality HIV care and treatment. It identifies areas in need of strengthening as well as areas of excellent capacity that may be used to exemplify best practices. The tool's components cover adult, youth, and maternal child HIV care; nursing; community based treatment support; quality improvement programs; finance and compliance; health care management; pharmacy; laboratory; strategic information; and fundraising and advocacy. The tool automatically calculates the facility's score for each component. Using the SCA tool scores, the SCA dashboard provides color-coded maps, charts and tables to support program decision making at all levels—global, country and facility. Results from a SCA help stakeholders to strengthen and maintain program standards by efficiently and effectively targeting scarce expert technical assistance, and to make sound decisions at site, district, and central levels. Chikuni Mission Hospital is one facility that has incorporated the AIDSRelief SCA tool for all clinic services, not only ART.

While data collection and reporting can easily be perceived as an administrative burden, AIDSRelief's approach to strategic information emphasized the application of that data in all facets of patient care and site management; that is, data demand and information use (DDIU) for continuous quality improvement (CQI). In addition to ensuring access to good data (e.g., physical access to SmartCare), collaborating with strategic information officials within the Zambian government, and strengthening the capacity of health facilities to plan, document, and implement

problem-solving approaches using data, AIDSRelief sparked a paradigm shift. Staff at CHAZ and at the facilities now understand data as a tool to provide quality patient care and identify capacity strengthening gaps, rather than viewing data collection as a task performed for a donor or ministry. For example, a quarterly chart review might reveal a facility-wide gap in co-trimoxazole prophylaxis among pre-ART patients. Further investigation by site managers could then determine possible explanations and responses, e.g., pharmacy stock-out (resolved by supply chain management), or a provider unfamiliar with national guidelines (indicating a need for refresher training or mentoring).

Additionally, with AIDSRelief support, the Mukinge health facility developed financial manuals and internal controls. All hospitals received laboratory equipment and the training to use that equipment. By making infrastructure improvements and making continuous quality improvement, robust financial management, and tools such as the SCA part of the facility's culture and processes, AIDSRelief facilitated systemic change and sustainability in Zambia's health system.

Investing in the Future of Zambian Healthcare

To ensure lasting change, capacity strengthening ideally should include efforts to make the external environment more supportive of the desired change or end goals. In the AIDSRelief context, this included development of innovative education programs in concert with Zambian health and



*Madalitso Phiri was born with HIV but was not diagnosed until age 15, when he fell ill and had to drop out of school. With AIDSRelief's support, he regained his health and is now in college. Here he helps his little brother Emmanuel with his studies outside their house in Kitwe, Zambia.
Photo by Jake Lyell for CRS.*

education institutions. These programs were designed to close identified skill gaps and address obstacles such as a shortage of physicians to initiate patients on ART, positioning Zambia to take complete ownership and leadership of its national HIV response.



*At St. Theresa Mission Hospital, Regina Mwape looks on while Dr. Kasong Tshijing examines her grandson, Josphat, who recently tested positive for HIV.
Photo by Jake Lyell for CRS.*

AIDSRelief provided on-site clinical training to more than 200 medical and clinical officers per year, all of whom work in LPTFs. The program has also worked with the MOH and General Nursing Council to establish a one-year diploma program for nurse practitioners (HIV NP); 20 of the 60 program graduates were AIDSRelief NPs as of June 2011. With University of Zambia, University Teaching Hospital, and the MOH, AIDSRelief also established an 18-month Master's of Science (MSc) program in HIV medicine. Twelve medical officers completed their coursework, remaining in Zambia to be a part of their country's HIV response. MSc graduates work throughout the country (public and private sector), playing a crucial role in managing complex patients, leading national HIV strategies and collectively training nearly 1,000 health care providers since June of 2010 (an aggregate calculation). These educational programs are institutionalized and will continue to train practitioners after the close-out of AIDSRelief.

Conclusion

During the program's eight years, AIDSRelief support helped Zambia's health system absorb and grow stronger with the influx of financial, human, and material resources; helped CHAZ greatly expand its capacity to provide clinical oversight,

effectively use data, and manage sites and direct funding from the U.S. government; and helped individual ART sites provide high quality care and treatment services to tens of thousands of Zambians who once faced certain death. Committed partnership and capacity strengthening between CHAZ and AIDSRelief were key to the program's excellent outcomes and its substantial progress toward a wholly Zambian-owned HIV response.

Developing a shared vision and understanding of success was an enormous challenge. Different understandings of "local partner" and "transition" were overcome through an intensive consensus-building process anchored by the Leadership Forum, which was critical in bringing all the stakeholders into agreement. Frequent communication and open discussion also defused tension and reassured staff as they worked through a period of uncertainty.

Another key lesson was the understanding that transition is closely related to, but distinct from implementation. Initially transition was not budgeted or specifically staffed because it was perceived as a part of everyday work. Only by going through the process did AIDSRelief realize that a successful transition requires dedicated resources for planning, monitoring, and implementation. A dedicated senior manager and budget allocation provided the full-time focus that transition required.

"[We have] given life where people were supposed to die....

Patients in our community can look after their families, participate in community development."

— Sister Beatrice Chanshi,
St. Theresa Mission Hospital

"We owe it to the millions worldwide on treatment who once had no hope."

— Karen Sichinga,
CHAZ Executive Director

The AIDSRelief Zambia experience also demonstrated the importance of taking a health systems strengthening approach. In low-resource settings, HIV care and treatment programs require building not only clinical skills but also technical expertise in areas such as strategic information, grants management, community outreach, and supply chain. Strengthening organizations and institutions at all levels ensures that quality HIV programming exists within a sustainable health system.

Partnership, capacity strengthening, and transition are often lengthy processes and rife with challenges. They are also essential to achieve the lasting change envisioned by AIDSRelief and our donors. CDC Zambia understands this and is to be commended for their commitment and foresight in designing complementary five-year funding opportunities (grants won by AIDSRelief, CHAZ and Chreso) for continued capacity strengthening and incremental transition of responsibilities from international organizations to the Zambian partners who will sustain HIV care and treatment in their country. The projects are supportive of transition and will enable the maintenance of high-quality service delivery in supported ART sites. Great gains have been made under AIDSRelief, but the new projects will secure the sustainability of Zambia's response to HIV.

In an effort to achieve truly sustainable change, health and development donors worldwide have worked hard to prioritize host-country engagement in programming. AIDSRelief's road has not been easy and the future will undoubtedly reveal more difficulties for new projects, but this is not unique to Zambia or to HIV programming. Any project seeking to strengthen local ownership should consider cultivating equitable partnerships and strengthening capacity as a means to reach their wholly attainable goal.

¹Zambia Demographic and Health Survey 2001/2002.

²Zambia HIV Prevention Response and Modes of Transmission Analysis, 2009.

³Zambia HIV Prevention Response and Modes of Transmission Analysis, 2009.

⁴Zambia HIV Prevention Response and Modes of Transmission Analysis, 2009.

⁵UMSOM-IHV outcomes assessments, 2006, 2007, 2008; patient at a mean of 14 months on therapy.

⁶Rice BD, Delpech VC, Chadborn TR, Elford J. "Loss to follow-up among adults attending human immunodeficiency virus services in England, Wales, and

Northern Ireland.” *Sex Transm Dis*. 2011 Aug;38(8):685-90. Keiser O, Orrell C, Egger M, Wood R, Brinkhof MWG, et al. 2008 Public-Health and Individual Approaches to Antiretroviral Therapy: Township South Africa and Switzerland Compared. *PLoS Med* 5(7): e148. doi:10.1371/journal.pmed.0050148

Annex A: Methodology

Partnership and capacity strengthening are among CRS’ core values and key components of the AIDSRelief Zambia country program. To capture lessons learned in these areas that can be applicable to future development work, the CRS Partnership Unit commissioned this case study with private funding. In July 2011, an independent consultant spent two weeks in Lusaka interviewing 33 people whose current or former roles with AIDSRelief included partnerships, capacity strengthening, and/or transition (see Annex B for a complete list of interviewees).

The consultant typically interviewed groups of two or three individuals who worked in similar capacities; some groups were larger or smaller to accommodate schedules. When possible, interviews were conducted in person in Lusaka, but time limitations required phone and Skype calls for interviewees based outside of Lusaka or who were away from post during the consultant’s visit. All interviewees were given the option of a private and confidential conversation with the consultant, as well as the opportunity to provide anonymous, written information. No interviewees took advantage of these options.

The interview format was deliberately open in order to encourage dynamic discussion and reflection among stakeholders. Respondents were encouraged to focus on capacity strengthening and partnership for transition, but were free to talk about other technical work as well (e.g., medical-clinical, strategic information, and site management), particularly as it related to the other topics. The following questions provided a broad framework for the conversations; the consultant drew out additional detail through follow-up and clarifying questions:

- Did AIDSRelief do what it was supposed to do?
- Did that work the way it was supposed to work?
- Did it matter or make an impact?
- Will it last after transition?

The consultant analyzed notes from the interviews and noted the recurring themes and lessons highlighted in this document to generate early drafts. Stakeholders including leadership from CRS, IHV, Futures Group, and CHAZ reviewed early drafts, confirming facts and providing feedback on structure and presentation.

Annex B: List of Interviewees and Affiliations

CRS

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 Emily Burrows
 Ana Maria Ferraz de Campos
 Dr. Herby Derenoncourt
 John Donahue
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 Dane Fredenburg
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 Dr. Mope Shimabale
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Dr. Modester Bwalya
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 Karen Sichinga
 Stenford Zulu

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Nzooma Mataa
 Lawrence Michelo

Chikuni Mission Hospital

Dr. Claudia Caracciola

Chilonga Mission Hospital

Dr. Claude Nsumpi K
 Fr. Patrick Chibuye

St. Francis Mission Hospital

Dr. Shelagh Parkinson
 Danwel Simbeya

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Annex C: List of Reviewers and Affiliations

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Dr. Robb Sheneberger

Futures Group

Lawrence Michelo
 Biko Soko

CHAZ

Karen Sichinga

Annex D: Key Tools & Resources

These select resources—and many more relating to HIV, capacity strengthening, partnership, and transition—are available at www.crsprogramquality.org.

[The AIDSRelief Model](#) describes the program’s approach to high-quality, sustainable HIV care and treatment. The model consists of three pillars – medical, strategic information, and site management – supported by a foundation of health systems strengthening.

[The AIDSRelief Rwanda Partnership](#) documents the transition of AIDSRelief’s responsibility for overall management of a large antiretroviral treatment program to the Rwanda Ministry of Health. It is hoped that this case study will contribute to the learning of other programs as they embark on the road to transition.

[The AIDSRelief South Africa Partnership](#) documents the transition of AIDSRelief responsibility for overall management of a large antiretroviral treatment program to local partners in South Africa. It is hoped that this case study will contribute to the learning of other programs as they embark on the road to transition.

[The Institutional Strengthening Guide](#) serves as a reference for organizations wishing to develop or improve existing institutional strengthening systems and processes. The Guide presents principles, minimum standards and best practices, business processes, references and tools deemed important for effective, efficient, and sustainable organizations and consists of ten chapters that cover the key functional areas of most organizations. Each chapter can be used as a stand-alone document as an adaptable tool which may be used to develop new, or strengthen existing, policies, processes and practices.

The Site Capacity Assessment (SCA) Toolkit consists of the SCA tool, dashboard, and action plan. The SCA Tool helps program managers to assess the capacity of health facilities to provide quality HIV care and treatment, identify gaps and weaknesses in capacity, and target and track the progress and impact of technical assistance. It covers medical care and treatment, quality improvement, management, pharmacy, laboratory, strategic information and fundraising and advocacy public relations. The tool automatically calculates the health facility's capacity score on each component, and the dashboard provides color-coded maps, charts and tables to support program decision making at all levels—global, country, region and facility.

Posters presented at the 2010 International AIDS Conference

- [HIV Programming Contributes to Institutional Capacity Building in Uganda](#)
- [Managing Programs for Sustainability: Site Capacity Assessment \(SCA\) Tool](#)
- [Transitioning Leadership of a large HIV treatment program to Local Partners \(South Africa\)](#)
- [The AIDSRelief Rwanda Transition Model for Sustainability](#) was developed to ensure that the Rwanda Ministry of Health has the capacity to support sustainable care and treatment at the central and district levels.

Annex E: The AIDSRelief Consortium in Zambia

Formed to maximize the strengths of each partner in pursuit of mitigating the HIV crisis in Zambia, the AIDSRelief consortium is comprised of the following organizations.

Catholic Relief Services (CRS): CRS is the official international humanitarian agency of the Catholic community in the United States. As Zambia works to reduce poverty and mitigate the impact of the HIV epidemic, CRS engages in development activities in health, food security and livelihoods, and child protection. CRS is the prime grantee for AIDSRelief.

University of Maryland School of Medicine Institute of Human Virology (IHV): IHV combines basic science, epidemiology and clinical research to expedite the scientific understanding of HIV and to develop therapeutic interventions. As AIDSRelief's lead agency for clinical care and treatment, IHV uses evidence-based strategies and integrated outcomes evaluation to guide both scale-up and technical assistance. IHV's training and capacity building activities focus on a clinical mentorship model that encourages learning along with real time patient care.

Futures Group: As AIDSRelief's lead agency for strategic information, Futures builds strong, sustainable systems for clinical records and program information that can be uniformly used to collect and track data. This information is essential to providing high-quality care and treatment regimens, ensuring drug durability, tracking progress, and accurate reporting.

Children's AIDS Fund (CAF): CAF is a U.S.-based non-profit, non-partisan, nongovernmental international organization dedicated to limiting the suffering of HIV-impacted children and their families. In Zambia, CAF works to build local capacity in a broad range of areas related to site and grants management.

Acknowledgments

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

We are grateful for the financial and technical support from the program’s donor, the Health Resources and Services Administration (HRSA) through funding from PEPFAR. We also appreciate the CDC team in Zambia for their on-the-ground program oversight, guidance, and support. The program’s impact would not have been possible without the tremendous dedication from all levels within the Zambian Ministry of Health and with our local partner CHAZ. Each and all were essential to AIDSRelief’s success and are helping make sustained country ownership possible in Zambia.

We also want to acknowledge the health workers and managers in treatment sites and communities across Zambia. These often-unsung heroes and heroines of the epidemic work under challenging circumstances and directly serve those in need. It has been an honor to work in partnership with them.

Thank you to the past and present staff of AIDSRelief, CHAZ, and individual health facilities who agreed to be interviewed and share their experiences for this case study. Lastly, thank you to the author of this document, Rebecca Bennett, and to the reviewers whose thoughtful comments on early drafts were invaluable.

CRS Partnership Principles

1. Share a vision for addressing people's immediate needs and the underlying causes of suffering and injustice.
2. Make decisions at a level as close as possible to the people who will be affected by them.
3. Strive for mutuality, recognizing that each partner brings skills, resources, knowledge, and capacities in a spirit of autonomy.
4. Foster equitable partnerships by mutually defining rights and responsibilities.
5. Respect differences and commit to listen and learn from each other.
6. Promote mutual transparency regarding capacities, constraints, and resources.
7. Engage with civil society, to help transform unjust structures and systems.
8. Commit to a long-term process of local organizational development.
9. Identify, understand, and strengthen community capacities, which are the primary source of solutions to local problems.
10. Promote sustainability by reinforcing partners' capacity to identify their vulnerabilities and build on their strengths.



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