



The AIDSRelief South Africa Partnership



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Julia Mosoma has been on ART since January 2006. She receives treatment at the Kurisanani clinic in the Diocese of Tzaneen. Willie Pietersen for CRS.

Purpose

This is the story of how AIDSRelief in South Africa transferred responsibility for overall management of a large antiretroviral treatment program to local partners. The purpose of documenting this transition to local leadership is twofold: First to demonstrate how Catholic Relief Services (CRS) fosters long-term relationships with church partners and how this engagement with partners strengthens their capacity to provide sustainable services to those most in need; and second, to share the successes and the challenges AIDSRelief South Africa experienced in this process. It is hoped that the South Africa story will contribute to the learning of other countries, working in AIDSRelief or other programs, as they embark on the road to transition.

Background

Catholic Relief Services is the official international humanitarian agency of the Catholic community in the United States. The agency alleviates suffering and provides assistance to people in need in more than 100 countries without regard to race, religion or nationality. In late 2000, CRS began working in South Africa as a small outreach office at the invitation of the Southern African Catholic Bishops Conference (SACBC). Based on extensive consultations, CRS committed to work in close partnership with and through the local church in two program areas: HIV and AIDS; and Justice and Peace.

In 2004 the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) awarded CRS, as the prime of a five member consortium of organizations, a grant to provide care and antiretroviral treatment to people living with HIV in nine countries, including South Africa. The resulting program was called AIDSRelief. The five-year funding award was managed globally by CRS headquarters, in collaboration with the Human Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services.

The funds flowed from HRSA through CRS to the implementing partners. In South Africa, the U.S. Centers for Disease Control and Prevention (CDC) oversaw the grant, and two local umbrella organizations implemented the activities. These two local implementing partners were the AIDS Office of the Southern African Catholic Bishops Conference (SACBC) and the Institute for Youth Development/South Africa (IYDSA) in collaboration with the Children's AIDS Fund (CAF), another international faith-based nongovernmental organization (NGO) that had partnered with CRS in the AIDSRelief program.

The AIDS Office of the SACBC coordinates the Catholic Church's response to the HIV epidemic and supports numerous church service programs throughout South Africa, Botswana, and Swaziland. Twenty of these programs, located in areas of need throughout South Africa's provinces, were selected to participate in the AIDSRelief program and to provide antiretroviral treatment in addition to their other HIV care and support services. These included two hospitals, four primary care clinics, and six hospices. Nine of the twenty programs offer clinical outreach services in a variety of community settings. Eighteen of the twenty programs provide home-based care.



At an ART outreach center in the the Kosi Bay region, a counselor collects medical records, checks vital signs, and refers patients for nursing care. Debbie DeVoe/CRS.

IYDSA is a faith-based NGO based in the Eastern Cape Province of South Africa. This umbrella organization initially used AIDSRelief funds to develop four antiretroviral

treatment sites in needy communities.

Over the five years of the grant, the program grew to include five antiretroviral treatment sites and ten clinical outreach centers.

From 2004, AIDSRelief worked in collaboration with the SACBC and IYDSA to provide community-based care and clinical treatment to people affected by HIV. Treatment facilities were expanded and equipped. Financial compliance systems were put in place, and treatment sites were prepared to implement a new electronic database to assist with patient management. Over the five years (through September 2009), a cumulative total of 73,293 people received HIV care and 35,038 were enrolled on antiretroviral treatment. Throughout the project, hundreds of health workers have been trained, 296 in the 2008-2009 grant year alone.

AIDSRelief committed to activities that would ensure the sustainability of treatment for people living with HIV (PLHIV) when donor funds were no longer available. Linkages were established with local clinical experts and as well as with health training institutions and organizations. Relationships with South African government health and social services were strengthened.

“By working together we learned from one another and, over time, built a strong team characterized by trust and mutual respect. It was not always smooth sailing. We did not always agree. But our commitment to the work we were doing together got us through the rough seas.”

Ruth Stark, CRS South Africa

Sustainability plans for some programs involved a variety of public-private partnership arrangements where government would cover the costs for certain services, including laboratory services, antiretroviral drugs, and even, in several cases, staff salaries. For other programs, the sustainability of PLHIV on antiretroviral treatment involved the transfer of patients to South African government health services as they became available and accessible. Over the five years, 6764 patients have been transferred to accredited government facilities where they will continue to receive life-long HIV treatment. The strong partnership with the local church, the commitment to collaborate with the local government, and the encouragement and support of the activity manager at the U.S. Government (USG) mission in South Africa made the transfers possible.

After five years of developing a successful implementation model, the program is now embarking on a new direction, with local South African organizations taking the lead. The local organizations now receive their PEPFAR grant funds directly from CDC and are responsible for managing all aspects of the program. AIDSRelief will serve its partners as a sub-grantee in specified technical areas and will accompany partners as they take up their new role.



Thabisile Mazibuko lost two newborns to HIV before starting ART in December 2007. She now has a healthy son, born in April 2008. Debbie DeVoe/CRS.

South Africa is the first of the PEPFAR HIV treatment programs to transition to local leadership. This is the story of what made it happen.

Partnership for Sustainable Transition

Transition began before Day One

CRS' relationship with the SACBC goes back to the year 2000, when CRS first came to South Africa. The seeds of transition were planted then, three years before CRS could even dream of providing antiretroviral drug treatment to those in need. In those early days of the CRS/SACBC collaboration, from 2000 to 2004 (when PEPFAR funding became available), CRS allocated privately donated funds to the SACBC AIDS Office to support small HIV projects in church service programs in needy communities throughout the country. Ordinary people who wanted to help their neighbors suffering from the effects of this devastating epidemic implemented most of the projects. They often had little education, no prior experience in project management, no skills in handling project funds and no access to computers or electricity, making it unlikely that they would qualify for most donor funds. But the SACBC AIDS Office saw the need to support these small community-driven projects and requested

“The AIDSRelief PEPFAR program came at a time when the government hospital couldn’t cope with the number of patients. It came at a right time, and reduced the pressure on the hospital. The Church’s caregivers were helping sick people. It is a lot easier now, because the caregivers refer to the Catholic treatment site nearest to them.”

*Silindile Mhlongo, Administrator,
Mtubatuba SACBC treatment site*

CRS support as a matter of priority. Through this early SACBC/CRS collaboration, communities received training and funding to implement HIV prevention activities and to care for those affected by HIV, with a strong emphasis on providing home-based care. Over the past five years CRS has provided \$2.5 million in private funds to support these small projects, serving over 200,000 people in a network of HIV support that has extended to 130 needy communities.

In 2002, Professor Stuart Bate evaluated the projects and concluded that through these small projects, “The Catholic Church is making a powerful response to the prevention of HIV and the care of those infected and affected by the epidemic.”¹ Cardinal Wilfred Napier, Archbishop of Durban, summed it up this way, “For me, one of the best features of the SACBC-CRS partnership is that this arrangement allows small projects to be approved simply and quickly. This has enabled the smaller dioceses, that do not have the personnel or resources to plan, formulate, and execute major projects, to get moving on the fight against HIV. This procedure has helped even the remote, rural parishes to set up projects for those who would otherwise be totally abandoned.”²

Preparation for transition to local leadership began with the funding of these small projects. The Management Board of the SACBC, not CRS, selected the projects. SACBC staff monitored the projects. SACBC staff planned and conducted training courses. CRS and other donors provided the funding and gave technical support when requested, but management remained in the hands of the SACBC AIDS Office.

From the beginning, staff from CRS and the local partners attended trainings together, planned activities collaboratively and made decisions jointly. By working together staff

1 Report of an Independent Evaluation of SACBC Small Projects by Professor Stuart Bate, D.Th., St. Augustine College, Johannesburg, July 2002

2 Interview with Wilfred Cardinal Napier, O.F.M. Archbishop of Durban, 10 February 2003

learned from one another and, over time, built a strong team characterized by trust and mutual respect.

Funds for antiretroviral drug treatment become available

Many of the small projects the SACBC and CRS supported had no buildings or other infrastructure. Care and support was provided for people in their homes, including bathing and feeding the sick, caring for the children, assisting families to cope, and, inevitably, helping infected people to die with dignity. But when antiretroviral medications became available, people didn't have to die. So the SACBC AIDS Office set about developing a program for providing antiretroviral therapy in these needy communities. In consultation with local clinical experts, pharmaceutical suppliers and clinical laboratories, the staff from the SACBC AIDS Office wrote a proposal and began the search for funding.

Meanwhile, funds for treatment became available from the PEPFAR, and CRS decided to submit a proposal. South Africa was one of nine countries that

“Treatment is available in places where there is nobody else doing it, and where patients wouldn't have access to treatment were it not for the Church. Where treatment sites were opened and the government subsequently started providing antiretroviral treatment, patients were transferred to the government program and the AIDSRelief/SACBC program was closed down. In this way, resources could be used to expand the antiretroviral treatment programs in other areas of great need.”

Johan Viljoen, SACBC

requested to be included in the CRS funding application. CRS South Africa and the SACBC AIDS Office then incorporated the treatment proposal they had previously developed into the CRS multi-country application.

While developing the proposal, the SACBC AIDS Office had assessed the interest and the capacity of the small HIV organizations that had received SACBC/CRS funding. Using an assessment tool developed by John Snow, Inc (JSI), the SACBC concluded that 20 of the organizations had both the will and the capability to expand their services to include treatment. These were included in the proposal along with four potential treatment sites that IYDSA selected.

Training the staff of the selected sites began even before the outcome of the proposal was known. Using funding from CRS, CORDAID (Caritas Netherlands) and other church-related donors, the SACBC AIDS office trained 100 staff members on antiretroviral treatment in a government-accredited training program. Then, using funds from CORDAID, the eight potential sites most prepared to begin treatment were readied to accept patients. Doctors and nurses were hired, laboratory services were secured, and arrangements were made for the delivery of the life-saving drugs. By the time the CRS proposal was approved and the funds were flowing, the SACBC treatment program was in full swing.



At the Phelandaba outreach center, Sister Gladness Ntuli meets with patient Thabisile Mazibuko to review her health status and to dispense her antiretroviral medications. Debbie DeVoe/CRS.

“The AIDSRelief team and the SACBC had to learn to work together in South Africa. Initially there were tensions, as each organization learned what needed to happen and who needed to do what. There are responsibilities for PEPFAR reporting, financial management, technical assistance to local partners, relationships with the provinces and with the National Department of Health, training for local partners, and overall program management. Over the years, roles and job descriptions have changed. Now the division of labor relates more to expertise than to organizational territory.”

Sister Alison Munro, Director, SACBC AIDS Office

Here again, preparation for transition began even before the funding arrived. By supporting the SACBC AIDS Office in the decisions they made about the projects that should be developed into antiretroviral treatment sites and by following their lead as they initiated treatment, a pattern of supportive partnership was established--a pattern that would set the tone for collaboration in the years to come.

Utilizing local resources

The CRS proposal was successful and the funds arrived. The AIDSRelief program is comprised of a consortium of five US-based organizations led by CRS. Some of the organizations in the consortium had a high level of clinical

expertise, and these clinical experts were available to the countries included in the AIDSRelief program. But early on, the SACBC, IYDSA and the AIDSRelief South Africa team concluded that there was ample expertise available in-country and that the assistance of local experts was more appropriate, more helpful, and far less costly than using external clinical experts. Accordingly, the South Africa AIDSRelief team proceeded to engage local clinicians, institutes, and universities in the treatment program. These local experts, in turn, trained project doctors and nurses, evaluated the clinical outcomes of the treatment, and served in an advisory capacity on a broad range of issues. The strong and productive relationships established between the treatment sites and these local experts has contributed immeasurably to the sustainability, the appropriateness, and the affordability of the treatment program, and has been a major contributing factor in preparing the way for transition to local leadership.



St. Gabriel's parish ART center now has a Toga laboratory, a fully functional mobile lab designed by lab partner Toga Laboratories in Johannesburg. St. Gabriel's serves around 3,000 patients in Mtubatuba town. Debbie DeVoe/CRS.



St. Gabriel's provides services directly out of Church facilities. The building is a renovated tavern which holds mass on Sundays and provides an office for data entry, a storage room for patient files and another room for patients' monthly antiretroviral medications packets, packaged and sent by a pharmaceutical partner in Johannesburg. Debbie DeVoe/CRS.

Building a team

The staff of AIDSRelief South Africa and the staff of the SACBC AIDS Office initially assigned roles and responsibilities on the basis of organizational identity; that is, AIDSRelief staff performed certain roles and SACBC staff performed others. This turned out to be difficult to sustain. Many functions overlapped and dividing up the work along organizational lines led to tensions among staff and resulted in mixed messages going out to treatment sites. Over time, we realized we needed to build a more functional team.

There was no great breakthrough, no dramatic change, but little by little staff from the two organizations changed the way they interacted with one another. The team leaders started scheduling meetings more regularly and more frequently and chaired them jointly.

They assigned tasks, not on the basis of organizational affiliation but on the team members' competencies and on other factors that contributed to a good outcome. This made it possible to manage a large program with very few AIDSRelief and SACBC staff.

Month by month, the team became more cohesive and more effective. Team members communicated more regularly and attended donor meetings and trainings together. When contentious issues arose, the team members debated them openly to reach consensus. Working side by side, team members learned together, made decisions jointly, and, in the end, spoke with one voice.

Team building was successful because the key staff of both organizations remained with the program over the five years and shared the same vision. All had a willingness to compromise and a commitment to South African ownership.

Building partnership between partners

A relationship between the umbrella partners, the SACBC AIDS Office and IYDSA, developed by working together and during quarterly meetings with AIDSRelief. These meetings provided an opportunity for the two umbrella organizations to share information and resources and to plan joint training programs. Each organization brought something to the table and had something significant to contribute. An example is the patient data system (PDS) that IYDSA had developed and field-tested. This system for recording patient data was so successful that the SACBC eventually adapted it for use in their treatment sites as well.

Another example of productive collaboration between the umbrella partners is illustrative. When IYDSA needed South African government concurrence to provide antiretroviral treatment in the Eastern Cape province, the Secretary General of SACBC gave assistance by introducing IYDSA to the provincial health leaders and by speaking on their behalf. Four years later, when IYDSA had developed a strong program in that province and a productive relationship with the health authorities, the SACBC transferred two of their treatment sites to the IYDSA so they could be better integrated into the government health services, thus making them more sustainable.

Building capacity within the umbrella partner organizations

Over the five years of the AIDSRelief project, there was a strong emphasis on strengthening the capacity of the individual church service programs within each umbrella organization (SACBC and IYDSA). The individual treatment sites were encouraged to partner with other local organizations, to attend training programs and conferences, to develop sound financial systems, and to engage with local government departments. As a result, some of the treatment sites now receive services and benefits from the South African government including medications, laboratory, staff salaries, and even government subsidies. Some have been accredited as government treatment sites; others have established public-private partnerships of various types. Still others have developed collaborative relationships with other PEPFAR-funded partners. Each of these linkages has the potential to contribute to their long-term sustainability. Linkages with government will be a source of continued funding. Linkages with local clinical experts and educational institutions will provide continued technical support. Linkages with other local treatment organizations will provide opportunities to share information and resources.

“Graduating” St. Mary’s Catholic Hospital

Some of the implementing organizations within the umbrella organizations now have the capacity to function on their own, independent of both AIDSRelief and the umbrella organization. The first to do so was St. Mary’s Catholic Hospital, the largest treatment site in the AIDSRelief South Africa network. Founded in the late 1880s, St. Mary’s has long provided services for all patients in the area, public and private. The hospital provides antiretroviral drug treatment for over 4,000 people living with HIV. The South African government funds 70% of the hospital’s operational costs, as St. Mary’s is the only hospital in a large district.

During the years of its partnership with AIDSRelief, St. Mary's Hospital qualified as a government-accredited antiretroviral drug rollout site and now receives HIV drugs and laboratory support from the government for HIV treatment, in addition to its 70% subsidy for general patients. Through its partnership with AIDSRelief, the pharmacy has been renovated, repairs made to the hospital building, a monitoring and evaluation system established, four mobile units equipped, a patient data system installed, and over 200 health professionals trained. AIDSRelief assisted St. Mary's to make these changes by providing the needed resources, by sponsoring training, and by seconding AIDSRelief and SACBC staff to St. Mary's for extended periods of time. By working together, AIDSRelief staff and the staff of St. Mary's improved the infrastructure, strengthened the financial systems and introduced effective systems for monitoring the quality of clinical care. St. Mary's Hospital now has the infrastructure, the equipment and the staff capacity to move forward independently, fulfilling its mission of providing quality health care to the community it has served for so many years.

“St. Mary's Hospital and its patients and their families have benefitted immeasurably from the AIDSRelief program. Thousands of patients who would otherwise have died are living productive lives with their families because of this program. Through the PEPFAR-supported antiretroviral treatment program, the Hospital's financial and clinical systems have been strengthened and the infrastructure improved... The Hospital and AIDSRelief have learned a lot during this five year journey together.”

Dr. Douglas Ross, CEO St. Mary's Hospital

Moving toward transition

Beginning June 2009, PEPFAR funds go directly to the local partners through CDC cooperative agreements, following successful applications to a local USG process. IYDSA and St. Mary's Hospital implement their programs independently, with support from CRS in certain areas. IYDSA has requested continued CRS technical involvement in monitoring and evaluating clinical services, and St. Mary's Hospital has requested continued support in the implementation of their patient data system.

The SACBC AIDS Office also receives funds directly as the "prime" recipient, sub-granting certain functions to CRS, including aspects of monitoring and evaluation, clinical coordination, financial management and training--functions to which CRS brings considerable expertise. But, as is the case with IYDSA and St. Mary's Hospital, overall responsibility for the management of the care and treatment project will be in the hands of the SACBC.

The local partners are ready. Each partner has mastered the US Government regulations and is able to comply with the financial reporting requirements. In preparation for the transition to local leadership, CDC awarded each organization a separate, small grant to administer independently. All three local partners demonstrated the ability to manage these grants successfully, earning the trust and respect of the donor, the local government, and the communities they serve. Now leadership is where it belongs--in the hands of the local organizations.

Performance Measures for Transition

The partnership experience in South Africa can be analyzed in terms of certain measures of performance toward transition: effectiveness; ethical soundness; relevance; efficiency and cost effectiveness; and sustainability.

Effectiveness: The South Africa partnership has been effective in transitioning leadership of a large complex antiretroviral treatment program from AIDSRelief, an international consortium, to the local organizations. The transition was planned and executed with the full support of the USG PEPFAR team at the country level as well as in Washington, DC, and was approved by the Office of the Global AIDS Coordinator.

Ethical soundness: The process of jointly implementing the AIDSRelief program with the umbrella partners as equal decision-makers promoted equity in relationships between the international partners and the local umbrella organizations. The responsibility given to the umbrella partners for managing the procurement of pharmaceutical supplies and laboratory services and for supervising the performance of the community treatment sites reflected one of the hallmarks of the AIDSRelief South Africa program—the principle of subsidiarity.

Where there were concerns that certain activities or situations might cause harm to the treatment program, the potential risks were discussed openly and frankly and were addressed with one voice by the international and local partners.

Hands-on intensive support for community treatment sites strengthened financial and management systems as well as the patient care programs in the treatment sites. As a result, one of the sub-partners, St. Mary's Hospital, was able to “graduate” from the umbrella partner as well as from AIDSRelief.

Relevance: The South African government has the largest rollout of antiretroviral treatment in the world and has an ambitious strategic plan to extend services to 80% of all South Africans that need antiretroviral treatment by 2011. AIDSRelief South Africa is supporting the government's national plan by providing HIV care and treatment in communities where such services are currently limited or unavailable.

PEPFAR funding supports the South African government's national strategic plan with the long-term goal of transitioning US Government-supported HIV programs to local leadership. PEPFAR project officers in South Africa know the capacity of the AIDSRelief partners and have encouraged and facilitated this transition.



Mapule Maganedis, a nurse at the St. Francis Care Centre's Rainbow Cottage for Babies in Johannesburg, South Africa, administers antiretroviral medication to Sinenthlantla, a child living with HIV. Photo courtesy of Paul Jeffrey/Ecumenical Advocacy Alliance

Efficiency and Cost Effectiveness

CRS /South Africa and the SACBC and IYDSA managed the AIDSRelief program with very few staff. In the case of CRS and SACBC, the staff worked together as a team, with areas of work assigned on the basis of an individual's knowledge and skills, not on the basis of organizational identity. All staff working on the project met on a regular basis, to share information, to plan next steps, and to work through any challenges they encountered. The leaders of the two programs were in frequent contact, consulting one another almost daily. Staff from the two organizations often traveled together to the treatment sites to provide technical support and encouragement. When there were meetings with the donor, both the international and the local partner organizations were represented.

As a result of frequent communication and close coordination, AIDSRelief South Africa and the SACBC spoke with one voice. The CDC PEPFAR activity manager of the program knew that she could contact the leader of either of the organizations and receive the correct information. Through this direct contact with the local partner, the donors saw the capacity of the SACBC and in 2006 awarded them funds to support orphans and vulnerable children (OVC), independent of AIDSRelief. The SACBC successfully implemented the financial and technical aspects of this grant independently, demonstrating to the donor that they had the capacity to take on the next challenge— management of the AIDSRelief project.

“From the beginning of the program, we were told that the ultimate goal was to transition the program to local partners, and to this end AIDSRelief South Africa worked with IYDSA to make this possible. AIDSRelief South Africa provided training and assistance on a number of levels. To say that all went well would not be true. However, differences never got in the way of doing the job to the best of our ability.”

Darren Gough, Director, IYDSA

Sustainability

Partnerships with St. Mary’s Hospital and with the SACBC AIDS Office will be sustainable for the long term. The partnership with these organizations began when CRS first established an office in South Africa and involves programming other than the PEPFAR antiretroviral treatment program. In addition, CRS has committed to supporting the PEPFAR HIV care and treatment program after the transition to local leadership.

In the post-transition program, SACBC has sub-granted CRS South Africa to provide continued collaborative support in

the areas of clinical coordination, monitoring and evaluation, training and finance. CRS South Africa has also committed to supporting St. Mary's Hospital in implementing the newly-established patient data system and will continue to collaborate with IYDSA as the patient data system is expanded and refined.

“Sustainability” does not necessarily mean sustainability of each of the local partner treatment sites; rather, it refers to the sustainability of patients' access to quality care and treatment. USG funding for antiretroviral treatment at the many small local partner treatment sites will not always be available, so the sustainability strategy is to develop productive relationships with other health care providers and with the South African government at the national as well as at the district and provincial level to ensure that patients will receive life-long treatment. Several sustainability approaches have been pursued:

- (1) Seek accreditation of the local partner sites as South African government antiretroviral treatment rollout sites. This approach succeeded at St. Mary's Hospital, the largest AIDSRelief supported site. The provincial government now covers the cost of drugs and laboratory services. Accreditation is currently in process in a number of other sites.
- (2) Transfer stable AIDSRelief patients to South African government antiretroviral treatment sites. This can be implemented when the Department of Health (DOH) rolls out antiretroviral treatment at a site accessible to the AIDSRelief patients and when the site has the capacity to absorb the additional numbers. This has been implemented at three local partner sites. In most cases, the local partner site continues to provide home-based care and other related support services.
- (3) Transfer the local partner's treatment program to another donor-funded program providing services in the area. An

example would be the HIV care and treatment program in the Northern Cape province, where the treatment was taken over by a PEPFAR-funded local organization and the cost of the home-based care was picked up by the European Union (EU) in collaboration with the DOH. This was a success story in that both the partners and the EU acknowledged that the financial management skills the partners gained through AIDSRelief helped them qualify for EU funding.

- (4) Obtain antiretroviral medications from the South African government for local partner sites accredited as down-referral clinics. Negotiations with the DOH are ongoing with regard to this approach, and it is expected that at least one AIDSRelief supported site will implement this approach in the very near future.



Elizabeth Ntahlaba gets her blood drawn by nurse Frederica Mokyadi Ramashapa at the St. Francis Care Centre ARV Clinic in Johannesburg. Photo courtesy of Paul Jeffrey/Ecumenical Advocacy Alliance.

These approaches require adherence to South African government standards and treatment protocols and the development of a productive relationship with government officials at all levels. In South Africa, all AIDSRelief partners are encouraged to attend government policy meetings and training. In addition, government staff have been invited to AIDSRelief training programs and to other related activities. Every month the AIDSRelief monitoring and evaluation officers send patient statistics to the national government and to all provinces. Since each province uses different statistics forms, this is quite a time-consuming exercise, but it has earned AIDSRelief the support of many government officials.

Lessons Learned

What are the lessons learned about partnership? What are the lessons learned that could benefit other country programs as they transition to local leadership?

- **Respect local capacity.** Transition to local leadership begins even before the beginning of the project. It begins with an understanding that the participation of the international organization is only temporary; with an acknowledgement that the local partner is the one who knows what will work best in the local context and that the local partner is the one best suited to implement activities in their own country. It begins with the mind-set that success in the long term depends on the extent to which the local partner is at the helm.
- **Begin early.** Transition should inform the planning process from the earliest days. All program planning should take into account the final goal of transition to local leadership, and all activities should be planned with that goal in mind.
- **Learn together.** Local partners should attend training courses with international staff. If the donor conducts a

training course on financial compliance, for example, local partners should attend with the staff of the international organization, as opposed to having the international staff attend and then pass on the information learned to the local partner.

One of the challenges of the transition process arises when the local partner has little experience working with external donors and perceives the international partner's efforts to ensure compliance as interference in their internal affairs, as undue pressure on their staff, and as unnecessary added work. When the local partner is given the opportunity to participate directly, for example, in training on donor regulations, they will learn the requirements first-hand and will not perceive them as arbitrary requirements imposed by the international partner. Learning the regulations together is a collegial sharing experience; far more acceptable than the teacher-student dynamic created when the international partner is the one to deliver the information.

- **Approach donors jointly.** Local partners should be included in all meetings with donors or consultants, whatever the issue. This allows local partners to get to know the donors directly, to understand the donor perspective, and to gain experience in working with them. It also gives the donor the opportunity to know the local partners and to see their capacity.

The international partner may have issues to discuss with the donor that relate to partner capacity or performance and may be concerned that addressing these issues with the partner present could put the relationship at risk. And it could. But meeting privately with the donor could risk the relationship as well. Transparency is the best way forward. Meet the donor together with the partner and share ownership of the situation; that is, speak to the donor about "our" concern, about the challenges "we" face. This approach will strengthen the relationship with the partner and earn the respect of the donor.

- **Utilize local resources.** The linkages established with local resource people and institutions will provide continued long-term, cost-effective support for the local partners after the external funding has come to an end.

However, in countries where local experts are oversubscribed and institutions stretched to the limit, external experts may be the best option. The challenge is to guide the external experts to ensure that their input is appropriate to the country context and that they work collaboratively with their local counterparts. An international exchange of knowledge and perspectives can be an enriching experience for all stakeholders and can pave the way for transition down the road.

- **Work with the host government.** In most countries, health services are the responsibility of government. External donor funding for PLHIV will not continue forever. If life-long treatment is to be sustained, local government must be on board.

The challenge comes when government resists working with local and/or international organizations and when the local implementing partner does not want to invest the time and energy in establishing a relationship with officials who are not supportive of their work. Relationship-building activities can help overcome these barriers—activities such as inviting government officials to project workshops; sharing educational resources; and looking for ways to be helpful. In all cases, international and local organizations should refrain from criticizing government health services. In all instances, all partners should convey the message that their work is in support of government efforts to provide treatment.

- **Reinforce local ownership.** Local partners should be the face of the program.

For example, when there are presentations to be given, the local partner should be the speaker, if possible. The challenge comes

when the local partner is inexperienced in preparing presentations and in speaking publicly. In these circumstances joint presentations (preparation and delivery) will help the partner gain these skills and will reinforce the collaborative nature of the partnership.

Similarly, in meetings with program stakeholders, the local partner should take the lead in the discussions, where possible, with the international partner providing support and technical back-up as required.

- **Build an effective team.** Team building should be a priority, with joint implementation of activities, and shared and joint decision-making. Mutual respect and a consultative relationship should characterize all interactions.

The test of shared leadership and joint decision-making comes when the partners disagree about a key issue—and disagree they will—and when each partner is convinced that the wrong decision could be damaging to the implementation of the program. If the goal is transition to local leadership, it is essential that the international partner avoid “pulling rank” and try to work through the issue with the partner and come to a consensus. In the long term, it will be easier to repair a “wrong” decision than to mend a broken relationship.

- **Work side by side.** Joint implementation of activities, with local and international partners working side by side contributes to team-building and builds the capacity of both. But it is not always easy.

The challenge lies in the fact that the international organization, as the grant holder, is ultimately responsible for the deliverables of the project as well as for timely submission of reports to the donors. Joint activities remain the responsibility of the international partner, no matter which organization is implementing them. If the work is divided and the local partner doesn't do their part or doesn't deliver on time, it is the international partner who will be called to account. But if

transition is the goal, sometimes the international partner will just have to take the heat.

In a relationship of equals, partners help one another. In a good relationship, the local partner will appreciate being asked to help the international partner, once they understand the need.

- **Disengage gradually.** As the time for transition to local leadership draws near, the staff of the international organization should gradually disengage from day-to-day implementation, while continuing to accompany the local partner and provide support when requested. Every effort should be made to make the transition as seamless as possible. The pending transition should be evidenced by the international partner letting go of certain activities. For example, the role of chairperson should first alternate between the two organizations and then gradually be assumed by the local partner. The international partner should gradually withdraw from representational activities. The outcome should be a transition that is so natural that it is hardly commented upon.

Conclusion

This is the story of how AIDSRelief South Africa transitioned to local leadership. It is hoped that the South Africa experience will be useful to others working in partnership, regardless of their field. There is no one formula, no one map for the road to transition. Each country situation is unique, each with different resources, stakeholders, and challenges. Transition is a process that builds on country capacity and partner commitment. No one model will work for all.

But there is one aspect of the process that applies across the board: transition to local leadership requires a respectful relationship between partners. When it comes to transition, relationship is everything.

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