

Evaluation of Transitioning an HIV Response to Local Ownership in Four Countries

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Acronyms

| | |
|--------|--|
| ART | Antiretroviral therapy |
| CAF | Children's AIDS Fund |
| CDC | Centers for Disease Control |
| CHAK | Christian Health Association of Kenya |
| CHAZ | Churches Health Association of Zambia |
| CMMB | Catholic Medical Mission Board |
| CSSC | Christian Social Services Commission |
| EID | Early infant diagnosis |
| eMTCT | Ending Mother to Child Transmission (Uganda) |
| FOA | Funding opportunity announcement |
| GOT | Government of Tanzania |
| HMIS | Health management information systems |
| HPAC | Health Policy Advisory Committee (Uganda) |
| HRSA | Health Resources and Services Administration |
| IHV | University of Maryland School of Medicine Institute of Human Virology |
| INGO | International nongovernmental organization |
| IP | International partner |
| IYDSA | Institute for Youth Development—South Africa |
| JMS | Joint Medical Stores (Uganda) |
| KCCB | Kenya Conference of Catholic Bishops |
| KEC | Kenya Episcopal Conference |
| LEAD | Local Partners Excel in Comprehensive HIV and AIDS Service Delivery (Tanzania) |
| LP | Local partner |
| LPTF | Local partner treatment facility |
| LTFU | Lost to follow-up |
| MAUL | Medical Access Uganda, Ltd. |
| MEAL | Monitoring, Evaluation, Accountability and Learning |
| MOHSW | Ministry of Health and Social Welfare (Tanzania) |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PICT | Provider-initiated counseling and testing |
| PMTCT | Prevention of mother-to-child transmission |
| SACBC | South African Catholic Bishops Conference |
| SCA | Site Capacity Assessment |
| UCMB | Uganda Catholic Medical Bureau |
| UEC | Uganda Episcopal Conference |
| UPMB | Uganda Protestant Medical Bureau |
| USAID | U.S. Agency for International Development |
| WHO | World Health Organization |

Executive Summary

Between 2004 and 2013, the global AIDSRelief program supported rapid scale-up of HIV care and treatment services for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. AIDSRelief served more than 700,000 clients, including more than 390,000 who enrolled in antiretroviral therapy (ART) through 276 facilities.

AIDSRelief established basic packages of HIV care and treatment that exceeded what many thought possible in resource-constrained environments. The program helped broad cadres of health workers to identify and manage treatment failure or other adverse drug events; to diagnose, treat, and prevent opportunistic infections; and to provide patients with adherence counseling and support, empowering them to effectively manage their own treatment. The program also cultivated sustainable patient access to quality services provided and managed directly by local partners.

To capture and share knowledge gained through AIDSRelief's transitions to local partners, the Health and Social Services unit at Catholic Relief Services (CRS) has developed this learning document. Interviews with project staff, local partners, and facility personnel involved with transition provide the foundation for an exploration of challenges, successes, and potential best practices identified in five AIDSRelief countries.

The experiences of transitioning grant management, clinical oversight, and strategic information management from a consortium made of international organizations to wide-ranging local partners varied tremendously. In the four countries profiled in this document, common themes appeared: cultivating a shared vision, bringing partners "to the table" in a meaningful way, encouraging staff continuity, and balancing flexibility with prescription. Shared common understanding vision and commitment to transition process, as well as improving local partner's systems and building trust, confidence among stakeholders, facilitated the transition process toward local ownership.

This analysis also made clear that sustainability is a process and there are degrees of organizational maturity. For a successful transition, the receiver or local partner needs to have adequate organizational and technical capacity. Many local partners already have substantial capacity and most have the potential to strengthen their capacity. They are best positioned to address local problems because of their situational knowledge and existing networks and relationships. However, even the most robust organizations benefit from targeted outside expertise, which is often best provided by international partners (IPs):

- Large, well-resourced international institutions continue to have greater access to highly specialized skills and knowledge than local partners. IPs are well positioned to provide technical assistance in these areas (e.g., U.S. government grant and financial management, state-of-the-art technology or clinical practices).

- Competencies such as financial management and human resources typically take priority in organizational development interventions. They are essential, yet a fully realized organization must perform other functions (e.g., communications, documentation, advocacy, and qualitative research). IPs can provide resources and technical assistance in areas such as these.
- Successful transition to a truly local partner has emerged as a skill in itself and direct experience is relatively rare. Transition requires dedicated resources; it must be scheduled, budgeted, staffed, and monitored, and it requires targeted capacity strengthening. Donors and implementers must be willing to set up local partners for success by investing in deliberate, context-specific transition planning and implementation. Experienced IPs and organizationally mature local organizations have important roles to play in future development efforts.

Background

CLINICAL EXCELLENCE, OPTIMAL HEALTH OUTCOMES

Between 2004 and 2013, the global AIDSRelief program supported rapid scale-up of HIV care and treatment services for poor and underserved people in 10 countries across Africa, the Caribbean, and Latin America. AIDSRelief served more than 700,000 clients, including more than 390,000 who enrolled in antiretroviral therapy (ART) through 276 facilities.

AIDSRelief established basic packages of care and treatment that exceeded what many thought possible in resource-constrained environments. The program helped health workers identify and manage treatment failure or other adverse drug events, diagnose, treat, and prevent opportunistic infections such as tuberculosis or pneumonia, and provide patients with adherence counseling and support, empowering them to effectively manage their own treatment.

A VISION OF SUSTAINABILITY & LOCAL OWNERSHIP

The sustainability of patient access to quality HIV care and treatment was at the heart of AIDSRelief's design. The program incorporated a vision for transitioning full responsibility to local partners without compromising the quality of care or program management. Local partners were chosen for their national presence and interest in strengthening their capacity to provide and expand high-quality HIV care and treatment services. They also were expected to become eligible for U.S. government funding as part of the transition. By late 2014, local partners in eight of the 10 countries received U.S. government funding for programming related to HIV care and treatment, six AIDSRelief country programs had completely transitioned responsibilities to the local partners, and transition was underway in two countries (see Table 1). Five of these programs are profiled in this report.

THE STRUCTURE OF AIDSRELIEF

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funded the program through a grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Local Centers for Disease Control (CDC) offices oversaw day-to-day, in-country program implementation. Operating largely through faith-based rural facilities, AIDSRelief staff worked shoulder-to-shoulder with local implementing partners and facility staff to ensure local capacity was enhanced in all areas of program implementation.

The five AIDSRelief consortium members had distinct and complementary roles; their involvement in each country program was determined by their country presence and the needs of the host-country local partners. Engaged consortium members provided technical support in areas of expertise to local partners and supported health facilities.

AIDSRelief Consortium Members & Roles

Catholic Relief Services (CRS): Prime grantee, technical lead for grant management and organizational development

University of Maryland School of Medicine Institute of Human Virology (IHV): Technical lead for clinical care and treatment

Futures Group: Lead agency for strategic information

IMA World Health and Catholic Medical Mission Board (CMMB): Key sub-grantee, site management

Children's AIDS Fund (CAF): Key sub-grantee, site management

TABLE 1. AIDSRELIEF COUNTRIES, LOCAL PARTNERS, AND TRANSITION STATUS.

| COUNTRY | LOCAL PARTNER(S) | TRANSITION STATUS |
|---------------|---|--|
| Ethiopia | Ethiopian Catholic Secretariat | Follow-on project awarded to INGO. |
| Guyana | Ministry of Health Davis Memorial Hospital St. Joseph Mercy Hospital | Transitioned (2012) to local partners that receive U.S. government funding for HIV care and treatment. |
| Haiti | St. Boniface Foundation | Follow-on project awarded to INGO. |
| Kenya* | Christian Health Association of Kenya Kenya Conference of Catholic Bishops | Transitioned (2013) to local partners that receive U.S. government funding for HIV care and treatment. |
| Nigeria | Christian Health Association of Nigeria Catholic Caritas Foundation of Nigeria | Transitioned (2012) to local partners that receive U.S. government funding for HIV care and treatment. |
| Rwanda | Ministry of Health | Transitioned (2012) to local partners that receive U.S. government funding for HIV care and treatment. |
| South Africa* | First transition: Southern Africa Catholic Bishops Conference International Youth Development—South Africa St. Mary's Hospital Second transition: Department of Health | First transition: Transitioned (2010) to local partners that receive U.S. government funding for HIV care and treatment. Second transition: Transition from local partners to Department of Health is underway. South Africa's public health system is taking full ownership of HIV care and treatment. |
| Tanzania* | Christian Social Services Commission | Transition underway through follow-on awards to AIDSRelief consortium members and local partners. Local partners receive U.S. government funding for HIV care and treatment. |
| Uganda* | Uganda Catholic Medical Bureau Uganda Protestant Medical Bureau CAF Uganda | Transitioned (2012) to local partners that receive U.S. government funding for HIV care and treatment. |
| Zambia | Churches Health Association of Zambia Chreso Ministries | Transition underway; local partners receive U.S. government funding for HIV care and treatment. |

*Profiled in this report

LEARNING FROM AIDSRELIEF EXPERIENCES WITH TRANSITION

To capture and share knowledge gained through AIDSRelief's transitions to local partners, the Health and Social Services unit at CRS prepared this exploration of challenges, successes, and potential best practices in five AIDSRelief countries. Interviews with project staff, local partners, and facility personnel involved with transition provide the foundation for this learning document.

Most former AIDSRelief local partners have expanded the number of clients they serve and services they provide since taking responsibility for their own programs, while maintaining service quality. In some cases partners identified a drop in quality, determined the cause or causes, and made needed adjustments. These monitoring and problem-solving skills are quite literally lifesaving given the changing contexts in many developing countries and the evolving HIV epidemic.

Historically, local organizations have not had direct access to large amounts of funding or international donors. Former AIDSRelief local partners developed the capacity to apply for, receive, manage, and effectively use substantially more money than in the past. They complied with U.S. government financial requirements and opened doors to other funders.

The achievements of former AIDSRelief local partners are often remarkable, particularly when one considers that widespread treatment for HIV was barely imaginable when PEPFAR was launched in 2003, much less coordinated, quality treatment delivered and managed by local providers and organizations.

ST. MARYS RURAL HEALTH CENTRE
VISITING TIME
MORNING 10 00HRS TO 11 00HRS
AFTERNOON 15 00 HRS TO 16 00 HRS
SUNDAY
MORNING 10 00HRS TO 11 00HRS
AFTERNOON 13 30 HRS TO 14 30 HRS
DEPARTMENTS
OUT PATIENT ➡
ADMINISTRATIVE OFFICERS ➡
⬅ **IN PATIENT**
MATERNITY WARD
GLAN MARIA CENTRE

A public health clinic in the small town of Lufwanyama, Copperbelt, Zambia is one of many that received technical support from CRS staff.
Photo by M. Jean Claude Kazadi.

Methodology

This qualitative exploration consisted of a review of AIDSRelief program documents pre-transition, including transition plans, and 61 phone/Skype interviews (Appendix A) with CRS staff, local partners (LPs), current and former AIDSRelief staff, and local partner treatment facility (LPTF) staff. (See Table 2.)

For the Tanzanian documentation, the research team also interviewed government health ministry staff. In South Africa, the team conducted formative interviews with former AIDSRelief staff that transitioned to LP management in 2008. Interviews with the LP provided context and hindsight, especially as the LP is now leading the transition to the government.

A common interview guide (Appendix B), developed in consultation with various CRS former AIDSRelief staff, was used in all interviews. The guide varied slightly in line with each interviewee's function in the organization and/or follow-on award. For example, researchers interviewed LPTFs regarding their experience as a subgrantee of a local organization in comparison to their experience with AIDSRelief.

Interviews were conducted by a consultant, and typically lasted 1.5 to 2 hours. They began with an introduction of the purpose of the interviews and their future use, as it was explained by the research team to the consultant. Most interviews were held with multiple individuals to minimize scheduling challenges and limit access to the Internet, which would impact the quality of the Skype calls. However in some cases, individuals spoke for the group. The interview team encouraged free discussion and reflection without bias.

Following the interviews, CRS reviewed, triangulated and analyzed data for commonalities within the countries and across the countries. Each country profile was shared with CRS headquarters staff and with the respective country to solicit additional information, clarity, and comments and to ensure the intent of their responses was accurately conveyed. In some cases, the country disagreed with the observation of the LP and insisted on revisions.

TABLE 2: INTERVIEWS BY COUNTRY.

| | CRS/PROGRAM/ INGO STAFF | LOCAL PARTNERS | LPTF | GOVERNMENT |
|------------------------|----------------------------|-------------------|------|------------|
| Headquarters/CRS Field | 16 | N/A | N/A | N/A |
| South Africa | 2 | 1 | 0 | 0 |
| Uganda | 0 | 9 | 0 | 0 |
| Kenya | 1 | 2 | 1 | 0 |
| Tanzania | 1 | 4 | 0 | 5 GOT |
| Total | 20 | 16 | 1 | 5 |

Each CDC country office is semi-autonomous. Local decisions for specific strategies to achieve a common goal are determined by the local office, which may account for the variance in transition strategy. CDC Zambia indicated that each CDC country is responsive to individual country context and that in Zambia, the intent and desire was to get transition right from the very beginning. They also indicated that the program scale-up was new, as was the transition process.

The documentation exercises consisted of key informant interviews that relied on memory recall of events over two years ago and individual perceptions of relationships and performance. In all qualitative exercises relying on memory recall, there are several opportunities for inaccurate recall, given the time between the transition and the interview. As previously mentioned, interviews were triangulated, in part to account for these potential biases.

Skype was the primary method of interviews. Internet bandwidth restrictions did not allow video calls and affected quality, which often resulted in a longer call. The interviewer remained flexible in rescheduling calls, monitoring the time and allowing for the completion of questions offline, especially if the interviewee was to travel in the field without Internet for some time.

Country Profile: Uganda

AIDSRELIEF UGANDA ACHIEVEMENTS

AIDSRelief Uganda supported 18 facilities providing comprehensive HIV care and treatment services in Northern, Western, and Central Uganda. The program provided care to a total of nearly 88,000 patients, including more than 35,000 on ART as of February 2012. Quality indicators were excellent: only 4.8 percent loss to follow-up (LTFU), 88.5 percent retention, and 7.5 percent mortality.

All HIV-positive patients younger than 2 years old in Ugandan AIDSRelief-supported facilities were started on ART. AIDSRelief Uganda successfully lobbied the Ministry of Health to consider Option B for prevention of mother-to-child transmission (PMTCT) of HIV. In October 2011, the ministry invited AIDSRelief to launch a pilot study of the country's first PMTCT Option B program. AIDSRelief shared details of this pilot (which began with 12 facilities and 184 patients) to inform nationwide implementation plans.

TRANSITION OVERVIEW

Engaged consortium members: CRS, IHV, Futures, CAF

Local partners: Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), CAF Uganda

Transition year: 2012

Transition period: Less than one year (August 2010 to February 2012)

| TWELVE-MONTH QUALITY INDICATORS, BY IMPLEMENTER | | | | |
|---|------|----------|---------------|---------------|
| Implementer | Year | LTFU (%) | Retention (%) | Mortality (%) |
| AIDSRelief | 2012 | 4.8 | 88.5 | 7.5 |
| UPMB | 2014 | <15 | 85.4 | 5.7 |
| UCMB | 2014 | <20 | 84 | 5 |
| CAF Uganda | 2014 | 6.9 | 81.9 | 6.6 |

Source: UCMB, UPMB, and CAF data as orally reported, May 2014.

| ART COVERAGE (CURRENT), BY IMPLEMENTER | | |
|--|------|------------------|
| Implementer | Year | ART patients (#) |
| AIDSRelief | 2012 | 35,047 |
| UPMB | 2014 | 7,950 |
| UCMB | 2014 | 41,000 |
| CAF Uganda | 2014 | n/a* |

Source: UCMB and UPMB data as orally reported, May 2014.

*CAF orally reported 26,000 patients ever on treatment as of May 2014; number of patients currently on treatment was not available.

AIDSRelief advocated for and trained staff to implement nurse refill programs, which allow nurses with specialized training to provide routine care for stable patients, reduce patient wait times (facilitating clinic attendance and adherence), and lighten physician workloads (allowing time for more patients). By the end of 2011, 18 AIDSRelief sites offered nurse refill services for stable patients. The practice is now common in Uganda.

TRANSITION PLANNING

Transition to local partners was part of the 2004 project design in Uganda, but it took time to cultivate a shared understanding of what “full transition” meant and how to achieve it. AIDSRelief worked closely with HRSA and CDC to develop a common understanding. In late 2010, representatives from the AIDSRelief consortium, local partners, and CDC Uganda formed the Uganda Leadership Forum on Transition based on the AIDSRelief Zambia model. The forum was designed to provide direction and transparency in the transition process and to monitor transition plan implementation. Equal participation among forum participants was encouraged, for example, through relatively simple policies such as rotating the organization responsible for hosting and chairing each meeting.

AIDSRelief Uganda had a preliminary transition plan in place when HRSA, CDC, and AIDSRelief jointly assessed Ugandan local partner capacity in 2010. (HRSA conducted similar assessments of local partners in each Track 1.0 country.) AIDSRelief and local partners jointly developed an implementation plan and timeline for capacity strengthening that responded to gaps identified by the HRSA assessment. Interviewees from local partners reported that the transition plan began to feel “real” to them at this point. HRSA’s final assessment in August 2011 found that AIDSRelief and local partners were meeting their planned benchmarks.

To further foster a smooth process, the transition plan also anticipated that local partners would sub-grant to AIDSRelief consortium members to directly receive U.S. government funding. In the post-transition period, former consortium members would provide need-based technical support in clinical care and treatment (University of Maryland School of Medicine Institute of Human Virology-IHV); strategic information (Futures); and finance, compliance, and site management (CRS and CAF).

NEW CIRCUMSTANCES REQUIRE A CHANGE OF COURSE

The CDC released a U.S. government funding opportunity announcement (FOA) for local organizations to assume management of components of the AIDSRelief program. CRS used private funds to support local partners UCMB, UPMB, and Joint Medical Stores (JMS) to develop and submit proposals in response. After a competitive bidding

AIDSRRELIEF UGANDA TRANSITION PLANNING MILESTONES

AUGUST 2010

- HRSA conducted first local partner assessment in Uganda.
- AIDSRelief Uganda hired full-time health systems strengthening manager and transition coordinator.

SEPTEMBER 2010: CRS organized proposal development training for local partners.

NOVEMBER 2010

- AIDSRelief established Leadership Forum on Transition.
- Forum ratified AIDSRelief Uganda transition plan.

NOVEMBER 2010: Transition plan presented to facility representatives, and introductory meetings organized between local partner and facility representatives.

JANUARY 2011: A CRS-sponsored business development specialist worked with local partners to develop necessary documentation and plans for anticipated U.S. government bid.

MARCH–APRIL 2011: CDC announced funding opportunity and CRS dedicated substantial resources in support of local partners’ bid development.

AUGUST 2011: Final HRSA assessment finds AIDSRelief and local partners achieving transition plan benchmarks.

SEPTEMBER 2011: CDC awards AIDSRelief program components to UCMB, UPMB, and MAUL.

process, CDC awarded the major AIDSRelief program components to local entities: site management to UCMB and UPMB and supply chain to Medical Access Uganda, Ltd. (MAUL). Components of the awards varied from what was anticipated in the AIDSRelief transition plan:

- MAUL was a new supply chain partner for AIDSRelief-supported facilities. (JMS had handled supply chain for HIV-related medicines under AIDSRelief.)
- The FOAs did not include the four sites managed by CAF under AIDSRelief. (In response to partner concerns about this omission, CDC later asked UPMB to subcontract management of the four sites to CAF Uganda for about one year, and then issued another FOA and award to fund CAF directly.)
- Under the new awards, partners were expected to maintain and expand service coverage with significantly less funding than AIDSRelief.
- Timing of funding was unclear; for about six months, both AIDSRelief and local partners had funding to manage the same sites and services.
- The new awards did not include technical support from international partners.

In response to these changes, HRSA assessment results, and the imminent closure of AIDSRelief, representatives from CDC, HRSA, AIDSRelief, UCMB, and UPMB revised the existing transition plan. By prioritizing and revising planned activities, these stakeholders developed a fast-track transition plan for the last six months of AIDSRelief. Key AIDSRelief activities included:

- Final-round health facility assessments jointly conducted by AIDSRelief, UCMB, UPMB, and CAF using the Site Capacity Assessment (SCA) tool developed under and used throughout AIDSRelief
- Completion of computer networking and roll-out of financial management systems to all supported health facilities
- Identification of significant project assets and creation of a final disposition plan to benefit supported facilities and local partners
- Managing the transition of project staff to local partners to preserve collective institutional knowledge.

AIDSRelief started to transition programmatic responsibilities and reduce technical support to the local partners in accordance with the fast-track plan. Monthly meetings between CDC Uganda, AIDSRelief, and local partners replaced the Leadership Forum, and CDC Uganda put each partner in charge of implementing and reporting its progress against assigned benchmarks. AIDSRelief no longer played a coordinating or leadership role with regard to transition.

Some interviewees representing local partners said they felt that, in hindsight, the fast-track transition period was not optimally used and that transition happened too fast. AIDSRelief representatives also noted some frustration with the process, including the

consortium's rapidly diminishing role after eight years of deep personal investment. However, as one interviewee pointed out, facilities continue to receive technical and financial support and provide quality care to HIV patients in Uganda.

POST-AIDSRELIEF IMPLEMENTATION & TRANSITION

In the post-transition period, each local partner expanded coverage in terms of the number of patients served, geographical catchment areas, and/or services offered. The organizations did so with proportionally less funding and largely continue to deliver quality services.

Initially, some facility staff funded by AIDSRelief left their positions, but many remained and provided continuity at the service delivery level. As the global project closed down, local partners hired a number of former AIDSRelief staff to perform functions previously led by the project. While formal technical support from international consortium members to local partners did not continue after the project closed, this retention of human resources was essential to preserving capacity and institutional memory and sustaining the high quality of care established under AIDSRelief.

ACHIEVEMENTS: UGANDA CATHOLIC MEDICAL BUREAU

As of April 2014, UCMB managed 19 facilities (up from 12 under AIDSRelief). UCMB added HIV services such as male circumcision, worked to integrate HIV with other health care provision, streamlined some activities conducted under AIDSRelief, and improved alignment with the Ministry of Health. UCMB serves on the Ministry of Health's Health Policy Advisory Committee (HPAC) and co-owns (with UPMB) the Joint Medical Store (one of three pharmaceutical warehouses in Uganda). UCMB reported that these relationships have helped UCMB to campaign for equitable access to care and treatment of HIV and other diseases.

UCMB's quality indicators remained good. Since transition, it has doubled the number of patients enrolled on ART at UCMB-managed sites to more than 41,000. In response to the donor's reemphasis of a combination of HIV prevention approaches (as opposed to stand-alone interventions), UCMB has advocated for dedicated "abstinence and be faithful" prevention programs for faith-based organizations that might object to other prevention approaches.

Since transition from AIDSRelief, UCMB began implementing an award from the World Health Organization (WHO) for a tuberculosis testing project (TB REACH). This project helped to further strengthen UCMB linkages to Uganda's National Tuberculosis Program. Additionally, two UCMB facilities (Kalongo and Aber hospitals) were designated as regional hubs for early infant diagnosis (EID) of HIV and other laboratory services.

ACHIEVEMENTS: UGANDA PROTESTANT MEDICAL BOARD

As of May 2014, UPMB managed 13 sites (up from two under AIDSRelief) and had nearly 8,000 patients on treatment. Since transition, UPMB has scaled-up PMTCT efforts, and added male circumcision, provider-initiated counseling and testing (PICT), and PMTCT Option B Plus to its scope of HIV services.

.....
"On the ground, little actually changed... that's the legacy of the program."
—Former AIDSRelief staff

Uganda Catholic Medical Bureau (UCMB)

is the technical arm of the Uganda Episcopal Conference (UEC), responsible for coordinating the network of health facilities of the Roman Catholic Church in Uganda. It was founded in 1935 and recognized by the colonial government in 1955. The Catholic Church has a total of 281 health facilities under the UCMB umbrella. These facilities operate as part of the national health system and district health systems in which they are located, constituting a sizeable component of Uganda's public health system

UPMB has maintained quality of care indicators comparable to those achieved under AIDSRelief, and doubled the number of patients enrolled on ART in UPMB-managed sites. In addition to its 2012 U.S. government grant, the organization has received new funding from the African Christian Association (for family planning activities integrated with HIV services). UPMB hired a new grants and fundraising advisor to lead growth efforts.

Additionally, UPMB reported increased internal capacity (and confidence in that capacity) for grant management and improvements in an already-sound relationship with the Ministry of Health. Related efforts included joint mentorship of facility staff, spearheading the roll out of Ending Mother to Child Transmission (eMTCT), joint scale-up of quality safe medical male circumcision, and joint management and rationalization of logistics. UPMB is also working with WHO to lead work on patient safety.

ACHIEVEMENTS: CHILDREN'S AIDS FUND UGANDA

At the time of data collection, CAF Uganda managed eight sites (up from four under AIDSRelief) and received nearly twice the funding it did under AIDSRelief. The organization has more than doubled the number of patients in care (from 12,000 at transition to more than 26,000 patients in 2014) and thus found it necessary to drop complementary program components and seek additional funding to cover programming not included in its post-AIDSRelief award.

CAF Uganda has maintained quality of care indicators comparable to those achieved under AIDSRelief and reported an improved capacity to support and mentor facility staff. The organization also reported that the program is more streamlined than under AIDSRelief, and that it is now better recognized on the national stage by donors, government, and other mechanisms related to health—prominence that could help the organization influence policy and garner new funding opportunities.

Children's AIDS Fund (CAF) Uganda

was registered in 2005 as a local NGO, established by the Children's AIDS Fund which has been working exclusively in HIV and AIDS since 1987. Two of the CAF-managed treatment and care sites in Uganda preceded the start of PEPFAR by approximately six months and were incorporated into the AIDSRelief Uganda program.

FIGURE 1

UGANDA TWELVE-MONTH QUALITY INDICATORS By implementer

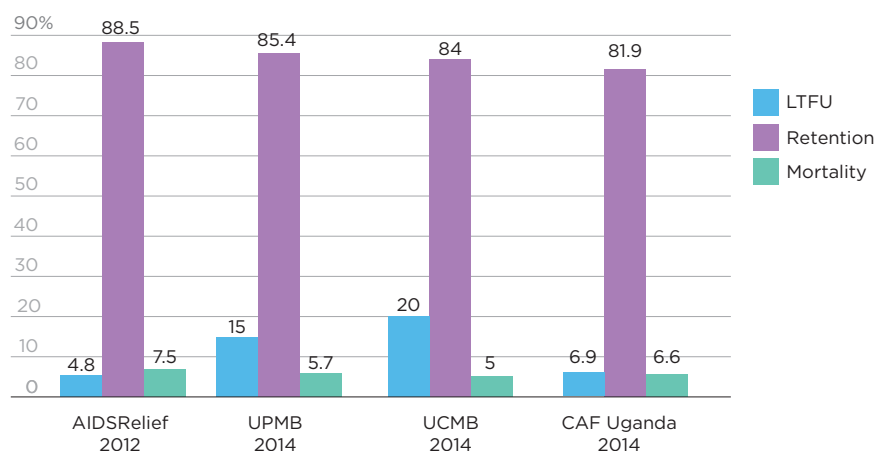
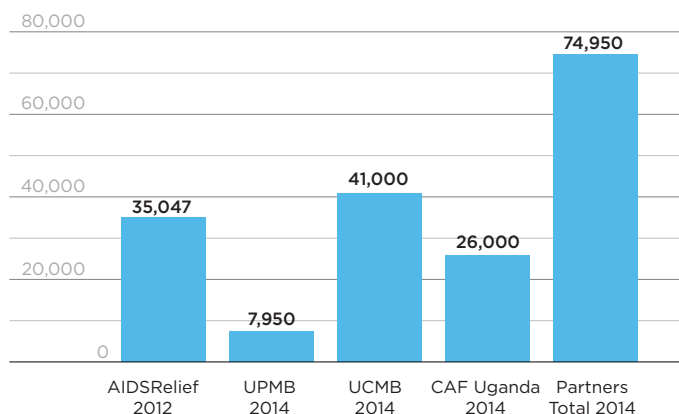


FIGURE 2

UGANDA ART COVERAGE

By Implementer



KEY TRANSITION LESSON: CULTIVATE SHARED VISION AND UNDERSTANDING

In spite of several months of efforts to plan and execute a smooth transition, unanticipated factors forced stakeholders to adapt and develop a fast-track transition plan after the 2011 awards. This revised plan achieved its general purpose—transition of program components from AIDSRelief to local partners—but reportedly left many dissatisfied. Interviewees representing local partners and AIDSRelief in 2014 expressed directly and indirectly that the donor, consortium partners, and local partners did not share a clear vision of the process or even the end result of transition.

One example is the planned but unrealized role for AIDSRelief consortium members to provide technical support to local partners after the project closed in 2012. Partner representatives also reported that the period of overlapping funding was somewhat duplicitous and ineffective. It is unlikely that the months of overlap could have filled the need for even one or two years of phased technical support, but a clear vision for post-transition operations might have helped consortium members and local partners to better address critical priorities and concerns during this time.

Another example relates to perceptions of local partner capacity. Internal evaluators used standardized capacity assessment tools and the external HRSA assessments assured objectivity. Local partners and AIDSRelief reported that HRSA's 2010–2011 capacity assessments were valuable in identifying gaps. However, local partner representatives reported feeling that assessments did not accurately or completely reflect their strengths. There was some agreement about this within AIDSRelief as well.

The fast-track transition plan, the circumstances that required its development, and the (actual or perceived) lack of a clear driver or party responsible for transition likely contributed to uncertainty and a lack of clarity among partners. Months of careful

planning and consensus building were condensed or put aside in order to achieve what was regarded as the minimum requirements for successful program transition. Although partners helped develop the new plan, the process seems to have felt rushed or forced by comparison. Additional causes of dissatisfaction and disconnection might include strained personal relationships, a tense political climate as individuals and organizations sought to determine their immediate future, and a lack of clarity around donor expectations for direct grantees.

Unexpected changes are a reality of development work, and some challenges surrounding the fast-track transition plan and implementation might have been inevitable. However, the challenges might have been mitigated by:

- Efforts to leverage more of the ratified transition plan in the new context. This might have encouraged ownership, alleviated feelings of wasted time and effort, and perhaps helped retain some of the previous buy-in.
- More direct engagements between local partners and the donor (particularly prior to transition). Such efforts might have helped clarify donor expectations and better distinguish donor requirements from consortium or prime grantee demands.
- Additional transparency and robust, mutually respectful discussions, particularly with regard to assessment findings. Increased application of these approaches might have mitigated feelings of being unfairly assessed. In any capacity strengthening arrangement, both parties (the “expert” and the learner) must be open to constructive criticism. These interactions can be difficult, but they are invaluable in the longer term. If the resources are available, engaging outside evaluators or facilitators also can help avoid potentially adversarial situations.

.....
 For a successful transition, stakeholders must work to achieve shared vision, regardless of the underlying causes—as the adage goes, “perception is reality.”



Six local health partners in Kenya received ambulances for HIV service delivery from the AIDSRelief consortium. The ambulances enable the mission hospitals to transport extremely ill patients and extend service outreach in remote communities. *Debbie DeVoe/CRS.*

Country Profile: Kenya

AIDSRELIEF KENYA ACHIEVEMENTS

AIDSRelief Kenya supported 31 facilities providing comprehensive HIV-related services to more than 141,000 patients (cumulative), of whom more than 60,000 were on ART at the end of the project. Patients receiving ART through AIDSRelief-supported sites represented 10 percent of all patients on treatment in Kenya in late 2011, and 15 percent of Kenya's overall pediatric patients on treatment in 2012 were from AIDSRelief facilities.

IQCare, an electronic patient management and monitoring system implemented under AIDSRelief, was rated by the WHO in a 2010 evaluation as one of the best health management information systems (HMIS) in Kenya. Later, WHO awarded a grant to Futures to help establish Kenya's national HMIS; IQCare is one of three products that Kenyan facilities can choose from.

AIDSRelief Kenya tested more than two-thirds of their HIV patients' sexual partners using a "family form" to identify and offer testing to people close to HIV patients who might be at risk for infection.

TRANSITION OVERVIEW

Engaged consortium members: CRS, IHV, Futures, Catholic Medical Mission Board (CMMB)

Local partners: Christian Health Association of Kenya (CHAK) and Kenya Conference of Catholic Bishops (KCCB), formerly Kenya Episcopal Conference (KEC)

Transition year: 2013

Transition period: Three years

| TWELVE-MONTH QUALITY INDICATORS, BY IMPLEMENTER | | | | |
|---|------|----------|---------------|---------------|
| Implementer | Year | LTFU (%) | Retention (%) | Mortality (%) |
| AIDSRelief | 2013 | 5.9 | 87.2 | 6.1 |
| CHAK | 2014 | 32.5 | 62.8 | 28.5 |
| KCCB | 2014 | 5 | 85 | 8 |

Source: CHAK data from monthly program report, March 2014. KCCB data from IQCare/Blue Card MOH257 April 30, 2014.

| ART COVERAGE (CURRENT), BY IMPLEMENTER | | |
|--|------|------------------|
| Implementer | Year | ART patients (#) |
| AIDSRelief | 2013 | 60,549 |
| CHAK | 2014 | 34,242 |
| KCCB | 2014 | 41,000 |

Source: CHAK data from monthly program report, March 2014. KCCB data from IQCare/Blue Card MOH257 April 30, 2014.

TRANSITION PLANNING

As with all AIDSRelief country programs, transition to local partners was part of AIDSRelief Kenya's original design. The first years of the program were focused on rapid scale-up of services, and transition rapidly came into focus in 2009 when HRSA renewed funding for three years. (AIDSRelief Kenya received an additional one-year extension in 2012.) The renewal made transition a donor-monitored milestone, defined "local partner," and established criteria these partners had to achieve before taking responsibility for grant and program management.

With donor approval, AIDSRelief Kenya identified Christian Health Association of Kenya (CHAK) and Kenya Conference of Catholic Bishops (KCCB) as implementing partners.

HRSA conducted capacity assessments of all AIDSRelief local partners in 2010 and 2011. Interviewees representing CHAK and KCCB report that their organizations found the HRSA assessments to be helpful, particularly in how they informed transition planning. To strengthen capacity and prepare for transition (see box), staff from AIDSRelief and CHAK or KCCB (depending on facility) started to jointly monitor and provide technical assistance to health facilities in 2010. In anticipation of post-AIDSRelief funding opportunities from the U.S. government, CRS used private resources to provide local partners with training and accompaniment for proposal development.

Local partner interviewees reported some frustration with building consensus around transition, noting that the process was time consuming, and that sometimes a mutual understanding of roles remained elusive. On the whole, representatives from local partners and AIDSRelief felt the process was effective and worthwhile. The donor's commitment to successful transition became clear, consortium roles in transition became clear, consortium members stepped back, and local partners stepped up to fulfill new roles and responsibilities in new funding opportunities.

POST-AIDSRELIEF IMPLEMENTATION & TRANSITION

When CDC awarded AIDSRelief follow-on projects to CHAK and KCCB, former AIDSRelief consortium members continued to provide technical assistance as sub-awardees to the local partners. Consistent with the transition plan, as CHAK and KCCB acquired the necessary expertise, they received less external technical assistance and took on responsibilities (including provision of technical assistance to health facilities). Former consortium members are still valued resources; for example, CRS was asked to provide facilities with resource mobilization training, and IHV remains available for highly complex clinical consultations.

CHAK and KCCB have substantially increased the number of sites they managed and the patients in care at those facilities. Quality indicators remained good overall and CHAK and KCCB have seen a 218 percent increase in CDC funding. Nationally, CHAK and KCCB are more involved in technical working groups, further positioning them as technical leaders in Kenya's HIV care and treatment.

Both local partners have adopted and sometimes scaled-up key systems and tools developed under AIDSRelief: preparing site budgets, monitoring work plans, site capacity assessments, paperless reporting systems, and IQCare.

AIDSRelief Kenya's Transition Approach

- Identify local partner(s)
- Build capacity of local partner(s) to provide and manage HIV-specific program services
- Provide support and incrementally transition functions and funding to identified local partner(s)
- Monitor the transition to assure optimal and uninterrupted quality of HIV services during and after transition.

.....
"This transition was much better than any that I've heard of."
—CHAK primary investigator

Transition has been complicated by political devolution and reorganization (i.e., from provincial to county administrative structures), increased compensation packages at public health facilities (affecting retention at faith-based facilities that typically pay staff less), and multiple health worker strikes (driving patients to non-government sites for essential services like ART). Decisions about staffing, commodity distribution, and funding are now made at the county level instead of nationally or provincially, so implementers such as CHAK and KCCB are developing county-level relationships and adapting to new systems.

ACHIEVEMENTS: KENYA CONFERENCE OF CATHOLIC BISHOPS

As of April 2014, KCCB serves nearly 47,000 patients through 18 facilities (up from 13 facilities under AIDSRelief). Almost 41,000 of these patients are on ART. KCCB now provides clinical technical assistance to facilities (a role previously filled by internationally recognized IHV) and has a 5 percent LTFU and 85 percent retention rate in supported facilities.

KCCB has a long history with the Government of Kenya and participating in health-related working groups, however KCCB reports that they have become even more involved since the transition from AIDSRelief. The group is currently involved with Kenya's national HIV program and national working groups for PMTCT, emergency HIV response, tuberculosis and HIV, and third-line ART. KCCB's chief of party attributed much of the increased representation to KCCB's ability to gather and use data to inform programming and capture evidence-based best practices in HIV service delivery—a pillar of the AIDSRelief Model of Care and a major capacity strengthening focus of the program.

ACHIEVEMENTS: CHRISTIAN HEALTH ASSOCIATION OF KENYA

With more than 34,000 patients on ART and more than 38,000 in care as of March 2014, at the time of data collection, CHAK, supported 20 facilities (up from 15 under AIDSRelief) and 37 satellite sites. CHAK reported 32.5 percent LTFU, 62.8 percent retention, and 28.5 percent mortality as of March 2014.

CHAK expanded services to include cervical cancer screening and community prevention activities, but recent funding reductions have forced the organization to drop those services, to postpone renovations and equipment purchases, and to conduct fewer trainings than under AIDSRelief. As of May 2014, CHAK implemented paperless electronic medical records at three facilities (with plans to roll out to all facilities). Interviewees at paperless facilities say that the change has been CHAK's greatest post-transition achievement and that it has significantly reduced staff workloads.

Like KCCB, CHAK has a long history and substantial presence in Kenya's health sector; it continues to represent Christian faith-based organizations in policy and partnership discussion forums. Since the transition from AIDSRelief, CHAK representatives report that the organization has become better at advocacy (e.g., with the U.S. Government), but health facility representatives reported a sense that CHAK could more strongly represent site needs (e.g., commodities distribution) to county-level government and donors.

Kenya Conference of Catholic Bishops (KCCB)

Formed in 1946 as the umbrella body of the Catholic bishops in Kenya. Its Catholic Health Commission of Kenya coordinates all KCCB-affiliated health facilities in the country. Together, this network and CHAK provide about 40 percent of health services in Kenya. KCCB also supports two Catholic universities training nurses at degree level, 15 medical training colleges training nurses at diploma level, one pharmacy training school, and one clinical medicine college.

FIGURE 3

KENYA TWELVE-MONTH QUALITY INDICATORS

By implementer

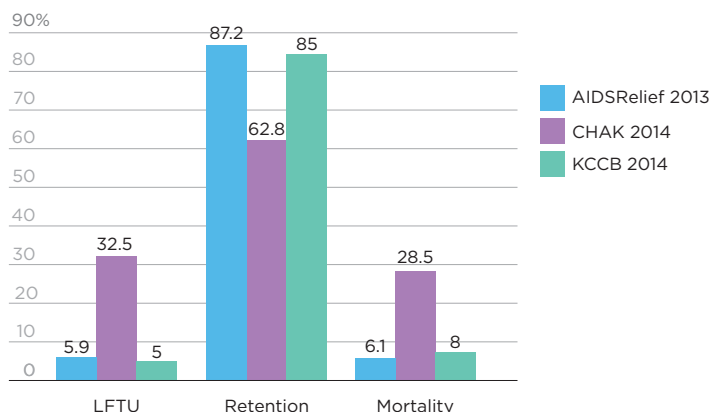
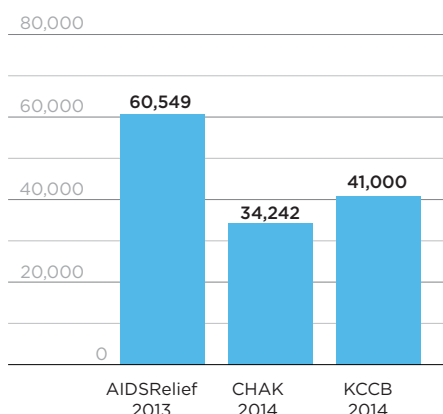


FIGURE 4

KENYA ART COVERAGE

By implementer

**Christian Health Association of Kenya (CHAK)**

was born out of the National Council of Churches of Kenya in 1946, CHAK is a national ecumenical network of Protestant churches and their health facilities. The network includes more than 25 hospitals, 48 health centers, 328 dispensaries, and 17 church health programs throughout Kenya. CHAK has steadily grown in size and scope and now serves and assists member health units in planning, advocacy, capacity building, technical support, essential drugs access, medical equipment procurement and maintenance, networking, information management, health and HIV & AIDS programs.

KEY TRANSITION LESSON: STAFF CONTINUITY IS VALUABLE AT ALL LEVELS

A large part of AIDSRelief's work focused on strengthening the capacity of staff at facilities and within local partner organizations slated to take responsibility for facilities. Staff retention helps ensure the quality of patient care, information use, and organizational management, and helps to ensure that institutional memory—vital in a complex project like AIDSRelief—remains accessible.

Staffing at the facility level was a challenge under AIDSRelief and remained so during transition, particularly as the Kenyan government substantially increased staff pay at public facilities. Furthermore, widespread respect for the AIDSRelief's Model of Care and training programs made AIDSRelief-trained staff highly sought-after. To keep

.....
"[We are] very proud that we are able to maintain, that we are able to continue what AIDSRelief was doing."

—CHAK
 Representative

staff while staying within budget realities, local partners innovated: KCCB employed an annual (renewable) bonus to encourage facility staff to stay through the end of each fiscal year and changed contract periods from one year to the life of the grant, reinforcing job security. CHAK also continued to encourage supported facilities to develop additional incentives for staff retention.

Assisting the management of this award, KCCB acquired the former AIDSRelief Kenya chief of party as its chief of party for the follow-on award. This has facilitated continuity in services and contacts at CDC, and enhanced KCCB's familiarity with cooperative agreement management. Furthermore, about 40 percent of staff on the current KCCB project worked on AIDSRelief. Internally, competitive compensation packages have helped KCCB retain senior project management.

The situation varied a bit with CHAK, as interviewees report mixed messages about whether local partners should recruit AIDSRelief staff before the end of that grant. As of mid-2014, CHAK only employed six former AIDSRelief staff. Many positions were filled with outside candidates who, while qualified, needed time and resources to get up to speed on approaches and activities familiar to AIDSRelief staff. In 2014, CHAK's principal investigator accepted an appointment in the Ministry of Health, leaving another important gap in institutional memory. However, this appointment could prove to be beneficial as CHAK expands its current advocacy in the Kenyan government.

A healthy institution must be able to survive staff turnover, and fresh outside perspectives are valuable; however, staff continuity is vital during tumultuous periods of transition. While individuals must be free to pursue their own career opportunities, there are ways organizations can promote retention during a transition, for example:

- Emphasize transparency and develop clear plans and policies related to staff recruitment by partners and other stakeholders. Individual employees, managers, and human resources staff should understand when it is appropriate to recruit from the transitioning organization and when it would be detrimental to project goals. Leaders and managers should also be frank and forward thinking, planning for efficient re-allocation of staff as responsibilities and functions transfer from one organization to another. During a transition, these approaches could also help retain staff who might otherwise be uncertain of their career future and—out of a concern for their own livelihood—seeking other employment.
- Staff should not be forced to leave one organization or to join another in the name of transition; changes in employment should be voluntary. However, approaches such as secondment can play a pre-transition role in support of responsibility and capacity transfers.



The pharmacy at Sekou-Toure Regional Hospital, a local AIDSRelief partner in Tanzania, provides HIV care and treatment to adults. The facility also serves pediatric clients living with HIV. *Debbie DeVoe/CRS.*

Country Profile: Tanzania

AIDSRELIEF TANZANIA ACHIEVEMENTS

Mandated to work within the Government of Tanzania's systems and structures, AIDSRelief Tanzania supported public healthcare institutions and a wide network of faith-based health service providers in increasing access to comprehensive HIV care and support in four regions. AIDSRelief supported as many as 126 care and treatment centers, reaching more than 165,000 patients (cumulative), including nearly 45,000 who were on treatment when AIDSRelief closed in 2012. In spite of the challenges of operating within multiple facility-management systems and supporting a large number of sites, AIDSRelief Tanzania achieved respectable quality indicators.

The project integrated or linked PMTCT with labor and delivery services, establishing systems for postnatal follow-up, counseling for infant feeding, and treatment provision. By 2012, AIDSRelief Tanzania was supporting the Tanzanian government to implement PMTCT services at 698 health facilities and helped more than 587,000 pregnant women receive HIV counseling and testing and receive their results. Additionally, 15,000 HIV-infected pregnant women received antiretroviral prophylaxis to prevent transmission of HIV to their infants.

TRANSITION OVERVIEW

Engaged consortium members: CRS, IMA World Health, IHV, and Futures

Local partner: Christian Social Services Commission (CSSC)

Transition year: In process

Transition period: Five years

| TWELVE-MONTH QUALITY INDICATORS FOR MWANZA REGION, BY IMPLEMENTER | | | | |
|---|------|----------|---------------|---------------|
| Implementer | Year | LTFU (%) | Retention (%) | Mortality (%) |
| LEAD | 2013 | 22 | 66 | 10 |
| CSSC | 2014 | 18.8 | 73 | 10.4 |

Sources: LEAD Semiannual Progress Report, March 2013. CSSC Semiannual Progress Report, March 2014.

| ART COVERAGE (CURRENT) FOR MWANZA REGION, BY IMPLEMENTER | | |
|--|------|------------------|
| Implementer | Year | ART patients (#) |
| LEAD | 2013 | 24,583 |
| CSSC | 2014 | 34,220 |

Sources: LEAD Semiannual Progress Report, March 2013. CSSC Semiannual Progress Report, March 2014.

TRANSITION PLANNING

As in other AIDSRelief countries, transition to a local partner was a fundamental part of project design in Tanzania. Significant transition planning in the country began with a 2009 mandate from CDC. AIDSRelief's transition model was unique in Tanzania. Other PEPFAR-funded programs in the country formed new local organizations under their management, while AIDSRelief chose to work with CSSC. CSSC is an established organization with longstanding ties to faith-based health facilities and the Ministry of Health and Social Welfare (MOHSW), a strong history of advocacy in Tanzania, experience with AIDSRelief, and experience managing funds from bilateral and multilateral donors. The project also was unique in its inclusion of regional and council health management teams and MOHSW line ministries in both transition planning and implementation.

AIDSRelief Tanzania consortium members and CSSC established a Sustainability Working Group and Transition Task Force to provide strategic guidance, operationalize the transition process, and facilitate an exchange of information and ideas across organizations. The group sought input from stakeholders such as supported facilities, Tanzanian government representatives (including regional and council health management teams), and U.S. government donors. The transition strategy was further informed by ideas shared among AIDSRelief country programs and Track 1.0 partners within Tanzania.

From 2009 to 2013 (when AIDSRelief transferred responsibility for sites in the Mwanza region to CSSC), the working group employed a transparent four-step transition process:

1. Identify local partners and assess their capacity in key areas;
2. Develop capacity strengthening work plans based on strengths and areas for improvement identified in assessments;
3. Strengthen local partner capacity according to above assessments and work plans;
4. Transition responsibility to local partners as they achieve capacity strengthening milestones.

Transition preparation activities culminated in late 2011 when the U.S. government issued funding opportunity announcements to follow AIDSRelief. Transition began with the gradual transfer from AIDSRelief to CSSC of eight care and treatment centers and eight PMTCT sites in two districts (in Mwanza and Mara regions).

POST-AIDSRELIEF IMPLEMENTATION & TRANSITION

AIDSRelief Tanzania closed as planned in 2012, but patient care, capacity development, and transition continue under the Local Partners Excel in Comprehensive HIV and AIDS Service Delivery (LEAD) project, which was designed to incrementally transfer program responsibility to a local partner. CSSC won funding for the ART Program, providing a mechanism for CSSC to progressively assume oversight of facilities as the organization strengthened capacity in key areas.

CSSC established an ART team from scratch and began to strengthen its clinical and management capacity with support from AIDSRelief. This work continued and evolved with LEAD to address needs specific to transition and CSSC's increasing responsibilities. Beginning in 2010, the LEAD team used a graduated approach to help CSSC prepare their staff and structures for eventual grant management through a number of capacity strengthening efforts that included:

- Exposing CSSC personnel to all technical areas (clinical, programmatic, supply chain, and strategic information) through training, mentoring, and accompaniment opportunities
- Sharing policies, guidelines, and tools (many of which CSSC still uses)
- Transferring relevant assets
- Transferring knowledge and institutional memory by transitioning 13 LEAD consortium member staff to CSSC.

The AIDSRelief/LEAD program approach informed CSSC's decisions to establish clinical, strategic information, and site management teams. CSSC also chose to replicate another AIDSRelief/LEAD approach: participatory budget development with regional and council health management teams and health facilities.

CSSC interviewees reported that transition had been too slow, and suggest that early development of clear transitional guidelines would have helped to speed up the transition process. In spite of these frustrations, CSSC is successfully managing a U.S. government-funded, comprehensive HIV program at facility, district, regional, and national levels—an impressive accomplishment.

Staff and leadership from CSSC and the LEAD consortium continue to talk and exchange ideas; this has helped the organizations to sustain their relationship even as formal collaboration has changed.

ACHIEVEMENTS: CHRISTIAN SOCIAL SERVICES COMMISSION

Building upon the 2011 transition under AIDSRelief, LEAD transitioned all care and treatment centers in Mwanza region to CSSC in January 2013. By March 2014, CSSC had expanded coverage in that region by working with district health management teams to open an additional 25 care and treatment centers, were providing ART to more than 34,000 clients (current), and reported a 73 percent retention rate.

In conjunction with some of the clients who stopped coming to ART clinic, CSSC also initiated a “back-to-care” campaign to encourage treatment defaulters to come back for services. As of September 2014, more than 1,100 clients returned to care as a result of the campaign. CSSC is also supporting the Tanzanian government to integrate cervical cancer screening at two facilities; CDC provided two cryotherapy machines for this effort. (The LEAD program initiated the same activity in another region and is providing technical support to CSSC.)

Christian Social Services Commission (CSSC)

is an ecumenical nonprofit umbrella organization of the Tanzania Episcopal Conference and the Christian Council of Tanzania. It has been operating since 1992 and has been registered as a legal agency in Tanzania since 1993. CSSC focuses on improving quality, accessibility and availability of health and education services by fostering partnerships and institutional development, capacity building, and lobbying and advocacy.

CSSC has been an important part of national efforts to roll out PMTCT Option B+ since October 2013, training more than 700 health care workers (as of March 2014) to deliver the intervention in all of the country's 325 health facilities that provide PMTCT services.

In October 2013, CDC invited CSSC to assume responsibility for financial and technical support to a second region, Geita. CSSC took on the first batch of Geita sites by June 2014 and is expected to add another 14 by October 2015. In total, CSSC is managing 88 care and treatment centers, 316 PMTCT sites, and 180 early infant diagnosis sites. These transitions have occurred concurrently with (and in response to) political and administrative reorganization initiated by the Tanzanian government.

CSSC's strengthened capacity and credibility in the sector is also evident. CSSC has taken over all mentoring and training responsibilities previously performed by AIDSRelief and LEAD, and interviewees from the line ministries spoke well of CSSC's work. Interviewees stated that CSSC's mentoring and training efforts are on par with those of its predecessors, and noted that CSSC is maintaining quality while increasing the number of sites it manages.

CDC funding to CSSC has increased by almost 18-fold: from US\$400,000 (2011) to more than US\$7,000,000 (2014). Work with AIDSRelief and LEAD helped to make this possible and to ensure that CSSC has the absorptive capacity to manage such funding effectively. For example, with support from LEAD, CSSC has established a new procurement unit with a competent team that is helping the organization better align with U.S. government requirements. CSSC has strengthened its grants management unit, dedicating a staff member to grants management; developed a financial manual; developed leave and benefit policies; and hired additional staff when needed, including staff for human resources tasks.

.....
 “[We were] really doubtful that the local partner could do what CRS was doing, but we don’t see any changes now that CSSC started. They are ready to help any time.”
 —A District AIDS Control

FIGURE 5

TANZANIA TWELVE-MONTH QUALITY INDICATORS By implementer

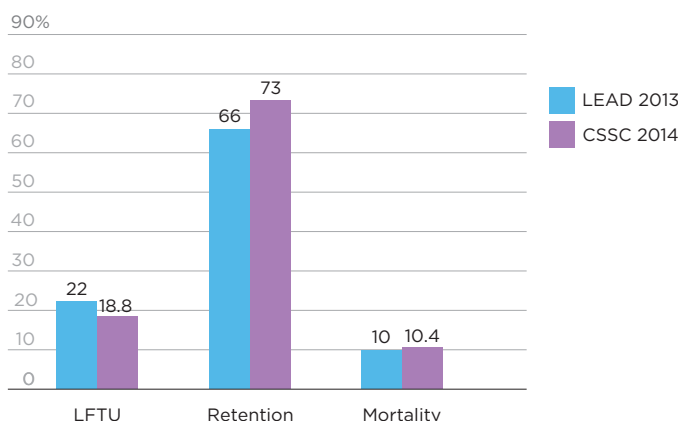
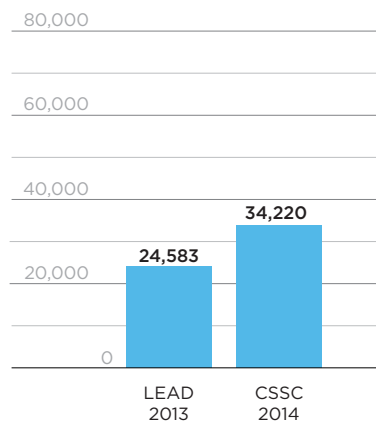


FIGURE 6

TANZANIA ART COVERAGE For Mwanza region by Implementer



KEY TRANSITION LESSON: BALANCE PRESCRIPTION AND FLEXIBILITY

Stakeholders (including CSSC) participated in the AIDSRelief Sustainability Working Group and Transition Task Force and other knowledge-sharing forums. However, interviewees representing CSSC remarked that donor demands/requirements were not always clear, and in-country transitional strategy lacked specific guidelines to help speed up the transition process. Interviewees noted that the lack of guidelines caused a bottleneck, further slowing transition. Instead of being developed in advance, the transitional guidelines (or “transitional road map”) seemed to be the result of learning along the way. This was in line with observations from interviewees representing government line ministries, who found the transition process and timeline to be unclear before early 2013. Efforts to make transition guidelines and work plans more specific have also been complicated by changes in the Tanzanian context, such as political reorganization of districts and regions.

From the perspective of the AIDSRelief (and later, LEAD) consortium, the roadmap was a living document that remained nimble and responsive to changes in Tanzania’s HIV context, partner performance, and donor demands. Some stakeholders seemed to see these generalities as a shortcoming, while others perceive them as an advantage.

Similarly, interviewees reported that former AIDSRelief and LEAD staff hired by CSSC bring experience and continuity that benefit ART Program efforts. However, some interviewees pointed out that hiring so many “insiders” might limit flexibility, innovations, and rethinking of standard operating procedures.

Each organization’s needs and transition roles impact how it perceives processes and tools. These perceptions might be in conflict, but they are equally valid. To encourage mutual understanding, transition partners can:

- Encourage open communication and transparency, so that materials and strategies are useful to all parties, and that stakeholders fully comprehend the strategies’ different functions.
- Acknowledge and discuss the relative merits of prescription and adaptability in different contexts.



Julia Mosoma receives treatment at the Kurisanani clinic in the Diocese of Tzaneen in South Africa. After receiving five years of support from AIDSRelief, the clinic transitioned to local leadership in early 2010. *Willie Pietersen for CRS.*

Country Profile: South Africa

AIDSRELIEF SOUTH AFRICA ACHIEVEMENTS

Working through 28 treatment facilities between 2004 and 2009, AIDSRelief South Africa provided care and treatment to more than 73,000 clients, of whom more than 35,000 received ART. AIDSRelief expanded and equipped treatment facilities, established financial compliance systems, and prepared sites to implement a new electronic database to assist with patient management. The project also trained hundreds of South African health care workers to provide community-based HIV care and treatment. Notably, these efforts took place before the South African government had begun its ART program on a large scale.

AIDSRelief South Africa was successful in no small part because it adapted its program model in response to the country's context during implementation, for example:

- AIDSRelief-supported facilities were standalone HIV treatment sites rather than a service or unit in a primary health care setting. To facilitate comprehensive care, providers worked to refer patients for complementary services such as tuberculosis testing for patients presenting with a cough, or maternal and child health services for HIV-positive women and children.
- Recognizing that in-country capacity in South Africa is very high, AIDSRelief used only local clinical experts as consultants and advisors. This helped local partners establish and reinforce good working relationships with local universities, laboratories, government officials, and clinical societies.

TRANSITION OVERVIEW

Engaged consortium members: CRS, CAF

Local partners: Southern African Catholic Bishops Conference (SACBC), Institute for Youth Development—South Africa (IYDSA), St. Mary's Hospital

Transition years

- From AIDSRelief to local partners: 2010
- From IYDSA and St. Mary's Hospital to Department of Health: 2012–2013
- From SACBC to Department of Health: In process (to be completed May 2015)

Transition periods

- From AIDSRelief to local partners: Five years
- From IYDSA and St. Mary's Hospital to Department of Health: Two and three years
- From SACBC to Department of Health: Five years (including one-year no-cost extension)

This model of flexibility has served partners and facilities through AIDSRelief and subsequent programming.

In what was arguably among its greatest achievements, AIDSRelief South Africa transitioned management of supported facilities to local partners in February 2010. AIDSRelief South Africa was the first Track 1.0 program in any country to do so, operating two years ahead of most other programs. Lessons from this transition process can be found online in [The AIDSRelief South Africa Partnership case study](#).

A TWO-PHASED TRANSITION

AIDSRelief's legacy in South Africa is unique. Since the 2010 transition, local partners IYDSA, St. Mary's Hospital, and SACBC have worked with the Department of Health to help ensure that all HIV patients are served with public resources by 2015. AIDSRelief and subsequent PEPFAR-funded treatment projects were designed with this second transition in mind. It was also consistent with declining PEPFAR funding to South Africa and the South African government's goals to mainstream HIV services with other health care.

Transition to the Department of Health has typically followed one of two models:

- Patients are transferred from stand-alone local partner facilities to a government-run, integrated primary health care setting that can provide comparable HIV services. (This is the most common situation.)
- If a public facility or comparable public HIV services are not available, the Department of Health will provide a partner serving that area (e.g., a faith-based hospital) with funds for HIV-related medicines and laboratory services or some salaries.

TRANSITION PARTNER: INSTITUTE FOR YOUTH DEVELOPMENT—SOUTH AFRICA

IYDSA is a local NGO based in the Eastern Cape Province of South Africa. Through AIDSRelief, IYDSA developed five ART sites and 10 clinical outreach centers in underserved communities. As part of the overall transition process, the ART patients served through IYDSA sites were transitioned into the government treatment system.

TRANSITION PARTNER: ST. MARY'S CATHOLIC HOSPITAL

The largest treatment site in AIDSRelief South Africa's network and the only hospital in a large district, St. Mary's has served its community since the late 1880s. During AIDSRelief, the hospital provided ART to more than 4,000 people living with HIV.

AIDSRelief worked with St. Mary's to develop the hospital's infrastructure and the capacity of its clinical staff; after the initial transition, SACBC continued to support implementation of a robust patient data system at the hospital.

Before transitioning from AIDSRelief support, St. Mary's qualified for government accreditation as an antiretroviral drug rollout site. This certification allowed the hospital to receive HIV medicines and laboratory support from the South African government—

in addition to the substantial existing government subsidy to the hospital. (At the time, the subsidy covered 70 percent of general patient and operations costs.)

At the time of data collection, St. Mary's filled an important gap in public health coverage in its area. Since the closure of AIDSRelief, St. Mary's remains a Catholic hospital and continues to serve patients in close collaboration with (and with subsidies from) the Department of Health. However, because ART is now dispensed at district-level clinics instead of the hospital level, St. Mary's has transitioned patients to Department of Health feeder clinics, relieving pressure on the hospital and bringing treatment closer to patients.

TRANSITION PARTNER: SOUTHERN AFRICAN CATHOLIC BISHOPS CONFERENCE

The AIDS Office of the Southern African Catholic Bishops Conference (SACBC) coordinates the Catholic Church's response to the HIV epidemic and supports church service programs throughout South Africa, Botswana, and Swaziland. In terms of coverage, SACBC was AIDSRelief South Africa's largest partner.

Building on its existing HIV care and support services, SACBC delivered ART through 22 sites under AIDSRelief and maintained good LTFU (22 to 23 percent) and mortality rates (3 to 4 percent) for two years after the first transition. SACBC subcontracted CRS from 2010 to 2013 to provide technical support for M&E and financial functions.

Since treatment is now almost entirely within the government's purview, as of May 2014, SACBC had transitioned 20 of its 22 sites to the government and reassessed what services it could provide in pursuit of its efforts to mitigate HIV's impact in South Africa. Under the same grant through which it is transitioning treatment to the government, SACBC also supports orphans and other vulnerable children at 25 sites. SACBC was recently granted a no-cost extension (to May 2015) for this award.

Using financial management and resource mobilization skills honed under AIDSRelief and with later CRS support, the SACBC has received awards from sources including the South African Lottery and the Global Fund. To support home-based care and tuberculosis services, SACBC has also sought and received funding from the government of South Africa.

In transitioning to government, SACBC reports that sites have adapted to many different scenarios; for example, the Department of Health might fund HIV medicines and laboratory services, but not salaries of staff providing HIV services. At least one facility used skills developed with SACBC support to solicit and win outside funding to pay salaries not covered by the Department of Health. Other sites also have sought and obtained outside funds for various services.

One SACBC interviewee attributes part of these achievements to the AIDSRelief experience. SACBC and individual sites were trained in financial management, responsible for their own (often comparatively large) budgets, and experienced rigorous internal audits. As a result, SACBC and facility staff developed and maintained robust financial systems that helped them become eligible for new funding.

.....
**"Those nurses are
 wonderful assets to
 Department of Health
 programs."**
*—SACBC Principal
 Investigator*

FIGURE 7

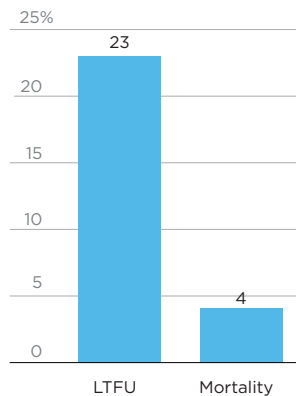
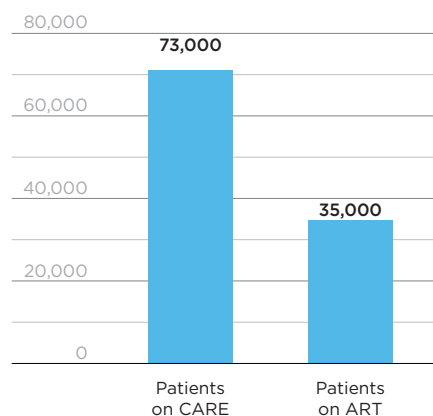
**SACBC
QUALITY INDICATORS**

FIGURE 8

**SOUTH AFRICA
ART COVERAGE****KEY TRANSITION LESSON: STRENGTHENED INDIVIDUAL AND ORGANIZATIONAL CAPACITY STRENGTHENS THE HEALTH SYSTEM**

AIDSRelief South Africa deliberately leveraged the country's substantial clinical capacity to improve health worker skills and HIV service delivery, particularly in underserved locations. The project also took advantage of opportunities to fortify critical management skills among local partners and the facilities they went on to support. These efforts helped to strengthen the capacity of individuals and organizations, consequently strengthening South Africa's health system.

By its nature, this work is time-consuming and its systems and health impacts are not immediately felt. However, South Africa's early transition of ART services to local ownership revealed progress in just a few years. Through nearly two full transitions, partners have seen staff members, teams, and entire organizations adapt to changing circumstances, be it to meet complex U.S. government regulations, to mobilize new resources, or to change a technical focus in the face of a community's need. This sort of resilience is critical to any organization and bodes well for the sustainability of South Africa's HIV response.

It must be said that South Africa's robust economy and infrastructure reinforced efforts to strengthen capacity. Despite the migration of qualified personnel to and from other countries, South Africa's strong regional presence helps overall to develop and retain talented and skilled human resources.

U.S. government funding has put substantial resources into capacity and systems strengthening in recent years. Donors and implementers can encourage meaningful application of training and organizational development through efforts such as:

- Accompaniment, mentoring, and other hands-on skills applications (e.g., local facilities that managed budgets and underwent audits)
- Encouraging staff and organizations to be open to change (e.g., SACBC seeing their niche in orphan care as South Africa's model for providing ART shifted).

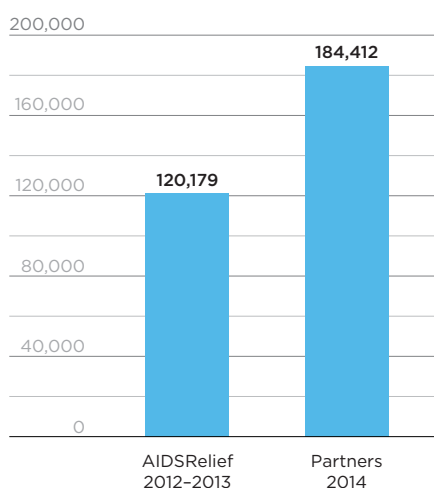
.....
"SACBC will disappear from the treatment scene but the programming will continue."
—SACBC Principal Investigator

Key Lessons Learned & Recommendations

CRS conducted a comparison of AIDSRelief and three local partner patient enrollment on ART for years 2012/13 (AIDSRelief/LEAD) and 2014 (Kenya, Tanzania and Uganda LPs). The range of increase in patient enrollment on ART was between 24% and 40% (with an average of 33%). Uganda had the highest increase in patient enrollment (40%). Local partners initiated care and treatment services at 57 additional facilities and the number of patients enrolled on ART increased by 53%.

FIGURE 9

ART COVERAGE All countries by implementer



CRS used quality indicator information for three countries: Kenya, Tanzania and Uganda. LTFU, Retention and Mortality rates were analyzed and general LP performance is at similar level as AIDSRelief (80% of cases).

FIGURE 10

TWELVE-MONTH QUALITY INDICATORS Three Country average by implementer

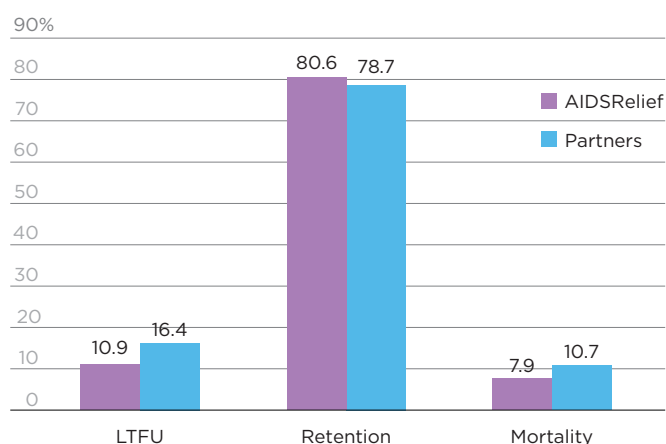
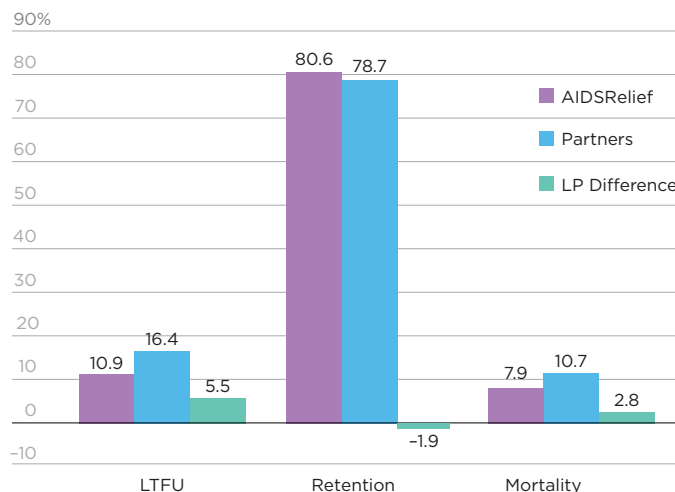


FIGURE 11

TWELVE-MONTH QUALITY INDICATORS

LP Difference



Each of the four countries profiled in this document faced internal and external challenges as they worked to define and then actualize “transition” in a manner suitable to the country context, the partners, the facilities, and most important, the patients served by the programs. While not without obstacles, the process has largely been successful. Following are key themes arising from an analysis of AIDSRelief’s struggles and accomplishments in four countries: Uganda, Kenya, Tanzania, and South Africa.

CULTIVATE A SHARED VISION

A shared understanding of success helps any team or partnership achieve its goals. It guides members in their actions and decision-making, and helps ensure that the team’s efforts contribute to its goals. A shared vision can facilitate compromise, reinforce commitment, and inspire perseverance. Developing mutual understanding can be time-consuming and at times elusive (as noted by Kenyan local partners interviewed), yet this is time well spent. To varying degrees in all countries, transition (and subcomponents of transition) was most successful when donor and AIDSRelief consortium member commitment to transition became clear; when donor, AIDSRelief, and partner roles were defined; and when concrete implementation plans were developed.

TO MORE EFFECTIVELY RESPOND TO CHANGE

As AIDSRelief Uganda entered its last year, the reality of transition abruptly deviated from the original plan around which stakeholders had developed consensus. In particular, long-term technical support from international AIDSRelief consortium members was not part of the projects that followed AIDSRelief. To ensure that local partners had the essential capacities and program knowledge for this rapid transition, AIDSRelief and representatives from the donor and local partners convened to triage the original plan.

These changes to the vision caused significant discord, leaving some stakeholders feeling they had been excluded from an endeavor in which they were greatly invested, and others frustrated by what felt like an ineffective or rushed transition process. More consensus building around the revised plan could have helped improve the “fast-track” transition plan, but it is also important to note that the overarching vision of sustainable patient access to care ultimately helped to ensure continuity and expansion of the HIV-related services once provided through AIDSRelief.

TO BRING PERSPECTIVE TO PERCEIVED CRITICISM

Local partners and treatment facilities in every AIDSRelief country conducted internal and external assessments with standard tools to identify capacity strengthening and technical support needs. These assessments—particularly Health Resources and Services Administration’s (HRSA) assessments in 2010 and 2011—also informed most transition plans.

Most countries reported some frustration with assessments. Many local partner representatives felt that some assessments failed to properly recognize their organization’s strengths or overstated its areas for improvement. Using assessments to inform country-level transition plans—plans that encapsulated the program’s vision for quality care and local ownership—helped contextualize perceived criticism.

THERE IS NO SUBSTITUTE FOR A SEAT AT THE TABLE

Even with prior grant management experience and time as a sub-grantee to CRS, several local partners were surprised when they began to administer their own grants or otherwise become more engaged with the donor. Interviewees in most of the countries profiled commented that managing a U.S. government grant was more rigorous than they had anticipated. In some cases, interviewees commented that what they thought were superfluous CRS demands turned out to be contractual donor requirements that required new or reorganized systems. A partner in Kenya even admitted surprise that the donor would be involved in decisions about spending, employment, and technical implementation.

Local partners benefited from direct donor interactions before becoming direct recipients. It helped legitimize them in the eyes of the donor and other stakeholders, including facility staff and implementers like AIDSRelief consortium members. One consortium member representative in Tanzania noted, “I think [private meetings between the local partner and the donor] hurt our pride initially, but then we realized that we needed to step back and allow them the space to be the implementing partner.”

By making local partners full consortium members in Zambia, the AIDSRelief Transition project helped to elevate each organization’s profile with the donor, the Zambian government, and other stakeholders. Other ways to meaningfully engage and raise the profile of local partners include full participation in internal and external meetings such as routine internal management discussions, technical working groups, and donor presentations.

STAFF CONTINUITY IS VALUABLE AT ALL LEVELS

Staffing at facility and organizational levels was a challenge in most AIDSRelief countries before and after transition. Widespread respect for the AIDSRelief's Model of Care and training programs made AIDSRelief-trained staff highly sought-after; in some countries higher salaries in the public sector also made retention difficult. As transition approached and got underway, confusion and insecurity about employment often arose—individuals were concerned about their livelihood and organizations were unsure about if, when, and how to voluntarily transfer staff from AIDSRelief to the local partner.

Staff retention helps ensure a continuity that is especially important during transitions. While individuals must be free to pursue their own career opportunities, organizations can promote retention. Local partners in Kenya devised incentive packages like annual bonuses to encourage retention, and transferred employees brought their desks and laptops when they went to work for the local partner in Tanzania.

BALANCE FLEXIBILITY AND PRESCRIPTION

These notions of flexibility and planning may be contradictory, but they are equally valid and require a delicate balance. Implementers must seek to mitigate the impact of this tension through efforts such as open communication and transparency, rebuilding of consensus or buy-in, and mutual respect.

Redistricting in Tanzania changed program coverage, and late revisions to a ratified transition plan in Uganda (as discussed previously) caused uncertainty among stakeholders. Large-scale program transition was largely uncharted territory when most AIDSRelief programs started to develop their transition plans. These factors required great degrees of flexibility at the country level.

Yet transition, like most program components, requires dedicated resources and concrete plans, objectives, and indicators. And different organizational needs and roles might impact whether a plan is seen as nimble and responsive, or inconsistent and unreliable. Interviewees from Tanzania reported disappointment with what they considered an overly slow pace of transition, noting that a lack of clear guidelines for the transition process seemed to further hinder progress.

STRENGTHENED ORGANIZATIONS, STRENGTHENED HEALTH SYSTEM

By its nature, capacity strengthening is time-consuming and its impact on systems or health outcomes is not immediate. However, South Africa's early transition of ART services to local ownership revealed progress in just a few years. Through nearly two full transitions—from AIDSRelief to local partners in 2010, and now from those partners to the South African government—staff members, teams, and entire organizations have adapted to changing circumstances to meet complex U.S. government regulations, mobilize new resources, or change a technical focus in the face of a community's need. This sort of resilience is critical to any organization and bodes well for the sustainability of South Africa's HIV response.

Appendix A: Interviewees

| NAME | POSITION |
|--|---|
| CRS HQ/Field | |
| John Donahue | Former AIDSRelief Global COP |
| Kazadi Mwayabo Jean Claude | Senior Technical Advisor-HIV |
| Alberto Andretta | Senior Technical Advisor/Capacity Building |
| Becky Bennet | AIDSRelief Consultant |
| Karen Moul | Communication Officer |
| Leia Isanhart | Senior Technical Advisor-Health |
| Elizabeth Pfeiffer | Uganda Country Manager |
| Paul Perrin | Monitoring, Evaluation, Accountability and Learning (MEAL) Director |
| SOUTH AFRICA | |
| CRS/South Africa | |
| Davor Dakovic | Country Program Manager CRS/South Africa |
| Ruth Stark | Former AIDSRelief Chief Of Party South Africa |
| KENYA | |
| CRS Kenya | |
| Maina Martha | Program Manager CRS |
| Christians Health Association of Kenya (CHAK) | |
| Dr. Samuel Mwenda | General Secretary |
| Sister Veronica | Project Coordinator at LPTF, CHAK Mombassa |
| Kenya Bishop Catholic Conference (KBCC) | |
| Dr. Daniel Kabira | Chief of Party (Former AIDSRelief Staff) |
| Nkatha Njeru | Program Officer |
| South Africa | |
| Sister Allison | Director CDC AIDS Office |
| TANZANIA | |

| CRS/ Tanzania | |
|--|---|
| Mwikali Kioko | Deputy Chief of Party Program Quality and Knowledge Management. |
| Government of Tanzania | |
| Dr. Charles Kasuka | Tanzania Ministry of Health |
| Isabella Minga | Tanzania Ministry of Health |
| Dr. Bwire Chirangi | Tanzania Ministry of Health |
| Dr. Pius Maselle | Regional AIDS Control Coordinator |
| CSSC | |
| Charles Suka | Project Officer CSSC |
| Benedict Andrea | PMTCT Officer CSSC (Former AIDSRelief Staff) |
| Moses Ringo | Clinical Advisor |
| Pastory Sekula | Program Manager for the ART Program (Former AIDSRelief Staff) |
| UGANDA | |
| Uganda Protestant Medical Bureau (UPMB) | |
| Dr. Luke Lakidi | Program Manager HIV/AIDS |
| Uganda Catholic Medical Bureau (UCMB) | |
| Dr. Sam Orach | UCMB Secretary General |
| Ronald Kamara | Chief of Party for the follow on AIDSRelief program |
| Dr. Henry Mwesezi | Deputy Chief of Party for the follow on AIDSRelief program |
| Children AIDS Fund (CAF) Uganda | |
| Jackson Bitarabeho, | Executive Director |
| Robinson Ogwang | Director of Programs, Strategic Information and Partner Issues |
| Dr. Caroline Sekimpi | Medical Director |

APPENDIX B: Interview Guides

AIDSRelief Transition Interview Guide

Current Title:

Title during AIDSRelief:

Length with AIDSRelief:

Interview Guide for AIDSRelief Transition

Introduction of the scope of work for the documentation exercise.

- I. Self-introduction
 - a. Background
 - b. Role in documentation process
- II. Overview of SOW – 53 days phone interviews.
- III. Transition experience and post transition experience for local partner
 - a. Achievements and challenges to date
 - b. Identify gaps in transition process AND what really proved beneficial during transition
- IV. Purpose:
 - a. Post transition learning and documentation (emphasize that the interview is not an evaluation)
 - b. Audience is internal but may serve as external advocacy information
- V. Process
 - a. Review of AIDSRelief documentation, including transition plans
 - b. Calls with staff, CRS assigned focal people and local partner (2-3 each one for call, maybe another for confirmation and follow-up)
 - c. Possible contacts:
 - i. COP/EXEC
 - ii. Transition/sustainability person
 - iii. LPTF staff (ideally 2)
 - iv. Program manager
 - v. Etc.

- d. Create a transition profile or story based on interviews, documentation, etc. for each country and if possible, overall learning
- e. Develop a report for CRS documenting process, findings and recommendations for future transitioning of programs
- VI. Timeline: will be conducting interviews until about March 30
- VII. Questions, Comments, Concerns
 - 1. Is the numbering correct?
 - Please describe your relationship with CRS POST TRANSITION and with the other consortium members.
 - 2.
 - In your opinion, when did transition begin? Was the transition timeline clear, consistent? Were there changes along the way?
 - 3.
 - Thinking back to that time (if appropriate), did you think what you do now was transition? If yes, describe how/why your organization was aware, what was your understanding of transition. If not, describe what you expected versus what it actually is.

Identity & Governance

- Who is the head of the follow-on award? (name, position) How long have they been in this position?
- For LPTF, who is the point of contact within the organization?
- 4.
 - When did management quality (MQ) capacity building begin? Was it clear to your organization why CRS/AR approached MQ capacity building this way?
 - Was the MQ capacity building useful post-transition? Why or why not?
 - Was your organization aware of the rigor of U.S. government funding? How were you aware? If aware, has the awareness of these demands changed post-transition? If unaware, was your organization prepared for these demands post-transition?
 - Was the way CRS/AR transitioned beneficial to your organization? Why or why not?
 - Were there assumptions about your organization pre-transition that helped transition? Assumptions that hindered transition? What were they?

Programming

- Please describe (briefly) the current programming overview of the follow-on award (sites, activities, etc.).
- 5.
- Have you taken on new activities since the follow-on award? If so what? Who is the donor? Have you ceased any activities since the follow-on award? If so, why?
- 6.
- Are there activities tools (Site Capacity Assessment, HoCAI, CLASS, etc.), or processes that were “standard” in AIDSRelief that you have dropped since taking the lead? If so what are they? Why did you drop them? If there was a problem, what was it? How was it identified and fixed?
 - At the time of transition, how were your organization’s strengths factored into the transition plan? Since transition, what strengths that existed then have you relied on? What challenges existed during the transition plan that you have had to overcome during post transition?
- 7.
- How were your organization’s capacity building needs determined? Was your organization in agreement with this determination? Why or why not?
- 8.
- Please describe your organizations patient level quality. Can you provide the following key measures of quality to support your description?
9. Loss to follow-up
10. Adherence
11. Mortality
- 12.
- Does current funding allow quality and to meet the donor’s expectation? Why or why not?
- 13.
- Are there particular programming challenges faced by your organization due to changes in the local context, political, social, or other? How are they identified, documented, addressed, and resolved?
 - What are your greatest programmatic achievements post-transition?

General Management

- Please describe your reporting successes, challenges and lessons learned.
- 14.
- Do you have standard operating procedures for all positions? If so how/where is this information contained?
- 15.

Organizational Learning

- Were there expected challenges from/during the transition period that have continued post transition? E.g. staff retention.
- 16.
- Were there unexpected challenges? What were they? How were these challenges overcome/addressed?
 - What is the most important thing your organization learned during AR that has helped you implement the current award?
- 17.
- Please describe how your organization uses data for learning, advocacy, sustainability, etc. Can you give a recent example of each?
 - FOR CHAZ: Who is the CQI counterpart? How long have they been in that position? How many mentoring sessions have they had since the transition?
 - For CHAZ: Who is the lab partner? How long have they been in that position? How many mentoring sessions have they had since transition?
 - Has your organization “published” any papers, posters, or articles post-transition? If so, can you provide a list?
- 18.
- Are there particular challenges to organizational learning that have arisen post-transition? If so, what? How have these challenges been addressed?
- 19.
- What are your greatest achievements in organizational learning post-transition?
- 20.
- Will your organization attend IAC, ICASA, or other international health conferences? Why or why not?

Strategy & Management

Human Resources Management

- Are all key positions currently filled? How long have the individuals been in these positions? Did they receive training under AIDSRelief?
- 21.
- How many of your current staff were trained by AIDSRelief pre-transition? How many of your current staff were AIDSRelief staff pre-transition? Can you give a breakdown of what positions those individuals occupy?
- 22.
- What is the staff turnover situation in the follow-on award? Is this consistent in the LPTFs? How is staff turnover different post-transition?
- 23.
- Are there new human resources post-transition that your organization has faced? Ongoing? How have these challenges been addressed? How will they be addressed?
 - Has your organization developed specific strategies retain, train or incentivize staff?

Financial and Physical Management

- Has your organization been funded by the donor as expected, to the level expected? If no, please describe. How has this impacted your implementation?
- 24.
- What has your organization done to address these funding changes? In the future how will your organization deal with funding changes?
 - Has your organization undergone any audits? If so, by whom? Results?

External Relations

- Please describe your organization's interaction with CDC and USAID.
- 25.
- Is your organization able to advocate on its own behalf with the CDC or other donor agencies? Can you give an example? Have you had to renegotiate a budget with CDC or other donor agencies? If so, please describe the experience and the result.

- Is your organization an advocate for change in your country? Can your organization advocate for change in HIV and AIDS care and treatment in your country? If yes, please describe how. If no, please describe why. Can you give a concrete example when your organization had to exercise advocacy skills? What was the result?

26.

- Please describe your relationship with the MOH, National AIDS Control Mechanisms, and technical working groups. Have these relationships changed since transition?

27.

- Please list which committees, boards, working groups your organization participates in post-transition versus pre-transition.

28.

- What is the best lesson your organization learned during transition that helps create or maintain external (other organizations and donors) relationships?

Sustainability

- In addition to the follow-on funding, has your organization secured additional funding post transition? If so from which donor? (e.g. USAID, The Global Fund to Fight AIDS, Tuberculosis and Malaria, EU, DFID,) Was the transition preparation helpful in obtaining this funding? Why or why not?

29.

- Has your organization used data for advocacy? If so, with whom? What was the result?
- Please describe your organization's post-award plan. What will you do when this capacity building/transition award ends?

30.

- Has your organization been asked to join consortiums to go after funding with other INGOs post-transition? Did you win?
- Did the transition process help your organization negotiate itself into a better position in that funding opportunity in terms of funding or scope of work? If so, please describe.
- Recognizing that all programs and organizations grow and change with developments (in the science, in country outlook, in technology) how will your organization adapt and grow as HIV changes? Do you have an example of a recent time your organization had to adapt?

Follow-Up (Big Picture View)

- Knowing what you know now about the implementation of this program, what lessons should be learned from your organization's transition experience, i.e., what could have been done differently to prepare your organization? More focus on a specific area, time, structure or strategy?
- 31.
- Were you fully prepared from your organization's skill set and the transition process and activities to take lead as the implementer in this program? With this donor? If yes, what specifically did the transition process do to help you assume that new role? If not, what did the transition process lack that you needed to assume the new role?
- 32.
- Are there ways that you would suggest that CRS can support you without a formal award? If so what are they?
- 33.
- What else should I know about your transition and post-transition experience that I have not asked?

AIDSR relief Guide for Facilities**DATE**

