



TRANSITIONING LARGE-SCALE HIV CARE AND TREATMENT
PROGRAMS TO SUSTAINABLE NATIONAL OWNERSHIP
THE PROJECT HEART EXPERIENCE

ISSUE BRIEF

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THE PROJECT HEART EXPERIENCE

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LIST OF ABBREVIATIONS AND ACRONYMS

AGPAFSA	Ariel Glaser Pediatric AIDS Foundation South Africa	HST	Health Systems Trust
AGPAHI	Ariel Glaser Pediatric AIDS Healthcare Initiative (Tanzania)	M&E	Monitoring and Evaluation
AHF	AIDS Healthcare Foundation	MOH	Ministry of Health
AIDS	Acquired Immune Deficiency Syndrome	NGO	Nongovernmental Organization
AIDSRelief	Catholic Relief Services Consortium	OCVAT	Organizational Capacity and Viability Assessment Tool
ART	Antiretroviral Therapy	PBF	Performance-Based Financing
CBO	Community-Based Organization	PEPFAR	President's Emergency Plan for AIDS Relief
CDC	Centers for Disease Control and Prevention	PLHIV	People Living with HIV/AIDS
CIDRZ	Center for Infectious Disease Research in Zambia	PMTCT	Prevention of Mother-to-Child Transmission
DOH	Department of Health	Project HEART	Project to Help Expand Antiretroviral Therapy to children and families
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation	SCP	Site Capacity Profile
FBO	Faith-Based Organization	UAB	University of Alabama at Birmingham
HCAT-2	HIV Care and Treatment Capacity Assessment Tool	USAID	U.S. Agency for International Development
HIV	Human Immunodeficiency Virus		
HRSA	Health Resources and Services Administration		
HSS	Health Systems Strengthening		



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EXECUTIVE SUMMARY

The rapid scale up of life-saving HIV care and treatment services has been a public health success. To date, the U.S. Government-funded rapid HIV program scale up efforts in resource-limited settings have been implemented mostly through funding international nongovernmental organizations (NGOs). Over the past few years, funding priorities for the global health and development community have shifted from an emergency response to local ownership and longer-term health systems strengthening. The expectation is that host country governments and local NGOs fully own and manage implementation of their HIV care and treatment services.

Since 2004, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF or the Foundation) has supported HIV care and treatment programs through Project HEART (Help Expand Antiretroviral Therapy to children and families) in five countries: Côte d'Ivoire, Mozambique, South Africa, Tanzania, and Zambia. Project HEART, a program funded by the U.S. Centers for Disease Control and Prevention (CDC) as a part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Track 1.0 program for HIV care and treatment, and has provided antiretroviral

therapy (ART) to more than 560,000 patients, care and support to more than 1 million patients, and testing and counseling to more than 2.5 million pregnant women. In the renewal of Track 1.0 in 2009, the U.S. Department of Health and Human Services mandated that all recipients transfer responsibilities for HIV care and treatment to national or local entities by February 2012. Since that time, the project has continued to scale up and at the same time focused on transitioning the programs to local and national health authorities and civil society through capacity-building and systems-strengthening activities.

Project HEART's Global Strategy for Transition

Promoting long-term sustainability has been central to Project HEART from its inception, with the goal of ensuring continuity of HIV service delivery programs and patient care. To achieve this, the Foundation defined a two-pronged transition approach:

1. Strengthen leadership and management capacity of governments through national and sub national health authorities.
2. Improve the technical and organizational capacity of existing nongovernmental and community-based organizations (NGOs and CBOs) and establish new local independent NGOs, where

needed, to assume responsibility for Project HEART's activities to support quality HIV services, engage civil society, serve as technical leaders, and continue to strengthen government capacity.

The Foundation anticipates that in the long term, the national health systems will assume full responsibility for ensuring accessible, comprehensive, high-quality HIV care and treatment services as they do for other critical primary care services.

Realizing Transition

Project HEART's transition approach was to reinforce facility- and community-level achievements by strengthening systems and building the capacity of local and national health authorities and the civil society sector to support HIV clinical service delivery activities. Strengthening civil society included partnering with existing national NGOs and supporting the creation of new NGOs where gaps in HIV programming were identified. Building the capacity of national NGOs as "lead transition partners" to seamlessly support HIV care and treatment services was particularly urgent given the ending of Project HEART in 2012 and the length of time necessary to adequately capacitate local and national health authorities. With regard to the two-pronged approach, the transition plan was as follows:

1. *Strengthening health systems:* Through the District Approach and performance-based financing (PBF) models, the Foundation directly financed and built needed capacity for district health authorities to establish, expand, and maintain quality HIV care and treatment services. Implementation of these system strengthening models resulted in greater ownership by local health authorities and improved their financial management, planning of service delivery activities, data use and quality, and quality of patient care. PBF mechanisms have been used in Côte d'Ivoire and Mozambique to incentivize performance improvements among health workers at the district and site levels. Early results of PBF activities have shown improvements in performance on core programmatic indicators at the site level.
2. *Improving the capacity of existing NGOs and community-based organizations (CBOs) and establishing new local independent NGOs to support quality HIV services:* Project HEART recognized the importance of the nongovernmental sector in strengthening

government health systems. Where strong NGO partners were identified to implement programs and provide technical assistance, those organizations were prioritized for enhanced organizational development support. In Zambia, support was provided to the Center for Infectious Disease Research in Zambia (CIDRZ) to establish independent governance and operations systems to manage direct U.S. Government funding.

In Côte d'Ivoire, Mozambique, and Tanzania, Project HEART converted parts of its current country program into national independent affiliated NGOs (Affiliates) to manage large-scale HIV care and treatment services. These new Affiliates were established with the short-term vision that they would progressively assume the majority of Project HEART's service delivery support functions and in the longer term continue strengthening national capacity for HIV program implementation. The establishment of the Affiliates involved strategy development and organizational start-up, human resource and systems capacity development, and the transfer of program management roles and functions, as well as corresponding funding. A model of affiliation was developed that creates a long-term partnership between the Affiliates and the Foundation to achieve a shared mission of the elimination of pediatric HIV. Additionally, the model facilitates access to technical and financial resources required to enhance the Affiliates viability and sustainability as local NGOs.

Monitoring the Transition

A key element of the transition process was the establishment of monitoring systems designed to assess capacity at the health facility, decentralized health authority, NGO, and community levels. Tools were developed to assess capacities required at each level and to measure them against benchmarks of viability and quality. Implementation of these tools has generated baseline capacity data to monitor future improvements and inform programming needs.

One tool, the Site Capacity Profile (SCP), provided a comprehensive survey of the systems, processes, and resources supporting the provision of HIV services in place at health facilities. The Foundation collaborated with the CDC in developing the HIV Care and Treatment Capacity Assessment Tool (HCAT-2), which assesses the capacity of district and provincial health



Elizabeth Glaser Pediatric AIDS Foundation President and CEO Charles Lyons accepts a gift from the First Lady of Tanzania, Mama Salma Kikwete, Dar es Salaam, May 17, 2011

PHOTO: JAMES PURSEY

authorities to manage HIV service delivery programs. The Organizational Capacity and Viability Assessment Tool (OCVAT) was used to identify the capacity development needs of Project HEART country offices (from which the Affiliates were developed) and other existing NGO transition partners. Project HEART used the NGO/CBO HIV Community Support Service Provider Capacity Profile or the PLHIV Group Capacity Profile to assess availability and quality of community-based HIV support services, referral systems, community engagement efforts, barriers to service utilization, and key areas of organizational development areas.

Key Achievements of the Project HEART Transition

- As of February 2012, preparations and the initial transfer of programs to local entities have gone smoothly, and no disruptions in HIV services are anticipated as a result of the transition.
- With the exception of South Africa, each Project HEART–selected lead NGO transition partner has successfully obtained direct funding for the next five years and established scopes of work that will be incrementally expanded. In Zambia, CIDRZ is directly funded by CDC and will continue to

support HIV services with the Ministry of Health. In Côte d’Ivoire, Mozambique, and Tanzania, the new Affiliates will take over a portion of the service support. In South Africa, CDC awarded funding to Health Systems Trust and Aurum Institute, existing South African NGOs. The Foundation is working closely with Health Systems Trust to ensure a seamless transfer of responsibilities.

- Refinement and scale up of the district approach and PBF models in several different country contexts has established a platform of direct government financing with measurable improvements as well as strong partnerships with and greater ownership by host country governments.
- Tools have been developed and implemented as rigorous monitoring instruments to measure baseline capacity of decentralized health authorities and NGOs and use of data to guide capacity-building activities. These tools are an important resource for the Foundation, its local partners, and other international NGOs engaged in similar transition activities.



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I. BACKGROUND

A. Context

Launched in 2003, the President's Emergency Plan for AIDS Relief (PEPFAR) holds a place in history as the largest effort by any nation to combat HIV/AIDS, a bold new approach that also provided an unprecedented injection of funding to 15 high HIV burden countries, most of them in sub-Saharan Africa. PEPFAR represents the U.S. Government's extraordinary political and financial commitment to addressing the global AIDS pandemic and the first initiative of its kind with clearly articulated target linking inputs to performance.

Phase I: In the first five years of the program, the first phase of PEPFAR focused on *rapidly establishing and scaling up prevention, care, and treatment programs* and achieved success in expanding service delivery access in low-resource, high HIV prevalence settings.

Phase II: Reauthorized under new 2008 legislation, and building on previous successes, the second phase of PEPFAR focused on *transitioning from an emergency response to promoting sustainable, country-owned-and-led programs*. Embraced within the Global Health Initiative,¹ phase II continued care and treatment delivery scale up while prioritizing a more

comprehensive, multisectoral health and development approach. PEPFAR II, the second five-year strategic plan, embraced the aid-effective principles of local leadership, mutual accountability between donors and host country governments, and improved health outcomes through sustainable health systems, policies, high-impact interventions, and cost-effective services.

1. Historical Significance of the Track 1.0 Program

The Track 1.0 anti-retroviral therapy (ART) program was a set of multi-country grants that collectively formed the *first and largest care and treatment initiative* awarded by PEPFAR. Track 1.0 was competitively awarded to international organizations already supporting the expansion of programs to prevent mother-to-child transmission of HIV, who building on these existing programs, could rapidly scale up HIV care and treatment. It was administered by the Global AIDS Program of CDC and the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA).

In 2004, the Foundation was selected through a competitive process as *one of four implementing partners to receive Track 1.0 funding* to scale up ART and increase the number of people with access to comprehensive HIV prevention, care, and treatment

Approximately 20 percent of all Africans enrolled in ART in sub-Saharan Africa are supported by the Track 1.0 ART program, resulting in more than one million individuals receiving antiretroviral treatment.

services. The three other Track 1.0 ART partners were AIDSRelief (Catholic Relief Services Consortium), Harvard School of Public Health, and the Mailman School of Public Health at Columbia University.

In collaboration with the respective Ministries of Health (MOHs) and provincial and district health authorities, the four implementing partners have supported the initiation and scale up of treatment services at more than 1,300 health facilities in 13 countries: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. Approximately 20 percent of all Africans enrolled in ART in sub-Saharan Africa are supported by the Track 1.0 ART program, resulting in more than one million individuals receiving antiretroviral treatment.

2. Project HEART

Building on the Foundation's existing prevention of mother-to-child transmission (PMTCT) initiatives, and with the strong support and leadership of the CDC and PEPFAR through Track 1.0, in 2004, the Foundation launched Project HEART (Help Expand Antiretroviral Therapy to children and families), originally a five-year initiative to scale up access to HIV prevention, care, and treatment services in Côte d'Ivoire, South Africa, Tanzania, and Zambia. Expanding upon the Foundation's PMTCT project (Call to Action) funded by the U.S. Agency for International Development (USAID), Mozambique was subsequently added to Project HEART in 2006.

In 2009 Project HEART and other Track 1.0 partners were granted a waiver for a noncompetitive extension of three years with the condition that the partners "transition management of the programs to local partners by February 28, 2012." This approach balanced the need for a continuity of critical HIV services, with a commitment to the rapid transition of the management of these services to local partners over a three-year period.

Project HEART supported Ministries of Health to provide comprehensive HIV prevention, care, and treatment services in 1,053 PMTCT sites and 510 ART sites in five countries in sub-Saharan Africa. By September 2011, Project HEART supported national health systems to achieve the following:

- Enrolled 1,029,014 HIV-positive people in care, of whom 79,677 (7.7 percent) were children
- Initiated 569,637 HIV-positive people in ART, of whom 47,154 (8.3 percent) were children, reaching more than 100 percent of the target
- Provided HIV counseling to 2,862,682 pregnant women and tested 2,507,621 pregnant women for HIV

By September 2010, 9.7 percent of all PEPFAR-supported patients on ART worldwide received their treatment through a Project HEART partner and site.

B. Building Country Ownership: Project HEART's Vision for Locally Led, Sustainable Programming

From the outset in 2004, Project HEART's approach to providing HIV care and treatment emphasized strengthening the capacity and ownership of host country governments and local implementing partners and promoting local leadership in the provision of HIV services. Each Project HEART country program prioritized building strong health systems and fostering overall self-sufficiency. In order to avoid creating parallel systems for HIV service delivery, the Project HEART programs worked closely with each MOH to identify sustainable approaches to scale up based on the existing health system, local epidemiology, and sociocultural contexts.

Project HEART's principal approaches to building sustainable HIV care and treatment services were about working with and through local partners. Specific approaches included:

- Technical assistance and capacity building* to MOH, district health authorities, and health facilities in clinical and operational areas;
- Technical assistance and capacity building to nongovernment service providers* including nongovernmental, community-based, and faith-based organizations (NGOs, CBOs and FBOs) in clinical and operational areas; and
- Financing needed inputs* (health worker salaries, medical equipment, supplies, and infrastructure).

Box 1. Project HEART Activities to Support Local Ownership and Strengthened Health Systems

- All EGPAF country programs developed joint Memoranda of Understanding (MOUs) with MOHs or regional health authorities and strengthened existing government-supported monitoring and evaluation (M&E) systems rather than establishing parallel project-based M&E systems.
- Tanzania initiated direct financing of health districts for them to support care treatment and PMTCT at sites.
- Mozambique initiated subgrants with districts and provinces for them to directly manage funds to strengthen ART activities.
- Côte d'Ivoire financed the Health Services Payment Authority for prevention, care, and treatment activities within public facilities.
- At the Ministry of Public Health's (MOPH) request, the Foundation hired and seconded hundreds of staff to work at public health facilities in South Africa.
- In Zambia, the Foundation supported technical advisors to work in the MOH developing national care and treatment standards.

By September 2010, 9.7 percent of all PEPFAR-supported patients on ART worldwide received their treatment through a Project HEART partner and site.

In phase I (see Box 1) Project HEART focused on building the capacity of national, regional, and district levels to manage and provide HIV care and treatment services. The Foundation initiated transition to decentralized government and local bodies with the introduction of the District Approach,² a capacity-building approach to directly fund local health authorities with U.S. Government funding. This direct financing approach used subgrants to put the locus of control in the hands of local authorities and aligned Project HEART activities with host country decentralization efforts. The subgrants enabled the Foundation to promote accountability and build local capacity in key management functions such as budgeting, financial management, and the development of human resources.

C. Track 1.0 Transition Mandate

In 2008, the Department of Health and Human Services issued a three-year continuation of the four Track 1.0 ART awards through February 2012. As part of the continuation, the Track 1.0 ART partners were required to do the following:

- Ensure the uninterrupted provision, and in some cases expansion, of quality HIV care and treatment programs and services; and
- Transition the management of the programs to local partners by February 28, 2012.

The use of the terms of assistance awards to mandate the transition of financing and support for the provision of care and treatment to national organizations, with timelines and explicit implementation criteria, was unprecedented within health development assistance history, particularly at this very large scale.

The mandate was made with the vision that the transition process would lead to enhanced local ownership and leadership of HIV care and treatment programs via the following:

- Focusing on strengthening the MOH with emphasis on the regional and district health system responsibilities to support HIV services
- Building the capacity of local partners and civil society institutions (NGOs, FBOs) to support the MOH in response to HIV/AIDS
- Strengthening the ability of the MOH and local partners to compete for and manage direct U.S. Government, host country government, private and other funding

These activities would lead to the gradual transition of administrative and clinical responsibilities to the MOH and local partners, while the provision of quality care and treatment services to clients is continued uninterrupted.

FIGURE 1. CDC'S VISION FOR THE TRACK 1.0 PROGRAM TRANSITION PROCESS




FUNCTIONAL ANALYSIS OF TRANSITION	Track 1.0 Program Functions	Responsibility of		
		International Partner	International Partner <i>subcontracted to Local Partner/MOH</i>	Local Partner <i>through direct USG Award</i>
	Clinical Service Delivery <i>(site-level salaries, supplies, maintenance)</i>			
	Routine Supervision of HIV Services	Local Partner Development Strategy 		
	Training			
	Clinical Mentoring			
	Lab Support	Timeline 		
	Infrastructure Rehabilitation			
	Supply Chain Support			
	Community/Patient Services			
	Monitoring and Evaluation	Funding Mechanism 		
	Technical Assistance to MOH on Policy, Procedure, Guidelines			

Figure 1 depicts CDC's vision for the transition process. During the transition period, U.S. Government funding mechanisms will move from financing international partners to direct financing for independent local partners or Ministries of Health. Additionally, through

the local partner development strategy, international partners will transition capacity and responsibility for supporting implementation of HIV programs to local partners and Ministries of Health.



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II. THE FOUNDATION'S GLOBAL STRATEGY FOR TRANSITION

A. The Vision for Transition

The infusion of PEPFAR resources led to significant health gains and demonstrated the feasibility of scaling up HIV care and treatment in Track 1.0 countries and beyond. This rapid scale up of HIV services required substantial involvement from many partners, including national governments, Ministries of Health, health facilities, universities, private sector partners and international NGOs such as EGPAF. Sustaining long term health gains will require local governments and national organizations to own and manage the programs. The long-term goal of transition is to build the capacity of national organizations to provide high-quality, accessible HIV care and treatment services within a strengthened health system. This can only be achieved if the local organizations have the means, capacity, and authority to assume responsibility for the programs. The capacity of local organizations is improving but takes time. For the short term, financial, technical and operational support is still necessary to manage large scale service delivery with international donor funding.

EGPAF's approach to transition is to strengthen local organizations as the best way to sustain the health gains of PEPFAR. Based on Project HEART's prior experience supporting locally owned and sustainable large-scale HIV care and treatment programs, the Foundation defined a two-pronged transition approach:

- Strengthen leadership and management capacity of governments through national and subnational health authorities.
- Improve the technical and organizational capacity of existing nongovernmental and community-based organizations (NGOs and CBOs) and establish new local independent NGOs, where needed, to assume responsibility for Project HEART's activities to support quality HIV services, engage civil society, serve as technical leaders, and continue to strengthen government capacity.

Health systems in Track 1.0 supported countries have lacked resources, resulting in particular challenges in the quality of decentralized facility-level service delivery, financial management; human resources; basic infrastructure; logistics; and other areas.³ Given the time-consuming nature of policy change and capacity building that is necessary to address these gaps, local independent organizations will continue to build government capacity in management and implementation of HIV programs in the short to medium term. As national and local health authorities manage increasing resources with greater capacity in the long term, EGPAF envisions that the NGOs will transfer those responsibilities which are best managed within the national health system. Local NGOs

TABLE 1. GUIDING PRINCIPLES FOR PROJECT HEART TRANSITION

The U.S. Government and the Elizabeth Glaser Pediatric AIDS Foundation contributions must be well integrated and consistent with host-country HIV plans.
Community engagement and advocacy to promote a favorable operating environment are essential to successful programming during the transition period and into the future.
Host governments and other stakeholders are to be partners in defining sustainability and transition in Project HEART countries. For efficient program planning and implementation, communication and coordination among all stakeholders will be essential.
Prevention of new infections, including vertical transmission, must be included as a component of any long-term response to HIV.
High priority should be given to providing services to children, especially the youngest children.
Leadership development at all technical and managerial levels is considered an essential component necessary for success.
Building capacity in administration and management, maintaining quality and continuity of service delivery, and expanding services are building blocks of the transition plan.
Services provided must have a client focus, and to the extent possible, clients, especially people living with HIV/AIDS, must have opportunities for active engagement and representation in program planning and implementation.

will then continue to serve important civil society roles as patient advocates, technical or professional organizations and/or to assist the Government in other areas where they have comparative advantages.

Detailed country plans were developed to carry out an orderly transition of all Project HEART’s program management, implementation, and capacity-building responsibilities to host governments and local NGOs. With the end of Project HEART, EGPAF’s role has evolved from supporting rapid scale up of large HIV care and treatment programs to long-term capacity building and specialized technical assistance to national partners who will strive for a sustained and locally led HIV response.

B. Guiding Principles for Transition

The Foundation established its transition strategy in keeping with the tenets of sustainable development and health systems strengthening, ensuring that local ownership and capacity building remain central to the strategy. To inform its strategy, the Foundation set forth eight Project HEART Transition Guiding Principles (see Table 1), which aim to ensure that service delivery programs are vested in local leadership and reflect community-specific priorities. These principles informed the development of country-specific transition plans, modes of engagement with

transition partners, and the implementation of capacity development activities.

C. Selection of Lead Transition Partners

Ultimately, the selection of organizations to continue Project HEART programs was made by CDC in competitive solicitations for funding. However, to prepare for a successful and smooth transition, EGPAF identified target transition partners in advance of the selection process and prepared them to apply for the new awards. In order to maintain the capacity built under Project HEART and achieve a rapid transition to local ownership, EGPAF, together with local partners, decided to convert or transfer Project HEART in-country programs to new independent national NGOs. These NGOs were given the opportunity for voluntary affiliation with EGPAF to facilitate organizational development, long-term access to key technical resources, and a smooth program transition. This strategy was chosen in Côte d’Ivoire, Mozambique, Tanzania, and South Africa to facilitate the conversion of the Project HEART program to independent management through a local organization. In Zambia, the Foundation’s primary implementing partner during Project Heart, Center for Infectious Disease Research in Zambia (CIDRZ), was the most logical organization to take over program responsibility.

Table 2 provides an overview of the transition partners selected by the Foundation in each of the Project HEART countries. Successful transition depended on buy-in, capacity building and engagement of all partners listed in the table below.

In each country, the initial lead transition partner identified through the planning process was successful in securing follow-on funds from CDC, with the exception of South Africa. In South Africa, CDC chose two established local organizations to continue Project HEART activities, Health Systems Trust and Aurum Institute, and EGPAF's strategic focus shifted in the final months of Project HEART to ensure a seamless transfer of responsibilities to these organizations.

D. Critical Donor Leadership

CDC and President's Emergency Plan for AIDS Relief (PEPFAR) leadership played an important role in guiding the Foundation through the transition process. CDC had several main roles during the transition process, including: providing technical assistance and guidance at the global and country levels, fostering learning and exchange across the Track 1.0 partners to ensure effective coordination of activities and approaches, and monitoring site transition to ensure continuity of services.

CDC facilitated meetings at the global and country levels where Track 1.0 partners were able to raise challenges and identify successes. This ongoing communication ensured that CDC's funding and capacity-building strategy was informed by the

TABLE 2. PROJECT HEART FINAL TRANSITION PARTNERS BY COUNTRY

Planning Phase: Project HEART Initial Transition Partners by Country (Lead Partner in BOLD)	Project HEART Final Transition Partners by Country (Lead Partner in BOLD)
Côte d'Ivoire <ul style="list-style-type: none"> Ministry of Health and Health Districts Fondation Ariel Glaser pour la Lutte Contre le SIDA Pédiatrique 	<ul style="list-style-type: none"> Ministry of Health and Health Districts Fondation Ariel Glaser pour la Lutte Contre le SIDA Pédiatrique
Mozambique <ul style="list-style-type: none"> Ministério de Saúde (Ministry of Health) Direcção Provincial de Saúde (Provincial Directorate of Health) Serviço Distrital de Saúde Mulher e Acção Social (Social District Service of Health and Social Affairs) Fundação Ariel Glaser contra o SIDA Pediátrico 	<ul style="list-style-type: none"> Ministério de Saúde (Ministry of Health) Direcção Provincial de Saúde (Provincial Directorate of Health) Serviço Distrital de Saúde Mulher e Acção Social (Social District Service of Health and Social Affairs) Fundação Ariel Glaser contra o SIDA Pediátrico
South Africa <ul style="list-style-type: none"> Department of Health and district and provincial health teams Ariel Glaser Pediatric AIDS Foundation South Africa McCord Hospital 	<ul style="list-style-type: none"> Department of Health and district and provincial health teams McCord Hospital Health Systems Trust Aurum Institute
Tanzania <ul style="list-style-type: none"> District health teams Pediatric Association of Tanzania Kilimanjaro Christian Medical Center Ariel Glaser Pediatric AIDS Healthcare Initiative 	<ul style="list-style-type: none"> District health teams Pediatric Association of Tanzania Kilimanjaro Christian Medical Center Ariel Glaser Pediatric AIDS Healthcare Initiative
Zambia <ul style="list-style-type: none"> Center for Infectious Disease Research in Zambia (CIDRZ) Ministry of Health Tiny Tim and Friends Africa Directions 	<ul style="list-style-type: none"> Center for Infectious Disease Research in Zambia (CIDRZ) Ministry of Health Tiny Tim and Friends Africa Directions



PHOTO: JAMES PURSEY

experiences of each of the implementing partners and that partners worked together on common approaches. CDC also took the lead in developing an MOH capacity assessment tool with ICF International, which the Foundation piloted in Côte d'Ivoire and expects to use in other countries and settings over time.

III. REALIZING TRANSITION

A. Supporting Leadership, Capacity, and Good Governance within Ministries of Health to Manage National, Integrated HIV Care and Treatment Services

From the beginning, Project HEART has supported steady progress toward the ultimate transition: full ownership of HIV care and treatment services by strengthened national health systems. In all Project HEART countries, the greatest health capacity gap has been at the district health level. Strong relationships with national counterparts and direct financing through subgrants promoted a locally-driven transition process and established a high level of trust between Project HEART and government authorities in each country, which facilitated strong partnerships for health systems strengthening activities.

The Foundation's health systems strengthening approach was designed to address key capacity areas required for enhanced ownership and leadership of HIV programs. Specifically, the Foundation focused on three specific management capacity areas:

- *Planning capacity*, based on data-driven decision making and strategic planning of all management

and program implementation functions, including coordination of donor investments, human resources, and geographic coverage;

- *Implementation capacity*, based on achieving care and treatment targets and quality in the delivery of services and administrative management; and
- *Financial management capacity*, starting with the management of Foundation subgrants with the end goal of readiness to receive direct donor support and manage decentralized government budgets and/or direct donor support.

During Project HEART, the Foundation provided significant investment in basic health system inputs, including infrastructure, renovations, major medical equipment procurement, pre-service and in-service training, and laboratory improvements, among others (see Box 2). However, to ensure sustainability, efforts were focused beyond direct inputs, engaging the central

Box 2. Project HEART Health System Investments

- Health facility renovations
- Contracting and secondment of health personnel
- Laboratory and medical equipment procurement and maintenance
- Faculty and curriculum development
- Information systems development, training, equipment, and medical record development
- Transportation systems for lab samples

Ministry of Health (MOH) and decentralized health authorities to strengthen their financial and human resource management, including continuing quality improvement and improved data quality and use for decision making.

Two key approaches the Foundation used to achieve sustainable improvements in capacity, described below, have been recognized by MOHs for their success in capacity building and have provided evidence to inform decentralization and other national health reform:

1. The District Approach, and
2. Performance-based financing (PBF).

1. The District Approach

Beginning in 2004, the Foundation initiated the District Approach, where EGPAF subgranted funds to districts to support HIV services, instead of EGPAF directly procuring and providing services with these funds. After evaluation of districts' programmatic and financial management capacity, district health authorities received Foundation funds to support care and treatment services. The evaluations revealed a number of weaknesses in the authority and capacity of districts to effectively manage service delivery (see Box 3). The Foundation provided a broad range of integrated capacity-building support, including clinical, monitoring and evaluation (M&E), financial management, human resources, planning and budgeting, and other technical assistance, as requested, to district health authority staff, in combination with financing through subgrants.

Using subgrants to provide direct funding to the

districts, Foundation staff worked with the district health management teams to develop work plans, budgets, data collection plans, quality improvement committees, and so forth. The district teams were multidisciplinary and varied from country to country. District staff were responsible for mentoring staff at lower-level health facilities and implementing activities and trainings to upgrade their skills. This approach fostered local ownership and built the capacity of district teams to supervise the health network within the district, allowing them to gain experience in managing U.S. Government funds; in some districts, this was their first experience managing any funding at all.

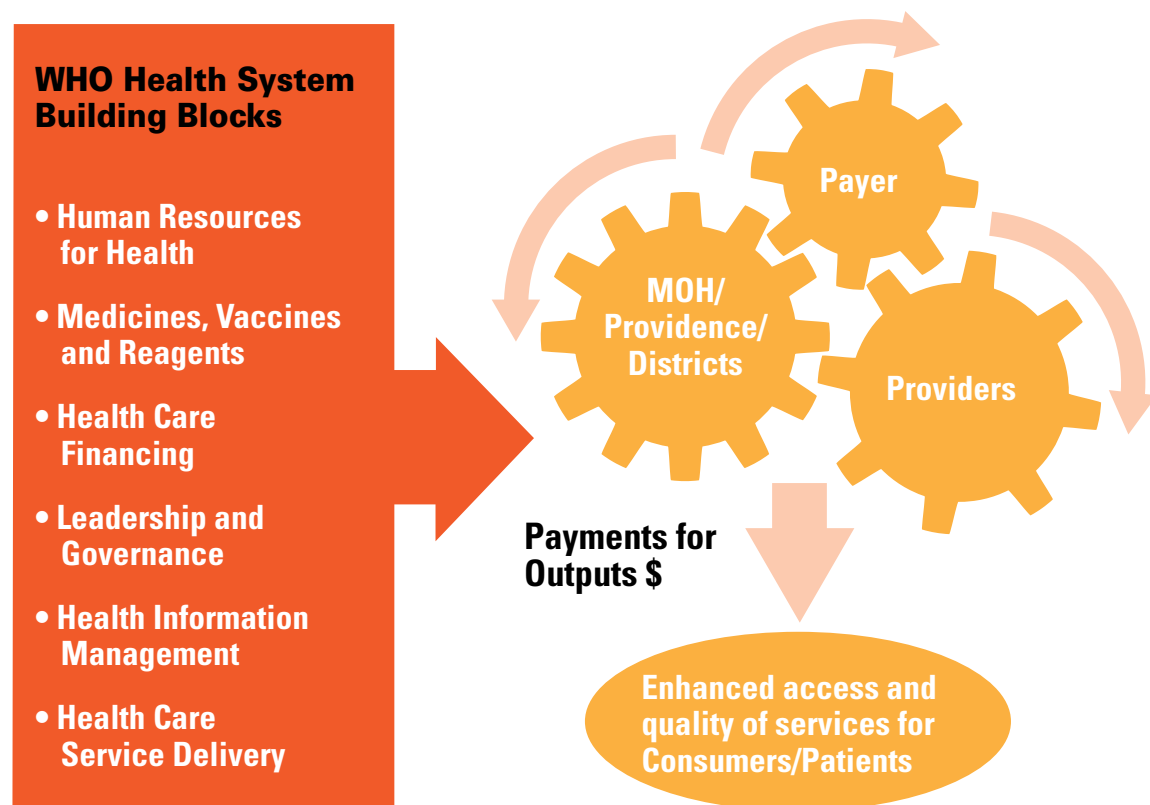
The district approach empowered and mobilized district health departments to better plan, manage, implement, and monitor HIV clinical services integrated within strengthened basic services. Building the capacity of district health staff and managers created a pool of well-trained professionals who were able to mentor and supervise staff at lower-level health facilities. This strategy promoted public-sector sustainability and enabled district leaders, managers, and health-care providers to assume greater responsibility and accountability for program results.

Directly financing decentralized health authorities allows them to use HIV funds to maximally achieve health system aims while also supporting HIV care and treatment. Host country health systems have a broader mandate than HIV and will not sustain parallel systems, such as different procurement, distribution and information systems for ARVs than for essential drugs. Using President's Emergency Plan for AIDS Relief (PEPFAR) funds via district subgrants to support integrated HIV care and treatment services also strengthens other related services: antenatal care, maternity, pediatric, hospital, laboratory, administration, pharmacy, M&E, patient information, human resources, and continuing medical education for health-care workers. District subgrants also require regular program and financial reporting, thus strengthening the use of data. Subgrants have been data-driven, emphasizing continuous monitoring, service delivery improvements, and attention to data quality—efforts that are always challenging in lower levels of centralized public health systems. The District Approach has been a win-win opportunity, allowing support for care and treatment scale up while simultaneously building health system capacity.

Box 3. Evidence of Existing Weak District Health Authority Capacity

- Health provider personnel contracts at provincial or national level and not at district level
- Minimal budgets held at district level
- Cost recovery of funds returned to national levels
- Facility managers without authority to make personnel or budget decisions
- Procurement decisions made at the national rather than district level
- Limited accountability at the district level for quality of care or access to care

FIGURE 2. OVERVIEW OF PBF CONTRACTING AND REMUNERATION PROCESS



2. Performance-based Financing

Like the District Approach, PBF uses subgrants with districts to build their management capacity. Payers (EGPAF or other funders) provide cash incentives to districts or facilities based on measured service delivery outputs, using a fixed-obligation grant instead of a cash reimbursement grant. In PBF, different award instruments are used to finance providers proportionate to the quantity and quality of services provided. Payments are then partly distributed to individual health workers and partly reinvested in the health facility. The goal is to incentivize health workers to provide a higher quantity and quality of health services. Health donors, particularly the World Bank, are supporting the scale up of PBF as a more cost-effective way of supporting and sustaining health services than traditional donor financing. Compared with traditional donor support, PBF has been shown to improve the quality and quantity of health services, including HIV services.^{4,5}

PBF is considered a health systems strengthening intervention because it expands the capacity of the health system to expend resources in a more cost-effective manner to achieve measurable results. PBF has impacts across many of the health system's building blocks (human resources, finances, information, logistics, etc.) and has been shown to impact multiple health outcome indicators. Financing mechanisms managed by the MOH and payers for health care services are utilized to provide performance incentives that operate at the provider level. Performance incentives are provided as payments at the provider level based on service delivery outputs, which are monitored and measured through clinic based strategic information systems. The result is to incentivize high-quality services by enhancing staff motivation. (see Figure 2).

The Foundation has used PBF with good results in Project HEART programs in two countries, Côte d'Ivoire and Mozambique (see Table 3). Using fixed-obligation subgrants, the Foundation provided financial incentives for health providers at district and site levels based on their performance. The quality and quantity

TABLE 3. COMPARISON OF THE AVERAGE CHANGE IN STANDARD PEPFAR INDICATORS PER FACILITY AT 26 FACILITIES IN MOZAMBIQUE AFTER THE INITIATION OF PBF, QUARTER 1 (PRE-PBF) TO QUARTER 3 (AFTER INITIATION OF PBF)

Indicator	Average Change per Facility (Q1 to Q3)	P value	t-test
Number of pregnant HIV+ women that completed ARV prophylaxis (initiated prophylaxis in ANC in the maternity)	154.4%	.043	*
Number of HIV+ pregnant women who initiate ART	128.6%	.004	*
Number of partners tested	223.8%	.027	*
Number of children born to HIV+ women who were tested (PCR) for HIV between 4-8 weeks of age.	35.6%	.041	*
Number of children born to HIV+ women who were tested via rapid test for HIV with 9-12 months after birth.	136.3%	.030	*
Number of new children (0-23m) initiating ART	126.5%	.006	*
Number of pediatric patients (0-14) alive on treatment 12 months after initiating ART.	167.0%	.037	*
Number of adults (excluding pregnant women) who initiate ART	127.0%	.010	*
Number of adults co-infected with TB who initiate ART	153.7%	.020	*
Number of HIV+ patients who initiate INH prophylaxis	612.9%	.024	*
Number of patients lost to follow-up who return to Care and Treatment.	663.4%	.015	*

**Statistically significant at 5% level using standard t-test.*

of clinical services were formally measured and verified each quarter by joint EGPAF–provincial health teams. In contrast to classic cost-reimbursement subgrants, fixed-obligation granting instruments allow facilities to receive funds per service provided and/or based upon the quality of the services. These funds are then distributed within facilities among staff as performance bonuses. Part of the performance payments can be invested in the facility to improve future performance, thus increasing potential future revenue.

In implementing PBF, the Foundation worked closely with the MOH and provincial and district health authorities to clearly define the roles and responsibilities of each level of the health system, specifically the roles of regulators, providers, and payer, to segregate financial responsibilities and avoid conflicts of interest. Thus, PBF is more than simple performance bonuses but helps to motivate health workers to improve their performance. PBF also clarifies the regulatory responsibilities of subnational health authorities.

In Côte d’Ivoire, for example, the PBF program grew from four awardees in 2006 to 32 health facilities in 2011, which were run by community-based organizations (CBOs). PBF activities used indicators linked to Project HEART and PEPFAR programmatic priorities. The PBF approach proved effective in increasing the uptake of prevention of mother-to-child transmission (PMTCT) services in comparison with sites that were not implementing PBF, and it enhanced accountability of the subgrantees. Results included substantial increases of 63 percent and 31 percent of infants and women, respectively, who were able to access antiretroviral drugs from public-sector facilities. Based on these successes, the Ivorian government has considered the integration of PBF into public sector health service delivery systems.

In Mozambique, after two years’ experience with traditional subawards, in collaboration with provincial health authorities, two provinces (Maputo and Cabo Delgado) have opted to implement PBF in all districts. The existing subawards with districts were modified so

Civil society capacity in Project HEART countries varies greatly. Zambia and South Africa have networks of faith-based organizations (FBOs), NGOs, and CBOs with extensive experience in clinical and psychosocial support services for people living with HIV.

that part of the funding received by the sites is based on performance and can be used for staff bonuses for strong performers. Although results are early and preliminary, after measurement over three fiscal quarters, on average, sites have measurably improved their performance on 16 out of 21 indicators (Table 3). A prospective program evaluation of PBF in Mozambique is underway to evaluate longer-term outcomes.

Achieving universal access to high-quality antiretroviral therapy (ART) is interdependent with strengthening national health systems. Project HEART has evolved its approach from a primary focus on the emergency to full engagement with strengthening core health system functions (see Box 4).

B. Improving the Capacity of Existing NGOs and CBOs and Establishing New Local Independent NGOs to Support Quality HIV Program Implementation

The second prong of the Foundation's transition strategy is to improve the technical and organizational capacity of existing nongovernmental organizations (NGOs) and CBOs, where possible, and to establish new NGOs and CBOs, where needed, to support implementation of HIV services and engage civil society. Throughout Project HEART, numerous NGOs, CBOs, and private-sector entities have contributed to a strengthened health system. The Foundation has supported these organizations to extend services beyond the health facility, to empower citizenry, and to advocate for local health needs.

Civil society capacity in Project HEART countries varies greatly. Zambia and South Africa have networks of faith-based organizations (FBOs), NGOs, and CBOs with extensive experience in clinical and psychosocial support services for people living with HIV. Civil society capacity to lead and manage HIV service delivery programs is more nascent in Côte d'Ivoire,

Box 4. Possible Relationships between Vertical Programs and Health Systems Strengthening⁶

1. Focus exclusively on the emergency
2. Focus primarily on HIV goals with opportunistic health systems–strengthening (HSS) activities
3. Proactive HSS activities when win–win for both HIV and health system (positive spill-over)
4. Participate in joint support or joint platforms (logistics, training, antenatal care, etc.)
5. Engage fully in HSS at country level: human resources for health, financing health services, major challenges

Mozambique, and Tanzania, leading to the decision to establish new NGOs to fill existing gaps.

1. Strengthening the Capacity of Existing Local NGO and CBO Transition Partners

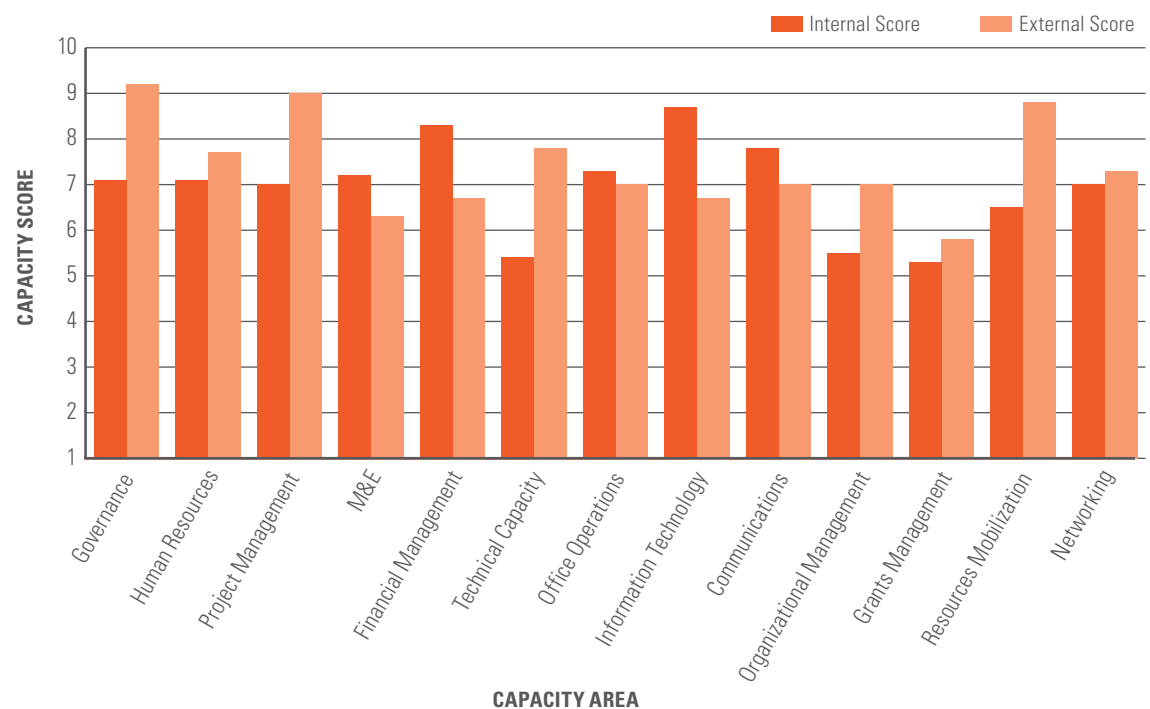
In its partnership with existing organizations, the Foundation recognized that each started with a different baseline level of capacity. Additionally, each organization would eventually take on a different role in the health system (e.g., technical assistance provider, service delivery, program management), thus requiring that capacity-building support be tailored to that role. Thus, the transition of Foundation responsibilities to existing NGOs and CBOs had two key components, which aimed to tailor activities to the longer-term role of the organization:

1. Organizational evaluation and customized capacity development, and
2. Transfer of program management responsibilities and corresponding funding.

a. Organizational Evaluation and Customized Capacity Development for Existing Civil Society Partners

Capacity development activities were designed to gradually transfer program management activities and funding to the local partners, thus supporting the assumption of greater planning, implementation, and financial ownership in existing NGOs in an integrated, gradual fashion. Activities in each of these areas were tailored to the needs of each partner and to the long-term role that each partner was anticipated to fulfill. Depending on the existing capacity and mission of each

FIGURE 3. RESULTS PROFILE OF OCVAT ASSESSMENT, REPORTED BY CAPACITY AREA



NGO, capacity development activities were tailored to the needs of each partner. For lead transition partners, the Foundation followed three steps:

1. Conducting capacity assessments;
2. Jointly developing capacity-building plans with the NGO; and
3. Implementing targeted activities defined in the capacity-building plans.

Where feasible, the Foundation used the Organizational Capacity and Viability Assessment Tool (OCVAT), a tool designed for facilitated self-assessments of organizational systems to guide the development of capacity-building plans for existing NGOs and CBOs through a participatory approach that promotes ownership of the process. Developed in collaboration with ICF International, the tool was adapted to assess capacity benchmarks for organizations engaged in HIV/AIDS programming. The OCVAT evaluates a broad range of organizational systems: financial management, grants management, human resources, program management, M&E, communications, advocacy, and resource mobilization.

The tool reduces subjectivity associated with self-assessments by providing specific descriptions for each score on a scale of indicators. Results are validated through a comparison of results generated from external reviewers. Figure 3 provides an example of how results from the self-assessment and external reviews are shared and can be used for analysis. The OCVAT also evaluates the organization's autonomy to identify where and how the organization was dependent upon other organizations to perform some basic functions. OCVAT results were a key resource to identify priority areas for systems development.

In Zambia, the Center for Infectious Disease Research (CIDRZ) was the Foundation's lead transition partner. Although CIDRZ was registered in Zambia as a local organization, at the initiation of the transition process its governance was largely controlled by the University of Alabama at Birmingham (UAB). This structure reflected CIDRZ history as a project of UAB to implement HIV/AIDS-related research in Zambia. Complementing its established research expertise, CIDRZ grew significantly to assume more leadership and expertise in HIV program implementation and

needed relatively little capacity building from the Foundation. To assess organizational capacity, the Foundation facilitated the OCVAT with CIDRZ. CIDRZ scored very well, but the OCVAT enabled both UAB and CIDRZ staff to identify areas of weakness that needed support to function independently from UAB. These areas included establishing the independence of governance systems, finance systems, grants management, and M&E. Additionally, lack of

Four out of five lead transition partners received independent donor funding to manage programs as of October 2011, prior to the end of Project HEART.

data quality assurance within M&E systems was noted. CIDRZ staff were subsequently trained on EGPAF's data quality assurance tools and procedures, and tools and processes were adapted for their use.

The OCVAT was also conducted with Africa Directions, a Zambian local NGO providing services to HIV-positive youth. The resulting capacity building plan was fully implemented with Africa Directions leadership taking an active role. Two other transition partners, the Pediatric Association of Tanzania, and the Kilimanjaro Christian Medical Center in Tanzania also received targeted capacity building, although an OCVAT assessment was not feasible.

b. Transfer of Program Management Responsibilities and Corresponding Funding

The transfer of program management responsibilities and funding occurred through subagreements that outlined obligations of the Foundation and the transition partner. Where possible, Project HEART provided subawards to private-sector and government service providers, including McCord Hospital in South Africa and Kilimanjaro Christian Medical Center in Tanzania. The subawards defined the subawardees' financial and program management responsibilities and the Foundation's capacity-building, technical assistance, and oversight responsibilities.

Four out of five lead transition partners received independent donor funding to manage programs as of October 2011, prior to the end of Project HEART. The issuing of these awards was a major milestone reflecting the point in time when these partners began to work directly with CDC, rather than through

a capacity-building partner such as EGPAF. The Foundation trained lead partner staff on agreement management practices to ensure proper administrative and financial compliance with U.S. Government rules and regulations. The Foundation and each organization actively communicated during this time to identify essential program elements to ensure continuity of service delivery and to agree upon how those program elements would transition from management to the new partner.

In Zambia, as the Foundation's partner under Project HEART, CIDRZ had been principally responsible for site-level support. During the transition, along with the MOH, the two partners developed a joint plan for site-level support for district health facilities under new direct donor funding to CIDRZ. The strategy included identifying key procurement contracts for drugs, laboratory equipment, maintenance, and supplies that would need to be transitioned.

2. Transforming Project HEART Country Programs into Independent National NGOs to Be Lead Transition Partners

Where no appropriate existing partner was identified, the Foundation supported the gradual transformation of parts of current Project HEART country programs into independent local affiliated organizations to become lead transition partners. The clear advantage was that these offshoots of Project HEART were ideally situated to ensure no interruptions in care and treatment in the short term. The Affiliates would continue the majority of Project HEART functions and activities and the strengthening national capacity for HIV program implementation. These organizations would temporarily support high-quality HIV/AIDS prevention, care, and treatment service delivery programs at the district and site levels until the national health system can take over support. Given the undeveloped state of civil society, many potential long-term opportunities for national organizations exist. Such opportunities include developing partnerships with a range of public- and private-sector entities to contribute to national health policy development or leadership for HIV programming.

The transition of Project HEART responsibilities to Affiliates had three key components:

1. Strategy development and organizational start-up;
2. Capacity development for the Affiliates; and
3. Transfer of program management roles and functions, and corresponding funding.

Box 5. Core Components of the Foundation's Affiliation Model

- **Guiding principles and standards** that list the programmatic and operational standards that affiliates must meet.
- **An affiliation agreement** to ensure that there is legal accountability within the arrangement.
- **An accreditation system** to conduct regular reviews to assess adherence to the principles and standards for affiliation and facilitate organizational strengthening.
- **A system for Foundation-Affiliate coordination and resources**, which establishes structures to ensure clear communication and coordination between the Foundation and the Affiliates to promote sharing of resources and complementarity of programs.

The result of the organizational development process was the establishment of four national organizations in Côte d'Ivoire, Mozambique, South Africa, and Tanzania, which maintain a long-term affiliation with EGPAF.

Affiliation between the new organizations and the Foundation was established so that the Affiliates could optimize national expertise and long-term commitment with international standards of technical and financial performance. Affiliation would enhance their long-term access to technical and financial resources that are essential to establishing themselves as credible and viable local partners (see Box 5). Affiliation with the Foundation is a voluntary decision by the new organization's independent board of directors.

a. Strategy Development and Organizational Start-Up of New NGOs

Foundation country program staff worked jointly with the headquarters in developing the model of organizational development for the new NGOs. In each of the four countries, workshops were held with the country offices to identify key roles for the new organizations, based on the challenges and needs of the host country. These workshops also served as an opportunity to identify challenges that would be faced in the organizational development process. At that time, national Foundation staff voiced the need to establish an enduring connection with an international entity that could:

- Promote accountability and offer incentives to adhere to international standards;
- Provide access to technical resources and knowledge exchange;
- Protect against inappropriate influence from host country governments or other partners;
- Share systems to manage human resource, operations and finances, and program implementation tools;
- Provide a financial "safety net" to support lead transition partners until they were positioned to independently attract new funding streams; and
- Provide credibility and enhance brand visibility.

In response to national staff concerns and the Foundation's responsibility to ensure successful transition of care and treatment programs, the Foundation proposed a model of affiliation for the new NGOs. To allow for a long-term partnership, the Foundation evaluated various models for organizational partnerships and affiliations between local and international partners in the development community. Included within the affiliation model is the use of the EGPAF logo, critical to conveying credibility to external partners. Each Affiliate has a name that includes *Ariel Glaser*, which reflects the history of the Foundation and the new partnership it would have with the NGOs.⁷

To continue to elevate the voices and expertise of national staff in the organizational development process, national staff formed committees that served as founding members of the Affiliates for defining the vision, mission, leadership, and programmatic scope and for registering the new organizations. The core focus was on the development of governance structures, selection of the board of directors, local registration of the organization, and identification of executive leadership. Issues identified by the founding members

Box 6. Affiliate Start-Up Checklist Focus Areas

- Legal registration
- Governance
- Human resources/staff transition
- Administrative and financial systems
- Program management
- Monitoring and evaluation systems
- Branding and external communications materials

also guided the development of the affiliation model and nature of support provided by Foundation global staff during the transition process.

The founding members were also responsible for overseeing the implementation of Affiliate start-up checklists (see Box 6), which cataloged the various steps in the process and systems that would need to be created before the organizations were ready to take on staff, funding, and program implementation. Recognizing that Foundation country offices already had strong operational procedures and significant capacity for program implementation, new Affiliates adopted and adapted existing systems to serve the needs of these new organizations. This facilitated a smooth transition of management functions to the Affiliates.

b. Evaluation and Capacity Development for the Affiliates

Like the transition process for existing national NGOs, the capacity-building process for the Affiliates was based in systematic assessment to inform the development and implementation of capacity-building

plans. As was done with other transition partners, the OCVAT was administered by Foundation country offices in Côte d'Ivoire, Mozambique, and Tanzania in preparation for the conversion to new NGOs. Capacity-building plans were then developed that were tailored to the scope of the Affiliate in the country and actual capacity of the country program. The plans were harmonized with the Affiliate start-up checklists and have been used to manage the organizational development process.

The Foundation's capacity development activities have been phased to facilitate a progressive transfer of functions through organizational capacity building and monitoring of readiness to assume programmatic ownership and leadership. Consisting of four successive phases, the intention was for lead transition partners to initially take on a small component of program implementation with the goal of incrementally expanding their geographic, program, and management scope over time as they demonstrate capacity to sustain HIV care and treatment activities at the same level of quality as Project HEART. Defined as the major stages

FIGURE 4. FOUNDATION AFFILIATED ORGANIZATIONS ESTABLISHED UNDER PROJECT HEART

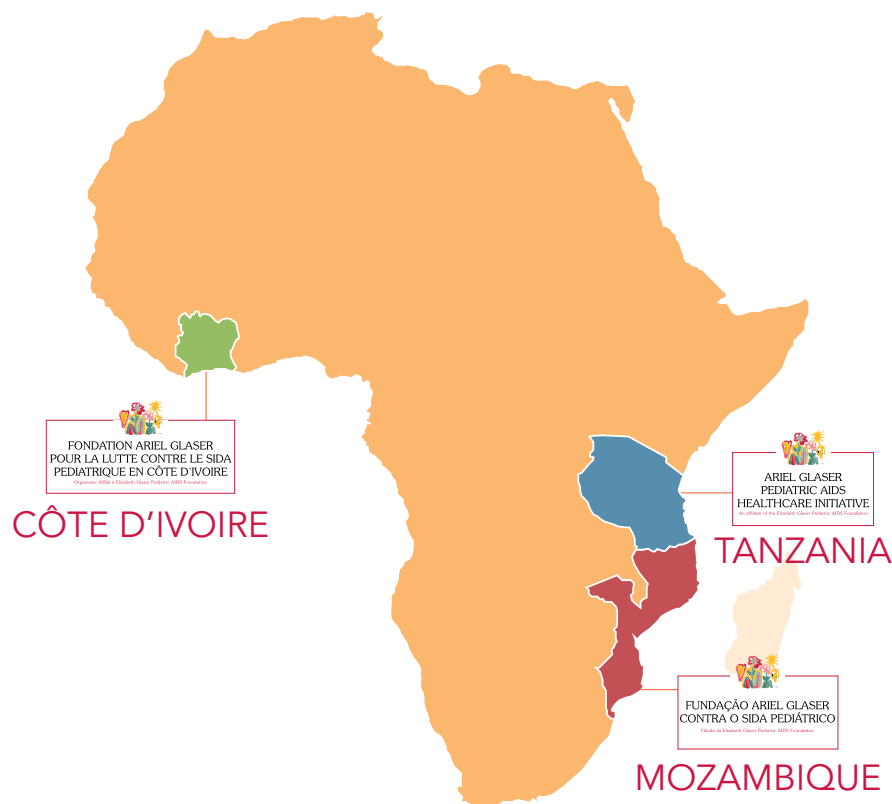
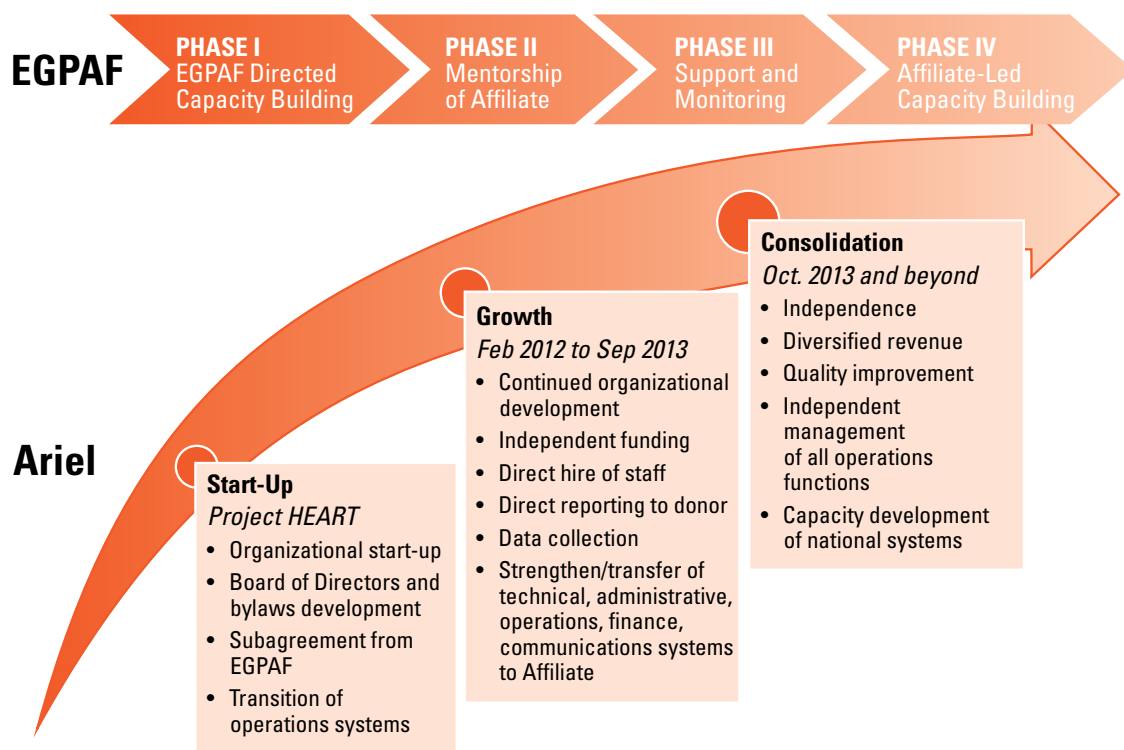


FIGURE 5. PHASES OF EGPAF SUPPORT AND NEW NGO AFFILIATE DEVELOPMENT: 2011–2016



of progressive capacity development, the four phases (see Figure 5) are as follows:

Capacity development and program direction that are principally driven by EGPAF, with Affiliate input;

- Mentorship by EGPAF to support program implementation where program management is the primary responsibility of the transition partner;
- Technical assistance provided by EGPAF to lead partners as needed based on structured monitoring, reporting, and annual performance reviews through the accreditation process; and
- An NGO-driven process of requesting targeted capacity development support from EGPAF.

Under Project HEART, capacity-building support was able to progress through the first two phases, as shown in Figure 5. At the outset, Foundation staff drove the process, but as the Affiliates developed and Foundation staff transitioned to new employment by the Affiliates, the Affiliates have taken on increasing leadership in the implementation of activities. Future collaborations between the Foundation and the Affiliates will be based

Future collaborations between the Foundation and the Affiliates will be based on a mutually beneficial partnership among equals, utilizing the comparative advantages of both national and global organizations.

on a mutually beneficial partnership among equals, utilizing the comparative advantages of both national and global organizations.

Throughout the transition, there was intense collaboration between the Foundation headquarters, country programs, and the Affiliates with planned, phased capacity building and transfer of responsibilities. Major organizational development accomplishments for the Affiliates included the convening of boards of directors, development of bylaws, completion of the registration process with the host country governments, and hiring of executive leadership. Foundation and Affiliate staff established financial management systems

A major benchmark for the transfer of program management roles was the success of the Affiliates in securing independent funding from the CDC for program activities initiated under Project HEART.

and grants management systems, including policies and procedures and opening of bank accounts. Tools and guidance were developed by the Foundation's global accounting staff to support the building of affiliate accounting systems, ensuring that appropriate internal controls were established. Focus was placed on ensuring that as the transition evolved, the program management, M&E, and quality oversight would remain the same or improve.

Additionally, the Foundation has supported the Affiliates in the continued use of project management software to monitor program activities, track expenditures, and facilitate project planning. A toolkit for designing programs for sustainable health outcomes, a program implementation manual, and standard operating procedures for HIV care and treatment were developed and adopted by the Affiliates to provide guidance for technical program implementation and agreement management. Finally, the Foundation has placed significant focus on strengthening organizational capacity to manage subgrants per U.S. Government requirements at the district and site levels, for example, by providing templates, tools, and training on the content, issuance, monitoring, and close out of these subgrants.

c. Transfer of Program Management Roles and Functions and Corresponding Funding

After basic operating systems had been established for each Affiliate, the Foundation transitioned program management roles via funding to the Affiliate through a subagreement. As a subgrantee, the Affiliates became responsible for implementing a defined set of program activities. In each country, the programmatic scope was different and tailored to the transition plan and program needs. Initially, each Affiliate supported integrated HIV prevention, care, and treatment activities in a limited geographic region previously supported by the Foundation under Project HEART. The Foundation's previous staffing, program support, subawards with partners, and office structures were apportioned

Box 7. Initial Programmatic Scope of the Affiliates (April 2011 through February 2012)

- Fondation Ariel (Côte d'Ivoire): Agnéby, Bas-Sassandra, Lagunes, Moyen-Comoe, N'zi Comoé, and Zanzan regions
- Fundação Ariel (Mozambique): Maputo Province
- AGPAHI (Tanzania): Shinyanga Region

geographically, thereby permitting seamless support for partners and minimizing administrative and financial complexities.

A major benchmark for the transfer of program management roles was the success of the Affiliates in securing independent funding from the CDC for program activities initiated under Project HEART. As of October 2011, the Fondation Ariel, Fundação Ariel, and AGPAHI were recipients of direct CDC funding for activities consistent with their initial programmatic scope under Project HEART (see Box 7). Fondation Ariel took on the majority of the Foundation's previous responsibilities in Côte d'Ivoire, including site-level support and health systems–strengthening activities in three provinces. Under separate new awards, the Foundation will continue to provide capacity development and transition additional geographic regions to each Affiliate to reinforce their role as leaders in service delivery and program implementation in their own countries.

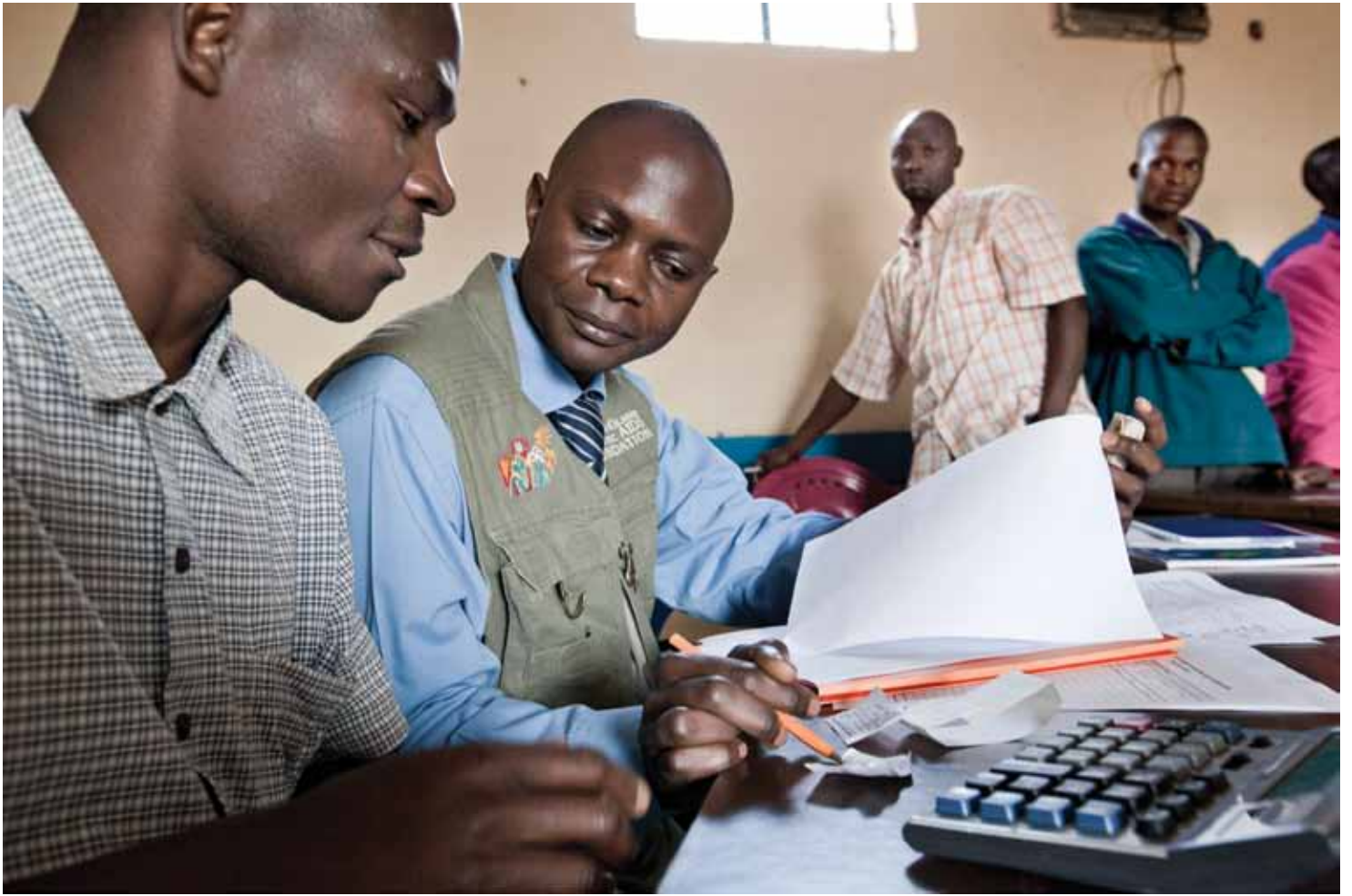


PHOTO: JAMES PURSEY

IV. MONITORING THE TRANSITION

Ultimately, the success of the transition will be marked by the continuation and expansion of quality HIV care and treatment services under full ownership and management of the national health system, including viable local organizations. A full transition will likely not be observable for five or more years. As such, Foundation monitoring focused on the immediate and short-term goals of comprehensively assessing capacity in the following areas:

- The organizational capacity of existing and new nongovernmental organization (NGO) partners serving as lead transition partners.
- The capacity of health facilities and community-based providers of HIV support services to provide quality HIV care and treatment and maintain continuity of care.

For each area, Project HEART country teams carried out comprehensive assessments using capacity-assessment tools that were adapted from existing tools

or created to serve transition-monitoring needs and beyond (see Table 4).

A. Assessing the Organizational Capacity of New and Existing NGO Partners Serving as Lead Transition Partners

As previously described in Sections III.B and III.C, the Organizational Capacity and Viability Assessment Tool (OCVAT) was used to identify the capacity development needs of the following:

- Foundation country offices from which new NGOs would be developed, and
- Existing NGO transition partners.

Application of this tool fostered team building and stimulated important dialogue among staff on how to improve organizational effectiveness, resulting in the development of detailed capacity-building plans for each local entity.

For the new NGOs that elected to be Affiliates, the Foundation developed an accreditation review tool to evaluate organizational systems for adherence to the principles and standards for affiliation. As a condition of affiliation, Affiliates in Côte d'Ivoire, Mozambique,

TABLE 4. PROJECT HEART CAPACITY ASSESSMENT AND TRANSITION MONITORING TOOLS

<p><i>Organizational Capacity and Viability Assessment Tool (OCVAT)</i></p> <ul style="list-style-type: none"> Assesses organizational capacity and viability across 13 capacity areas covering technical and operational functions. Designed to be implemented as a facilitated self-assessment in conjunction with an external assessment, resulting in the development of capacity-building plans.
<p><i>Accreditation Review Tool</i></p> <ul style="list-style-type: none"> Assesses organizational performance and compliance with operational and technical standards outlined in the principles and standards of affiliation with the aim of proposing recommendations for continued organizational development of the affiliates.
<p><i>HIV Care and Treatment Capacity Assessment Tool (HCAT-2) for Provincial and District-level Assessments</i></p> <ul style="list-style-type: none"> Assesses subnational health authorities' capacity to manage HIV programs based on World Health Organization Building Blocks. The tool was developed by the Centers for Disease Control and Prevention (CDC) and ICF International; however, it was not widely implemented as it was still being piloted at the time of this publication.
<p><i>Site Capacity Profile (SCP)</i></p> <ul style="list-style-type: none"> Comprehensively assesses health facility capacity to provide quality HIV care and treatment through systems, processes, and resources existing across 13 capacity areas. Provides automatically calculated scores per capacity area.
<p><i>NGO/CBO HIV Support Service Provider and PLHIV Group Capacity Profile</i></p> <ul style="list-style-type: none"> Assesses community-based providers of HIV support services and the availability of HIV support services, quality of services, linkages with health facilities and communities, and utilization barriers. Also assesses selected organizational capacity areas such as governance, monitoring and evaluation (M&E), and Finance. Provides automatically calculated score per capacity area.

and Tanzania underwent accreditation by the Foundation. The accreditation tool facilitates regular assessment of internal system quality, organizational development, and capacity-building needs.

Development of comprehensive capacity-building plans for financial, grants management, M&E, and program management systems resulted from the accreditation process. Subsequent accreditation reviews are planned on an annual basis.

High scores on the OCVAT and accreditation reviews are two proxies the Foundation has developed to measure organizational effectiveness. However, the most important benchmarks of success will be successful implementation of programs and wide recognition and appreciation of the organization's contribution by key local stakeholders.

B. Assessing the Capacity of Health Facilities to Ensure Continuous Quality HIV Services

The application of the Site Capacity Profile (SCP) provided the Foundation, lead transition partners, and

government health authorities at regional and district levels with a comprehensive survey of the systems, processes, and resources in place at health facilities that impact the provision of HIV services. All facilities were assessed in accordance with national standards for their designated service level. The tool also provided scores for each capacity area allowing the facilities to be ranked and those requiring additional support to be easily identified.

The SCP was conducted at a total of 214 HIV care and treatment sites being transitioned to NGO lead partners in Côte d'Ivoire, Mozambique, Tanzania, and Zambia. Results of the SCP document facility-level capacity to provide HIV services prior to transition, and provide the baseline assessment data for new projects awarded to lead transition partners.

C. Assessing the Capacity of Community-based HIV Support Service Providers to Provide a Continuum of Services

The Foundation conducted an inventory of all CBOs providing HIV support services directly to patients in

the transitioning regions of Côte d'Ivoire and Tanzania. The inventory was followed by a survey covering all or a sample of the organizations using the NGO/CBO HIV Support Service Provider Capacity Profile or the PLHIV Group Capacity Profile for independently registered PLHIV Groups (primarily found in Tanzania). The Foundation developed these tools to assess availability and quality of community services, referral systems, community engagement efforts, barriers to service utilization, and key organizational development capacity areas. In addition to documenting the pre-transition status of community-based HIV support services, lead NGO transition partners will use this information to identify CBOs needing support and to prioritize capacity-building interventions for these local entities.

Overall, EGPAF's transition-monitoring process has effectively documented the capacity of the health system in transitioning areas to provide a continuum of quality HIV services and guided capacity-building efforts. The comprehensive capacity assessments of HIV service providers at the facility and community levels also serve as baseline data for areas undergoing transition, allowing EGPAF and its lead transition partners to measure ongoing improvements in local HIV program sustainability after Project HEART.



PHOTO: OLIVIER ASSELIN

V. PROJECT HEART TRANSITION ACHIEVEMENTS

The original priorities of the Centers for Disease Control and Prevention (CDC) and the Foundation regarding transition were to transfer large-scale HIV care and treatment programs to local or national organizations to increase sustainability, without interruptions in high-quality, accessible HIV care and treatment programs.

While considerable investment has been made in national health systems, additional investment in infrastructure and in health system governance is needed. Significant progress has been made toward the long-term goal of strengthening national health systems to ensure high-quality, accessible, integrated HIV care and treatment services. In particular, direct financing has improved the ownership of health authorities in their planning, implementing, and financial management capacities. Transitioning large-scale HIV care and treatment programs to national health systems will require large-scale system strengthening to be sustained.

Other critical and important results of the Project HEART transition are the development of rigorous monitoring tools resulting in the following:

- Baseline capacity measurement of health facilities providing care and treatment services;
- Baseline capacity measurement of lead transition partners;
- Baseline inventory and capacity measurement of community organizations providing care and treatment support services; and

Significant progress has been made toward the long-term goal of strengthening national health systems to ensure high-quality, accessible, integrated HIV care and treatment services. In particular, direct financing has improved the ownership of health authorities in their planning, implementing, and financial management capacities.

- Baseline ministry of health (MOH) and decentralized health authority capacity assessment.⁸

With the exception of South Africa, each of the lead transition partners has successfully obtained direct funding from CDC for the next five years and established a scope of work that will be incrementally expanded over the next five years. In Côte d'Ivoire, Mozambique, Zambia, and Tanzania, the affiliates and CIDRZ are well staffed with highly skilled professionals and have in place essential operating systems, governance structures, and detailed capacity-building plans. High-quality, accessible HIV care and treatment services have continued in these countries without interruption. CDC is directly negotiating with the Affiliates for continued expansion in the future.

In all countries, the selection of partners to continue Project HEART responsibilities was ultimately made by CDC through a competitive process. In South Africa, CDC chose to award funds to two well-established national NGOs: Health Systems Trust (HST), who had worked more than 10 years with the Department of Health (DOH) to provide clinical technical assistance, and Aurum Institute (Aurum), to continue support for human resources. EGPAF South Africa has been working closely with both HST and Aurum to ensure a seamless transition to these national organizations by the end of Project HEART. Additionally, previous Foundation subgrantee, McCord Hospital in South Africa, has received direct U.S. Government funding to support care and treatment activities.

The Foundation will no longer have a significant presence in South Africa to support continued transition activities beyond February 2012. The Foundation has met regularly with and shared all program information with the Department of Health, HST, and Aurum to facilitate a smooth program transition. At the time of writing, the board of Directors of the Ariel Glaser Pediatric AIDS Foundation South Africa has decided to be dormant for one year to allow it to assess future growth opportunities.

During the last eight years, Project HEART has worked to strengthen capacity within South Africa DOH structures to ensure continued expansion of quality service delivery. The Foundation, together with the DOH, has also empowered local organizations to provide continued support to national, provincial, and district health management teams after the conclusion of Project HEART.

TABLE 5. TRANSITION HIGHLIGHTS OF LEAD NGO AND MOH PARTNERS AT THE END OF PROJECT HEART

Country	Transition Accomplishments
Côte d'Ivoire	<ul style="list-style-type: none"> • Established Fondation Ariel, a 100 percent Ivoirian independent NGO in 2011 with appointed executive director and board of directors. • Fondation Ariel has initiated work in six provinces, has been awarded CDC funding to continue service provision, and assumed responsibility for additional provinces over the next five years. • EGPAF will support University of Abidjan-Cocody's pre-service training institutions, including the Schools of Medicine, Nursing, Pharmacy, and Social Work. Further transition of EGPAF functions is anticipated.
Mozambique	<ul style="list-style-type: none"> • Registered Fundação Ariel as a local foundation with executive director and board of directors in April 2011. • EGPAF launched performance-based financing mechanisms for government health entities in two provinces. • EGPAF expanded subgrants to an additional 15 districts to build capacity of MOH. EGPAF and Fundação Ariel are now directly financing 56 out of 121 health districts in the country. Thirty-one of these districts are initiating performance-based financing prior to the end of Project HEART. • Fundação Ariel has implemented work in Maputo Province and has been awarded CDC funding to continue the work and assume programmatic responsibility for additional provinces over the next five years. Fundação Ariel is responsible for one of four provinces previously supported by EGPAF. Transition of a second province is planned for the second year of funding.
South Africa	<ul style="list-style-type: none"> • In July 2010, McCord Hospital began receiving direct CDC funding. • In 2011, Ariel Glaser Pediatric AIDS Foundation South Africa, completed in-country registration, appointed a board of directors, and finalized its EGPAF subgrant. • At end of 2011, all of the professionals seconded to the Department of Health by EGPAF have been absorbed into the national health system. • At care and treatment sites previously supported by the AIDS Healthcare Foundation (AHF), a U.S.-based international NGO, AHF is working to develop Memoranda of Understanding with provincial Departments of Health to ensure a smooth transition to provincial and district support. • District-level support is being transitioned to Health Systems Trust (HST), a South African NGO. • Human resources management is being transitioned to Aurum Institute, a local South African NGO.
Tanzania	<ul style="list-style-type: none"> • EGPAF provided 66 subgrants to 34 district health authorities to build MOH capacity, with accompanying support to strengthen technical, management, administrative, and financial systems. • In 2011, established AGPAHI as a local affiliate with executive director and board of directors fully in place. • AGPAHI has been awarded funding to carry out HIV care and treatment activities in Shinyanga Region over the next 5 years. • EGPAF provided capacity development support for Kilimanjaro Christian Medical Center and the Pediatric Association of Tanzania to improve clinical knowledge and skills of health-care providers in delivering care and treatment to HIV-affected and HIV-infected children.
Zambia	<ul style="list-style-type: none"> • EGPAF supported restructuring of the CIDRZ governance body to solidify local leadership. CIDRZ received funding from CDC as a local organization to continue its HIV-related activities over the next five years. • EGPAF enhanced the capacity of Africa Directions, a local CBO, to implement a voluntary counseling and testing program in selected areas, and establish pediatric support groups. • In collaboration with CIDRZ, EGPAF improved the infrastructure and provided mentoring to technicians at Kalingalinga Lab, including capacity-building technical assistance for the Pharmacy and Logistics departments to operate independently. • EGPAF contributed to roll out of Smart Care, an innovative health information systems data collection and analysis tool, to more than 570 sites to build MOH capacity.



PHOTO: JAMES PURSEY

VI. PROMISING PRACTICES AND LESSONS LEARNED

A. Strengthening National and Local Health Systems

1. Building Equal Partnerships and Ownership with the Ministry of Health

Providing basic inputs was critical to scaling up prevention, care, and treatment programs. Directly financing decentralized health authorities via subgrants to implement prevention, care, and treatment programs has strengthened equality of partnerships between Project HEART and beneficiaries, improving their ownership of prevention, care, and treatment programs. Subgrants with decentralized health authorities helped build their planning, implementation, and financial management capacity.

2. Paying for Performance

Early evidence indicates that in addition to input-based subgrants, an output-based agreement instrument, as in performance-based financing (PBF), can measurably improve results. This approach is new and innovative, but a lot remains to be learned.

3. Continuing to Transfer and Integrate HIV Care and Treatment into Existing Health Service Platforms

Local nongovernmental organizations (NGOs) can fill gaps in national health systems temporarily as needed until the national health systems can integrate HIV prevention, care, and treatment programs. Ultimately, to be sustainable, HIV services need to be supported by the same logistics, human resources, information, quality, and financing systems that support other critical primary care services. Local NGOs can then continue to provide technical expertise to ensure the maintenance of quality and continuity of care.

4. Building National Systems Takes Time and Motivation

During eight years of Project HEART, including three years of transition, much has been learned about effective partnerships and mutual interdependency of large-scale HIV programs and strengthening of health systems. Health system weaknesses present major impediments to scale up and quality. These weaknesses are best addressed through health-system-level interventions, which require time-consuming capacity building interventions. Since staff are the heart of the health system, interventions require that they not only be provided with opportunities for skills-building, but also motivation to apply new skills to yield system-wide changes.

B. Building National NGO Capacity

Accomplishing a transition from international NGOs to national NGOs at the scale attempted under Project

HEART required a strong commitment from the lead NGO transition partners, Foundation leadership and staff at both headquarters and country offices and a concerted effort from every EGPAF department over three years. Looking back at the experience, a number of issues and how they were addressed emerge as critical to the successful results achieved.

1. Dedicated Staff to Lead the Implementation of Transition

Dedicated staff at both Project HEART headquarters and in each Project HEART country, fully supported by the country and global leadership, was essential. For the Affiliates, leadership from both EGPAF and among the executive staff of the Affiliates has been important to establish a vision for the organizations and build ownership among staff and partners to help them grow. Valuable skill sets included organizational development, monitoring and evaluation (M&E), and operations.

2. Communication and Coordination

Transitioning large-scale care and treatment programs required proactive change management that was focused on regular, frequent communication and based on open dialogue and discussion. Communication and coordination among Project HEART field staff, country office leadership, Foundation headquarters, lead partners, donors, and new affiliates, along with their governing bodies, was essential to address the following:

- Inherent conflicts of interest between the Foundation and the Affiliates regarding funding and staffing decisions as the transition progressed;
- Country staff concerns about financial sustainability to prevent attrition of experienced staff from the Affiliates, as the success of the new organizations was in large part based on maintaining the highly trained experienced staff serving under Project HEART; and
- The need for effective change management throughout the organization.

3. Reallocating Human Resources and Other Valuable Assets

The determination of which staff should remain with the Foundation and which should be transitioned to the NGO partner was difficult. Human resources planning involved an evaluation of the roles and functions that would need to exist within the new organizations. Initial staffing of the new Affiliates was based on geographic scope (staff from smaller field offices in the transitioned project areas were transferred). Critical

Throughout the transition process, transition plans were designed to address these risks head on by building in monitoring and capacity building activities that targeted each one.

skills needed were not always present at the smaller field-office levels as informed by the Organizational Capacity and Viability Assessment Tool (OCVAT) and accreditation review results. To address legal and change management needs, prior to receiving direct funding, staffing for the Affiliates was established primarily through secondment from the Foundation. Once the Affiliates began to receive direct CDC funding, staff were then transitioned to full employment by the Affiliates.

4. Managing Risk

Transition of large-scale HIV care and treatment programs carries with it a number of inherent risks for all involved. These risks include the following:

- Interruption in quality and continuity of care and treatment for patients;
- Mismanagement of funding or new donor priorities; and
- Reputational risks if relationships with partners and donors decline.

Throughout the transition process, transition plans were designed to address these risks head on by building in monitoring and capacity building activities that targeted each one. For example, to facilitate continuity of care for patients, as funding transitioned to the new partners, EGPAF and the partners worked closely to ensure that quality monitoring was in place and service delivery systems would be maintained. Capacity building for partners included a focus on administrative, financial, and donor management to facilitate compliance with donor obligations. Additionally, to address reputational risks, communications materials and outreach strategies were implemented to ensure open engagement with partners and donors throughout the process.

The Foundation also established four principal strategies to mitigate the risks associated with affiliation with the new NGOs, which included (1) conducting an annual accreditation review process; (2) annual external

audits of financial systems of the Affiliates; (3) using Foundation policies, procedures, and tools as models for the Affiliates; and (4) providing specialized training opportunities for their executive leadership, financial management, and program management staff.

VII. CONCLUSION

Project HEART's short- and medium-term transition strategy was to actively build the capacity of local and national government authorities and independent national nongovernmental organizations (NGOs) to ensure access to high-quality HIV care and treatment services. Medium-term goals are for national and local governments and NGOs to take over the national HIV response and to integrate HIV clinical health services in a gradual but fixed time frame into the national health system, ensuring strong ownership of HIV programs in terms of planning and implementation. Financial ownership, the ability of governments to fully fund the national HIV program through the country's own resources, is a long-term goal.

From the outset of Project HEART in 2004, the Foundation's long-term approach has emphasized strengthening national ownership and capacity of government health authorities and local implementing partners. Although the transition process is ongoing, the Foundation has reached key milestones for the sustainable transfer of leadership, ownership, and implementation of large HIV care and treatment programs to national entities.

The success of the Affiliates in three countries and the transfer to other partners in Zambia and South Africa suggests that multiple routes are possible to ensure sustainable HIV care and treatment programs.

The Foundation's transition achievements thus far can be attributed to creating a shared vision with lead transition partners, host country national and local health authorities, and local NGOs—a vision responsive to country-specific challenges and that promotes locally led programs and transition processes. Another key ingredient for the success is the Foundation's targeted capacity building. This was conducted based upon systematic monitoring and on remaining flexible and responsive to the evolving capacity-building needs of government health authorities, lead implementation partners, and local communities.

The Foundation's historical commitment to health systems strengthening laid the groundwork for the anticipated long-term success and sustainability of

transition. Continued commitment of national health systems and civil society, beyond the usual donor funding cycle of international donors, will be required in the near and medium terms to ensure high-quality, universally accessible HIV care and treatment services.

While the long-term impact of transition cannot be measured immediately, the Project HEART transition model has established a foundation for future evaluation of success. Measures of success in achieving the transition vision would include the following:

Lead NGO transition partners:

- Have local leadership roles in their respective country's HIV response (ex. serving on national technical committees).
- Achieve financial security and demonstrate ability to support their objectives.
- Make measurable contributions to strengthening the health system or HIV response in their country and continue to transfer appropriate functions to governments.

National and local governments:

- Effectively ensure public and private providers are contributing to national health priorities and the national HIV response.
- Manage the provision of high-quality, accessible HIV care and treatment services within a strengthened health system.
- Finance the services in the long term.

The spotlight on transition has encouraged all stakeholders, international and multilateral donors, U.S. Government partners, including the Foundation, national and local governments, and nongovernmental transition partners, to prioritize host country and local leadership and sustainability in all aspects of HIV program planning, management, implementation, and financing.

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