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Learning Agenda Mini-Case #10

Tanzania

Localization: Three Partner Transition Models

Introduction

Tanzania offers a near comprehensive set of potential responses by USAID's implementing partner community at the country level to new policies, such as USAID Forward, that emphasize direct contracting to local institutions. Taken individually these responses are not unique to Tanzania, but the plurality of approaches occurring all in the same context appears noteworthy and suggests the potential for future comparative examination.

Two broad response types by the implementing partner community in Tanzania were noted during the field visit: 1) those mandated by the donor community, in this case the Centers for Disease Control and Prevention (CDC), and 2) those undertaken freely by institutions, often driven by the perception that such moves will confer a competitive advantage when competing for future contracts. The former case consisted of four Track 1.0 PEPFAR implementing partners unilaterally directed by CDC to transfer their existing programs to local management and ownership, while the latter consists of several different efforts by international institutions to re-register or re-brand themselves to appear more "local", such as Deloitte and Touche's status as a local company in Tanzania.

The following sections provide an overview of the different approaches to "localization" observed in Tanzania drawing from both key informant interviews and organization publications designed to showcase their efforts and focusing specifically on PEPFAR Track 1.0 implementing partners. Time did not permit us to interview all of the target organizations directly and this is noted where relevant.

PEPFAR Track 1.0 Partner Transition Models

Each of the four prime PEPFAR Track 1.0 implementing partners in Tanzania—Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), AIDSRelief (Catholic Relief Services Consortium), Harvard School of Public Health, and the Mailman School of Public Health at Columbia University—developed different strategies in response to the directive from CDC that they hand over their projects over a three year period to local institutions without interrupting the services provided to the target populations. The approaches used by these institutions offer a key insight into the potential impact on program quality, service delivery, learning, and project results should USAID significantly accelerate its implementation of USAID Forward.

PEPFAR Track 1.0 Background[1]

[1] This section is largely excerpted from an EGAPF publication titled "Transitioning Large-scale HIV Care and Treatment Programs to Sustainable National Ownership: The Project Heart Experience".

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, the idea being that by building on these existing programs, rapid scale up HIV care and treatment could be realized. 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, four organizations were awarded Track 1.0 funding through a competitive process to scale up ART and increase the number of people with access to comprehensive HIV prevention, care, and treatment services: Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), AIDSRelief (Catholic Relief Services Consortium), Harvard School of Public Health, and the Mailman School of Public Health at Columbia University. The four partners, in collaboration with the respective Ministries of Health (MOHs) and provincial and district health authorities, 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.

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.

Transition Models
Interviews with representatives from CRS and EGPAF[2] suggest that the organizations received no directive from CDC Tanzania outlining to *whom* to transfer PEPFAR Track 1.0 activities or *how* to do so. CDC reportedly played no coordinating role among the partners during transition, nor did it guarantee that once activities were under local management they would continue to receive PEPFAR funds. Under these conditions by 2012 we note the emergence of the following transition models.

A. Affiliate Model: Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI)

EGPAF opened its offices in Tanzania in 2003 and since then has directly implemented all of its activities partnering directly with local health clinics, district councils, and other Government of Tanzania (GOT) medical facilities. Faced with pressure from CDC to move quickly, EGPAF undertook a survey of existing local organizations to determine if there was one capable of taking on a project with this level of technical and financial complexity and size. Unable to identify such an organization, EGPAF instead chose to establish a new, independent organization

[2] No interviews were conducted with either Harvard School of Public Health or the Mailman School of Public Health at Columbia University.

that would assume responsibility for the program, but still maintain a voluntary affiliation with the parent. EGPAF's affiliation establishment process included the following steps:

1. Visioning- EGPAF chose to divide the project between itself and the new affiliate geographically (as opposed to functionally) designating the Shinyanga Zone as the locus of the new organization. Shinyanga was chosen because it was the most well-run zone under EGPAF management and had attained a degree of operational autonomy. This approach still presented a challenge because the total package of interventions was also partially funded by USAID, meaning that the plan would need their support as well. An additional challenge was building support from the local EGPAF staff in Shinyaga who now faced the prospect of leaving a well-respected international NGO for a new untried local enterprise.
2. Planning- Believing that it was essential for the local staff to drive the process, EGPAF established a founding committee and recruited a Tanzanian transition manager from outside the organization to oversee the process, especially the legal issues. EGPAF's expatriate country director was also a part of the committee, but deliberately took a back seat, only weighing in on big picture issues.
3. Incubation- The affiliate began taking shape while still being housed within EGPAF's offices. The founding committee with leadership from the transition manager worked through a transition checklist with the following headings: legal registration, governance, human resources transition, admin and finance systems, program management, monitoring and evaluation, and branding and external communications materials. A temporary board consisting of largely EGPAF staff was established under the condition that within three months a local, independent permanent board was assume responsibility. During this period the affiliate chose a name, the Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI). [3] AGPAHI developed its own mission, vision, and interim strategic plan, but chose to retain the EGPAF logo.
4. Launch- Prior to launching AGPAHI, a new executive director was recruited. Laurean Bwanakunu came to AGPAHI with several years of professional international experience with the International Committee for the Red Cross among others. Most of the field staff from Shinyanga transitioned into AGPAHI easily, though there were some HR complications. Approximately 15 new staff were recruited for various head office functions based in Dar es Salaam. In May 2011, AGPAHI officially launched. At that stage 100% of its funding was through sub-contracts from EGPAF on its PEPFAR and USAID-funded projects in Shinyanga.
5. Post-launch Support- EGPAF's framework for affiliate strengthening envisions the following phases over a five year post-launch period:
    a. Phase 1: EGPAF-directed Capacity Building: Consists of start-up activities surrounding the launch
    b. Phase 2- Mentorship of Affiliate: Runs from Feb 2012 to Sept 2013. Increasing independence in technical direction, data collection and management, and donor reporting. Additional emphasis on financial independence and sustainability.
    c. Phase 3- Support and Monitoring- October 2013 and beyond. Independent management of all operational functions and diversified revenue.
    d. Phase 4- Affiliate-led Capacity Building- New technical and managerial competencies developed independently.

[3] Ariel Glaser was the daughter of Elizabeth Glaser. Affiliates use this name noting the symbolic relationship they retain to EGPAF.

So far, EGPAF has established three other affiliates in Ivory Coast, Mozambique, and South Africa[4] using the same basic approach. All affiliates have adopted the Ariel Glaser name and use the EGPAF logo. EGPAF globally has adopted the following core components under its Affiliate 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.

B. Hand-over Model: Catholic Relief Services (CRS) and Christian Social Services Commission (CSSC)[5]

Catholic Relief Services' (CRS) presence in Tanzania dates back to 1962 when it responded to a devastating drought in the Arusha region. Since that initial effort, CRS Tanzania has continued to work closely with the Tanzania Episcopal Conference, other faith-based and peer organizations, GoT, and the private sector. Today, through its network of local implementing partners, CRS supports rural livelihoods through projects in agricultural development, health system and institutional strengthening, vulnerable children and youth, and integrated water resource management. In 2004 when CRS began implementing its PEPFAR Track 1.0 programs in Tanzania as head of the AIDSRelief Consortium, it engaged Christian Social Services Commission (CSSC) as a local implementing partner.

CSSC is a faith-based organization (FBO) established in 1993 to coordinate and oversee the extensive network of educational and health facilities owned and operated by the Catholic and Protestant churches in Tanzania. Together the churches own 889 health and education facilities nationwide including 2 large hospitals, 37 district hospitals, several smaller clinics, health training institutions, dispensaries, secondary schools, primary schools, polytechnics, and universities. CSSC maintains offices in Dar es Salaam and 5 zones with approximately 40-50 staff.

With the PEPFAR directive in 2008 to transition Track 1.0 activities to local ownership CRS Tanzania opted, as it has in several other countries, to shift PEPFAR-funded personnel, assets, and budgets to its local implementing partner. This represented a major challenge given that CSSC had previously never been a prime recipient of U.S. Government funding, though it had implemented several sub-awards. CRS Tanzania received guidance and support from its headquarters for the transition, but largely led the process directly.

[4] The South African affiliate suspended operations in 2012 to assess market opportunities after 12 months due to the decision by PEPFAR to fund pre-existing South African institutions.

[5] This section draws from interviews with senior management from both CRS and CSSC only. While CRS has published transition reports for its PEPFAR work in Nigeria, South Africa, Rwanda, and Zambia, there is no comprehensive account for Tanzania.

In 2009 CRS and CSSC began by establishing a transition committee to lead the planning process. The committee focused on identifying what resources and personnel would be required for CSSC to assume responsibility for operations, monitoring and evaluation, reporting, and financial management. Capacity building had been a feature of the project since the beginning, with CRS performing institutional capacity assessments and dedicating one team to visiting field sites and mentoring CSSC staff. Both CRS and CSSC feel this has aided the transition effort.

The transition committee developed a plan to gradually hand over responsibilities for implementation on a geographic basis with CSSC initially taking over operations in two districts. The vision was to have one entire region managed by CSSC by January 1, 2013 with CRS continuing donor relations and reporting through March 31, 2013. CRS will still oversee operations in the remaining three regions. It is not clear what proportion of the total portfolio this division represents.

Both CRS and CSSC cited numerous challenges in the transition process so far. Transferring staff from one organization to the other proved difficult due largely to inconsistencies in staff salary grades and hiring procedures. In addition, a number of CRS staff were reluctant to join a local organization. In time these issues were resolved. CRS reported frustration with what they view as lack of follow through by CSSC on action plans resulting in missed transition milestones. For their part CSSC seemed very eager to assume responsibility for the project.

Looking Ahead

CSSC has a long history and body of work that pre-dates its association with either CRS or PEPFAR. Unlike with AGPAHI (and the other newly established organizations discussed here), its long-term viability as an organization is not really in question. However, it is unclear how prepared CSSC is in the short term to assume new higher-level responsibilities for compliance, financial management, and reporting.

Another cause for some concern (and a key difference from the affiliate model) is the lack of a common vision for what future relationship, if any, CRS and CSSC will have. EGPAF and AGPAHI have established formal terms for their relationship moving forward based on shared values that are not purely dependent on donor funding. In interviews with both CRS and CSSC, all notions of continuing to work together post-transition was purely based on funding such a partnership, and even then there seemed to be no idea of how the relationship might look.

C. Spin-off Model: Harvard School of Public Health and the Mailman School of Public Health at Columbia University

During the field visit, we were unable to speak directly with any representatives of either Columbia or Harvard. Also, unlike CRS or EGPAF, neither Harvard nor Columbia has released any publications outlining their response to CDC's request for them to transition PEPFAR Track 1.0 activities to local ownership. However, drawing from 3rd party interviews and internet research, it appears that Harvard and Columbia have spun off their Tanzania project offices into stand-alone local organizations. Unlike EGPAF's affiliates in Ivory Coast, Mozambique, and

Tanzania, these new local organizations appear to have no co-branding or long-term structured partnership.

In 2010 Harvard created Management and Development for Health (MDH), a locally registered limited liability corporation in Tanzania. MDH has a board consisting of both Tanzanians and Harvard University professors, with the distinction that all Board "Directors" are Tanzanian and most Board "Members" are not. Dr. Guerino Chalamilla is MDH's founding CEO and the former Deputy Country Director for Harvard's PEPFAR program. MDH recently began receiving funding from the Elton John AIDS Foundation, but before that was 100% PEPFAR-funded with some funds coming directly from CDC and the balance channeled through Harvard.

Columbia University's Mailman School of Public Health established its International Center for AIDS Care and Treatment Programs (ICAP) in 2004 after first being awarded PEPFAR Track 1.0 funding. ICAP implements PEPFAR work in all 13 focus countries. ICAP reportedly re-registered its Tanzanian office as a local organization in order to comply with CDC's directive, but the research team could find no additional information about it. ICAP-Tanzania does not have a web page and no reference to ICAP-Tanzania as a stand-alone organization could be found on either ICAP or Mailman School of Public Health's web sites or in the sources such as local media stories, Google searches, or even ICAP-Tanzania organizational profiles contained in job advertisements.

Looking Ahead

It is far too early to assess the success of EGPAF's affiliate model in Tanzania, though at this stage AGPAHI appears to have strong, capable leadership and positive buzz about it. Yet, in the short term the approach comes with both pros and cons for both parent and affiliate. EGPAF's short-term success in transitioning project roles to AGPAHI meets CDC's expectations and builds credibility among donors for its capacity building capabilities, which could lead to new donor-funded projects. At the same time it has simultaneously lost a key program and introduced a competitor. AGPAHI is able to compete using EGPAF's brand and reputation, but offer a lower cost and a local face, both very attractive to donors. So far, AGPAHI's affiliation is helping it overcome a key barrier facing most local start-up NGOs: lack of donor confidence.

AGPAHI has won new projects from CDC and USAID, but its long-term viability is still unknown. Its status as a local organization is important to donors, but over time it will need to build a solid reputation based on transparency and results as well as diversify its revenue further. One potential stumbling block could be access to indirect cost recovery. AGPAHI currently collects no indirect costs from its USAID and CDC contracts. It hopes to establish a NICRA in the future, but obtaining a NICRA is difficult and time consuming assuming the U.S. Government will even grant one. For the time being EGPAF is still subsidizing AGPAHI to a degree, but this will likely not continue for long.

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