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Brief Report

# Lessons Learned From Transitioning PEPFAR Track 1.0 Care and Treatment Programs: Case Studies in Financial Management Capacity Building in Zambia and Botswana

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In 2008, the United States government mandated transition of internationally managed HIV care and treatment programs to local country ownership. Three case studies illustrate the US Health Resources Services Administration's fiscal assessment and technical assistance (TA) processes to strengthen local organizations' capabilities to absorb and manage United States government funding. Review of initial, TA and follow-up reports reveal that the 1 Botswanan and 2 Zambian organizations closed 10 of 17 financial capacity gaps, with Health Resources Services Administration assisting on 2. Zambian organizations requested and absorbed targeted TA on the basis of the consultant's desk review, their finance staff revised fiscal policies and procedures, and accordingly trained other staff. In Botswana, delays in integrating recommendations necessitated on-site TA for knowledge building and role modeling. Organizational maturity may explain differences in responsiveness, ownership, and required TA approaches. Clarifying expectations of capacity building, funding agreement, and nonmonetary donor involvement can help new organizations determine and act on intervening actions.

**KEY WORDS: assessment, capacity building, financial management, technical assistance**

*J Public Health Management Practice*, 2015, 21(6), 564–572


During phase I of the US President's Emergency Plan for AIDS Relief (PEPFAR), the US Congress rapidly deployed US $15 billion to ameliorate HIV-related morbidity and mortality and the accompanying burden on individuals, families, and health systems in 15 focus countries.[1,2] At the outset, 4 US-based academic

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This work was supported by the US Department of Health & Human Services, Health Resources and Services Administration (Cooperative Agreement U91HA06801) for the development of the CIASS modules and subsequent assessments. The authors thank the staff of all the Track 1.0 implementing partner agencies and the local partner staff in Botswana and Zambia for their hard work throughout the CIASS assessment process and throughout the transition processes. The CIASS toolkit and related materials were developed by the University of Washington and International Training and Education Center for Health on the basis of a Ryan White Care Act domestic assessment model called the Primary Care Assessment Tool (PCAT).

The views expressed in this publication are solely the opinions of the authors and do not necessarily reflect the official policies of the U.S. Department of Health & Human Services or the Health Resources and Services Administration, nor does mention of the department or agency names imply endorsement by the U.S. Government.

The authors declare no conflicts of interest.



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DOI: 10.1097/PHH.0000000000000194

and nongovernmental organizations (NGOs) successfully competed for PEPFAR funds to introduce urgently needed HIV care and treatment services through the PEPFAR-initiated "Rapid Expansion of Antiretroviral Programs to HIV Infected Persons in Selected Countries in Africa and the Caribbean under the President's Emergency Plan for AIDS Relief," also known as the Track 1.0 Care and Treatment Program.[3] In 2008, the US Department of Health & Human Services mandated the transition of HIV care and treatment programs from US-based implementing partners to host governments and indigenous local partners.*

The Obama Administration's subsequent Global Health Initiative supported the increasing emphasis on country ownership for PEPFAR phase II (2009-2013).[4] Track 1.0 implementing partners rose to the challenge, demonstrating strong leadership and creativity in providing the technical assistance (TA) needed to transition emergency HIV care and treatment services to country-led, sustainable programs. They continued to work closely with host governments and increased their efforts to strengthen select local partners' capacity to provide sustainable clinical oversight through reliable and compliant systems for administrative, financial, and grants management of Track 1.0 care and treatment programs.[5]

The transition from US-based organizations to local partners required a change in the flow of funding. Pretransition funds flowed from the Office of the Global AIDS Coordinator (OGAC) at the Department of State to the Department of Health & Human Services and subsequently to the implementing agency, the Health Resources and Services Administration (HRSA), and HRSA awarded the funds to its US-based academic and NGOs implementing partners who then transferred funds as needed to their country offices. Posttransition, for organizations funded by HRSA, the funding would flow directly from the OGAC through HSS to the US Centers for Disease Control and Prevention (CDC) offices in-country to host governments and local partners. This dramatic change created the need for collaboration between key stakeholders to ensure a high level of financial capacity and accountability from local partners in managing direct US government (USG) funding. These key stakeholders included HRSA, the US-based funding/monitoring agency working with OGAC; US-based international NGOs funded by HRSA to manage large HIV support programs; local partners and host governments subcontracted by international NGOs; and the in-country CDC offices that would eventually manage direct funding to local partners posttransition.

Consequently, HRSA adapted its TA framework, successfully used to strengthen domestic AIDS service organizations through the Ryan White Care Act, to support Track 1.0 implementing partners' efforts to strengthen local partners in multiple resource-constrained settings.[6] Health Resources Services Administration developed and implemented the Clinical Assessment for Systems Strengthening (ClASS) framework with the contractual support of the International Training and Education Center for Health at the University of Washington and the University of California, San Francisco.[7]

The theoretical model that best fits the ClASS framework is that of the much evolved Appreciative Inquiry as described by Bushe.[8] The application of Appreciative Inquiry is based on grounded observations on existing organizational strengths. The appreciation of strengths promotes dialogue on areas where further strengthening is needed to realize organizations' aspirations and encourages organizations to experiment with and adapt best practices to achieve the desired outcomes. The ClASS framework serves as an intervention facilitated by reviewers skilled at generating positive affect, hope, aspirations, and authentic engagement required to increase stakeholder receptiveness to new ideas. Being uninvolved in daily program activities, the reviewers can challenge stakeholders to reconsider current practices. The ClASS implementation helps governments and other local partners to consider their strengths and donor expectations to motivate normative and procedural changes to meet their organizational goals.

In practice, the ClASS framework's unique approach favors a participatory, holistic assessment over an audit. As a result, the assessment team, comprising HRSA project officers, in-country CDC officers, expert reviewers, Track 1.0 implementing partners, and local partners' personnel, jointly identify an organization's administrative, fiscal and technical strengths, and opportunities for improvement. The ClASS framework aims to build mutual trust through the collaborative development of the scope of work and an expert-driven assessment and review process. The ClASS reviewers use qualitative interview methods to assess and make recommendations specific to each local partner. Thereafter, local partners develop action plans and immediately begin building their organizational capacity using internal resources. Local partners can request targeted TA when needed and assume

*To meet the definition of a local partner, the Office of the Global AIDS Coordinator requires that the partner organization be legally organized under the laws of the host country; 66% beneficially owned by citizens or permanent residents of the country (51% for fiscal year (FY) 2009-2010, 75% for FY 2013); and be staffed and managed by 66% citizens or permanent residents of the host country (51% for FY 2009-2010, 75% for FY 2013). Entities with a board of directors are required to have 51% membership on that board also be citizens or permanent residents of the host country.[2]

the responsibility for institutionalizing the new or enhanced capacity. Through follow-up ClASS visits, HRSA project officers monitor progress in addressing capacity gaps, and reviewers provide additional input to further enhance the organization's capacity to implement quality HIV care and treatment programs.

This article presents 3 case studies that illustrate the application of the ClASS framework for strengthening financial management by 3 local partners in Botswana and Zambia. Although offered to all 26 local partners reviewed between August 2010 and November 2011, only these local partners requested direct HRSA assistance to implement recommendations for stronger financial management and they, therefore, provided HRSA the opportunity to test the ClASS framework in its entirety. Primary components of PEPFAR II and the Global Health Initiative prioritize financial management, accountability, and planning systems in the transition to local partners to assure Congress and the US public of due diligence and fiduciary responsibility.[9,10] Possible explanations for the similarities and differences between the 3 cases and lessons learned from the provision of TA to strengthen financial management are also discussed.

## Methods

The first author reviewed reports from initial and follow-up ClASS visits conducted between August 2010 and November 2011 to gather recommendations for improvement, identify resolved and outstanding capacity gaps, and gather new recommendations for improved financial management made to the 3 local partners. The 3 organizations were chosen from a pool of 26 local partners that received assessments from August 2010 to November 2011. The 3 local partners (≈10%) were the only ones to receive expert driven, HRSA-funded TA on the basis of either self-request or at the direction of the HRSA Project Officer.

The TA consultant formatted the reports as per the specifications of the HRSA scope of work. The report was read for processes used, analysis of the problems, TA provided, and outcome. The subsequent ClASS report written by the fiscal reviewer was used to validate the information provided in the TA reports. The TA reports were reviewed to understand the nature of assistance provided and its expected impact on financial management. The number and type of financial management opportunities for improvement pre- and post-TA were compared for each local partner. The role of HRSA-supported TA in these improvements, as well as its scope and impact, was considered in relation to the structure and maturity of the organization. Tables 1 and 2 summarize some of the common financial management concerns, their relevance to capacity building, as well as the impact of TA on subsequent gaps identified at follow-up. The Figure links some of the identified areas for improvement with the specific TA interventions and improvements noted during the follow-up assessment.

The activities described in this article did not meet the US federal definition of human subjects research. As such, the University of Washington Human Subjects Division determined that human subjects ethics review and oversight was not required for these activities.

### Case study settings and process

Each case study includes a description of the organization; the financial management-related opportunities for improvement resulting from the ClASS assessment; the subsequent TA requested and provided; and the resulting capacity enhancements.

In each case, the HRSA planning process and assessment implementation process was identical. Six to 12 months before an assessment, an HRSA project officer began working with the Track 1.0 implementing partner and local partners to initiate the participatory assessment process through conference calls with leadership staff. HRSA, with assistance from International Training and Education Center for Health, selected a team of expert reviewers, including a finance consultant, who read background documents to prepare for the assessment. The expert reviewers participated in a second call with the Track 1.0 implementing partner and local partner leadership to fine-tune the assessment scope of work and to address initial questions on the basis of the advance documents provided to the assessment team. Once on-site, the fiscal reviewer (along with other team members assessing administrative and clinical program functions) conducted qualitative interviews, followed by document verification over a period of several days. At the end of the visit, the fiscal reviewer facilitated a discussion with leadership and staff on the strengths identified in the finance systems along with opportunities for improvement. The fiscal reviewer documented their observations in a written report that HRSA forwarded to the Track 1.0 implementing partner to share with each proposed local partner as well as applicable USG field staff.

The ClASS financial module utilized in each of these case studies was identical and focused on areas key to USG regulatory compliance and best practices around accountability and transparency, including program financial management; financial management policies and procedures; budget management; financial management information systems; accounting systems (payroll, documentation, internal

**TABLE 1 ● Common Priority Financial Management Capacity Concerns and Relevance to Capacity Building**

| Common Priority Financial Management Concerns | Relevance to Capacity Building |
|---|---|
| Annual audit not completed | Meeting standards increases ability to maintain USG funding and improves opportunities for new sources of funding through demonstrated accountability and transparency |
| Audit findings around retirement of travel advances not resolved | |
| Policy to advance cash to local sites does not meet USG regulations | |
| Finance and Accounting Policy and Procedure Manual was generally weak, outdated, or did not specifically address one or more of the following issues: reasonable distribution of incurred costs, allowable costs, or treatment of administrative fees | Complete and updated manual provides guidance and instructions that support consistent and accurate financial management |
| Grants Management Manual does not adequately explain cost allocation methodologies | A separate manual for grants management policies and practices improves accountability and supervision of subcontractors |
| Lack of grants management processes and subcontracting/bidding processes | |
| Time and effort (payroll) tracking not in place to match grants | |
| Lack of adequate infrastructure and staffing in finance department | Adequate staffing/resources and clear supervision reduces costly staff turnover and decreases common errors |
| Poor oversight of finance department staff and activities | |
| Board of directors not receiving/approving regular financial statements | Informed board members leads to better decision making and ensures members fulfill fiduciary roles and responsibilities |
| Lack of internal controls in place | Improving separation of duties helps protect against fraud |

Abbreviation: USG, United States government.

controls, and cash management); accounts payable and receivable; procurement, purchasing, inventory, and travel; financial management program monitoring and oversight; and grants, contracts, and subcontract management.[7]

## Case study #1

An NGO in Zambia, identified to assume responsibility of a care and treatment program from a US-based partner, underwent an initial comprehensive HRSA assessment, including a finance capacity review, during a 10-day period in May 2010. The organization managed 135 health facilities in Zambia, accounting for about 50% of the health services in rural Zambia and about 30% of the health services countrywide. The organization manages a substantial budget of more than US $49 million with funding from 7 different donors. The organization is supported by a structure that includes department heads, regional offices, and a strong base of community-level workers/volunteers.

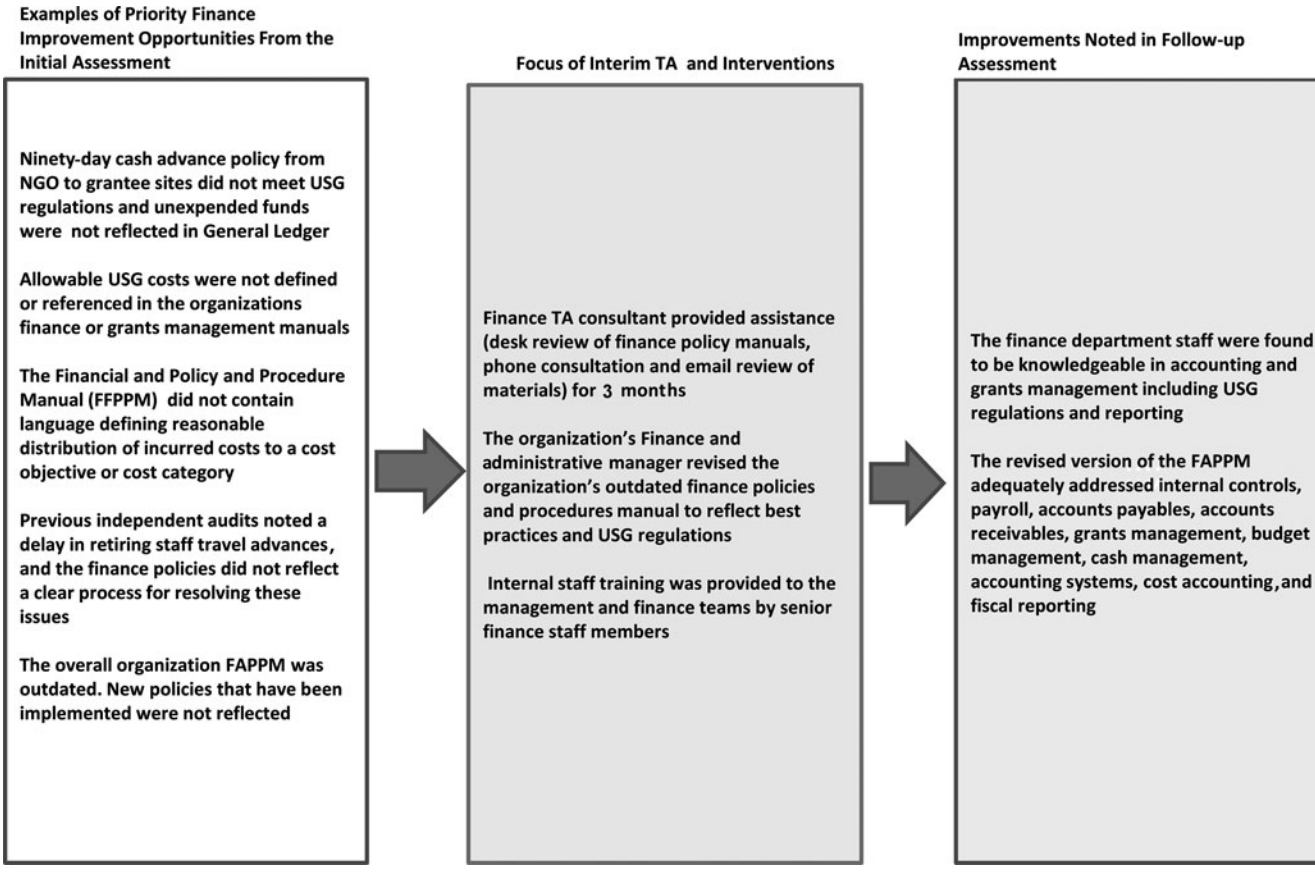
Following a HRSA assessment in May of 2010, this organization received 5 specific recommendations to improve financial management (Table 2). The HRSA encouraged the Track 1.0 implementing partner and local partners to make related improvements and offered HRSA-funded TA as needed. In the subsequent 12 months, the HRSA project officer monitored the progress on priority issues related to transition as well as on more general opportunities for improvement. The local partner, through the Track 1.0 implementing partner, requested TA to meet only 1 of the 5 recommendations. Specifically, the local partner requested TA to complete a Finance and Accounting Policies and Procedures Manual (FAPPM) that was responsive to USG funding requirements and that also addressed policies

**TABLE 2 ● Summary of Priority Financial Management Capacity Concerns During Initial Assessment and at Follow-up Across all 3 Case Studies**

| Number of Priority Financial Management Capacity Concerns | LP/Case Study #1 | LP/Case Study #2 | LP/Case Study #3 |
|---|---|---|---|
| During initial assessment | 5 | 2 | 10 |
| Resolved with or without IP support | 3 | 1 | 4 |
| Resolved with HRSA support | 1 | 1 | 0 |
| Not resolved at follow-up | 1 | 0 | 6 |

Abbreviations: HRSA, Health Resources Services Administration; LP, local partner.

**FIGURE ● Examples of Finance Problems Identified and Resolutions Following TA**




Abbreviations: TA, Technical assistance; USG, United States government.

and procedures associated with effective financial management systems. Rather than providing a consultant to create an FAPPM, HRSA contracted a US-based international consultant to support the local partner to create their own policies and procedures in the hope of enhancing organizational capacity and sustainability of the changes. Finance TA consultants were typically accountants familiar with USG regulations and refer to individuals used to exclusively provide TA either between or after regular ClASS assessments.

Over a period of 3 months, beginning in July 2011, the finance TA consultant exchanged e-mails and phone calls with the organization's finance and administration manager on matching the organization's policies and procedures to USG regulatory requirements. The director of the Track 1.0 implementing partner organization participated in the discussions and monitored local partner progress on recommended changes. The TA resulted in a fully revised FAPPM that reflected USG regulations, specifically those related to cost allocation, asset management, cash management, separation of duties, and other risk management policies, as well as adaptations to the organization's software to accommodate these changes. The organization's finance and administration manager felt confident enough with the revisions to present the changes to the organization's management team and to provide the subsequent internal training to the finance and accounting staff. The TA was low cost because the consultant did not need to travel to Zambia and the organization's staff did the majority of the work to rewrite policies and procedures and develop the internal trainings. The Track 1.0 implementing partner organization and the local partner worked on the implementation of the new policies and procedures.

HRSA conducted a follow-up assessment over a 10-day period in November 2011, 18 months following the initial assessment. A different financial management reviewer conducted the subsequent finance capacity assessment and noted significant improvements both in the quantity and quality of the finance and accounting policies and procedures and in staff knowledge of USG regulations. The consultant requested 1 clarification in the FAPPM and, separately, noted that 1 other

recommended change was pending, most likely due to competing priorities and time constraints. Overall, by the time of the follow-up assessment, 3 of the 5 original opportunities for improvement were addressed by the local partner with support from the Track 1.0 implementing partner and the fourth with HRSA-sponsored TA (Table 2).

### Case study #2

During the same 10-day period in May 2010, a second NGO in Zambia that had been identified as a potential local partner was assessed by a ClASS team.

This 14-year-old organization managed public health clinics and orphan care, generating income through the provision of education and conference services. In the previous 10 years, it oversaw the management of 3 HIV treatment facilities in Zambia. The organization managed approximately US $12.8 million from 10 different donors.

The fiscal reviewer identified 2 key opportunities for improvement related to USG regulations (Table 2). One year later, in April 2011, at the request of the local partner and the Track 1.0 implementing partner, HRSA contracted an international finance consultant to assist the organization in completing their FAPPM to ensure that it was responsive to USG funding requirements and that it addressed other common policies and procedures associated with effective financial management systems. In addition, the HRSA project officer requested that the consultant provide samples and resource documents as needed to reinforce and support policy and procedural changes.

During the course of the next 3 months, the consultant reviewed the local partner's existing FAPPM (last updated in 2009) and the FAPPM of another local NGO (considered a good model for USG regulatory compliance) and compared and contrasted the 2 financial management manuals. The consultant then developed an "Annex" for the local partner's manual including new policies addressing all USG rules and regulations and recommending whole sections to be duplicated from the "model" NGO manual. Specific changes updated the sections on internal controls, particularly, cash control and payments, including bank and petty cash reconciliations; travel advances; authorization and approvals of expenditures; and preparation and review of financial statements. The organization's finance director reviewed the revised policies and procedures and finalized agreements in phone calls and e-mail exchanges with the consultant.

A subsequent HRSA assessment was conducted in November 2011 by a different team of reviewers and included a follow-up financial compliance review. In the follow-up report, the fiscal reviewer noted among the organizational strengths, "an improvement in FAPPM around internal controls, including procedures for a hierarchy of signatory approvals, separation of duties, and detailed explanations of allowable costs and unallowable costs." In addition, the reviewer noted that the manual "addressed all donor requirements and USG regulations." Overall, by the time of the follow-up assessment both of the original opportunities for improvement identified at this local partner were resolved following HRSA-sponsored TA (Table 2).

### Case study #3

In January 2010, an initial ClASS assessment was done with a newly incorporated 3-year-old local NGO in Botswana to which the Track 1.0 implementing partner was in the process of transitioning its training programs as well as the related fiscal and administrative functions. The NGO was to take over the training services budget of around US $1.8 million from the Track 1.0 implementing partner. Unlike the previous 2 case studies, the new local partner did not yet have full autonomy from the Track 1.0 implementing partner, nor did it meet the OGAC definition of "local partner." Many of the leadership and decision-making functions for the new organization still resided with the Track 1.0 implementing partner.

During this assessment, the fiscal reviewer complimented the Track 1.0 implementing partner on its comprehensive and detailed FAPPM while simultaneously expressing concerns about the pace of the transition of responsibility for implementing those policies and practices to the new local partner staff. The consultant recommended 10 areas of action to hasten transition of program implementation to the new NGO (Table 2). The HRSA ClASS team, Track 1.0 implementing partner and local partner, discussed these recommendations in a debriefing session at the end of the 2010 assessment, which were captured in the HRSA report. The HRSA project officer monitored the work of the Track 1.0 implementing partner to provide guidance and TA during the subsequent year of ongoing transition planning.

At the time of the follow-up financial management review, 1 year later in January 2011, the HRSA project officer identified the local partner as being further along in becoming autonomous and in having the capacity to be independently funded by the USG and HIV treatment support program. The fiscal reviewer noted significant progress in increasing finance-related staffing and systems infrastructure in the local partner organization. This included hiring an international accounting firm to provide financial leadership support, senior leadership training around grants management, and increased finance team staffing and oversight. More experienced personnel filled new finance positions at the

local partner organization. The fiscal reviewer praised the local partner for the level of detail included and the comprehensive nature of its FAPPM but suggested testing compliance with those policies on the basis of concerns raised in the first assessment.

Overall, 6 of the original 10 opportunities for improvement remained despite TA from the Track 1.0 implementing partner (Table 2), as noted in the follow-up ClASS report. Also, 3 new areas of concern were identified. Consequently, HRSA contracted 2 financial management consultants to test 4 to 5 key policy areas, test procurement policies and procedures against actual practice and recommend systemic changes to address any inconsistencies observed, and finalize the reclassification of specific financial transactions. The 2 consultants developed a tool to assess the policies against the actual practices on the basis of a review of the existing FAPPM, Procurement Manual, assessments reports, and external audits. The consultants worked with the in-country CDC grants manager in the development of the tool and eventually tested 30 policies and procedures from the various manuals against actual practices to assess compliance. They also evaluated progress on findings from the annual audit. During the 1-week period, the consultants simultaneously provided training and guidance and facilitated a debriefing session with senior leadership from the CDC, Track 1.0 implementing partner and local partner.

Based on their review, the consultants recommended greater board involvement, the addition of a chief financial officer, more structured procurement processes, and acceleration of the software conversion process to strengthen enactment of the NGO's policies.

## Discussion

The use of the ClASS framework to support the transition of HRSA-supported Track 1.0 HIV care and treatment programs appears successful in uncovering gaps in capacity critical to transition and in strengthening the financial management of USG funds at all 3 organizations. Table 1 reflects 11 of the 15 most common financial management capacity gaps found in ClASS reports, many unique to each organization, with the exception of those related to the FAPPM that was common to all 3 local partners. The Figure shows the pathway from initial identification of opportunities for improvement to their resolution through external TA. As seen in Table 2, over time, all 3 local partners, with Track 1.0 implementing partners' and HRSA support when requested, demonstrated stronger capacity for financial management in ClASS-identified areas for improvement, albeit at different paces. Inaugural assessment visits established the systemic needs and built the initial relationships and trust needed to facilitate the provision of contextual and locally owned TA, which, along with sustainability, is deemed critical to the medium and long-term success of capacity-building activities.[11-13] The follow-up assessment visit increased understanding of the capacity and challenges faced by the local partners, reinforced positive changes, and identified any outstanding and new capacity gaps that needed to be addressed. Partially due to their ability to meet USG financial regulations and requirements, the 3 local partners competed successfully to implement and manage HIV care and treatment programs by the target date of March 2012, with continued support from the CDC and Track 1.0 implementing partners to close any remaining capacity gaps.[14]

Track 1.0 implementing partners identified potential local partners on the basis of compatibility with their mission and organizational structure to meet their client population expectations rather than to meet USG criteria, requirements, and regulation.[15] Consequently, while the Zambian Track 1.0 implementing partner could find suitable local partners, the Botswana Track 1.0 implementing partner had to incorporate a new local partner to accommodate its own ongoing research activities and in recognition of the small number of NGOs with even smaller capacities in Botswana.[16] Most newborn organizations struggle with new roles, new relationships, and the fine-tuning of organizational structure and processes,[17] which may explain the greater number of arising and ongoing recommendations. Early establishment of policies and procedures, financial indicators for external and internal monitoring, and input of resources offer new organizations some protection from early demise.[17,18] Conversely, as organizations age, they face reduced injections of resources, vigilance in monitoring, and static policies,[17,18] as somewhat found in the Zambian organizations.

The TA models between the 2 countries differed in strategic approach. In Zambia, HRSA responded to requests for TA on the basis of an identified need,[19] whereas in Botswana it proactively provided TA in anticipation of need. The 2 Zambian local partners quickly exhausted the Track 1.0 implementing partner's TA resources and asked for direct HRSA support to realign their FAPPM to USG regulations. The third local partner, in Botswana, had strong policies and procedures adapted from the Track 1.0 implementing partner, which it was not yet able to fully implement. Possible explanations for not asking HRSA for assistance include not recognizing the need for external TA[20] and being diverted by the steep learning curve required of new organizations.[17]

A sound financial objective and a combination of strong, internally determined and donor-required policies provide the foundation for proficient financial

management in the NGO sector.[21] To that end, the ClASS fiscal module integrated specific USG regulations with other generally accepted accounting practices. New organizations, such as the local partner in Botswana, need the gradual rather than swift withdrawal of sponsors so that local boards can assume greater responsibility and consolidate long-term decisions.[22] Yet, gradual withdrawal of support by the sponsor can prolong reliance on the organization providing the required TA and can delay adequate structuring, staffing, and training of the new organization's finance team. Explicit statements of expectations of capacity-building activities with funding agreements that specify the required steps and donor involvement beyond funding can better support building the capacity of new organizations.[22]

The mode of delivering TA around financial management differed between the 2 countries. Consultants to the 2 Zambian programs provided a low-cost "desk review" of policy and procedure manuals without traveling to the country.[22] The Zambian teams themselves worked on policy and manual revisions, with the HRSA consultants playing the role of reviewers using telephonic and e-mail communications.[23] The ClASS framework and TA approach used in Zambia were consistent with what West et al[24] cited in their extensive review of published evaluations and relevant theory as "effective technical assistance models," which are based on "two-way interactions, collaboration and relationship-building."(p922) In Botswana, delays in integrating recommendations necessitated on-site presence which, over time, appeared more conducive to knowledge-building and role modeling in the provision of TA.[25]

The 2 organizations in Zambia, perhaps due to the ages of the organizations, were better able to utilize and absorb the TA to build their own capacity, resulting in fewer subsequent recommendations for improvement. The Zambian local partners demonstrated more "absorptive capacity," a concept first introduced more than 20 years ago by Cohen and Levinthal.[26] Lewin et al[27] point out that organizations with absorptive capacity are more mature, with senior staff and internalized systems and "organizational routines" in place. Uli[17] describes these routines as "repetitive, recognizable patterns of interdependent actions carried out by multiple actors."(p5) Lewin et al[27] further argue that such organizations not only have the ability to expand on the basis of new ideas, but are more flexible about "sharing knowledge and superior practices across the organization and reflecting, updating and replicating."(p87) The Zambian local partner's finance staff took ownership of the improvement processes, including writing revisions to the policies and procedure manuals and implementing internal finance staff trainings on the basis of those revisions. As a result, they ultimately displayed more capacity to move the change and transition process along more quickly. We hypothesize that in Botswana, fears around the "liability of newness," as Uli[17] calls it, and the overall weak NGO sector in Botswana led the international partner to move more slowly with transition, resulting in slow integration of the TA there and necessitating additional, more intense and more expensive HRSA-supported on-site training.

## Conclusions

Despite the overall successful capacity development described in these case studies, some questions remain: Can TA approaches like those described in this article, including the low-cost, more self-directed approach, lead to longer-term success as measured by ongoing compliance with USG and/or other national regulations? Will the absence of close monitoring of indigenous organizations by outside entities affect consistent performance over time, especially in countries with weaker NGO functioning? Do the theoretical assertions hold up that a more mature organization is a better choice for transitioning than a newly created entity? Longitudinal follow-up is also needed to determine whether the capacity building achieved in cases like those described here can be sustained in the face of historically high staff turnover in organizations working in low-resource settings.

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