The field of HIV is complex; no one government or organization is able to address all of the related issues. Instead, the HIV response requires a multitude of stakeholders with a variety of strengths to collaborate in order to be effective. Together, they are the building-blocks of strong health systems and contribute to improved health of the people in southern Africa.

Launched in 2010, the **Building Local Capacity for Delivery of HIV Services in Southern Africa Project (BLC)**, funded by the US Agency for International Development (USAID) and implemented by Management Sciences for Health (MSH), works with governmental, parastatal, and civil society entities to strengthen the quality, reach, and sustainability of effective HIV and AIDS interventions. Throughout the southern Africa region, and with specific activities in six countries—Angola, Botswana, Lesotho, Namibia, South Africa, and Swaziland.¹

¹ BLC also works in Zimbabwe through its Migration Corridor partners.
<table>
<thead>
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<th>BLC provides technical assistance in five areas:</th>
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<tr>
<td>1. Leadership, management, and governance</td>
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<td>2. HIV prevention</td>
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<td>3. Care and support for orphans and vulnerable children (OVC)</td>
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<td>4. Global Fund grant management</td>
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<td>5. Health facility quality improvement</td>
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BLC’s activities fall within four interconnected levels: regional, national, civil society, and health facility. BLC’s support is customized to a particular context and need within a particular level, resembling a puzzle. For example, civil society organizations (CSOs) have an important role in providing services within countries and coordinating with national governments and health facilities. BLC is strengthening CSOs through the provision of grants and institutional and technical capacity building. Consequently, BLC’s partners provide better-quality services and are more sustainable—enabling them to contribute to the long-term HIV response.

BLC customizes its technical assistance to the specific context and needs of the particular level—and with a keen eye on the interconnections among the levels. As a regional project, BLC shares and applies good practice across its programs, resulting in a reach and impact far greater than the sum of its parts.

BLC’s work with various types of organizations, each with its own individual strengths and weaknesses, has yielded a wealth of experience, including successful approaches and significant results, as well as lessons learned. Although each partnership is unique, BLC provides three actual scenarios which demonstrate the specific challenges, needs, and potential in the region.

<table>
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<th>BLC’s value-add</th>
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<td>• BLC taps into MSH’s international expertise as well as its 40 years of technical and contract experience working with the US government (USG), USAID, and local governments.</td>
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<tr>
<td>• The project’s ready access to a vast range of technical expertise and financial resources permit a rapid response to regional and local government priorities as well as USAID Mission needs.</td>
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<tr>
<td>• Rapid start-up of country and regional programs is further enhanced by BLC’s use of validated tools, approaches, and strategies that are adapted and customized for country and organizational contexts.</td>
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<tr>
<td>• BLC’s time-tested processes prioritize close collaboration with partners to identify needs and implement contextually appropriate interventions. The project often brings different partner organizations together to learn from each other’s successes and challenges and create linkages among them.</td>
</tr>
<tr>
<td>• BLC gets results. By the time the work is done, the partner organization owns the process, and leads the way in continuing to build and sustain organizational and technical capacity.</td>
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Scenario A: From internationally funded project to locally owned organization

Supporting a long-time USAID-funded project implemented by an international Non-governmental organization (NGO) to become a wholly locally owned entity operating in several countries, and capable of receiving direct funding from USG.

Challenge: This scenario reflects BLC’s mandate from USAID to assist indigenous CSOs to qualify for and successfully manage USG funds, in line with the USAID Forward Agenda Procurement and Implementation Reforms which aim to strengthen local ownership and sustainability for a strong regional response to the HIV pandemic. This new organization had the technical capacity to carry out activities and fulfill the deliverables expected by USAID. However, it was an emerging entity, lacking essential policies, procedures, and structures to function independently and to successfully secure and manage funding.

Intervention: After identifying specific needs through the Organizational Capacity Assessment (OCA), BLC provided technical assistance in: developing policies and providing training on human resource management, finance, and operations; regular coaching and mentoring; hiring operational staff; and developing communication materials that met USG reporting requirements and marketed the organization. In addition to capacity building assistance, the organization received USAID-funded grants via BLC to support the implementation of technical activities in two countries.

The grants were essential to maintain the organization’s viability. Following one year of support, BLC commissioned a USAID simulated pre-award survey and a USAID A-133 audit, both of which uncovered financial irregularities. In response to these findings, BLC and the organization agreed to implement a 90-day accelerated capacity building plan to further strengthen financial and human resource management, structures, and systems. BLC conducted leadership and management training to address deficiencies in corporate governance and operational management, including coaching for the Executive Director.

Results: While the capacity development journey has been tumultuous for the organization, from the perspective of the beneficiaries of its technical assistance, there has been no gap in its services. The organization is on the road to financial compliance by implementing new financial management practices, internal controls, and accounting systems aligned with international best practices and USAID requirements. A recent OCA reassessment yielded an overall score of 62 out of 100, with most of the components close to the score of 75, the benchmark for BLC’s recommendation to USAID for “graduation” to direct funding from USG.

Replication: Since launching the regional capacity building program in 2010, BLC has:

- Provided capacity building assistance to 16 regional CSOs, of which:
  - Five have graduated and are eligible to receive direct USG funding;
  - Four have passed a simulated USAID audit to become a direct recipient of USG funding;
  - Two are receiving direct funding from the USG.

- 187 individuals have received technical support in building their leadership, management, and governance capacity.
- BLC aims to graduate a total of 10 organizations by 2015.
One woman’s passion arising from her own HIV status results in the birth and growth of a new organization, whose purpose is to help other HIV-positive women.

**Challenge:** Rosa Pedro, an HIV-positive mother of two young children living in Angola, started Mwenho (meaning “life” in the local language) in 2006. Registered in 2011 and now recognized at the national level for its work, the organization encourages positive living for those infected with and affected by HIV and AIDS, including promoting access to antiretroviral therapy. Mwenho delivers its messages through individual communication with women, group sessions, family visits, distribution of behavior change communication materials, and theatrical dramas. While Rosa was working full-time to educate others about HIV, she did not have the skills to run an organization or to receive USG funding directly or through a sub-grant.

**Intervention:** BLC’s highly innovative and adaptable small grants program is one of the project’s key tools for achieving its vision at community, national, and regional levels across all technical areas. The grant mechanisms vary widely in terms of the types and size of awards, the types of organizations supported, the areas of programmatic focus, the level of BLC involvement in the award, and the means of identifying partners. BLC often works with local organizations that have limited or no experience with USG rules and regulations. Consequently, the entire grants cycle—the negotiation process in particular—requires a great deal of capacity building woven into BLC’s engagement with partners. The grants program is differentiated by three characteristics:

6. **Flexibility and adaptability:** no two awards are the same. Each award is geared to the unique needs of each country context, the capacity of each partner, and the programmatic objectives.

7. **Performance-based:** almost all of the awards are developed as performance-based mechanisms. This facilitates a focus by both the partner organization and BLC on the achievement of tangible results, keeping the focus of activities on the beneficiaries and the ultimate aim of health impact. The performance-based approach permeates the whole grants program, from activity-focused budgeting to structures of payments, to the number of beneficiaries whose lives are improved because of the program funded by the award.

8. **Capacity building is woven into all stages of the project’s interactions with partners.** Even for some of the largest and most mature organizations that BLC funds, capacity strengthening is at the core of the work to support awardees to become stronger organizations that are better managed and more resilient.

**Results:** Mwenho now meets PEPFAR requirements and demonstrates better communication and M&E, as well as improved systems and structures. The small grant from BLC to Mwenho has allowed the organization to enhance and expand its work disseminating HIV and AIDS information to increase awareness and uptake of HIV counseling and testing among women. From 2013-2014, community health agents (CHAs) trained by Mwenho reached 627 people living with HIV (PLHIV) and 8,586 individuals with HIV prevention messages, and tested 1,766 people for HIV. In collaboration with health facility nurses, Mwenho also conducted home visits to PLHIV who had been taking antiretroviral therapy (ART) but were “lost to follow-up,” or did not return for appointments and medication. Together, the CHAs and health facility nurses provided counseling on ART adherence and related issues to improve quality of life of these PLHIV.
BLC’s support has helped make Rosa’s vision a reality. She now works full time to educate others about HIV. Registered in 2011, Mwenho is recognized for its work at the national level.

“Every time I cried, but with every testimony my crying started to reduce. If when I talk I feel better, then I am going to talk… I have changed people’s minds: before they discriminated against me, but now my house is a reference center for information.”

* translated from Portuguese

Replication: Since BLC launched the grants program in 2010:

- 60 small grants have been issued, with a total value of more than $14 million.
- BLC currently has 22 active small grants in seven countries in the region.
- Technical assistance has been provided to 58 organizations in leadership and management; 23 organizations in OVC support services, and 43 organizations in HIV prevention.

2 Read more about Rosa’s story, Turning a tragedy of one into hope for many, at http://www.hivsharespace.net/node/3853
The BLC grants program has facilitated the delivery of care and support services to more than 66,000 OVC; HIV prevention messages to more than 40,000 individuals; and HCT to nearly 30,000 individuals.

Building capacity at multiple levels of the health system to facilitate an enabling environment at the national level, promote coordination at the district level, and deliver services at the community level.

Challenge: Lesotho has the third highest HIV prevalence in the world, estimated at 23% by the National AIDS Commission. The 2011 Lesotho Orphans and Vulnerable Children Situation Analysis report estimated that 33.8% of all children under 18 are orphans. The National Strategic Plan on Vulnerable Children 2011 by the Ministry of Social Development (MOSD) documented the following challenges: the response to the needs of OVC was largely fragmented and uncoordinated, and coordination among service providers, especially CSOs, was ineffective.

Psychosocial support services were likewise found to be ad hoc and non-responsive, and over 50% of staff lacked adequate understanding of recent trends in psychosocial care and emerging child protection issues, including the new Child Protection and Welfare Act enacted by the Government of Lesotho in 2011.

The MOSD recognized that service providers in government and civil society sectors needed to have practical leadership and management skills to be able to mobilize community members and leaders, and other key stakeholders for sustainable and coordinated community based services for the OVC and their caregivers. However, the majority of senior managers in the government and CSOs did not have adequate leadership and management skills to effectively engage and manage teams to improve the quality of social services, as these skills are not normally integrated into professional training and performance management programs.

Intervention: BLC’s efforts at several levels simultaneously serve as a link between them, supporting greater integration and an enhanced overall response. BLC support builds the leadership and management capacity of each level to fulfill its mandate—from policy to practice—recognizing that each plays an essential role and is dependent on the others to be effective. At national level, BLC is supporting the MOSD to develop legal and policy frameworks (such as the Child Protection and Welfare Act) to guide care and support to orphans and vulnerable children. BLC supports dissemination of these policies and coordination of OVC interventions through its partnership with District Child Protection Teams (DCPTs) and Community Councils. Policies are applied through local organizations, which BLC provides with small grants and capacity building technical assistance to deliver holistic and comprehensive services to OVC and their caregivers.

Results: Since the program’s inception in October 2011, BLC grantees have reached 66,071 unique beneficiaries with comprehensive services for OVC and caregivers, exceeding the overall target of serving 62,547 beneficiaries during the life of the project (2010-2015). At the national and district levels, BLC continues to collaborate with the National OVC Coordinating Committee to enhance its capacity to provide training and ongoing mentoring for 198 DCPT members for the effective coordination and delivery of OVC-related services. BLC has supported the MOSD to simplify and translate the Child Protection and Welfare Act and develop national standards of care for OVC.

Replication: BLC is applying this model and the lessons learned to a variety of other contexts. For example, BLC is working at national and provincial levels in Angola to support coordination between civil society and government structures, as well as to develop, revise, and implement policy frameworks, such as the country’s Accelerated National Strategic Plan on HIV and AIDS and the Manual do Activista (Activists’ Manual), providing guidance on HIV-related messages and services to community health agents. In collaboration with government structures and CSO partners, BLC is piloting a referral system which, if successful, will be adopted at the national level.

In November 2013, the Government of Swaziland requested assistance from MSH (through BLC) to develop a robust voluntary medical male
circumcision (VMMC) strategic plan for 2014–2018 and an associated costed operational plan to attain the country’s goals for adult and adolescent male circumcision. BLC used an in-depth consultative approach for this six-month project funded by the Bill and Melinda Gates Foundation. This approach provided opportunities to engage and involve all stakeholders, explore the strengths and weaknesses of the previous plan, and share key messages on this key HIV prevention strategy. The strategic and operational plans are currently being finalized.
Lessons learned

- Being adaptive while maintaining vision and mission is important. The establishment of leadership and management capacity of organizational systems takes time. Management of operations and grants is often underestimated by organizational leaders and donors alike.

- Technical assistance must be pegged to the capacity of the organization and individuals to absorb and apply what is imparted.

- Assisting an organization to become eligible for direct donor funding is not always a straightforward process. Some organizations need long-term assistance to address previously identified and emerging challenges to institutionalize new systems and navigate the landscape to meet requirements. Indigenous organizations have tremendous knowledge and expertise to offer the southern Africa region, without funding, they may not be able to start up a new project. Furthermore, their policies and procedures may not be aligned to those of the donors and they need time to adapt to new business models.

- Sharing evidence and experience in structured ways, for example, through case studies, success stories, technical briefs, and fact sheets, is key to expanding the knowledge base. These products, and web-based platforms such as the Southern Africa HIV and AIDS Regional Exchange portal (SHARE), extend BLC’s technical assistance beyond its specific regional and country programs.

- Ownership of the technical assistance approach, processes, changes, and expected and realized results by the organization is crucial to the success of any intervention. A partner applying new knowledge, skills, or procedures on its own is one of BLC’s measures of success.

BLC Organizational Capacity Assessment

When beginning its work to strengthen the response of southern African institutions to the HIV pandemic, BLC recognized that measurement and monitoring, and evaluating changes in organizational capacity over time are critical. The OCA was developed by BLC in 2011 to examine the strengths and deficiencies of various types of organizations working in HIV and AIDS. The OCA is designed to: measure an organization’s capabilities before a capacity building program is implemented; provide evidence-based qualitative and quantitative data on specific areas that can be improved; and over the long-term, quantify the effects of capacity building efforts. The tool measures organizational health by gathering and analyzing data on a comprehensive range of performance parameters. The OCA is administered in a highly participatory manner, involving staff from all levels of an organization, during a two- to three-day facilitated workshop. Based on the assessment findings, BLC and the organization develop and implement a customized action plan to address identified gaps. The OCA has proven to be a critical first step in any new partnership BLC initiates with an organization, whether large or small, newly established or long existing.

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