

U.S. Government Interagency Paper on Country Ownership

Global Health Initiative

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INTENT OF THE DOCUMENT

The intent of this document is to provide a common understanding for accelerating country ownership and sustainability in all health programs that the U.S. government (USG) supports, as part of its public health and broader development agenda. This paper is informed by the larger experience of the USG in its existing global health programs. It is not formal guidance but expands on the principle of country ownership underlying the Global Health Initiative (GHI). The ultimate goal of the USG is to support host country partners (including local stakeholders) in planning, overseeing, managing, delivering and eventually financing a health program responsive to the needs of their people to achieve and sustain health goals.

The concept of country ownership is not new; USG agencies in partnership with host country partners have been working to accomplish sustainable, country-led and country-owned responses for many years. However, under GHI there is an opportunity to accelerate efforts, and realize the potential of a collective USG approach across all health areas. Moreover, we are seeing increasing economic growth and political leadership in the developing world. As a result of these changes, there is increasing local responsibility for health and development, and opportunities for new partnerships with donor countries. Within specific programs, steps are being taken to do business differently and advance this vision for the sustainable improvement of health outputs, outcomes, and impacts. These steps are evident in coordinated efforts within the USG to assist build the capacity of organizations and improve health systems in the countries where the USG works.

This document:

- Highlights the urgency and importance of country ownership in achieving overall health policy objectives of the USG;
- Provides a common framework for assessing, implementing, and monitoring progress in transitioning USG ownership towards country ownership;
- Provides an understanding of which stakeholders are needed for a country ownership acceleration process, and a description of the steps which USG can take to involve the relevant stakeholders in such a process;
- Provides examples of country ownership success in action, lessons learned, and the approaches teams can replicate or apply to create those successes elsewhere; and
- Encourages USG country teams to accelerate efforts to advance ownership of USG programs by local governments and institutions by providing specific actions they can consider implementing.

POLICY IMPORTANCE OF COUNTRY OWNERSHIP

Approximately 24¹ percent of the foreign assistance budget for the Department of State and USAID is in the health sector; it is a critical component of our diplomatic engagement.² In the current development arena, this investment constitutes the largest contribution to a single sector from any one country, and is critical to understanding the USG approach to promoting country ownership. In fulfilling its responsibilities, the U.S. Congress sets high expectations on the use of taxpayer dollars; a responsibility ultimately borne by the programs and people tasked with delivering and reporting on the use of USG assistance for health. Ideally, country ownership results in sustainable health systems and outcomes. However delivering on country ownership is often a challenge as USG priorities do not always align with the priorities of recipient countries.

Countries that effectively manage their public health response demonstrate leadership over their health budgets, policies and strategies, and coordinate public health actions, including the contributions of the private sector, donors and civil society. Country ownership involves shared responsibility and mutual accountability with donors and other partners, particularly when outside financial and technical resources are needed to fully respond to the health sector needs of host countries. The USG fosters country ownership by investing in high impact and evidence-based country-led priorities, plans and systems. The USG also encourages country ownership when it promotes direct financing by recipient countries for priority interventions such as malaria and family planning commodities. Ultimately, a well-coordinated, country-led health response enhances efficient use of resources and contributes to long-term sustainability of global health programming.

The concept of country ownership has been widely endorsed by both donor and recipient nations. The Paris Declaration, developed in 2005 and supported by the United States outlines country ownership as one of five fundamental principles for aid effectiveness.³ The Paris Declaration calls for countries to take the lead in developing strategies for poverty reduction and notes their accountability for improving institutions and addressing corruption. Post the Paris Declaration, in 2008, developing countries joined together to develop the Accra Agenda for Action, which stated:⁴

“Country ownership is key. Developing country governments will take stronger leadership of their own development policies, and will engage with their parliaments and citizens in shaping those policies. Donors will support them by respecting countries’ priorities, investing in their human resources and institutions, making greater use of their systems to deliver aid, and increasing the predictability of aid flow.”

The goals of the Paris Declaration and the Accra Agenda for Action are reflected in the foreign policy goals of the United States. Country ownership is a priority for achieving programmatic and diplomatic goals, and has been emphasized in speeches, policy statements and actions at the country level. President Obama has highlighted the importance of countries and their people taking control of their political and economic destiny. In Ghana in 2009, he stated “We must start from the simple premise that Africa’s future is up to Africans”, as he implored the continent to do more.⁵ The same position is reinforced by the President’s Policy on Global Development (PPD), the first-ever directive regarding development promulgated by any U.S. administration. As the PPD notes, the U.S. government will “hold all recipients of U.S. assistance accountable for achieving development results.”⁶ In exchange, the U.S. government will support plans that are responsive to country priorities and plans and work through national institutions.⁷

In her speech at Busan in November 2011, Secretary of State Hilary Clinton underscored the importance of country ownership:

“...[W]e need to get serious about what we mean when we talk about country ownership of development strategies. Let’s be clear. Too often, donors’ decisions are driven more by our own political interests or our policy preferences or development orthodoxies than by our partners’ needs. But now our partners have access to evidence-based analysis and best practices, so they can better decide what will work for them. We have to be willing to follow their lead..... Today, we know donors must do more to support country ownership, but we also have to expect more from developing countries. The political will must be mobilized to take on the biggest obstacles to a country’s own development.”

The Secretary of State further emphasized what the U.S. government meant by country ownership in her remarks on “A world in transformation” in Oslo in June of 2012

- “To the United States, country ownership in health is the end-state where a nation’s efforts are led, implemented, and—eventually—paid for by its government, communities, civil society, and private sector. To get there, a country’s political leaders must set priorities and develop national plans to accomplish them, in concert with their citizens—women and men. These plans must be effectively carried out primarily by the country’s own institutions—government, civil society and faith-based organizations, and private sector alike. And these groups must be able to hold each other accountable for improving and saving lives.”⁸

The U.S. government at its highest level has made a strong commitment to country ownership. In line with the Secretary’s remarks at Busan and Oslo, country ownership is of importance to public health policy. All USG agencies must do business differently by: shifting from aid to investment and relying more on host country systems and organizations; emphasizing mutual accountability and transparency; improving coordination with other donors, NGOs, and the private sector; and making our

investments predictable and sustainable. USG's global efforts to foster "country-owned" and "country-led" health responses indicate a fundamental shift in our orientation towards achieving sustainable health outcomes concurrent with a recipient country's ability to support and achieve better health and security for its own people. This shift involves moving from providing aid to investing in countries, relying on local systems and organizations, emphasizing mutual accountability and transparency, and improving coordination with both countries and other stakeholders.

DEFINING COUNTRY OWNERSHIP FOR USG-SUPPORTED GLOBAL HEALTH PROGRAMS

Developing countries operate along a spectrum of capacity for addressing the burden of morbidity and mortality as well as: managing, owning, and financing their health sector, and the systems that deliver care. Any definition of, or criteria for, country ownership must therefore recognize this spectrum. There is no “one size fits all” for country ownership; the goal of USG efforts at fostering country ownership is to assist host countries transition to more advanced stages along the continuum of the country ownership spectrum while continuing to improve health outcomes.

Criteria for country ownership

Country ownership is characterized by government, communities, civil society and private sector- able to lead, prioritize, implement and be accountable for a country’s health response.

For the U.S. government, country ownership in health is conceptualized along the four dimensions illustrated in Table 1 below (“Factors for Strong Country Ownership”): – 1) Political leadership and stewardship, 2) Institutional and community ownership, 3) Capabilities, and 4) Mutual accountability, including finance. These reflect the continuum of actions taken by political and institutional stakeholders in host countries to plan, finance and manage, their own health sector activity, responsive to the needs of host nationals. They are supported by capacity strengthening actions for individuals, institutions, and systems, which ensure sustainability.

Country ownership is best advanced in a country with progress towards all four dimensions. While the four dimensions operate independently, each is dependent on the other, and the complex interplay between them, essential to improving country ownership. With no single sequencing or formula for how to improve the various elements of country ownership, countries should first do an overall assessment along all four dimensions, then develop a roadmap based on the findings of the assessment for how to prioritize and address country ownership gaps, and finally implement an action plan.

Table 1

Factors for Strong Country Ownership	
Ownership Dimensions	General Characteristics
Political ownership and stewardship	<ul style="list-style-type: none"> ▪ Host Government has a clear aspiration for what should be accomplished in each stage of program development, implementation and monitoring, generated with input from their own cities and rural areas, civil society, NGOs, and private sector, as well as their own citizens ▪ National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated ▪ Host country (public and private sectors) is the architect that fully implements and provides oversight of national plan to achieve results and applies and scales-up evidence-based best practices; this includes specific activities conducted by stakeholders in each stage from design to delivery of programs
Institutional and community ownership	<ul style="list-style-type: none"> ▪ Host country institutions (inclusive of government, NGOs, civil society, and the private sector) constitute the primary vehicles through which health programs are delivered and take responsibility for each program ▪ Host country institutions adopt and implement transparent, evidence-based policies/regulations for priority areas that align with national plans ▪ Host country institutions manage funds
Capabilities	<ul style="list-style-type: none"> ▪ Host country has effective workforce, organizations and systems at all levels able to perform activities and carry out responsibilities that achieve priority health outcomes ▪ National coordinating bodies and local institutions have the ability to gather and analyze epidemiological and program data to plan and measure program progress and results ▪ Host country institutions have the capabilities required to perform or oversee activities for programs ▪ Host country institutions have the ability to dynamically modify programs based on evidence and feedback from monitoring processes
Mutual accountability, including finance	<ul style="list-style-type: none"> ▪ Host country is responsible to country citizens and international stakeholders for achieving planned results ▪ Host government is responsible for financing and financial stewardship over health ▪ Explicit roles and responsibilities are described with appropriate management of performance in place ▪ Measures are robust ▪ Information and processes are transparent and there are mechanisms for input and feedback from civil society, the private sector and donors

SOURCE: Adapted from “Paris Declaration on Aid Effectiveness,” 2005; “Accra Agenda for Action,” 2008; “Country ownership in the context of Rwanda,” Y. Rajkotia, USAID, 2010. Informed by interviews conducted by McKinsey and Co. with leaders from HHS/CDC, USAID, Peace Corps, DOD, UNAIDS, S/GAC, Botswana and South Africa country stakeholders.

TRANSITION: A PROCESS FOR COUNTRY OWNERSHIP

Transition towards country ownership is a purposeful shift from a USG-led and funded program, to an integrated and country-led program. The transition process is intended to facilitate a smooth transfer of the program's management, implementation, and "ownership" to the intended host country recipient. Transition is integral for the partner country to assume ownership and responsibility for strong, sustainable, country-owned programs. It focuses primarily on technical, managerial, and financial aspects of the program. The ultimate intention of a transition is a changed relationship, one of a mutually beneficial technical partnership between USG and the partner country. It is fully acknowledged that country progress may occur at different rates depending upon individual country circumstances. This is particularly true with respect to finance. For example, a financial transition is more likely to occur with a faster pace in upper middle-income countries, later in lower middle-income countries and later still in low-income countries.

In countries that do not yet fully own and fully lead their health response, USG may fund and support health activities through international and local partners. Eventually as technical and financial capacity is strengthened, government and local institutions will take over and own the activities and programs. Thus management, technical and financial competencies are critical and mutually supportive to a truly country-owned program. The transition from USG to partner country will proceed based on the country context and capacity for ownership. In certain situations, the country's Ministry of Health will assume complete control of the country's program; in other country contexts, USG will continue to assist build the institutional capacity of a local MOH institution, or other entities such as community stakeholders, to carry on quality programs. In some instances, USG may continue to support monitoring and data collection to help promote quality oversight.

In one example of programmatic transitions, during the initial phase of PEPFAR, Track 1.0 partners provided direct care and treatment in nearly all PEPFAR 'focus countries'. In keeping with the priorities of PEPFAR's second phase, USG agencies worked with their US-based grantees to ensure local partners and Ministry of Health entities were appropriately trained to provide both high quality programmatic services as well as effectively administer/manage their programs. Once the local partners and Ministry of Health entities were deemed ready through a series of assessments, programs were transitioned to direct funding from USG as prime partners. Currently, all Track 1.0 care and treatment programs are on course to be managed by in-country partners. This transition reflects what the USG hopes to achieve across similar health programs.

In a second example of programmatic transition, a number of USG family planning programs were successfully phased out over many years using processes from which other programs can now learn. These processes included long-term and short-term plans to transition to increased sustainability based on strong use of in-country data and monitoring of intermediary and impact, or threshold indicators such as modern contraceptive prevalence rate and total fertility rate. There was attention paid to changing policies, strengthening local capacity of individuals, organizations, and systems, finding

local solutions to challenges and barriers, and developing leadership and management skills.

Using the four dimensions to country ownership, in each country where present, USG can use a participatory process engaging in-country partners to assess the current context and status along the country ownership continuum, and develop a roadmap towards advancing country ownership. Each country will find itself in a very different place in the overall status of country ownership and will find different “state of plays” even within each of the four dimensions. The development of a roadmap with ownership goals, key activities, and clear roles and responsibilities for each dimension is considered a good practice that will help countries plan, implement and monitor progress.

Role for USG Country Teams

Through the framework presented below, this document provides an approach for accelerating country ownership of USG-supported health programs. It also provides USG country teams with several successful strategies for achieving country ownership that have been utilized in the past, tailored to the type of USG support offered to a recipient country. For example, in USAID-supported programs in Latin America, Asia and Eastern Europe, country ownership efforts have been used to support and “graduate” family planning programs. In PEPFAR-supported countries, the FY 2012 Country Operational Plan (COP) guidance included consensus-developed guidance to accelerate country ownership and implement and monitor the Partnership Frameworks negotiated during the second phase of PEPFAR.

To facilitate a coherent transition in ownership, USG country programs have benefited from understanding the “vision” for USG engagement in specific countries and discussions on transition strategies to advance national ownership.

- In many countries where the AIDS epidemic continues to be high and countries need significant assistance, a long term strategy (LTS) of engagement is warranted. The determination that a country is a LTS country is based on HIV prevalence, resource needs, and Global Fund financing available, unmet service needs, gaps in capacity and U.S. geopolitical interests. Countries that are rebuilding after war or natural disaster, such as South Sudan and Haiti, are in this category. It also includes countries where poverty remains high and development needs remain great;
- In some countries USG support is specific such as to key populations only or priority technical areas. Typically USG support is targeted towards technical assistance and capacity strengthening efforts with some direct funding for service delivery to key populations. These “TA” countries include the Caribbean Regional countries amongst others;
- As our partner countries experience economic growth and produce annual growth rates of 5 – 8%, a shared responsibility is feasible and opportunities for co-financing (CoF) grow. Countries with growing economies and the ability to

increasingly self-fund programs are targeted for technical assistance and capability strengthening efforts for programs to be co-financed or wholly financed by the country. Excellent examples of these efforts can be seen in USG engagement in South Africa, Namibia and Botswana; and

- In countries that have advanced management, implementation, and ownership, the USG engagement will shift to a technical collaboration (TC) model between peers. In these TC countries such as Brazil, India, and Mexico, health collaborations are peer-to-peer and center on the exchange of technical ideas and joint research and innovation. Tripartite agreements may emerge to provide joint technical assistance to a third country as Brazil is doing for Mozambique and Angola.

The USG recognizes that achieving country ownership implies changes in USG roles, policies and responsibilities, and the way USG country teams interact with host country partners. USG internal institutional practices can act as barriers to achieving full country ownership and some business practices need to be changed. For example, the USG should strive to move away from direct service delivery towards technical assistance and capacity strengthening. This shift is dependent on the country context. The USG must evaluate and adjust how it delivers technical assistance ensuring that support enhances host country leadership and stewardship, while encouraging the use of evidence for decision-making. The USG should examine the manner in which it consults in country and with in-country partners; national and local governments, civil society, and private sector, and ensure that host country partners are in a leadership role in defining needed technical assistance. Finally, the USG must create an environment of mutual accountability by evaluating the impact of the USG-supported activities and by being more transparent about the use of USG-generated programmatic and financial data with country partners.

Potential metrics of success could be demonstrated through some of the following:

- USG has aligned its country plans with the government plans
- USG is engaged as a key stakeholder as part of the national strategic planning process
- USG is transparent in sharing its total funding for programs in country and makes the information available to partner governments in an understandable manner
- USG has engaged partner government in resource allocation discussions and decision for prioritized programs

ACCELERATING, MONITORING, AND EVALUATING PROGRESS OF COUNTRY OWNERSHIP

Defining and establishing a country-owned and country-led approach to public health and delivery of health services is a complex process with no single formula or blueprint for success. The process must be flexible enough to make progress on programs but at the same time thorough enough to capture local political, economic and institutional dynamics and priorities. Success will be achieved by encouraging sociopolitical, policy and organizational change that would support the achievement of development goals that are country-owned and country-led.

A sample specific tool⁹ which might be used to promote country ownership is included as an annex in this paper. The USG has used this previously in Botswana and South Africa. It is offered as an example of an organized process and approach to promoting country ownership. Additional tools will be made available as resources for country teams.

Broadly speaking, we recommend that the following steps be taken as an overall approach to country ownership:

- Identify a core team that will manage the country ownership process, and use the conceptual framework we have introduced in this paper to guide an assessment of the current state of country ownership throughout USG-supported health programs. This team would develop a plan to move forward;
- Identify the critical stakeholders necessary for the success of country ownership and create a forum and methodology for them to actively participate in this process;
- Help stakeholders, including the U.S. team, to create a plan to move towards country ownership of health programs (including indicators, milestones, resources needed and roles, responsibilities and specific accountability); and
- Include regular measures of progress at set intervals e.g. every one or two years, both so that countries can know if their strategies are succeeding, but also to help USG teams report on progress to the U.S. Congress and other U.S. stakeholders.

To prepare for any assessment that may be undertaken, team members may:

- Review relevant documents to understand the history of health sector development, highlight key gaps, identify key stakeholders, prioritize areas for intervention and strengthening, and identify whether a cohesive vision for the future state of the health sector exists;
- Conduct initial key stakeholder interviews to generate hypotheses for what should be changed and how to best approach it; and
- Work with stakeholders on a plan, led by government, for how to best to achieve country ownership and report on progress towards that achievement.

As we have indicated in this paper, some of this work will require a change in our own approach as members of USG health teams. In working with local stakeholders it is critical that USG teams be available to advise but that USG teams not drive the process.

It will also be important to work outside of the health space and enlist the assistance of the Ambassador and DCM as needed in negotiations with senior-level government officials. Finally, given that country ownership should not vary much by health element or activity area, it is important that USG teams keep each other informed about country ownership activities they are conducting.

PROMOTING AND ENGAGING IN-COUNTRY PARTNERS

The process of advancing country ownership requires strengthening the capabilities and changing the dynamics between the USG and in-country partners with increasing host country and institutional leadership for the health response. In-country partners include government entities at national and sub-national levels, academia, civil society, the private sector and other key stakeholders with country presence.

Government:

Government plays a central role in country ownership. It is the architect of, and provides oversight and coordination for, the entire health sector.

Ministry of Health: The Ministry of Health is often the primary provider of health care services in developing nations, and holds the mandate on setting policies, guidelines and national priorities. Country ownership discussions should support the Ministry of Health in creating and implementing its national public health system which should be able to:

- monitor health status to identify and solve health problems;
- diagnose health problems and health threats in the community;
- educate individuals and clinicians about public health issues;
- collaborate with key multi-sector partners to identify and solve health problems;
- develop policies and plans that support individual and community health efforts;
- help enforce regulations that protect health and ensure safety;
- implement health services and link patients to care;
- assure a competent public health workforce;
- evaluate effectiveness, accessibility, and quality of health services;
- research, analyze and synthesize innovative solutions to health problems; and
- manage and provide technical and fiduciary oversight of public health programs, and advocate for the programs and finances.

Ministry of Finance: In most countries, financial support for the Ministry of Health and other related line Ministries is approved each year through the host government's budgetary processes through the Ministry of Finance. USG teams have supported Ministries of Health in this role by collecting data and cost analysis of public health programs, enabling Ministries to advocate for change.

Cabinet and Parliamentary Committees or Departments: Country ownership is not possible without the high-level leadership of other stakeholders of the national government. The President or Prime Minister can, through speeches or statements, demonstrate the broader political will to improve health care. First Ladies and other presidential spouses have also been a force for change, with many of them bringing important attention to public health issues like maternal and child health, family planning, HIV/AIDS, and other infectious diseases. USG country teams should engage Ministerial-level officials and their staff in discussions. It is critical that country ownership discussions extend beyond the Ministry of Health to include departments/ministries dealing with finance, education, planning, human resources, agriculture, gender, child

and community development, youth, and local government relations – in short, all of the stakeholders needed to mobilize a country-led response. Cabinet officials and parliamentary committees who have experience in dealing with aid effectiveness and allocation of resources are also critical in discussions, and teams are encouraged to ensure they engage with them.

Local (District and Provincial) Governments: In many cases, the actual service delivery is dependent upon the local government, which can allocate land, utilities, or transportation services in a way that enables better care. Local governments, at the district, provincial or other levels, may also be accountable for the delivery of care in decentralized health systems, and are thus key partners. In addition, they may be the source of providing specific care to populations or health conditions that do not occur nationwide. Country ownership discussions should effectively engage these local as well as national stakeholders. USG can harness its community-based practices and expertise, through its core and partner implementing mechanisms, to strengthen local government and district services and ensure its connection to communities to enhance service delivery as well as demand creation and accountability.

Ministry of Defense and other military organizations: Another component of governments which support health programs for specific populations is military organizations. While military involvement in health care is often centered on care for personnel, military hospitals often provide important care to the civilian population. Some estimates are as high as 80% of care benefiting civilian populations (Nigeria, Tanzania, Uganda and Kenya). They also often serve as research centers, and the health information gathered from military populations may provide insight into the broader health needs in country.

Examples of USG Engagement with Governments:

Bilateral Agreements/Negotiated Documents: The U.S. government often has the opportunity to craft assistance agreements with its partner governments, ranging from MoUs to broader multiyear engagement efforts. The Zambian government, as part of the PEPFAR Partnership Framework implementation process, delivered on pledges to increase domestic financing for the national HIV response. Here, country ownership has been further catalyzed by government-to-government bilateral institutional partnerships in health which included direct funding, collocation of staff, attention to institutional partnerships in technical and management capabilities, and joint system strengthening activities.

Strategic Partnerships: Strategic partnerships define a type of engagement where USG partakes in a peer-to-peer relationship with countries that are at an advanced stage of country-led efforts and often those that are already middle income countries. Here USG health engagement is characterized as a technical collaboration partnership, and involves not only health programs, but broader diplomatic engagement. For example in India, the USG is working to partner with the Government of India in what is termed the USG-India Strategic Dialogue. Through this dialogue, the USG and Indian governments are

strengthening linkages in a variety of areas, including health. The Health Dialogue provides a framework to discuss ways to accelerate bilateral cooperation and collaborations, including exchanging views on extending affordable healthcare to all sections of the population and to continuing education and training for health care practitioners at all levels of service.

What can USG country teams do: To accelerate country ownership by the host government, USG country teams can:

- Support host government institutions in primary leadership of the design and implementation of their own costed national health plans, including oversight and coordination of stakeholders in each stage of health programming;
- Fully align and prioritize USG health activities to support the national plan, even those that are specific to ministries such as defense or gender;
- Support the managerial, financial, governance and technical capacity development of government institutions;
- Support expenditure analysis of health programs to better define the needs and advocate for the financial support needed for a national health plan;
- Negotiate with host governments to assume increased local responsibility for financing health activities;
- Coordinate with and leverage USG expertise and investments in other (non-health) sectors supporting development;
- Support host government systems to ensure quality programs with adequate staff, oversight, planning and procurement, including drug supply;
- Contribute to the workforce analysis and planning for future health professionals and managers with effective retention strategies and practices;
- Support host government systems and practices that promote transparency and accountability;
- Promote transparency and accountability of USG programs to recipient governments;
- Work with local ministries and USG to understand the local fiscal envelope in the context of a country's economic growth, and plan to "crowd back" (allocate) government financing to health care; and
- Utilize Peace Corps Volunteers at local government/district government health systems to build capacity of local institutions to deliver services at the community level, reach the last mile for implementation at the beneficiary level, complement country efforts towards decentralization, and enhance demand creation and education at the family, community-based organizations (CBO), and local government district levels.

Potential metrics of success could be demonstrated through some of the following:

- Increased domestic government health spending over time
- Increased number of programs of proven efficacy taken to scale by local entities
- A shift and/or expansion of direct funding to government institutions

- A shift and/or expansion of direct funding to non-governmental local institutions
- Use of government planning and management systems
- Demand created at the community level which enhances accountability for government and/or local service delivery

Civil Society:

Civil society includes an array of non-governmental local organizations and networks (professional associations, religious organizations, community associations (local school committees, health user groups), not-for-profit organizations at national district and local levels), and has a multiplicity of potential roles in a country's health response. These roles include service delivery, advocacy, health education and promotion, and as a key stakeholder that engages in planning and monitoring at multiple levels. Civil society as an advocate for the health care needs of a country is a significant feature in country ownership.

A great deal of the success of the health sector relies upon non-governmental institutions assisting governments in delivering health services. These groups include those supplying care – such as faith-based organizations, NGOs, peer support efforts, or professional associations. They also include those representing consumers, such as local patient-led boards of health clinics, media and press associations. Country ownership efforts must ensure that those providing services have the capacity, training, and motivation to deliver quality services and receive feedback on the impact of their efforts. These efforts must also work to ensure that consumers have the ability to recognize and demand quality services in their community, and hold governments accountable for their delivery. The USG has worked with civil society in several countries to support the development of a civil society engagement strategy to enable better coordination and engagement with the national government.

Communities:

A sub-set of civil society engagement is community engagement. The definition of who constitutes a community changes depending on the context. Communities can involve existing community-based organizations (CBOs), such as microfinance groups, HIV peer support networks, or youth groups. Communities can also be organized along geographic principles, such as a village, or around shared interests, such as faith-based groups or people working to attain gender equality. Finally, communities (community health workers, volunteers) serve as a bridge between individuals or families and government and private sector services. Community leaders are the gatekeepers between the community and external organizations, academia, and donors.

In the country ownership context, communities are valuable partners in terms of monitoring accountability of governments. They can ensure that the needs of impacted populations are included in health systems, and provide services, among other efforts. Communities also have a critical role in creating for example, a sustainable health and social-welfare response within the country context that require long term care and routine follow-up such that provided to people infected and affected by HIV/AIDS.

Communities are also an important entry point into households, providing opportunities for strengthening families most affected by HIV/AIDs, addressing family planning needs and case findings for TB and Malaria. The role of the community in a country's health and social-welfare response is important to country ownership because communities influence the day-to-day decisions that impact the health and social well-being at the

household and beneficiary level. This includes decisions on access to education for OVC, utilization of household/community resources to access health services and the ease at which PLWHA and their families are able to live without stigma and discrimination.

Examples:

In Haiti, USG and the Northwest Departmental Directorate supported the Community Leadership Development Program (LDP) in the town of Anse à Foleur through a community mobilization effort, to make significant strides in health indicators. Local leaders from Méance, Dity, Anse à Foleur, and Côtes de Fer gathered together despite their distances and differences to identify and address the problems confronting their communities. Program participants succeeded in gaining support of decision makers and individual community members to rally around health-related causes, despite minimal resources. Participants examined the problems of maternal health, vaccination, family planning, cholera, and other issues, and brainstormed how they might mitigate some of these problems. In Dity, for example, leaders were able to address selected needs in the fight against cholera and, as a result, the community cleaned 10 water sources, distributed 2,079 aquatab water purifiers and vaccinated more than 2,100 children.

In Guatemala, the USG supported the establishment and growth of the national Alliance of Organizations for Reproductive Health of Indigenous Women of Guatemala (ALIANMISAR), whose purpose is to develop leadership and encourage participation by citizens to monitor and ensure compliance with reproductive rights. ALIANMISAR supports women indigenous leaders to organize, increase their awareness of women's sexual and reproductive rights, analyze existing reproductive health inequities and engage in advocacy to guarantee access to high-quality, culturally-relevant services.. These volunteers make it possible for indigenous organizations to identify specific situations where health rights are being violated and then follow-up on those situations through with the Human Rights Office. This strategy has improved organizations' capacity to monitor and ensure compliance with reproductive health rights in Guatemala.

In Malawi, USG has placed experienced short-term (one-year) Peace Corps Response Volunteers (PCRVs) at local districts health departments, with targeted and specialized assignments to assist build the capacity of the decentralized health system to plan, collect, analyze, and utilize data for decision-making. The Ministry of Health together with the USG Peace Corps collaborated on the design of technical assistance for increased capability building in local government planning, and specifically data collection and analyses through GIS and other mapping means. The USG/PC team was able to design targeted specialized assignments for PCRVs over a one-year period. This partnership has helped build local institutional knowledge and capabilities of district and city assemblies in planning and data collection.

What can USG country teams do: To accelerate country ownership by civil society, USG country teams can support civil society as follows:

- Foster civil society organizations where they are nascent;
- Support civil society to advocate for better programs and policies;
- Support civil society to hold government to account;

- Improve capacity strengthening to provide services;
- Promote organizational strengthening including governance and funding;
- Support participation in planning, M&E of national and sub-national health programming – part of the evaluation process; and
- Assist government establish systems to engage and fund civil society.

Potential metrics of success could be demonstrated through some of the following:

- Increase in the percentage of USG funding that is awarded to local partners through contracts, cooperative agreements and grants
- Number of new prime partners in fiscal year who were sub-awardees in the past
- Number of effective civil society organizations with mechanisms in place for citizens to express views to government bodies (social responsiveness and accountability)
- Average % change in organizational capacity amongst our direct local NGO implementing partners as measured by a defined organizational capacity assessment tool (e.g. (e.g. Organizational Capacity Assessment (OCA), Organizational Capacity Assessment Tool (OCAT), Institutional Development framework (IDF), Discussion Oriented Organizational Self Assessment (DOSA))
- Representation of community members and active participation of communities in governance structures

Private Sector:

The private sector is comprised of a complex array of diverse local entities that may be directly involved in health care or are potential partners in financing, creating efficiencies, ensuring quality or providing other additional resources for the health response. Private sector partners often have skills that complement the public sector's technical focus, including marketing and distribution networks.

The private sector plays an important and increasingly relevant role particularly to long term financing and sustainability of the health sector. The local private sector includes: private clinics, hospitals and pharmacies; private provider networks and associations; social marketing companies; insurance providers; manufacturers of health commodities, technologies and drugs; large employers and small and medium sized enterprises in such areas as agriculture, extraction/mining, tourism, and banking; multinational corporations; for-profit local companies; local business communities; and the informal sector of alternative and traditional health care providers. All have a potential role to play in improving access to and sustaining health care.

Effectively engaging the in-country private sector is an important way to support host countries' investments in their futures. Public-private partnerships (PPPs) are a tool that can enhance country government approaches to health care provision and strengthening of overall health systems, keeping long-term sustainability on the forefront. The private sector can accelerate country ownership by helping governments to meet the cost of providing services to its people, expand delivery of services, sustain health care outcomes by employing market solutions and improve the overall quality and standards of care.

In some partner countries, the private sector provides more than 60 percent of the health care services.¹⁰ Over the years, private sector engagements for health provision have included: contracting services, social marketing, social franchises, privatization, subsidies, and financing. However, in several partner countries, the policy environment restricts the role of the private sector, in health. The USG can play a role in helping partner governments create an enabling environment that allows the private entities to thrive, while maintaining the necessary safeguards that promote quality and manage risk.

Examples:

Public Private Partnerships (PPPs) to improve quality of care: The USG-supported PPP between Becton Dickinson (BD) and the Kenyan government was directly responsible for improving safe, quality blood drawing procedures, specimen handling and strengthening prevention and management of needle stick injuries. The PPP produced a government endorsed in-service and pre-service training curriculum on safe phlebotomy, developed registers for needle stick injuries, post-exposure prophylaxis, and institutionalized a system for specimen rejection. The MOH has requested the model be scaled to four provincial hospitals, one district hospital, and six blood banks. The PPP is now being expanded to other countries.

Training of private sector providers to ensure uniform standards of care: In Honduras, the commercial private sector (including social marketing programs) is the source of FP

for one-quarter of users. A private not for profit organization, ASHONPLAFA, has been a leader in FP service provision for over 40 years and provides about 25 percent additional FP services. It has struggled to become self-sufficient over the past decade as donors have reduced funding in Honduras. ASHONPLAFA has responded to the challenge of remaining sustainable by developing and offering new services to its low middle-to-middle class clientele (e.g., such as dental services, eye care, mammograms, pediatrics, and internal medicine) to subsidize its FP services. At present, it has reached 97 percent self-sufficiency, running on a very tight budget. Currently, USAID and the International Planned Parenthood Foundation provide only 5 percent each of ASHONPLAFA's operating budgets.

Public Private Partnerships (PPPs) to strengthen health systems: The USG supported PPP between Pfizer's Global Health Fellows program and countries provides Pfizer's expertise to help increase the breadth, quality, and efficiency of local health systems. This partnership supports the loan of Pfizer's expertise in financial management, supply chain management, health care education and marketing, manufacturing, human resources, business forecasting and strategic planning, and other disciplines, to Kenya, South Africa, Namibia, Malawi, Tanzania, Ethiopia, and Uganda.

What can USG country teams do: To accelerate country ownership USG country teams can support the private sector/host country stakeholder relationship as follows:

- Conduct an assessment of the in-country private sector to identify potential partnerships;
- Encourage the public sector stewardship of the private sector by helping to identify where the private sector can add value and providing a conducive policy environment;
- Partner with private companies to access technical expertise in areas of their specific core competencies, such as, supply chain, manufacturing, logistics, health education and marketing, financial management, strategic planning and forecasting, and information technology;
- Partner with private health care companies and build patient advocacy groups to ensure consumers have the ability to recognize and demand quality services in their community, and hold governments accountable for their delivery;
- Provide financial and technical support to build the capacity of governments to develop PPPs and/or enforce quality standards for private providers;
- Include private sector providers in public sector training; and
- Engage with the Ambassadors, Economic Officers in US Embassies and other USG staff who have vast knowledge of the in-country commercial private sector to identify opportunities for partnerships.

Potential metrics of success could be demonstrated through some of the following:

- Increased number of trainings in financial management convened by the private sector for the public health sector
- Joint financing agreement is developed with the private sector and government
- Increased number of private health facilities certified by the government

- Increases in the percentage of Total Health Expenditure (THE) attributed to the private sector
- Increases in the percent of out-of-pocket expenditure for health attributed to the private sector

Bilateral/Multilateral Organizations and Regional Bodies:

Host country partners receiving USG foreign assistance for their health sector engage other important partners for the same assistance. These partners include multilateral partners including the Global Fund for HIV/AIDS, TB and Malaria (Global Fund), the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Bank, Global Alliance for Vaccines and Immunization (GAVI), International Financial Institutions (IFI), and the United Nations (UN) family. Bilateral partners contributing to these efforts include the Department for International Development (UK) (DFID), Australian Agency for International Development (AusAID), European Union, and Norway. Harmonization and effective partnerships collectively can reduce the reporting burden on partner governments and maximize limited global resources. The USG is not the sole donor to governments, and should work cooperatively with other donor partners. As per the Paris Declaration, USG activities must be coordinated with other donors along a “costed” national plan, yet USG must also adhere to congressionally determined mandates. As the capacity of developing nations is strengthened, the relationship with USG and other donors will also evolve.

Regional bodies such as the Africa Union, Southern Africa Development Community (SADC), and other regional economic groups are important stakeholders for the USG in the health and development. Regional engagement greatly influences recipient nations in their bilateral relationship with USG. Regional bodies are an important stakeholder for country ownership particularly because of the emerging influence on south-to-south learning amongst recipient nations.

Examples: Tanzania’s national HIV/AIDS response leverages PEPFAR technical assistance to government-implemented grants responsible for procuring the majority of HIV/AIDS commodities, with the Ministries of Health and Finance in both mainland Tanzania and Zanzibar serving as Principal Recipients. At the point of delivery site- and community-level, Global Fund grants support the purchase of antiretroviral (ARV) drugs, while PEPFAR’s bilateral programs support test kits, training, and the delivery of ARVs to patients. Joint planning to most efficiently meet the treatment needs of Tanzanians is an effective approach to ensuring sustainability.

In Namibia, the Global Fund, Government of the Republic of Namibia, and PEPFAR established the Human Resources for Health Task Force, culminating in a joint request to the Ministry of Finance for a phased approach to reallocating health worker positions from the Global Fund and PEPFAR payrolls to the public system. These investments set the stage for an eventual transition to country-led HIV/AIDS efforts supported through Global Fund financing with USG technical collaboration.

In May 2009, African Union governments committed to improving maternal health. The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was launched. As a result, the Zambian government developed its own plan to reduce maternal mortality. The Saving Mothers, Giving Life endeavor, which is being spearheaded through the Global Health Initiative, is seen by the Government of the Republic of Zambia, as an opportunity to achieve CARMMA goals in Zambia.

What can USG country teams do: With bilateral, multilaterals and regional bodies, USG country teams can:

- Hold partner meetings to align work plans and reporting of implementing partners in HIV, malaria, and TB activities with those supported by financing from the Global Fund and other bilateral donors;
- Assist the government in convening multilateral and bilateral stakeholders to cost national health plans;
- Facilitate a path for recipient nations to create the right regulatory frameworks to work with emerging donors such as India in the use of generic pharmaceuticals; and
- Facilitate engagement with nations such as South Korea, Brazil, Russia, India, China and South Africa as they engage with the nations we have traditionally supported. These emerging economies are becoming donors and the USG can facilitate new partnerships for greater self-sufficiency in countries.

Potential metrics of success could be demonstrated through some of the following:

- Government reveals a costed health strategy budget that is inclusive of Global Fund, USG, and other donor annual contributions
- The government annual work plan includes the activities being conducted by all stakeholders

Academia: As the source of formal training for local health professionals, managers and administrators, academic institutions are significant partners in creating an environment for sustained country ownership, where trained academics can flourish and continue to support the growth of a nation's next generation of public health providers, pharmacists, managers and other professionals. Research institutions and local scientists also have an important role to play and contribute to the leadership within a country, leading research and surveillance on the major health conditions in country, and should collaborate as equals with researchers from other countries.

Example: The Medical and Nursing Education Partnership Initiatives (MEPI & NEPI) - funded by the USG through PEPFAR and the NIH, respond to the severe shortage of healthcare professionals and focus on strengthening institutional capacity, a key necessity for successful country ownership. These programs seek to increase the number of qualified health professionals, revise curricula and support educational reforms, and expand retention activities. They have been structured with commitments to recruit and retain those trained into government service or other in-country capacity strengthening.

What can USG country teams do: To accelerate country ownership within academic institutions, for example, USG country teams can:

- Support host country academic institutions to sufficiently plan and manage host country health programs to serve as sustainable primary vehicles through which health training and management programs are delivered in the country;
- Support the capacity development of academic institutions to develop host country workforce; and
- Enable local scientists to lead research, program evaluation and surveillance. Demonstrate this priority through a shift and/or expansion of direct funding to local institutions and researchers.

Potential metrics of success could be demonstrated through some of the following:

- Increased number of health-related research projects conducted and disseminated by host country academic institutions
- Increased number of research conferences convened by host country academic institutions
- Increased number of local academic institutions engaged in health surveillance, research and evaluation

ANNEX 1: Illustration of USG country ownership approach

Country Ownership Elements and Processes

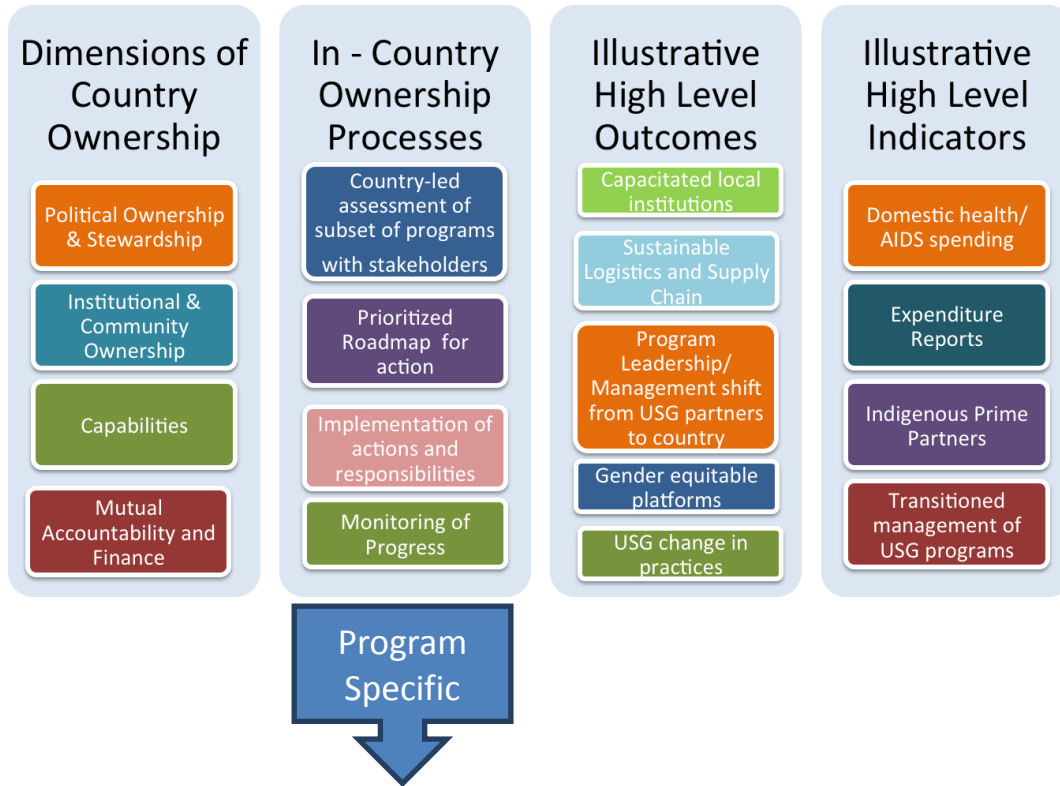


Figure Legend: Column 1): Working approach to country ownership and expected outcomes: Four dimensions criteria for country ownership. Column 2): In country processes could represent two tiers: Tier 1 - broad high level discussions; Tier 2 - actions targeted to specific programs (e.g. PMTCT or Malaria) and supported by program specific guidance. Column 3): Illustrative high level outcomes that can be monitored every two years. Column 4): Illustrative high level indicators that can be reported annually though existing reporting structures for health.

ANNEX 2: Examples of country ownership from GHI strategy documents

Common USG Goals	Approaches
Strengthened Human Capacity/Human Resources for Health	
<p>Mozambique: “Expanding usage of host country systems, mandate joint planning, and “base implementation on institutional perspectives.” Mozambique will build the capacity of civil society to influence policy and demand access to quality care.”</p>	<p>Ethiopia: “In addition to the training of service providers for facilities and outreach programs, the USG is providing support to the Human Resources for Health (HRH) Strategic Plan 2009-2020, improving the quality of public health teaching institutions and the availability of key HRH categories through scaling up the training of doctors, midwives, health information technicians, emergency surgical officers and anesthetists, postgraduate public health training, and strengthening health extension workers. The USG provides comprehensive support for the pre-service training of urban and rural health extension workers and health officers under the GOE’s accelerated training program.”</p>
Strengthened Commodity Logistics Systems	
<p>Nigeria: “Supporting and strengthening the national health supply chain system at a much broader scale than previously to fulfill a vision of greater country ownership. The USG is moving towards one unified HIV/AIDS supply chain system to improve the performance and reduce the overall cost of the USG, through a pooled procurement approach, which promotes added visibility into the supply system and decreased wastage. Also, promotion of various additional improvements to the actual distribution system and reviewing key logistics data captured in a scorecard with USG activity managers each quarter will strengthen the system. In addition, the GON and USG will begin to conduct regular joint monitoring and support visits to USG-supported facilities to review inventory management practices and provide feedback to partners supporting those facilities.”</p>	<p>Zambia: “Through pre-service and in-service training, the USG has built the capacity of the Zambian workforce to manage the supply chain. The USG has trained hundreds of MOH, Mission Hospital and NGO personnel in supply chain reporting and ordering for different commodity logistics systems, and developed MOH capacity to assess supply chains and lead quantification and forecasting exercises. The USG will continue to train them and transition the role to the MOH to lead the quantification exercises in different commodity areas (lab, ARVs, OIs, HIV test kits, essential medicines). The USG transitioned the Logistics Management Unit at the central warehouse (Medical Stores Limited) from being staffed by USG partner staff to being staffed by the staff of Medical Stores Limited. This signified an increase in country ownership of the logistics management system.”</p>
Strengthened HMIS	Improved Quality of Care
<p>Uganda: “The team has made significant investments in Health Systems Strengthening (HSS) and Health Management Information Systems (HMIS) with broad benefits across disease areas and the national program. Integration of HIV/AIDS surveillance and case</p>	<p>Rwanda: “With a stronger health system, Rwanda will be able to achieve its ambitious targets for the improved health of its population, including those for the GHI target areas. At the policy level, the USG is closely involved in the review and revision of decision-</p>

<p>reporting into the national integrated disease surveillance and HMIS is critical for rationalization of the sometimes-parallel HIV/AIDS reporting systems. The commodity security and national HMIS programming has a direct benefit to the HIV and AIDS response while leading to system-wide strengthening and scaled engagement with the Village Health Teams (VHTs) in PMTCT, HCT, and care.”</p>	<p>making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp).”</p>
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ANNEX 3: Examples of the dimensions of country ownership at work.

Stakeholder – Government

Bilateral Agreements/Negotiated Documents

Negotiated documents have helped to advance country ownership goals in Nigeria. As the USG worked with the government of Nigeria to develop a Partnership Framework and an implementation plan, a key approach involved aligning the health programs financed by USG with those within the national health plan. Each party agrees to certain contributions to make the goals of the PF sustainable. These contributions include increases in budgets at all levels of the public health care system, collaborations with the private sector to ensure services reach primary health care clinics in hard-to-reach areas, and skills development for community-level advocates. In addition to the Partnership Framework, the Head of State and all of the State Governors agreed to actively support polio eradication in Nigeria. This agreement committed governors to providing active leadership in the polio eradication efforts, allocating additional resources, and improving overall immunization programs. They established indicators for monitoring their performance as well as local government performance. The quarterly reporting of Governors on these indicators are monitored and published in national and local newspapers.

Strategic Partnerships

The USG Field Epidemiology and Laboratory Training Program (FELTP) is a 2- year program that builds capacity in applied epidemiology and public health laboratory practice for future public health leaders in partner countries such as Rwanda. Like other field epidemiology training programs, the residents spend approximately 25% of their time in the classroom and 75% in mentored field assignments. During field assignments, residents provide public health services to the Ministry of Health and other government institutions. These services include investigating and responding to public health emergencies, evaluating existing public health surveillance systems, analyzing routinely collected data, and implementing surveys. Since its inception in Rwanda, the program has trained 145 health personnel from the country's 30 districts on disease surveillance, outbreak investigation and response. Trainees have helped to improve the frequency of reporting of outbreaks to national authorities, as well as the complete and timely reporting of local disease information. As a result of the residents' investigations, the country has undertaken key public health actions such as measles mass vaccination campaigns, reviewing malaria diagnostic criteria, and sensitizing all district medical directors about outbreak preparedness.

Sector Wide Approaches (SWAp)

Several partner countries utilize a Sector-Wide Approach (SWAp) to more effectively deliver health care services supported by donors. In countries with a SWAp, the USG has been able to negotiate inclusion of activities supported with US financing into a single sector-wide work plan and results framework with multiple partners. In a select but growing number of countries, including Bangladesh and Nepal, the Joint Financing Agreement (JFA) modality is being used to align direct financing and programmatic activities of donors, with host country priorities. As either discrete donors or joint financing donors in a SWAp, these agreements can provide a vehicle through which partner countries can provide a single joint progress and expenditure reports on outputs and outcomes prepared for the entire sector and all donors as is the case in Nepal. With SWAp, partner governments reduce transaction costs and can demonstrate increased aid effectiveness. Using a JFA in Bangladesh, USG service delivery efforts were aligned with the host government and resulted in the provision of direct grants to host national agencies and promote private sector engagement, including a new partnership with Johnson and Johnson. To further promote innovations in health, USG funds in Bangladesh were also included in a multi-donor trust fund and an innovations fund for impact to promote greater country ownership.

Stakeholder – Private Sector

Engagement of the for-profit Sector to improve access to health services

Other private sector engagements leverage local business communities - both medium and large size companies- to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community members. In Uganda, the Health Initiatives for the Private Sector (HIPS) project leverages the role of the private sector in improving and expanding access and utilization of health services in the private sector. HIPS recently demonstrated that the provision of AIDS treatment from government and donor stocks to accredited private providers resulted in AIDS treatment reaching additional patients at little or no cost to the government. In exchange for these drugs, employer clinics assume the non-drug costs of treating patients, spending \$80-\$100 per year/per person for the necessary staff, tests and other services, resulting in savings to the government.

Capacity Strengthening through Private Sector partnerships

The USG supported Public Private Partnership (PPP) between Standard Bank and the Malawi government enabled the decentralization of funds, from the National Aids Council, to nine District Assembly sites in Malawi. This partnership supported the temporary placement of Standard Bank's personnel, aiding local staff in the development and implementation of permanent business procedures. These systems are crucial for the local governments to fulfill its mission, as well as develop and maintain sound fiduciary practices to enhance long-term institutional capacity and organizational growth.

Expansion of coverage of private health insurance to make health care affordable

By targeting USG technical assistance to address the health needs of the poor and disadvantaged and better utilize private health insurers, private insurance schemes are now a means to affordable healthcare in countries such as Georgia and Kenya. In Georgia, the USG has supported health insurance schemes that positively impact access to and quality of services for target populations. Health insurance coverage for poor women of reproductive age (15 - 49 years) and children under five years of age expanded over the 2008-2009 period by 29 % and 59 %, respectively. The expansion of health insurance for the poor has led to a 50 % decrease in out-of-pocket payments for medical care among beneficiaries.

Stakeholder – Civil Society and Communities

Community Partnerships

The USG supported the establishment of the Purple Sky Network (PSN) in 2006 as a network of HIV/AIDS organizations, experts, professionals and volunteers for men who have Sex with Men (MSM) and transgender populations in the Greater Mekong sub-region. This sub-region includes Cambodia, Laos, Myanmar, Thailand, Vietnam and two provinces in China. As a network of Technical Working Groups, it primarily focuses on information sharing to strengthen the response to HIV through capacity strengthening activities with MSM communities. A Regional Coordinating Secretariat based in Bangkok supports the overall network. Through Purple Sky, civil society is able to put MSM-related health issues on national agendas, by advocating for the development of appropriate and effective programs, services, and policies for reducing HIV and STI transmission.

In collaboration with community stakeholders in Malawi, USG has been working to integrate PEPFAR funded support to PLHIV and OVC with the Feed the Future initiative. In some areas, PEPFAR will support HIV patients with complications from malnutrition to receive prescribed nutritional supplements, usually in the form of supplemental or therapeutic foods. When the patients' nutritional status stabilizes, PEPFAR will support workers who assess the patient's long term food security, and refer the patients to available economic strengthening and livelihoods programs, such as those supported by Feed the Future.

Stakeholder - Academia

North-South research collaboration

The National Institute of Allergy and Infectious Diseases (NIAID)/University of Bamako International Center of Excellence in Research has a primary focus on strengthening local capacity to manage infectious diseases, particularly malaria. NIAID has collaborated with Malian investigators in malaria research, including laboratory, clinical and field-based research on malaria, malaria vectors and pathogenesis. Through the intramural program in Mali, multiple research milestones have been met, including management of research funding. The initiative has trained dozens of young Malian scientists at academic institutions and laboratories in Mali and the United States. Today, Malian researchers collaborate with NIAID scientists on multiple projects, including studies on malaria drug resistance, neglected tropical diseases, and immunologic and microbiologic studies of patients co-infected with HIV and tuberculosis. NIAID and Malian colleagues have also recently initiated research programs on relapsing fever and Lassa fever. These academic partnerships foster country ownership and reduce reliance on external technical resources.

Similarly, the Fogarty International Center (FIC) at the NIH funds research scientists at US institutions to partner with research scientists in partner countries and provide training for national scientists. Since its establishment by Congress, more than 3600 scientists (mostly scientists and public health leaders from the most resource-constrained nations) have received greater than 6 months of research training and received research awards through FIC programs; tens of thousands more have received shorter-term training.

Stakeholder – Multilateral Partnerships

The strategic collaboration between the USG's President's Malaria Initiative (PMI), the Global Fund, and the Government of Angola helps Angola plan to procure malaria commodities with GOA financing. At the request of the MOH, PMI and the Global Fund provided short-term assistance in building local capacity in forecasting, procurement, and a costed supply management plan, which rapidly brought the MOH into compliance with the Global Fund quality assurance policy. This assistance helped enable Angola to procure and distribute lifesaving commodities.

The African Society for Laboratory Medicine (ASLM) was created to advance professional laboratory medicine practice, science, systems, and networks in Africa needed to support preventive medicine, quality care of patients and disease control through partnership with governments and relevant organizations. To ensure country ownership and sustainability, although initially funded by PEPFAR, ALSM leveraged the efforts of several Ministries of Health in Africa, the African Union, WHO-AFRO, UNAIDS, the Clinton Health Access Initiative, and Foundation Merieux. As such, ASLM has been fully endorsed as a Pan-African professional body by the African Union. Since its launch in March 2011, ASLM now operates a functional secretariat in Addis Ababa; is collaborating with the \$63 M World Bank-supported laboratory strengthening project in Eastern Africa including Tanzania, Kenya, Uganda, and Rwanda; and has trained and certified auditors in the East Africa Public Health Laboratory Network.

ANNEX 4a: Excerpt from country ownership assessment tool: developing roadmap

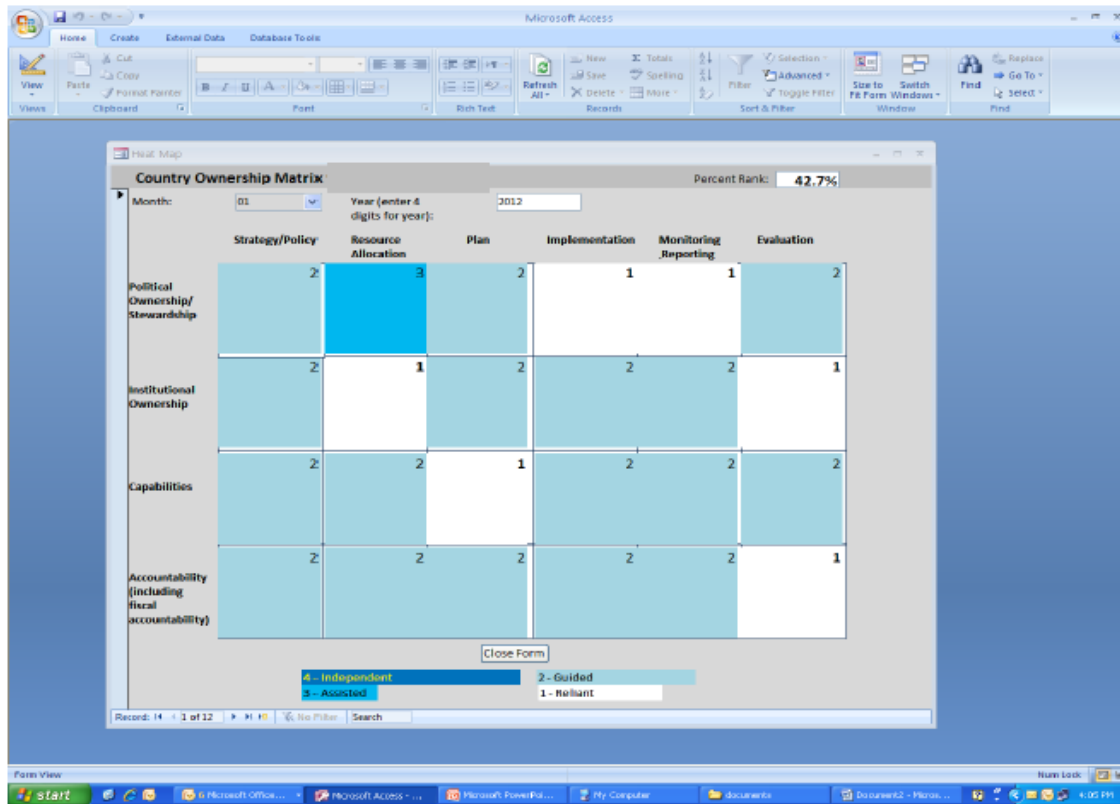


Figure Legend: The Country Ownership Assessment Tool (COAT) will be used by the US team and national stakeholders led by government to assess a baseline of country ownership and use its finding to develop a thematic road map for country ownership. Led by country government, USG and local stakeholders, with facilitation by McKinsey and Company, utilized this methodology in Botswana and South Africa to determine a baseline for all 4 dimensions, develop an action plan and determine a path for monitoring and reporting, and evaluating impact. Botswana, stakeholders identified the following themes as the highest priority for country ownership for the HIV and AIDS response. As a result, an agreed upon roadmap was synthesized with roles and responsibilities and associated benchmarks.

In **Botswana**, the joint plan of the UGG-GOB included the following plans and actions:

- i. **Drive delivery through effective coordination, joint planning and performance management:** NACA delivery unit has been launched
- ii. **Maximize stakeholder impact through national capability building and enabling mechanisms:** objective is to strengthen civil society, national capability building plan in place
- iii. **Sustainably ramp up impact of high priority programs:** GOB has shifted to treatment at 350 (April 2012); voluntary medical male circumcision scale-up by PEPFAR and ACHAP, coordinated by GOB; combination prevention evaluation to take place in Botswana
- iv. **Establish national research and evaluation programs:** partnered with U.S. academic institutions Harvard, Baylor and University of Pennsylvania to provide national capacity in clinical training and build a national medical school
- v. **Drive effective cost management to enable financial sustainability:** Under GHI, USG will provide TA while reducing funding; transition USG-funded "seconded" staff to the GOB within three years; and funds will be leveraged from private sector and other (non-USG) resources to fund community programs. Costing TA will be provided to the GOB by PEPFAR

ANNEX 4b: Excerpt from country ownership assessment tool (COAT)

DIMENSION OF COUNTRY OWNERSHIP	POLICY/STRATEGY DEVELOPMENT	RESOURCE ALLOCATION	OPERATIONAL PLAN	IMPLEMENTATION PLAN	MONITORING AND REPORTING	EVALUATION OF IMPACT
Political Ownership and Stewardship	Government leads and involves stakeholders in the development of a national strategy and policies , which are clearly articulated and widely known	Government allocates program resources according to priorities in the national strategy ensuring sufficient resources to achieve goals and targets	Government leads a clear process to develop operational plans representative of the national down to a local level with input from stakeholders	Government leads, oversees and makes requisite corrections to the implementation of the operational plan which is consistent with strategy	Government leads in implementing clear standards and processes for an integrated monitoring and reporting system	Government mandates and ensures an open, participatory, understood process and framework for evaluation
Institutional and Community Ownership	Local government and institutions align their plans and processes to reflect the national strategy and ensure that the goals and targets of the national strategy are met	Local government and institutions plan, direct and oversee final decisions on resource allocation of their programs	Local government and institutions coordinate (with stakeholders) the development of their operational plans that are in alignment with the national strategy	Local government and institutions lead the delivery of core programs in the national plan and manage the funds for implementation	Local government and institutions lead the process of monitoring and reporting for their programs, integrating and aligning with national reporting and monitoring systems	Local government and institutions lead an open and rigorous evaluation process of their programs in alignment with government mandated evaluation framework which is open and participatory
Capabilities	Government and local institutions can develop policy and strategy, communicate the vision internally and externally, and coordinate alignment of stakeholders	Government and local institutions can assess needs and identify sources of all required resources, prioritize and cost activities and communicate the costed plan to align stakeholders	Government and local institutions can generate detailed operational plans with targets, milestones, timelines and responsibilities and can assess delivery options, providers, scale-up and costs	Government and local institutions can design and prioritize activities for cost-effective programming, can select and manage implementing partners and/or implement programs	Government and local institutions can develop and implement a robust, aligned and integrated system to monitor and report program outputs, outcomes and impacts	Government and local institutions can set priorities for evaluation, communicate evaluation results and critically assess data identify trends and implications, and lead change according to results of the evaluation in an open, transparent way.
Mutual Accountability including Finance	Government and stakeholders participate in an agreed, transparent, process to assess and revise the national strategy	Government and stakeholders participate in an agreed, transparent process to assess, report on and revise resource allocation	Government and stakeholders participate in an agreed, transparent process for 'delivering' and 'reviewing' the operational plans and a process to promote responsiveness to feedback	Government and stakeholders participate in an agreed, and transparent process for assessing the implementation and costing of the operational plan	Government and stakeholders participate in an agreed, transparent, responsive process to assess and modify the monitoring and reporting system in line with the assessment	Government and stakeholders participate in implementation of a mechanism and agreed open, transparent, responsive process to assess and revise the effectiveness of the evaluation framework. There is a clearly defined group implementing evaluation

ANNEX 4c: Excerpt from diagnostic assessment on USG shifting roles and responsibilities

Overarching principles: To increase country ownership, the USG will need to change the way it currently does business. USG will need to:

- **EMPOWER:** Encourage and empower host country policy-makers, planners, health providers, civil society and influential individuals to lead, own and be good stewards of their own health response;
- **ALIGN:** Whenever possible, work through and strive to improve host country public and private sectors, civil society, and academia and align with host country data-driven priorities;
- **STRENGTHEN:** Strengthen the effectiveness and efficiencies of national and sub-national key health systems and policies: Health Management Information Systems, Human Resources for Health, financial and accountability systems, infrastructure, supply chain management, and service delivery;
- **CONTEXUALIZE:** Be aware of the country context and build on the strengths and opportunities while addressing the weaknesses and threats;
- **PARTNER:** Recognize and treat the bi-lateral relationship as a mutual partnership based on trust and respect. Establish clear guidelines and expectations for the various partners at all levels as well as consequences for breeches;
- **COORDINATE:** Work in close collaboration and coordination with other donors;
- **MEASURE:** Assess the level of country ownership, develop a roadmap and track the progress over time in increasing a country owned and lead health response with clear indicators and benchmarks; and
- **MODEL CHANGE:** Demonstrate and exhibit a new way to work; encourage the host country to be in the drivers' seat and provide technical, financial and capacity strengthening support as appropriate to the context.

ENDNOTES

¹ In FY2012, the United States government provided ~27% in global health assistance to the health sector of partner countries. Approximately 24% was in the foreign assistance budget for the Department of State and USAID; ~3 percent through both the Department of Health and Human Services and the Department of Defense. – Source, State F bureau

² Tarnoof, Curt & Lawson Leonardo, Marian; Foreign Aid: An Introduction to U.S. Programs and Policy; Congressional Research Service; [website]; Available WWW: <http://fpc.state.gov/documents/organization/157097.pdf>. Online. Internet. Accessed 2011 Sept. 7.

³ Organization for Economic Co-operation and Development; Development Co-operation Directorate; [web site]; Available WWW: http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html. Online. Internet. Accessed 2011 Sept. 7.

⁴ Accra Agenda for Action 2008; [website]; Available WWW: http://www.oecd.org/document/3/0,3746,en_2649_3236398_41297219_1_1_1_1,00.html. Online. Internet. Accessed 2011 Sept. 8.

⁵ America.gov Archive; President Addresses the Ghanaian Parliament in Accra (transcript); [website]; Available WWW: <http://www.america.gov/st/texttrans-english/2009/July/20090711110050abretnuh0.1079783.html>. Online. Internet. Accessed 9 September 2011.

⁶ Fact Sheet: U.S. Global Development Policy, White House; [web site]; Available WWW: <http://www.whitehouse.gov/the-press-office/2010/09/22/fact-sheet-us-global-development-policy>. Online. Internet. Accessed 2011 Nov. 8.

⁷ Ibid.

⁸ “Clinton's Remarks at the Global Health Summit, June 2012.” Council on Foreign Relations. Online. Internet. Accessed: 6 June 2012. Available WWW: <http://www.cfr.org/global-health/clintons-remarks-global-health-summit-june-2012/p28420>

⁹ There are a number of accepted tools and approaches that could be used to measure progress towards country ownership. These include USG-supported Service Provision Assessments (SPAs); the Demographic and Health Surveys (DHS); National health Accounts (multiple technical areas); Improvement Collaborative methodologies, through the work of the USG Health Care Improvement (HCI) project; Capacity Plus project's suite of electronic databases for tracking the deployment, recruitment and retention of the health workforce; work and standards of international auditing firms to certify capabilities

in a variety of administrative functions. USG teams can request the country ownership toolkit from headquarters.

¹⁰ IFC, *The Business of Health in Africa*, p.5