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PEPFAR
U.S. President's Emergency Plan for AIDS Relief

# ISSUE BRIEF
# Country Ownership

"We must crowd in local resources. Host country-led investment ... is absolutely critical. Countries themselves must take ownership and accountability in the fight, and local civil society has a critical role in ensuring sustained commitment and investment at a country level."

Interview with Dr. Ariel Pablos-Méndez, June 13, 2013

## Introduction

Creating an AIDS-free generation is a shared responsibility between the United States and host country partners. In 2008, the U.S. Congress reauthorized the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), moving from an emergency response toward a more sustainable and country-owned response to the HIV epidemic. In 2011, Secretary of State Hillary Clinton emphasized "country ownership" as a key step to sustainability and called upon donors to shift "our approach and our thinking from aid to investment."[1] The recent passage of the 2014 PEPFAR Stewardship and Oversight Act demonstrates the United States' sustained commitment to fighting HIV and AIDS and emphasizes that the United States cannot do it alone. Achieving an AIDS-free generation is a shared responsibility. Country ownership is characterized by government, communities, civil society and the private sector being able to lead, prioritize, implement, be accountable and eventually pay for their country's HIV and AIDS response.

Ugandan President Yoweri Museveni takes an HIV test at Kisana Health Center in the capital Kampala.
Photo Credit: Stephen Wandera/Associated Press

The U.S. Agency for International Development (USAID) has worked with host country partners to accomplish sustainable, country-led and -owned responses for half a century, including significant investment in health systems strengthening and local capacity building. USAID has learned from experiences transitioning numerous family planning programs in Latin America and Asia that were phased out over many years based on tailored graduation plans. USAID monitored threshold indicators such as modern contraceptive use and total fertility rates to decide when a country was ready to graduate. Lessons learned from family planning graduation, such as market segmentation to include public and private sectors, in-country administrative capacity to maintain quality service delivery and ongoing financing of essential products and services can be applied to HIV and AIDS programming. From these graduation experiences, the Agency is in an excellent position to make HIV and AIDS programs more sustainable.[2]

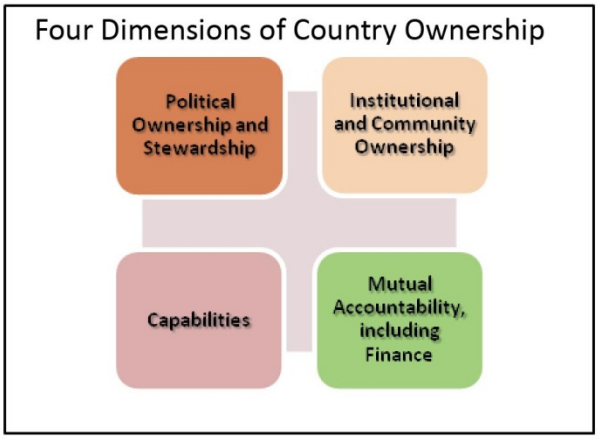
## Roadmap to Shared Responsibility

The PEPFAR Blueprint for an AIDS-Free Generation describes how the U.S. Government is supporting an "AIDS-free generation" through shared responsibility, smart investments, saving lives and results driven by science. The U.S. Government increases the efficiency and cost-effectiveness of evidence-based interventions to ensure they are scalable and sustainable while helping build capacity of the local workforces, systems and institutions. The PEPFAR Blueprint outlines a roadmap for shared responsibility in the HIV and AIDS response through four specific action steps:

- Partnering with countries in a joint move toward country-led, -managed and -implemented responses
- Increasing support for civil society as a partner in the global AIDS response
- Expanding collaboration with multilateral and bilateral partners
- Increasing private sector mobilization toward an AIDS-free generation[3]

## Operationalizing Country Ownership

USAID works across the four dimensions of country ownership as outlined in the U.S. Government Interagency Paper on Country Ownership (See figure).




**Political Ownership and Stewardship** refer to the host country (private and public sectors) leading the development, implementation and oversight of the national strategic plan. **Institutional and Community Ownership** refers to host country institutions serving as the primary vehicles through which HIV and AIDS programs are delivered. **Capabilities** refer to when a host country has an effective workforce, organizations and systems to achieve priority outcomes. **Mutual Accountability, including Finance,** is when explicit roles and responsibilities are described with appropriate management of performance in place.[4]

## Countries Pass along a Continuum to Country Ownership

Transition toward country ownership is a deliberate shift from a U.S. Government-led and -funded program to an integrated country-led program. The length and types of the United States' future investments will vary according to where countries fall along the continuum of country ownership, economic transitions and epidemiological trends. The goal is to move countries along the country ownership continuum, from parallel systems developed during the emergency response to fully integrated systems managed by the local government in partnership with civil society and the private sector. Countries such as Malawi and Kenya have generalized epidemics and large complex programs and continue to require significant and long-term external support to achieve and sustain results. They are characterized by high HIV prevalence, gaps in service delivery and insufficient domestic financial resources to cover their needs. Countries in Central America, Asia, parts of Africa and Eastern Europe that have concentrated epidemics receive targeted support for key populations and priority technical areas. There are also countries, including Botswana, with generalized epidemics that receive only technical assistance as they are farther along the country ownership continuum and the government has the financial capacity to address the response. The ultimate goal is for countries to lead and finance their response and reach a sustained partnership with the U.S. Government based on technical collaboration. India is a good example of this relationship. With USAID's technical assistance and strategic investments, India has transitioned from an early pilot phase to a more sustainable national approach. Some countries are increasingly able to fund their own national response based on rising national incomes. For example, Namibia is a middle-income country, and the cost of the health care workforce is gradually shifting to the government. In contrast, the Rwandan Government's capacity is high, and it is managing both the technical and programmatic responsibilities of the national HIV response. However, it is not able to fully fund the response due to the country's economic situation.[5]

## USAID Forward and Country Ownership

USAID Forward is an Agency-wide approach that encourages country ownership. It facilitates host country engagement and increases the opportunities for local government, private sector and civil society organizations to directly implement activities. USAID Forward focuses on building country ownership and capacity and strengthening local civil society organizations and private sector capacity. USAID now requires that any new contract or grant with a host country partner perform a sustainability analysis to identify how local partners and government-to-government support could achieve sustainable goals and institutional capacity (systems, policies and skills).[6]

## Country Ownership in Action

**Namibian Ministry of Health and Social Services improves distribution of health workers and facilitates the transitioning of PEPFAR-supported health workers to local organizations.** Initially, the public health sector was overburdened by the HIV and AIDS epidemic. HIV program staffing needs were unknown. There were severe staff shortages and inequities in staffing. One way to improve the accessibility and quality of health care workers was to determine the types of health workers needed in various facilities. With technical assistance from a USAID implementing partner, the Namibian Government applied a workforce planning tool, Workload Indicators of Staffing Need (WISN), that calculated the numbers and types of staff a health facility would need based on client flow. The analysis revealed staff shortages of medical officers and inequities in staffing between health centers and clinics. For example, there were two clinics each with one registered and enrolled nurse. Data revealed that one clinic had seen 13,541 patients in a year, while the other had only seen 1,867. Based on these results, the Ministry of Health and Social Services decided to restructure the health workforce, including recruiting additional staff and transitioning doctors onto the government payroll.[7]

**Zambia's public private partnerships for HIV and AIDS increase worker productivity, decrease worker mortality and expand services to the greater community.** Recognizing the negative correlation between HIV and AIDS and productivity and the serious impact of the epidemic on Zambia's economy, USAID collaborated with private mining and agribusiness companies to implement HIV and AIDS prevention, care and treatment programs. To obtain private sector buy-in, USAID highlighted the links between investment in HIV and AIDS programs and business profitability. USAID supported the establishment and maintenance of HIV and AIDS workplace and community programs, including support of policy and action plan development and community outreach. USAID's implementing partner offered supportive supervision and facilitated links to HIV care and treatment. These partnerships served 34,635 employees and 3 million community members and leveraged close to $10 million from the private sector. Key achievements of this project include increased community coverage of HIV testing and counseling, increased community access to treatment, reduced worker absenteeism and worker mortality, reduced incidence of new HIV infections among workers and improved worker health and productivity.[8]

**USAID Transitions Funding and Management of Local Civil Society Organizations to Government of South Africa**

In South Africa, USAID has had great success in partnering with local civil society organizations. About half of all USAID funding has gone directly to local partners, mostly non-governmental organizations (NGOs), many of which receive significant support. It has been a deliberate strategy for USAID's mission in South Africa to build local capacity and provide funding to local organizations that know the setting and have deep connections with the communities they are supporting. The capacity of many organizations serving orphans and vulnerable children (OVC) has been built over the last several years. More recently, the emphasis has shifted to providing more support to the Department of Social Development (DSD), which supports OVC. The capacity building efforts have included strengthening the DSD's ability to fund and manage civil society organizations. To date, the DSD has funded eight of the OVC service providers that USAID had previously supported and will support more in the future. The transition of OVC work has been successful thanks to strong capacity building of NGOs and the government and the good relations developed between DSD and USAID.

**Jamaica takes measures to ensure the sustainability of its response.** HIV- and AIDS-related deaths dropped by 41 percent from 2004 to 2011, but hard won gains were at risk due to budget constraints and increasing HIV treatment costs. The U.S. Government often supports countries like Jamaica with costing studies to advocate for funding national HIV and AIDS strategic plans. Jamaica's study, financed by USAID, UNAIDS and the World Bank, projected the annual cost of the HIV program would double by 2030. As a result, Jamaica modified its National Strategic Plan to focus on key populations, such as men who have sex with men, sex workers and injecting drug users. The Family Planning Board decided to integrate with the HIV Program to lower administrative costs. Jamaica is also exploring opportunities to purchase antiretroviral treatment at a lower cost regionally.[9]

**The Supply Chain Management (SCMS) project is fostering greater country ownership and reduced operational costs by integrating supply chain management systems in Ethiopia.** The Pharmaceuticals Fund and Supply Agency (PFSA) was operating an externally developed and owned commodity system. This system required licensing fees and maintenance costs and was not sustainable in the long term. Together, PFSA and SCMS developed a new system, Pharmaceutical Logistics Information Tracking System (PLITS), locally. The new software operates online and offline to synchronize when connected to the Internet. Since it is country owned, there are no licensing fees, and it is locally developed, which facilitates maintenance. PLITS connects to thousands of health facilities. PLITS connects with the Health Commodities Management Information System developed under the USAID | DELIVER Project, enabling data exchange between systems, and avoids duplication in data entry. PFSA's staff was trained in how to use the system. Since it is owned and operated by PFSA, it is a more financially sustainable system.[10]

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