TECHNICAL **BRIEF**

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Contributing to stronger, more sustainable, country-led HIV/AIDS programs

COUNTRY OWNERSHIP AND ORGANIZATIONAL CAPACITY BUILDING

Beyond Principles to Practices

"We appreciate support from the outside, but it should be support for what we intend to achieve ourselves."

— Paul Kagame, President of Rwanda, 2009

INTRODUCTION

In 1997, the global development community started to discuss a new global value—country ownership of foreign aid-supported development efforts. Obviously, this was and still remains an important and positive step. From purely social and sovereignty-related perspectives, some developing countries dislike the term country ownership—some even view it as condescending or impolite. But, when treated by the standards applied to some of the practical concepts on how development actually happens and eventually takes root, country ownership captures the main implications of a large body of research evidence and practical experience.[1]

Over the years, evidence on this topic has reinforced two oft-quoted points: First, that developing countries cannot achieve development solely on the basis of foreign aid or external technical assistance—there need to be local endogenous and capable drivers; and second, that the two main mechanisms that donors have sometimes used to address the lingering challenge of sub-

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optimal endogenous commitment may not, in fact, work in the long term, that is: a) project funding that bypasses country institutions and their systems, and b) reform conditionalities that are often tied to grants or loans.[2]

With the evidence on these two points already compelling in the late 1990's, a substantial international consensus on the need to develop a country-led approach to development assistance also began to emerge at that time. Over the last decade, "country ownership" has been a recurrent theme in international aid policy discourse. This led to the 2005 Paris Declaration on Aid Effectiveness, which was reviewed and reinforced in 2008 by the Accra Agenda for Action. Click here to learn more: ***http://www.oecd.org/dataoecd/11/41/34428351.pdf***

In November 2011, country ownership was again the central theme at the 4th High Level Forum on Aid Effectiveness that was hosted by the Republic of Korea, and for the first time, the civil society sector was formally represented at one of these high level summits. Country ownership, at the core of all these meetings and documents, urges national governments, civil society organizations, and ordinary citizens to fully participate in the process of planning, setting priorities, monitoring, and taking ownership of development policies and activities in their country.

Despite the articulation of a set of global principles for more effective aid delivery, and although changes are underway, the current development assistance landscape at country level is still characterized, albeit partially, by fragmentation and lack of coordination, with a wide array of well-intentioned initiatives. Many of these may not be directly led or implemented by host country organizations, and often focus on short-term project results, raising some questions about country ownership and sustainability.

Today, it is heartening that major donors are moving beyond the declarations and promises of Paris, Accra and Busan by promulgating and putting new policies into practice with host governments. The United States Agency for International Development through its Implementation and Procurement Reform (IPR) initiative under USAID Forward stresses country-led development and contracting directly with more local organizations.[3] Major European donors are taking a similar approach. Between 2008 and 2010, the Department for International Development (DFID), the United Kingdom's primary aid agency, cut its technical and administrative staff by 30 percent and channeled about two-thirds of its funds through host country systems. The Global Fund to Fight AIDS, Tuberculosis and Malaria also channels substantial amounts of resources through country systems.

There is still a significant gap between the rhetoric of ownership and practices on the ground. We hope the capacity building practices and approaches presented in this technical brief will assist donors, government institutions, and civil society organizations to better target investments in this area and plug the existing gap, as capacity building can help to make country ownership a reality. ■

1. Booth, 2011. Aid effectiveness: bringing country ownership (and politics) back in. ***http://www.odi.org.uk/resources/docs/6028.pdf***

2. OECD, 2010. Inventory of Donor Approaches to Capacity Development: What We Are Learning. ***http://www.oecd.org/dataoecd/50/12/42699287.pdf***

3. USAID Forward, ***http://pdf.usaid.gov/pdf_docs/PDACS878.pdf***

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ACRONYMS

AIDSTAR	AIDS Support and Technical Assistance Resources
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
LDP	Leadership Development Program
MCC	Millennium Challenge Corporation
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOHP	Ministry of Health & Population (Egypt)
NACOPHA	National Council for People Living with AIDS
NGO	Non-governmental Organization
PBF	Performance-based Financing
PEPFAR	President's Emergency Program for AIDS Relief
RFA	Request for Application
SWAp	Sector-wide Approach
USAID	United States Agency for International Development

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We appreciate the support of the US President's Emergency Plan for AIDS Relief (PEPFAR) through the Office of HIV/AIDS at USAID for providing the funding for the development of this publication. Their continued investment in capacity building tools and resources demonstrates their firm commitment to organizational capacity building as a critical factor in improving the quality, effectiveness and ownership of local programs and organizations. ■

I. PURPOSE OF THE TECHNICAL BRIEF

"True country ownership is the full and effective participation of a country's population via legislative bodies, civil society, the private sector, and local, regional and national government in conceptualizing, implementing, monitoring and evaluating development policies, programs and processes."

— *Inter-Action Aid Effectiveness Working Group, 2011*

Keeping the historical evolution and emerging trends of country ownership in mind, the purpose of this technical brief is to discuss country ownership in the context of organizational capacity building in public institutions and civil society organizations in the health sector.

The paper outlines some key practices and approaches that can be used to strengthen country ownership, and the required shifts in behavior among donors, countries, and implementing partners to strengthen local institutions and organizations. It also provides case vignettes to demonstrate the role of organizational capacity building in a variety of settings including the public sector and HIV/AIDS local civil society organizations in strengthening country ownership in the context of AIDS response. ■

II. WHAT IS COUNTRY OWNERSHIP?

> *"In Africa, if it's not happening in the community, then it's not happening."*
>
> — *Professor Miriam Were, Kenyan Community Health and CSO Leader, and first winner of the Hideyo Noguchi Africa Prize, 2011*

Country ownership is not a new concept. It is the first principle of the 2005 Paris Declaration on Aid Effectiveness. What continues to pose challenges is the lack of a common understanding about the practice of country ownership, including how to advance country ownership in general and how to achieve a "whole of society" approach that encompasses civil society, the private sector as well as government. Moreover, the lack of common metrics that can be used to track and measure progress makes it difficult to make the case for country ownership, compounding the challenge even further.

However, development thought-leaders and practitioners agree on certain important assumptions that should frame and guide the much needed transition from rhetorical statements and declarations of intent in the form of principles to pragmatic action on country ownership and measurement of progress toward this goal. Some of these key assumptions include:

- Ownership extends beyond national governments and their agencies to include civil society and private sector. Effective participation of both citizens in various key sectors and government in shaping and defining development efforts is at the heart of country ownership.
- Successful ownership involves empowering local actors (government and civil society) and giving them space to assume direct responsibility for their own development, create their own solutions and accountability mechanisms, and demonstrate measurable results.
- Capable country partners, with the institutional capacity to review evidence, set priorities, develop plans, and implement and sustain programs at all levels are needed.

III. COUNTRY OWNERSHIP AND CAPACITY BUILDING: MOVING BEYOND PRINCIPLES TO PRACTICES

In the past decade, increased commitment and funding from multiple streams has enabled countries to provide prevention, treatment, care and support services to millions of people and boost their programmatic responses to HIV and AIDS. Many of these gains still remain fragile, however, as countries and their local institutions—including but not limited to ministries of health and social welfare, national AIDS commissions, civil society organizations and Global Fund country coordinating mechanisms and principal recipients—face capacity-related challenges that hinder their ability to take charge and sustain their own HIV and AIDS responses.

The conversation on country ownership has often focused on government and excluded civil society organizations and the private sector. All these entities, along with the overall citizenry, form the foundation of country ownership. Civil society organizations are important actors in this process.

There are many definitions of civil society. Here we define it as the arena, outside of family, state, and the market, where people associate to advance common interests. Examples of civil society organizations (CSOs) include community groups, non-governmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.

In the last 30 years, the number of civil society organizations active in the provision of health and other programs that promote human development have grown exponentially, especially in most countries in Africa. The number of civil society organizations registered in Kenya alone has grown from less than 100 in 1970 to more than 7,000 in 2011.[4] And, in many countries, CSOs have a long history of advocacy and providing health services to poor, marginalized, or hard-to-reach populations. They tend to be closely connected to the community; they are often more adept at opening up channels of communication and participation with community groups; and they strengthen local-level planning, provide training, and even promote equity and social justice. All these dimensions of their work are essential for laying the foundations of country ownership, and provide strong rationale for building CSO capacity and supporting their full participation in the realization of country ownership goals.

A broad-based country ownership approach that focuses on strengthening the capacity of public sector institutions like government ministries of health and social welfare, private sector, and civil society organizations is needed to create opportunities for stronger local organizations with better program design and implementation.

Capacity building, often also referred to as capacity development, is a popular and oft-expressed critical need in all documents and declarations related to country ownership. There are many different ways in which national and international organizations define and implement capacity building programs and interventions. The box on the next page provides a summary of key capacity building terms and definitions.

4. NGO Bureau. ***http://www.ngobureau.or.ke/***

- **Capacity:** the ability or power of an organization to apply its skills, assets and resources to achieve its goals.
- **Capacity building:** an ongoing evidence-driven process to improve the ability of an individual, team, organization, network, sector or community to create measurable and sustainable results.
- **Organizational capacity building:** the strengthening of internal organizational structures, systems and processes, management, leadership, governance and overall staff capacity to enhance organizational, team and individual performance.

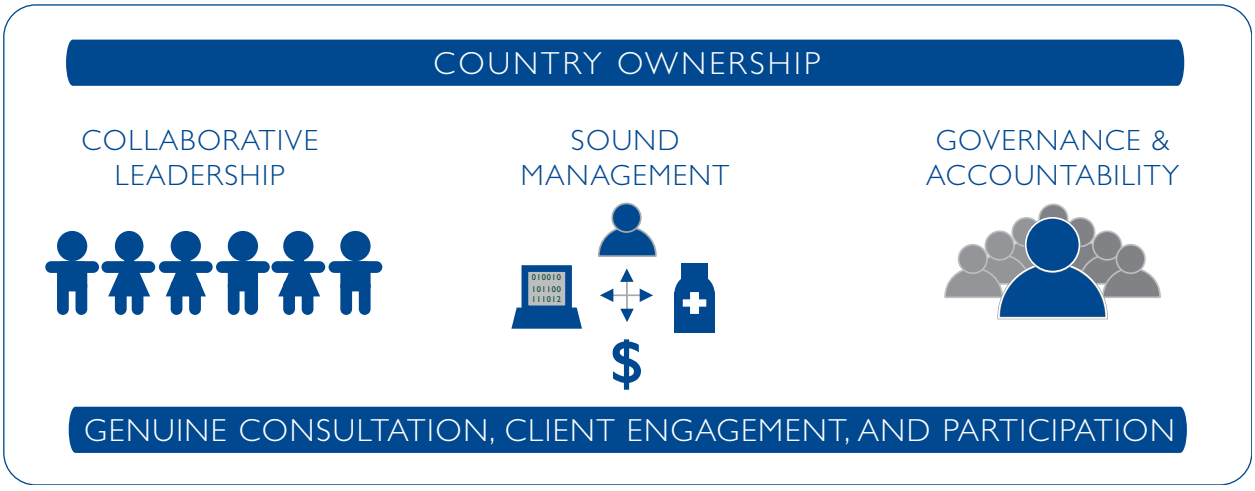
Source: Organizational Capacity Building Framework: A Foundation for Stronger, More Sustainable HIV/AIDS Programs, Organizations & Networks. AIDSTAR-Two Technical Brief No: 2, January 2011

These definitions highlight the orientation toward results as well as the impetus to shift from input, and focus more on evidence-driven process and outcome measures, a new strategic goal that is also a cornerstone of both the US Government's Global Health Initiative and PEPFAR. To learn more, click on: ***www.aidstar-two.org/upload/AS2_TechnicalBrief-2_4-Jan-2011.pdf***

In this era of declining external resources for HIV/AIDS and global health and development and the emphasis on country ownership, providing external assistance in a way that empowers and builds lasting capacity among local actors becomes ever more critical.

Efforts to strengthen country ownership will look very different depending on the unique context of each country. For example, strengthening country ownership in a fragile state with equally nascent or fragile local institutions would assume a different pace and approach to what would be done in a relatively stable, pluralistic, lower-middle income developing country. Nonetheless, there are some essential core practices in the realm of organizational or institutional strengthening, that when developed and applied together, can serve to strengthen and advance the implementation of country ownership principles. These include:

- Collaborative leadership
- Sound management capacity
- Governance and accountability



Successful country ownership relies on these three core practices which are in turn built upon a foundation of true partnership with the stakeholders involved.

Investing the time and resources in these three practice areas through genuine consultation, client engagement, and participation is necessary to move beyond principles to practice, achieve maximum effectiveness, promote ownership, and sustain change.

In this section, we will highlight and analyze each of these practices through an organizational capacity building lens, and use short case vignettes from both the CSO and public sectors to illustrate their value and results that can be realized.

1. Collaborative leadership

At one level, the challenge of country ownership is fundamentally a leadership challenge. Leading is enabling others to face challenges and achieve results. Long-term health and development challenges require a critical mass of local leaders at all levels and in all parts of the health sector who are able to not only lead but also to collaborate and take ownership of health policy and practice.

In the context of country ownership, there is an implicit assumption that "ownership" requires "owners." Such owners, however, cannot be confined to the top leadership of central government, as ownership also requires action and support from leaders at the regional, district, and community levels, as well as across all sectors, including the private sector and civil society. In the health sector, a lingering challenge revolves around what needs to be done to facilitate or broker processes through which these leaders, especially across sectors, can work better together to share ownership of locally appropriate and legitimate institutions, policies, and programs. In other words, for country ownership principles to be translated into actionable practices, strong leadership within organizations and institutions and a high degree of collaboration among leaders of these agencies across the health and social welfare sectors will be required.

The role of leaders in any collaborative endeavor is to:

- Set direction and create common ground for people to talk, work and decide together
- Align teams, inspire and support others to identify and address challenges and produce results.

They do so by scanning their internal and external environments, consulting and listening; translating meaning across sectors and teams; and building common understanding with respect to information, evidence, and decisions under consideration. They also keep people focused on strategies or common good, and outcomes which helps to overcome vested or narrow interests.[5]

The two case vignettes on page 6 provide examples of ***proven practice*** for developing collaborative, developmental leadership to foster country ownership. The Zambia case demonstrates multi-sector ownership at the national level, while the Aswan, Egypt case shows the impact of a similar leadership approach at sub-national and local levels.

2. Sound management capacity

Typically, managing involves the practices of planning, organizing, implementing, monitoring, and evaluating the activities of an organization in accordance with certain policies in order to accomplish defined objectives and results. Without soundly led and managed local institutions and organizations, country ownership will fail to advance. In any country, irrespective of its social, political, cultural, or economic circumstances, it is institutions, organizations, and their teams that will ultimately plan and deliver lasting programs, services, and development actions. In many developing country contexts, local institutions (public, private, or CSO) will require additional management strengthening support before they effectively own and sustain their own programs

5. Chrislip, David D. and Carl E. Larson (1994): Collaborative Leadership: How Citizens and Civic Leaders Can Make a Difference. San Francisco: Jossey-Bass

BOX 1.

Leading together to address common challenges

ZAMBIA SECTOR ADVISORY GROUPS

In the late 90's, Zambia's public sector reform program was plagued by lack of coordination and ineffective multi-sector collaboration. Following the elections of 2001, a new administration came to power on the promise of good leadership, domestic accountability, and sound governance of public affairs, and it was committed to changing the status quo.

To assist in developing, implementing, and monitoring Zambia's strategy and national plan for poverty reduction, the new government established a system of sector advisory groups (SAGs) with representatives from civil society, the private sector, and donors. Each of the core sectors like health, education, agriculture, and mining had a sector advisory group assigned to specific tasks under the national poverty reduction strategy. The SAG leadership teams met regularly to share updates and review progress. The SAG teams' activities were characterized by a high degree of collaboration across sectors, and a sense of shared mission and common good—poverty reduction in the country. The SAGs worked so well that the government turned to them for proposals for a Millennium Challenge Corporation (MCC) compact or agreement. This process yielded 37 proposals representing five priority sectors; the ideas in several of these proposals were incorporated into the Zambia Compact with MCC.

Because the government of Zambia had brought varied stakeholders into the original development planning process, and aligned multi-sector developmental leaders, there was consensus on the national poverty reduction strategy and plan. Within this common understanding, the government continued to draw on the varied insights of SAGs representing every sector of society, to frame a successful proposal from a receptive donor.

Source: Millennium Challenge Corporation: Country Ownership—Principles into Practice, 2010

MAINSTREAMING AND SCALING UP LEADERSHIP DEVELOPMENT: THE CASE OF ASWAN, EGYPT

For ministries of health around the globe, growing and sustaining successful health programs are key challenges to producing stronger organizations and sustainable health improvements. In 2002, at the request of Egypt's Ministry of Health and Population (MOHP), USAID sponsored the first year of a new type of leadership development in the Aswan governorate. Co-led by the MOHP and Management Sciences for Health, the Leadership Development Program (LDP) they designed enrolled 10 teams with a total of 41 primary health care workers and focused on developing leadership in teams, over time, and at all levels from the governorate and district down to the primary health units at the village level. For the first time, ownership was put into the hands of local facilitators and participants. The program gradually took root and began to tap people's ingenuity and commitment. They realized that they could address specific service delivery challenges and achieve results, empowering them to identify and address other health care challenges in their communities and replicating the program.

As a result of internal improvements and selecting specific health challenges in the communities, service delivery improved. Antenatal care visits increased across the teams, with one team increasing its facility's average number of postpartum visits from 0.2 visits to 3.6 visits per woman. Of participating program teams, 75 percent of the original 10 health teams achieved 95 percent or more of their desired results, and 80 percent of the teams selected a new challenge without being prompted.

Click here to learn more: *http://www.msh.org/projects/lms/Documents/upload/Aswan_Seeds_Success.pdf#search=%22Seeds of Success%22*

This proven practice for strengthening leadership within organizations and institutions was fully owned by local teams and replicated many times to several other provinces in Egypt with Ministry resources.

"Sustainable country programs must be country-led, country-owned and country-driven. The country must be in the driver's seat at all times."

— Dr. Tedros Ghebreyesus, Minister of Health, Ethiopia.
Remarks during a Ministerial Leadership Institute High Level Panel, Washington DC, January 2012.

and organizations, and remain accountable to their mission and beneficiaries.

It is critical to strengthen the capacity of these institutions and organizations in areas such as:

- strategic thinking and planning
- financial and administrative internal systems and controls
- overall organization and project management
- management of performance-based grants or contracts
- procurement
- human resource management
- business planning, resource mobilization and diversification
- monitoring and evaluation
- community partners consultative processes
- knowledge and information management systems
- managing external donors and funding

The AIDSTAR-Two project has identified these areas of organizational growth and development through our consultations and engagement with local implementing organizations in many countries. Without adequate and evolving capacity in these and other necessary areas of management and institutional capability, local institutions that could otherwise be at the forefront of the country ownership drive, will in fact not be able to participate productively in their country's development process, let alone manage and sustain their own programs.

Effective capacity building is an endogenous process that takes years to evolve and mature, depending on the organization. The impulse and motivation for lasting change always needs to come from within. One common challenge is the tendency by donors and external capacity building program implementers to demand quick, sometimes superficial results that are tied to project or donor reporting timelines. This is especially challenging where in-house management capacity and structures for planning, decision making and change management are still immature and may have to be developed, often a longer-term process. There is ample evidence that taking time to develop sound management practices ultimately leads to capable local organizations that are able to render more effective and sustainable development results. [6]

The case vignette on the following page describes a ***proven practice*** that focuses on internal management improvements combined with technical capacity building, with performance-based contracting. The capacity building initiative in Honduras described below targets local HIV/AIDS CSO implementers that serve most at risk populations for HIV/AIDs.

6. INTRAC (2006) Learning from Capacity Building Practice: Adapting the "Most Significant Change" (MSC) to Evaluate Capacity Building Provision by CABUNGO in Malawi. ***http://www.intrac.org/data/files/resources/408/Praxis-Paper-12-Learning-from-Capacity-Building-Practice.pdf***

BOX 2.

Performance-Based Organizational Capacity Building for CSOs in Honduras

As international resources for HIV become scarcer, Honduras is assuming greater responsibility for its overall response to the epidemic. The HIV prevalence among men who have sex with men is as high as 10% in some parts of the country; is 4.6% among commercial sex workers; and 4.4% among the Garifuna population. Along with government, CSOs are often best positioned to expand the delivery of prevention services to reach vulnerable populations. Funded by USAID Honduras, the AIDSTAR-Two Project, in collaboration with local CSOs, has delivered a set of interventions to strengthen CSO organizational capacity by improving their financial, administrative and monitoring processes, and strengthening their service delivery systems. Through a competitive process, performance-based contracts are also provided to each CSO.

In 2009, a baseline study gauged the organizational capacity of CSOs and the knowledge, attitudes and practices (KAP) of their target audiences. Between 2010 and 2011, the CSOs developed and implemented action plans based on diagnosed needs, and received technical assistance through supportive supervision, M&E visits and workshops. Progress toward meeting targets for various indicators was analyzed and discussed with the CSOs monthly. Leadership and board strengthening activities were also implemented along with strategies to raise new funds. A mid-line assessment was conducted to evaluate the effect of these interventions and the impact of the prevention services delivered by these CSOs to their target populations.

The mid-line assessment showed an emergence of new mission-driven leaders in the CSOs, more engaged boards of directors, improved staff attitudes, and improved service delivery. CSOs reported that practical approaches and systematized tools allowed for the institutionalization of improved practices, team work, and organizational integration. The annual KAP studies found a positive change in the level of knowledge and the adoption of preventive methods (such as the correct and consistent use of condoms, accessing HIV counseling and testing, and postponing sexual debut). In 2012, the CSOs are achieving 100% of their targets for different indicators in the performance monitoring plans in their contracts.

This dual approach (technical and organizational) to capacity building and the use of requests for applications (RFAs) and performance-based contracts and monthly monitoring of progress (financial and progress toward achieving agreed upon targets) is an effective way of strengthening local CSOs to deliver high quality HIV-related services to most-at-risk populations in a decentralized manner and prepare them for RFAs and funding from other donors.

3. Governance and Accountability

Donors have channeled increased amounts of financial resources for health to civil society organizations and public sector institutions in recent years. The questions that some people are asking today include: are these local institutions ready for the influx of new, additional funds that will be funneled directly to them? How will they prepare and adapt to all the procurement changes that are taking place? Who will ensure accountability?

These concerns of institutional governance and domestic accountability, though legitimate, are not new. While donors, governments and even CSOs themselves aspire to a comprehensive view of this topic, accountability for some tends to boil down to the domain of finance. This narrow definition may partly be a consequence of the ease of establishing specific and quantifiable criteria for measuring financial management and accountability—such as passing pre-award audits, submitting regular financial

reports and having clean audits. But accountability needs to be understood more broadly, as it also encompasses producing high quality services, reaching segments of the population in need, and meeting agreed upon service delivery targets.

The ability of local citizens, at all levels, to have a voice and demand accountability is perhaps the most essential ingredient that needs to be strengthened for country ownership to take root—whether the discourse is on the public sector, the private sector, or civil society. It is also vital to understand the dimensions of accountability that could also strengthen governance and country ownership.

For example, when we look at CSO accountability, the following three basic dimensions of accountability can help shape our understanding:

- **Accountability vis-à-vis the CSO's mission:** As an institution committed to social change, a CSO needs to define, refine, and pursue a clear mission.
- **Accountability vis-à-vis the CSO's performance in relation to that mission:** Demonstrable performance, in financial, process and service outcome terms, is essential to generate feedback to the programs and approaches implemented in a given timeframe.
- **Accountability vis-à-vis the CSO's role in civil society:** Norms, rules, values and styles of functioning that match standards of being a good civic organization.[7]

7. Adapted from: "Board Games": Governance and Accountability in NGOs

Some of these dimensions are also applicable to public sector institutions.

Country ownership is enhanced when all local health sector organizations pay adequate attention to not only fiduciary but also non-financial and non-regulatory dimensions of accountability.

Performance-based financing is increasingly becoming a proven practice and a key element of health sector reform in developing countries. The example on the next page demonstrates that it is possible to improve services in poor countries by introducing market forces, and carefully balancing the use of clear, agreed-upon performance incentives, verifiable service standards and targets to promote mutual accountability.

An effective structure and process of governance for health sector institutions that sets and enforces ethical standards and values is required to foster country ownership. There is also a need to document, analyze, and promote good governance practices. Such interventions should be at the core of capacity building efforts needed to strengthen country ownership.

"Good governance is a transparent decision-making process in which the leadership of a nonprofit organization, in an effective and accountable way, directs resources and exercises power on the basis of their mission and shared values."

—Adapted from Marilyn Wyatt: A Handbook on NGO Governance (2004)

BOX 3.

Performance-Based Financing to Promote Accountability: The Experience of Rwanda

Performance-based financing is a contracting mechanism that is rooted in a simple premise: holding health service providers and their organizations accountable and rewarding them for positive results leads to additional positive results, which contributes to improved health outcomes. The USAID funded HIV/PBF Project started in 2005 with the objective of improving the access, quality, and efficiency of HIV clinical services while ensuring that incentives for HIV services did not negatively affect primary care services. After four years, the project not only achieved that objective, but also contributed to overall improvement in the quality and delivery of basic health services and the strengthening of the Rwandan health system.

The successful design and implementation of performance-based financing rested heavily on the Ministry of Health's leadership and commitment. Drawing on the positive lessons of four small PBF pilots in the country, the senior MOH leadership embraced the urgency of the task at hand and deftly managed the transition from multiple threads held by the various stakeholders to a single strand managed by the Ministry with the support of the stakeholders.

The PBF program was built on clearly defined, agreed-upon, measurable, and achievable goals. Effective coordination with all stakeholders and key partners was an important success factor, as were efforts to strengthen organizational and health system management components such as information technology, financial management, leadership, and governance.

Results from a 2008 World Bank-sponsored PBF impact evaluation revealed that overall care improved significantly in districts where PBF had been introduced. Also, according to data from the Interim Demographic and Health Survey (2007-08) and other sources, indicators measured by the HIV/PBF Project showed the following improvements in primary health care:

- An increase in the contraceptive prevalence rate among married women from 10 percent in 2005 to 36 percent in 2007-2008
- An increase in the percentage of births attended by skilled health personnel from 31 percent in 2005 to 52 percent in 2007
- A reduction in childhood mortality from 152 per 1,000 live births in 2005 to 103 per 1,000 live births in 2007
- Almost 100 percent increase in the average number of women per health center vaccinated against tetanus, an avoidable and often fatal disease.

Source: A Vision for Health: Performance-based financing in Rwanda, Management Sciences for Health

The Government of Rwanda has made peformance-based financing a national policy to be rolled out across all sectors, and work that has been done has served as a model for replication."

— Dr Luis Rusa, National PBF Director, Ministry of Health, Rwanda

The Health Systems Assessment Approach: A How-to Manual (Islam, 2007) suggests four broad dimensions of governance in the health sector. The box below provides brief descriptions of these dimensions:

DIMENSIONS OF GOVERNANCE

1. Information and assessment capacity: tracking and using information about health care and health system performance for planning and decision making
2. Policy formulation and planning: there is a functional planning process in place as well as consistency and coherence between health sector laws, plans and actual implementation
3. Social participation and system responsiveness: a broad range of stakeholders, including government and CSO representatives, are involved in planning, budgeting and monitoring health sector actions.
4. Accountability, transparency and regulation: health sector information such as plans, health statistics and fee schedules are published and made available. The sector is also able to oversee the quality of services and has the power to enforce guidelines, standards and regulations.

To learn more, click here and scroll to Chapter 3:
http://www.msh.org/Documents/upload/msh_eHandbook_complete.pdf

In the health sector, the Global Fund country coordinating mechanisms (CCMs) in each country are a good example of a multi-sectoral approach that encourages and promotes effective governance practices. These Global Fund CCMs include governments and many non-state actors.

Box 4 on the next page describes a ***proven practice*** that illustrates importance and results of good governance and accountability practices that promote country ownership in a multi-sectoral context:

BOX 4.

Investing in Governance for a common good: Ghana Global Fund Country Coordinating Mechanism

The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), is a multilateral donor with a unique approach to country-ownership and country-led development. The Global Fund doesn't design or implement programs; they leave this to the countries that are supported. The Fund's approach to county-led development is distinguished by a unique decision-making structure and an unrelenting focus on performance at every stage of program development. Decisions on how Global Fund resources are used are made by developing country governments and civil society.

The Global Fund requires beneficiary countries to establish a country coordinating mechanism (CCM) to administer the funding with at least 40 percent of its members drawn from civil society. The CCM model brings together multiple stakeholders to collectively identify country needs, design programming, and oversee implementation of Global Fund-supported grants. The CCM is a governance model that recognizes that many kinds of groups and people—including government agencies, private sector, providers, civil society, researchers, and affected communities—must be engaged in planning and optimizing resources to deliver services.

In its early days, the CCM in Ghana was often cited as a successful example of multi-sectoral collaboration. Ghana had one of the best implementation records of GFATM projects. For example, it was the first country in the world to fulfill the conditions for disbursement dating back to 2003. The CCM was originally established "hurriedly" in 2002, primarily to meet the very tight deadlines for the development of the first proposal to the GFATM and also to fulfill the GF requirement that proposals must be developed and submitted through a multi-sectoral mechanism. However, in 2003, the CCM moved rapidly to create a Bylaws Task Team headed by the private sector representative to develop draft CCM by-laws based on the GFATM guidelines on the purpose, structure, and composition of Country Coordinating Mechanisms. The provisions of the by-laws were subsequently implemented, including the establishment and staffing of a CCM secretariat.

Several factors played a critical role in the success of Ghana CCM's multi-sectoral engagement, including:

- The government of Ghana's genuine commitment to scale up the national response to the 3 diseases
- The government's belief in the value of public-private partnerships and willingness to involve civil society
- Ghana's successful ongoing experience with sector-wide approach (SWAp) in the health sector—a common-basket funding and planning mechanism that requires the collaboration of several partners
- Early integration of the GFATM programs into national strategic plans and existing systems
- A strong secretariat and regular CCM meetings
- Seamless and open communications
- Participatory decision making. The CCM functions in a democratic way, each member has a voice, and representatives of all sectors feel ownership and their contributions are valued.

Source: Ghana Country Coordinating Mechanism: A Case Study, The Global Fund, 2003

Genuine consultation, client engagement and participation

At its core, country ownership is embodied in partnership.[8]

The design, implementation and effectiveness of interventions in any of the three practices (collaborative leadership, sound management capacity, governance and accountability) can be enhanced by a process that promotes genuine consultation and participation of local health sector organizations and institutions. These two commonly used terms—consultation and participation—are like two sides of the same coin, but they do not necessarily mean the same thing.

Typically, we consult in order to solicit the input and expertise of local stakeholders. All the available evidence from decades of development experience by donors, NGOs and public sector entities suggests that participatory approaches provide the foundation for sustainable development, and consultation and engagement are key components of participation.[9] Effective and ongoing consultation and engagement that encourages a diversity of input, combined with committed participation of all key local stakeholders who are well informed and grounded in the local context, are important pillars upon which country ownership should rest.

On the other hand, activity-driven, one-off stakeholder engagement events that rely on prepackaged tools and methodologies that are often not tailored to the needs, values, and beliefs of the target audience, may represent a common weakness that continues to pose challenges to this process. In order to plug this "client engagement gap" and ensure successful country ownership—what may be required is a strategically organized process that creatively combines consultation and participation, and weaves in relevant aspects of indigenous knowledge, expertise and leadership to promote effective engagement and commitment of local stakeholders.

In real settings, such a process may actually require considerable levels of dialogue and analysis, and as a result may appear slow, unstructured, uncertain and iterative. But, in the end it may be a more effective engagement methodology that will generate not only trust and legitimacy with local actors but also eventually provide space for the emergence of home-grown solutions and sustainable results. And since participation is always about people and the way we interact with them, we need to actively and patiently listen to them rather than try to hurriedly fit their inputs into a universe that we understand.[10]

Box 5 on the next page is an example of a ***proven practice*** used in Tanzania and elsewhere that highlights that client engagement or participation is not so much "who tells whom what to do," as it is about building a two-way partnership, and the power to decide, instead of the power to carry out what others have decided for you. ■

8. Millennium Challenge Corporation, 2011. *Principles into Practice: Country Ownership.* ***http://www.mcc.gov/documents/reports/issuebrief-20110020942O1-principles-country-ownership.pdf***

9. InterAction, 2011. *"Country Ownership: Moving from Rhetoric to Action"* ***http://www.interaction.org/country-ownership***

10. Rifkin, 2009. Lessons from community participation in health programmes: a review of the post Alma-Ata experience. ***http://www.internationalhealthjournal.com/article/S1876-3413(09)00002-3/fulltext***

"We cannot own or implement what we did not create."

— Professor James Ole Kiyiapi, former Permanent Secretary in the Ministry of Medical Services, Kenya. Remarks made at a meeting in Washington, DC September 2009

BOX 5.

Deciding Together, Working Together: The Experience of the National Council for People Living with AIDS (NACOPHA) in Tanzania

Registered in 2005 and headquartered in Dar es Salaam, the National Council of People Living with HIV (NACOPHA) is an umbrella organization of all individuals, groups, organizations and networks of PLHIV in Tanzania. Since its inception, the council has registered 12 national networks of PLHIV and 74 PLHIV district clusters. The district PLHIV clusters are structures through which NACOPHA coordinates programs and activities that are implemented in support of PLHIV in the country.

AIDSTAR-Two received a draft scope of work from NACOPHA through USAID Tanzania. The request for technical assistance was rationalized, prioritized and finalized in consultation with the NACOPHA executive director, his staff and the board chairperson. The first activity involved the development of a new 4-year strategic plan, using a local consultant identified by the client. This involved a series of activities including a two-day skill building workshop on the principles and practices of strategic planning. The second activity, following a similar process, involved the development of an advocacy and communications plan. The final activity is the development of a resource mobilization and sustainability plan.

This program of assistance for NACOPHA, implemented over a period of 10 months, generated some interesting lessons in client-engagement, consultation, and participation in the planning and delivery of technical assistance. In this case, NACOPHA:

1. generated the request for technical assistance
2. actively participated in the identification of suitable local consultants for each assignment
3. carefully managed the stakeholder invitation process
4. identified the best workshop venues to maximize attendance, and determined the timing and sequencing of the activities to fit their schedule, absorptive capacity and other needs
5. contributed to the plans and strategies, reviewed all drafts that the consultants produced and signed off on every final product.

What this meant was that, sometimes, AIDSTAR-Two was ready to move an activity along quickly but NACOPHA was not ready, and the project had to adjust and move at the client's own pace. Such an approach that puts the onus on the client to create and articulate the "demand" for donor funded technical assistance, and actively manage the entire process, helps to foster genuine ownership and commitment on the part of the client—an important ingredient for the effectiveness of technical assistance.

Participation is a topic that beneficiaries of aid or technical assistance are always eager to discuss. People in organizations and institutions want and expect bigger roles in assistance efforts that are intended to improve the performance of their organizations. But they want "real" rather than rhetorical participation or consultation, which in most cases is nothing more than the validation of strategies or decisions that have already been made by projects or the use of tools and approaches that may not fit or relate to the organization's top capacity building challenges and priorities.

One important aspect that characterized engagement with NACOPHA was that both partners considered themselves as equal partners, allowing them to play active roles in the entire project cycle, expanding their space to manage, influence and provide meaningful inputs at every stage: from identifying needs, determining priorities and timelines, mobilizing and aligning stakeholders, to developing and finalizing the final products. When local organizations experience change and improved organizational processes and systems in which they have a voice, and they feel that they contributed to the creation of the solutions being implemented, they are more likely to own, manage, and sustain that change.

IV. SHIFTS IN PERSPECTIVES AND PRACTICE TO STRENGTHEN COUNTRY OWNERSHIP AND ORGANIZATIONAL CAPACITY BUILDING

Succeeding in all the three practice areas (collaborative leadership, sound management and governance and accountability), and ensuring that they are always underpinned and facilitated by genuine consultation, client engagement and participation will not always be easy on the ground.

True country ownership of development initiatives implies new understandings and behaviors for both country partners and donors. The tables below provide examples of some of those broad shifts than need to happen over time.

Country partners shift from . . .	to. . .
Prescriptive development priorities and activities that are top-down, unclear, not evidence-based, and not commonly understood among stakeholders: government officials, parliamentarians, civil society, and donors	A bottom-up, inclusive process in place for all stakeholders to discuss and agree on evidence-based development priorities as a framework for policies, strategies, and activities
Government making development decisions alone without adequate input from other stakeholders	A multi-stakeholder process for capturing input from local communities and civil society groups into development decisions
Financial and programmatic monitoring and reporting mechanisms that are lacking in transparency and accountability	A transparent and accountable process with clearly defined structures and measures for monitoring and reporting results and impact
Institutionalized bureaucratic procedures and protocols that delay or prevent timely implementation of significant change	Updated and simplified internal procedures and routines that support change management and foster country ownership

Donors shift from . . .	to. . .
Contradictory views of country ownership among different donor levels, agencies, and locations	A common, practical and contextualized understanding of and vision for country ownership among donor levels, agencies, and locations
Country ownership seen as a low priority	Country ownership as a long term policy priority for donors
Inconsistent or onerous aid delivery mechanisms, conditions, and requirements that confuse implementers and impede country ownership	Processes streamlined and requirements contextualized to support country ownership
Safeguarding and playing an operational role within their own systems	Willing to take risks, encourage innovation, and play a technical assistance role in support of the country's systems
Final decisions on resource allocation between priority programs are made unilaterally	Resource allocation priorities and process are transparent and the country partners have oversight on stakeholder resource allocation activities

Similar shifts also need to happen, over time, when it comes to capacity building. If done well, the process and practice of institutional capacity building, should lead to self-reliance, national ownership, and sustainability. Yet practice in this field, in most cases, may fall short of this promise. The table below outlines examples of the kinds of capacity building conceptual and practical shifts that are required to promote ownership and lasting organizational and social changes:

Capacity building providers shift from . . .	to. . .
Organizational capacity building assessments that have neither been requested nor sanctioned and fully supported by the leadership of the local organization	Guided inquiry and client engagement processes to identify and verify needs as well as planned improvements that are defined and carried forward by the implementing local organization, with the guidance and assistance of any external partners as needed
Supply-driven technical assistance and capacity building efforts that fail to invest in client engagement, collaboration, and co-creation of tools, solutions, and approaches	Demand-driven capacity building efforts in which local organizations work collaboratively with any external capacity building provider to identify, participate in, co-create, and potentially endorse the key concepts, tools, and approaches of any external technical assistance
Transfer of capacity building approaches, tools, and methodologies that may have worked in other contexts, and trying to replicate them in a totally different context	Careful selection and adoption of capacity building approaches, tools, and methodologies, based on the context in which the organization, team, or individual operates and its current level of capacity
Use of approaches, tools, and methodologies that are lacking in evidence of impact and appropriateness	Capacity building approaches, tools, and methodologies are designed or selected based on proven evidence of impact and appropriateness for the type of organization, setting, and needs
Design and implementation of capacity building interventions with no indicators to measure progress, effectiveness, and impact	Careful selection of a suite of indicators to measure progress toward achieving capacity building results and impact

Capacity building beneficiaries shift from . . .	to. . .
Capacity building seen as a low priority that is left to donors or other external agencies to handle	Capacity building seen as everyone's business and as a long term policy priority for the organization
Inconsistent or incoherent demand for capacity building support and technical assistance	Mechanisms for demand-driven capacity building streamlined and contextualized to support organizational growth and sustainability
Capacity building plan that is primarily donor funded and characterized by ad hoc off-site workshops and training programs that focus narrowly on the skills and competencies of individuals	A coherent capacity building plan that focuses on individual, team and organizational performance improvements, and with a line budget to support implementation
Senior leadership not fully committed to capacity building plan and processes	Senior management fully committed to the plan and providing ongoing leadership, management, and technical support
Strengthening the capacity building evidence base is not a high priority	All those involved in capacity building prioritize the documentation, dissemination, and application of lessons learned and proven practices in this area and share this information

V. CONCLUSION

"In this field of CSO capacity building, business as usual is no longer tenable."

— Kelvin Storey, Executive Director, Regional AIDS Training Centre. Remarks made at the Inaugural Africa HIV/AIDS Capacity Building Partners Summit, Nairobi, Kenya 2011

While there are no simple answers to the issues and questions raised in this technical brief, no one can discount the fact that country ownership—a process by which countries decide, plan and direct their own development paths—is the cornerstone of sustainable development. Effective, efficient, home-grown policies and programs that are adapted to local realities and needs as well as nationally developed and implemented accountability mechanisms can assist countries to tap and maximize external development assistance resources. Those policies, programs and mechanisms must have "owners" and leaders, as it is the absence of ownership that makes the development process fail to meet the critical tests of relevance, inclusiveness, and demonstrated effectiveness of impact—all essential ingredients for sustainable development.

There is widespread agreement on the gap that still exists between the theoretical or conceptual understanding of country ownership and actual practices at the country level. Experience has also shown that some define country ownership too narrowly, principally focusing on ownership by the national government, irrespective of whether it is legitimately elected or representative of all segments of society, rather than the authentic participation of wider civil society groups and other actors. Perhaps the most fundamental question that needs to be tackled is: How can country ownership be promoted and progressively supported through donor funded projects in the health sector?

The answer to that question, partly, lies in demand-driven capacity building programs targeting institutions and organizations within the health and social sectors that are designed by the full and genuine participation of the country actors including public sector institutions as well as civil society organizations, to meet their identified needs and priorities, and focusing on medium and longer-term impact. The process will play out differently in different contexts. In order to make this happen, organizations and institutions in developing countries also need to invest in their human capital, adopt effective strategic approaches to identify and articulate their capacity building needs, and put in place appropriate institutional arrangements to plan, absorb, implement, monitor, and evaluate externally funded programs to ensure that they respond to their priority needs. [11]

Global and national players alike may have to move beyond rhetoric to ensure that necessary shifts in behavior among key players happen and that structural changes are put in place, both globally and locally, so that developing countries can truly assume ownership of their HIV/AIDS and other health and development policies and programs. At the end of the day, real development is about the decisions, behaviors and visions of the people of every developing country, and external development assistance is a tool or catalyst that can facilitate the creation of that reality. ■

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