

Unpacking Country Ownership: A Call to Action

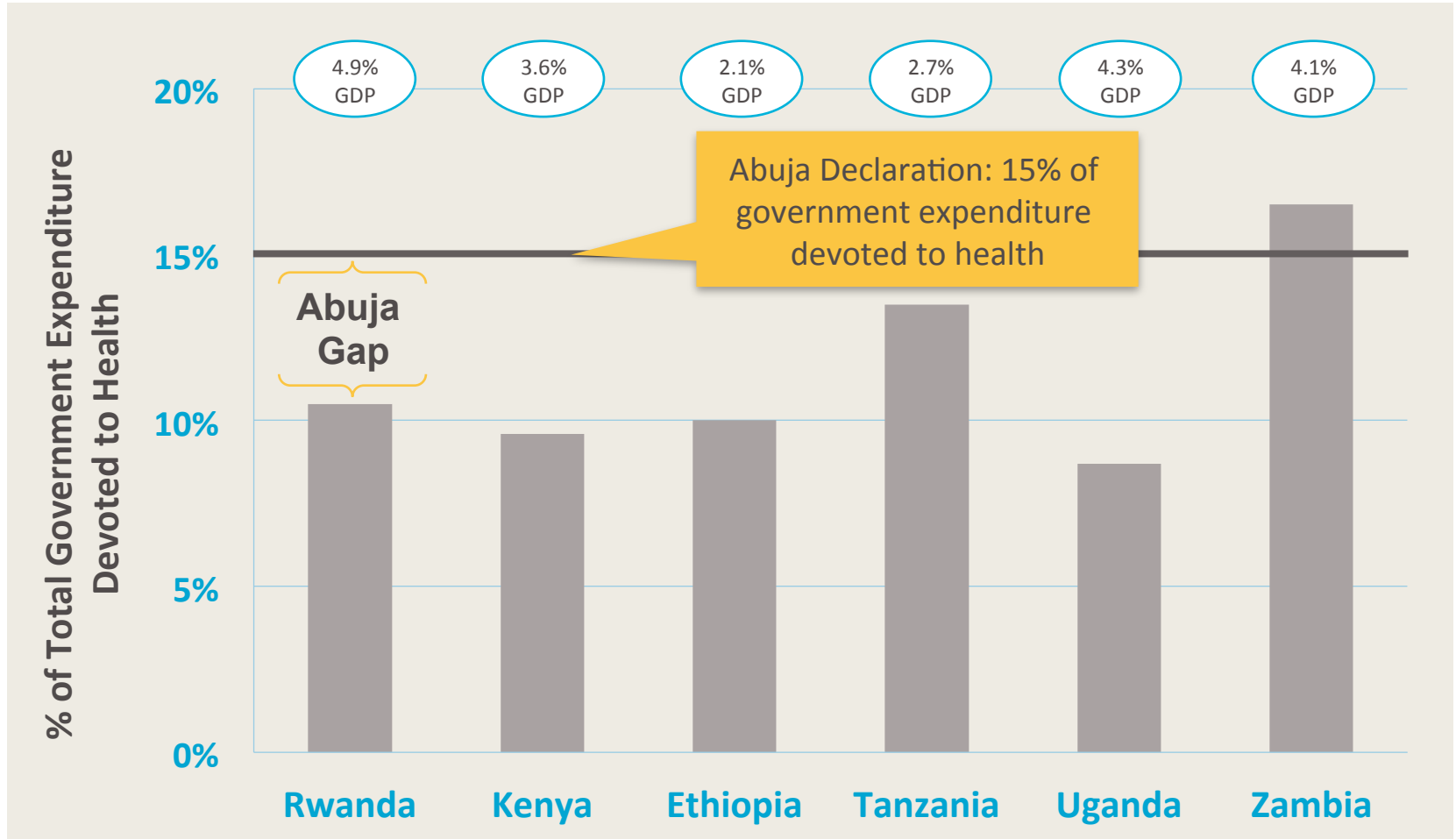
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Yogesh Rajkotia, PhD
Managing Director, ThinkWell

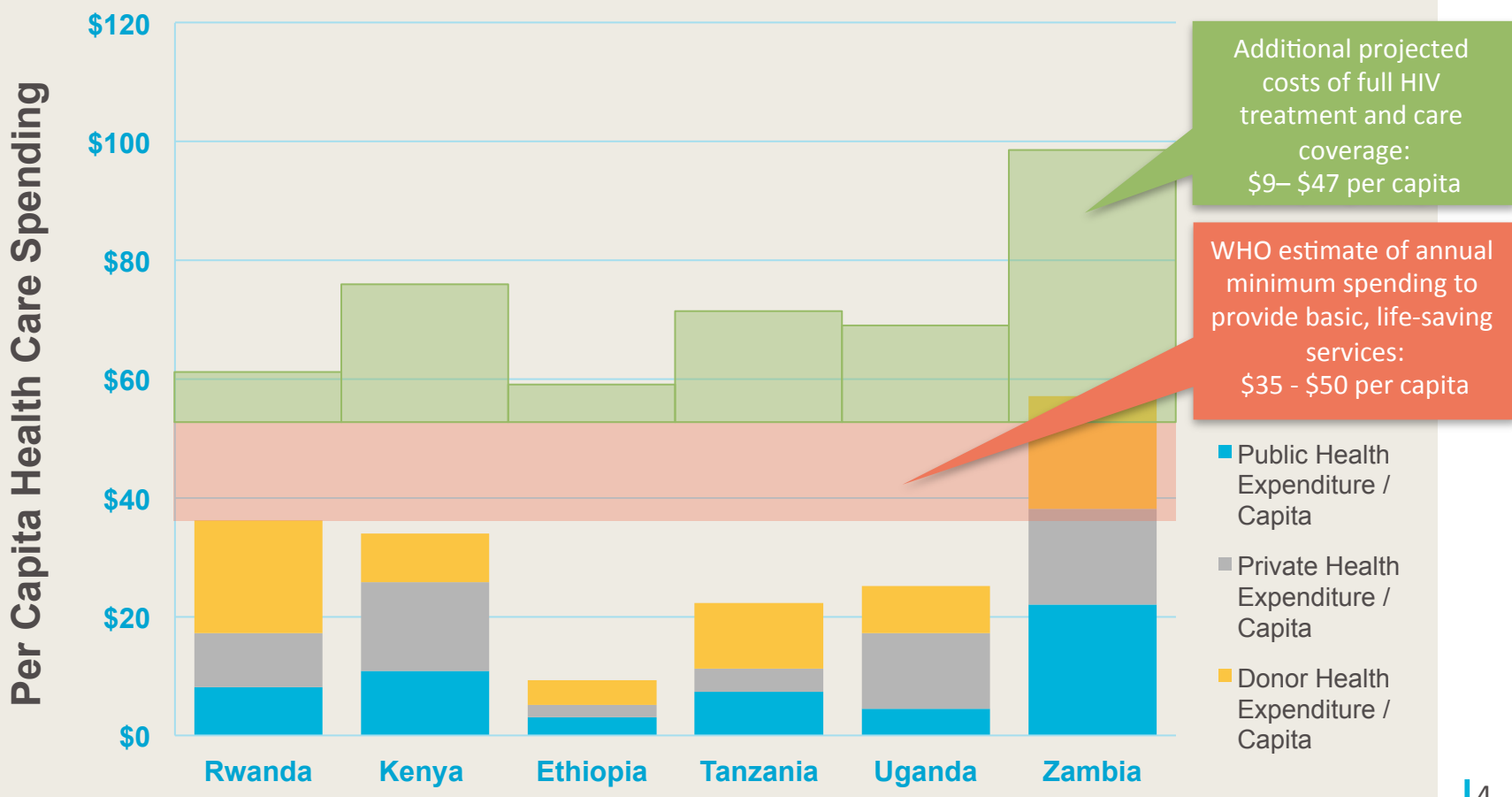
OBJECTIVES

1. Define and unpack country ownership
2. Discuss HSS approaches to enhance country ownership
3. Recommend way forward for USG Implementing Partners

POTENTIAL FOR ADDITIONAL PUBLIC FINANCE IS LIMITED...



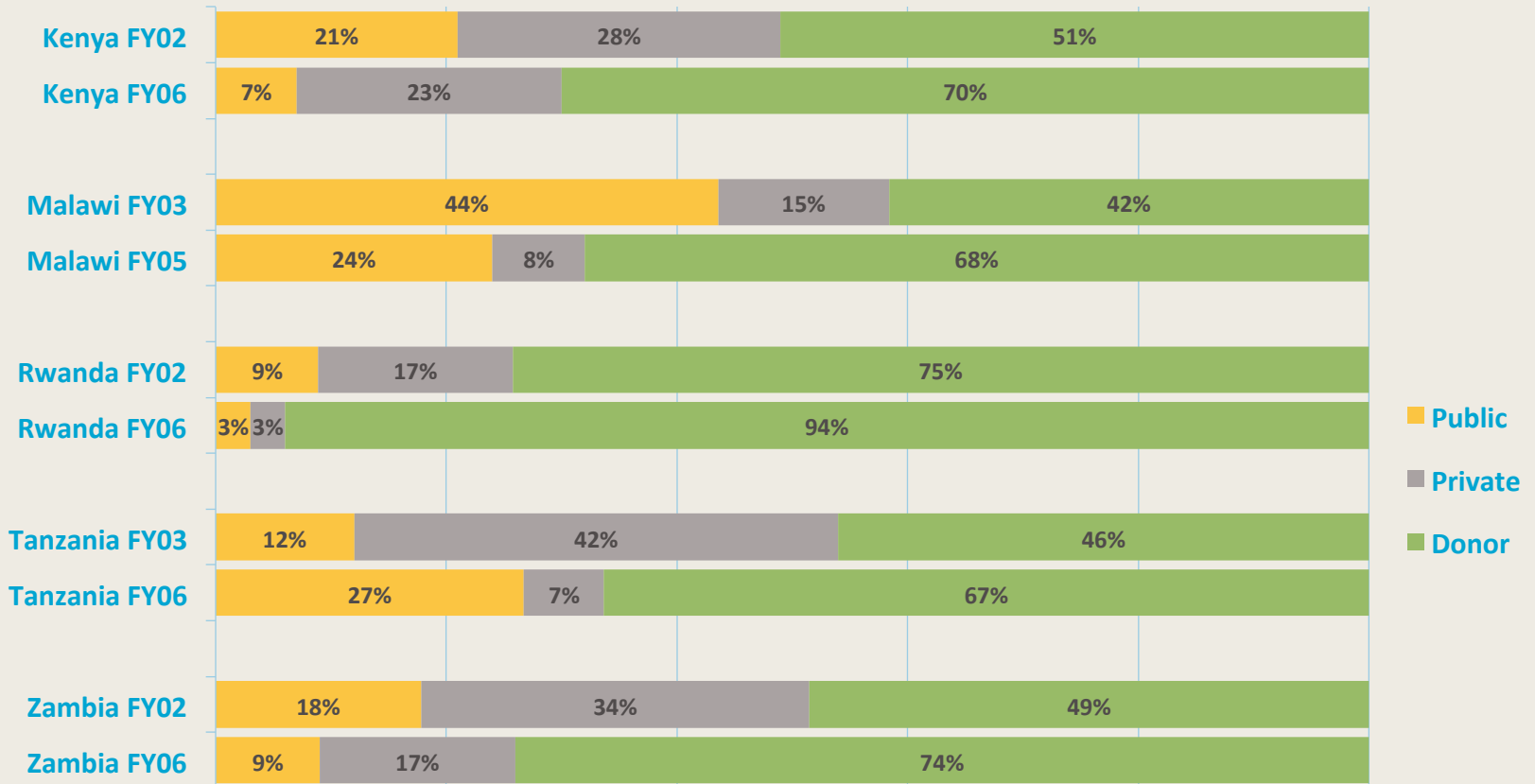
...YET RESOURCE REQUIREMENTS FOR HEALTH REMAIN SIGNIFICANT



Sources: Health Expenditure: 2007 World Development Indicators (WDI) Data
 HIV Costs – (Bollinger, Stover 2007); Rwanda 2010 Budget, MINECOFIN

DOES LACK OF PUBLIC FINANCE EQUAL LACK OF COUNTRY OWNERSHIP?

Relative Share of Financing Sources of HIV/AIDS Health Care



Source: HIV/AIDS Sub-Accounts

HOW IS COUNTRY OWNERSHIP DEFINED?

- Partner countries exercise effective leadership over their development policies and strategies” – Paris Declaration
- “Sufficient political support (exists) within a country to implement its development strategy.” and “demand is driven by the country” – World Bank
- “Broad participation of all stakeholders in countries’ development and...all parts of society take part.” – European Commission

UNDERSTANDING OWNERSHIP BY UNPACKING SUSTAINABILITY

1. Institutional Sustainability:

- Prevailing structures and processes (public and private) have the capacity to continue to perform their functions over the long term
- USG assistance works effectively through national systems and services

2. Political Sustainability:

- USG priorities are shared and championed by the political leadership
- USG priorities are governed by national policies and plans and are not vulnerable to changes in political leadership

3. Social Sustainability:

- Sufficient demand for priority services is generated and priority services are culturally and socially accepted

4. Financial Sustainability:

- Ability to maintain the required level of resources for a particular priority over time in a predictable manner, independent of financing source

HEALTH SYSTEMS APPROACH IS CRITICAL

- 1. Perspective broader than individual facility level**
- 2. Health interventions conceptualized in a broader institutional context**
 - Ex/Governance, organizational development
- 3. “Process” recognized as an important driver of institutionalization**
 - Not just “what” is achieved, but “how” it is achieved.

CHALLENGE 1: HEALTH WORKERS LACK CLINICAL COMPETENCE

Traditional Response	Deliberate Health Systems Approach
<ul style="list-style-type: none"> • In-service training financed and delivered by USG clinical partners (\$310 million FY08) 	<ul style="list-style-type: none"> • Capacity to provide in-service training institutionalized locally • Policy mandate and regulatory standards for regular in-service training enforced • System for regularly providing in-service training in place • Strengthen system of pre-service training (\$45 million FY08)

CHALLENGE 2: HEALTH WORKERS NOT INCENTIVIZED FOR OUTPUTS

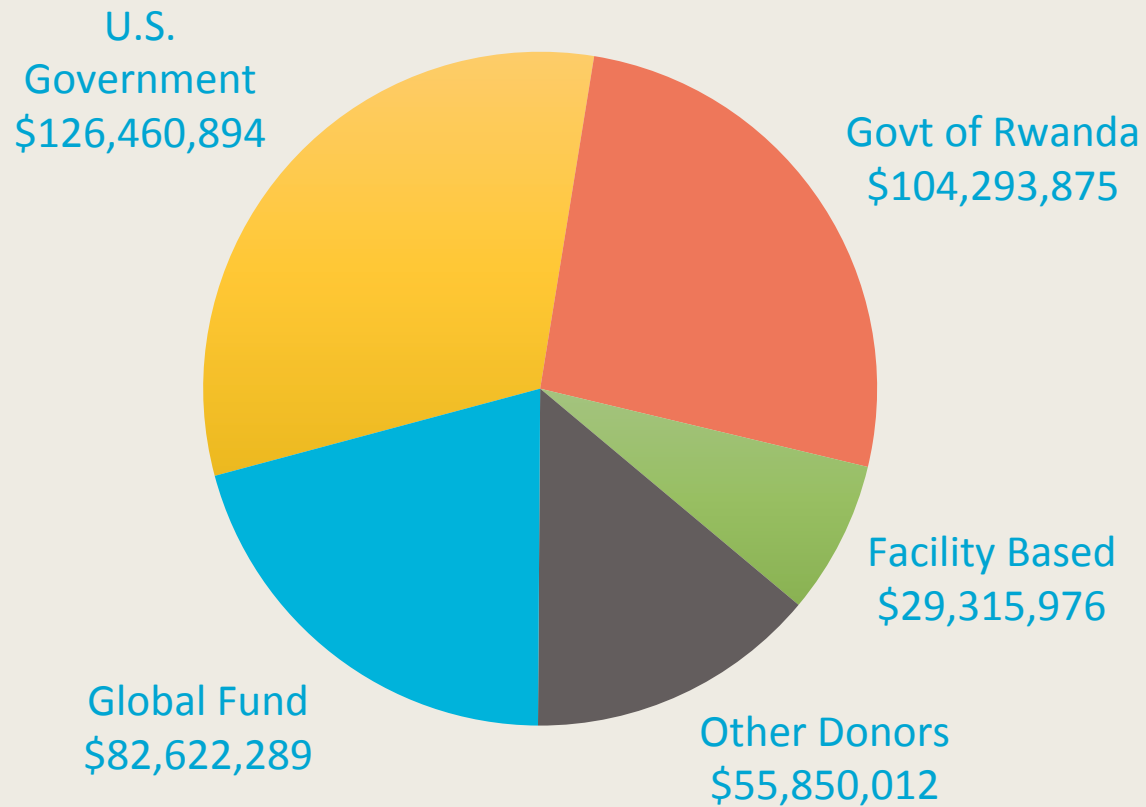
Traditional Response	Deliberate Health Systems Approach
<ul style="list-style-type: none">• Establish pay-for-performance mechanism in which USG partner develops indicators, monitors output and pays incentives• Capacitate local entities based on pre-existing relationships instead of reinforcing role of appropriate players	<ul style="list-style-type: none">• Establish pay-for-performance system in which appropriate local entities monitor & validate results• Develop indicators jointly with local and national officials• Capacitate and finance MOF to pay performance bonuses

CHALLENGE 3: FINANCIAL BARRIERS REDUCE DEMAND FOR HEALTH SERVICES

Traditional Response	Deliberate Health System Approach
<ul style="list-style-type: none"> •USG partner develops voucher system for targeted services •USG partner provides free services for PEPFAR-supported sites •USG partner pilots and administers health insurance 	<ul style="list-style-type: none"> •Direct finance into health insurance mechanism (if exists), supported by TA •Work with local officials to develop district voucher program, not site-specific •Improve availability and use of evidence to increase health budget •Civil society/media pressure to increase health funding

USG SHARE OF FINANCING INTO THE HEALTH SECTOR

RESOURCE ENVELOPE FOR HEALTH: 2010



CHALLENGE 4: COUNTRY COORDINATING MECHANISMS WEAK

Traditional Response	Deliberate Health System Approach
<ul style="list-style-type: none">• Focus on delivering USG programs rather than waste time in cumbersome coordination meetings• Bi-laterally negotiate with government or other donors for collaboration	<ul style="list-style-type: none">• Participate in coordination mechanism or SWAp, providing TA to improve overall governance and management if needed• Use SWAp as forum to coordinate with other partners and GOR, rather than bi-laterally• Open programmatic approaches to scrutiny of SWAp members

CHALLENGE 5: MTEF, MBB AND MOH BUDGETS ARE FOREIGN CONCEPTS

Traditional Response	Deliberate Health System Approach
<ul style="list-style-type: none">• Ignore MTEF, MBB, and MOH budgeting process• Set priorities based on USG assessment of needs• Develop reporting structure that does not communicate with MTEF or MOH budget categories	<ul style="list-style-type: none">• Harmonize USG reporting requirements to MTEF and MOH budget codes• Use national priority setting exercises (such as MBB) to set USG priorities

CHALLENGE 6: FIXATION ON INDIVIDUAL “SITES” INSTEAD OF SYSTEMS

Traditional Response	Deliberate Health System Approach
<ul style="list-style-type: none">• Focus on improving service delivery in “our sites”• Acknowledge existence of district administration and inform them about our assistance• Little to no focus non-adopted ‘sites’ within same district• Bi-laterally monitor performance	<ul style="list-style-type: none">• Adopt a district-wide approach• Build district capacity to provide or manage health services• Embrace systemic approaches that bolster more than the adopted ‘sites’ in a district (ex/drug distribution)• Work to ensure district-led performance monitoring

CHALLENGE 7: USG RACE TO PROVIDE DIRECT SUPPORT TO COUNTRIES

Traditional Response	Deliberate Health System Approach
<ul style="list-style-type: none"> • Focus on direct counterparts (NAC, MOH) and ignore other players (MOF, MinLoc) • Directly finance health agencies to undertake roles that may or may not be in their mandate • Bi-laterally monitor performance of recipients 	<ul style="list-style-type: none"> • Understand financing flows within entire public system • Understand appropriate role of each agency • Assess capacity of main financing agent to disburse funds • Engage with sector budget support donors to develop a joint monitoring system

WHAT DO THESE EXAMPLES HAVE IN COMMON?

- All use host country systems whenever possible
- All are less “interventions” and more approaches
- All mandate joint conceptualization planning & design
- All are based on a solid understanding of the overall system, even beyond health
- All involve a large LOE towards external relations
- All are based on an institutional perspective to health interventions
- All involve greater attention to “process”

WHAT WILL COUNTRY OWNERSHIP REQUIRE OF YOU?

1. Tolerance & patience:

- Tight coordination with donors and host-country governments takes time and energy from what we normally consider our ‘real jobs’

2. Longer-term horizon:

- Building institutional, social and political ownership, in contrast to an emergency/relief approach, requires a medium to long-term perspective.

3. Flexibility:

- Priorities not wholly controlled by us are riskier and less within our manageable interest. We must accept this as an artifact of country ownership.

WHAT WILL COUNTRY OWNERSHIP REQUIRE OF US? (CONTINUED)

4. Broader perspective:

- Understand that process, often painful, is critical to developing political ownership
- Value good governance as a fundamental component of good health programming

5. New skills:

- Mechanics of SWAps, sector budget support, and other national/international alignment mechanisms
- Understanding the systems, checks-and-balances and organizational structure of the entire country system, not just the sub-area we focus on

USAID COOPERATING PARTNERS: THE KEY TO REFORM

Do's	Don'ts
Engage in dialog with USAID to advocate for a HSS approach to implementation	Acquiesce to USAID requests for the “traditional approach” or support the status quo because it is easy
Enter global & USG dialog with evidence of HSS vs. non-HSS	Abdicate your responsibility for global leadership
Leverage your global implementation experience to ‘fill in’ principles of GHI	Assume that GHI is a closed process
Demand guidance on GHI where it is unclear by offering your own interpretation	Operate in the unaccountable ‘grey area’ of undefined technical guidance

CHANGE COMES FROM WITHIN...

Do's	Don'ts
Rigorously assess whether your approach is building country ownership	Label everything as HSS
Recognize that the HSS model of health development requires both public health and development expertise	Assume that public health experts can 'figure it out'
Apply an HSS perspective to everything – from service delivery to social welfare protection	Believe that your work is service delivery, therefore HSS does not apply to you
Internalize and accept that USAID is evolving and needs your help in regaining technical competence	Operate assuming that all technical thinking and leadership has been outsourced to you
Advocate to USG & other CAs to have a harmonized activity-based budget for in-country planning	Continue with your own systems that do not map to that of the host country

HARMONIZATION: FUNDAMENTAL TO COUNTRY OWNERSHIP

“If you plan with us, if you implement with us, if you report with us, then you are harmonized with us.”

Honorable Minister Richard Sezibera; Minister of Health, Government of Rwanda