Advancing Country Ownership:
Civil Society's Role in Sustaining Public Health

KEY POINTS IN THIS REPORT

- Donor governments and foundations have made substantial investments in global health, and civil society has played a key role in maximizing their impact. In the implementation of country ownership, the participation of civil society will be essential to ensure that these investments continue to pay off.

- As international development aid structures are transitioning toward a country ownership model, the role of civil society remains ill defined. The role of civil society as an essential development partner must be affirmed and codified.

- "Country" should not be defined as "government," but rather must include all stakeholders, including civil society. As governments are ultimately responsible to citizens, civil society should be empowered to hold governments accountable for the delivery of health services.

- Above all, protecting and improving the health status and human rights of vulnerable and marginalized populations must be the priority. As the primary representative for key populations, civil society must participate at every stage of the development process, from program planning and design to resource allocation, program implementation, monitoring, and evaluation.

- Sustained capacity-building focused on institutional and programmatic strengthening will be essential to confer sufficient skills to civil society to participate in every stage of development, and for governments to partner effectively.

- Civil society organizations remain accountable to the communities from which they derive authority. As such, they are obliged to act with integrity, maintain transparent and accountable governance, and always act in the best interests of the populations they represent.

- While the move toward country ownership seems inevitable, and remains a commendable goal, without its careful and thoughtful implementation there is the risk of undermining the civil society engagement that has proved so critical to global health responses to the detriment of vulnerable and marginalized populations.

Foreword

In September 2012, four organizations with shared interests in family planning, reproductive and sexual health, maternal health, and HIV/AIDS (amfAR, The Foundation for AIDS Research; the Health Policy Project, a USAID-funded project of Futures Group; the International Planned Parenthood Federation Africa Region; and the Planned Parenthood Federation of America) joined forces to convene a multi-disciplinary consultation in Washington, D.C., Advancing Country Ownership: Civil Society's Role in Sustaining Global Health Investments. The organizations invited a diverse array of stakeholders to (1) consider the implications for civil society's role in the ongoing transition of development aid programs to a country ownership model, and (2) discuss ways in which civil society might participate as a partner in the country ownership paradigm, thus maximizing its potential as the representative for populations disadvantaged by poverty, marginalized due to stigmatization, or vulnerable to discrimination. This report builds upon those conversations and incorporates additional research. The views expressed are solely those of the sponsoring organizations.

Introduction

"Country ownership" broadly refers to the end point in a transition from a donor-led development process to one featuring greater participation of in-country stakeholders. During this transition, key stakeholders—primarily the government and civil society—begin to take the lead in (1) drafting and monitoring development plans and priorities, (2) coordinating aid, and, with respect to health programs, (3) using country health systems for aid delivery. The concept of country ownership is not new. During the 1990s, the World Bank and International Monetary Fund began shifting focus to a development paradigm that emphasized *good governance*—itself a response to failed market-driven development policies of the 1980s.

While there is widespread international commitment to the concept of country ownership, many practical aspects, in particular the role of civil society, remain to be defined and are at times contested. Within the international development system, civil society organizations (CSOs) function as the primary representative of populations that are often marginalized and made vulnerable by stigma and discrimination. This includes women and girls, young people, people living in poverty, people with HIV, racial and ethnic minority groups and indigenous peoples, workers, people with disabilities, migrants, displaced populations, gay and transgender people, sex workers, and people who use drugs. By ensuring that these populations have a voice, CSOs strive not only to ensure their access to comprehensive health and other essential services, but to make certain that such services are of high quality, respectful, responsive to community needs and concerns, and offered and delivered in non-coercive ways that recognize health as a human right.

> CSOs help to enable marginalized and vulnerable populations to determine their own needs, and to maximize their potential to act as agents of change on their own behalf. At their best, CSOs "support grassroots experiences of people engaged in their own development efforts; are both donors and practitioners of development; promote development knowledge and innovation; work to deepen global awareness and solidarity among people across national boundaries; and advocate and seek out inclusive policy dialogue with governments and donors to work together for development progress."[1]

The integration of civil society in the development process has not been without challenges, however. For example, in instances where CSOs track funding allocations, monitor the quality of care in service delivery systems, and advocate for policies that expand access to services for marginalized or vulnerable populations, governments often neither welcome nor agree with the CSOs' conclusions and recommendations. As a consequence, the nature and extent of civil society participation in every level of the development process (planning, finance allocation, implementation, and monitoring of both program outcomes and finances) remains largely context-specific and a function of how receptive respective governments are to civil society.

While civil society participation has long been a hallmark of global health development programs—particularly family planning, sexual and reproductive health (SRH), maternal health, and HIV programs—it is essential to more carefully consider and define how civil society participation should function in order to achieve country ownership. Given the pivotal role of CSOs in the planning and implementation of family planning, maternal health, and HIV programs to date (see also Appendix 2: History of Country Ownership, p. 22), their inclusion will be vital to the success of the country ownership process.

Current Practice: The United States Government Approach to Country Ownership

Donors—including multilateral funders such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), as well as national governments, including the United States Government (USG)—have undertaken implementation of a country ownership approach in various ways. In the United States, the Obama administration has consistently expressed its commitment to country ownership principles, and most U.S. programs have incorporated the language of country ownership into program plans—including the Millennium Challenge Corporation (MCC), the U.S. Agency for International Development (USAID) family planning programs, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and, most recently, the Global Health Initiative (GHI).

MCC was the first USG program to explicitly incorporate country ownership principles. MCC selects partner countries based on their history of good governance, requires them to develop a constraints analysis (that identifies disincentives for households and firms to invest in strategies to increase income), and divests control of a five-year budget and implementation plan (i.e., compact) to the country. MCC looks to country governments to establish accountable entities—called Millennium Challenge Accounts—to lead implementation. MCC defines country ownership as follows: "When a country's national government controls the prioritization process during compact development, is responsible for implementation, and is accountable to its domestic stakeholders for both decision-making and results." Importantly, MCC notes that ownership is an evolving process and that governments are ultimately accountable not only to MCC, but to their citizens.[2]

For decades, USAID's practice was to redirect family planning resources away from countries once they had developed greater domestic capacity to countries where family planning needs were greater. In 2004, USAID began implementing a more formal and systematic process for "graduating" countries from family planning assistance. Over the past 40 years, USAID has graduated 22 countries. Current criteria for "imminent" graduation (2–5 years) are based on country-level indicators, including total fertility rates and use of modern contraceptives.[3] Though experience with the USAID graduation model has been mixed, its successful implementation provides lessons for transitioning health programs to a country ownership

model. In an assessment of its long graduation history, USAID identified four key factors that are essential to ensure program sustainability: country-level financing; policy and regulation to ensure an enabling environment, often the result of years of advocacy on the part of civil society; strengthening of both government institutions and non-governmental organizations (NGOs); and host government leadership and stewardship.[4]

The 2008 PEPFAR reauthorization shifted the program to a focus on sustainability (i.e., building health systems through capacity-strengthening in favor of providing services directly). To that end, PEPFAR has established Partnership Framework agreements with 21 countries to align its investments with host-national priorities, health systems, and specific HIV outcomes. As an extension of their Partnership Framework discussions, PEPFAR country teams are now instructed to pursue a country-level dialogue among a range of local stakeholders about country ownership.[5]

The Global Health Initiative, launched in 2009 by the Obama administration, established cross-cutting principles for the U.S. global health portfolio, including the better integration of health programs across agencies, the development of functioning country health systems, and the promotion of country ownership and outcome targets for maternal and child health, nutrition, family planning, and HIV (through PEPFAR).

In her keynote address at the 4th High Level Forum on Aid Effectiveness in November 2011 in Busan, South Korea, U.S. Secretary of State Hillary Clinton said, "Our new U.S. Global Health Initiative supports country-led plans to try to strengthen health systems so our partners can eventually address more of their own health needs." In addressing civil society, she also urged organizations to "end the practice of creating your own strategies independent of a country-led plan," noting that "it is in your interest to coordinate with government agencies and other NGOs."[6] In a subsequent speech in Oslo in June 2012, Secretary Clinton expanded on the definition of country ownership:

> *"To us, 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… and these plans must be carried out primarily by the country's own institutions, and then these groups must be able to hold each other accountable…. So, while nations must ultimately be able to fund more of their own needs, country ownership is about far more than funding. It is principally about building capacity to set priorities, manage resources, develop plans, and carry them out."[7]*

A recent GHI discussion paper, *U.S. Government Interagency Paper on Country Ownership*, declares that "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," yet also adds a caveat: "USG priorities do not always align with the priorities of recipient countries." The document also frames country ownership along a spectrum of country capacity for addressing morbidity and mortality, as well as managing, owning, and financing the health sector and health care delivery systems. Moving forward, the U.S. conceptualizes country ownership along four dimensions: (1) political leadership and stewardship; (2) institutional and community ownership; (3) capabilities; and (4) mutual accountability, including finance. These dimensions reflect a continuum of steps undertaken by country stakeholders to plan, finance, and manage their own

health sector and respond to the needs of citizens. The need for capacity-strengthening among individuals, institutions, and systems to ensure sustainability is also specifically acknowledged.[8]

Moving Forward: A Checklist for Civil Society Participation in Country Ownership

The promise and pitfalls of country ownership have been widely debated, and practical and theoretical recommendations form the basis for multiple reports and consensus processes.[9,10,11,12,13,14,15] Though widely acknowledged, the role of civil society, has yet to be fully defined. The sections that follow reflect the perspectives of participants at the **Advancing Country Ownership: Civil Society's Role in Sustaining Global Health Investments** consultation which represent key discussions for donors, governments, international NGOs, and CSOs.

COUNTRY OWNERSHIP CHECKLIST

- **The needs of populations that are marginalized or vulnerable due to stigmatization or disadvantaged by poverty must be addressed.** By definition, country ownership must account for the needs of populations with fewer opportunities to represent themselves.

- **Civil society participation must be codified.** Civil society organizations must have the freedom and wherewithal to participate as full development partners. Mechanisms for civil society engagement must be specific, practical, consistent, and measurable.

- **Transparency and accountability are essential for all development actors**. A country ownership model implies trust and equal access to information. Donors, government, and civil society partners must share information resources equitably.

- **Country ownership requires that governments and CSOs have the capacity to collaborate**. Sustained capacity-strengthening focused on institutional strengthening rather than individual programs is required to ensure 1) that CSOs have the skills to understand and analyze programmatic and financial information, assess policy proposals, and conduct advocacy and monitoring activities, and 2) that governments have the willingness and skills to convene consultations and collaborate with civil society partners.

The Need to Protect Marginalized, Vulnerable or Disadvantaged Populations

With a sector-wide movement toward country ownership, CSOs have raised numerous theoretical and practical concerns, which include the theoretical impact of such a shift on the marginalized and disadvantaged populations they represent and their practical role and influence in shaping development policy and practice. *Insofar as civil society is seen by many as the primary representative for marginalized, vulnerable, or disadvantaged populations, the concern that country ownership will erode, rather than enhance, available services underpins all other practical concerns related to how and whether CSOs are effective and accountable.*

In particular, CSOs have expressed concerns that governments will decline to support services targeting key populations, especially those stigmatized by risk behaviors that are considered illegal in-country, such as sex workers, people who use drugs, or, in many settings, lesbian, gay, bisexual, or transgender (LGBT) people. In many countries, owing to government indifference or outright hostility, international donors remain the primary funder of services to these populations. For example, in many countries and regions of the world, the Global Fund finances the majority, or in some instances, the totality of harm reduction services (i.e., needle and syringe programs, opioid substitution) targeting people who use injection drugs. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), in low- and middle-income countries with available data, international donors provide more than 90 percent of total funding for HIV programs for sex workers, gay men,[*] and people who inject drugs.[15] A successful transition to a country ownership paradigm must ensure that available health resources are allocated equitably and based on epidemiology, disease burden, and the health needs of populations.

When at-risk populations (i.e., sex workers, people who use drugs, gay men) are criminalized in-country for their behaviors, donors must confront the reality that governments may *never* appropriately target resources to these populations, and to ensure an effective mix of services, it may be necessary to maintain international donor support to address the needs of vulnerable populations to retain some level of control over programming. One approach may be for donors to insist on adherence to UN standards, to which most countries are signatories and which include comprehensive human rights protections.

Experience to date suggests that concern regarding in-country health services for these populations is warranted. In Romania, one quarter of the US$11.4 million awarded by the Global Fund to a national NGO from 2007–2010 was allocated for harm reduction services targeting people who inject drugs (PWID); as a consequence, nationwide HIV prevalence among PWID remained relatively low, at about one percent. In spite of such success, no Romanian government funding has ever been made available for harm reduction programs. When Romania no longer qualified for Global Fund support, NGOs became dependent on other international donors, including the European Social Fund, under which most medical consumables (such as needles and condoms) are not eligible expenditures. As a consequence, overall funding for harm reduction in Romania is lower, and the proportion of PWID who have access to harm reduction services has declined from 76 percent in 2009 to 49 percent in 2010. One harm reduction site in the capital closed when Global Fund support was withdrawn, and another was expected to shut down. The proportion of newly reported HIV infections among PWID in 2011 was higher than in previous years, and their share of all new HIV cases (15 percent) was also larger.[16]

The redirection of USAID support for family planning programs (through the graduation process) has raised similar concerns. USAID has been the largest bilateral donor to family planning and sexual and reproductive health (SRH) programs in the developing world since the 1960s, contributing to substantially

---

[*] In this report, we use the term "gay men" to refer both to men who have sex with men, and to men who experience same-sex attraction as part of their sexual, cultural or community lives; as well as to men who are perceived (in the context of laws and policies) as such. While the term is obviously imperfect – some of these men may not so self-identify, while others may find characterizations of sexual orientation to be too limiting – the alternatives (most commonly "MSM") are too clinical for many individuals for whom being gay has cultural and social, as well as sexual dimensions, and may fail to describe men who are stigmatized because of their appearance or non-sexual behaviors.

greater access to services. By some estimates, 31.6 million women rely on USAID-funded family planning services.[17] For example, partly as the result of USAID programs, the Latin American and Caribbean region has one of the highest contraceptive prevalence rates in the developing world, and progressive family planning and SRH policies have contributed to decreasing infant mortality and total fertility rates. But while the graduations of several countries (e.g.., Mexico, Morocco) have gone smoothly, others have raised concerns. In Indonesia, which graduated in 2007, early reports suggest that the availability of family planning services declined in many districts, with only 20 percent of districts having a full complement of facilities, and that family planning programs may be reverting to a medical model (e.g., with trained midwives not allowed to insert implants).[18] In anticipation of the scheduled graduation of family planning programs in Peru (later postponed), a 2010 analysis revealed high inequalities in access among rural, indigenous, and poor populations, which were masked by national averages that otherwise met USAID graduation criteria. The analysis highlighted that an ambitious decentralization of health care services would pose new challenges to the sustainability of family planning programs, especially for vulnerable groups. CSOs also expressed concerns that a withdrawal of USAID money would diminish their capacity to monitor the Peruvian government, which they worried would become increasingly uninterested in sustaining family planning investments.[19]

> **PROTECTING VULNERABLE POPULATIONS**
>
> - As part of the graduation process, USAID and other donors should give special attention to ensuring continuity in services for vulnerable populations, including exploring collaboration with CSOs and the private sector.
>
> - Donors should consider supporting a transition period to allow time for local agencies to acquire the skills needed to manage and fund services that the government does not support.

Ensuring an Enabling Environment for CSOs

From a practical perspective, the importance of including civil society as a key stakeholder in any country ownership model, at least in the broadest terms, has been widely, though not universally, accepted. Significantly, CSOs were recognized as development actors in their own right in the Accra Agenda for Action, which followed the High Level Forum on Aid Effectiveness convened in Paris in 2005. However, implementing a true country ownership paradigm will require that governments and donors alike unequivocally affirm and ensure the full participation of CSOs in every phase of the development process, distinct from other development actors, including the private sector.

At the most basic level, this means that CSOs must be free to function without undue legal or political restrictions—i.e., the "enabling environment" envisioned by the Accra Agenda. They must be able to operate within a policy framework that recognizes their relevance and right to self-govern, meet and express opinions, conduct independent activities without government pre-approval (including accepting donations from foreign donors), engage in advocacy, and monitor the work of government.[12] The International Framework for CSO Development Effectiveness (the Istanbul Principles) developed by civil society through a consensus process, notes that "CSOs… are profoundly affected by the context in which they work. The policies and practices of developing country governments and official donors affect and shape the capacities of CSOs to engage in development. Progress in realizing the Istanbul Principles … depends in large measure on enabling government policies, laws, and regulations." For example, the

Framework calls upon governments to "fulfill obligations to fundamental human rights that enable people to organize and participate in development" and identifies some pre-conditions for a robust and effective civil society. These pre-conditions include: (1) freedom of association and assembly; (2) legal recognition facilitating the work of CSOs; (3) the right to freedom of expression; (4) freedom of movement, mobility rights, and the right to travel; (5) the right to operate free of unwarranted state interference; and (6) the legal space to seek and secure necessary resources in support of legitimate roles in development.

Concerns about an "enabling environment" for CSOs are legitimate. In practice, in many cases CSOs face increasingly restrictive government policies, including pervasive anti-terrorism legislation, government regulations restricting "political" activities, repression of CSOs and their leaders who defend human rights or criticize government policies, and, particularly in Africa, travel restrictions (e.g., visa delays) that prevent international collaboration.[1] By some indications, more than 90 countries have recently tightened restrictions on CSOs in the name of national security.[20] Such restrictive government policies may be especially acute among criminalized populations (i.e., sex workers, people who use drugs, gay men) for whom the burden of restrictions may be as high as to preclude effective organizing. One African HIV activist commented, "in Senegal, the Minister of Health consults with MSM [men who have sex with men] while the Minister of Justice throws them in jail."

In 2009, Ethiopia passed The Proclamation to Provide for the Registration and Regulation of Charities and Societies (CSP), the first Ethiopian law to require registration and regulation of NGOs. The CSP restricts NGOs that receive more than ten percent of their financing from foreign sources from engaging in essentially all human rights and advocacy activities. Moreover, registrations may be denied if the organization is deemed "likely to be used for unlawful purposes or for purposes prejudicial to public peace, welfare or good order in Ethiopia," or the name of the charity or society is illegal or contrary to the government's view of public morality. NGOs are restricted in the activities they may undertake, including "the advancement of human and democratic rights, the promotion of equality of nations and nationalities and peoples and that of gender and religion, the promotion of the rights of disabled and children's rights, the promotion of conflict resolution or reconciliation and the promotion of the efficiency of the justice and law enforcement services to Ethiopian Charities and Societies."

As a large donor, USG often has a significant impact at the community level, which has effects that pose challenges to some communities. For example, the "Mexico City Policy," which was most recently in effect from 2001–2009, required non-U.S. NGOs to certify that they would not perform or promote abortion with any funds as a condition for receiving U.S. family planning assistance. In practice, the policy prohibited organizations from providing services related to abortion or participating in advocacy for legal abortion in their country. Similarly, since 2003, the U.S. has required groups that receive federal anti-HIV/AIDS or anti-trafficking funds to adopt an "anti-prostitution pledge" opposing prostitution and sex-trafficking. The pledge remains a requirement for groups receiving PEPFAR funds. The policy has diminished services offered by organizations supporting the health needs of sex workers, in the process worsening stigmatization of such populations.[22] In addition, both policies have in some places led to stronger divisions among civil society groups who may have otherwise operated with more collaboration.

ENSURING AN ENABLING ENVIRONMENT FOR CSOs

- Governments and donors alike must unequivocally affirm the full participation of CSOs in every phase of the development process. The participation of CSOs is distinct from other development actors, including the private sector, and must incorporate not only those CSOs currently funded by donors.

- CSOs must be free to function without undue legal or political restrictions, operating within a policy framework that recognizes their relevance and right to self-govern, meet and express opinions, conduct independent activities (without government pre-approval), engage in advocacy, and monitor the work of government.

- Governments must "fulfill obligations to fundamental human rights that enable people to organize and participate in development." These obligations include: (1) freedom of association and assembly; (2) legal recognition facilitating the work of CSOs; (3) the right to freedom of expression; (4) freedom of movement, mobility rights, and the right to travel; (5) the right to operate free of unwarranted state interference; and (6) the legal space to seek and secure necessary resources in support of legitimate roles in development.

Formalizing the CSO Role in Country Ownership: Practical Aspects of CSO Participation

In many settings, the practical aspects of CSO participation in the development process remain undefined. It is therefore important to clarify roles and expectations of CSOs—not only for other development actors (government, donors, the private sector, the international NGO community), but for civil society itself. Defining CSOs' roles at every stage of the development process (to include planning, financing, implementation, and monitoring and evaluation (both program outcomes and finances) would institutionalize civil society participation at every stage and encourage collaboration and coordinated strategic efforts with local and international stakeholders.[12] In addition to clearly defining CSO roles, mechanisms for CSO participation should be transparent and tailored to reflect country-level circumstances. For example, in countries with weak civil society and government structures, information sharing and dialogue might ensure that at minimum, stakeholders are informed of each other's priorities. In countries with solid civic institutions, a more extensive partnership between civil society and government would be warranted.

Involving CSOs in the development process is likely to pay off, as comprehensive and effective stakeholder participation will result in (1) increased sustainability, owing to greater buy-in from affected groups; (2) more effective targeting of resources, as programs are more likely to respond to local needs; and (3) mutually accountable relationships among stakeholders, resulting from shared risks for program outcomes.[10] CSO involvement may also ensure greater sustainability in the face of government transitions—and vice versa.

The White Ribbon Alliance (WRA) comprises an international coalition of 16 National Alliances, working to amplify the voices of women and communities and hold governments accountable for commitments to reduce maternal mortality. Through a country-led campaign with unified messages and strategies to mobilize civil society, the Tanzania WRA recently drew attention to the poor status and working conditions of midwives, which had significantly diminished the quality of maternity care. WRA first convened community dialogues to develop consensus on the best approaches to promote and advance midwifery, then initiated the Parliamentary Group for Safe Motherhood (PGSM), to work with members of parliament (MPs) to secure support for an enabling environment and decent working conditions for midwives. After a short film (*What I want is simple…*) generated substantial community support, WRA worked with PGSM to introduce a safe motherhood bill, which is now under discussion with the Ministry of Health and other stakeholders.[23]

Stakeholder consultation

Consultations with a wide range of stakeholders, ensuring a diversity of input, are often a primary vehicle for soliciting stakeholder views. Effective consultations require planning and preparation—hastily convened or "one-off" consultations that cannot be reconvened are often perceived by CSOs to be a waste of time. MCC defines the purpose of an effective consultative process as: "to establish a sustainable mechanism for effective civic (and other public) engagement… consequently, it should make as much use of existing domestic institutions and processes as possible, and avoid one-off efforts to gather information from citizens or civic groups through forums that cannot be re-convened later." To ensure a diversity of views and guard against bias, it is critical to solicit views from groups beyond those that are already funded.

Key, of course, is whether information gleaned from consultations is translated into program priorities. MCC notes that consultations are only effective to the extent that "the information gathered in these consultations… contribute[s] directly to the country core team's prioritization of obstacles and/or sectors for intervention."[24] The development of specific guidance related to stakeholder consultations, including metrics to assess quality, is essential.

By many accounts, the Global Fund's country coordinating mechanism (CCM) provides a good theoretical model for civil society involvement, though its implementation at the country level has not always been problem free. The Global Fund requires proposals to be submitted through a multi-stakeholder CCM, comprised of government, civil society, multilateral and bilateral agencies, the private sector, affected communities, and marginalized groups. CCM members are selected by their respective sectors, and are required to consult with and provide feedback from the communities they represent. The Global Fund strongly recommends that a portion of the total grant be disbursed through an NGO, thereby increasing the likelihood that CSOs are involved in the design, implementation, and monitoring of programs. The Global Fund claims to enhance country ownership and the development of national health strategies by directing 35 percent of funding toward health and community systems strengthening.[25] However, critics doubt this figure and suggest that Global Fund requirements and recommendations concerning the inclusion of civil society are too weak and are poorly enforced. Many fear that these requirements will be even weaker more difficult to enforce in the newly reorganized grant management system. Others say that even when CSOs do participate, they lack sufficient capacity or strength to have the intended impact. There are anecdotal reports that conflicts of interest occasionally plague CCMs, particularly when Global Fund recipients hold seats. Not all countries are serious about their obligation to include CSOs. The Tanzania CCM provides a model of multi-sector collaboration. Among 22 members, seven are CSO representatives, while six are government officials, six are development partners, two are academic researchers, and one is from the private sector.[26]

Monitoring programs and holding government accountable

Beyond consulting on program planning, design, and implementation, another key role CSOs fulfill in the context of country ownership is monitoring government performance to reinforce accountability. In this way, civil society can create a closed feedback loop, ensuring that programs for which they advocate are appropriately implemented and evaluated. With CSOs empowered to provide appropriate feedback, this not only ensures that government commitments are met, but that programs adjust to reflect experiences and evolve to meet population needs as they change. As a consequence, the public will have greater confidence in government, which in turn may raise expectations and reduce incentives for corruption.[27]

In Guatemala, several USAID-supported NGOs, including the Women's Network for Building Peace (REMAPAZ), the Women's Health and Development Organization (INSTANCIA), and the Network of Indigenous Organizations (ALIAMISAR) joined efforts to form the Multi-sectoral Monitoring Board, which successfully advocated for the Guatemalan Congress to implement the National Reproductive Health Monitoring Board (OSAR) in 2008. In turn, OSAR strengthens capacity among CSOs to monitor implementation of SHR and family planning laws and policies, including the Social Development Law (2000), the Social Development and Population Policy (2001), a law mandating that 15 percent of alcohol taxes be allocated to SRH programs (2004), a law on universal access to family planning (2005), and a law on safe motherhood (2010). After a successful pilot, OSAR was expanded to 19 of 22 Guatemalan departments (i.e., states), many supported by USAID. As a consequence, the environment for supportive family planning/SRH policies/laws and financing has improved, barriers to family planning/SRH services at the national and local levels have been reduced, inter-cultural health services were developed, and the security of family planning/SRH services has increased.[28]

<div style="background:#c5d5ed;padding:10px">

FORMALIZING CIVIL SOCIETY'S ROLE IN COUNTRY OWNERSHIP

- Mechanisms for CSO participation at every stage of the development process—including planning, financing, implementation, and monitoring and evaluation (both program outcomes and finances)—should be clearly defined, transparent, and tailored to reflect country-level circumstances.
- CSOs should monitor government performance to reinforce accountability and create a closed feedback loop.

</div>

Transparency and Accountability

While CSOs may fulfill a "watchdog" role to ensure government accountability, their success in this regard is dependent on the transparency of governments and donors with respect to finances as well as development priorities, strategies, plans, and actions. Transparency and access to timely, relevant, comparable, and accessible data are also essential for CSOs to participate in program planning, design, implementation, and evaluation. To ensure that governments and CSOs can more effectively manage resources, donors should provide clear information concerning their plans and priorities in recipient countries. The USG has become increasingly transparent, with MCC programs having incorporated information-sharing mechanisms from the outset. The Global Fund provides another model of exemplary transparency. Allies within government may also lack information. Advocates report many instances where information provided by activists builds support among government functionaries and technicians, who can then use the information to move programs forward. In 2011, leading up to the High Level Forum on Aid Effectiveness in Busan, the Make Aid Transparent campaign (www.makeaidtransparent.org/) called on donors to publish more and better information about aid dollars.

<div style="background:#c5d5ed;padding:10px">

In 2010, the International Planned Parenthood Federation Western Hemisphere Region and the International Budget Partnership implemented a pilot project in Costa Rica, Guatemala, El Salvador, Panama, and Peru to assess whether governments accurately report on the steps they take to fulfill international obligations to reduce maternal mortality. Working as partners, organizations focused on maternal health and those focused on budget issues then searched all available data to determine the extent to which they could measure progress on a common framework that included (1) comprehensive reproductive health care; (2) skilled pre- and post-delivery personnel; (3) emergency obstetric and neonatal care; and (4) immediate postnatal care. The availability of data—and the ease of obtaining it—varied substantially, demonstrating the need for improved budget transparency for maternal health goals.[29]

</div>

In addition to information about financing, appropriately targeted health responses require epidemiologic and program data. Effective country ownership requires the capacity and commitment to gather, analyze, and apply data to guide planning, resource allocation, program implementation, and evaluation. As UNAIDS notes with respect to HIV (but which applies equally to other health issues): "For countries to own their national AIDS responses, they need to have a clear understanding of the burden of disease, patterns of HIV transmission, and key populations at risk for HIV infection. Without this information, it will be impossible to develop effective strategies to respond to AIDS. It is not possible for a country to own its

response without effectively understanding its epidemic."[15] Countries that own their national AIDS responses by gathering, analyzing, and disseminating epidemiologic and surveillance data on HIV also provide a tool for CSOs to ensure government strategies are appropriately addressing those most impacted by the epidemic. Beyond access to data, all development partners should commit to working toward public health outcomes, which by definition will require programming that is responsive to epidemiology.

ENSURING TRANSPARENCY AND ACCOUNTABILITY

- Donors should publish more and better information about aid dollars and provide clear information concerning their plans and priorities in recipient countries.

The Imperative for Capacity Strengthening

Effective multistakeholder participation in the development process requires capacity for both governments and CSOs. For example, governments are able to convene and facilitate effective in-country consultations, to participate in consultations convened by development partners, to track and monitor program expenditures and outcomes) and CSOs (to participate at every level of the development process). Substantial capacity-strengthening may be required for CSOs to effectively partner in program planning, implementation, and evaluation. This will ensure that they have the skills to understand development mechanisms and processes (including country budgeting and fiscal reporting) and performance indicators; advocate on behalf of their constituents and conduct watchdog activities; monitor implementation and establish accountability mechanisms; develop and maintain strong internal management structures; and form alliances and partnerships.

Such skills may be different from those presently supported by donors. Many CSOs receive support for service delivery, but far fewer receive funds for advocacy, watchdog activities, monitoring and evaluation, or policy analysis. In some instances, restrictions on funding create divisions among advocacy coalitions and other civil society alliances. It may be possible to leverage some donors' flexibility to fund advocacy in order to complement funding from donors who only support services, or who impose other restrictions associated with using funds for policy and/or advocacy work. Much results-focused funding also neglects to support ongoing institutional development, management, or governance systems. For CSOs to thrive, donor support is required for infrastructure and organizational development. Effective capacity-strengthening, in turn, requires sustained funding support, the active engagement of recipients, flexibility to adjust to local needs, and sufficient time to demonstrate results. Particularly for donors, the need for quick, demonstrable results must be tempered by the reality that developing capacity may sometimes take years.

The Joining Forces for Voice and Accountability Initiative of the International Planned Parenthood Federation (IPPF) Western Hemisphere Region strengthens capacity among CSOs to hold national governments accountable for their commitments to reproductive health and gender equality. In Mexico, where the International Conference for Population and Development Programme of Action was embraced in comprehensive national policies, but rarely implemented, Mexfam (IPPF's member association) first encountered denial from state officials that such policies existed, then claims that no money was available for implementation. This claim turned out to be true, as no budget had been allocated at the national level. After joining in coalition with maternal health advocates, Mexfam persuaded the Mexican Congress to earmark 100 million pesos (US$7.8 million) in 2011 followed by 200 million pesos (US$15.6 million) in 2012—the first time the government had earmarked funds for adolescent sexual and reproductive health. Mexfam then continued to work in four states to ensure implementation of these projects. Esperanza Delgado, Mexfam's Director of Evaluation and Development, notes: "Mexico, as with many of the countries in this region of the world, is still learning how to be a democracy."[30]

In El Salvador, USAID collaborated with the Central American Ministries of Health Council and several universities to develop the Central American Diploma Course on Monitoring and Evaluation for HIV/AIDS Policy and Program Management. In El Salvador, 12 of 34 participants were affiliated with CSOs. Many of these organizations now participate in multisectoral committees, such as the National AIDS Commission and Global Fund CCM. CSOs now implement HIV/AIDS programs that include condom distribution, educational activities with gay men and sex workers, and raising awareness among key populations. As a consequence, the relationship between civil society and the National AIDS Council has improved, and Global Fund projects are aligned with the National Plan.[31]

Capacity-strengthening can be incremental and slow-going. It is critical to allow sufficient time for change to occur, as development actors adjust to changing imperatives and players acquire the skills necessary to operate in a new paradigm. In the second phase of Avahan—the HIV/AIDS program in India supported by the Bill & Melinda Gates Foundation in collaboration with in-country partners—a transition to the Indian government and local communities represents the culmination of a 10-year process.[32]
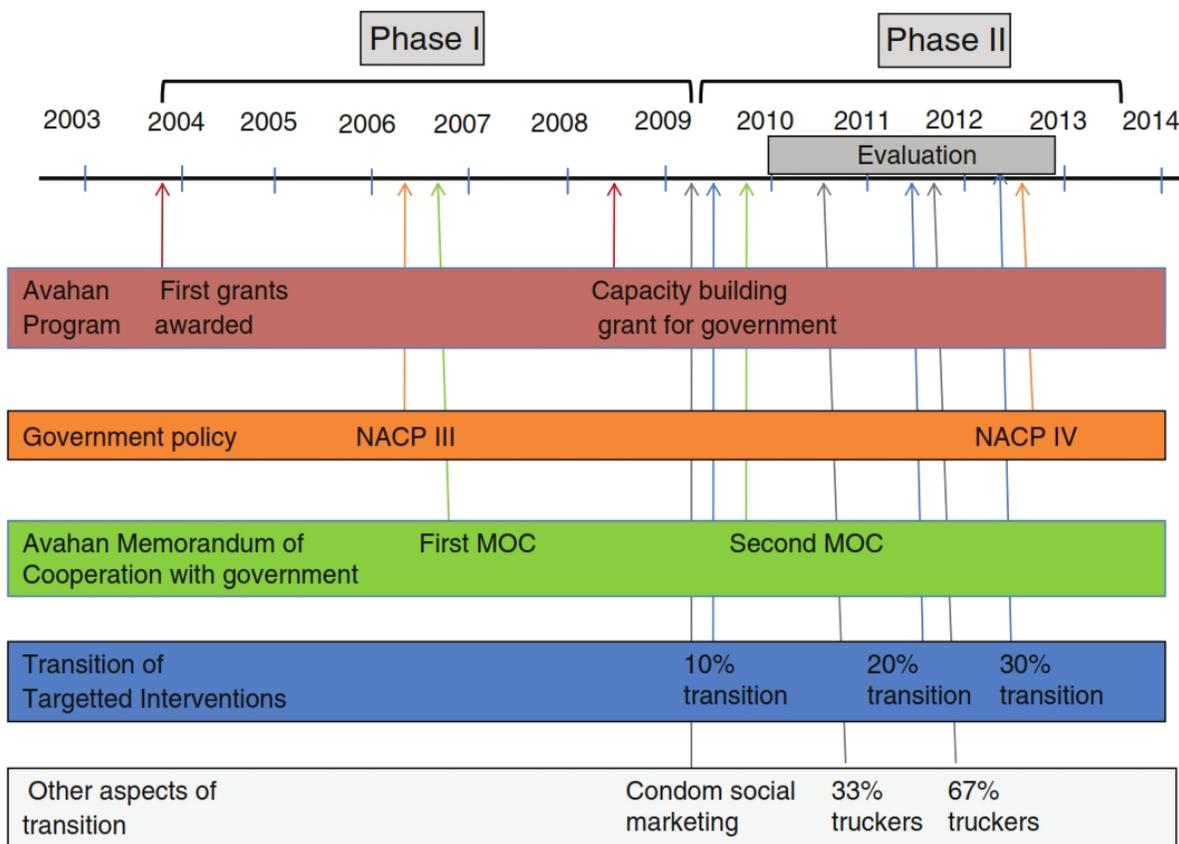
Figure 1. Gates Program's Avahan Initiative Transitions to the Indian Government

It is also important to acknowledge that civil society is multifaceted, and includes participants ranging from solo activists to highly evolved NGOs. In many instances, *champions* develop and nurture CSOs through capacity building and training. While such champions are often able to substantially leverage support at the local level, it is also essential that donors support the institutional maturation of organizations founded by charismatic leaders, to ensure that they survive and flourish once the champion moves on. Donors should also understand and respect that an effective civil society response includes many types of stakeholders and communities, and full-fledged NGOs with mature governance structures represent only one of them.

RECOMMENDATIONS FOR U.S. GOVERNMENT

As the largest global donor of health-related aid, the USG holds strong influence in—and bears substantial responsibility for—ensuring that the transition to a country ownership model preserves and maximizes the value of global aid investments. To that end, the USG should:

- Unequivocally affirm that civil society constitutes an essential development partner in its own right, distinct from the private sector, the participation of which is essential at every stage of the development process.

- Ensure in each case that transitions to country ownership are accomplished through an explicit management plan that articulates expectations on both sides and specifies benchmarks at every stage.

- Develop guidelines that ensure a consistent and measurable approach to country ownership across programs and agencies such as MCC, USAID, and PEPFAR, etc., including metrics for consultation and advocacy.

- Build upon lessons learned from the MCC consultation process to establish standards for civil society consultations across sectors that ensure a diversity of views, emphasize systematic mechanisms, and discourage ad-hoc approaches.

- Retain conditions on development aid to ensure that the needs of marginalized and vulnerable populations are met, and through this effort continue to direct support in instances where governments are unable or unwilling to address the needs of key populations.

- Be fully transparent about USG aid and programming across all health programs. With PEPFAR, for example, USG should develop a transparent, systematic plan for civil society engagement in the Partnership Framework process and in its implementation, monitoring, evaluation, and revision.

- Support sustained and long-term efforts to strengthen capacity among civil society organizations to conduct advocacy, monitoring and evaluation, and watchdog activities.

Donors should also acknowledge that civil society incudes a range of voices, some of which oppose certain services or programs that specifically target vulnerable or marginalized populations. In many countries, there are major debates on issues, such as harm reduction services for people who use drugs; non-punitive services for sex workers; respectful services for gay men or transgender people; sex education for adolescents; and provision of safe and legal abortions. Many such groups are supported by government or other powerful stakeholders, including business and organized religion; their perspectives may come to dominate as donor support for more progressive voices is withdrawn.

STRENGTHENING THE CAPACITY OF COUNTRY OWNERSHIP PARTNERS

- Donors should provide support for strengthening CSOs' capacity to engage in advocacy, watchdog activities, monitoring and evaluation, and policy analysis.

- Donors should also support CSOs' ongoing institutional development, including building management and governance systems and the skills to form and sustain alliances and partnerships.

- Donors should work with CSOs to develop appropriate performance indicators for advocacy work and allow sufficient time for CSOs to demonstrate the results of their work.

- In addition to supporting local champions, donors should aim to make organizations strong and sustainable, ensuring that they are able to survive and flourish once their founders move on.

Civil Society and Self-Governance

While, as noted above, effective CSO participation is predicated on other development actors (primarily governments and donors) reducing barriers and ensuring an enabling environment, CSOs must also have effective self-government and be transparent and accountable to the populations they represent. It is not always clear which CSOs are best suited to represent key populations. Particularly in the context of development consultations, stakeholder organizations must be representative of affected populations—and civil society must ensure that local and regional, as well as national NGOs are engaged.

CSOs have an institutional obligation to ensure that vulnerable and marginalized populations have a voice in the development process, as well as in organizational management and governmental structures. As articulated in the Istanbul Principles, CSOs must strive for transparent, mutually accountable democratic practices that reinforce core values of social justice and equality. As such, to the extent that is possible without undue risk, CSOs should maintain public access to audited financial and programmatic reports, be open to challenges or criticisms, and maintain mechanisms for resolving disputes. CSOs should practice and promote a transparent and democratic culture within their respective organizations, with accountable leadership, clearly assigned roles, transparent operational procedures, anti-corruption policies, ethical information practices, and a demonstrated respect for gender balance, human rights standards, integrity, and honesty. While CSO monitoring is essential to deter or expose government corruption, CSO representatives also have an obligation for integrity in their actions. In some instances, primarily in the international HIV sector, CSO representatives are paid for their participation in consultations beyond reimbursement for expenses, a practice that many feel is unsustainable at best and unethical at worst. Conflicts of interest pose as predictable a challenge for community activists as they do any other development actors, and civil society should lead by embracing strong conflict of interest policies.

To ensure the most qualified and capable CSOs, member associations of the International Planned Parenthood Federation Africa Regional Office undergo an accreditation review every five years to make sure that they comply with 49 federation standards, based on 10 principles:

Figure 2. Building Blocks of International Planned Parenthood Africa's Accreditation System

IPPF develops capacity-strengthening plans for member associations that fail the accreditation review. Focusing on good governance and accreditation helps to improve accountability at all levels, which in turn builds public confidence.[33]

IMPROVING CIVIL SOCIETY SELF-GOVERNANCE

- CSOs must ensure effective self-government, with mutually accountable democratic practices that reinforce values of social justice and equality, and be transparent and accountable to the populations they represent.

- To guarantee vulnerable and marginalized groups have a voice in the development process, CSOs must ensure organizations are representative of affected populations and that those representatives extend beyond national NGOs.

- Whenever possible, CSOs should maintain public access to audited financial and programmatic reports, be open to challenges or criticisms, and maintain mechanisms for resolving disputes.

- CSOs should show leadership on anti-corruption by embracing strong conflict of interest policies.

Conclusion

The transition of health programs to a country ownership paradigm is complex, requires sustained negotiations among key stakeholders, and must be implemented incrementally, with vigilant monitoring to ensure that the needs of marginalized, vulnerable, or disadvantaged populations remain a priority. As described above, the participation of civil society at every stage is essential.

The potential of country ownership is significant, with the promise of stronger country health systems, greater buy-in from affected populations, increased correlation between health needs and programs, better services for the most vulnerable populations, more sustainable health interventions, and ultimately healthier populations. Nonetheless, it is important to recognize that country ownership is not the first new development paradigm to be embraced by global development actors—and examples of broad transformative change propelled by development aid are few and far between, while examples of failed development innovations abound. For those seeking to transform societies, the long history of economic development aid may provide lessons with respect to unintended consequences. In some instances, for example, countries that received the most aid achieved the least growth.[34]

For civil society, by definition, country ownership implies country *control*—that donors will ultimately respect decisions made by country governments.[35] For those who care about marginalized or vulnerable populations, that prospect carries as much dread as it does promise. But in spite of this caveat, the potential for country ownership to leverage large, relatively new investments in global health (historically directed primarily to HIV/AIDS) and to more fully integrate civil society actors in country-level decision making has provoked substantial optimism among stakeholders. To ensure that country ownership lives up to its promise, it will be essential to monitor its implementation and measure its outcomes before donors withdraw.

Appendix 1: Istanbul CSO Development Effectiveness Principles

Civil society organizations (CSOs) are a vibrant and essential feature in the democratic life of countries across the globe. CSOs collaborate with the full diversity of people and promote their rights. The essential characteristics of CSOs as distinct development actors—that they are voluntary, diverse, non-partisan, autonomous, non-violent, working and collaborating for change—are the foundation for the Istanbul principles for CSO development effectiveness. These principles guide the work and practices of civil society organizations in both peaceful and conflict situations, in different areas of work from grassroots to policy advocacy, and in a continuum from humanitarian emergencies to long-term development.

1. Respect and promote human rights and social justice. *CSOs are effective as development actors when they …* develop and implement strategies, activities and practices that promote individual and collective human rights, including the right to development, with dignity, decent work, social justice and equity for all people.

2. Embody gender equality and equity while promoting women and girls' rights. *CSOs are effective as development actors when they …* promote and practice development cooperation embodying gender equity, reflecting women's concerns and experience, while supporting women's efforts to realize their individual and collective rights, participating as fully empowered actors in the development process.

3. Focus on people's empowerment, democratic ownership and participation. *CSOs are effective as development actors when they …* support the empowerment and inclusive participation of people to expand their democratic ownership over policies and development initiatives that affect their lives, with an emphasis on the poor and marginalized.

4. Promote environmental sustainability. *CSOs are effective as development actors when they …* develop and implement priorities and approaches that promote environmental sustainability for present and future generations, including urgent responses to climate crises, with specific attention to the socio-economic, cultural and indigenous conditions for ecological integrity and justice.

5. Practice transparency and accountability. *CSOs are effective as development actors when they …* demonstrate a sustained organizational commitment to transparency, multiple accountability, and integrity in their internal operations.

6. Pursue equitable partnerships and solidarity. *CSOs are effective as development actors when they …* commit to transparent relationships with CSOs and other development actors, freely and as equals, based on shared development goals and values, mutual respect, trust, organizational autonomy, long-term accompaniment, solidarity and global citizenship.

7. Create and share knowledge and commit to mutual learning. *CSOs are effective as development actors when they …* enhance the ways they learn from their experience, from other CSOs and development actors, integrating evidence from development practice and results, including the knowledge

and wisdom of local and indigenous communities, strengthening innovation and their vision for the future they would like to see.

8. Commit to realizing positive sustainable change. CSOs are effective as development actors when they … collaborate to realize sustainable outcomes and impacts of their development actions, focusing on results and conditions for lasting change for people, with special emphasis on poor and marginalized populations, ensuring an enduring legacy for present and future generations.

Guided by these Istanbul principles, CSOs are committed to take pro-active actions to improve and be fully accountable for their development practices. Equally important will be enabling policies and practices by all actors. Through actions consistent with these principles, donor and partner country governments demonstrate their Accra Agenda for Action pledge that they "share an interest in ensuring that CSO contributions to development reach their full potential". All governments have an obligation to uphold basic human rights – among others, the right to association, the right to assembly, and the freedom of expression. Together these are pre-conditions for effective development.

Istanbul, Turkey
September 29, 2010

Appendix 2: History of Country Ownership

In the last decade, it has been primarily within the context of deliberations on *aid effectiveness* that the concept of country ownership emerged and evolved. These deliberations began in earnest among international development stakeholders following the ambitious development targets and funding commitments articulated in the Millennium Development Goals (MDGs). A series of high-level meetings convened by the Organization for Economic Co-operation and Development set the stage for country ownership. In Rome in 2003, at the High Level Forum on Harmonization, donor agencies committed to work with developing countries to better coordinate and streamline their activities at the country level.

Two subsequent meetings laid the foundation for country ownership and established the importance of civil society's role. In 2005, the **Paris Declaration on Aid Effectiveness** established a framework with intersecting commitments: alignment, harmonization, managing for results, mutual accountability, and *ownership* (defined primarily at the country level as when "Partner countries exercise effective leadership over their development policies and strategies and coordinate development actions").[36] The Paris Declaration acknowledged that CSOs play an important role in ensuring that governments remain accountable to the people, particularly vulnerable and marginalized populations. Governments were charged with using "broad consultative processes" to encourage CSO participation.

Three years later in 2008, the Paris Declaration was followed up at a meeting convened in Accra, Ghana. The **Accra Agenda for Action** established the primacy of country ownership as a key component of aid effectiveness, and signatories committed to broaden country-level dialogue on government strategies and ensure consistency with international gender and human rights commitments. CSOs also committed to apply aid effectiveness principles to their own work, and signatories agreed to participate in a "CSO-led multistakeholder process to promote CSO development effectiveness, including improved coordination of CSO efforts with government programs, enhanced CSO accountability, and improved information on CSO activities." The signatories committed to "working with CSOs to provide an enabling environment that maximizes their contributions to development."[36] Of note, the Accra High Level Forum was the first aid effectiveness meeting to convene a parallel civil society conference, in which more than 700 civil society representatives participated.

The Accra Agenda for Action propelled the international CSO community to initiate a consensus process to define its own role in country ownership. In 2010, the **Istanbul Principles** (see Appendix 1) affirmed the role of civil society to "respect and promote human rights and social justice" and noted that "CSOs are effective as development actors when they support the empowerment and inclusive participation of people to expand their democratic ownership over policies and development initiatives that affect their lives, with an emphasis on the poor and marginalized." One principle calls for "people's empowerment, democratic ownership, and participation."[37]

The **International Framework for CSO Development Effectiveness***,* the result of a subsequent consensus meeting in Siem Reap, Cambodia in 2011, operationalized the Istanbul Principles, noting that CSO effectiveness is contingent on country-level "enabling policy and legal environments," the concept of which governments had agreed in Accra to support. To that end, the International Framework calls on

governments to increase transparency and on donors to ensure that CSOs have a role in development strategies and implementation plans. The consensus also underscores the importance of strengthening mechanisms to ensure CSO accountability and delineates the multiplicity of roles played by civil society. As noted in the Framework, CSOs work in collaboration with other civil society entities and other actors to:

- Direct engagement and support for communities, poor and marginalized groups in self-help and local development innovation.

- Deliver basic services and essential infrastructures at local level, particularly in social services such as health protection and care, education, water and sanitation, while empowering communities to seek fulfillment of their right to these services from government.

- Empower marginalized grassroots communities and people living in poverty, particularly women, to claim their rights, through inclusive capacity-strengthening and promoting social mobilization and peoples' voices in democratizing local and national development and participation in public policy.

- Engage communities, civil society, the private sector, local government authorities and other development actors to collaborate and seek synergies based on mutually agreed development priorities and approaches.

- Enrich the public policy agenda with CSO knowledge, issues, perspectives and proposals which respect and are informed by spiritual virtues embedded in cultural values, including indigenous peoples' rights and their notions of "vivir bien" ("living well").

- Monitor government and donor policies and development practices, through policy research and development, policy dialogue and facilitating democratic accountability for excluded and marginalized populations, based on local knowledge.

- Educate and help shape social values of democracy, solidarity and social justice through production of knowledge, sharing information, and encouraging peoples' action for global citizenship.

- Encourage domestic and international volunteering engagement, whether in the creation and support of CSOs and/or contributing in the ongoing organizational life and mission of CSOs.

- Find and leverage sources of financing and human resources for development, including sustaining domestic and local sources of finance in developing countries, directly as CSO recipients or as donor channels at local, national and international level.

- Connect and network CSOs within and between civil societies in ways that encourage accountability to people for positive impacts on the rights and lives of target populations.

Source: Open Forum for CSO Development Effectiveness Forum. Istanbul CSO Development Effectiveness Principles (September 29, 2010). Available at www.cso-effectiveness.org/IMG/pdf/
final_istanbul_cso_development_effectiveness_principles_footnote_december_2010-2.pdf

The conceptual framework for country ownership, and the role of civil society therein, continue to evolve as various development actors struggle to define and implement the Accra Agenda for Action in light of the principles for CSO involvement articulated in the International Framework. In some instances, substantial disagreements remain concerning the specific roles and responsibilities of donors, government, and civil society itself. In 2011, the **Busan Partnership for Effective Development Cooperation** articulated four "shared principles to achieve common goals," including "ownership of development priorities by developing countries." Tellingly, the document did not formally specify the actors, although it included strong language about the importance of civil society, stating: "Civil society organizations play a vital role in enabling people to claim their rights, in promoting rights-based approaches, in shaping development policies and partnerships, and in overseeing their implementation."[38] While some observers have concluded that the document thus defines country ownership to include civil society, the private sector, local government, and citizens in addition to national governments, there is not consensus on this point.

A recent series of UNAIDS consultations in 18 countries, for example, concluded that "country" refers not simply to governments, but includes civil society, persons living with HIV, affected communities, and the private sector. These consultations were not able to arrive at a universal definition of country ownership. They did, however, agree that the term applied more to a graduated process than an end state and affirmed that country ownership is not a goal in itself; instead, it is a means to an end for achieving effectiveness, efficiency, and sustainability of national AIDS responses.[39]

The Contribution of Civil Society in Practice

The definition of civil society is somewhat mutable. In the International Framework, CSOs are defined "to include all non-market and non-state organizations in which people organize themselves to pursue shared interests in the public domain. They cover a wide range of organizations that include membership-based CSOs, cause-based CSOs, and service-oriented CSOs. Examples include community-based organizations and village associations, environmental groups, women's rights groups, farmers' associations, faith-based organizations, labor unions, cooperatives, professional associations, chambers of commerce, independent research institutes, and the not-for-profit media."[40] CSOs have been instrumental in the development and implementation of family planning, sexual and reproductive health (SRH), and maternal health programs for decades, and in HIV programs for the duration of the epidemic.

Family Planning and Reproductive Health

For decades, family planning associations (FPAs) and NGOs, many of which were affiliated with the International Planned Parenthood Federation (IPPF), provided family planning/SRH services directly while advocating for greater government involvement. In addition to access to services, FPAs also pushed for reforms to reduce coercive practices and to ensure that family planning services were embedded within a rights-based framework. When government programs spread during the 1970s and 1980s, government and FPA roles were often complementary, with FPAs undertaking more controversial sex education and comprehensive reproductive health services, including safe and legal abortion. At the 1974 Bucharest World Population Conference, many country delegations included FPA representatives. In 1994, civil society participation in family planning/SRH policy and program development was codified by the UN

International Conference for Population and Development (ICPD). At that meeting, 179 countries were signatories to the **ICPD Programme of Action** (the Cairo Consensus),[41] which connected reproductive health with human rights, equality, and economic, social, and environmental justice.

Since 1994, CSOs have been instrumental in implementing the Programme of Action, and examples of government/civil society partnerships abound. While the MDGs, established in 2000, did not initially include family planning/SRH, Goal #5 ("improve maternal health") was subsequently expanded with Goal #5b ("achieve universal access to reproductive health") as a result of civil society advocacy. Most recently, country ownership was deemed a key principle of FP2020 (the London Summit on Family Planning, July 2012), where donors and Global South countries committed to provide family planning/SRH services to an additional 120 million women by 2020.

Maternal Health

Similarly, civil society has also been actively engaged in maternal health program implementation. For example, the Safe Motherhood Initiative, a global advocacy network dedicated to maternal health, was established in 1987. More than a decade later, in 1999, the White Ribbon Alliance (WRA) was formed; it comprises in-country coalitions of policymakers, legislators, NGOs, healthcare providers, communities, and individuals. Today, WRA has national alliances in 15 countries and members in more than 150 countries and is often represented in stakeholder groups convened by government.

HIV/AIDS

Civil society has had a profound impact in shaping the global HIV response. For decades, activism at the national level has pushed societies and governments to recognize HIV as a public health crisis. The Global Fund, among the largest donors in the response, requires civil society representation on country coordinating mechanisms (CCMs), which oversee country programs' design and in-country monitoring, ensuring greater transparency at the national level. Through dual-track financing, a recommended implementation process where at least one government and one nongovernment principal recipient lead program implementation, the Global Fund empowers civil society and NGOs. It also supports civil society networks that monitor government programs to ensure accountability. As a consequence, the Global Fund has become the largest global donor to support programs for key marginalized communities, including gay men and people who inject drugs.[25]

In 2003, at the International Conference on AIDS and STIs in Africa, held in Nairobi, Kenya, officials from African nations, major funding mechanisms, multilateral and bilateral agencies, NGOs, and the private sector developed consensus on UNAIDS's "Three Ones" principles, which call for one national AIDS strategy framework, one national AIDS coordinating body, and one national monitoring and evaluation framework. As a result of civil society advocacy, the majority of program guidance promulgated by the UN system, including operational guidelines for HIV programs from the World Health Organization (WHO), reflect priorities articulated by marginalized populations (e.g., addressing stigma and discrimination).

Appendix 3: Meeting Agenda

Advancing Country Ownership:
Civil Society's Role in Sustaining Global Health Investments

September 12–13, 2012
Open Society Institute
1730 Pennsylvania Avenue Northwest, #700
Washington, D.C.

Objectives

- Discuss lessons learned and models for promoting engagement, equity, and results in transitioning to country ownership

- Identify strategies for multiple players in countries to advance country ownership through Global Fund CCMs, GHI compacts, and PEPFAR Partnership Frameworks as opportunities for broader engagement

- Develop recommendations for countries and donors seeking to implement country ownership to ensure civil society engagement and good health outcomes

Agenda

Day 1		
Time	**Topic**	**Speakers**
9:00–9:45	**Opening and Introductions**	Chris Collins, Vice President and Director of Public Policy, amfAR, US Sarah Clark, Vice President and Director, Center for Policy and Advocacy, Futures Group, US Dr. Yilma Melkamu, Team Leader for West and Central Africa sub-Region, International Planned Parenthood Federation, Africa Regional Office, Nairobi Chloe Cooney, Director of Global Advocacy, Planned Parenthood Federation of America

Day 1		
Time	**Topic**	**Speakers**
9:45–11:15	**Plenary 1**—What is country ownership and why is civil society's engagement important?	**Moderator**: Dr. Yilma Melkamu, Team Leader for West and Central Africa sub-Region, International Planned Parenthood Federation, Africa Regional Office, Nairobi Raymond Yekeye, Program Director, National AIDS Council, Zimbabwe Mande Limbu, Lawyer and Human Rights Advocate, White Ribbon Alliance, Tanzania/ Global Maria Antonieta Alcalde, Deputy Director of Public Affairs, IPPF Western Hemisphere Region, New York
11:15–11:30	**Coffee/Tea Break**	
11:30–1:00	**Plenary 2**—How do we support engagement for country ownership?	**Moderator**: Amb. Jimmy Kolker, Principal Deputy Director, Global Affairs at US Dept. of Health and Human Services Hon. Sylvia Ssinabulya, Member of Parliament, Uganda Dr. Regina Ombam, Head of Strategy, National AIDS Control Council, Kenya George Liendo, COO Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (Promsex), Peru
1:00–2:00	**Lunch** **Panel:** Country Ownership: The Role of Civil Society and USG Policy	**Moderator:** Joel Nana, Executive Director, The African Men for Sexual Health and Rights (AMSHeR), Cameroon Mamadi Yilla, Director for Sustainability and Integration, U.S. Department of State, Office of the Global AIDS Coordinator Roxana Rogers, Director, Office of HIV/AIDS, U.S. Agency for International Development Scott Radloff, Director, Office of Population and Reproductive Health, U.S. Agency for International Development

Day 1		
Time	**Topic**	**Speakers**
2:00–3:30	**Plenary 3**—How do we measure and improve civil society engagement? How do we leverage it for accountability?	**Moderator**: Smita Baruah, Director, Global Health Policy and Advocacy, Save the Children, US Theo Macha, Chief Executive Officer, Development Impact Limited, Tanzania Lucia Merino, Chief of Party, USAID-funded PASCA Project, Guatemala Morolake Odetoyinbo (Rolake), Executive Director, Positive Action for Treatment Access, Nigeria
3:30–4:45	**Task Groups**—To determine opportunities, challenges, and strategies in framing country ownership. 1. What is country ownership and why is civil society's engagement important? 2. How do we support that engagement? 3. How do we measure and improve that engagement and make it accountable?	**Group Facilitators:** Rev. MacDonald Sembereka, Executive Director, MANET+, Malawi; and Cynthia Green, Futures Group, US Emira Woods, Co-director of Foreign Policy In Focus (FPIF), Liberia, US; and Kate Goertzen, amfAR, US Dr. I.M. Ibrahim, Director General, PPF Nigeria; and Tisha Wheeler, Futures Group, US
4:45–5:00	**Recap of Day One**	**Moderator**: Ron MacInnis, Deputy Director HIV, Health Policy Project, Futures Group, US

Day 2		
Time	Topic	Speakers
9:00–9:15	**Objectives for Day 2**	**Moderator**: Ron MacInnis, Deputy Director HIV, Health Policy Project, Futures Group, US
9:15–10:15	**Task Group Summaries**	Group leads report back
10:15–10:30	**Coffee/Tea Break**	

Day 1		
Time	**Topic**	**Speakers**
10:30–11:45	**Plenary 4** –What are the policy implications for the role of civil society in country ownership? **Questions and Answers**	**Moderator**: Jennifer Kates, Vice President and Director of HIV Policy, Kaiser Family Foundation, US Dr. Olivia McDonald, OB/GYN Policy Leader, Jamaica Margot Fahnestock, Population Program Officer, William and Flora Hewlett Foundation, US Malala Mwondela, Executive Director, AIDS Law Research and Advocacy Network, Zambia Noah Metheny, Esq., MPH | Director of Policy The Global Forum on MSM & HIV (MSMGF), US
11:45–12:30	**Closing Remarks and Lunch**	Chris Collins and Sarah Clark

Appendix 4: Meeting Participants

Advancing Country Ownership: Civil Society's Role in Sustaining Global Health Investments
September 12–13, 2012

Open Society Institute
1730 Pennsylvania Avenue Northwest, #700
Washington, D.C.

Name	Position	Affiliation
Maria Antonieta Alcalde	Director of Advocacy	International Planned Parenthood Federation (IPPF)/Western Hemisphere Region
Patty Alleman*	Senior Technical Advisor	United States Agency for International Development (USAID)
Victoria Bachman	Allan Rosenfield HIV/AIDS Policy Fellow	amfAR, The Foundation for AIDS Research
Susan Blumenthal	Senior Policy and Medical Advisor	amfAR, The Foundation for AIDS Research
Linda Cahaelen*	Health Development Officer	USAID
Allison Campbell*	Senior Region Team Lead for East and West Africa	United States Office of the Global AIDS Coordinator (OGAC)
Rochika Chaudhry*	GHI Senior Country Advisor	USAID
Sarah Clark	Vice President and Director - Center for Policy and Advocacy	Futures Group
Susan Cohen	Director of Government Affairs	Guttmacher Institute
Chris Collins	VP and Director of Policy	amfAR, The Foundation for AIDS Research
Chloe Cooney	Director of Global Advocacy	Planned Parenthood Federation of America
Elisha Dunn-Georgiou	Vice President of Advocacy	Population Action International
Margot Fahnestock	Program Officer, Population Program	William and Flora Hewlett Foundation
George Fistonich	Allan Rosenfield HIV/AIDS Policy Fellow	amfAR, The Foundation for AIDS Research
Latanya Mapp Frett	Vice President - Global	Planned Parenthood Federation of America
Kate Goertzen	Research & Policy Asst. Coordinator	amfAR, The Foundation for AIDS Research
Cynthia Green	Senior Technical Advisor	Futures Group
Karen Hardee	Senior Fellow	Futures Group
Mai Hijazi*	Health Development Officer	USAID

Name	Position	Affiliation
Derek Hodel**	Consultant	amfAR, The Foundation for AIDS Research
Anne Jorgensen	USAID Health Policy Project Team Leader and Technical Director	CEDPA
Rajiv Kafle	President	Nava Kiran Plus
Jennifer Kates	VP and Director of Global Health & HIV Policy	Kaiser Family Foundation
Valerie Kirby	Allan Rosenfield HIV/AIDS Policy Fellow	amfAR, The Foundation for AIDS Research
Jimmy Kolker*	Principal Deputy Director	United States Department of Health and Human Services, Office of Global Affairs
Sijia Liang	Program Operations Associate	Futures Group
George Liendo	Chief Operating Officer	PROMSEX
Mande Limbu	Maternal Health Technical Advisor	White Ribbon Alliance
Theo Macha	Chief Executive Officer	Development Impact
Ron MacInnis	Deputy Director - Health Policy Group	Futures Group
Olivia McDonald	Executive Director	National Family Planning Board, Jamaica
Amy McDonough	Program Assistant	Open Society Foundations
Yilma Melkamu	Team Leader, West and Central Africa	IPPF Africa Region
Lucia Merino	Chief of Party	Futures Group / PASCA
Noah Metheny	Director of Policy	The Global Forum on MSM & HIV (GFMSM)
Malala Mwondela	Executive Director	Zambia AIDSLaw Research & Advocacy Network
Joel Nana	Executive Director	The African Men for Sexual Health and Rights (AMSHeR)
Regina Ombam	Head of Strategy	Kenyan National AIDS Control Council
Morolake Odetoyinbo	Executive Director and Founder	Positive Action for Treatment Access
Ryan Ubuntu Olson	Program Advisor	Futures Group
Anjana Padmanabhan*	Public Affairs Advisor	OGAC
Tonia Poteat*	Senior Technical Advisor	OGAC
Scott Radloff*	Director, Office of Population and Reproductive Health	USAID
Roxana Rogers*	Director, Office of HIV/AIDS	USAID
Nana Amma Oforiwaa Sam	Project Coordinator, Advocacy	Planned Parenthood Association of Ghana

Name	Position	Affiliation
MacDonald Sembereka	Executive Director	Malawi Network of Religious Leaders Living with HIV/AIDS (MANERELA)
Sylvia Ssinabulya	Chairperson of the Network of Women Ministers and Parliamentarians	Member of Parliament, Uganda
Reshma Trasi	Director, Monitoring, Evaluation and Research	Management Sciences for Health
Tisha Wheeler	Senior Technical Advisor	Futures Group
Emira Woods	Co-Director of Foreign Policy In Focus (FPIF)	Institute for Policy Studies, Foreign Policy in Focus
Jason Wright	U.S. Director	International HIV/AIDS Alliance
Raymond Yekeye	Program Director	National AIDS Council
Mamadi Yilla	Director, Senior Public Health Advisor for Sustainability and Integration	OGAC

* NOTE: The information provided in this report is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development (USAID) or the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

**Derek Hodel was primary writer for this report.

ENDNOTES

[1] Open Forum for CSO Development Effectiveness Forum. The Siem Reap CSO Consensus on the International Framework for CSO Development Effectiveness (June 28-30, 2011). Available at www.cso-effectiveness.org/IMG/pdf/international_framework_open_forum.pdf

[2] Lucas ST. Millennium Challenge Corporation principles into practice: country ownership (November 2011).

[3] Bertrand JT. USAID graduation from family planning assistance: Implications for Latin America (October 2011).

[4] USAID. Graduation and phase out in the health sector – what have we learned? Pre-publication draft (January 2012).

[5] PEPFAR. FY2013 country operation plan guidance, version 2 (October 12, 2012). Available at www.pepfar.gov/documents/organization/198957.pdf

[6] Remarks of U.S. Secretary of State Hillary Clinton. Keynote at the opening session of the Fourth High-Level Forum on Aid Effectiveness. Busan, South Korea (November 30, 2011). Available at www.state.gov/secretary/rm/2011/11/177892.htm

[7] Remarks of Secretary of State Hillary Rodham Clinton. A world in transition: charting a new path in global health. June 1, 2012, Oslo, Norway. Available at www.state.gov/secretary/rm/2012/06/191633.htm

[8] Global Health Initiative. U.S. government interagency paper on country ownership (July 2012). Available at www.ghi.gov/documents/organization/195554.pdf

[9] Interaction. Country ownership: moving from rhetoric to action (November 2011). Available at www.interaction.org/sites/default/files/Country%20ownership%20paper.pdf

[10] Save the Children. Consultation and participation for local ownership: what, why, how? (September 2010). Available at www.savethechildren.org/atf/cf/%7B9DEF2EBE-10AE-432C-9BD0-DF91D2EBA74A%7D/consultation-local-ownership.pdf

[11] Dennis S. Making aid effectiveness work for family planning and reproductive health (September 2009). Available at www.populationaction.org/oldmedia/WP_AE_FIN2.pdf

[12] Mas de Xaxás M, Vogel CG. Making country ownership a reality: an NGO perspective. Population Action International Research Commentary (September 2007), 2/3.

[13] Lucas ST. Principles into practice: country ownership (November 2011). Available at www.mcc.gov/documents/reports/paper-2011001093802-principles-country-ownership.pdf

[14] Dodd R, Shieber G, Cassels A, Fleisher L, Gottret P. Aid effectiveness and health – making health systems work working paper #9. Available at www.who.int/hdp/publications/aid.pdf

[15] UNAIDS. Global fact sheet: World AIDS Day 2012. Available at www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf

[16] Eurasian Harm Reduction Network. Quitting while not ahead: the Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe & Central Asia (May 2012). Available at www.aidsalliance.org/includes/Document/Quitting-While-Not-Ahead.pdf

[17] Guttmacher Institute. Just the numbers: the impact of U.S. international family planning assistance (April 27, 2012). Available at www.guttmacher.org/media/inthenews/2012/04/27/index.html

[18] Tulane University Population Institute. USAID graduation from family planning assistance: implications for Latin America (October 2011). Available at www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf

[19] International Planned Parenthood Federation Western Hemisphere Region. IPPF/WHR – UNFPA/DC executive summary draft report on the USAID graduation policy for population funding in Latin America and the Caribbean, fact-finding mission to Peru (May 16-22, 2010). Available at www.ippfwhr.org/sites/default/files/DRAFT_EXECUTIVE_SUMMARY_PERU_.pdf

[20] Civicus. Civil society: the clampdown is real; global trends 2009-2010. Available at www.civicus.org/content/CIVICUS-Global_trends_in_Civil_Society_Space_2009-2010.pdf

[21] International Center for Not-for profit Law. NGO law monitor: Ethiopia (December 6, 2012). Available at www.icnl.org/research/monitor/ethiopia.html

[22] Middleberg MI. The anti-prostitution policy in the U.S. HIV/AIDS program. *Health and Human Rights* (2006), 9/1. Available at www.hhrjournal.org/archives-pdf/4065386.pdf.bannered.pdf

[23] Limbu M. Opportunities for Strengthening country ownership in maternal health: the role of civil society, presented at: Advancing country ownership: civil society's role in sustaining global health initiatives (September 12-13, 2012), Washington, D.C.

[24] Millennium Challenge Corporation. Guidelines for the consultative process (February 2009). Available at www.mcc.gov/documents/guidance/guidance-2010001005001-consultativeprocess.pdf

[25] Atun R, Kazatchkine M. Promoting country ownership and stewardship of health programs: the Global Fund experience. *Journal of Acquired Immune Deficiency Syndromes* 52/suppl 1 (November 1, 2009), S67-S68.

[26] Macha T. Measuring and Improving CSO engagement and fostering government accountability: experience from Tanzania, presented at: Advancing country ownership: civil society's role in sustaining global health initiatives (September 12-13, 2012), Washington, D.C.

[27] Alcalde M-A. Governance and civil society participation, presented at: Advancing country ownership: civil society's role in sustaining global health initiatives (September 12-13, 2012), Washington, D.C.

[28] USAID Health Policy Initiative. Stories from the field: Guatemala Congress establishes policy monitoring board. Available at www.healthpolicyinitiative.com/Publications/Documents/518_1_Guatemala_Policy_Imp_Assess_Tool_FINAL.pdf

[29] International Planned Parenthood Federation Western Hemisphere Region. Assessing budget transparency and maternal health: how five countries measure up: pilot experience (July-December 2010). Available at www.ippfwhr.org/sites/default/files/ippf%20j-d%202010.pdf

[30] International Planned Parenthood Federation Western Hemisphere Region. Holding governments accountable: experiences from five Latin American countries. Available at www.ippfwhr.org/sites/default/files/Voices_english_FNL%20new.pdf

[31] Merino L. Moving forward to FP/RH/HIV policy monitoring and implementation: key civil society contributions in Central America – experiences in Guatemala and El Salvador [written remarks], presented at: Advancing country ownership: civil society's role in sustaining global health initiatives (September 12-13, 2012), Washington, D.C.

[32] Bennett S, Singh S, Ozawa S, Tran N, Kang JS. Sustainability of donor programs: evaluating and informing the transition of a large HIV prevention program in India to local ownership. Glob Health Action 2011; 4: 10.3402/gha.v4i0.7360. Available at www.globalhealthaction.net/index.php/gha/article/view/7360

[33] Melkamu Y. Country ownership and civil society's engagement: experience from IPPF Africa region, presented at: Advancing country ownership: civil society's role in sustaining global health initiatives (September 12-13, 2012), Washington, D.C.

[34] Bendavid E, Miller G. The US Global Health Initiative: informing policy with evidence. *Journal of the American Medical Association* (*JAMA)* (August 10, 2010); 304/7: 791-792.

[35] de Renzio P, Whitfield L, Bergamaschi I. Reforming foreign aid practices: what country ownership is and what donors can do to support it. Available at www.globaleconomicgovernance.org/wp-content/uploads/Reforming%20Aid%20Practices,%20final.pdf

[36] Organization for Economic Co-operation and Development. The Paris Declaration on Aid Effectiveness (2005) and Accra Agenda for Action (2008). Available at www.oecd.org/dataoecd/11/41/34428351.pdf

[37] Open Forum for CSO Development Effectiveness Forum. Istanbul CSO Development Effectiveness Principles (September 29, 2010). Available at www.cso-effectiveness.org/IMG/pdf/final_istanbul_cso_development_effectiveness_principles_footnote_december_2010-2.pdf

[38] Organization for Economic Co-operation and Development. Busan partnership for effective development co-operation: fourth high level forum on aid effectiveness, Busan, Republic of Korea (November 29-December 1, 2011). Online: www.oecd.org/dac/aideffectiveness/49650173.pdf

[39] UNAIDS. Discussion paper: Country ownership for a sustainable AIDS response: from principles to practice (July 2012).

[40] Advisory Group Synthesis of Findings and Recommendations, August 2008. From Siem Reap CSO consensus document.

[41] International Conference on Population and Development. Programme for Action. Available at www.unfpa.org/public/publications/pid/1973