

**Evaluation of the Implementation of the
Paris Declaration:
United States Government**

**Department of Health and
Human Services
Case Study**

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Independent Evaluation Team:

George F. Grob

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Social Impact, Inc
2300 Clarendon Blvd. Suite 300
Arlington, VA 22201

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ACRONYMS

CDC	Centers for Disease Control and Prevention
CGH	CDC's Center for Global Health
DAC	Development Assistance Committee
DOL	Department of Labor
DOS	Department of State
DOT	Department of Treasury
FDA	Food and Drug Administration
GHA	Global Health Initiative
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
KI	Key Informant
NIH	National Institutes of Health
ODA	Official Development Assistance
OECD	The Organization for Economic Cooperation and Development
OGAC	Office of the U.S. Global AIDS Coordinator
OGHA	Office of Global Health Affairs
PD	Paris Declaration
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
MCC	Millennium Challenge Corporation
SAMHSA	Substance Abuse and Mental Health Services Administration
USAID	United States Agency for International Development
USDA	U.S. Department of Agriculture
USG	U.S. Government

EXECUTIVE SUMMARY

On March 2, 2005, ministers of developing and developed countries and heads of multilateral and bilateral development institutions, meeting in Paris, issued a resolution to reform the ways they deliver and manage international aid. They established five principles to guide aid participants:

- **Ownership.** Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption
- **Alignment.** Donor countries align behind these objectives and use local systems
- **Harmonization.** Donor countries coordinate with host countries to simplify procedures and share information to avoid duplication
- **Results.** Developing countries and donors shift focus to development results and results get measured
- **Mutual Accountability.** Donors and partners are accountable for development

The United States is one of more than 150 nations and donor organizations to endorse the resolution, known as the Paris Declaration on Aid Effectiveness. The Organization for Economic Cooperation and Development (OECD) is sponsoring a simultaneous, multinational review of the implementation of the Paris Declaration. This report reviews implementation within the U.S. Department of Health and Human Services (HHS), and is part of the larger review of implementation by the U.S. government as a whole.

HHS Global Health Programs

Though international work is on the periphery of such a domestic agency, there are nonetheless six agencies with responsibilities to address global health challenges through direct assistance, technical and program support, training and capacity building, and research:

- Office of Global Health Affairs (OGHA) within the Office of the Secretary;
- Centers for Disease Control and Prevention (CDC);
- National Institutes of Health (NIH);
- Food and Drug Administration (FDA);
- Health Resources and Services Administration (HRSA); and
- Substance Abuse & Mental Health Services Administration (SAMHSA).

Although not officially tracked in the HHS budget, we estimate total HHS funding that could be considered to be for international programs was \$2.2 billion in FY 2009, the largest share by far through the Centers for Disease Control and Prevention, with \$1.8 billion.

Methodology

We conducted a case study, combining a review of foundation documents (legislation, budgets, program descriptions, policy statements) and structured key informant interviews.

We interviewed twenty-one senior and mid-level professionals across five agencies within HHS. We elected not to include SAMSHA, due to its relatively minimal international programs.

Summary Findings

Based on our analysis and assessment, we assess the HHS implementation of the Paris Declaration Principles as follows:

- 1) Knowledge of the Paris Declaration itself is generally limited; HHS has not been provided with implementation guidance and, in turn, HHS has provided no formal announcement, explanation, or commitment to its component agencies, separate from what the U.S. government as a whole and the lead USG foreign assistance agencies have announced or published.
- 2) Commitment to its principles is strong, nevertheless, especially among those responsible for day-to-day management of HHS global health programs.
- 3) HHS global health initiatives' operating procedures and tactical measures reflect the principles and objectives of the Paris Declaration.
- 4) The strongest incentive for HHS staff to embrace Paris Declaration principles is the inherent value of effective and sustainable international aid.
- 5) The most commonly expressed disincentives are the difficulty of implementing it and the time it takes get results.
- 6) Major disincentives and obstacles to *alignment and mutual accountability* include:
 - The lack of capacity of some countries to serve as true partners;
 - The possibility of corruption; and
 - Difficulties resulting from disconnects between the United States' and foreign governments' policies and goals.
 - The major disincentive and obstacle to *harmonization* is the required accountability of government agencies to their program offices, the president, and Congress.

Considerations

- 1) HHS could benefit from guidance by USG lead agencies in the implementation of the Paris Declaration as to the formal policy regarding the importance and applicability of the Paris Declaration, and the Office of Global Health Affairs could be tasked with assuring that all HHS operating divisions and staff divisions are aware of the USG policy on implementation.

Issuance of such formal guidance would reinforce principles of international partnership that are well engrained in the culture and practices of HHS global health agencies.

- 2) The above policy should provide practical guidance regarding realistic expectations and appropriate actions to be taken in dealing with potential problems such as those relating to:
- The proactive development of the partner country's management capacity and adaptations to joint project plans to accommodate the country's ability to participate in planning, budgeting, financial control, monitoring, and project management;
 - The potential for fraud;
 - A disconnect between fundamental policies or priorities of the U.S. government and that of the partner country; and
 - Accountability to senior HHS program officials, other executive branch officials, and the Congress, and; improvement of monitoring and evaluation, including impact evaluation, as inherent features of international programs, including the development of the host country's participation in the project evaluation and the general development of its evaluation capacity.

1 INTRODUCTION TO STUDY

Over 150 countries, donors and international organizations signed the Paris Declaration on Aid Effectiveness (PD) in 2005, in an effort to improve the quality and effectiveness of development assistance. The Declaration was further elaborated on at the Accra workshop in 2008. This study focuses on the PD principles, including the Accra Agenda for Action (AAA) of 2008.

The PD is built around five principles: ownership, alignment, harmonization, managing for results, and mutual accountability. This evaluation is part of an independent international evaluation of the PD to examine its implementation and explore its impacts. Beginning in 2007 and ending in 2010, over thirty

developing partner countries, and almost twenty donor countries and international organizations, will participate in case study evaluations. The case study results will be incorporated into a Synthesis Report to be presented to the Fourth High Level Forum on Aid Effectiveness in December 2011 in Busan, Korea.

The U.S. government (USG) is participating in this effort by conducting an independent evaluation of its commitment to and efforts towards implementing the PD. To better reflect the reality of USG Foreign Assistance (FA), SI has prepared separate case studies for each of the four main agencies involved in providing U.S. foreign assistance: United States Agency for International Development (USAID), Department of State (DOS), Health and Human Services (HHS), and Millennium Challenge Corporation (MCC), and three smaller case studies on the Department of Labor (DOL), Department of Treasury (TREAS), and the U.S. Department of Agricultural (USDA). To enable comparative analysis, all case studies have used the same conceptual framework. A synthesis report draws on the data and information generated by the case studies.

1.1 The assessment approach and methodology

The USG study, along with all the donor studies, assesses four broad areas:

- 1) Leadership and staff commitment to the PD principles;
- 2) The agency's (or agencies') capacity to implement the Paris Declaration and the steps that it has undertaken to enhance its capacity;
- 3) Incentives and disincentives for implementing the PD principles; and

Paris Declaration Principles*

Ownership - *Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.*

Alignment - *Donor countries align behind these objectives and use local systems.*

Harmonization - *Donor countries coordinate, simplify procedures and share information to avoid duplication.*

Results - *Developing countries and donors shift focus to development results and results get measured.*

Mutual Accountability - *Donors and partners are accountable for development results.*

*www.oecd.org

4) Coherence, political framework and coordination.

The Paris Declaration is directed at the effectiveness of development aid, and specifically Official Development Assistance (ODA),¹ as the endorsers of the PD are governments and official agencies. This may include humanitarian and emergency assistance, and other aid in fragile situations.² The international management team guidance provided to the SI Evaluation Team (“Evaluation Team” or “the Team”) stated that this should also include “vertical funds” that combine resources from several types of donors (bilateral, multilateral, private, corporations, etc.).

The guidance continued, “[a]t the same time, the Paris Declaration and AAA are also explicitly and repeatedly concerned with ‘other development resources’ and their inter-relations with the aid flows most targeted by the Declaration. . . . The Evaluation design aims to place aid in its proper context. For this reason, the substantial domestic and external resources available for development other than ODA will be given major attention in the contextual analysis. Beyond their contextual importance, moreover, the Evaluation approach recognizes that other providers of development aid and finance are concerned with ensuring and improving the effectiveness of their own contributions. Even if they have not been so directly targeted by the Declaration, they have nevertheless been participating or taking account of global reform initiatives.”

The SI Evaluation Team’s substantive approach to assessing these areas started with the question: “To what extent are U.S. foreign assistance policies and practices consistent with the five principles of the Paris Declaration?”, rather than limiting our research to those policies and practices specifically labeled, “Paris Declaration.” The team used a mixed-methods approach, including literature and documentation review, semi-structured interviews and focus group interviews of senior and other selected agency headquarters staff. The SI Evaluation Team designed a Key Informant (KI) interview guide that included content and rating scales for the interviewers and interviewees to provide ratings and rankings on important topics/questions. This helped to ensure consistency in data gathering and allowed for greater comparability across agencies. Twenty-five of the fifty-five commitments apply to donors; the Team determined that eleven (at least one under each of the five principles) of them were key commitments that should be analyzed for the USG evaluation, as they are relevant and operational in the USG context. A commitment guide was created and used in interviews as a probe for interviewees less familiar with the Paris Declaration. It allowed the evaluators to find out what practices or processes are consistent with a PD principle, but not necessarily labeled as such.³ The Team also met with representatives from HHS and the Office of the Director of Foreign Assistance (F) and the USG

¹ ODA as defined by the OECD/DAC: “Grants or Loans to countries and territories on Part I of the DAC List of Aid Recipients (developing countries) which are: (a) undertaken by the official sector; (b) with promotion of economic development and welfare as the main objective; (c) at concessional financial terms [if a loan, having a Grant Element (q.v.) of at least 25 per cent]. In addition to financial flows, Technical Co-operation (q.v.) is included in aid. Grants, Loans and credits for military purposes are excluded. For the treatment of the forgiveness of Loans originally extended for military purposes, see Notes on Definitions and Measurement below. Transfer payments to private individuals (e.g. pensions, reparations or insurance payouts) are in general not counted.”

² The general principles of the Paris Declaration are expected to apply in “challenging and complex situations.” to these forms of aid, with some special requirements for adaptation. (See PD para. 7). In the main, however, humanitarian assistance is excluded from coverage under the Paris Declaration and AAA.

³ Both the interview guide and commitment guide can be found in Annex 1

Reference Group, consisting of representatives from each case study agency, to discuss and confirm the evaluation process and design. With a few exceptions, the case study evaluations do not include interviews with field staff. However, field perspectives will be assessed in the team’s synthesis report, through survey and field interview data.

Each case study team worked with their agency representative to identify key informants from program, policy, and functional offices, in addition to senior leadership. The final list of key informants was subject to participant availability and willingness to participate. All interviews are confidential.

Successful implementation of the Paris Declaration principles is not the responsibility, nor even within the reach, of any single government agency. Rather, it relies upon the combined efforts and actions of the agency being reviewed, as well as the host countries it intends to help, other U.S. government donor agencies, other donor countries, and non-government organizations. The purpose and nature of the assistance provided can also have an effect. This report will provide insights into the achievements, challenges, and varying incentives and disincentives to implementing the PD Principles, and present relevant considerations or implications to HHS.

1.2 Key Informants and document review

The team reviewed foundation documents that guide HHS’ operations, including strategic plans, annual program reports, program websites, official statements from key leadership, budget reports, PEPFAR legislation, Global Health Initiative, etc.⁴

For the HHS study, the team met with twenty-one individuals:

- Seven from the Office of Global Affairs (OGHA);
- Nine from the Centers for Disease Control and Prevention (CDC) (six of whom work within CDC’s Center for Global Health);
- Two from the Health Resources and Services Administration’s (HRSA) Global HIV/AIDS Office;
- One from the National Institutes of Health Fogarty International Center; and
- Two from the Food and Drug Administration’s (FDA) Office of International Programs.

We specifically chose this mixture to cover all major HHS offices involved in international programs, but give greater weight and coverage to the two HHS agencies that bear the largest responsibility for international policy and programs—OGHA and CDC. We elected not to include SAMSHA, due to its minimal role in international programs.

⁴ For a list of key references, see Annex 2, “References”

Our interviewees cover the gamut of senior positions:

- Three provide(d) executive direction in the Office of Global Health Affairs and CDC's Center for Global Health;
- Twelve are responsible for managing major international programs;
- Three provide significant support functions (e.g., management and support of overseas operations, PEPFAR liaison, policy coordination);
- One serves as HHS health attaché stationed in South Africa; and
- Two serve as senior analysts.

1.3 Limitations

The lack of randomness in the selection of key informants and their relatively small number are the primary limitations of this review, raising potential issues of representation and bias. The small sample was due to time and resource restrictions; several methods were implemented to mitigate the effect of these conditions. A purpose-based selection method attempted to achieve some even representation for the agencies surveyed. Advice, solicited from two senior officials in OGAH regarding the selected individuals, sought to eliminate bias. The established criteria for selection, which included key informants' knowledge and experience, the seniority of the positions held, and the mix of functions they perform, limited the effects of any bias. Only interviews that displayed consistent responses across all interviewees, and for which documentary support was available, formed the basis for this Evaluation's conclusions.

This study's scope was intentionally limited to headquarters informants. The Team interviewed only one official stationed in a field office at the time of review, detailed there from her position in headquarters. The decision to exclude field staff was intentional: the objective of the study was to evaluate the depth of knowledge and orientation of agency leadership at headquarters. Field-level studies of implementation are being conducted in a coordinated manner by thirty host countries. There was no need to duplicate, or interfere with, the methods used in those studies.

2 THE DEPARTMENT OF HEALTH AND HUMAN SERVICES INTERNATIONAL PROGRAMS

This section describes information on the international programs carried out by the Department of Health and Human Services (HHS) collected through the foundation documents described above and the interviews. First, it positions these activities within the broader Department. It then describes the total level of funding for international programs, the sources of these funds, and the relative amounts for various programmatic categories of aid. This is followed by more detailed descriptions of the various international programs and how they are organized within each of the relevant components of the Department. Finally, it describes several recent Presidential initiatives which govern the conduct of global health overall and international programs for HIV/AIDS and malaria in particular. These Presidential initiatives are particularly germane to our study, as they contain specific and far reaching policy and procedural guidance that largely reflects the principles of the Paris Declaration.

2.1 Overall Organization of HHS Global Health Programs

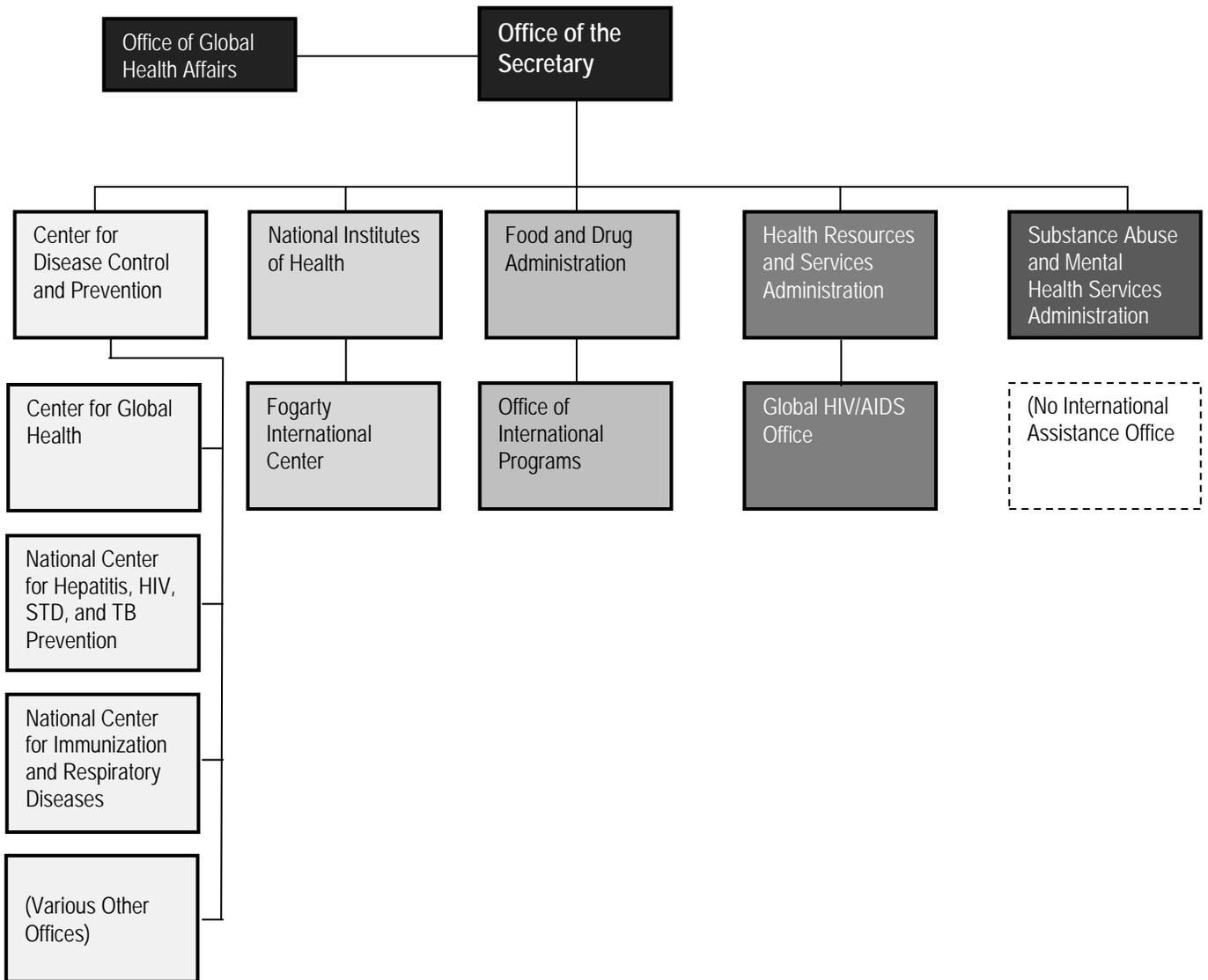
HHS is primarily a domestic agency, with a broad array of programs, including Medicare and Medicaid; biomedical research; health services; development of health professionals; disease control and prevention; food and drug safety; family support and child development; and assistance for seniors and for developmentally disabled persons. Its total outlays for 2009 were \$794 billion.

Though international work is on the periphery of this primarily domestic Department, six agencies seek to address global health challenges through direct assistance, technical and program support, training and capacity building, and research:

- Office of Global Health Affairs (OGHA) within the Office of the Secretary;
- Centers for Disease Control and Prevention (CDC);
- National Institutes of Health (NIH);
- Food and Drug Administration (FDA);
- Health Resources and Services Administration (HRSA); and
- Substance Abuse & Mental Health Services Administration (SAMHSA).

Figure 1 below displays the significant HHS agencies and offices responsible for activities that could be considered international programs and illustrates their relationship to the larger operating components of the department. Only HHS components and staff offices with some connection to international programs are displayed. Similarly, not every office with a responsibility for international programs is displayed, as these are carried out in connection with national programs and are not separately organized or funded.

Figure 1: HHS offices providing international assistance



2.2 Budget and Resources

Total estimated HHS funding for international programs, based on the information we were able to gather, was \$2.2 billion in FY 2009. Table 1 summarizes funding for the international programs carried out by HHS agencies.⁵

Table 1, HHS funding for international programs ⁶ (\$ millions)					
	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Office of Global Health Affairs	\$9.7	\$3.8	\$4.0	\$6.5	\$6.4
Transfers from U.S. Global AIDS Coordinator	16.1	15.3	17.8	3.0	NA
Centers for Disease Control and Prevention Global Health Initiatives	379.6	307.5	302.4	319.1	336.1
Other Centers for Disease Control and Prevention Funds					
Afghanistan Health Initiative	5.9	5.9	5.8	5.8	5.8
Health Diplomacy Initiative				4.5	2.0
Global Tuberculosis	2.2	1.9	2.0	1.6	1.6
Pandemic/Avian Flu	132.0	22.0	67.8	156.0	156.3
Transfers from Global AIDS Coordinator	573.2	910.1	1,336.0	1,395.1	NA
Transfers from USAID for Malaria	2.8	9.6	12.6	TBD	NA
NIH Fogarty International Center	67.0	66.4	67.4	68.7	70.1
Transfers from U.S. Global AIDS Coordinator	12.8	3.3	4.5	5.1	NA
Food and Drug Administration					
Transfers from U.S. Global AIDS Coordinator	3.7	3.7	4.2	4.2	NA
Health Resources and Services Agency Transfers from U.S. Global AIDS Coordinator	143.5	215.4	292.1	252.3	NA
Substance Abuse and Mental Health Services Administration					
Transfers from U.S. Global AIDS Coordinator	0.6	0.3	0.6	0.7	NA
TOTAL	1,343.0	1,565.2	2,117.2	2,222.6	TBD

NA = Not available

⁵ Detailed descriptions of the programs are in the Appendix A, HHS Global Health Programs

⁶ Sources: HHS FY 2011 Congressional Budget Justification, HHS budget records, and Congressional Research Service analysis

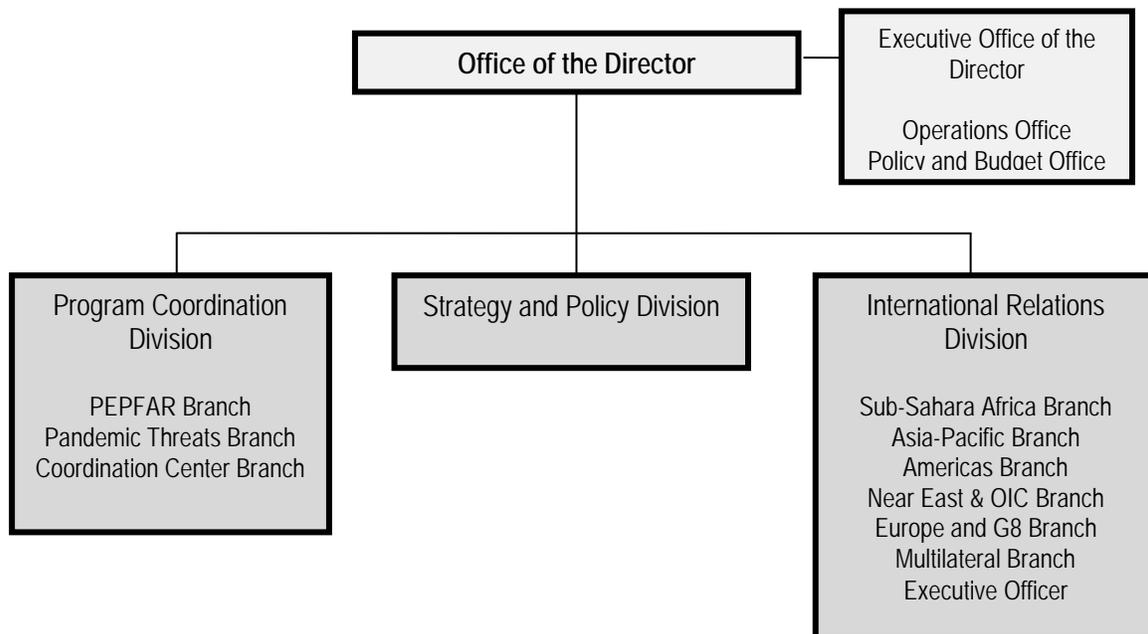
As noted in the table, HHS agencies receive funding for international programs from various sources, including congressional appropriations for budget line items for global health, allocation by agencies from broader appropriations, and transfers from the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI). The latter two account for \$1.7 billion, or seventy-eight percent, of the total \$2.2 billion in HHS international assistance activities. This is particularly important to this study, since the use of these transferred funds are governed, not by HHS administrative procedures but by those issued by the U.S. Global AIDS Coordinator for PEPFAR and by USAID for Malaria.⁷

2.3 Major HHS International Programs and Offices

2.3.1 Office of Global Health Affairs (OGHA)

OGHA is located organizationally within the Office of the Secretary of Health and Human Services. It coordinates USG inter-agency processes related to presidential and secretarial initiatives, multilateral organizations, and HHS bilateral cooperation with specific countries. It also leads and coordinates HHS participation in the implementation of the president’s Global Health Initiative, as well as existing commitments to the president’s PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the PMI.

Figure 2: Offices of Global Health Affairs



⁷ More information about the funding of these programs and offices can be found in Annex 2, Section E

OGHA largely serves to coordinate policy development and engagement across HHS in global health matters. Some of OGHA's main activities that could be considered to be international programs include:

Health attachés: Supports HHS international health attaché positions in U.S. missions to international organizations in Switzerland, India, South Africa, and China.

Global Health Security Initiative: Provides a global forum for high-level discussion around, and the coordination of, public health emergency preparedness and response policies. OGHA, together with the Office of the Assistant Secretary for Preparedness and Response, represents the U.S. for the HHS at annual meetings with country members.

HIV/AIDS: Coordinates HHS policy and budget for all HHS operating divisions serving as implementing agencies for PEPFAR, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

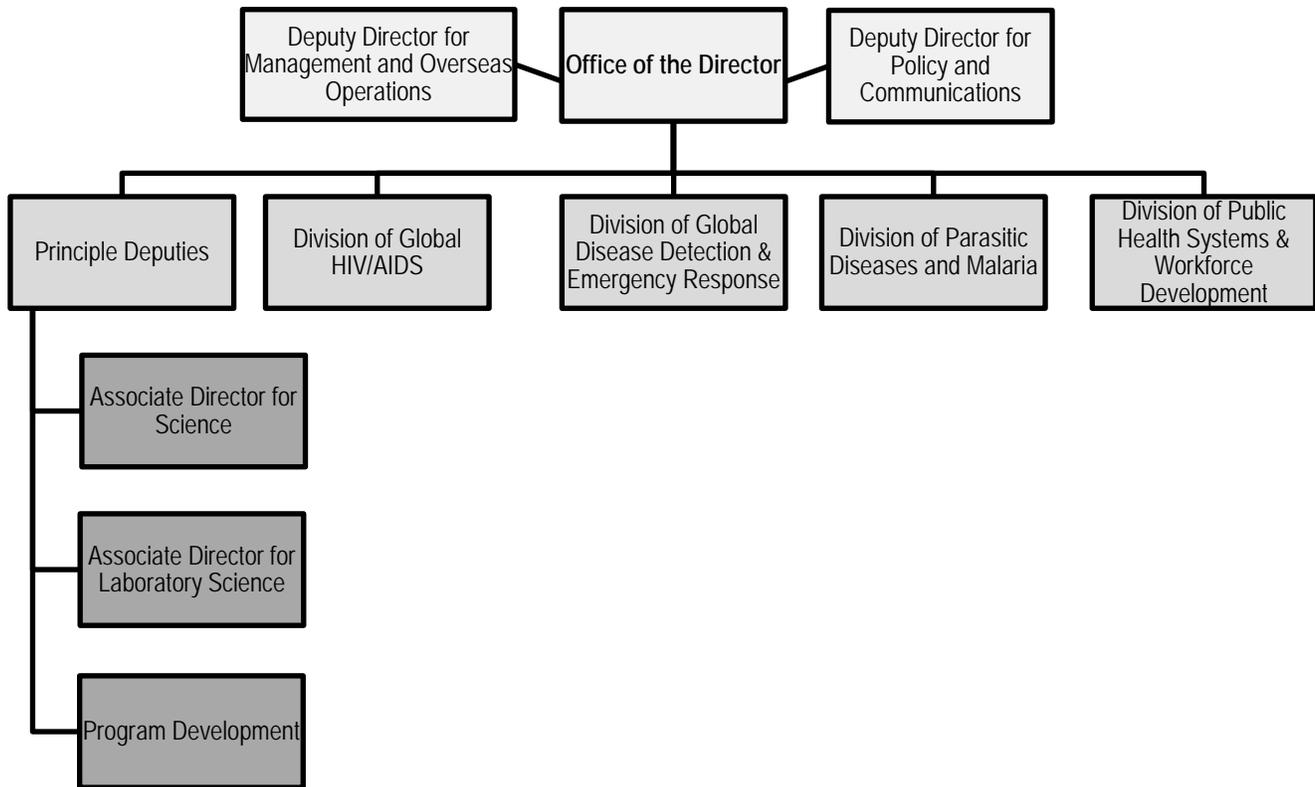
International Organizations: Serves as the department's principal liaison with international health organizations, such as the World Health Organization and the Pan-American Health Organization.

United States-Mexico Border Health Commission: Provides international leadership to optimize health and quality of life along the United States–Mexico border.

2.3.2 Centers for Disease Control and Prevention

Congress appropriates funds to CDC for its global health efforts through five main budget lines: (1) Global HIV/AIDS; (2) Global Immunization; (3) Global Disease Detection; 4) Malaria; and, (5) Other Global Health. CDC addresses these priorities mainly via technical assistance to health ministries and field training programs. CDC also receives and leverages other resources to respond to global requests for technical assistance in outbreak response, prevention and control of injuries and chronic diseases; emergency assistance and disaster response; environmental health; reproductive health; and safe water, hygiene, and sanitation. Most of CDC's global health initiatives were consolidated in 2010 under a new center, the Center for Global Health. Figure 3 depicts the larger program and staff offices of this new organization. However, some of its international programs are provided through other CDC centers as an extension of their more general disease control and prevention functions, such as tuberculosis prevention and control.

Figure 3: CDC Center for Global Health



It is not practical to describe all of CDC’s global health programs; the following is a description of major programs and a representative sampling of others:

Global HIV/AIDS Program: CDC provides technical leadership and direct assistance to ministries of health and other partners in over seventy countries to expand quality HIV/AIDS care and treatment, and transition these services to local ownership; implement effective HIV/AIDS prevention programs; conduct research on program impact and cost effectiveness; build sustainable public health information, laboratory, and management systems; and build local workforce capacity. These contributions include key program focus areas in maternal and child health and health systems strengthening, with an emphasis on program and health-delivery integration. CDC receives funds from the Office of the Global AIDS Coordinator (OGAC) to combat HIV/AIDS globally.

Field Epidemiology and Laboratory Training Program: Since 1980, CDC has worked in collaboration with local and international organizations to help ministries of health develop field epidemiology and laboratory programs that build capacity in a range of areas, including epidemiology, outbreak investigation, health surveillance systems, applied research, program evaluation, communications, and program management. CDC generally supports a country’s program for about six years, gradually transferring responsibility and program costs to ensure that the country can sustain the program once

CDC staff is no longer present. This program is carried out through the Center for Global Health's Division of Public Health Systems and Workforce Development.

Global Immunization: CDC provides technical assistance to promote improvement in immunization against transmittable diseases worldwide through the National Center for Immunization and Respiratory Diseases. CDC officials serve on the Global Alliance for Vaccines and Immunization (GAVI) and act as implementing partners in a number of initiatives, including GAVI's Hib and Accelerated Vaccine Introduction Initiatives and the Meningitis Vaccine Project, all of which seek to accelerate introduction of new or underutilized vaccines in developing countries that can reduce child mortality.

Global Malaria: CDC contributes to global malaria prevention and control as a key implementing partner for the President's Malaria Initiative (PMI), including assisting with enhancement of vector control, case management, surveillance, monitoring and evaluation, and capacity building, as well as working with ministries of health and other partners to conduct essential operations research to develop new tools and strategies to prevent malaria. CDC also conducts activities to monitor malaria among U.S. travelers and visitors.

Sustainable Management Development Program: CDC offers technical assistance to ministries of health, universities and non-governmental organizations to strengthen public health leadership and management capacity. Currently, CDC has active collaborations with Ghana, Nigeria, Botswana, Ethiopia, Malawi, Georgia, Vietnam, and Macedonia. Previously, it collaborated with Mexico, the Philippines, Taiwan, Thailand, Serbia, Croatia, and Guatemala. Public health outcomes of these collaborations have included improved immunization coverage, tuberculosis treatment, bed net usage, and adherence to HIV/AIDS treatment.

Afghanistan Health Initiative: Since 2004, OGHA has implemented a program of health cooperation with Afghanistan, focusing on strengthening maternal and child health and improving health outcomes of mothers and newborns in Kabul. HHS proposes transfer of this program to CDC in FY 2011.

The Health Diplomacy Initiative: This program channels U.S. government and private sector resources to deliver direct patient care and train local health workers, starting in Central America. This program will be carried out by CDC and OGHA in FY 2011, subject to funding.

Water and Sanitation Programs: CDC's approach to water, sanitation, and hygiene programs includes research, training, and technical assistance to improve health by promoting better access to safe drinking water; a new program in global safe water, sanitation, and hygiene is proposed for 2011. CDC activities include distribution of the Safe Water System, a water quality intervention developed by CDC that makes water safe to drink through a simple process of disinfection and safe storage at the point of use (e.g., in the household); development of water safety plans; and integration of water supply with point-of-use water purification, sanitation, and hygiene elements. CDC implemented the Safe Water System in more than twenty countries, yielding an estimated twelve billion liters of treated water annually and contributing to a demonstrated fifty percent reduction in diarrheal disease in those areas.

Maternal, Newborn, and Child Health programs: The President's FY 2011 budget includes \$2 million for a new initiative in global maternal, newborn, and child health. Funding for maternal, newborn, and child health will support implementation of country-specific activities with an emphasis on: (1) integrating and expanding service delivery; (2) building capacity in laboratory, surveillance, and monitoring and evaluation activities; (3) providing technical assistance to ministries of health on laboratory diagnostics, surveillance, logistics, and monitoring and evaluation to ensure that these interventions are fully integrated into MNCH programs; and (4) evaluating the impact of an integrated approach to MNCH health services delivery, using a standard package of services, on maternal, infant and early childhood outcomes.

2.3.3 National Institutes of Health (NIH)

- Of its twenty-seven centers and institutes, NIH's Fogarty International Center and the Office of AIDS Research conduct foreign assistance via research training for foreign staff involved in scientific and medical research.
- **Fogarty Research Grants, Fogarty International Center:** Through Fogarty grants, U.S. universities extend their reach by collaborating with overseas institutions to conduct and collaborate on research and provide research training. Over the past forty years, Fogarty training programs have helped to train over five thousand investigators around the world.
- **Training, Research and Capacity Building, Office of AIDS Research:** NIH supports the training of domestic and international biomedical and behavioral AIDS researchers, and provides support for the equipment necessary for the conduct of AIDS-related research and clinical studies. The expansion of NIH-funded HIV research globally has necessitated the development of research infrastructure in many locations, including resource-limited settings in Africa, the Caribbean, India, and Asia.

2.3.4 Food and Drug Administration

FDA has over one hundred formal agreements with its counterparts in twenty-nine countries to provide technical assistance and training. Its global health activities include:

- **Beyond our Borders Initiative:** FDA is working to establish offices overseas in parts of the world where the agency believes a much closer working relationship with its counterpart regulators will improve FDA program results. Projects with countries abroad seek to: (1) share human, scientific, and investigational resources and knowledge; (2) share scientific expertise; and (3) promote responsible international standards and regulations.
- **PEPFAR:** Through guidance and an active outreach program to the pharmaceutical industry, FDA actively encourages prescription drug sponsors worldwide to submit U.S. marketing applications for single entity, fixed-dose, combination and co-packaged versions of previously approved antiretroviral therapies—even if patent or exclusivity market protection for the product in the U.S. exists. This process has significantly reduced the cost of treatment by making quality, generic products available for registration and marketing in fifteen focus countries.

2.3.5 Health Resources and Services Administration (HRSA)

HRSA's HIV/AIDS Bureau builds human capacity for scaling up care and treatment to underserved communities through training and technical assistance, twinning, rapid rollout of antiretroviral drugs, mentoring for nursing leadership, and enhancement of the continuum of palliative care. Major programs include:

- **Improving HIV/AIDS Care and Treatment.** Resources are provided to organizations delivering HIV care and treatment programs for low-income, HIV-infected persons in a manner that is consistent with national plans. Activities are underway in ten countries: Botswana, Guyana, Haiti, Kenya, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia.
- **Quality Improvement Capacity Development.** One program provides a systematic methodology for measuring quality of care in clinical settings. It has been used in different geographic and cultural settings where HIV/AIDS services are provided.
- **Training Capacity Development.** This program, modeled after HRSA's domestic AIDS Education and Training Center, aims to develop field offices' capacity to establish a global network of nongovernmental organizations (NGOs) specializing in human capacity development in resource-poor settings. The program provides technical assistance in the planning, design and management of training programs; disseminates new treatment information and new curricula; and mentors physicians, nurses, and other healthcare professionals. The program currently operates in Botswana, Ethiopia, Haiti, India, Malawi, Mozambique, Namibia, South Africa, Tanzania, Vietnam, Côte d'Ivoire, and China.
- **Nursing Capacity Building.** The program increases the number of nurses trained and prepared to work with HIV/AIDS, and develops training and education tools adapted to local needs. The goal is to strengthen nurses' clinical and professional leadership capacity. The program currently operates in South Africa and Swaziland, and is expected to expand to other countries.

2.3.6 Substance Abuse and Mental Health Services Administration

While mainly focused on domestic work, some SAMHSA international activities are worth noting:

- **Iraq-SAMHSA Initiative on Trauma and Behavioral Health Services.** For the past five years, SAMHSA has helped Iraq rebuild its capacity to provide mental health services through an exchange of mental health experts. SAMHSA hosted six teams of mental health professionals from Basra, Iraq who spent approximately one month in the fall of 2008 at facilities in the US. SAMHSA is currently working on hosting a second cohort of behavioral health providers in 2010 under the Iraq-SAMHSA Initiative on Trauma and Behavioral Health Services.

Detailed descriptions of these international programs and offices can be found in Annex 3, Sections E and F.

2.4 Federal Government Global Health Initiatives

In addition to HHS' international programs, understanding of the role played by the President's Global Health Initiative, PEPFAR, and the PMI is critical to this Evaluation.

2.4.1 The President's Global Health Initiative

On May 5, 2009, President Obama announced his new Global Health Initiative: a six-year, \$63 billion plan that uses an integrated approach to fight the spread of infectious diseases while addressing other global health challenges. All of HHS' international health programs are subject to the principles articulated in this initiative.

HHS' top leadership has cited the initiative as a driving force behind the agency's global health activities. At a World Trade Organization meeting in Geneva in May 2010, HHS Secretary Kathleen Sebelius praised the initiative, saying: "This is part of what we call our 'whole-of-government' approach. It means that HSS will work closely with USAID, the State Department, and other U.S. government partners to achieve our global health goals."

In each country receiving global health assistance, USG experts work with partner governments and counterparts from other countries to strengthen and support country-led, national health plans. The process of implementation begins with an assessment of existing national health plans, health systems, current financing gaps, and the capacity to use additional resources effectively. Based on this assessment, the Global Health Initiative works with partner governments and other development partners to identify goals, strategies, and approaches to which it can contribute, including identification of a plan to build an evidence base and capture progress.

2.4.2 The President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR, launched in 2003 by President George W. Bush's administration, made the largest commitment by any nation to combat a single disease. In its first phase, the program supported the provision of treatment to more than two million people, care to more than ten million people, and mother-to-child prevention treatment services during nearly sixteen million pregnancies. During the first phase of implementation, establishing services took precedence over prolonged engagement in planning and coordination with some country governments or other donors.

In 2010, PEPFAR entered its second phase (FY 2010-2015), with a new program strategy reflecting President Barack Obama's administration's overall shift in emphasis—from emergency treatment to country capacity and sustainable responses—while continuing to support existing and emerging prevention, care and treatment needs. The new strategy mirrors many of the Paris Declaration principles. Its focuses: country-ownership; integration of interventions with programs of the USG, country partners, multilateral organizations, and other donors; multi-lateral engagement; monitoring and evaluation; and managing for results. Planning and programming for FY 2010 are already incorporating and implementing these changes. Over the next year, PEPFAR will be working closely with country teams in order to translate, prioritize, and implement this strategy in a manner appropriate to the country context.

The Department of State's Global AIDS Office administers PEPFAR. It transfers funds to HHS to support U.S. government international HIV/AIDS programs. The board policies and the detailed procedures connected with PEPFAR govern more than three-quarters of HHS' global health programs.⁸

2.4.3 President's Malaria Initiative (PMI)

PMI was launched in 2005 as a five-year, \$1.2 billion expansion of U.S. government funding to reduce malaria-related deaths by fifty percent in fifteen focus countries with a high burden of malaria. In 2008, the Lantos-Hyde Act authorized an expanded PMI program for 2009–2013 so the program could continue through the six-year funding period (2009–2014) of the Global Health Initiative. The expanded malaria initiative will work with national governments and global partners to halve the burden of malaria through four main program areas: (1) insecticide spraying in communities; (2) insecticide-treated bed nets; (3) lifesaving drugs; and, (4) treatment for pregnant women. In the target countries, PMI coordinates with national and international partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Malaria Booster Program; Roll Back Malaria Partnership; nongovernmental organizations, including faith-based and community groups; and the private sector. USAID administers this initiative, transferring some funds to HHS (mainly CDC) for support and assistance.

The HHS malaria program is governed by the broad policies and the detailed procedures connected with the President's Malaria Initiative. More information on this initiative can be found in Annex 3, Section D.

Beginning with the next section, we present our analysis and overall assessment of the implementation of the Paris Declaration with HHS. We do this in three steps. In the first step, we consider a variety of factors that can facilitate or impede implementation. This includes the clarity and strength of the Department's leadership of and commitment to the Paris Declaration, the capacity of the Department to embrace fully its principles, and the current and potential incentives and disincentives to its implementation. In the second step, we draw upon the results of the first step and on additional evidence to examine and assess the actual implementation of the Paris Declaration principles, considering each of them individually. Finally, in the third step, we summarize the results of the above two steps in the form of findings and conclusions followed by recommendations.

3 LEADERSHIP AND COMMITMENT TO THE PARIS DECLARATION

In order to understand the scope and manner of senior HHS officials' leadership in implementing the Paris Declaration, the Evaluation Team strove to establish both their specific knowledge of the Paris Declaration, as well as the extent to which they embrace and follow its five principles, *the spirit of the declaration*, without specific reference to it.

⁸ More information on PEPFAR can be found in Annex 2, Section B, "PEPFAR"

3.1 No formal HHS policy or procedures

The Paris Declaration is not mentioned by name in any official policy, planning, or procedural document specific to HHS, or in any recorded speeches or guidance memoranda of senior HHS official that the Evaluation Team could identify. Two of the interviewees volunteered that they, too, had looked for references to the Paris Declaration within HHS but could not find any. When asked where and when they first learned about the Paris Declaration, senior staff cited exposure to the concept outside HHS, at meetings of the World Health Organization (WHO) or USAID, for example.

3.2 Awareness and understanding of the Paris Declaration

Despite the lack of formal written guidance, some of our interviewees were aware of the Paris Declaration. The evaluation process revealed that thirteen appeared to be moderately or highly aware, while eight had limited or no awareness. However, those who were moderately aware were only familiar with two or three of the principles—primarily country ownership, harmonization, and managing for results—and these only in a general way. As an example, their knowledge pertaining to managing for results focused on departmental attention to the impact of their programs, rather than on the joint management of results between the U.S. government and the host countries.

Key informants were even less aware of efforts to implement the Paris Declaration. Of the responses that could be rated, seven demonstrated moderate or high awareness of implementation steps being taken within HHS agencies; eleven had limited or no knowledge of such steps.

At the highest level of policymaking, generally high awareness of the Paris Declaration exists. All seven of those working in the Office of Global Health Affairs were moderately or highly aware of the Paris Declaration. Senior executives are strongly committed to country ownership, alignment, and harmonization wherever feasible. However, they expressed strong reservations about the practical aspects of harmonization—reliance on country management systems, and mutual accountability.⁹ Within those agencies most directly connected to managing international aid programs, awareness of the Paris Declaration was more limited. Six were highly or moderately aware of it but ten had limited or no knowledge. However, their commitment to the five principles was very strong.

3.3 Commitment to the five principles, with or without reference to the Paris Declaration

Overall, the level of awareness and understanding of the Paris Declaration within HHS ranges from none to high, but commitment to its principles is generally strong. There is, in fact, a deep, abiding, and practical commitment to, and implementation of, the five principles as a way of ‘doing business.’ All five principles pervade the culture of agency officials responsible for conducting international programs.

The explanation for this seemingly contradictory result stems from the mission of the international program offices. Fifteen KIs currently hold positions responsible for directing,

⁹ For a detailed exploration, see section V, “Incentives and Disincentives”

managing, or supporting international global health assistance programs. They explained that as public health officials, they had adopted approaches to carrying out their missions in ways that they discovered are consistent with the Paris Declaration long before the PD was promulgated—and in several cases, even though they had never heard of the declaration.

Interviews with officials responsible for program implementation included questions about how they manage or oversee their development projects. Interviewees were asked how, within the legislative and budgetary limits of their program, they decide with which countries to work and what projects to implement. The interview moved on to focus on the rest of the process: project planning, monitoring, oversight, performance measurement, and evaluation. Officials were then asked about the management capacities of their host countries and how shortcomings were handled; their relationships with other federal government agencies, foreign government and non-government organizations; and widely used performance metrics.

The responses were very consistent. Public health professionals in the international field work directly with the public health ministries of the host countries, and only work in countries whose governments want to receive assistance. Working under collaborative agreements rather than grants or contracts, they provide technical assistance, not services. They involve the host governments in choosing from among options that will meet the needs of the country and jointly plan the program's execution. Their goal is to build up the capacity of the host country; they strive to achieve a practical level of self-sufficiency within ten to twelve years. Almost all work in collaboration with international organizations and under international standards.¹⁰

While not a perfect match, the Key Informants' descriptions of how they conduct their work align well with the five Paris Declaration principles. The interviewees received a list of the Paris Declaration Commitments;¹¹ using the commitments as a reference, they were then asked to review the implementation steps they had just discussed. A typical reaction: "If that's what you meant by the Paris Declaration, then, yes, we do that." Table 2 below illustrates the results of this review with the fifteen HHS officials most closely connected to directing or managing global health projects.

¹⁰ For a list of many of these international organizations, see Annex 2, section G, "Selected International Organizations and Partners". For a description of international standards, see Annex 2, section H, "International Standards and Metrics".

¹¹ The one-page description is included in our survey and commitment form, Annex 1, "Interview and Commitment Guides"

Table 2: PUBLIC HEALTH PRACTICE IN INTERNATIONAL PROGRAMS

<i>Public Health Practice Principles</i>	<i>Paris Declaration Principle</i>
HHS public health official consults with host country health ministry regarding broad public health objective	Ownership
HHS official suggests options	Alignment
Host country chooses preferred option	Alignment
HHS and host country form team to jointly plan implementation	Alignment
Plans are developed in accordance with international priorities, standards	Harmonization
Implementation plan designed to develop sustainable public health capacity in host country	Ownership Alignment
HHS team provides technical assistance to country team implementing the program	Alignment
Project management, budget, and oversight are carried out jointly. Host country systems used to the extent possible	Alignment Mutual Accountability
HHS team provides management capacity training when feasible	Alignment Mutual Accountability
Specific objectives set in accordance with broadly adopted standards and metrics (e.g. PEPFAR or international organizations)	Results Harmonization Mutual Accountability
Joint monitoring leads to gradual governance by host country	Ownership Alignment
HHS team leaves the country, but remains available to provide occasional technical assistance	Ownership Alignment

It is important to note that interviewees expressed reservations about relying on country systems, something that currently is rarely done. However, they tended to discuss these as problems that they were working on in tandem with the host country, and noted that they try to encourage and assist the host countries in improving capacity.

Adherence to the above principles and steps was not consistent among all of the interviewees: while this process was explicitly described by officials working in the fields of disease prevention and laboratory development, others alluded to most of the steps, but in a much more informal way, without the depth described in Table 2. Global HIV/AIDS programs also adopt these steps, although it is too early to determine if they are close to achieving the last two—sustainable, country-led public health programs.

We “live these principles.... The process is slower and not as pretty but it works”...“We have been doing these principles for over 30 years”
– Senior CDC public health official

Of great importance to this study is the fact that interviewees independently emphasized the use of principles that are in line with the PD principles and furthermore, that this process has become endemic to the way HHS public health officials conduct business. When asked where they receive guidance for this approach, they remarked that it is simply “in the air,” and that they had gradually developed this approach as the only one that works when the goal is to achieve sustainable improvements in the public health systems of other countries.

4 STRATEGY AND CAPACITY FOR IMPLEMENTING THE PARIS DECLARATION

The traditional practice of international public health officials as described in the previous section is not simply an indication of the established commitment of HHS global health officials to PD principles: it also indicates a viable implementation strategy and increases the capacity of the Department to embrace the principles in a practical way.

Formal directives and procedures that either provide an indication of reinforcement for support for the Paris Declaration, or that enhance the probability of its success—by prescribing specific, administrative steps to carry out the principles in the course of planning, conducting, or assessing international programs—were sought as part of this evaluation.

HHS has issued no formal policy or procedural guidance regarding the implementation of the PD. However, two documents issued from outside the Department do govern internal health programs and are allied closely to the PD. These are the President’s Global Health Initiative and the PEPFAR program.

The policies and procedural documents of the GHI *apply to all six HHS agencies* involved in international health aid programs. For all practical purposes, no other distinct policies and procedures exist for international programs. The Global Health Initiative applies to all federal, international health programs, including PEPFAR. For three of the smaller programs—FDA, HRSA, and SAMHSA—PEPFAR is their only source of dedicated funding, and they are subject to the policies and procedures of that program. The PEPFAR program is also the major source of funding for CDC, supporting almost three-quarters of its global health effort. The remainder of its global health funds is governed by procedures that apply to the entire Center for Disease Control and Prevention. In fact, in two CDC international programs, there is no dedicated funding for global health. Rather, it redirects a portion of its general public health funds to

international projects on a yearly basis. The same is true for FDA’s “Beyond our Borders” program, which is funded entirely on the basis of opportunistic redirections of funds from several of its broader food, drug, biologic, and medical device programs, almost all of which are focused on domestic implementation of safety regulations. Hence, there are no procedures for its international work that are distinct from the procedures used for its domestic safety programs. In the same vein, the NIH International Fogarty Center is one of twenty-seven “institutes” within the National Institutes of Health, and its procedures for funding health research are essentially those used by all the institutes.

One notable exception to the above are the distinct procedures for the President’s Malaria program; the Evaluation Team could not find written procedures for this program. Thus, the policy and procedures below, with a few exceptions, are the ones most germane to this study.

4.1 Formal, Written Operating Procedures

4.1.1 Paris Declaration Principles Inherent in the President’s Global Health Initiative

The five principles of the Paris Declaration are prominently and frequently discussed in the President’s Global Health Initiative (although without reference to the Paris Declaration itself), which provides a broad, comprehensive, particularized framework for the conduct of international health assistance. The Global Health Initiative seeks to expand the global health successes of the past decade, such as PEPFAR and PMI, by implementing a new business model for global health assistance. This new strategy is based on principles that mirror those of the Paris Declaration. Most of our interviewees were aware of the Global Health Initiative.

The Global Health Initiative highlights five foundational principles for U.S. Global health programs that directly correlate with the Paris Declaration, as illustrated in Table 3 below.¹²

¹² Further elaboration of these principles is found throughout the GHI. More details are found in Annex 3, Section 2, “Implementation of the Global Health Initiative—Consultation Document”

Table 3: GLOBAL HEALTH INITIATIVE—FOUNDATIONAL PRINCIPLES	
Global Health Initiative Principles	Paris Declaration Principles
Increase impact through strategic coordination and integration—including joint programming among U.S. government agencies, other donors, and partner country governments, and other institutions to increase efficiency and effectiveness	Results Alignment Harmonization
Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement	Harmonization
Encourage country ownership and invest in country-led plans	Ownership Alignment
Build sustainability through strengthening health systems	Ownership Alignment
Improve metrics, monitoring, and evaluation	Results Mutual Accountability

4.1.2 Formal Guidance on Paris Declaration in PEPFAR

In the case of transfers from the Office of the U.S. Global AIDS Coordinator to CDC and HRSA for PEPFAR, the use of program funds is governed by the HIV/AIDS portions of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and the related administrative provisions issued by the OGAC.

The PEPFAR program is of paramount importance to HHS global health programs. PEPFAR, administered by the Department of State’s Global AIDS Office, transfers funds to all six HHS agencies involved in global health to support USG international HIV/AIDS programs. More than three-quarters of HHS global health programs are governed by the board policies and the detailed procedures connected with PEPFAR.

Twelve interviewees explicitly mentioned PEPFAR as germane to their developmental efforts. Most of them credit PEPFAR, since its reauthorization, as a leading force in advancing Paris Declaration principles.^{13,14}

Formal operational procedures further reflect and reinforce the Paris Declaration principles and facilitate the conduct of international health programs in ways that are compatible. Three

¹³ Support of this perspective can be found in the PEPFAR policy and implementation procedures , source in Annex 2, Section B

¹⁴ For a more in-depth elucidation of the overall principles for PEPFAR operating procedures, see Annex 4, "Excerpt: Executive Summary of PEPFAR’s Strategy"

procedural documents stand out in terms of the intimate connection between the PEPFAR program and the Paris Declaration:

1) **PEPFAR Partnership Frameworks and Partnership Framework Implementation Plans**¹⁵

This provides detailed guidelines for forming PEPFAR partnerships with host countries and explicitly references the Paris Declaration's points on aid effectiveness, going so far as to publish that document as part of its guidelines.

2) **PEPFAR Country Operational Plan (COP) Guidance**¹⁶

“The COP is the vehicle for documenting USG annual investments and anticipated results in HIV/AIDS, and the basis for annual USG bilateral HIV/AIDS funding approval. For programs that have, or are negotiating, Partnership Frameworks, it serves as the annual work plan for the USG's contribution to the Partnership. . . . [It] combines all USG agencies' planning and reporting on PEPFAR activities into one database built around funding mechanisms and provides a basis for funding review and approval, as well as congressional notification, allocation, and tracking of budget and targets. It is essential to PEPFAR's transparency and accountability to key stakeholders.”

The most important part of the COP process however, is the interagency, country planning process, which includes partner performance reviews and partner consultation, analysis and planning. All USG agencies working to fight HIV/AIDS in each partner country come together as a single team under the leadership of the U.S. ambassador to develop one annual work plan. That work plan—the COP—is reviewed by interagency headquarters teams, which make recommendations to the U.S. global AIDS coordinator on final review and approval.

- **PEPFAR Next Generation Indicators Reference Guide**¹⁷

While not a mandatory program guide, this document serves as a resource to be used in connection with PEPFAR partnership frameworks, strategy and implementation plans. It provides practical guidance and suggested indicators and metrics for monitoring and assessing the PEPFAR grants. This guide includes not only suggested output measures, but also metrics to measure the outcome of the PEPFAR grant and, more broadly, what is known as 'national outcomes'. The latter measure results from a countrywide perspective, recognizing that PEPFAR is not the only force at work in reducing HIV/AIDS.

The document itself contains the following advice as to how it is to be used:

The indicators in this guidance meet the minimum needs of PEPFAR to demonstrate progress in the fight against HIV/AIDS. Taken together these indicators promote responsible program monitoring across and within PEPFAR funded technical areas. These indicators may not satisfy every country need. They

¹⁵ Source: <http://www.pepfar.gov/guidance/framework/index.htm>

¹⁶ Source: <http://www.pepfar.gov/guidance/cop/index.htm>

¹⁷ Source: <http://www.pepfar.gov/documents/organization/81097.pdf>

are not designed to provide information on all dimensions of a program in country-specific settings. Strong program monitoring at the country-level requires a broad range of indicators, which can measure quality, coverage, and other aspects of programs.

From the perspective of the Paris Declaration, the document provides a tool that contributes to the fulfillment of all five of its principles.

5 INCENTIVES AND DISINCENTIVES

This Evaluation bases its analysis of possible incentives and barriers to the adoption of Paris Declaration principles in HHS global health programs on information provided by experienced, Key Informants.

5.1 Incentives

Individuals working directly on global health programs asserted that their organizational missions (which almost all regard as their life's work) are powerful incentives for them to adopt principles similar to those of the Paris Declaration. They do not receive bonuses, favorable performance ratings, or formal awards or recognition for abiding by the Paris Declaration, nor do they see any need for such incentives. Their formal program and personal goal is sustainability, and they plan to leave each country in which they work after about ten years. Statements by Key Informants reflect the general position that the chief incentive for implementing the Paris Declaration lies in its potential for favorable results.

Incentives for Adopting Paris Declaration Principles

- “People are dedicated and want to make a difference.”
- “This is what health people do.”
- “Public health staff subscribe to these principles.”
- “If they make sense, we should do it.”
- “Feeling you are doing good, sense of mission.”
- “The possibility of sustainability.”

–HHS Senior Public Health Officials

5.2 Disincentives and Barriers

Four interviewees stated that they saw no disincentives in pursuing implementation of the Paris Declaration. Others mentioned various factors: some general, some specific to one or more of the five principles.

5.2.1 General Disincentives

The most frequently mentioned disincentive to adoption of the Paris Declaration principles is the difficulty of carrying them out. The most common remark was that this is “hard work” and “takes time.” Interviewees expressed frustration with time-consuming meetings and collaborative consultations; how slowly the process moves; and how long it takes to get results. Many believe, however, that this approach is effective in the end, inasmuch as it results in sustainable programs after USG assistance ends.

Two interviewees mentioned barriers on the host-country side of the equation— “countries feeling they are not getting much for their efforts,” for example, and “difficulties of countries making matching payments”.

5.3 Harmonization

Most interviewees work with USAID, and some with the Department of State. They all emphasized that in the field of international public health, the international associations such as WHO and others¹⁸ help to provide some level of coordination. The interviewees were largely positive about harmonization and agreed that working with these agencies and groups is mostly successful. However, about half of the people interviewed expressed reservations about harmonization, stating that some agencies and organizations are jealous of their own reputations and contributions and exhibit understandably territorial behavior. Of even greater concern, however, is the fact that each Federal employee is accountable to its agency for its performance, the president, and the Congress and therefore is reluctant to trust success to the actions of partners. Other mentioned that congressional earmarks and reporting requirements are barriers that stand in the way of harmonization.

5.3.1 Alignment

Interviewees who have worked closely with the other nations’ public health ministries have reservations about the use of country-based management systems (financing, project management, monitoring, evaluation), stating that they can almost never rely on country systems. They see this as something to improve through the way they conduct their work and through the Sustainable Management Development Program.

Staff members with broad experience in foreign assistance, including work in programs outside HHS, are more cynical about the capacity of some nations to serve as reliable working partners, either because of a lack of capacity or because the nation’s goals are not tightly aligned with those of the U.S. aid program. Several mentioned that host country capacity is hard to build; corruption is sometimes a concern. Most commonly, they say that the prospects of mutual

¹⁸ See Annex 3, Section G, “Selected International Organizations and Partners”

accountability vary considerably from place to place and time to time, and that a responsible policy would recognize the differences and act accordingly.

5.3.2 Results

The interviewees did not identify disincentives specifically related to managing for results. However, some of the reservations they expressed about alignment are also germane to results. In particular, while HHS public health officials in the areas of disease detection and prevention, laboratories, tuberculosis, malaria, and HIV/AIDS can make use of international metrics to engage their grantees in the mutual goal of measuring results, similar international metrics are lacking in other areas.

5.3.3 Paris Declaration Guidance Regarding Fragile States

It is worth noting that both the Paris Declaration and the Accra Accord for Action recognize the difficulties of working with what the signatories call “fragile states”. The following statements are found in the introductory section to the Paris Declaration and in the section on harmonization. For further elaboration, refer to the Accra Agenda for Action.

From the introduction:

In fragile states, as we support state-building and delivery of basic services, we will ensure that the principles of harmonization, alignment and managing for results are adapted to environments of weak governance and capacity. Overall, we will give increased attention to such complex situations as we work toward greater aid effectiveness.

From the section on harmonization:

The long-term vision for international engagement in fragile states is to build legitimate, effective and resilient state and other country institutions. While the guiding principles of effective aid apply equally to fragile states, they need to be adapted to environments of weak ownership and capacity and to immediate needs for basic service delivery.

It is thus consistent with the Paris Declaration to recognize these problems when they occur and to adapt the manner in which aid is provided accordingly. The majority of interviewees stated that they try to work with such countries to improve their management capacity gradually, while providing basic services.

6 CONSISTENCY OF HHS GLOBAL HEALTH PROGRAMS WITH THE FIVE PRINCIPLES OF THE PARIS DECLARATION

In examining and assessing the actual implementation of the Paris Declaration principles, it is helpful to consider each principle separately. This Evaluation rates HHS implementation of each of the Paris Declaration’s five principles from two perspectives: (1) the department’s practical commitment to action, and (2) the actual results. The first of these reflects the strength of effort, and the feasibility and practicality of the steps the department is currently taking with regard to

each principle. The second reflects not only what the department is doing, but also the results of action or inaction by others. Successful implementation is not the responsibility, or even within the reach, of any single government agency. Rather, it relies upon the combined efforts and actions of the agency currently being reviewed and the host countries it intends to help; other USG donor agencies, other donor countries; and non-government organizations. Success may also be affected by the purpose and nature of the assistance provided.

For each of these two perspectives, this Evaluation employed a five-point scoring system, with ‘5’ being the highest and ‘1’ the lowest. The Evaluation’s rationale draws heavily on the Team’s assessments of leadership and commitment, strategy and capacity, and incentives and disincentives, discussed in Sections 1–5. The results of interviews and document reviews are also considered. Scores on actual results take into consideration the scores our interviewees assigned when asked to rate the status of implementation, using a five-point scale.

6.1 Ownership

Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption

Practical Commitment to Action

Score: 5

Actual Results

Score: 4

Section III notes that HHS aid officials had already ‘bought into’ the Paris Declaration principle of country ownership, even before the Paris declaration was issued. For the most part, officials only give assistance to foreign governments directly through the health ministries (there are some exceptions, such as international research, where grants are made to foreign educational institutions). In addition, HHS only works with countries that desire the type of technical assistance HHS offers—capacity building. HHS agencies generally do not enter a country for the purposes of delivering health services. Instead, they focus on building the capacity of host countries (through their health ministries) to administer health services independently.

Most interviewees described a similar process for determining what kind of assistance to provide. Typically, once the agency begins discussions with another country and they have agreed upon general needs, the HHS agency offers several forms of optional assistance to the receiving country. Once the receiving country makes its selection, the HHS agency requests that the receiving country prepare a plan. They then work on this together, and upon receipt of the plan, assistance begins. In this manner, the receiving country is an integral part of the aid from the start. There are instances where this approach cannot work. In cases such as international research, assistance follows the traditional processes and relationships of academic institutions. Yet, even in these cases, the HHS agencies aim to improve the ability of those foreign institutions to perform research, as well as promote effective research on important topics of mutual interest.

COUNTRY OWNERSHIP

- “CDC has always had the mindset of working with host governments, using an approach of negotiation and recipient leading the way.”
- “The U.S. government has no power to tell the host country which accreditation to achieve in their lab quality standards. The country can decide this for itself.
- “TB work comes at the request of the host country. The country sets its own strategies and all have their own TB strategy. HHS will sometimes help the country in developing its strategy.”
- “Countries are very involved in formulating programs. CDC works with ministries and governments. Side by side relationships exist with technical people and leadership in each country.”

–HHS senior public health officials

All five of the Paris Declaration principles are the mutual obligations of both the developing countries and the assisting countries or international agencies. Some interviewees reiterated the idea that PD principles are about partnership and will only work if both donors and recipients want—and have the capacity—to be partners. Generally, HHS avoids this problem by only working with countries who are willing partners. Sometimes a serious disconnect in public health policies stands in the way of traditional, international, public-health partnerships. One well-known example is the fundamental disagreement between the government of South Africa and other nations about the nature of and response to HIV/AIDS.

6.2 Alignment

Donor countries align behind these objectives and use local systems

Practical Commitment to Action

Score: 4

Actual Results

Score: 3

An important goal of the Paris Declaration is for donor nations and organizations to rely on country systems for planning, budgeting, project management, oversight, and monitoring and evaluation. HHS agencies go as far as they can in doing this, but recognize that some developing countries have limited capacity to perform these tasks independently. The HHS agencies simply adapt to the conditions at hand. In fact, some interviewees emphasized that, when working with low-capacity countries, they make it a part of their technical assistance program to help gradually develop the country’s management capacity. CDC goes even further by establishing a formal program for this purpose, the Sustainable Management Development Program. It trains managers from developing countries in basic management skills, such as planning, setting priorities,

problem solving, budgeting, and supervision, and promotes broader assessments of leadership. This additional training is not always provided, and HHS global health officials have not paid as much attention to this aspect of assistance as they have to the public health aspects of their work.

ALIGNMENT

- “HHS has progressed fairly significantly towards using country systems. Host governments are responsible for planning, budgeting, evaluation. The expectation is that the country does the work.”
- “PEPFAR and the President’s Malaria Initiative have country-level operational plans”.
- “CDC does strategic planning with host country ministries and works with national strategic plans to plan the U.S. government Partnership Plan, which was developed in PEPFAR module and for Malaria”.
- “PEPFAR has a formal procedure for joint operating plans with the host country. This is a ‘highly articulated’ process – long and exhausting, formal, and requires approval to release money. Approval for Malaria is even more daunting. ”

–HHS senior public health officials

Interviewees almost always stated that they do their best to form partnerships with countries on the management, budgeting, oversight, and evaluation systems of their assistance projects. They also note that, in most cases, they cannot rely entirely on these country systems. The situation, they say, varies from place to place and time to time.

6.3 Harmonization

Donor countries coordinate, simplify procedures and share information to avoid duplication

Practical Commitment to Action

Score: 5

Actual Results

Score: 3

HHS collaborates with various domestic and international partners in order to implement, monitor and regulate its global programming. USG partners include U.S. Departments of State (including USAID and the Office of the Global AIDS Coordinator), Defense, Agriculture, Homeland Security, Commerce, and the Environmental Health Agency (EPA). NGO partners include bi-lateral relationships with:

WHO
World Bank

Global Fund
Global Roll Back Malaria Partnership

International Federation of Red Cross and
Red Crescent Societies
United Nations Foundation
United Nations Children’s Fund
(UNICEF)
CARE

Health Commissioner of the European
Union
The Bill and Melinda Gates Foundation
Carter Center
Rotary International

HARMONIZATION

- “The World Health Organization has a draft template of a national strategic plan that host countries may start from. These provide guidance on national lab plans and policies to bring up standards, safety and training.... PEPFAR also has indicators which serve as guiding tools to accredit lab/quality management system...”
- “Harmonization has been improving recently – not because of the Paris Declaration per se, but because of the financial stress of global economic crisis forcing donors to be more cost effective and less duplicative, and also because of the existence of mechanisms for harmonization, such as the Global Fund and GAVI.”
- “Some countries want to pool funds in health but the U.S. government is not interested due to issues of attribution, accountability, and reporting requirements to Congress.”

--HHS senior public health officials

In addition, HHS also maintains bilateral relationships with host-country ministries of health. Many of the worldwide public health efforts have evolved as international partnerships through organizations such as WHO and the Global Roll Back Malaria Partnership. The developing countries’ public health ministries are accustomed to working through such alliances. Working relationships among the participating countries are typically effective and mutually appreciated. None of our interviewees had anything negative to say about their dealings with other Federal agencies, and all were positive about their relationships and the resulting coordination and advancements in public health resulting from years of collaboration with international organizations. Several saw no impediments or disincentives to harmonious relationships with all these groups. Nevertheless, disincentives to harmonization, discussed in Section 5, are inherent in government laws, funding, and organizations.

6.4 Managing for Results

Developing countries and donors shift focus to development results and results get measured

Practical Commitment to Action

Score: 4

Actual Results

Score: 3

A pervasive movement to focus on results is underway throughout the federal government, beginning with the Government Performance and Accountability Act, the Performance Assessment Rating Tool, and now with the current administration's emphasis on high-performance government and the analysis and evaluation of government programs. The president's Global Health Initiative and the PEPFAR program continue this movement. The gradual and recent development of internationally-recognized metrics in disease prevention and detection, laboratories, tuberculosis, and malaria have provided strong practical tools for donor-host collaboration on measuring results. More importantly, they set practical, achievable goals. The PEPFAR program, especially in its most recent publication of metrics and its emphasis on evaluation, has been recognized for its potential to significantly advance results management.¹⁹

MANAGING FOR RESULTS

- "Within the HIV/AIDS world, key indicators are agreed upon by host countries and PEPFAR."
- "Our work has a more "output focus and focus on intermediate outcomes... there are so many partners in the health field that no one player can claim credit for any one outcome or result."
- "[In reference to the CDC Field Epidemiology program], managing for results is tricky. There are systems building process indicators but it is hard to show the impact of the work. Example of a result is when one can credit a policy intervention due to the training the ministry of health received."
- "In the specific case of TB, there is a common set of indicators that all countries report on and these remain fairly consistent and were developed collaboratively with the country."

--HHS senior health officials

Nevertheless, in discussing results, some of our interviewees concentrated on USG processes like GPRA, focusing on how their programs were being assessed, rather than on the mutual assessment of results with the host country.

Interviewees believe that the emphasis on managing for results in the president's Global Health Initiative and PEPFAR may gradually build capacity for this function within U.S. and foreign governments. Interviewees also acknowledge that they are in the early stages of building impact evaluation into their program management. They are less optimistic about the early development of host countries' capacity to participate systematically in the evaluation of their programs.

6.5 Mutual Accountability

Donors and partners are accountable for development results

Practical Commitment to Action

Score: 4

¹⁹ For more on these measurement systems, see Annex 3, Section H.

Actual Results
Score: 3

At the most fundamental level, mutual accountability is built into the kind of capacity-building partnerships that characterize most of the foreign aid the HHS agencies provide. A receiving country’s public health capacity is the yardstick by which HHS agency global health programs measure success. Mutual accountability’s success is measured by the sustainability of the public health improvements that result from the HHS interventions. HHS public health officials organize their efforts accordingly, and their successes validate their strategies and practices.

MUTUAL ACCOUNTABILITY

➤ “HHS supports PD principles, but congressional demands are more important”

–HHS senior public health official

Interviewees realistically view mutual accountability as dependent upon the management capacity of the receiving country. The discussions of this topic under the sections on alignment and managing for results are germane to mutual accountability, as well.

7 SUMMARY FINDINGS

Consistency of HHS global health programs with Paris Declaration Principles is rated as follows:

Table 4, HHS implementation of Paris Declaration on Aid Effectiveness and the Accra Agenda for Action Principles*					
	Country Ownership	Alignment	Harmonization	Management for Results	Mutual Accountability
Practical Commitment to Action	5	4	5	4	4
Actual Results	4	3	3	3	3

Ratings from 1-5, 5 being the highest score

7.1 Leadership and Commitment

Knowledge of the Paris Declaration itself is generally limited; HHS has not been provided any implementation guidance and in turn HHS has provided no formal announcement, explanation, or commitment to its component agencies, separate from what the U.S. government as a whole and the lead USG foreign assistance agencies have announced or published. Nevertheless, a culture of commitment to its principles is strong, especially among those who are responsible for the day-to-day management of HHS global health programs.

HHS global health agencies have been gradually developing their own principles of partnership with the health ministries of the countries for whom they provide technical assistance; these principles are entirely consistent with the Paris Declaration. Similarly, the principles articulated in the President's Global Health Initiative reinforce HHS agency practices and are supportive of the PD. The partnership framework that has emerged in Phase II of the (recently reauthorized) PEPFAR program makes explicit reference to the Paris Declaration and is largely consistent with its principles.

7.2 Strategy and Capacity

Fundamentally, the operating procedures and tactical measures of HHS agency global health initiatives reflect the principles and objectives of the Paris Declaration. This is largely because the *modus operandi* of most HHS global health programs has, for many years, been to use cooperative agreements to provide technical assistance to willing foreign governments with whom they partner. The agency has built an abiding tradition of working directly with and enhancing the overall capacity of developing countries' health ministries.

7.3 Incentives and Disincentives

The strongest incentive for HHS staff to embrace the Paris Declaration principles is the inherent value of effective and sustainable international aid. The HHS global health staff of highly motivated, seasoned government officials considers the sustainable improvement of public health functions worldwide to be their life's work. This is the only incentive they require. The most commonly expressed disincentives include the difficulty of implementation and the time it takes get results. HHS staff pointed out the difficulties and burden of scheduling numerous meetings with stakeholders and the slowness of the process that causes delays in achieving important objectives.

Major disincentives and obstacles to *alignment and mutual accountability* include:

- The lack of capacity of some countries to serve as true partners;
- The possibility of corruption; and
- Difficulties resulting from disconnects between U.S. and foreign governments' policies and goals.

The major disincentive and obstacle to *harmonization* is the required accountability of government agencies to their program offices and the Congress. In the Global health arena, HHS staff generally work cooperatively with other foreign governments, other Federal agencies, and international organizations. Staff members recognize that some host countries lack the capacity

to plan, budget for, account for, and evaluate their program entirely on their own and are therefore reluctant to fully rely upon them. Senior staff with foreign aid work experience in other agencies or international organizations is wary of the possibility of corruption and of differences between USG policies and goals and those of other nations. Ultimately, each federal agency must be responsible directly to its own agency leaders and to Congress; this accountability is a great disincentive to the principles of harmonization.

8 CONSIDERATIONS

HHS could benefit from guidance by USG lead agencies in the implementation of the Paris Declaration as the formal policy regarding its importance and applicability, and the Office of Global Health Affairs could be tasked with assuring that all HHS operating and staff divisions are aware of the USG policy on implementation. The issuance of such formal guidance would reinforce principles of international partnership already ingrained in the culture and practices of HHS global health agencies.

The above policy should provide practical guidance regarding realistic expectations, and appropriate actions to be taken, in dealing with potential problems in these areas:

- The proactive development of the partner country's management capacity and adaptations to joint project plans to accommodate the country's ability to participate in planning, budgeting, financial control, monitoring, and project management;
- The potential for fraud;
- A disconnect between fundamental policies or priorities of the U.S. government and that of the partner country;
- Accountability to senior HHS program officials, other Executive Branch officials, and the Congress; and
- Improvement of monitoring and evaluation, including impact evaluation, as inherent features of international assistance, including the development of the host country's participation in the project evaluation and the general development of its evaluation capacity.

ANNEXES

ANNEX 1 INTERVIEW AND COMMITMENT GUIDES

Introduction

The Paris Declaration (PD) on Aid Effectiveness 2005 has become a major milestone in development assistance. Designed to improve the quality and effectiveness of development assistance, it is built around five principles – ownership, alignment, harmonization, managing for results, and mutual accountability. These principles are meant to guide interactions, relationships, and partnerships between development agencies and partnering countries. In addition to monitoring the progress of the implementation of the PD, OECD/DAC has launched a major evaluation of the PD to examine its implementation and explore its impacts.

The USG has joined this international effort and is committed to conducting an independent review of its commitment to and efforts towards implementing the PD. Since the USG review is a part of a larger study, its primary focus is consistent with those of other reviews conducted by participating donor countries. Consequently, the USG review will primarily focus on: commitment to PD principles, capacity to implement, and incentives.

The USG has contracted our firm, Social Impact, to carry out this project. To better reflect the reality of USG foreign assistance, we will prepare separate case studies for each of the participating organizations: USAID, DOS, HHS, MCC, DOL, Treasury and USDA. All case studies will use the same conceptual framework, approach and variables to enable comparative analysis. A synthesis report will then be written using data and information generated by case studies.

To inform the individual case studies, we are conducting informational interviews with senior and mid-level leadership at each organization. These interviews will be completely confidential and no names will be referred to in the reports generated. In addition, we would like to emphasize that this review is an attempt to understand the current state of affairs surrounding the USG's implementation of the PD, not to act as a grading system. Your candid responses will allow us to gain insight into the achievements, challenges, and varying incentives and disincentives to implementing the PD principles, and present relevant recommendations to the USG.

Section A: PDE Key Informant Interview guide (core questions)

Interviewer: _____ Date: _____

Respondent: _____ Gender: Male Female

Office/Title/Rank: _____ Length of Service: _____

Thank you for meeting with me today. As introduced in the email from X, I would like to ask several questions about the Paris Declaration on Aid Effectiveness of 2005 and how you see [your Department’s/Agency’s/Unit’s] response to it. Please remember that this discussion will remain confidential.

- 1) How and when did you first learn about the Paris Declaration principles?
- 2) What can you tell me about them?

Scale for interviewer: (based on the answers, circle the most relevant answer below)

Highly aware	Modestly aware	Limited awareness	None
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Commitment:

- 1) How would you characterize the extent of awareness of the PD principles and their implications by the top leadership of your agency?

Scale for interviewer: (based on the answers, circle the most relevant answer below)

High	Modest	Limited	None
------	--------	---------	------

Probing Questions:

- How has top leadership shown commitment to implementation of PD principles?
 - If they have reservations about implementing the PD what are the underlying reasons?
- 2) [If applicable] How would you characterize the extent of awareness of the PD principles and their implications by the leadership of your agency in field missions or offices?

High	Modest	Limited	None
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- Probing Questions:
 - How does their understanding compare with that of top leadership at headquarters?
 - Why?

- 3) How has your agency taken steps to adopt the PD principles and incorporate them into your strategic plans?

Scale for interviewer: Based on answer, rate the KI's awareness level of agency steps

Highly aware	Modestly aware	Limited awareness	None
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- 4) To what extent have these attempts been successful?

Scale for interviewer: (based on the answers, circle the most relevant answer below)

High	Modest	Limited	None
------	--------	---------	------

Probing Questions:

What attempts have been made to translate PD principles into policies, guidelines, and operational directives?

- If successful, cite some examples. If not successful, can you give reasons?
- Are there documents where these are reflected? E.g. guidance or policy documents. If so, can we have copies of them?

Capacity:

- 1) To what degree do you believe your agency has the guidance and capacity to support implementation of the PD?
- If little or none, what are the main things that are weak or missing?

Scale for Interviewer: Based on answer, rate the capacity:

High	Modest	Limited	None
------	--------	---------	------

- 2) What steps, if any, are being taken to strengthen capabilities?
- 3) How has the PD affected cost-effectiveness of USG delivery of bilateral foreign assistance?
- If so, how?

Scale For Interviewer: Based on answer, rate the effect:

High	Modest	Limited	None
------	--------	---------	------

Incentives:

- 1) Are there any positive incentives provided to staff to implement PD principles?

(Provide examples, if any.) If so, how effective are they?

- | | | | |
|------|--------|---------|------|
| High | Modest | Limited | None |
|------|--------|---------|------|

2) Are there perceived disincentives amongst staff (at home and in the field) to implementing PD principles?

- If so, how constraining are they?

Scale for Interviewer: Based on answer, rate the level/intensity of disincentives present:

High	Modest	Limited	None
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General:

- 1) How would you rate your agency on implementation of the each of the five PD principles on a scale of 1-5, with 5 the highest?
- 2) How would you rank the five PD principles in terms of effectiveness of implementation by your agency?
- 3) What would be reasons for the least effectively implemented principles?
- 4) How would you rate the USG, beyond your agency, on implementation of each of the PD principles on a scale of 1–5?

For the interviewer: Effectiveness of Implementation: Scale 1–5, with ‘5’ being the highest.

	Ownership	Alignment	Harmonization	Managing for Results	Mutual Accountability
KI's Agency					
USG as a whole					

- 5) What recommendations do you have to better facilitate effective implementation of the PD principles by the USG in general and by your agency?

Section B: Selected questions about aid processes/ elements that lie behind the Paris Declaration

Thank you for meeting with me today. As introduced in the email from X, I would like to ask several questions about the Paris Declaration on Aid Effectiveness of 2005 and the

aid processes that lie behind it in relation to your (Department's/Agency's/Unit). Please remember that this discussion will remain confidential.

[These questions may well vary by country and operating unit within [name of Department/Agency/Unit]

1. What role, if any, do host countries or other donors play in the process by which [name of Department/Agency/Unit X] formulates its programs in a country?

If needed for illustrative specificity:

- To what extent does [Department/Agency/Unit X] coordinate with other donors or with the host country in developing its purposes, strategies, policy dialogues, programs, periodic reviews and the like? What are the mechanisms for doing that?
 - Is there a common framework of conditions or indicators jointly developed by [Department/Agency/Unit X] and the host country in the areas of programming? Is there any mechanism to ensure that your operating units have been using that common framework? To what extent do they share the common framework?
 - Is there a common framework of conditions or indicators jointly developed by [Department/Agency/Unit X] with other donors in the areas of programming? Is there any mechanism to ensure that your operating units have been using that common framework? To what extent do they share the common framework?
2. Turning from planning to implementation, to what extent, if any, does [Department/Agency/Unit X] use or rely on the recipient country's project implementation systems? What guidance, if any, is provided regarding use of recipient country systems?
 - For example, how common is it to use the recipient country's own institutions and systems for:
 - Procurement
 - Accounting
 - Project management
 - Project monitoring
 - Project assessment
 - What factors inhibit your greater use of host-country systems?
 - What about other donors? Does [Department/Agency/Unit] ever work out a division of labor with other donors, for example in carving out areas for your respective programming? If so, to what extent: is it common or rare? To what extent does [Department/Agency/Unit] join in consortiums of donors? To what extent, in general, does [Department/Agency/Unit X] act as the lead donor in a

consortium of donors? To what extent does it follow the lead of some other donor or delegate responsibility to another donor?

- To what extent has [Department/Agency/Unit X] collaborated with other donors on joint missions for e.g. analytic work, planning, monitoring, or evaluation? If so, what have been the benefits of such collaboration? What were the constraints and costs? Did the benefits exceed the costs?
 - Does it make any difference for the effectiveness of cooperation with other donors if the program is “cross-cutting” like gender or fragility or conflict?
3. To what extent, if any, has [Department/Agency/Unit X] used its funds to augment the capacity of the recipient countries to formulate, manage, monitor or assess the programs it funds? What has been your experience in doing that? In general, has it made any difference in your subsequent reliance on the mechanisms of the host country?
 4. What measures do you use to assess the development outcomes or results of your overall assistance program (or activity) in a given country?
 - Do you use host country sources of information for this assessment? Why or why not?
 5. How do you use information on the results being achieved by your assistance?
 6. How is the results information you collect used in the implementation of your current programs and in the design of future programs?
 7. Do you meet with representatives of the host country to assess the performance of your assistance program and propose plans for future assistance?
 - If so, how often do you meet? Who calls the meeting? Who sets the agenda? Who chairs the meeting?
 - Are you satisfied with these meetings? How could they be improved?

Section C: Paris Declaration Commitments

Donors commit to: (11 commitments, chosen for emphasis by the evaluation team. We have changed the wording slightly to fit better with the U.S. context)

- 1) Ownership. Respect host country leadership and help strengthen their capacity to exercise it. (This is the only PD commitment for donors under "Ownership." It received a lot of emphasis in Accra.)

- 2) Alignment. Donors should base their overall support -country aid strategies, policy dialogues and development cooperation programs - on the country's national development strategy and periodic reviews of progress in implementation.
- 3) Alignment. Use country systems and procedures to maximum extent possible.
 - Avoid creating dedicated structures for day-to-day management and implementation of aid-financed projects and programs. [i.e., Project Implementation Units – “PIUs” - this is]
 - Progressively rely on host country systems for procurement when the country has implemented mutually agreed standards and processes.
- 4) Alignment. Predictability. Provide reliable indicative commitments of aid over a multi-year framework and disburse aid in a timely and predictable fashion according to agreed schedules.
- 5) Harmonization. Work together to reduce the number of separate, duplicative, missions to the field.
- 6) Harmonization. Make full use of the respective comparative advantages of donors at sector and country levels by delegating, where appropriate, authority to lead donors for the execution of programs, activities and tasks.
- 7) Harmonization. Reform procedures and strengthen incentives, including for recruitment, appraisal, and training, for management and staff to work towards harmonization, alignment and results.
- 8) Harmonization. Harmonized activities with respect to cross-cutting issues, including fragile states, gender equality, and environment.
- 9) Managing for Results. Countries and donors work together in a participatory approach to strengthen country capacities and the demand for results based management.
- 10) Mutual Accountability. Provide timely, transparent and comprehensive information on aid flows so as to enable host country authorities to present comprehensive budget reports to their legislatures and citizens.
- 11) Mutual Accountability. Jointly assess through existing ("and increasingly objective") country level mechanisms mutual progress in implementing agreed commitments on aid effectiveness, including the [55] Partnership Commitments.

ANNEX 2 References

Section A: Paris Declaration and Accra Agenda for Action

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Section B: PEPFAR

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2. Centers for Disease Control and Prevention—Global Health Programs, FY 2011 Budget Justification for Appropriations Committees, page 242
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4. NIH Fogarty International Center, FY 2011 Budget Justification for Appropriations Committees
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ANNEX 3 Scope of Work

EVALUATION OF IMPLEMENTATION OF PARIS DECLARATION BY USG FOREIGN ASSISTANCE ORGANIZATIONS

1. Background

The Paris Declaration (PD) on Aid Effectiveness was endorsed in 2005 and has become a major milestone in development assistance. Designed to improve the quality and effectiveness of development assistance, it is built around five mutually reinforcing principles which should guide interactions, relationships and partnerships between development agencies and partnering countries:

**Ownership:* Developing countries must lead their own development policies and strategies, and manage their own development work on the ground. Donors must support developing countries in building up their capacity to exercise this kind of leadership by strengthening local expertise, institutions and management systems.

**Alignment:* Donors must line up their aid firmly behind the priorities outlined in developing countries' national development strategies. Wherever possible, they must use local institutions and procedures for managing aid in order to build sustainable structures.

**Harmonization:* Donors must coordinate their development work better amongst themselves to avoid duplication and high transaction costs for poor countries. In the Paris Declaration, they are committed to coordinate better at the country level to ease the strain on recipient governments.

**Managing for results:* All parties in the aid relationship must place more focus on the end result of aid, the tangible difference it makes in poor people's lives. They must develop better tools and systems to measure this impact.

**Mutual accountability:* Donors and developing countries must be accountable to each other for their use of aid funds, and to their citizens and parliaments for the impact of their aid.

The Paris Declaration provides a practical, action-oriented roadmap with specific targets to be met by 2010. It is a major international agreement on aid relationships which identifies appropriate roles for all major actors, specifies 12 indicators to provide a measurable and evidence-based way to track progress, and sets targets for the indicators to be met by 2010. At the Third High Level Forum (HLF 3) on Aid Effectiveness held in Accra in 2008, both donors and developing countries reaffirmed their commitment to the Paris Declaration and agreed to speed up the process of fulfilling the Declaration's pledges. This agreement was codified in the Accra Agenda for Action, which was endorsed at the HLF 3.

2. Purpose of Statement of Work

In addition to monitoring the progress of the implementation of the Paris Declaration, the Organization for Economic Co-operation and Development, Development Assistance Committee (OECD/DAC) has launched a major evaluation of the Paris Declaration. The overall objective of the evaluation is to assess the relevance and effectiveness of the Paris Declaration and its contribution to aid effectiveness and poverty alleviation. The evaluation is being carried out in two phases.

The Phase 1 evaluation assessed the early implementation of the Paris Declaration. It focused on four central questions: What important trends or events have been emerging during the implementation? What factors and forces are affecting the behavior of recipient and donor countries in relation to implementing their respective commitments? And, is the implementation leading towards the adoption of the PD principles? If not, why not? The Phase I findings of the assessments have been finalized and a synthesis report has been written which provides empirically grounded conclusions and recommendations.²⁰

The overall objective of this Phase 2 evaluation is to assess the relevance and effectiveness of the Paris Declaration and its contribution to aid effectiveness and ultimately to development effectiveness, including poverty alleviation. The evaluation is expected to document the results achieved through implementing the Paris Declaration, highlight the barriers and constraints which might limit its effectiveness and impacts, and strengthen “the knowledge base as to the ways in which development partnerships can most effectively and efficiently help maximize development results through aid in different contexts – including varying degrees of ‘fragility’.” Phase 2 evaluation plans to undertake 15 country case studies to examine in depth the effects of the Paris Declaration on aid and development effectiveness. In addition, it also plans to commission five special studies to examine critical issues. The evaluation will then synthesize the findings, conclusions and recommendation of all the studies, reports and documents in a comprehensive report.

As a contribution to the Phase 2 evaluation, the USG has committed to conducting an independent evaluation (“USG Evaluation”) of its headquarters’ commitment to, and efforts towards, implementing the Paris Declaration, consistent with the terms of reference provided for such studies as part of the overall evaluation. The purpose of this SOW is to outline the requirements and deliverables for the design and implementation of the USG Evaluation. The SOW specifies evaluation questions, evaluation design criteria, data collection approaches, estimated level of effort required, time table, evaluation criteria and the deliverables.

²⁰ Evaluation of the Implementation of the Paris Declaration:
http://www.diiis.dk/graphics/Subweb/paris_evaluation_web/index.htm.

3. Evaluation Questions

Since the USG evaluation is a part of a larger evaluation study, its primary focus must be consistent with those of other evaluations conducted or being conducted by participating donor countries. It must also take into account the multi-agency management structure of foreign assistance that is used by the USG. By agreement among international participants in the overall PD evaluation, individual donor evaluations are largely undertaken at headquarters and focus on three broad areas; commitment to the PD principles at the different levels of the foreign assistance agency, the agency's capacity to implement the Paris Declaration and the steps that it has undertaken to enhance its capacity, and incentives and disincentives for implementing the PD principles. In view of this focus, the following questions shall be answered by the evaluation:

Commitment

1. Are the top leaders of bilateral foreign assistance organizations aware of the five PD principles and their implications for the delivery of foreign assistance? Do they interpret them correctly? What sort of misconceptions, if any, do they seem to harbor?
2. Are the top leaders committed to implementing the Paris Declaration? Do they have any reservations about it? If so, what are these reservations? What are the underlying reasons for their reservations and concerns?
3. Are the managers of foreign assistance programs aware of their leadership's commitment to the five principles and their implications for the programs they manage? Has the implementation of PD affected foreign assistance program's priority setting?
4. How is foreign assistance agencies' commitment affected by the mandates and requirements of the Congress and Office of the budget and management and the demands of the civil society?
5. Has each bilateral foreign assistance organization formulated and implemented a coherent strategy to adopt the PD principles in its policies and programs? If so, what are the major elements of its strategy? If not, what are their reasons for not developing a strategy to internalize and implement the Paris Declaration?

Capacity

6. What attempts have been made by these organizations to translate the PD principles into their policies, guidelines and operational directives? To what extent have such attempts been successful (cite examples)? If they did not make efforts to revise their policies, guidelines and operational directives, what were the main reasons for this omission?
7. Did foreign assistance agencies launch special training programs to prepare their staff for implementing PD principles?

8. Are assistance organizations' mandates, organizational structures, budgetary processes, and capacities suitable to implement the Paris Declaration? What specific mandates, organizational structures, budgetary processes, and operational procedures have facilitated or impeded the adoption and implementation of the PD?
9. Has the Paris Declaration affected USG delivery of bilateral foreign assistance and its interactions with the recipient countries? If so, in what way? What are the examples of such effects? Are there major differences in the commitment and behavior of different USG assistance organizations?

Incentives

10. Are there perceived disincentives to implement PD principles both at the headquarters and the field?
11. Do bilateral foreign assistance organizations provide incentives to their headquarters and field staff to implement the PD principles? If so, what are these incentives? Did these incentives produce concrete, positive results (cite examples)? Did they also provide additional training to the staff in the field?

General

12. What factors have affected or are likely to affect the implementation or non-implementation of the Paris Declaration by bilateral USG foreign assistance organizations? How can they be categorized?
13. How do partner organizations, civil society organizations and host countries assess USG commitment to and efforts to adopt the PD principles? Do they have concerns about them? Are their perceptions justified and, if so, to what extent?
14. What recommendations can be made to facilitate the effective implementation of the PD principles by USG bilateral foreign assistance agencies and organizations individually and collectively? What general lessons can be drawn from the USG experience for other bilateral and multilateral donor agencies?

4. Multi-Case Study Evaluation Design

Unlike most bilateral donor agencies, there is no single unit of the USG which administers bilateral foreign assistance programs. Presently there are five organizations that manage the great majority of U.S. bilateral foreign aid – the U.S. Agency for International Development (USAID), Department of State (State), Department of Defense (DOD), Department of Health and Human Services (HHS) and the Millennium Challenge Corporation (MCC). In addition, there are 22 other USG agencies and organizations that manage the remaining bilateral foreign assistance. Although the volume of assistance they administer is relatively small as compared to the above mentioned organizations, it is nonetheless significant. This undoubtedly creates a major challenge to any evaluation of foreign assistance programs.

The problem is compounded by the fact that there are significant differences in the mandates and organizational structures of these entities. For example, the mandate,

policies and programs of the MCC are very different from the projects run by the State Department. The HHS works within its sectoral mandate, while USAID programs are highly diversified. Agencies managing smaller proportions of bilateral assistance also have different approaches – use of more headquarters line staff; fewer long-term field activities or presence, for example. Their mandates tend to be predominantly domestic. To capture these differences, the proposed evaluation shall follow a multi-case study method, focusing on both major and minor foreign assistance agencies and organizations. The evaluation undertaken as part of this SOW shall primarily focus on four of the five major bilateral foreign assistance organizations – USAID, the State Department, HSS and MCC. In addition, up to 3 smaller U.S. bilateral donors organization shall be selected on the basis of mutually agreed criteria between the evaluation COTR and the contractor. The contractor shall prepare separate case studies for each of these organizations. All case studies shall use the same conceptual framework, approach and variables to enable comparative analysis. A synthesis report shall be written using the data and information generated by case studies.

Each case study focuses on the topics identified below; the list is illustrative and not comprehensive. It is important that each case study individually examine each of the five principles (ownership, alignment, harmonization, managing for results and mutual accountability), as there are likely to be variations in their acceptance, internalizations and implementation within an organization.

1. Awareness of the five PD Principles and their Implications
 - Awareness of the five PD principles among leadership in headquarters
 - Awareness of PD Principles by operating units in the field in the case of major agencies and organizations that have a field presence
 - Misconception and misunderstandings about PD principles, if any
2. Political Commitment to the five PD Principles
 - Leadership's commitment to PD principles
 - The rationale for commitment
 - Reservations and doubts
3. Strategy for implementing the Paris Declaration, if any
4. Translation of PD Principles into Policies, Guidelines and Operational Directives
 - Extent of revisions and changes, if any
 - Effectiveness of such efforts
5. Training for facilitating adoption of the PD principles
 - Introduction of new training programs
 - Effectiveness of new training programs
6. Institutional capacity to implement the Paris Declaration
 - This section shall analyze the mandate, organizational structure, transfer of

authority to the field, budgetary processes including congressional earmarks, reporting requirements and general procedures to determine the extent to which they facilitate or inhibit the adoption of the PD principles.

7. Assessment of the direct or indirect impacts of PD on the organization/agency's

- Allocation of resources for capacity building in host nations
- Use of host country organizations to manage USG assistance programs
- Coordination with other USG agencies to avoid duplication and waste
- Coordination with other bilateral and multilateral agencies in the field
- Partnerships with host countries in performance management and evaluation

8. Findings, Lessons Learned, and Recommendations

-On the basis of the information, data and findings of the case studies, a synthesis report shall be prepared. This report shall address the topics above and shall include appendices on methodology, interviews and documents.

5. Data Collection Methods

The contractor shall use the following data collection methods to generate the needed information, ideas and recommendations:

- i) Content analysis of the mandates, policies, budgetary allocation processes, procedures and selected program documents of foreign assistance organizations.
- ii) Review of principal reports, analyses, evaluations and other documents on PD implementation issued by participating bilateral and multilateral agencies, NGOs, think tanks and other credible sources. (Note: There now exist a plethora of information which will be helpful in framing questions, sharpening the focus of case studies and developing suitable recommendations.)
- iii) Interviews with the senior congressional Staffers, OMB, staff at the selected USG agencies.
- iv) Semi-structured interviews with the senior officials of the foreign assistance organizations for which case studies shall be prepared.
- v) Key informant interviews with partnering organizations, including contractors and non-profit organizations which implement foreign assistance programs and projects
- vi) Telephone interviews with 1-2 host country officials in up to 10 countries based on selection criteria determined jointly by evaluation COTR and the contractor. Such interviews are necessary to understand their perceptions, concerns and assessment of USG's commitment to and efforts towards implementing the Paris Declaration. (Note: at least some of the countries selected shall be those undertaking country-level evaluations in Phase 2)
- vii) Mini-surveys through internet and/or telephone with USG managers of assistance programs and projects in the field. It is suggested that each case study conduct one survey. The number of respondents shall depend upon the size of assistance

programs, the number of countries in which they are located and the sectors in which they operate. (Note: at least some of the countries selected shall be those undertaking country-level evaluations in Phase 2)

- viii) Attendance at up to three international meetings in Europe; no other international travel is anticipated.

6. Deliverables

The Contractor shall propose dates to deliver the following in accordance with their technical approach and specific evaluation design. Exact dates will be determined upon the approval of a final management plan within one week after award:

1. A management plan
2. A comprehensive outline of the organizational case studies based on preliminary interviews with concerned agencies
3. Draft of organizational case studies
4. Revised case studies
5. Draft of the synthesis report*
6. Submission of the final synthesis report
7. A policy brief of no more than four pages summarizing the main findings and recommendations of the synthesis report
8. Three briefings or seminars** on the content of the synthesis report, accompanied by a Power Point presentation.
9. Brief monthly progress reports

* The contractor shall arrange for 2 peer reviewers of the draft. The reviewers must be approved by COTR.

**For planning purposes, the Contractor shall assume that the venue and duration of the briefings and seminars is: (1) Paris at the meeting of bilateral and multilateral donors – duration 3 hours; (2) Meeting of the U.S. bilateral donor agencies in Washington D.C, - duration 3 hours, and; (3) Briefing to the senior officials of the State and USAID in Washington D.C., - duration 1hour.

ANNEX 4: Excerpt: Executive Summary of PEPFAR's Strategy

Overall principles for PEPFAR operating procedures

The following is excerpted from the Executive Summary of PEPFAR's Strategy.²¹ The connection between these program strategy principles and the Paris Declaration is quite evident:

Health Systems Strengthening

PEPFAR has had a positive impact on the capacity of country health systems to address the WHO's six building blocks of health systems functions. However, the program to date has not placed a deliberate focus on the strategic strengthening of health systems. In its next phase, PEPFAR is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. PEPFAR now emphasizes the incorporation of health systems strengthening goals into its prevention, care and treatment portfolios. Doing so will help to reduce the burden of HIV/AIDS on the overall health system. Planned activities include the following:

- Training and retention of health care workers, managers, administrators, health economists, and other civil service employees critical to all functions of a health system;
- Implementing a new health systems framework to assist country teams in targeting and leveraging PEPFAR activities in support of a stronger country health system;
- Supporting efforts to identify and implement harmonized health systems measurement tools; and
- Coordinating USG activities across multilateral partners to leverage and enhance broader health system strengthening activities.

Country Ownership

PEPFAR's commitment to the principles of country ownership highlights a new focus on engaging in true partnership with countries. These partnerships pave the way for new approaches to foreign assistance based upon principles and directions common to partner country plans and USG objectives. Over the next five years, PEPFAR's emphasis on country ownership will include:

²¹ Source: <http://www.pepfar.gov/strategy/document/133244.htm>

- Continuing bilateral engagement through its Partnership Frameworks and other efforts to promote and develop a more sustainable response to the local epidemic, whether concentrated or generalized;
- Ensuring that the services PEPFAR supports are aligned with the national plans of partner governments and integrated with existing health care delivery systems;
- Strengthening engagement with diplomatic efforts at all levels of government to raise the profile and dialogue around the AIDS epidemic and its linkages with broader health and development issues;
- Expanding technical assistance and mentoring to country governments, in order to support a capable cadre of professionals to carry out the tasks necessary for a functioning health system; and
- Partnering with governments through bilateral, regional and multilateral mechanisms to support and facilitate South-to-South technical assistance.

Integration

As the largest component of President Obama's Global Health Initiative, PEPFAR is actively working to enhance the integration of quality interventions with the broader health and development programs of the USG, country partners, multilateral organizations, and other donors. Through activities like co-location of services and expanded training of health care workers, PEPFAR can expand access to overall care and support for infected and affected individuals. As noted earlier, a particular focus of PEPFAR's integration is to expand access to care for women and children. PEPFAR is also emphasizing engagement with broader health and development programs. Some examples include:

- Expanding HIV/TB integration by ensuring that PLWHA are routinely screened and treated for TB, and that people with TB are tested for HIV and referred, with follow up, for appropriate prophylaxis and treatment;
- Linking PEPFAR food and nutrition programs with the new USG Global Hunger and Food Security Initiative;
- Expanding partnerships with education, economic strengthening, microfinance, and vocational training programs; and
- Promoting accountable and responsive governance through increased bilateral engagement and capacity building with partner governments.

Multilateral Engagement

PEPFAR is part of a shared global responsibility to address global health needs. Its success has been closely linked to the success of newer multilateral initiatives such as the Global Fund for AIDS, Tuberculosis

and Malaria (Global Fund), and long-standing multilateral organizations including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO. PEPFAR is expanding its multilateral engagement with the goal of strengthening these institutions and leveraging their work to maximize the impact of PEPFAR. PEPFAR's multilateral engagement includes a new emphasis on the following:

- Supporting the Global Fund's efforts to improve oversight, grant performance, and its overall grant architecture in order to position it as a key partner for PEPFAR;
- Supporting UNAIDS efforts to mobilize global action and facilitate adoption of country-level changes that allow for rapid scale-up of key interventions;
- Negotiating a strategic framework for greater PEPFAR-WHO engagement; and
- Increasing coordination with multilateral development banks to improve the performance of health systems investments and better integrate with their broader economic development efforts.

Monitoring, Metrics and Research

PEPFAR's work can and should be systematically studied and analyzed to help inform public health and clinical practice. PEPFAR is not a research organization, but is expanding its current partnerships with implementers, researchers, and academic organizations to improve the science that guides this work. As PEPFAR transitions to support sustainable, country-led systems, it will improve efforts to contribute to the evidence base around HIV interventions, as well as broader health systems strengthening and integration. Over its next phase, PEPFAR will support the following new initiatives:

- Building the country capacity necessary to implement and maintain a fully comprehensive data use strategy;
- Reducing the reporting burden on partner countries and supporting transition to a single, streamlined national monitoring and evaluation system; and
- Working to expand publicly available data.