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Marcia Frimpong Date

A Case Study Assessing Gavi's Co-financing Policy as a Tool for Country Ownership

By

Marcia Frimpong
Master of Public Health

Hubert Department of Global Health

Deborah A. McFarland
Committee Chair

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By

Marcia Frimpong

Bachelor of Arts
Wellesley College
2015

Thesis Committee Chair: Deborah A. McFarland, MPH, PhD

An abstract of
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# Abstract

A Case Study Assessing Gavi's Co-financing Policy as a Tool for Country Ownership
By Marcia Frimpong

Gavi's co-financing policy is intended to strengthen country ownership of vaccine financing thus leading to financial sustainability, long-term programmatic impact, and increased immunization coverage. We conducted a systematic review of the term country ownership in the health and development discourse and literature specific to Gavi to define and a conceptualize a framework to assess how country ownership is operationalized via the Gavi co-financing policy. Country ownership was measured by a country's ability to meet a set of indicators under the following defined drivers of country ownership: accountability, commitment, partnership and capacity. We applied the indicators in a case study of Ghana, a country that is in transition from full dependence on Gavi for vaccines to complete independence. Gavi financing has resulted in increased immunization coverage in Ghana and the country is considered a success story in the Gavi network. Among the four drivers, Ghana has systems and processes that effectively meet the indicators under commitment and accountability. It was difficult to measure capacity and partnership was low. Accountability was evident in some areas but not others according to the indicators used. The following recommendations were made to address some of the deficiencies: update national health policy to reflect current national priorities to better align with cMYPs, increase collaboration between the MoFEP and MoH to draft a viable vaccine financing proposal and approach, create legislation that makes financing of vaccines and immunization a priority, and lastly strengthen the national logistics system.

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# Chapter 1: Introduction

As Gavi enters its 20th year, 16 countries are preparing to transition out of Gavi funding due to an increase in their GNI per capita, making them ineligible for Gavi support. This transition is a true test of Gavi's business model, Gavi's co-financing and transition policy, and Gavi's strategic goal of financial sustainability. As countries prepare to exit, some countries are entering or are in the accelerated phase preparing to transition. This presents an opportunity to assess the capacity of countries to meet standards set by Gavi to be financially sustainable by fully self-financing all vaccines in the routine immunization program without the aid of Gavi financial support. Since the majority (77%) of Gavi eligible countries are in sub-Saharan Africa, the region is an appropriate area for analysis of how a country prepares to be fully self-financing. Ghana, a country in the preparatory transition phase, has a current (2017) GNI per capita of $1490 USD. Ghana is expected to enter the accelerated transition phase in 2021 at which point co-financing responsibility, the percentage contributed to the procurement of vaccines, will continue to increase yearly. The purpose of this thesis is to determine and assess the benchmarks of country ownership in Gavi's co-financing policy and the implications for one country, Ghana, that will transition from Gavi funding in upcoming years through a case study. This chapter explains the purpose and significance of this thesis, the overall research question, the significance of the research question and provides background information on Gavi and context on Ghana, the case study country.

## Problem Statement

Vaccines are touted as one of the best buys in global health. They are one of the most effective health interventions ever introduced preventing millions of deaths yearly. According to a WHO report, vaccines prevent 2.5 million deaths per year. The impact on health has been significant reducing mortality and increasing life expectancy. It is estimated that between 2011-2020,

vaccines will prevent 25 million deaths globally (WHO, 2013). The Centers for Disease Control and Prevention (CDC) estimated that between 2011-2013, vaccinations saved lives and reduced the cost of illness preventing 322 million illnesses, 21 million hospitalizations, and 732,000 deaths resulting in savings of $295 billion direct costs and $1.38 trillion in total societal costs in the United States (Whitney, Singleton, Schuchat, & Zhou, 2015). In low- and middle-income countries, cost savings are also present. Ozawa et al found that for every dollar invested in vaccination programs in the 94 lowest income countries, 16 US dollars (USD) are expected to be saved in healthcare costs (Ozawa et al., 2016). Gavi supported countries as they transition will ultimately be responsible for self-financing their National Immunization Programs now with the Gavi introduced vaccines.

## Purpose

The main purpose of this study is to understand country ownership in Gavi recipient countries, to assess how Gavi operationalizes ownership, and to propose a possible methodology for assessing progress toward country ownership. A case study of country ownership will provide depth and illustrate the complexity and challenges around country ownership in a selected Gavi recipient country.

## Research Question and Aims

This qualitative study will aim to answering the following research question: How does Gavi operationalize country ownership in recipient countries? The following aims guide the study:

1. To define country ownership in the development/ health discourse;
2. To assess the metrics for country ownership proposed by Gavi;
3. To map progress toward country ownership for a selected country, Ghana;

4. To identify specific policy decisions and benchmarks to be taken by Ghanaian stakeholders to achieve country ownership for Gavi vaccines;
5. To identify incentives faced by each stakeholder in the policy agenda for country ownership.

## Significance Statement

As donor funding decreases and developing countries GDPs continue to rise, financial transitions of donor funded initiatives, such as PEPFAR and Gavi are underway. This period of transition is a true test of the sustainability of many of these initiatives and the capacity of aid recipients to sustain and organically manage the programs long after donors have left. Financial sustainability is a challenge to the sustainability of many of these programs and Gavi's model aims to address this challenge through its co-financing policy by enabling country ownership. For Gavi, country ownership is defined as the ability of the country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance.

## Gavi: The Organization

Launched in January 2000, Gavi, the Vaccine Alliance, came about to address the persistent low immunization coverage levels in developing countries("https://www.gavi.org/about/mission/," n.d.). With an initial donation of $750 million USD from The Bill and Melinda Gates Foundation, distributed over five years, the alliance of organizations, the key UN agencies, leaders of the vaccine industry, representatives of bilateral aid agencies and major foundations, aimed to increase immunization coverage in the 74 poorest countries of the world. Gavi's initial mission was "saving children's lives and protecting people's health through

the widespread use of safe vaccines with a particular focus on the needs of developing countries ("https://www.gavi.org/about/mission/," n.d.)." Over the years, this mission has stayed consistent having reached over 700 million children since its creation ("https://www.gavi.org/about/mission/," n.d.). Since that initial pledge of $750 million, Gavi's donor contributions have grown to an estimated 9.1 billion USD in contributions and pledges from 2016-2020 ("https://www.gavi.org/investing/funding/donor-contributions-pledges/," n.d.) Every five years, Gavi's reassesses its strategy that has resulted in four distinct phases since Gavi's inception:

- Phase I: 2000-2006
- Phase II: 2007-2010
- Phase III: 2011-2015
- Phase IV: 2016-2020

With each phase came new strategic goals and priorities for the organization influenced not only by vaccine issues but an ever-evolving global landscape.

## Gavi Eligibility and Transition Policy

For a country to be eligible for Gavi support, the country must meet the criteria set forth by Gavi's governing body in its *Eligibility and Transition Policy*. The first two phases of transition vary in their length but the last phase leading to fully self-financing has a set window of 5 years (see Figure 1). Country eligibility is determined by the most recent three-year average of Gross National Income (GNI) as recorded by the World Bank (Newman, 2015b) and must be equal to or below $1,580 USD. This threshold is updated annually to adjust for inflation. Countries who meet this criterion are eligible to apply for support in any of Gavi's three program areas: new and underused vaccine support (NVS), immunization support (ISS), or health systems strengthening

support (HSS). Countries can apply for one or all three types of support and each program has set criteria for countries to receive support. However, most of Gavi's financial support goes to the purchase of new vaccines (A K Shen et al., 2016). Through new and underused vaccine support, Gavi supports the introduction of nine vaccines in the routine immunization schedule through vaccine purchase, associated supplies and financial support and/or the implementation of a Gavi supported program ("How to Request New Gavi Support," 2018).

Beyond the financial eligibility requirement, the following conditions must be met for countries to receive support:

1. A functioning Inter-agency Coordination Committee (ICC) or Health Sector Coordinating Committee (HSCC)
2. Annual Progress Report
3. Multi Year Comprehensive Plan (cMYP)
4. The presence or creation of a National Immunization Technical Advisory Groups (NITAGs).

**Inter-Agency Coordination Committee (ICC)**

To be eligible for new Gavi vaccine or financial support, countries need to demonstrate that they have a functional ICC. The ICC is a key coordinating mechanism for immunization programs in developing countries. In the mid-90s WHO and national governments established ICCs to support polio eradication efforts (Grundy, 2010). A high-level official such as a Minister of Health or a Director General typically acts as the chair of the ICC. Members of the committee include development partners from civil society, bilateral and multilateral organizations (Grundy, 2010). The ICC is responsible for the coordination, support and planning of Gavi funds within the country.

However, researchers found there was little evidence that the ICC was consistently and effectively addressing the core issues of coordination and resource gap analysis (Grundy, 2010) with most Gavi eligible countries in SEARO using the ICC simply to receive Gavi endorsement.

**Annual Progress Report**

All countries receiving support from Gavi must submit an annual progress report to receive continued support. Countries submit annual reports to the Gavi's Independent Review Committee (IRC) which assesses and provides recommendations for approval to the Gavi Board.

**Multi Year Comprehensive Plan (cMYP)**

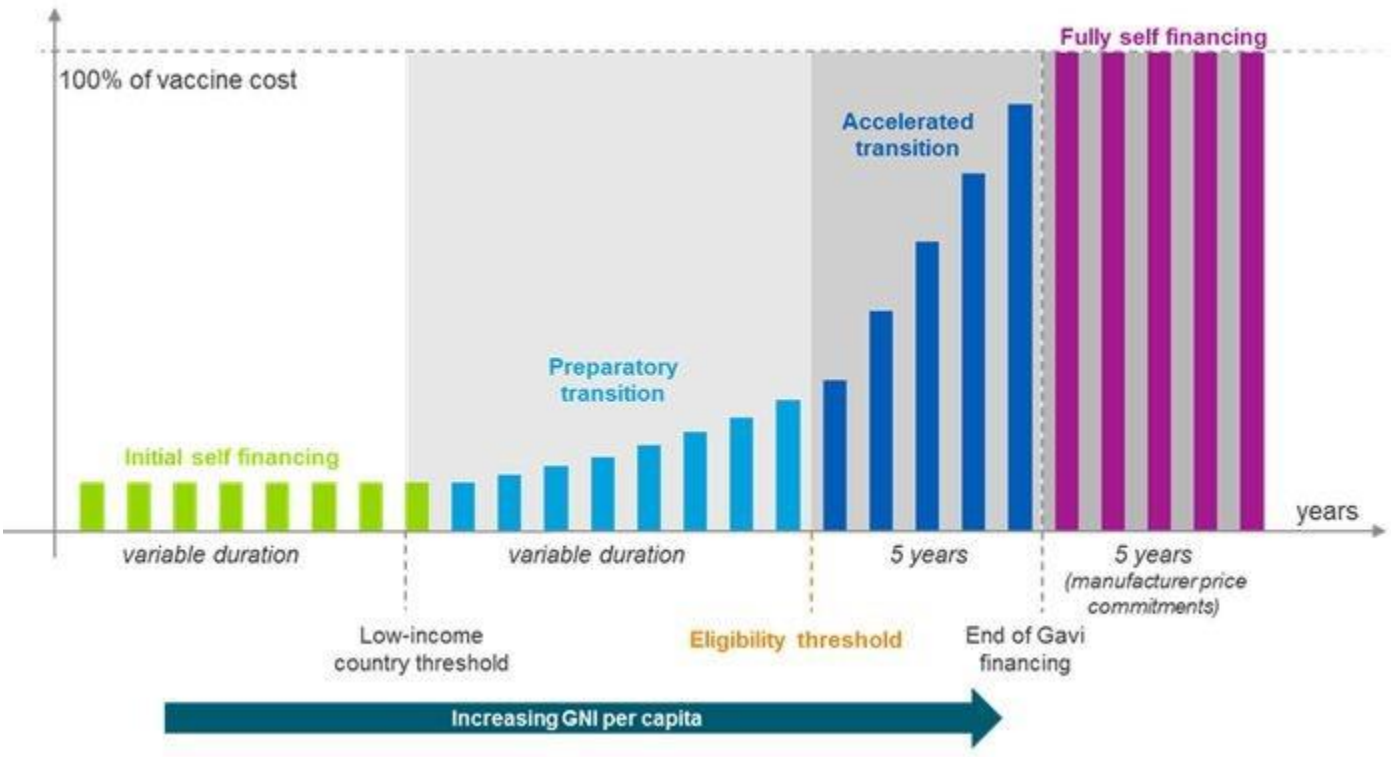
The Multi Year Comprehensive Plan (cMYP) is a key planning tool for governments receiving support from Gavi. It addresses global, national and subnational immunization objectives and strategies, and evaluates the costs and financing of national immunization programs (NIPs) (Newman, 2015b). The cMYP is developed in concert with WHO-UNICEF as part of the Global Immunization Vision and Strategy 2006-2015. It replaces the financial sustainability plan (FSP) previously used by Gavi to assess the financing challenges of a country's NIP. In the FSP, the recipient country was responsible for detailing how the government would mobilize and effectively use financial resources to support program plans both in the medium and long term (*The GAVI financial sustainability planning process*, n.d.)While requested by Gavi, these FSPs were used by national decision makers to understand the costs and financing of their immunization programs.

**National Immunization Technical Advisory Groups (NITAGs)**

To be eligible for new vaccine support from Gavi, countries must have NITAGs in place and explain how they are involved in decision-making processes. NITAGs are multidisciplinary

groups of national experts responsible for providing independent, evidence informed advice to policy makers and program managers on policy issues related to immunization and vaccines ("WHO | National advisory committees on immunization," 2018). According to Gavi, NITAGs "provide evidence-based decisions and enable countries to take full ownership of their policies and immunization programs" ("https://www.gavi.org/support/hss/leadership-management-coordination/," n.d.). The Global Vaccine Action Plan calls for all countries to have a functioning NITAG by 2020. NITAGs support evidence based decision-making and have been described as "instruments of country ownership which could use evidence to tailor immunization investments to country specific epidemiology and health systems, thus enhancing financial sustainability" (Howard, Walls, Bell, & Mounier-Jack, 2018). However, NITAGs come with challenges. In a comparative case study across 6 countries, researchers found concerns around a lack of guaranteed funding at the country level to maintain a functional NITAG (Howard et al., 2018). Additionally, not all countries have established or functional NITAGs. Some of the challenges to establishing a NITAG include a lack of political commitment, low awareness of the role of NITAGs, lack of financial resources, insufficient support to national authorities, lack of availability of qualified human resources, and political turmoil (*National Immunization Technical Advisory Groups*, 2017).

Figure 1: Diagram of Gavi's Eligibility and Transition Policy (GAVI, 2018)



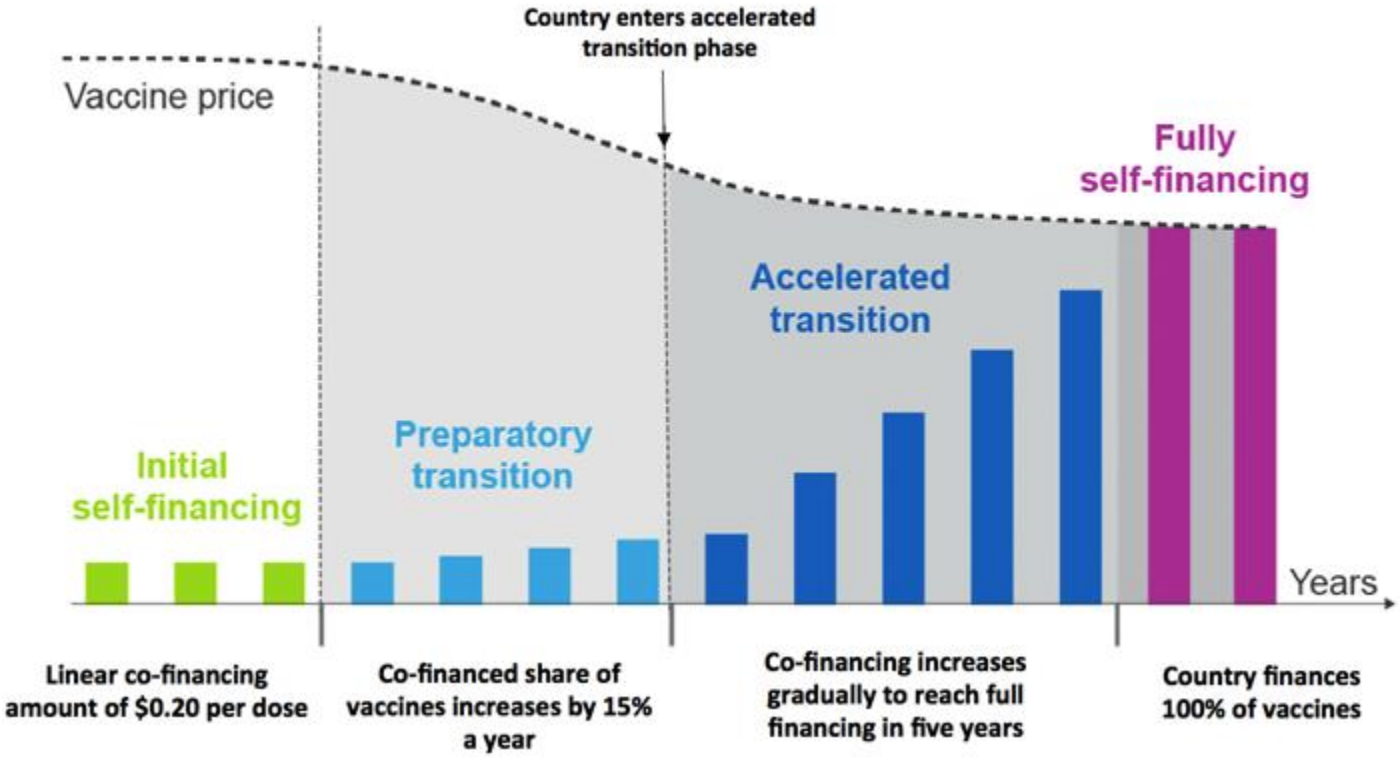

## Financial Sustainability and the Co-Financing Policy

From its onset, Gavi presented sustainability as a key goal in its work. During phase I, sustainability meant three things for Gavi: 1) supporting financial sustainability at the country level; 2) influencing vaccine supply and demand to reduce prices; and 3) developing innovative financing sources (Chee, Molldrem, Hsi, & Chankova, 2008). The co-financing policy, first introduced in 2007, was essential to Gavi's commitment to sustainability. Gavi defines co-financing as "contributions by national governments to cover part of the cost of Gavi-funded vaccines" (S Cornejo, Schwalbe, & Tanguy, 2011).

As a country transitions out of Gavi support, the country should have expanded their national immunization programs and created strong, robust health systems that can support the introduction of new vaccines. The co-financing policy prepares countries to be fully self-financing when country GNI exceeds $1580 USD per capita (see Figure 2). When a country

qualifies for Gavi support and if GNI per capita is at or below the World Bank's definition of low income, the co-financing requirement is a flat $0.20 USD per dose of Gavi introduced vaccine (Newman, 2015a). When GNI per capita exceeds the classification for low income, the country enters the preparatory transition phase, during which co-financing increases by 15% per year until the country's GNI per capita reaches the eligibility threshold, $1580 USD per capita, at which point a country enters the accelerated transition phase. The accelerated phase, usually 5 years, begins with a grace period year where the co-financing amount increases by 15% as it would have in the preparatory phase. Beginning in year 2 of the accelerated phase, co-financing requirements increase linearly until reaching 100% of the Gavi price of the vaccines (Newman, 2015a). At this point, the country becomes fully self-financing and can no longer receive new financial support from Gavi. After graduating from Gavi support, Gavi graduated countries are eligible to purchase vaccines at the same cost Gavi pays for a set period after they have transitioned out of Gavi financial support from certain manufacturers (Gavi, 2015). From the initial self-financing phase to fully self-financing, Gavi promotes a level of ownership in all activities by recipient countries.

Figure 2: Gavi Co-financing per Phase ("Transition process - Gavi, the Vaccine Alliance," n.d.)




Initially, Gavi utilized financial sustainability plans (FSPs) as a tool for long term financial planning for recipient countries. Gavi alleviates the uncertainty of funding by making five-year country commitments and clearly defines financial sustainability as a long-term objective rather than self-sufficiency as an end in itself (Kaddar, Lydon, & Levine, 2004). In 2001, the Gavi Board defined financial sustainability as "the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity" (Kaddar et al., 2004). Findings from these early FSPs found the introduction of new Gavi vaccines increased vaccine costs per child and that vaccine related activities need additional resources and support (Kaddar et al., 2004); findings also highlighted variability across countries

as to source of funding for vaccine programs. For some countries, like Lao PDR, 90% of its immunization program relied on external resources (Kaddar et al., 2004). Immunization financing is dependent on health sector financing (Kaddar et al., 2004) and health spending in low- and middle-income countries (LMIC) historically tends to be low (Jones, Jakovljevic, & Getzen, 2016). In low income countries (LIC), health expenditure constitutes on average about 7% of the GDP less than the 12% on average of high-income countries (Xe et al., 2017). These conditions are not unique to Laos and is applicable to Ghana, the case study country, where general government expenditure on health as a share of GDP is 1.7% (Global Health Expenditure Database, 2015).

## Case Study Country: Ghana

A Gavi success story, Ghana, since the introduction of Gavi funding has increased vaccine coverage from 77.9% to 98% coverage (Ministry of Health Ghana, 2011). Ghana has consistently performed high on all aspects of Gavi supported activities, introduced two new vaccines simultaneously demonstrating strong capacity for rollout. In the Sub-Saharan Africa region, it is a model for neighboring countries with one of the best performing immunization programs. In all aspects, Ghana is a success and as the second fastest growing African economy ("Ghana Overview- The World Bank," n.d.)), donor funding, including Gavi, is sure to change. . This makes the concept of ownership especially pertinent in the Ghanaian context as the country must be able to be financially sustain the immunization program to maintain impressive programmatic successes. This makes Ghana an ideal case study for country ownership.

Since 2001, Ghana has received over 206 Million USD in vaccine support from Gavi (*Ghana Gavi Country Profile*, n.d.). Since then, the country's DTP3 coverage, a proxy measure for full

immunization coverage, has increased from 79% to 99% (Health-Ghana, 2014).The Government of Ghana (GoG) pays for all traditional vaccines and co-finances the five Gavi introduced vaccines. Gavi and donors praise Ghana's immunization program for its high coverage rate and adoption of new vaccines into the national immunization program. The GoG provides vaccines free of charge to all children in Ghana (Saxenian, Arias, Bloom, Cashin, & Wilson, 2017). If Ghana enters the accelerated transition phase in 2021, co-financing obligations will increase gradually over five years until the GoG fully funds all vaccines (Gavi, 2019). In 2014 and 2015, Ghana defaulted on its co-financing obligations to Gavi (Saxenian et al., 2017). With co-financing obligations increasing and the level of contribution increasing,
the GoG must determine the best course of action for its Gavi funded vaccines.

## Background on Ghana

Ghana, officially the Republic of Ghana, is a country in West Africa with a population of 29.6 million inhabitants ("Ghana Overview- The World Bank," n.d.). Ghana functions as a constitutional republic with a unicameral parliament (*Government System in Ghana*, n.d.). Since its independence in 1957, the country has made tremendous strides in its development. Human Development Index for Ghana compared to others in the Sub-Saharan Africa at 0.592 is higher than the average in the region (0.537)(UNDP, 2018). The country functions with a unitary form of government with decisions made at the central level through the Cabinet of Ghana which consists of the President and the various Ministers. The Cabinet decides how to spend money and directs policy. Other stakeholders can make suggestions, but ultimately the decision is that of the Cabinet. Ministries oversee Agencies which are the implementing arm of the government (*Government System in Ghana*, n.d.). The Ministry of Health oversees several Agencies

including but not limited to the Ghana Health Service (GHS), National Health Insurance Authority (NHIA), Food and Drug Authority (FDA). The Ministry of Health is responsible for policy formulation, monitoring and evaluation, resource mobilization, and regulation of health service delivery per the enactment of Act 525 of Parliament which made provision and delivery of health services the responsibility of the GHS (Saleh, 2013). Per the law, all Agencies have some level of autonomy to operate independently. These Agencies in turn have regional and district offices, but this is not always the case.

The Government of Ghana operates in a decentralized manner as does the Ministry of Health:

- Central ministries are responsible for policy making, national planning, monitoring and evaluation, development of standards and indicators;
- Regions, through the Coordinating Councils (RCCs) and the RPCUs, are responsible for regional planning, harmonization and coordination of districts interventions, monitoring as well as supporting the districts in their respective role;
- Districts, through the partially elected District Assemblies (DAs), are responsible for adapting national policies to local realities, district-level development planning, and implementation of such plans and programs (Saleh, 2013).

This method of governance is not without challenges some of which Couttolenc highlighted*:*

- Mismatch between authority (the legal ability to do) and responsibility (assigned the function of executing or implementing), associated to lack of clarity about and competing views on decentralization;
- Tensions and conflicts among objectives (national policies versus local priorities or preferences; preventive versus curative care; and weak intersectoral coordination

- Capacity gaps (administrative, information, financial) at all levels, but especially at the local level;
- Weak policy implementation capacity at all levels, coupled with weak monitoring and supporting capacity;
- Weak economic basis of many districts;
- Tensions between vertical and horizontal integration (vertical programs VS integrated care at local level);
- Political and process dimensions (interest groups, resistance to change, political will, weak stakeholders' involvement and participation);
- Political and administrative instability: since the 1992 Constitution—which kept the number of districts at 110—60 more districts were created (an increase of 55 percent), 28 in 2003 and 32 in 2007 (Couttolenc, 2012).

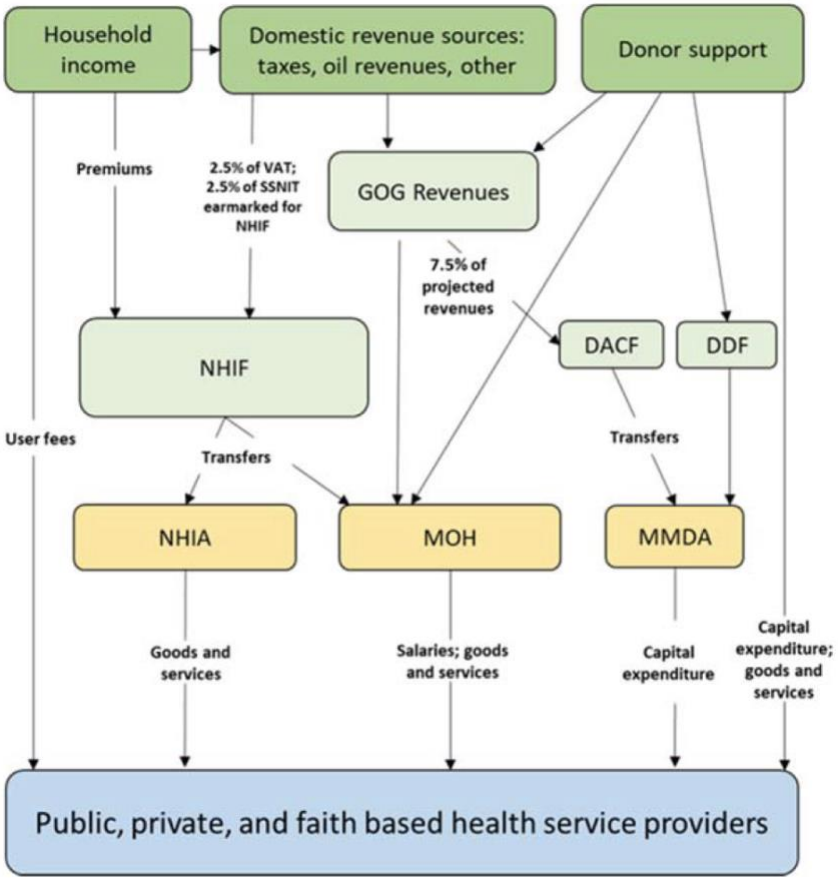
## Ghana: Health System and Financial Flows

The Minister of Health, appointed by the President of Ghana, oversees the Ghana health sector through the Ministry of Health. The MOH is responsible for formulating national policies, mobilizing resources, and regulating the eighteen agencies under its purview (CDDGHANA & HFG, 2018). Ghana Health Service (GHS), one of the eighteen agencies, is responsible for service provision and delivery. The GHS operates under the MOH governed by its own council, The Ghana Health Service Council. GHS is responsible for the delivery of public sector health services, such as the immunization program, and operates at the sub-national level through the Regional Health Directorates and District Health Directorates (CDDGHANA & HFG, 2018). Health sector financing comes from a mix of funds from public, private, household and donor

support (see Figure 3) (CDDGHANA & HFG, 2018; Couttolenc, 2012). Most of the total health budget comes from government/domestic resources accounting for 76% of the MoH's revenue (Schieber, Cashin, Saleh, & Lavado, 2012).

Ghana's programmatic success in expanding immunization coverage with the infusion of Gavi financing makes a successful transition from Gavi financing essential. The financing gap that Gavi will leave behind and Ghana's ability to fill that gap will determine if the national immunization program can maintain those programmatic successes. In figure 3, there are 3 main sources of financing in the Ghana health system and once Gavi funding ends that donor arm becomes more constrained. The government will need to effectively respond to this decrease by mobilizing resources from the other two sources. This might prove especially challenging when there potential areas of misalignment of priorities, between the central, regional, and district level. While the central is responsible for policy making and much of the resource mobilization that has to be informed by information coming from the regional and district level. As Couttolenc pointed out tensions and conflicts exist between amongst the three levels in what is a priority and if at the district level where implementation takes place immunizations are not a priority the information flow is subject to not being reflective of the actual need.

Figure 3: Flow of finances in Ghana Health System (CDDGHANA & HFG, 2018)




## Summary

This chapter presented the purpose of the study, the guiding research question and its significance to the investigation. Additionally, it gave an overview of Gavi, its evolution, focus area and the policies and mechanisms that guide its operations. Lastly, the chapter provided background on Ghana, the case study country, the country's involvement with Gavi and rationale for focusing on Ghana as a case study. The next section reviews academic literature on the concept of country ownership as manifest in the health/ development arena. The section then narrows the lens to focus specifically on how Gavi defines country ownership.

# Chapter 2: Literature Review

This chapter will examine literature on country ownership, Gavi's stated objectives for country ownership, and present the conceptual framework used in the case study.

## Country Ownership

Country ownership has existed in the development discourse (David Booth, 2012) since the 1990's. Esser asserts that the term 'national ownership[1]' can be traced back to the early 1990s within education and international development (Esser, 2014). In 2005, country ownership was formally established as a cornerstone of development aid by the 2005 Paris Declaration on Aid Effectiveness. The Paris Declaration and Accra Agenda define ownership as "partner countries exercise effective leadership over their development policies and strategies and coordinate development actions" (*The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, 2008). The Declaration goes on to say under the concept of alignment that "donors base their overall support on partner countries' national development strategies, institutions and procedures"(*The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, 2008). The mechanisms to enable country ownership were harmonization and alignment as defined in Table 1. This was meant to signify a paradigm shift from development aid of the past that was primarily external, and donor driven. Country ownership and sustainability became intertwined as the development community saw ownership as essential for sustainability of programs. The 2008 Accra Agenda for Action reaffirmed the initial Paris Declaration with modifications that broadened the notion of ownership as it was viewed as too state-centric

[1] Often used interchangeably with country ownership

(Dornan, 2017). The Accra Agenda broadened ownership to be inclusive of partners, meaning civil society, not just governments.

Table 1: Key Principles of Paris Declaration on Aid Effectiveness (The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, 2008)

| **Aid Effectiveness Principle** | **Definition** |
|---|---|
| Country ownership | Recipient government involvement, buy-in and leadership of externally funded health programs and donor programs working through and strengthening existing country health systems |
| Alignment | Donors and implementers working in alignment with recipient country priorities, policy frameworks and health systems |
| Harmonization | Donors and implementers coordinating programs |
| Transparency and accountability | Donor and implementer transparency and harmonized monitoring and evaluation indicators |
| Aid predictability | Assurance of longer term and more predictable donor funding |
| Civil society engagement and participation | Government responsiveness to civil society demands |

Country ownership has its fair share of critics. Faust argues country ownership as it set forth "ignores the political, iterative and experimental character of governance endogenous to democratic settings, which leave little room for encompassing ownership with regard to far-

reaching policy reforms"(Faust, 2010). Country ownership as commonly conceived in the development arena ignores the processes necessary for governments to make sound policy decisions and is rarely about the policies themselves. He states "'ownership' rarely refers to the content of policies. Instead, it only consists of broad procedural consensus regarding the basic principles that guide the political process" (D Booth, 2011; Faust, 2010) . This proves more difficult in emerging democracies where these relations are more tumultuous. Faust believes ownership as a requirement for aid effectiveness is too ambitious for recipient countries, simplistic, unable to measure and offers no guidance as to how to make aid more effective. Buiter describes country ownership as a property of programs, processes, plans or strategies involving both a 'domestic' party (generally a nation state) and a foreign party(Buiter, 2007). He characterizes ownership as a conditionality of donor funded programs. This conditionality isn't geared at specific actions, policies or outcomes but on promoting good governance; it focuses on a broad definition of capacity building that enables the implementation of a progress or institution(Buiter, 2007; Dornan, 2017). Buiter says country ownership as a term is misleading due to the multitude of ways it can be applied. Instead of focusing on country ownership, Buiter highlights a country's ability to take responsibility of donor funded programs via their ability to determining the agenda, implementing accountability measures, managing the overall process and engaging with partners as necessary (Buiter, 2007). Within the actions and processes described, the recipient country is granted a level of control and power.

When a country 'owns' development activities, they accept full responsibility for its success and failure with the assumption that the country will allocate the necessary resources and mobilize support for its sustainability(Goldberg & Bryant, 2012; Johnson, 2005). With this responsibility comes the onus to act or not act and Johnson argues if you take ownership you also take full

responsibility for the results of those policies or programs you implement (Johnson, 2005). Within country ownership, Goldberg & Bryant examine the idea of capacity building where donor assistance promotes partnership with recipients; donors equip recipients with the skills to respond effectively to challenges, solve problems and build capacity independently (Goldberg & Bryant, 2012). The authors characterize capacity building as "a continuous and participatory process undertaken independently or in collaboration with external partners to empower the organization to systematically identify and respond to its institutional needs and the needs of the population its serves in order to better meet its stated mission and goal, solve problems, implement change and increase efficiency"(Dornan, 2017; Goldberg & Bryant, 2012). The process expresses partnership, between partner and donor organizations, as a two-way street. Not only do donors gain knowledge from their partners, donors have a responsibility to empower partner countries/organizations to independently identify and plan to address areas of need. According to Hyden, this partnership moves these donor-recipient relationships from business contracts to social contracts with much more at stake than financial accountability (Hyden, 2008).

While the rhetoric and policies regarding country ownership exist in donor dialogues and declarations, action lags far behind. Countries are rarely in the "driver's seat" to invest in long-term priority setting and planning, instead donors focus on 'quick wins' and easily measurable returns through vertical programming(Sridhar, 2009). Donor priorities are not aligned to a countries national plans, and there is lack of harmonization amongst donors, resulting in "excessive transaction costs" for recipient governments (Sridhar, 2009). Accountability of donors to recipients and recipients to donors presents a challenge due to the imbalance of power.

Sridhar suggests the need for donor accountability measures just like that required of recipients and the adequate policy space for the development of national plans.

Ownership suggests that for a policy to work, it must be seen as legitimate by those on the ground who are responsible for implementing it. Simply put, the recipient doesn't have to agree with the donor's program but the recipient must have the political will to implement that program (Best, 2007). To achieve this sense of ownership and legitimacy is an inclusive approach focusing on increased participation of all relevant stakeholders including governmental, NGOs and other funders (Best, 2007). Ownership aligns the incentives of the borrower and the lender (Khan & Sharma, 2003). For the borrower, ownership demonstrates a firm commitment from the government and other stakeholders, and for the lender country, ownership increases the probability that the programs will succeed (Khan & Sharma, 2003). Khan describes this as a principal-agent relationship where the principal relies on the agent to achieve certain objectives and this relationship works best when the two parties' priorities are closely aligned (Buffardi, 2013; Khan & Sharma, 2003). Best states that ownership is inherently subjective and that poses a challenge to its operationalization(Best, 2007). Thus, determining country ownership presents its own challenges. Ownership has a capacity problem. Countries must have the capacity to exert "meaningful control over their decisions and actions"(Best, 2007), however countries seeking financial assistance lack the autonomy to exert real ownership. Countries only borrow when they are in financial distress. This dynamic is stated by Alejandro Diaz as "if you ask for a gift, you must listen to your patron" (Khan & Sharma, 2003). In a study on country ownership and health systems, the authors suggest that donors should relinquish some control of their aid funds (Martinez-Alvarez, 2018). This runs in contrast with current practices, where donors want accountability for where their funds go or have specific areas that they fund.

When a country owns a program, the country is more likely to make judicious decisions to enable success; additionally, ownership generates domestic political support because the program is seen as indigenous rather than foreign (Khan & Sharma, 2003). In a case study on Rwanda, national ownership and donor involvement, ownership is based on the notion that for aid to be effective, a country's national priorities as expressed in national policies align with that of the funders' priorities (Hasselskog & Schierenbeck, 2017). Policy development then becomes a component of country ownership. Donors are becoming ever more present in the policy making process through capacity building in the form of technical assistance (Hasselskog & Schierenbeck, 2017). This assistance is often given by resident external consultants and advisors who engage in the policymaking process thereby becoming stakeholders themselves. This might be representative of a lack of trust or belief in recipient governments' abilities to create and enact policies. Martinez-Alvarez suggests involving governments at all stages of planning and development(Martinez-Alvarez, 2018). Kindornay states country ownership is more than just nationally owned development strategies (Kindornay, 2015). External factors, such as the global environment and internal capacities, impact how a country exercises ownership. This is to say that a country doesn't exercise ownership in a vacuum; it responds to the changing dynamics and powers of influence.

Past WHO Director Margaret Chan and current Director Dr. Tedros Adhanom are advocates of country ownership and make connections between ownership and sustainability. WHO director Margaret Chan believes "we are not recognizing the importance of country ownership." According to Chan, countries need to own their health programs otherwise there is no responsibility and no accountability, furthermore it does not promote sustainability (Chan, 2011). Chan believes countries need to be in the 'driver's seat' developing plans with indicators,

measures and evaluations along with donors rather than being told what to do. Current Director General of the WHO and former Minister of Health for Ethiopia, Dr. Tedros Adhanom, is a staunch supporter of country ownership and its importance in scaling up programs. Ownership he believes removes a lot of the challenges in implementation such as duplication, high transaction costs, and misalignment of priorities (Adhanom Ghebreyesus, 2010). Furthermore, ownership leads to commitment and putting in checks and balances addressing some of the governance issues that might arise, "ownership reinforces commitment, and commitment in turn yields results and assures long term sustainability" (Adhanom Ghebreyesus, 2010).

## PEPFAR and Shifting Paradigms: A Model for Country Ownership in Global Health?

The U.S. Global Health Initiative has shifted the approach of US's global health programs making country ownership one of the core principles to increase effectiveness of the programs. One such program, the United States President's Emergency Plan for AIDS Relief (PEPFAR), made this shift by going from an "emergency response to that of a sustainable country owned response" (PEPFAR Blueprint: Creating an AIDS-free Generation, 2012), making country ownership a tenet of PEPFAR. Country ownership was defined as "the end state in which partner countries lead, manage, coordinate and over time increasingly finance the efforts needed to achieve an AIDS-free generation in order to ensure that the AIDS response is effective, efficient and durable"(PEPFAR Blueprint: Creating an AIDS-free Generation, 2012). In its efforts to transition to less of an emergency response to a sustainable country owned program, PEPFAR elicited the help of McKinsey & Company to define what country ownership is within the scope of PEPFAR's work. A definition of country ownership was clearly articulated by the United States Government in a paper on the topic (GHI, 2012):

> Countries that effectively manage their public health response demonstrate leadership over their health budgets, policies and strategies, and coordinate public health actions,

> including the contributions of the private sector, donors and civil society. Country ownership involves shared responsibility and mutual accountability with donors and other partners, particularly when outside financial and technical resources are needed to fully respond to the health sector needs of host countries. The USG fosters country ownership by investing in high impact and evidence-based country-led priorities, plans and systems. The USG also encourages country ownership when it promotes direct financing by recipient countries for priority interventions such as malaria and family planning commodities. Ultimately, a well-coordinated, country-led health response enhances efficient use of resources and contributes to long-term sustainability of global heath programming (GHI, 2012).

In 2009, the Obama administration launched the Global Health Initiative and one of the seven principles that guide the GHI is country ownership. Then Secretary of State, Hilary Clinton, further articulated the USG's position on country ownership at the 2012 Global Health Summit in Oslo:

> [It is] not just a matter of semantics, because if we are not clear about what country ownership means, we cannot know whether we are making progress toward achieving it. To us, country ownership in health is the end state where a nation's efforts are led, implemented, and eventually paid for by its government, communities, civil society and private sector. To get there, a country's political leaders must set priorities and develop national plans to accomplish them in concert with their citizens. . . And these plans must be effectively carried out primarily by the country's own institutions, and then these groups must be able to hold each other accountable. . .. So, while nations must ultimately be able to fund more of their own needs, country ownership is about far more than funding. It is principally about building capacity to set priorities, manage resources, develop plans, and carry them out. We are well aware that moving to full country ownership will take considerable time, patience, investment, and persistence. But I think there are grounds for optimism (Rodham Clinton, 2012).

This clarification is especially important as in the past "there is a long history of external partners playing these leadership roles in many countries, creating an unhealthy donor-recipient relationship of dependence that over time diminishes the capacity of the government and civil society to ensure that services persists and are of high quality" (Goosby, Von Zinkernagel, Holmes, Haroz, & Walsh, 2012). Goosby et al recommend a path forward with PEPFAR's new focus on country ownership and shared responsibility: (1) Dialogue with Country Partners; (2) Prioritizing Evidence- Based, Country- Specific Interventions; (3) Evaluating Impact; (4)

Investing in Local Institutions; (5) Building Country Capacity to Lead; and (6) Partnering with the Global Fund. A study on effective transition for PEPFAR countries identified six key steps: develop a roadmap, involve stakeholders, communicate the plan, support midterm evaluations, strengthen financial, technical and management capacity, and support ongoing M&E (Vogus & Graff, 2015).

As stated previously, Rwanda is a country that has shown a strong commitment to country ownership of donor funded programs with a strong focus on aligning national priorities to enable ownership. Doing so allowed Rwanda to successfully transition its HIV programs from donor-led agencies to the Government of Rwanda (GOR). While this was a primarily a program ownership shift not financial, but offers lessons on how a financial transition might be made. From the onset, the GOR clearly articulated national ownership as a goal of externally funded HIV programs. A key component to this successful transition created by the GOR and its partners was to allow for direct PEPFAR financing to the host country government, (Binagwaho et al., 2016). This change allowed the GoR to manage how and where financial resources would be allocated for a more effective and country specific HIV program response.

Planning for transition began in 2009 and full transition to the GOR occurred in 2012 when the Rwandan Ministry of Health (RMOH) became a direct recipient of PEPFAR funds and was responsible for coordinating the country's HIV services. The GOR implemented steps prior to transition to ensure that the transfer to country ownership would not disrupt or hinder the country's ability to provide services. Seven principles were instrumental to Rwanda's transition and enabled the country to own its HIV program:

1. *Political Decentralization: Rwanda has a decentralized health system that allows for its administrative districts to coordinate all health activities within their district health facilities and any NGOs providing health services;*
2. *Ownership through National Coordination: The RMOH governed under the principles of the three ones: one national HIV coordinating body, one national HIV strategic plan, and one national monitoring system. Everybody operating in the health sector, including NGOs, had to adhere to this policy and align their service accordingly which allowed for harmonizing not only policy but service delivery;*
3. *Participation and Partnership: An inclusive participatory approach was promoted, and key stakeholders were involved in the creation of the national HIV prevention, treatment and mitigation guidelines. Partners also provided key training to the RMOH which allowed them to develop national tools and electronic systems to track HIV program activities at the central, district health facility and community levels;*
4. *Equity: RMOH worked with civil society to develop an equitable approach for allocating resources. Additionally, committees were created with a diverse body to ensure the most vulnerable had access to services. To assure equitable geographic access, NGOs and GOR coordinated to staff newly built HIV clinic in these areas;*
5. *Efficiency: The Three Ones governance principles enabled an efficient system. Further, the system promoted efficiency by discouraging duplication and improving coordination by operationalizing the geographic mandate of NGO partners. The national plan required that each NGO partner undertake the full range of HIV services and supervision, training, and mentorship in an integrated manner which reduced the number of partners and logistics and transported related costs. In addition, the GOR implemented a national salary structure for all health personnel in all facilities;*
6. *Accountability: Rwanda implemented transparency, anticorruption and quality assurance policies for all sectors, including health. This allowed for oversight on donor and domestic government funds building administrative capacity;*
7. *Integration of HIV Care to Strengthen Health System: The GOR did not want to create a parallel system for just HIV care outside of the existing health system. HIV epidemic care was integrated within the existing health system and partner agencies supported this national policy and applied the chronic disease model to HIV care as a way to strengthen critical components of the Rwandan health systems* (Binagwaho et al., 2016).

Rwanda's transition to national ownership was not without difficulties yet the commitment and will is evident by the actions the GoR put in place to drive ownership. One thing to note is the government deciding the timeline by which they would transition ownership. It was much more ambitious than PEPFAR's but allowed Rwanda to set the pace of the transition. Another important thing to note is the way in which the GoR worked with PEPFAR to identify areas where Rwanda was weak thus directing capacity building efforts to those weak areas. Lastly, the

alignment of all national plans for HIV programs, monitoring system, and coordinating body ensured accountability and partnership removing duplicity and misalignment.

Lastly, The Global Fund places explicit emphasis on country ownership defining country ownership as one of its principles: country ownership means that people determine their own solutions to fighting these three diseases and take full responsibility for them. Each country tailors its response to the political, cultural and epidemiological context (Atun & Kazatchkine, 2009). This decision-making body makes up the Country Coordinating Mechanism (CCM) bringing together government, public sector, civil society, multi and bilateral organizations, private sector and affected communities to create a decision-making body at the country level (Atun & Kazatchkine, 2009). This promotes ownership by building capacity of local health leadership to oversee governance.

The objective of this literature review was to define country ownership, its evolution and its use in the broader discourse. The aim was not to characterize country ownership as negative or positive but rather what enables country ownership, what inputs, actions, and norms and how that leads to successful and sustainable donor-funded programs. The results of this synthesis present four key drivers I believe drive country ownership: accountability, commitment, partnership, and capacity. These drivers come from a synthesis of the criticisms and advocates of ownership and the example of a successful country owned program. While other drivers can be derived from this review and there are overlaps in some of the drivers, the author and this study focuses on these four drivers.

The drivers derived from the literature review for country ownership are as follow:

1. Recipients, donors, and other stakeholders are **accountable** to each other, the systems they have enacted and in all transactions;
2. **Commitment** by the government to mobilize support among political stakeholders to effectively implement and sustain aid funded programs;
3. A **partnership** between donors and recipients fostering country leadership and enabling the legitimacy and power of the recipient;
4. Recipient countries have the **capacity** implement, govern, enact policy and frameworks required for aid funded programs.

## Country Ownership and Gavi

The Paris Declaration of Aid Effectiveness is a core tenet of Gavi's approach (Gavi, 2010). In the area of country ownership Gavi states "Gavi provides support to expand access to immunization at the request of countries, committing support for the duration of individual countries health and immunization plans. Such predictability enables countries to better plan and increases the value of the support. A successful innovative co-financing programme has significantly increased country ownership" (Gavi, 2010). So, while not explicitly defining what country ownership means in the Gavi context, the prior statement describes the actions Gavi takes to increase country ownership 1) countries request support as they need; 2) Gavi commits to a predictable funding timeline; and 3) a co-financing program.

"Gavi's policies do not explicitly define country ownership as a principle, but the intent is clear" according to an evaluation of the Alliance's co-financing policy (Gouglas D, Henderson K, Plahte J, Årdal C, 2014). Gavi's co-financing policy aims to "put countries on a trajectory towards financial sustainability" (Kaddar et al., 2004). Gavi defines financial sustainability since 2011 as "the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance." There is no official or formal definition of country ownership set forth by Gavi; however, in reports Gavi has specified that "co-financing can still help to prepare these

countries by building procurement and budgetary processes while strengthening ownership of immunization decisions, even if the eventual goal of financial sustainability is still distant; as such, country capacity building and ownership are intermediate goals that the co-financing policy can support (Gonzalez-Canali, 2010; Newman, 2015a)." In this case, country ownership is not the end goal of Gavi's but rather a necessary intermediary step in achieving Gavi's strategic goal of financial sustainability via the co-financing approach. Gavi promotes country ownership through its co-financing policy as explained in the introduction (see Figure 2). Since Gavi asserts that the co-financing policy contributes to country ownership of vaccine financing and since there is no formal policy on country ownership, the co-financing policy is a proxy for country ownership in this study. As such, the indicators for co-financing / financial sustainability act as a proxy measure for country ownership (Santiago Cornejo, Theopold, & Johannes, 2016b, 2016a). The same evaluation that found "intent of country ownership", found countries lacked the institutional capacities and a lack of domestic funding for vaccine and immunization programs (Gouglas D, Henderson K, Plahte J, Årdal C, 2014). Institutional capacity for Gavi means the presence of a functioning NITAG to support country priority setting and evidence-based decision making on vaccines. The evaluation found 17 Gavi countries had relied on donors for financing traditional vaccines (Gouglas D, Henderson K, Plahte J, Årdal C, 2014). Gavi aims to build capacities in planning, vaccine introduction decision making and procurement, and contribute to strengthening linkages between ministries (Gouglas D, Henderson K, Plahte J, Årdal C, 2014). This evaluation found the co-financing policy significantly contributed to country ownership.

The evaluation defined ownership by the following actions: 1. domestic accountability; 2. operational linkages between MoH, MoF and parliament; 3. creation of separate budget lines; 4.

legislation on immunization; 5. prioritizing domestic funding for vaccines (old and new) and 6. institutional capacity (Santiago Cornejo et al., 2016a, 2016b).

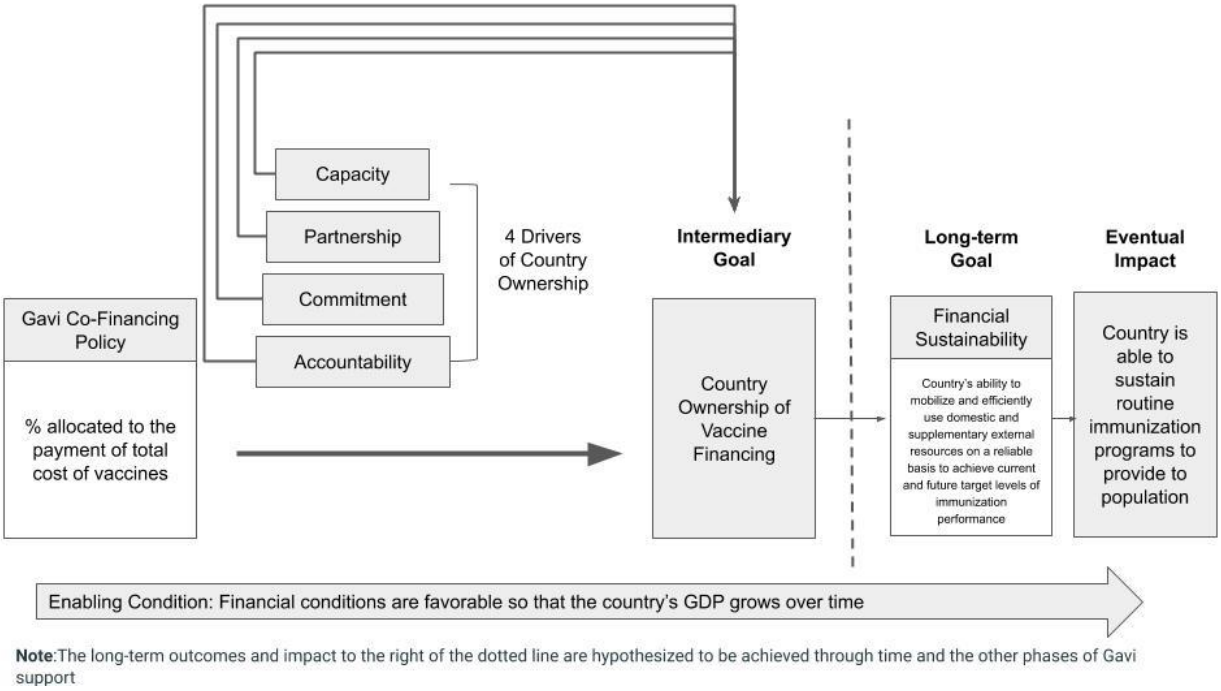
The purpose of this section was to understand if and how Gavi defines country ownership. First, we concluded Gavi has not formally defined ownership as an organization. Second, although there is no formal definition of country ownership in Gavi's model, the intent of ownership is present and promoted via the co-financing policy. Third, from the review, Gavi's conceptualization of country ownership is a financial one that is enabled via the co-financing policy. Like the Gouglas et al evaluation, this case study will have to define determine what actions/indicators might be a measure of country ownership and will use indicators from the sustainability and tracer framework proposed by Gavi's Policy and Program Committee specific to vaccine financing. These indicators guide the creation of the conceptual framework in addition to the drivers of ownership identified from the literature review.

## Conceptual Framework: A Potential Model for Operationalizing Country Ownership

The result of these two reviews is a conceptual framework (Figure 4) of country ownership in Gavi's co-financing policy developed by the investigator. The co-financing policy requires countries to pay a portion of the total costs of Gavi introduced vaccines. Meeting the co-financing obligation leads to the intermediary goal of ownership of vaccine financing. However, four indirect drivers of ownership, as uncovered in the literature review, influence the operationalization of this policy. Countries that have these four drivers are better able to buy into the Gavi model, allowing them to commit to the co-financing policy and meet the co-financing obligations. These direct and indirect mechanisms lead to the intermediary goal of country ownership of vaccine financing.

These drivers also help to explain and assess country ownership of vaccine financing. Specific to each driver are indicators informed by Gavi's proposed sustainability frameworks (Santiago Cornejo et al., 2016a) (see Figure 6) specifically some of the challenges countries faced in meeting their co-financing obligations. While country ownership is the intermediary goal, the policy's goal is financial sustainability, which is a country's ability to mobilize domestic resources to finance vaccines. The enabling condition/ assumption of this model is that economic conditions are favorable. The model makes the following assumptions and conditions: country's GDP or GNI per capita will increase; country will experience economic growth and financial conditions are favorable.

Figure 4: Country Ownership Conceptual Framework




**Note**:The long-term outcomes and impact to the right of the dotted line are hypothesized to be achieved through time and the other phases of Gavi support

# Chapter 3: Methodology

This chapter describes the methodology used to answer the key research question of assessing how Gavi operationalizes country ownership in its co-financing policy. There are two components of the methodology: 1) a literature review of country ownership; 2) country ownership as defined by Gavi through a review of Gavi publicly available documents. Lastly, the synthesis of this review resulted in a conceptual framework used to guide assessment of Gavi in Ghana. The search strategy and resulting evidence based are presented (Figure 5). Finally, the chapter discusses limitations of this methodological approach.

## Systematic Review

A systematic review of peer-reviewed and grey literature was conducted to answer the question: *What is known about country ownership and transition processes from the literature?* The search was initiated in November 2018 and was an ongoing process through February 2019. A systematic search of peer-reviewed articles was conducted through the following databases available at Emory University: PubMed, JSTOR, CABI Health and Scopus. Google Scholar searches supplemented database searches.

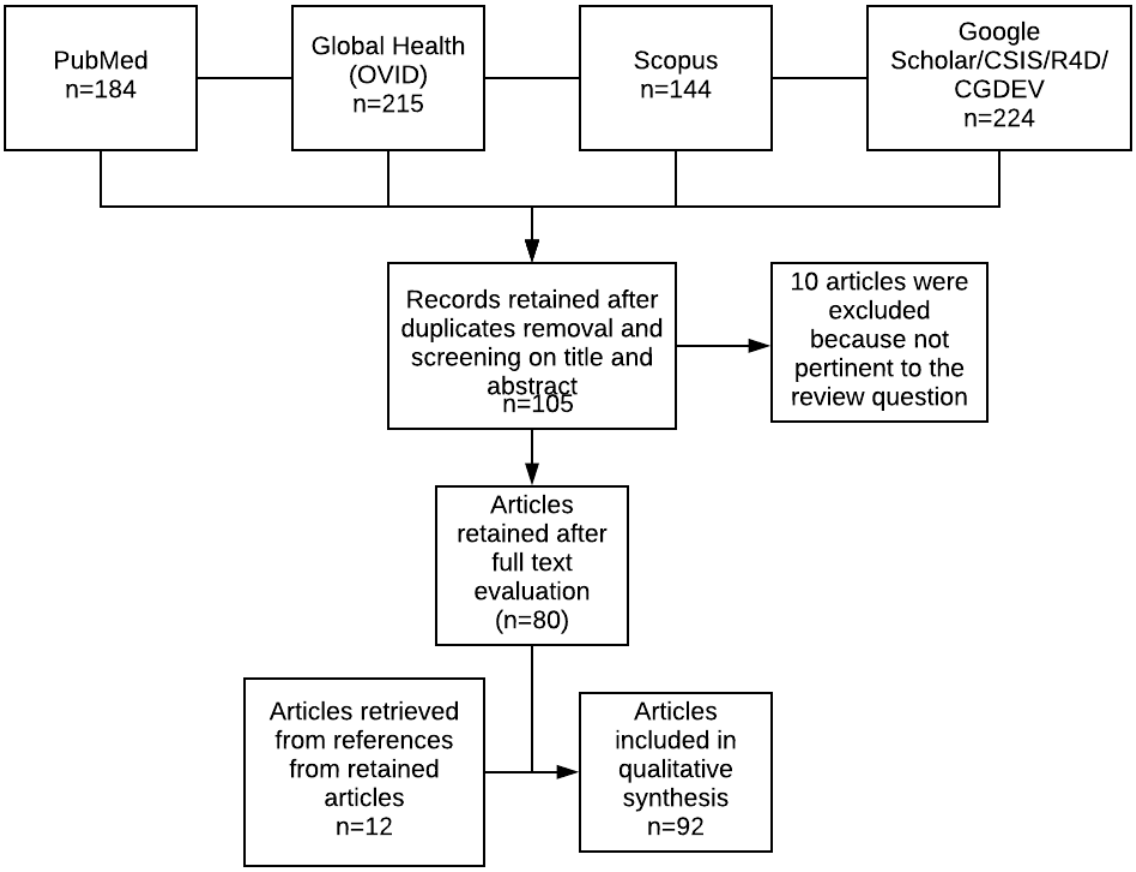
The search objective was to identify relevant articles focused on country ownership within development aid and/or health outside of high-income countries (as defined by the World Bank). Across all the databases used, the search terms were configurations of the following terms: 'country ownership', 'development assistance', 'donor funding', 'global health', 'sustainability', 'effectiveness', and 'transition'. Inclusion criteria were determined *a priori* and were as follows:

- Definition or description of country ownership;
- Specific to development or health;
- Describes aid transition process;

- Published in English.

The investigator reviewed the titles and abstracts of all articles. The investigator reviewed the references of included articles for additional articles not captured in the original search.

Figure 5: Country Ownership and Transition Literature Search




The systematic database search was supplemented by periodic searches via the Google search engine for relevant grey literature. Additionally, the websites of the following organizations, Organization for Economic Cooperation and Development (OECD), Center for Global Development (CGD), Center for Strategic and International Studies (CSIS), Results4Development (R4D), The World Bank, and The World Health Organization, were also screened, providing insight into ongoing dialogues around country ownership in donor agencies.

The literature review resulted in 92 articles included in the qualitative synthesis on country ownership.

### Systematic Review Limitations

It is possible that the databases do not capture all the information on country ownership. Additionally, since country ownership is a fairly recent area of investigation, literature around the topic is ever evolving. The choice of terms used in the search limited it to development aid or health which might have skewed the results.

## Gavi Document Review

The next objective was to conduct a review of Gavi documents on country ownership. A broad search of 'ownership' on Gavi's website (www.gavi.org) resulted in 728 matches all of which were publicly available. Excluding country specific documents, vaccine specific documents and Gavi organizational documents, approximately 100 documents were relevant to this investigation. The final review included 29 documents. Each of the initial 100 documents were reviewed and those that discussed more programmatic aspects of immunization were removed focusing only on the documents speaking to financing. These documents focused specifically on the co-financing policy, sustainability and metrics.

The purpose of this review was to give meaning to country ownership in Gavi making a document review an appropriate method.

### Document Review Limitations & Advantages

Document review allows for tracking information over time and how topics have evolved but run the risk of biased information due to the intended audience. The researcher is limited to what is publicly available.

## Case Study

With the conceptual framework of country ownership established from the literature review and document review, a case study utilizing content analysis describes how ownership is operationalized in Ghana, a Gavi country. The case study explores how country ownership has been operationalized in Ghana through the Gavi co-financing policy, by presenting an analysis of the four drivers that have been determined from the literature and document review to have an indirect impact on country ownership: (1) accountability; (2) partnership; (3) commitment; and (4) capacity.

A case study is appropriate because of the contemporary nature of the research question. A case study "has a specific advantage when a "how" or "why" question has been asked about a contemporary set of events, over which the investigator has little or no control"(Yin, 2003). Furthermore, a case study allows for understanding complex social phenomena and does not remove the real-life context that shapes the phenomena ((Yin, 2003). The unit of analysis for our case study is the co-financing policy of Ghana.

## Data Analysis

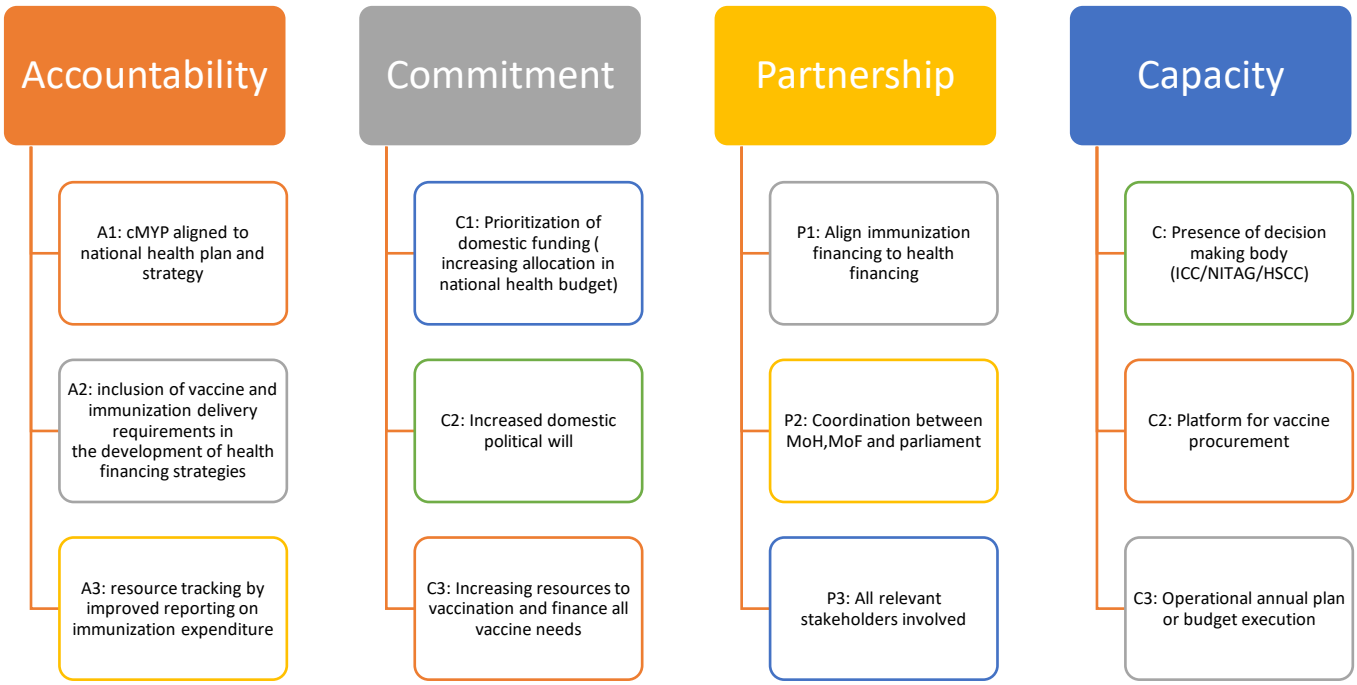
The case study relied exclusively on documentary review- content analysis of country submitted Annual Reports, Comprehensive Multi-Year Plans (cMYPs), Co-financing Information Sheet, and Targeted Country Assistance Plans downloaded from Gavi's webpage. Remaining documents for review came from Government of Ghana's Ministry of Finance and Ministry of Health webpages. Appendix A provides a comprehensive list of reviewed documents.

The scope of documents was what was available online and spanned the years 2001-2018.

The approach taken to the case study was exclusively content analysis around the four drivers of country ownership and the specific indicators for Gavi compiled from the Gavi document review (see Figure 6). To determine the extent to which the included documents described, addressed or

considered each of the identified drivers of country ownership (i.e. areas of analysis) each document was read and analyzed. Relevant text was highlighted in the document and manually coded by the author in an excel document. Based on the analysis of that text, the document was classified as good, ok, limited, no information or unclear, with the criteria for each classification explained (see Table 2).

Figure 6: Co-Financing Specific Indicators Aligned to Drivers of Country Ownership




The author classified each indicator as good, ok, limited, no information or unclear according to a basic qualitative scale (see Table 2). The ratings were developed iteratively during the content analysis. Results are reported only for those indicators where there are sufficient data. These indicators (Figure 6) come from a proposed Tracer framework for sustainability (Santiago

Cornejo et al., 2016a) and were grouped by the author to the four drivers of ownership defined in the literature review.

Table 2: Document Rating Guide

| Rating | Definition |
|---|---|
| **Good** | clear and consistent references to an indicator which related to that driver and would (ideally) also give sufficient information to judge that this driver was being carried out competently and with sufficient resource allocation |
| **Ok** | the presence of indicators related to that driver but where there was insufficient detail to confidently give a score of 'good' |
| **Limited** | a brief or cursory reference to an driver with little corroborative detail or contextual information on the level of resource allocation or prioritization |
| **No Information/ Unclear** | there was no information clearly attributable to a driver. |

## Case Study Limitations

First, the use of secondary data meant the data might not comprehensively capture all the drivers of country ownership. Second, our use of only document analysis limits the depth of understanding of the topic; the use of in-depth interviews or focus groups of individuals involved with Gavi process would have strengthened the study. The interpretation of the available data is not independent of the researcher's viewpoint. There is a lack of generalizability in a case because, by definition, a case has a unit of analysis of one.

# Chapter 4 –Case Study Results

The success of Gavi's support to a recipient country is the country's ability to sustain the vaccine and immunization program after Gavi support has ended. Financial sustainability is the goal in Gavi's co-financing policy, where the recipient must contribute an increasing percentage of the costs of Gavi introduced vaccines. This percentage increases as the country's GNI per capita increases until country is fully self-financing. The co-financing policy is to put the country on the path to financial sustainability by encouraging country ownership, limited in the case study to financial ownership. This study investigated how Gavi operationalizes country ownership in its co-financing policy and how successful a country, Ghana, that has been receiving Gavi support since 2001 and has improved immunization coverage since the influx of Gavi funding, has been in "owning" the financing of their national immunization program.

## Accountability

### **A1:** cMYP Aligned to National Health Plan and Strategy

The cMYPs available are consistent with the national plan and strategy for immunization. The cMYPs guide subnational plans and offer a strategic plan for the country. In all three available cMYPs, it explicitly stated that the document is "the medium-term planning tool for the National Immunization Program in Ghana." Furthermore, the cMYP when compared to the available Annual Plan(s) of Work (APOW) corroborated alignment with national priorities. For each available year, between 2002 to 2013, there is a section on the Expanded Program on Immunization (EPI). This section on the EPI in the APOW reports on current coverage rates and target coverage rates as well as a statement to commitment to EPI as a priority area and key to the health of the nation. The 2014 Health Sector Medium Term Development Plan (HSMTDP)

also mention the EPI as a "priority area …including the introduction of new childhood vaccines."

### **A2:** Inclusion of Vaccine and Immunization Delivery Requirements in the Development of Health Financing Strategies

While the 2015 Health Financing Strategy (HFS) document doesn't explicitly address vaccines, there is a push towards universal health coverage (UHC) in the Ghana health system and mobilizing novel resources to achieve UHC. This push towards UHC for Ghana meant a focus on Primary Health Care which includes preventative care such as immunizations. UHC would be achieve through the National Health Insurance Scheme (NHIS) which is compulsory for all Ghanaians but currently has less than 50% enrollment. The MoH in coordination with the National Health Insurance Agency aims to increase enrollment thereby expanding coverage and increasing pooled funds. The strategy would be to shift from "narrow program or scheme financing to broad system financing" as a means of improving resource mobilization to ensure an adequate and predictable revenue stream as well as an allocation mechanism.

### A3: Resource Tracking by Improved Reporting on Immunization Expenditure

Currently, there is a budget line in the national budget for vaccines as reported in the cMYPs and the WHO-Joint Reporting Form. The Public Financial Management (PFM) system tracks health expenditure; however, the PFM system is fragmented and does not adequately track resources and transactions.

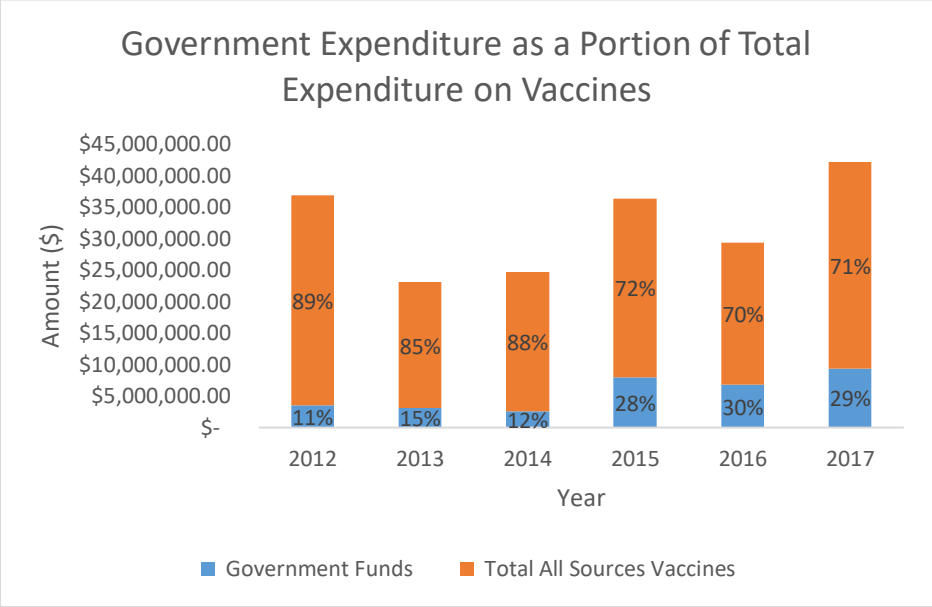
## Commitment

### C1: Prioritization of Domestic Funding: Increasing Allocation in National Health Budget

In 2017, the government allocated about 17 million USD for vaccine procurement for the next three years. The cMYP nor the budget for 2017 specify whether this allocation was an annual or one-time allocation. In 2017 Ghana was expected to enter the graduation phase due to GDP per

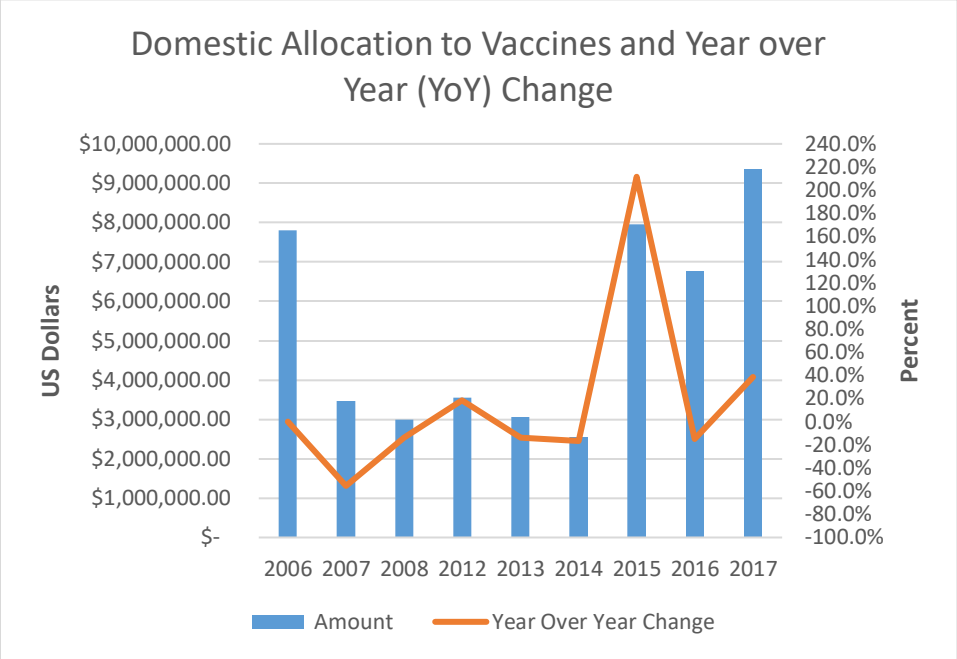
capita growth and the country began exploring ways to improve domestic financing. However, major funding gaps exist in the health sector, not only in vaccines, and as a result, priority programs like immunization can suffer if there are tradeoffs made. There has been exploration of alternative ways to increase domestic funding for the public health sector through the NHIS, including levying taxes on imports, "sin" taxes and local governments allocating some of their budgets to cover the funding gap. Over the period of 2012- 2016, government expenditure on vaccine financing increased (see Figure 7).

Figure 7: Government Expenditure as a Proportion of Total. Expenditure on Vaccines, source: WHO-JRF




Additionally, year over year change on domestic allocation to vaccines has gone up as reported in the WHO-JRF (see Figure 8).

Figure 8: Domestic Allocation on Vaccine and Year over Year Change, WHO- JRF




The spike in 2015 is possibly a result of allocating more to cover arrears from the previous year.

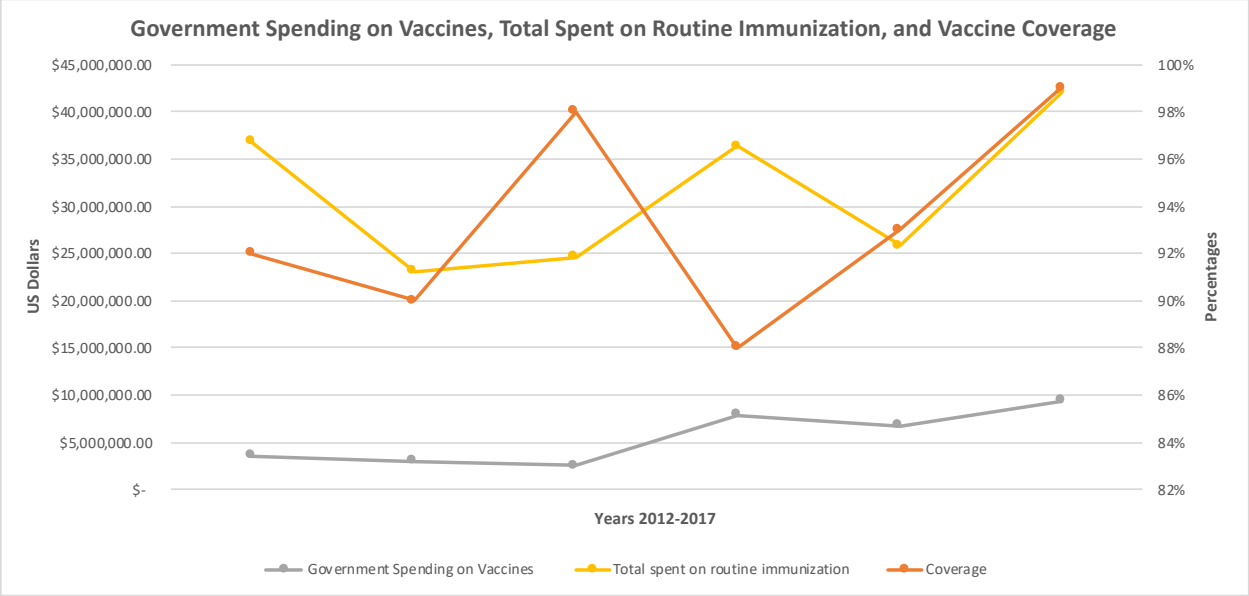
### C2: Increasing Domestic Political Will

Political commitment for immunization is strong in Ghana per the cMYP, JAR, and the 2007 National Health Policy. Ghana has met its co-financing obligation to Gavi every year except for two (2014 and 2015), but has since paid those arrears. There is an emphasis in the 2007 National Health Policy, which is the most current, on primary care that includes immunizations. There was also an emphasis within this same National Health Policy on MDG 4, reducing by two-thirds the under-five mortality rate. That same year, Ghana implemented a Child Health Policy (2007-2015) in response to MDG 4 addressing the continuum of care for children including vaccines which are free of charge. Ghana failed to meet the MDG goal by 2015 but reduced under 5 mortality by 58% over the period. These actions indicate a strong commitment to the immunization program through legislative action.

### C3: Increasing Resources to Vaccination and Finance all Vaccine Needs

Lastly, overall there is an increasing trend in both financial and programmatic areas of immunization. In figure 9, we see government spending on vaccines increases as does overall spending on immunization which theoretically is what is driving the coverage increase. Since vaccines constitute only one portion of immunization and overall spending on routine immunization is increasing. The decrease in spending might correspond to the years where the MoH budget was smaller (see Table 3) resulting in less allocation to the immunization program.

Figure 9: Trends in Government Spending on Vaccines, Total Spending on Routine Immunization and Vaccine Coverage




The MoH and its affiliated agencies find managing donor driven programs to be a challenge, especially financially. Although, allocations to the health sector have gone up (see Table 3), those increases have gone towards personnel emoluments across the sector (Saleh, 2013; Schieber et al., 2012). In a study on 2011 costs of routine immunization and the introduction of new vaccines in Ghana, salaried labor accounted for 61% of total cost and vaccines 17% (Le Gargasson, Nyonator, Adibo, Gessner, & Colombini, 2015).

Table 3: Health Sector Expenditure Trends by Source Between 2013 and 2018

| Expenditure Trends Between 2013 and 2018 in GHS Million | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2013* | | 2014** | | 2015 | | 2016 | | 2017 | | 2018 (Half Year) | |
| Source of Funds | Approved Budget | Actual Receipt | Approved Budget | Actual Receipt | Approved Budget | Actual Receipt | Approved Budget | Actual Receipt | Approved Budget | Actual Receipt | Approved Budget | Actual Receipt |
| Government of Ghana | 509.8 | 1,520 | 1,613 | 1,159.90 | 1308.13 | 2043.1 | 1613.37 | 2098.48 | 2480.02 | 3425.28 | 2613.43 | 1397.84 |
| Internally Generated Funds | 1,830 | 922 | 1,294 | 537.42 | 1003.78 | 907.43 | 1293.58 | 727.27 | 977.25 | 1029.04 | 1345.41 | 618.29 |
| Donors | 194.46 | 223.61 | 447 | 782.69 | 712.78 | 153.29 | 446.82 | 963.56 | 718.87 | 1039.51 | 413.51 | 59.57 |
| Annual Budget Funding Amount | 0 | 12.14 | 33 | 0 | 43.55 | 15.55 | 33 | 2.39 | 50 | 7.09 | 50 | 3.92 |
| **Total** | 2534.26 | 2,677 | 3,387 | 2480.01 | 3068.24 | 3,119 | 3,387 | 3791.7 | 4226.14 | 5,501 | 4,422 | 2079.62 |

Salaries account for more than half of recurrent spending in the MoH at the national level and even higher at the district level(Saleh, 2013). In all the budgets analyzed, changes in the approved budget were often the result of having to adjust the budget to account for an increase in expenditure on compensation. In the 2014 budget, the allocated budget for goods and services and assets decreased by 30 and 40 percent respectively to cover compensation.

## Partnership

### P1: Align Immunization Financing to Health Financing

In terms of aligning the immunization financing to health financing, Ghana does have as reported to the WHO-JRF a line in the national budget for vaccines. This was the only information that was specific to the immunization program.

### P2: Coordination between MoH, MoF, and Parliament

None of the reviewed documents provide information on the coordination between the MoH, MoFEP and Parliament. This might explain the delays in disbursements mentioned in all three cMYPs and the MoH budget which lead to delays in program implementation. There have been requests from the MoH to Gavi for technical help on how to engage these groups to more effectively manage disbursement and advocate for more domestic funding. Furthermore, co-

financing is dependent on the disbursement timeline of the MoFEP and when funds aren't disbursed in a timely manner, they hinder Ghana's ability to meet its obligations to Gavi.

### P3: All Relevant Stakeholders Involved

The coordinating committee has stakeholders from a wide array of sectors including development partners, civil society, and the private sector. However, the role of these stakeholders isn't clear from annual reports and cMYPs, other than a comment that they are "involved in the planning and implementation of the EPI." There is a national guideline on how DPs engage with the health sector laid out in the Common Management Agreements; specifically, for Gavi this partnership is through the Partner Engagement Framework. Currently, the Minister of Health sits on the Board of Gavi and will do so until December 2020. This provides a platform for him to make decisions and have an input into Gavi policies with Ghana's best interests at heart.

## Capacity

### C1: Presence of Decision-Making Body (ICC/NITAG/HSCC)

There is a functional ICC in Ghana that meets quarterly as reported in the cMYPs. The presence of the ICC aligns with the Common Management Arrangements (CMA) set forth by the Ministry of Health to guide dialogue and decision making in collaboration with Development Partners (DP). The ICC is also a condition of Gavi support and is responsible for applying for Gavi funds. In the Joint Appraisal Reports (JAR), the role of the ICC is "ensuring that the plan is on track". cMYP 2015-2019 discussed the role of the ICC in the decision to introduce two new vaccines, pentavalent and pneumococcal, to the vaccine schedule. Additionally, several of the Gavi submitted documents mention the ICC's role in fostering partnerships in and out of the country, communicating information between the country and partners, reviewing how funds are used regularly to enhance transparency and accountability, and providing political support to the EPI

program manager to effectively advocate. The Global Vaccine Action Plan (GVAP) and GAVI recommend the presence of a NITAG to promote evidence-based decision making on vaccines, Ghana does not have a NITAG but is in the process of establishing one. In the 2017 JAR, it states "the MoH is currently undertaking stakeholder consultations towards setting up NITAG by end of year 2017 to provide technical guidance and direction to support the advocacy for sustained, adequate, and increased funding for immunization services during the transition and beyond." As of June 2018, Ghana inaugurated a NITAG. In addition to the ICC, there exists a health sector working group/coordinating committee chaired by the Minister of Health which oversees the implementation of Gavi support; this group is also the highest decision-making body in the government health sector for the entire health sector. Various stakeholders sit in this working group and include partners such as Gavi. Unfortunately, none of the reviewed documents from the MoH described how these various groups were connected or if they were. The one common thread amongst the groups is that the Minister of Health chairs all of them.

### C2: Platform for Vaccine Procurement

Ghana has an existing procurement process for medicines and supplies through the national logistics system. Ghana does not use its national logistics system to procure vaccines. Vaccines are procured from UNICEF SD through Gavi (Appendix B). While Ghana has its own procurement system for medicines and supplies, it is inefficient and highly fragmented. The current procurement system through Gavi and UNICEF SD is functional. Procurement for vaccines fails if Ghana does not meet its co-financing obligations. In 2014 and 2015 Ghana did not meet its co-financing obligations although the country did subsequently meet financing arrears. This lack of payment is related to delayed disbursements from the Ministry of Finance and Economic Planning (MoFEP) and as noted in the cMYP is not unique to Gavi funds.

### C3: Operational Annual Plan or Budget Execution

There is an operational annual plan and budget execution for the health system. In none of the documents was there a mention of a specific annual plan or budget for immunizations or vaccines specifically. This does not appear to be unusual as the immunization program falls under the EPI under the Ghana Health System and it is possible those plans, and budgets exist within that branch of the MoH.

## Summary of Findings

Vaccines, specifically the immunization program are increasingly integrated into national guidelines and strategic plans in the country and indicated as national priorities. As the country works to achieve UHC through the National Health Insurance Scheme, immunization programs are likely to be incorporated and financed through primary health care.

The Ghanaian government continues to show a strong political commitment to immunizations, demonstrated through increased domestic funding for vaccine programming, meeting Gavi co-financing obligations, and emphasizing immunizations and under-five mortality reduction in the National Health Policy, subsequent annual Plans of Work resulting in high coverage rates. Although there are a number of stakeholders involved in the immunization program and overall health sector, their roles are not adequately defined. This may contribute to delays in disbursements of funds, a lack of knowledge on stakeholders capacities and other factors which affects program implementation timelines, Ghana's co-financing obligations to Gavi and an ability to plan appropriately.

There are two main coordinating bodies involved in immunization programming in Ghana – the ICC and a health sector working group/coordinating committee. The ICC generally fosters partnerships, coordinates communication between different stakeholders and provides support to

the EPI. While the health sector working group is the highest decision-making body, the roles of the members of this working group are unclear. And if any coordination occurs between the two committees exist, it is unclear. As per the recommendations of Gavi, Ghana is in the early process of setting up a NITAG.

Vaccine procurement occurs through Gavi and UNICEF SD and not through the Ghanaian procurement system for medicine and supplies. While Ghana could have opted to purchase through its own suppliers

# Chapter 5: Discussion

This study assesses how Gavi operationalizes country ownership and the challenges for Ghana in achieving country ownership. The study explored the general development and global health arena defines country ownership. Rather than any one single definition of country ownership, the concept of country ownership has evolved, and multiple drivers determine country ownership. Of those drivers, this study focused on accountability, commitment, partnership, and capacity. An analysis of Gavi's policies and documents gave no explicit definition of country ownership but stated that the co-financing policy enables country ownership by requiring countries to pay a portion of vaccine costs which increase as the country's GDP grows until the country is fully self-financing. The conceptual framework depicts this relationship (see Figure 4). Findings of this study suggest that for Ghana operationalizing country ownership specifically for Gavi is evident in some but not all ways but there are operational and measurable aspects of country ownership within the co-financing policy.

What I am trying to say here is that while Gavi states that the co-financing policy increases country ownership, it's not really the fact that a country is able to pay their vaccine bill that defines ownership, yes that's the outcome; rather, it's the processes that the co-financing policy from Gavi drives countries to undertake. This is consistent with the literature on country ownership not as a policy but a process. The co-financing policy's more direct output of ownership is being able to finance vaccines. Indirectly, it's the systems and processes that the policy enables, the indicators that we assessed. The drivers exist independently of the co-financing policy, but their existence makes Ghana more capable of meeting its financing obligations because of the specific and measurable indicators aligned to each driver.

The existence of the cMYP is important to note because it shows that there is a national plan for immunization, but it's also important to highlight that the cMYP is a requirement of Gavi financing. This is not to say the cMYP would not exist without Gavi since it came out of the GVAP jointly created by WHO-UNICEF. As stated in the literature review, country ownership isn't independent of external influences and if it were not for Gavi, it's possible the cMYP would have been a requirement of another donor with a focus on immunization. The cMYP aligns with the 2007 National Health Policy in a cursory mention of immunization of mothers and children as indicative of a healthy population. Since the 2007 National Health Policy, there have been three cMYPs covering the years 2007-2019, during that time immunization, vaccines, health priorities have shifted. This alignment is a superficial one at best. It brings up a question of what an organic plan independent of Gavi would be for Ghana one that truly aligned and informed from the national health policy.

Overall, there is more emphasis in all the documents reviewed on the programmatic components of the national immunization program, such expanding services to under reached areas through the Community-based Health Planning Services, than a financial one. This is evident in the programmatic success of the EPI since the introduction of Gavi funding, having expanded coverage from the low forties to over ninety percent. While domestic financial commitment to vaccines has not increased at quiet the same pace as programmatic reach (see Figure 9), there is growth. There is an emphasis in the MoH documents to expand coverage through service delivery and while that is essential, the MoH documents from the financial to the annual plans of work do not detail or expound on the financial aspects.

The same can be said of the ICC which is a condition of continued Gavi funding. While Ghana does not have a functional NITAG, which is the ideal for vaccine evidence-based decision making, ICC's can function in the absence of a NITAG to provide evidence-based decision making, not only programmatically, but also financially. Early planning for financial independence can inform Ghana on vaccine costs once Gavi financing ends. Gavi requests countries conduct costing of vaccines but one of the issues Ghana faces is underestimation of the budgetary needs of the health sector (see Table 3). This underestimation also occurs in routine immunization budgets. There are other costing and financing studies, specifically the EPIC studies funded by the Bill and Melinda Gates Foundation, to provide accurate information on the cost and financing of national immunization programs (Brenzel et al., 2016). Ghana is one of six countries in the EPIC study countries. The most recent cMYP submitted after the EPIC study showed no changes in budgeting processes but those studies offer a way for countries to build capacity around financing which Gavi can support thereby promoting both partnership and capacity.

ICCs can be a strong component in increasing if they conform to their original intent. This means ICCs are wholly involved in the process of which vaccines to introduce with Gavi support, understand the full costs of the vaccines, and how the government can prepare to finance these costs independent of Gavi. Unfortunately, neither the cMYP, JAR, or CMA provide much context as to what the ICC does or the specific activities it has undertaken to further domestic mobilization of resources. The creation of a NITAG might offer more around immunization and vaccine evidence-based decision making as well as more forethought to the financing of vaccines post Gavi. The risk with the creation of a NITAG is an overlap with the functions of the ICC.

Next, the use of UNICEF to procure vaccines through Gavi while probably easier and more assured creates a secondary procurement system in Ghana. The current national logistics system is used for all other health related purchases and while fragmented and inefficient will be the system used once Gavi leaves. Identifying and working with partners to build up this system to use would increase Ghana's ownership.

The shift to universal health coverage and a focus away from vertical programming is evident in government documents. UHC is extensively discussed in the 2015 Health Sector Financing Strategy document (Ministry of Health Ghana, n.d.) and appears to be the paramount objective of the Ghana health sector which is advocating the use of the NHIS by its citizens with the ultimate hope of it becoming a big financer of the health system (Schieber et al., 2012). It is important to know most of the health sector funding goes towards personnel with a little over 30% going towards goods and services which include vaccine costs. While this isn't unusual for a LMIC, it means that goods and services are underfunded. Coupled with decreasing donor funds, an adjustment will have to be made to be able to fund not only salaries but services and goods. For a country preparing to transition away from donor funding and currently financing less than 30% of the total vaccine cost this isn't feasible with the current budgetary allocation. However, Ghana does well in that the country's allocation to vaccines has been increasing along with total spending on immunization. Where the challenges lie is in the somewhat outdated national policies.

## Strengths and Limitations of Analysis

A strength of this analysis is the quality of the documents used in the analysis. All documents are products of the GoG and even though there were no interviews to support analysis, the

documents still gave a voice to the Ghanaian government. A limitation of the analysis, due to time constraints, is the limitation to documents only available online. We could not review EPI policies, minutes from ICC meetings and other relevant because of this limited access. As a relevant stakeholder, the EPI, this information could have provided missing information on some of those indicators measured.

## Implications for Ghana

Ghana's success in expanding coverage is commendable and there is clearly a commitment to maintaining high coverage rates. Being able to finance vaccine costs is a big part of maintaining those coverage rates. Gavi's co-financing policy wants to enable countries to own a portion of the total cost of vaccines placing a sense of ownership and responsibility on the recipient country. From the results of the case study, Ghana has several processes and systems in place to enable the country to meet its co-financing obligations. Strengthening those processes, building up weaker process will be necessary to own the financing of vaccines. Like other countries with growing economies, Ghana will have to prioritize immunization on the same level as infrastructure and economic investment with long term returns in the form of a healthier and more productive population (Angela K. Shen et al., 2016).

# Chapter 6: Conclusion and Recommendations

A set of specific actionable recommendations arise from the findings presented in this case study. These are the Ghana national government can undertake to truly enable country ownership of vaccine financing via the co-financing policy.

- The first recommendation is an update to the 2007 national policy so that subsequent cMYPs align to current national priorities. This will allow Ghana
- The financial commitment must match the programmatic. Vaccine budget allocation dialogue and action must exist beyond the MoH and must involve at the minimum the MoFEP. Vaccine procurement dialogue must exist at the highest-level involving parliament, MoF, MoH and stakeholders to effectively advocate for more funding.
- While the cMYPs exist, there is need for policies and laws that effectively outline the country's vision for immunizations and the actors involved in achieving this goal. Codifying the commitment to immunizations will create an effective tool for advocating for increased financing. Nepal's Ministry of Health has effectively lobbied in coordination with their Ministry of Finance to pass a bill that makes funding immunization programs a law (McQuestion et al., 2016).
- Procurement and supply chains must be strengthened to effectively procure vaccines. Currently, this is done through Gavi's systems with UNICEF SD but this will become the sole responsibility of the country once fully self-financing. Gavi can provide technical support in strengthening the procurement capacity of the country to address some of the issues presented earlier.

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# Appendices

## Appendix A: List of Documents Included in Data Analysis

| Document | Source |
|---|---|
| cMYP 2007-2011 | Gavi |
| cMYP 2010-2014 | Gavi |
| cMYP 2015-2019 | Gavi |
| Joint Appraisal 2014 | Gavi |
| Joint Appraisal 2015 | Gavi |
| Joint Appraisal 2016 | Gavi |
| Joint Appraisal 2017 | Gavi |
| Annual Progress Reports (2002-2014) | Gavi |
| | |
| Annual Program of Work (2002-2015) | Ministry of Health |
| 5Yr Program of Work 2002-2006 | Ministry of Health |
| 5Yr Program of Work 2007-2011 | Ministry of Health |
| Holistic Assessment of 2017 Health Sector Program of Work | Ministry of Health |
| Ministry of Health- Health Sector Medium Term Development Plan 2014-2017 | Ministry of Health |
| Ghana Health Sector Common Management Arrangements for Implementation of the Health Sector Medium Term Development Plan 2014-2017 | Ministry of Health |

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| Ghana National Health Policy (Wealth through Health) 2007 | Ministry of Health |
| Ministry of Health Program Based Budgets- Ministry of Finance and Economic Planning | Ministry of Finance |
| National Budgets | Ministry of Finance |

## Appendix B: Document Analysis Notes and Ratings

| Driver | Indicator | Analysis of the document | Rating |
|---|---|---|---|
| Accountability | cMYP aligned to national health plan and strategy | 3 cMYPs exist covering 2007-2011, 2010-2014 and 2015-2019; cMYP is strategic plan for Ghana's National Immunization Program (NIP); all three mention alignment to Child Health Policy; only one National Health Policy available from 2007; Health Policy focus on programmatic and mention child health which presuming to include vaccines because of mention of MDGs 4 and 5 as national priority; HSMDTP 2014 mention " priority activities include the scale of EPI services, including the introduction of new childhood vaccines" This Policy provides broad guidelines for the development of programmes by key stakeholders, namely Government, other Ministries Department and Agencies (MDAs), local authorities, such as district assemblies, the private sector, civil society organizations as well as communities and traditional leaders (2007 Health Policy) | Good |
| | Inclusion of vaccine and immunization delivery | 2015 Health Financing Strategy does not mention vaccines and immunization financing specifically; 2015 HFS focus on Universal Health Coverage "shift from narrow program or scheme financing to broad system financing"; annual | Limited |

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| | requirements in the development of health financing strategies | budget from 2017 and 2018 speak specifically to Gavi and paying off missed copayments; some of the budgets mention the exact allocation to vaccine purchase but not all; JRF and cMYP give exact numbers but in cMYP the authors state " there is a line in the national budget for vaccines" which isn't always reflected in the overall national budget but it in the MoH budget | |
| | Resource tracking by improved reporting on immunization expenditure | JRF reports immunization expenditure available from 2003 to 2016 but missing data from 2003-2005 and 2008-2010; Joint Appraisal Report(2015) discloses expenditure and source of funding for 2010-2014;<br>Total expenditure on immunization over the year has been increasing.<br>Greater awareness was raised when Ghana opted to introduce two more vaccine (Heb B and HIB) into routine immunization in 2002. | Limited |
| Commitment | Prioritization of domestic funding (increasing allocation in national health budget) | "To increase domestic resource mobilization in the health sector, the Ministry of Health has established a Resource Mobilisation Unit to start the process of exploring innovative strategies to increase domestic resources" from 2017 budget; health sector budgets have been increasing but multiple budgets state this has been due to increasing expenditure on salaries (doesn't specify if health | Good |

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| | | workers or overall); in cMYPs 2010-2014 and 2015-2019 mention exploring how to mobilize domestic resources from NHIS, sin taxes and import taxes; this is a shift in the overall sector and is not specific to vaccines ; push to register more ppl for the NHIS in aims of "primary sector financing"<br>Review of health budgets and JRF reports confirm increasing allocation to health sector. JRF more detailed and specific to vaccines. | |
| | Increased domestic political will | Comments on political will is not related to financing but commitment to overall EPI program evident in Health Policy, cMYPs, annual Programs of Work<br>Improving stewardship and core public health function such as policy making, monitoring and evaluation, disease surveillance, provider and insurance regulation, social mobilization, cross-sectoral action and overall management- Health Policy<br>Multiple policies for health→ possibly indicative of domestic will | Unclear |

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| | Increasing resources to vaccination and financing all vaccine needs | JRF reported numbers on vaccine expenditure shows upward trend, but Ghana has also introduced more vaccines which increases their overall cost; vaccines are free in Ghana<br>MoH budget numbers show increase trend to sector as a whole. Figures were graphed to confirm this.<br>As of now, the Government of Ghana (GOG) increases its contribution by 15% annually until 2011 when it is expected that GOG will be entirely independent in the area of vaccine procurement.<br>Advocacy will definitely be continued for effective resource mobilization to ensure the sustainability of this initiative | Good |
| Partnership | Coordination between MoH, MOF, and parliament | JAR requests support on advocacy between various agencies; delayed disbursement highlighted in all cMYPs as issue; there does not appear to be much coordination between the agencies; current coordination isn't detailed enough to get an accurate picture of the extent of coordination even at its lowest level | Limited |

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|---|---|---|---|
| | All relevant stakeholders involved | "The CMA describes interrelationships within the health sector and is aimed at ensuring effective harmonization of management systems in the implementation of the Health Sector Medium Term Development Plan. Under the guidance of the CMA, key sector partners supporting the sector are responsible for ensuring harmonization and alignment of all their activities toward government led policy and strategic recommendations." | Limited |
| Capacity | Presence of decision-making body (ICC/NITAG/HSCC) | "The Ministry of Health acknowledges its key role of coordination and strengthening evidence-based policymaking" - HSMTDP 2014; all cMYPs mention the presence of an ICC that meets about 3-4 times a year; Ghana has multiple health sector working groups that guide policy- members of this group includes development partners; | Good |
| | Platform for vaccine procurement | cMYPs mention all vaccines procured through UNICEF and not national procurement system; this is supported in joint appraisal reports and annual Programs of work; mention fragmentation in Ghana national procurement | Good |

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|---|---|---|---|
| | | system; not much detail included but Gavi document explain the procurement process in detail; Ghana has little operational involvement | |
| | Operational annual plan or budget execution | "Development Partners support (DPs) that comes in the form Sector Budget Support (SBS), which is grant funding channeled through the Ministry of Finance and Economic Planning (MOFEP) and programmed as part of the annual budget process. DPs support also come in the form of Earmarked funds, for specific projects or programs, from a variety of bilateral and multilateral partners, including global health initiatives such as the Global Fund for AIDS, TBand Malaria (GFATM), Global Alliance for Vaccines Initiative (GAVI) and concessionary private financing arrangements."<br>The Ghana Health Service has a robust financial management system with excellent control systems for managing public funds. The Service will continue to work on the occasional delays which directly or indirectly affect programme implementation- cMYP ; delays in disbursement often happens due to MoFEP timeline not aligning | Good |

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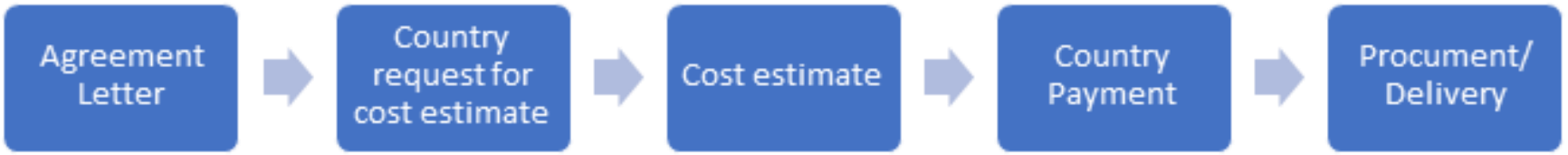
|---|---|---|---|
| | | Annual plan is for entire health sector, executed yearly; underestimation is commonplace and adjustments happen midyear some times | |

## Appendix C: Procurement Method

*Figure 10: Co-Procurement Model*




Method: Gavi funds are deposited to countries or vaccine purchase (UNICEF). Since this isn't the full cost of the vaccines and countries must pay their co-finance portion, the recipient country is responsible for initiating the procurement process as detailed next and in figure 10. This is accomplished through meeting co-financing obligations and procuring vaccines through UNICEF, PAHO, or other suppliers. Most countries purchase their vaccines through UNICEF Supply Division in a process that is led and driven by recipient countries. Through this mechanism countries direct when vaccines and supplies are ordered, their delivery and payment instead of Gavi coordinating those actions.