

MEMORANDUM
June 22, 2012

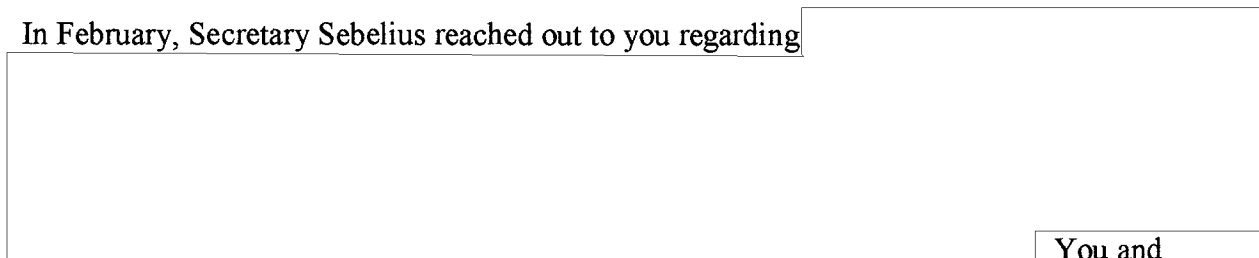
RELEASE IN PART
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TO: THE SECRETARY

FROM: Cheryl Mills
Jeanne Smith

SUBJECT: Government to Government Funding: Policy Guidance

In February, Secretary Sebelius reached out to you regarding



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You and

Secretary Sebelius delegated to Bill Corr, Deputy Secretary for Health and Human Services (HHS) and me the responsibility to return with a recommendation for the most efficient process for USAID as it went forward with G2G activity.

This memorandum outlines our conclusions and recommendations for next steps based upon extensive engagement over the past several months with officials from HHS, USAID, CDC and PEPFAR. I have also spent significant time discussing the key issues with Bill Corr, Eric Goosby and Raj Shah. Should you agree with this memorandum, we need to take steps to follow-up individually and institutionally with all affected parties.

PEPFAR G2G activity: The Current State of Affairs

The PEPFAR program operates as a funding agent, if you will, with two USG implementing partners – USAID and CDC. Both agencies share the value of and seek to implement best practices in growing the capacity of host government agencies to receive, monitor and manage USG funds in implementing programs funded by PEPFAR. Yet, while both entities share the long-term goal of G2G programming as the best practice objective, they have fundamentally different perspectives as to how best to achieve this outcome and navigate the road in the interim.

CDC has established G2G mechanisms in 62 countries that provide implementation capacity to MOHs for PEPFAR funded programming, and in some cases non-PEPFAR funded health programming. Due in large part to the absence of existing internal capacity in MOHs when CDC mechanisms were established, CDC's mechanisms operate as direct-funded planning and implementation units, and are intended over time to develop the technical and absorptive capacity of respective MOHs. These units are technically, financially and operationally supported by CDC, typically with a mix of USG direct hires and Foreign Service National (FSN) employees working in collaboration with MOH personnel. In many instances, these mechanisms have been in place for more than a decade; in no instance has CDC transitioned any of these mechanisms from being CDC-supported units to units that are part of the regular and internal operations of MOHs – despite the fact that in all cases that is CDC's long term objective.

Over the past two years, USAID has embraced a much more aggressive G2G strategy as part of its procurement reform practices. This strategy calls on Missions to shift a percentage of their existing resource portfolio from large-scale international contractors to local entities and contractors – including building up host country MOHs and other Ministry capacities using G2G mechanisms and practices. Unlike the existing CDC model, USAID is seeking to have host countries establish, supervise and operate their own regular internal planning, programming, and procurement implementation offices from the first instance. While USAID's execution of their G2G policy in health programs is nascent – having started with risk assessments of a first set of countries that take 18 months – they soon will begin to identify the building steps necessary to assist a host country achieve a sufficiently stable, transparent and corruption-free set of government structures through which USG funds can be provided directly to appropriate Ministries, including MOHs.

There is a considerable gap between the 'aspirational' goal that USAID has set for itself and the actual pace of groundwork to get ready to execute an action plan to build host country capacities in-country. Now that we appreciate the reality of this gap, there is no urgent operational imperative to define the broad policy on how/who can execute G2G mechanisms in-country for PEPFAR programs as this issue was first presented. However, there is considerable political and emotional pressure and tension around this issue, which is creating ill-will and absorbing considerable CDC, USAID and PEPFAR staff resources – making it urgent and prudent to resolve policy and operational conflicts in this area now for long-term efficiency and effectiveness.

Proposed G2G Policy Guidance

Consistent with the President's Policy Directive on Development (PPD) and best practices, PEPFAR, CDC, USAID share the end goal of host governments growing and gaining their own capacity to plan, program and manage USG funds as well as plan and execute their own country

health programs. To achieve this goal, all USG actors in the global health space will need to be directed, with explicit guidance, to embrace the importance of the dual mandate of: 1) saving more lives, 2) while building sustainable capacity and host country ownership/responsibility. Otherwise, there is a risk that we will not make progress on the long-term path to success.

Explicit policy and technical guidance is needed to adapt the processes and procedures to accommodate both CDC and USAID, each of whom seek either to expand or shift G2G funding capacity. This guidance, in more lay language, can be summed up as follows:

- CDC will present a multi-year plan that identifies the specific steps and timeline for transitioning each of its 62 direct funding mechanisms to regular internal MOH program, planning and implementation operations, while ensuring no diminution in PEPFAR services or impact while host country government capacity building and transition is underway.
- USAID will likewise present a multi-year plan that identifies the specific steps and timeline for how USAID will reach its overarching G2G procurement reform goal within the 30% target for Missions to move assistance to local mechanisms and contractors, and that includes the evidence base for how USAID will build host government capacity and how it will determine when that capacity is ready for increased G2G activities, while ensuring no diminution in PEPFAR services or impact while host country government capacity building is underway;
- Moving forward, PEPFAR will require a common set of protocols and processes that abides by all audit, compliance and IG standards and requirements for the central elements in any G2G mechanisms implemented by CDC and USAID. This common approach requirement will ensure host country governments are not burdened by multiple and differing requirements for PEPFAR funding and programming.
- Should USAID seek to execute PEPFAR programming activities using direct-funding planning and implementation units, USAID will be directed to use available existing CDC direct-funding mechanisms; if CDC has no such mechanism in place in the relevant country, USAID may establish a PEPFAR-approved alternative process or mechanism.
 - Where USAID uses an existing CDC mechanism, the existing CDC-MOH agreement will be refashioned to provide for USAID's lead role in all aspects of oversight, technical assistance for the funded activity and, if necessary, growth of the capacity of the CDC in-country mechanism to accommodate the incremental flow of funds and programming activity.

- Where USAID uses an existing CDC mechanism, CDC is a collaborator with, but not interlocutor on behalf of, USAID; this means that USAID will engage directly on its own behalf with MOHs, with CDC and USAID accountable to each other for transparency regarding their respective programming and activities to leverage the greatest USG results.
- And, in countries where USAID seeks to engage for the first time in G2G funding with non-PEPFAR health funds, USAID may use an existing, PEPFAR-approved regular internal host country governmental structure, or employ CDC's or its own PEPFAR-approved direct-funding mechanism.

To be very transparent, the guidance above will make each entity – PEPFAR, CDC and USAID – unhappy for differing reasons. PEPFAR because it properly is worried about maintaining its obligation to save more lives while these best practices are being implemented by USAID for the first time; USAID obviously does not yet have a track record of deploying PEPFAR funds in this fashion. USAID because it has deep-seeded distrust that CDC will act as an ecumenical partner should it use CDC mechanisms and therefore USAID will likely seek to implement their first programs in non-CDC countries or using non-PEPFAR funds. And CDC, because the root of their concern (and HHS' concern) is becoming less relevant in-country once USAID begins engaging in direct funding with MOHs because the volume of USAID resources will dwarf theirs and therefore potentially signal to MOHs that USAID is the only relevant USG partner in health.

To be honest, I have considerable skepticism as to how and if we can overturn a pervasive lack of trust borne from the history of competition between the two PEPFAR implementing agencies, to achieve a future that depends upon the collaborative approach called for in this policy guidance. The most substantive measure we have taken in this regard, which is more transparent in the technical guidance, is to position PEPFAR in a stronger leadership role for examining, evaluating, deciding how fast or slow the evolution of current or new G2G funding practices are paced with the preparedness of host government systems. And, placing them in this role may trigger the need for PEPFAR to build up or rely on other internal State Department technical expertise to feel they can adequately perform these new tasks.

We look forward to discussing these recommendations and next steps with you.

APPENDIX**Government to Government Funding: Policy Guidance
22 June 2012 Memorandum to Secretary Clinton**Proposed Technical G2G Policy Guidance

Explicit policy and technical guidance is needed to adapt the processes/procedures to accommodate both of PEPFAR's agency implementers (CDC and USAID) who seek to either expand or shift G2G funding capacity. This guidance requires:

1. PEPFAR to establish an annual process (ideally as a discrete part of an existing planning process such as Country Operating Plan (COP) planning, GHI planning, annual budget planning/execution) whereby PEPFAR solicits information and grants approval of shifts of PEPFAR funding for program activities to and from G2G mechanisms. The process requires:
 - CDC/HHS undertakes and presents a multi-year plan that assesses in each of the countries that CDC has PEPFAR direct-funding mechanisms the level of resources flowing in-country, current country capacity, mix of interventions necessary to increase country capacity without risk of diminution in PEPFAR services, and timeline for seeking/achieving measurable shifts from current direct funding mechanisms to regular internal program, planning and implementation units in each respective MOH.
 - USAID undertakes and presents a similar multi-year plan that provides the steps for how USAID will reach its overarching G2G procurement reform goal within the five-year 30% assistance target for Missions, providing specific documentation and data of host country government capacity for countries where risk assessments indicate the possibility of increased G2G activities, USAID actions planned or underway to build host country governmental capacity, timelines, and risk mitigation interventions or requirements to ensure no diminution of PEPFAR services.
2. PEPFAR to require a common, standardized approach that abide by all audit and compliance standards and IG requirements for certain key elements in all G2G mechanisms implementing PEPFAR programs. This is meant as an internal USG discipline-forcing measure that serves to reduce the complexity of USG G2G mechanisms so that host country governments are not burdened by multiple and differing requirements for PEPFAR funding and programming procedures. This approach is

intended to apply to all new mechanisms as well as the periodic renewal or amendment of existing CDC mechanisms (e.g., cooperative agreements, grant awards, direct cost agreements, fixed reimbursable agreements, etc). At least the following elements will have a common standard in all PEPFAR G2G mechanism agreements:

- Bank account/banking mechanism;
 - Single standard for USG required banking/accounting procedures;
 - Single standard for U.S. legislated audit and compliance procedures; and,
 - Single standard for impact, metrics & financial reporting.
3. As USAID works to assess and build regular internal Ministry capacity to enable a larger share of USG programs to use regular, internal host government structures, should USAID determine their capacity building interventions for PEPFAR-approved funding require the use of direct-funding planning and implementation units, USAID will be directed to use available existing CDC direct-funding mechanisms; if CDC has no such mechanism in place in the relevant country, USAID may establish a PEPFAR-approved alternative process or mechanism.
- Where USAID uses an existing CDC mechanism, the existing CDC-MOH agreement will be refashioned to provide for USAID's lead role in all aspects of oversight, technical assistance for the funded activity and, if necessary, growth of the capacity of the CDC in-country mechanism to accommodate the incremental flow of funds and programming activity.
 - Where USAID uses an existing CDC mechanism, CDC is a collaborator with, but not interlocutor on behalf of, USAID; this means that USAID will engage directly on its own behalf with MOHs, with CDC and USAID accountable to each other for transparency regarding their respective programming and activities to leverage the greatest USG results.
4. Finally, in countries where USAID seeks to engage for the first time in G2G funding with non-PEPFAR health funds, USAID may use an existing, PEPFAR-approved regular internal host country governmental structure, or employ CDC's or its own PEPFAR-approved direct-funding mechanism.