International Health Partnership (IHP+) Country Health Sector Teams

Background Literature Review

Final draft

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Date**:** 18th November 2008

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ACRONYMS AND ABBREVIATIONS

ACU	AIDS Coordinating Unit
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community Based Organisations
CCC	Country Coordinating Committee
CCM	Country Coordinating Mechanism
CDC	Council for the Development of Cambodia
CERF	Central Emergency Response Funds
CGD	Centre for Global Development
CHAP	Common Humanitarian Action Plan
CHST	Country Health Sector Team
CIDA	Canadian International Development Agency
CJSC	Central Joint Steering Committee
CNCA	Comité National de Coordination des Aides
CNCS	Nacional de Combate ao HIV/SIDA
CNLS	Conseil National de Lutte contre le Sida/ National Committee to Fight AIDS
CPSD	Concertation des Partenaires pour la Santé et le Développement
CS	Civil Society
CSO	Civil Society Organisation
DaO	Delivering as One
DoHS	Department of Health Services
DP	Development Partner
EA	Education Authority
ECHA	Executive Committee on Humanitarian Affairs
EDCC	Education Donor Coordination Committee
EDP	External Development Partners
EDPG	Education Development Partners Group
FBO	Faith Based Organisation
GTT	Global Task Team
GCP	Groupe de Coordination des Partenaires
GDCC	Government-Donor Coordination Committee
GFATM (GF)	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Burundi
GOC	Government of Cambodia
GOE	Government of Ethiopia
GOM	Government of Mozambique
GOT	Government of Tanzania
H&A	Harmonisation and Alignment
HACT	Harmonized Approach to Cash Transfers
HAPCO	HIV/AIDS Prevention and Control Office
HCNLS	The Supreme Council for AIDS Control
HMIS	Health Management Information System
HPG	Health Partners Group
HPN	Health Population and Nutrition
HR	Human Resource
HSCC	Health Sector Coordinating Committee
HSDPF	Health Sector Development Partners Forum
HSSP	Health Sector Support Project Partners
HZC	Health Zone Coordinators
IASC	Inter Agency Standing Committee
IATT	Inter-Agency Task Team
ICC	Interagency Coordinating Committee

ICRC	International Committee of the Red Cross
INEE	Inter-Agency Network for Education in Emergencies
INGO	Non-Governmental Organisation
IO	International Organisation
JAR	Joint Annual Review
JCCC	Joint Core Coordinating Committee
JICC	Joint Interagency Coordinating Committee
JP	Joint Programme
IHP	International Health Partnership
LCM	Light Coordination Mechanism
LGA	Local Government Authorities
LIC	low income countries
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MGFCC	Malawi Global Fund Coordinating Committee
MOE	Ministry of Education
MOH	Ministry of Health
MOHP	Minister for Health and Population
MOU	Memorandum of Understanding
MPF	Malawi Partnership Forum
MSPLS	Minister of Public Health and AIDS Control
NPF	National Partnership Forum
NAA	National AIDS Authority
NAC	National AIDS Council (or Commission)
NACC	National AIDS Coordination Committee
NASF	National HIV and AIDS Strategic Framework
NCFA	National Committee for the Fight against HIV/AIDS
NGO	Non-Governmental Organisation
NHDP	National Health Development Plan
NHSCC	National Health Sector Coordination Committee
NHSP-IP	National Health Sector Program Implementation Plan
NIS	Newly Independent States
OCHA	Office for the Coordination of Humanitarian Affairs
OVC	Orphans and Vulnerable Children
PAP	Programme Aid Partners
PDHSSP	Plan for the Development of the Health Sector and Social Protection
PEN II	National Strategic Plan for HIV and AIDS II
PEPFAR	Presidents Emergency Plan for AIDS Relief
PESS	Health Sector Strategic Plan
PLHIV	People living with HIV
PMU	Project Monitoring Unit
PR	Principle Recipient
PRGSP	Poverty Reduction and Growth Strategy Paper
PRODESS	Social and Health Development Plan
PS	Permanent Secretary
RC	Resident Coordinator
SAG	Sector Advisory Group
SEWF	System-wide effects of the Global Fund
SOP	Standard Operating Procedure
STARZ	Strengthening the AIDS Response Zambia
SWAp	Sector-wide Approach
SWiM	Sector-wide Management
TERG	Technical Evaluation Reference Group
TFA	Technical Facilitating Agencies

TNCM	Tanzania National Coordination Mechanism
TWGH	Technical Working Group for Health
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization

1   INTRODUCTION

1.1   What is effective national coordination in health?

Coordination is an activity that seeks to make closely related entities and activities more harmonious, efficient, and effective[1]. National coordination of health means coordinating the provision of health goods and services at the national level by a wide range of government, but also non-government actors, including civil society groups and private-for-profit firms, as well as the international donor community. National coordination of a complete health system would also typically require coordinating financial, information, supply chain, and human resources health sub-systems[2].

Definitions of coordination are not merely an academic exercise. Successful coordination of partnerships is often predicated on a shared understanding of what coordination, representation, and participation means to different partners. And as Mundy et al note, there are different interpretations of coordination: "For some civil society organisations (CSOs), coordination is about regulation and control, whilst for others the emphasis is on facilitation or information exchange. Some are genuinely interested in representing their constituents, whilst others see representation as a means to access resources or information about resource availability"[3].

Coordination is an indicator of how well a health service performs. An effective coordinated national health service will be *comprehensive* (all necessary resources, expertise and ranges of services are present), *accessible* (all resources, expertise and services are available), and *compatible* (all resources, expertise and services are appropriately linked and sequenced)[4].

Coordination will also be required at different levels of service, at the administrative level but also at the front-line. There are various ways that coordination can be achieved – impersonal, personal, and group methods – and they are distinguished by the degree of feedback required (see Table 1). The more complex the health system, the greater the degree of feedback required to achieve effective coordination[5].

Table 1: Achieving coordination[6]

Coordination type	Coordination methods
Impersonal	Utilisation of plans, rules, regulations, agreements and contracts
Personal	Person-to-person contact between workers, or the designation of an individual to act as a coordinator
Group	Face-to-face communication by two or more individuals planning and making decisions by consensus.

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[1] Conway S., Harmer A., and Spicer N (2008) IHP+ Short-term External Review, p5
http://www.internationalhealthpartnership.net/pdf/IHP_External_review_2008_EN.pdf
[2] Oomman N., Bernstein M., and Rosenzweig S (2008) Seizing the opportunity on AIDS and health systems, Centre for Global Development, Washington.
[3] Mundy J., Collins T., Simwanza A., and Mweene C (2007) Strategic partnerships for co-ordinating the AIDS response: lessons emerging in Zambia, Technical Approach Paper, HLSP, p5
[4] Alter C., and Hage J (1993) Organizations working together. Newbury Park: SAGE Publications.
[5] Strandberg-Larsen M., Nielsen M., and Krasnik A (2007) Are joint health plans effective for coordination of health services? An analysis based on theory and Danish pre-reform results, *International Journal of Integrated Care* 7:3 pp1-10.
[6] Adapted from Alter and Hage 1993

The following 'check list' is a useful starting point for thinking about effective CHSTs:

- Do the various partners that constitute the CHST share the same understanding of coordination?
- Does the CHST have the resources and expertise necessary to do its job?
- Are these resources and expertise available at all levels of 'the team'? This is particularly important in the context of decentralisation, which is an important component of most countries' national AIDS response.
- Are the different levels of the national health response compatible? This question speaks clearly to the international dimension of any national response. The challenge is to ensure that External Development Partners (EDPs) align with country health plans and priorities.
- Is there sufficient feedback, and is the method of feedback appropriate? Coordination of the national response is greatly assisted by forums where EDPs and government ministries can communicate, and there are plenty of good examples of this happening in the ten IHP countries covered here. Less satisfactory is communication of national policy down to the sub-national level. Conversely, there is little opportunity for feedback to the national and then on up to the global level with the result that valuable lessons in scaling up are being lost[7]

1.2   What has been the international response to effective coordination in health?

Various international processes have put coordination at the heart of national health reform in low-income countries:

- The Sector-wide Approach (SWAp);
- The United Nations' 'Three Ones' initiative: one action framework, one coordinating authority, one monitoring and evaluation system;
- Action by the Global Task Team (GTT) on improving AIDS coordination among multilateral institutions and international donors;
- The Paris Declaration on Aid Effectiveness, which articulated a commitment by the international donor community to, amongst other things, country-led coordination of health provision;
- The establishment of new, innovative financing mechanisms in health – notably the Global Fund for AIDS TB and Malaria (GFATM) and its Country Coordinating Mechanisms (CCM), and GAVI's Interagency Coordinating Committee (ICC);
- The development of an International Health Partnership (IHP) to coordinate the international response to health systems strengthening with national priorities;
- The High Level Forum and its follow-up – the most recent of which, the Third HLF on Aid Effectiveness was held in Accra 02-04 September, 2008. The *Accra Agenda for Action* commits donors and developing countries to "elaborate plans to ensure the maximum coordination of development cooperation"[8]. Evaluation of progress will begin in 2009.

[7] Kerkhoff L., and Szlezak N (2006) Linking local knowledge with global action: Examining the GFATM through a knowledge systems lens, Bulletin of the World Health Organisation 84(8): 629-33.
[8] Agenda for Action, final draft July 2008 http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAAFinalDraft-25July2008.pdf

1.3   A summary of the literature

Much of the peer-reviewed literature on coordination in the ten IHP countries, and other low income countries (LICs), focuses on Country Coordinating Mechanisms (CCMs) and/or National HIV/AIDS Councils. A general impression from this review is that quality longitudinal studies of coordination practices in-country are very thin on the ground. They are also out of date. Reporting on data collated in 2003, the findings of an influential four-country tracking study of the Global Fund, led by the LSHTM, are now five years old. More recently, in 2006, a research network led by a team from PHR*plus* produced studies of the system-wide effects of the Global Fund (SWEF) in Benin, Ethiopia, and Malawi. These studies provide a number of examples of innovative coordination mechanisms, for example Malawi's Partnership Forum on HIV/AIDS, but it is too early to determine whether or not they have proven effective. In 2008, it is evident that there is growing interest in coordination of health at the national level, and this is reflected by a scattering of studies from the Centre for Global Development (CGD) and HLSP[9].

Whilst most attention is given to CCMs and NACs, there is much less documentation on other established coordination bodies such as Interagency Coordinating Committees (Burundi, Kenya), or the experiences of nascent national mechanisms for coordination such as Technical Working Groups for Health (Cambodia), National Health Sector Coordinating Committees (Kenya, Nepal) or Partnership Forums (Malawi). Analysis of frameworks for coordination such as Codes of Conduct, Memorandums of Understanding, and Statements of Intent, is likewise in its infancy.

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[9] Dickinson C., Mundy J., Serlemitsos E., and Whitelaw Jones J (2008) A synthesis of institutional arrangements of national aids commissions in Africa, HLSP; Mundy et al (2007); Oomman et al (2008).

2 CURRENT ARRANGEMENTS FOR COUNTRY HEALTH SECTOR TEAMS IN TEN IHP+ COUNTRIES

(Refer to Annex C for a summary table)

2.1   Burundi

The highest national aid coordination body in Burundi is the *Comité National de Coordination des Aides* (CNCA), established by Presidential decree in December 2005. The MOH is not represented on its Board. The most important coordinating body specifically for the health sector is the *Concertation des Partenaires pour la Santé et le Développement* (CPSD), which was established in March 2007 by the Minister of Public Health and AIDS Control (MSPLS) to coordinate technical, material and financial support for the implementation of Burundi's National Health Development Plan (NHDP 2006-10)[10]. The GOB, CPSD, and Permanent Secretariat of the National Assistance Committee (PS/NACC) are in the process of establishing *a permanent multi-sector technical entity* of health and finance ministries to steer and monitor the evaluation of health development. Burundi has a National AIDS Commission – the *Conseil National de Lutte contre le Sida* (CNLS). It was established in July 2001 and has a decentralised structure down to colline level[11].

Following Round Table discussions with Development Partners (DPs) in May 2007, the GOB was encouraged to establish a *Groupe de Coordination des Partenaires* (GCP) as the dedicated framework for dialogue with national and international donors and international agencies. The GCP has a three-tier structure: seven sectoral working groups composed of representatives of the lead Ministry and, where necessary, representatives of other ministries involved in the sector; international partners; NGOs and other key actors involved in the sector, including women's groups; a strategic forum; and a political forum[12].

Burundi is also progressing towards implementation of a SWAp, a process that began in October 2007 with a joint mission with development partners (DPs) organised by the MSPLS. An MOU was signed between GOB and DPs in November 2007, which outlines a Code of Conduct and the results to be achieved by all parties. Both a Country Coordinating Mechanism (CCM) and an International Coordinating Committee (ICC) operate in Burundi, with funding from the Global Fund and the GAVI Alliance, respectively.

2.2   Cambodia

Cambodia has a comprehensive set of coordination groups and mechanisms for health. The MOH proposed that its *Technical Working Group for Health* (TWGH) constitute Cambodia's CHST. The TWGH has 74 official members, is MOH led and has broad participation from multiple MOH departments, national programs and institutions, other line ministries, CDC and bilateral and multilateral DPs, including NGOs (MEDICAM) and other CSOs working in the health sector[13][14]. The TWGH is strategy oriented, while its sub-TWGs focus on specific technical and cross-cutting issues, such as policy and capacity building and H&A, as well as multiple and disease-specific health programmes. There is

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[10] Burundi IHP+ Stocktaking Report, 2008
[11] UNAIDS Country data: Burundi http://data.unaids.org/pub/Report/2006/2006_country_progress_report_burundi_en.pdf
[12] Burundi Partners Coordination Group - http://binub.turretdev.com/en/images/articles/GCPE.pdf
[13] Cambodia IHP+ Stocktaking Report, 2008
[14] MEDICAM has additional information on Cambodia's TWGH - http://www.medicam-cambodia.org/hot_news/twgh/index.asp

an HIV/AIDS-specific coordinating group – the Government-Donor Joint TWG for HIV/AIDS (GDJ) which is chaired by the National AIDS Authority (NAA) – as well as a DPs Forum for HIV/AIDS.

The GOC has established a high level *Government-Donor Coordination Committee* (GDCC) to provide policy guidance and top-level coordination, involving ministers, heads of bilateral, multilateral organizations, CSOs and ambassadors. DPs to the TWGH also convene under various Working Groups – the Health Partners Group (HPG) and the Health Sector Support Project Partners (HSSP)[15].

Cambodia has recently re-affirmed its commitment to sector-wide management (SWiM) of its health sector[16]. Under SWiM arrangements, all stakeholders (including NGOs and other health-related private sector organisations, donor/lending agencies, MoH staff and others) work together within a common strategic framework and within a mutually reached management agreement, but falling short of establishing a mandatory pooled fund and/or completely adopting common project implementation arrangements[17].

Options for proceeding to a full SWAp are currently under review[18]. A CCC (Country Coordinating Committee) operates in Cambodia, sharing many of the same development partners and civil society groups as the TWGH. These include government ministries (Education, Women's and Social Affairs), the NAA and MEDICAM.

2.3   Ethiopia

Ethiopia signed its IHP Country Compact on the 28th August 2008. It details a three tier collaborative governance system: a Central Joint Steering Committee (CJSC) – in operation for several years and the principal body governing national health in Ethiopia; a Joint Consultative Committee (JCC) to promote dialogue between MOH and Health, Population and Nutrition (HPN) partners; and a *Joint Core Coordinating Committee* (JCCC) as the technical arm of CJSC.

The GOE set up a National AIDS Council (NAC) Secretariat in 2000. This has evolved to the current *HIV/AIDS Prevention and Control Office* (HAPCO), which was established in June 2002 to coordinate and facilitate implementation activities. In 2002/3 the National Partnership Forum (NPF) was established as a platform for all stakeholders engaged in the national response. It has various sub-forums representing PLHIV, women, youth, and media interests, which have strengthened overall coordination of the multi-sectoral response[19]. In 2004/5 a Task force was set up to coordinate provision of free, integrated, ARV treatment.

The Compact commits the GOE to "provide formal opportunities for consultation" with DPs, and the MOH and HPN partners to undertake an Annual Review Meeting, described as "the single opportunity for all Development Partners to comprehensively review policy, strategy, performance and capacity needs" of the health sector[20]. GOE also favours a system of 'lead donors' for particular issues to facilitate communication with the MOH.

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[15] Cambodia Second Health Sector Support Program, Appraisal Mission Aide memoire, April 21-30, 2008.
[16] Health Strategic Plan 2008-2015 – Accountability, Efficiency, Quality, Equity
[17] Performance monitoring frameworks within the health sector: Country Report – Cambodia. HLSP 2007
[18] Health Strategic Plan 2008-2015 – Accountability, Efficiency, Quality, Equity
[19] HAPCO, 2006 Report on Progress Towards Implementation of the Declaration of Commitment on HIV/AIDS
http://data.unaids.org/pub/Report/2006/2006_country_progress_report_ethiopia_en.pdf
[20] Compact between the Government of the Federal Democratic Republic of Ethiopia and the
Development Partners on Scaling Up For Reaching the Health MDGs through the Health Sector Development Programme in the framework of the International Health Partnership, Federal MOH, 2008.

'Silent donors' - donors that do not actively participate in a particular area but explicitly rely on another donor for representation and communication – are also encouraged.

The GOE favours a sector-wide approach as an appropriate mechanism to plan and coordinate all resources flowing into its health sector. A CCM has operated in Ethiopia since February 2002. At the end of 2006 it had 15 members with representatives from government, bilateral and multilateral DPs, and CSOs. New leadership provided by the MOH has resulted in an "open and facilitative" CCM that is working hard to be inclusive and transparent[21].

2.4   Kenya

The main coordination document for national health coordination in Kenya is the *Code of Conduct*[22] – a document which "contains the key elements needed in a Compact, and was developed in an appropriately consultative process to be the country's compact"[23]. The Code is not a legally binding instrument but provides a collaborative framework for health partners to implement Kenya's Joint Program of Work and Annual Operational Plans. Its purpose is to "guide, regulate, and monitor the operation of the partnership". The partnership is governed by the *Joint Interagency Coordinating Committee* (JICC) and *Health Sector Coordinating Committee (*HSCC).

Kenya's *National AIDS Control Council* (NACC) was established in 1999 through Presidential Order as a corporation under the State Corporations Act. As such, it is as autonomous and operationally independent as commercial state corporations. It has a 19 member Board, including representatives from various ministries, the private sector and civil society. The NACC Secretariat is mandated to perform a range of core coordination duties. The NACC heads a *Harmonisation Task Force*, which is the principal forum for national coordination with DPs.

There is an ICC and a CCM operating in Kenya. The ICC is "the primary forum for deliberating on AIDS policies and strategies, including coordination and review of the National Strategy"[24]. A novel development for the ICC is the 17-member NACC *Steering Committee*. The ICC sets priorities for the national response through this Committee, which are in turn reviewed by a Monitoring and Coordination Group. Membership comprises four DPs, and representatives from government departments, CSOs and the private sector[25]. The CCM works closely with, but has independent functions from, the ICC.

2.5   Madagascar

A joint review of the health sector was held in September 2007, with participation by all the technical departments, regional departments, development partners and civil society. The main guiding health sector document is the Plan for the Development of the Health Sector and Social Protection (PDHSSP), approved in 2007. It is the basis for the implementation of the SWAp in Madagascar. It provides a coordination structure of five

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[21] Banteyerga, Kidanu, and Stillman, SWEF in Ethiopia – Final Report, 2006:20.
[22] Kenya health Sector Wide approach – Code of Conduct, August 2007
[23] Kenya country proposal for IHP resources - 20th April 2008
http://www.internationalhealthpartnership.net/pdf/IHP_Proposal_Kenya.pdf
[24] Dickinson, Mundy, Serlemitsos, and Jones (2008) A Synthesis of Institutional Arrangements of National AIDS Commissions in Africa, HLSP, p22
[25] Ibid.

"strategic axes": HSS, mother and child health, environment and disease, healthy behaviour, and social protection. There are at least 13 health committees with coordination functions, including a *Partners Committee* and a Platform for Coordination of Communication Concerning HIV / AIDS[26].

The *National Committee for the Fight against HIV/AIDS* (NCFA) is the main coordinating body for HIV/AIDS in Madagascar. The Committee manages a range of national projects and thus "constitutes a tool to strengthen the coordination of interventions within a context of dynamic implementation". Civil society plays a highly important role in the NCFA by strengthening cooperation with the other partners of civil society[27].

2.6   Mali

In 1998, the Department of Health initiated a 10 year sector-wide social and health development plan (PRODESS). A PRSP called the Poverty Reduction and Growth Strategy Paper (PRGSP) 2007-2011 was approved by the Government of Mali in November 2006, integrating health into Mali's development program. The Department of Health has drafted PRODESS II in order to harmonize it with PRGSP, extending the life of PRODESS to 2011. The PRODESS document has become the common reference for coordinating and bringing together the visions of all the actors to achieve harmonious and sustainable health development.

The various coordination and steering committees in Mali - Monitoring, Technical, and Steering Committees, Regional PRODESS, Board of Management, Joint Monitoring Mission, Supreme Council for AIDS Control, Sectoral AIDS Control Coordinating Committee, as well as Regional, Circle, Commune and Village AIDS Control Committees - are organised into various "echelons": policy, strategic and operational. The United Nations system, bi- and multilateral cooperation, NGOs, public sector, private sector and civil society are all involved, but insufficient involvement by the private sector is identified as a serious 'bottleneck'[28].

The Supreme Council for AIDS Control (HCNLS) is the main national body for HIV/AIDS control in Mali.   Sectoral, Regional, Circle, Commune and Village AIDS Control Committees all report back to the HCNLS.

2.7   Mozambique

The Health SWAp is the main coordination forum for the health sector. There are regular SWAp DP meetings, and SWAp partners abide by a *Code of Conduct* and a health sector strategic plan (PESS)[29]. The *SWAp Working Group* (GT SWAP) is the main forum for information sharing and discussion. An Institutional Framework for Aid Management is provided by the Programme Aid Partners scheme (PAP).

A CCM operates in Mozambique, although the role and function of the CCM has now been folded into the Partners Forum and the Health SWAp. Informants suggest that the involvement of SWAp members appeared to result in more efficient decision making as

[26] IHP+ Stocktaking Report – Madagascar, 2008: 17
http://www.internationalhealthpartnership.net/pdf/05_MADAGASCAR_TSR_EN_FINAL.pdf
[27] IHP+ Stocktaking Report – Madagascar, 2008: 18
http://www.internationalhealthpartnership.net/pdf/05_MADAGASCAR_TSR_EN_FINAL.pdf
[28] IHP+ Stocktaking Report – Mali, 2008 http://www.internationalhealthpartnership.net/pdf/06_MALI_TSR_EN_FINAL.pdf
[29] IHP+ Stocktaking Report – Mozambique, 2008
http://www.internationalhealthpartnership.net/pdf/07_MOZAMBIQUE_TSR_EN_FINAL.pdf

there is greater neutrality between representatives[30]. The CCM experience provides a good example of how to rationalise coordination structures. Dickinson reports that "having SWAp members as CCM representatives appears to result in more rational and efficient decision making, primarily because there is more neutrality and less competition between the CCM representatives"[31].

Created in 2000 by Ministerial decree and located in the Office of the PM, Mozambique's *Conselho Nacional de Combate ao HIV/SIDA* (CNCS) coordinates the multi-sectoral response to HIV/AIDS. It has a Board (chaired by the Prime Minister with the Minister for Health as VP) & an Executive Secretariat. The Board has 13 commissioners representing various government sectors and CSOs. Notable is the CNCS' 'flexible apparatus' that has replaced standard bureaucracy and allows for practices such as the contracting of staff at market salaries. The main coordination forum for the multi-sectoral response to HIV and AIDS is the *Partners Forum*, established in 2003 as the forum for dialogue between the CNCS and its partners. It meets monthly to review progress made in implementing the National Strategic Plan for HIV and AIDS (PEN II). As the principal implementers, civil society is an important partner to the forum, which is chaired by CIDA and UNAIDS. The Forum is guided by its own Code of Conduct[32].

2.8   Nepal

Nepal's *National Health Sector Coordination Committee* (NHSCC) is chaired by the Minister for Health and Population (MOHP), with representative members of various government departments. The NHSCC leads coordination among MOHP/DoHS divisions and DPs. Coordination meetings take place at department level under the chair of the Director General of Health Services, mainly on technical aspects of funded programmes.

Nepal's National Health Sector Program Implementation Plan 2004-09 (NHSP-IP) is the operational guideline for coordinating action towards achieving the goals of the Health Sector Reform Strategy[33]. It is led by the MOHP and supported by 11 DPs, who are signatories to a *Statement of Intent* to guide the Partnership for Health Sector Development in Nepal[34]. All donor support is coordinated through this programme[35]. A *Health Sector Development Partners Forum* (HSDPF) was established in 2004 under the chair of the Secretary of Health to facilitate effective implementation of the Plan by all partners. The NHSP-IP indicates MOH preference for a SWAp to health sector management.

With the participation of all the partners, the MOHP conducts a joint review every six months to assess health sector performance. Based on analysis of progress made, relevant DPs and health sector officials develop an 'Aide Memoire' for the next fiscal year in consultation with the MOHP. A CCM operates in Nepal and is chaired by the Secretary of Health and with representatives from relevant UN and other external partners, INGOs and NGOs.

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[30] Dickinson et al 2008:12

[31] Dickinson et al 2008:26

[32] Dickinson et al 2008: 39

[33] National Health Sector Programme Implementation Plan, 2004

[34] The SOI re-affirms a commitment, first expressed in Nepal's 1997 2nd Long-term Health Plan, to: "A health system in which there is equitable access to coordinated quality health care services in rural and urban areas, characterized by: self-reliance, full community participation, decentralization, gender sensitivity, effective and efficient management, and private and NGO sector participation in the provision and financing of health services resulting in improved health status of the population"

[35] IHP+ Stocktaking Report – Nepal 2008
http://www.internationalhealthpartnership.net/pdf/08_TSR_Nepal_FINAL_July_2008.pdf

2.9   Nigeria

Nigeria joined the IHP+ in May 2008 and a stocktaking analysis is currently underway. Nigeria's Donor Coordination Group is a Constituency Coordinating Entity within the Nigerian HIV and AIDS Partnership.

2.10 Zambia

The primary implementation and coordination body in Zambia is the *Health Sector Advisory Group (SAG)*. SAG is a high level forum that brings together the MOH, DPs and CSOs, to provide advice to the Ministry on aspects of health sector governance. SAG members meet bi-annually to review progress, recommend solutions to identified bottlenecks and build consensus on the overall strategic direction of the NHSP[36].

The National HIV and AIDS Strategic Framework 2006-2010 (NASF) sets out the framework for government and its partners to work together in addressing HIV/AIDS. Unlike most other national AIDS coordinating mechanisms in the region, the relationship between Zambia's *National AIDS Council* (NAC) and civil society is not determined by grant-disbursement functions. Drawing on long-term technical assistance provided through DFID's STARZ programme, the NAC has been able to focus more fully on strategic efforts to strengthen civil society's involvement in the HIV response.

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[36] National Health Strategic Plan 2006-10, Zambian MOH.
http://www.moh.gov.zm/files/shared/alth_Strategic_Plan_Revised_July_20__2006_1_.pdf

3 SUMMARY OF GOOD PRACTICE AND EFFECTIVE NATIONAL COORDINATION IN HEALTH AND HIV/AIDS

National AIDS coordinating bodies and Country Coordinating Mechanisms are the most common governance arrangements for national coordination in health and HIV/AIDS. In this section of the report, existing good practices are identified and discussed in the context of various aspects of national health coordination.

3.1 National AIDS Councils/Commissions

A National AIDS Council/Commission (NAC) is defined as: "a stand-alone institution, independent of a government ministry, and usually comprising a governance body (the Board) and an operational body (the Secretariat), which together form the National AIDS Council or Commission (NAC)"[37,38].

The NAC was endorsed by the UN in its 3 'Ones' principles as the "One national AIDS coordinating authority". Application of a NAC should be appropriate to each countries needs and priorities, and there are various ways that a NAC can be used to bring together self-coordinating entities, partnerships and funding mechanisms for concerted action. A study of NACs in twelve countries by Clare Dickinson, Jackie Mundy, Elizabeth Serlemitsos, and Janet Whitelaw Jones from HLSP, is the most recent and comprehensive study. The twelve countries studied were: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe). Table 2 provides a summary of common features identified from in this study.

Table 2: Common Features of NACs

(Source: Dickinson et al 2008)

NACs are young institutions.
Eleven out of twelve NACs reviewed were under ten years old. Nine out of twelve have been established since 2000. Lesotho's NAC was established in 2006.

There is a predominant NAC model in place.
The institutional set up of a NAC comprises a governance body or Board of Commissioners - usually referred to as the National AIDS Commission/Council - and an operational Secretariat that supports the Commission.

Positioning in wider public administration system.
Nine out of twelve NACs reviewed were positioned under the Office of the President (OOP) or equivalent—a principle agreed by the African Union and endorsed by UNGASS. Reasons given for this included: giving political legitimacy and neutrality to the NAC, demonstrating political commitment.

Similar legal frameworks.
All the NACs reviewed in the study had been, or were in the process of being, set up by an Act of Parliament or Presidential Decree. In nine out of twelve cases the NACs were autonomous or semi-autonomous organisations, and several NACs have flexible apparatus (meaning that staff are contracted on market salaries rather than traditional civil service pay scales).

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[37] Dickinson et al 2008:4.
[38] A useful resource guide on NACs has been developed by HLSP and Eldis that summarises the issues and challenges facing the implementation of the NAC model (http://www.eldis.org/index.cfm?objectId=1FCF90A1-F33A-234E-8196773297F362EF).

> ***Decentralised structures at provincial and district level.***
> Most NACs have decentralised HIV and AIDS coordinating structures to provincial and district levels or below, in some form, but the function and representation differ according to context. For example, Mozambique has "provincial nuclei", Kenya has "District Technical Committees and Constituency AIDS Control Committees", Rwanda has District AIDS Coordinating Committees, Tanzania has "Multi-sectoral AIDS Councils" and Nigeria has "State and Local Action Committees on AIDS". In Nigeria, under the federal system, the States themselves are semi-autonomous and this has presented its own challenges for coordination.

The core functions of NACs were defined and agreed following a meeting of NAC and MOH staff in 2002 held by the Commonwealth Regional Health Community Secretariat for East, Central and Southern African. They include:

- Spearheading strategic initiatives such as policy development and strategic planning in sectors;
- Guiding the implementation of the national HIV and AIDS action framework;
- Resource mobilisation;
- Advocating and mobilising HIV and AIDS mainstreaming in all sectors at all levels;
- Building partnerships among all stakeholders in the country with regional and international linkages;
- Developing knowledge management approaches to document best practices;
- Dissemination and promotion of the best practices;
- Mapping interventions to indicate coverage and scope geographically;
- Facilitation and support for capacity building;
- Managing overall monitoring and evaluation of HIV and AIDS activities; and identifying HIV and AIDS research priorities.

3.2   Examples of 'good practice' in NACs

3.2.1   The politics of effective coordination

There is a political dimension to national health coordination that will affect the effectiveness of CHSTs. Walford warns that where health reforms involve reallocation of resources, staff, and/or contracts to non-state providers, resistance is likely[39]. Where implementation of reform is necessary, Dickinson et al conclude that the effectiveness of an NAC is "partly dependent" on whether its head has a dynamic personality, is well-connected, and has access to senior government[40].

3.2.2   The legal framework and institutional arrangements of NACs

To coordinate effectively, an NAC'S institutional arrangements and legal status must be clear. The institutional arrangements of Malawi's NAC were unclear, and its legal instruments were outdated. By changing its legal status to a private trust through a new Act of Parliament, the NAC was able to clarify its roles, responsibilities, and governance arrangements[41]. As a private trust, the Malawi NAC is also able to appoint staff on terms of service independent of the limitations in the public service. This flexibility in salary conditions is a feature shared by half of the NACs studied by Dickinson et al. It should be noted, however, that whilst the force of a legal instrument can add a degree of legitimacy

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[39] Walford V (2007) A review of health sector wide approaches in Africa, Technical Paper, HLSP, p19.
[40] Dickinson et al 2008:6
[41] Dickinson et al 2008:5

and clarity to the functioning of a NAC, it can also introduce rigidity to an otherwise flexible coordination   mechanism.

3.2.3 Overcoming capacity constraints

An NAC's ability to coordinate AIDS activities at sub-national levels is challenged by capacity constraints. Kenya and Rwanda have attempted to overcome these constraints by removing the provincial tier of AIDS coordination structures, thereby allowing the NAC to focus more on the community level.

3.2.4 The experience of civil society participation and representation

Whilst NACs are committed to these principles there is little evidence of practical measures to strengthen this commitment. Examples of good practice include:

- Development of an institutional framework for NACC coordination with civil society (Kenya)
- Developing a national election process for civil society representation on the CCM (Kenya)
- Creating new coordination structures with built-in civil society representation such as Nigeria's National Council on AIDS, Kenya's ICC-AIDS and its new apex Steering Committee and Uganda's Partnership Committee.
- Recognising the full potential of Civil Society (Zambia, see Table 3).

Table 3: Zambian national HIV/AIDS coordination and Civil Society

(Source: Mundy et al 2008)

The Zambian national AIDS coordinating body, the NASF, describes civil society as including national and international non-governmental organisations (NGOs), community based organisations (CBOs), faith based organisations (FBOs), the media, the trade unions, traditional healers, PLHIV and youth structures or groups.

Zambia's NAC has developed "a unique and systematic approach to defining and enabling civil society's contribution to the national response"[42]. It recognises, for example, the role of CSOs as more than just advocacy (important though this is). In addition, CSOs have an important role to play in building voice and accountability, providing services and promoting awareness and understanding of development through advocacy[43].

Since 2004, the NAC has made significant progress in the inclusion and representation of civil society in governance and coordination structures for the HIV response. Civil society representation in the Council's structure is now firmly established, as is civil society representation in the Country Coordinating Mechanism (CCM) for the GFATM, for which the NAC provides secretariat support.

There is also strong civil society participation in the NAC's technical Theme Groups (which monitor progress in implementing the NASF), as well as in the HIV and AIDS Sector Advisory Group (which monitors progress in implementing the Fifth National Development Plan or FNDP) and the Partnership Forum (a high-level forum for information exchange, cross-sectoral dialogue and advocacy).

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[42] Mundy et al, 2008:1
[43] Siamwiza, R (2007) Analysis of Financing for the National HIV and AIDS Response: Civil Society Component.

> In contrast to other national AIDS coordinating mechanisms in the region, the Zambian NAC's relationship with civil society is not determined by grant-disbursement functions. Drawing on long-term technical assistance provided through DFID's STARZ programme, the NAC has successfully focused on strategic efforts to strengthen civil society's involvement in the HIV response.

3.2.5   Coordinating the national response with External Development Partners

External development partner coordination mechanisms, such as the Harmonisation Task Force in Kenya, the Donor Coordination Group in Nigeria, the HIV and AIDS Cluster in Rwanda, or the Cooperating Partners Self-Coordinating Group in Zambia, are an effective fora for involving wider stakeholders, such as the Uganda HIV and AIDS Partnership and the Partners Forum in Mozambique[44]. Often, as in the case of the Tanzanian Development Partners Group, the coordination mechanism is an umbrella entity that addresses donor support in development cooperation. The use of sub-groups is a common feature of these fora, to assist with specific aspects of the AIDS response - H&A, resource mobilisation, and technical support.

3.2.6   Rationalising coordination

Problems for coordination occur when two potential coordination mechanisms have overlapping functions or mandates. For example, when the Ugandan CCM was formed, there was overlap in composition and functions with the Ugandan national AIDS Council. The result was two mechanisms of coordination. This led to "competitive tensions and potential duplication of efforts"[45].

It is therefore important to identify where multiple existing coordination mechanisms, systems, and processes can be rationalised or streamlined. Mozambique, Tanzania, and Malawi have attempted to do this by removing parallel mechanisms. For example, both Tanzania and Mozambique have sought to increase the efficiency of coordination mechanisms by aligning the CCM with existing coordination structures. Mozambique provides a good example of how to rationalise coordination structures. Dickinson et al report that "having SWAp members as CCM representatives appears to result in more rational and efficient decision making, primarily because there is more neutrality and less competition between the CCM representatives"[46].

Efforts to rationalise can, however, falter. Appointing the NAC as Zambia's de facto CCM was not successful, not least because it did not have a remit for malaria. As one multilateral respondent put it: "About 95% of NAC and CCM membership is the same…..the CCM is NAC with people co-opted for malaria"[47] (quoted in Donoghue et al 2005b:11). The NAC was appointed as Secretariat of the CCM, even though it was suffering from a serious HR deficit. One consequence of this was that it could not coordinate communication effectively. Even with weekly SWAp meetings and quarterly foreign investor meetings, neither the NAC nor the CCM took responsibility for communication flows (ibid, p20). Expectations that the CCM and NAC would merge did not materialise, and the CCM was dogged by a lack of clarity concerning its roles and responsibilities, and guidance issued by the GF was not distributed effectively.

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[44] Dickinson et al 2008:12
[45] Donoghue M., Brugha R., Walt G., Pariyo G., and Ssengooba F (2005) GF Tracking Study: Uganda Country Report.
[46] Dickinson et al 2008:26
[47] Donoghue M., Brugha R., Walt G., and Ndubani P (2005) GF Tracking Study Zambia Country Report

3.2.7 An innovative mechanism for enhanced coordination of health: Malawi's Partnership Forum on HIV/AIDS (MPF)

When Malawi first embarked on its health SWAp in 2005 it had numerous mechanisms for coordinating the HIV/AIDS response. These included: a Cabinet Committee and Parliamentary Sub-Committee on HIV/AIDS, the NAC Board, a Health Sub-Group of the Aid Coordination Group, UN Theme Groups on HIV/AIDS, an HIV/AIDS TWG, a CCM, and a Business Coalition against HIV/AIDS. Launched in 2005, the MPF functions as an advisory body to Malawi's National AIDS Council (see Table 4 below). It arose for two main reasons: stakeholder concerns that the GF Coordinating Committee in Malawi was insufficient in terms of involving all stakeholders: and the need for a coordination mechanism that would minimize duplication of efforts to scale up the national response.

Early responses to the MPF suggest a positive reception, but warn against seeing the MPF as a separate structure that will supersede the NAC. The interaction between the GF'S Coordinating Committee in Malawi is a novel arrangement and would warrant further exploration. As with Mozambique and Tanzania, Malawi is also considering aligning the CCM with other health and HIV and AIDS accountability structures[48]

Table 4: From duplication to coherence - Malawi's Partnership Forum on HIV/AIDS

(Source: Mtonya and Chizimbi 2006[49])

The MPF is a partnership that aims to reduce duplication in scale up through more effective and systematic coordination. Stakeholders from all sectors (public, private, civil society, and districts) convene at semi-annual review meetings, which are intended to be a cost-effective method of reaching out to all constituents.

The MPF comprises an *executive committee* which:
- Serves an advisory role to the NAC and the NAC Board and provides recommendations to NAC on policy and strategic issues;
- Employs a transparent and democratic voting process to elect representatives of the constituencies;
- Meets at least quarterly (in 2006 it met at least five times);
- Has a constituency that includes academic institutions, donors, GOM, the Parliamentary Committee on Health and HIV/AIDS, the NAC Board, the private sector, FBOs, youth organisations, and CBOs, amongst others.

The MPF also has *Constituent Blocks.* These are:
- Formal coordination structures for each constituency to facilitate the coordination task of NAC;
- They discuss and harmonize intra-constituency views prior to the MPF meeting;
- They are also fora for discussion, information sharing, consensus building, joint planning, and mutual support within each constituency and with special reference to issues raised by the executive committee;
- Block constituents include: public and private sectors, civil society, the PLWHA (people living with HIV/AIDS) network, academia/research institutions, development partners, and members of the Malawi Global Fund Coordinating Committee (MGFCC).

The MPF also incorporates *the HIV/AIDS Partnership Forum*, which constitutes the MPF General Assembly.

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[48] Dickinson et al 2008:12
[49] Mtonya B and Chizimbi S (2006) Systemwide Effects of the Global Fund in Malawi: Final Report.

3.3   Country Coordinating Mechanisms

The role of the CCM is clearly stated in the GF's 'Guidelines on the Purpose, Structure, Composition and Funding of Country Coordinating Mechanisms and Requirements for Grant Eligibility'50:

"the role of the CCM is to coordinate the submission of one national proposal for funding, drawing on the strengths of various stakeholders to agree on strategy, identify financing gaps in achieving the strategy based on existing support, prioritize needs, and identify the comparative   advantage   of   each   proposed   partner"

In terms of its structure, the guidelines state that the CCM should select a Chair and Vice-Chair, and recommend that they come from different sectors and from domestic organisations. Depending on its size, a CCM may have various Committees (e.g. executive, M&E, legal, ad hoc etc), Technical Working Groups to oversee proposal development, and a Secretariat. The CCM should determine the details of its organisational structure, election procedures, frequency of meetings, and TORs. The CCM should also be of "a manageable size in order to work and discharge responsibilities effectively"51.

The GF's commitment to inclusive stakeholder representation is supported in a 2005 evaluation of CCMs by TERG which found that 40% of CCM members were from NGOs, and 30% were women52. In addition, 39% were from government (with the MOH constituting 20%), and 21% from multilateral agencies and bilateral donors (15% and 6% respectively)53. In terms of consultative processes with non-government sectors, 8% of CCMs reported and documented consultation with the private sector, 12% with FBOs, 16% with the education sector, 25% with PLWHA, and 27% with NGOs 54. Table 5 below quantifies the number of CCMS with SOPs written into their TORs.

The legal status of CCMs varies amongst countries. AIDSPAN notes that a number of countries have decided to legally incorporate their CCMs as a foundation or non-profit corporation,   complete   with   by-laws55

Table 5: Standard Operating Procedures of CCMs

Standard operating procedure	%	Number of CCMs
CCM with written terms of reference, by-laws or operating procedures	52	43
Mechanism for decision-making	86	37
Defined roles and responsibilities vis-à-vis other relevant coordinating bodies	77	33

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50 Guidelines on the Purpose, Structure, Composition and Funding of Country Coordinating Mechanisms and Requirements for Grant Eligibility, http://www.who.int/hdp/publications/13d.pdf
51 *Ibid.*
52 TERG 2005, Assessment of CCM performance baseline http://www.theglobalfund.org/en/files/terg/17_ccm_assess.pdf
53 Garmaise and Rivers (2004) The Aidspan Guide to Building and Running an Effective Country Coordinating Mechanism (CCM)
54 TERG 2005 Fig 5
55 Garmaise and Rivers 2004:25

3.4 Lessons learnt from early experiences of CCMs

Findings from Tracking Studies of the GF in Mozambique, Tanzania, Uganda, and Zambia led by a research team from the LSHTM, do not paint a positive picture of the CCM's contribution to effective coordination of health. It should be noted, however, that the findings are based on 2003/4 data so it is possible that reform may have taken place in the intervening years. Nevertheless, summarising early experiences of CCMs provides a useful reminder of what can go wrong at start-up, and hopefully be avoided in future exercises in multi-sector/partner coordination.

3.4.1 Legitimate coordination

The experience of the early days of the CCM in Mozambique show how quickly perceptions of legitimacy can shift. By 2005, the perception from donors was that the CCM had lost its independence (and thus legitimacy) as both the Chair and Vice Chair of the CCM were PRs, high-ranking officials in the MOH, and also on the NAC[56].

3.4.2 Adequate Civil Society Participation

The experience of the CCM in Mozambique was initially positive. Representation was perceived to be good, and the formation of an INGO Umbrella Group helped facilitate non-government representation at SWAp meetings[57]. Civil society in Tanzania has been fragmented and without an umbrella organisation to represent it. CCM meetings were dominated by bilateral donors and multilateral agencies, with civil society a silent partner. Decisions at CCM meetings were largely determined by the action of the Chair, rather than by consensus - an area where the study recommended reform. An increase in initiatives meant added demands on the CCM to coordinate effectively. As one NGO respondent noted: "The CCM was a great idea, harmonising multi-sectorally, but we now need a mechanism to co-ordinate all of these initiatives. …. The CCM is losing direction, control and effectiveness"[58].

An interesting development in the Ugandan CCM was the formation of new alliances that drove reform. Most notable was that between private and civil society groups, who formed a *caucus* where they voiced common wants, for example, a rotating Chair, change in Secretariat, and control over the appointment of the CCM's Project Monitoring Unit [59].

Civil society participation in coordination of Benin's health service is relatively strong, with one study reporting "impressive progress in participation"[60]. One important change that facilitated civil society involvement was the CCM's use of *thematic sub-groups* which involved greater participation of civil society groups, PLWHIV, and the National Committee to Fight AIDS (CNLS). Shifting the PR from UNDP to the MOH appears to have been instrumental in encouraging wider participation in the CCM.

Effective coordination between the CCM and CNLS was hampered by confusion over roles. The CCM was perceived to be an attempt to coordinate three focal programs (National HIV/AIDS, Malaria, and TB Control Programs), while issues to do with HIV/AIDS were the responsibility of the CNLS.

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[56] Starling M., Brugha R., Walt G., Cliff J., and Fernandes B (2005) GF Tracking Study Mozambique Country Report.
[57] *Ibid*
[58] Quoted in Starling et al 2005
[59] Donoghue M., Brugha R., Walt G., Pariyo G., and Ssengooba F (2005) GF Tracking Study: Uganda Country Report.
[60] Gbangbadthoré, Sourou, Hounsa, Assomption, and Franco, Lynne Miller. October 2006: p21. Systemwide Effects of the Global Fund in Benin: Final Report. Bethesda, MD: Health Systems 20/20. Abt Associates Inc.

Whilst increased civil society participation in Benin's health sector is a positive development, MOH *health zone coordinators* (HZC) reported frustration at the direct relationships that some NGOs had with programs. NGOs operating at the sub-national level often used their contracted relation with programs to establish parallel action plans, and thus bypassing HZCs in accounting for their activities. This indicates "a lack of integration between NGO activities and those of the decentralized public sector"[61].

3.4.3   *Bloated membership*

Early experiences of the CCM in Tanzania were not positive. Its constituency was uncertain, and (too) large. One consequence was that while the GOT endorsed the CCM, senior level MOH did not participate enthusiastically. One government official described the CCM process as "a carpet (shotgun) wedding" where "participants are forced to work together"[62]. Civil Society/Government relations were also weak. Civil society regarded GOT representation on the CCM as top-heavy, while the GOT regarded civil society as trouble-makers. A knock-on effect of expansion of members has increased documentation which inevitably, given time and HR constraints, was not communicated effectively. As noted above, and as with the Mozambique CCM, the CCM in Tanzania has undergone a process of rationalisation, with the existing coordination mechanism being recast to form one Tanzania National Coordination Mechanism.

The CCM in Uganda is known as the National Co-ordination Committee (NCC). As with the Tanzanian CCM, early experiences of the CCM in Uganda were less than optimal. Whilst expansion of membership was promoted by the GOU as a way to promote inclusiveness, it meant that the CCM became unwieldy and by Round 4, according to a non-government source: "the CCM simply wasn't working"[63]. Lack of information and lack of timely circulation of documentation was also a problem for the Uganda CCM. In an effort to address problems around CCM composition and function, Standard Operating Procedures were drafted, and a 'declaration of interest' procedure was introduced to manage conflicts of interest.

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[61] *Ibid p25*
[62] Starling et al 2005:20
[63] Donoghue et al 2005:15

4   COORDINATION AND WORKING PRACTICES: EXPERIENCES FROM THE EDUCATION SECTOR

The principal interagency network for education in the context of humanitarian intervention is the **Inter-Agency Network for Education in Emergencies** (INEE). INEE is "a global, open network of NGOs, UN agencies, donors, practitioners, researchers and individuals from affected populations working together within a humanitarian and development framework to ensure the right to education in emergencies and post-crisis reconstruction" (INEE 2006). Box 1 summarises suggested actions for utilizing INEE *Minimum Standards* to strengthen inter-agency coordination within an education cluster (Table 6)[64].

Table 6: INEE Minimum standards for effective inter-agency coordination

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- **An Education Authority** (EA) will lead the coordination effort and establish an Inter-Agency Coordination Committee which will provide guidance and lead in the absence of the EA;

- **Financing structure** - Authorities, donors and other agencies will establish financing structures that are coordinated with and support activities of education stakeholders;

- **A common statement of coordination** aims, indicators and monitoring procedures is in place, and all education actors commit themselves to work within that framework and make key information and statistics available in the public domain;

- **Inclusive participation in decision-making** – Affected communities are authorised and able to participate in decision-making that directly affects them, particularly in policy or programme formulation, implementation and monitoring;

- **Information-sharing –** A transparent and active mechanism exists for sharing information across sectors and between key national and international stakeholders.

Suggested actions for increasing coordination in the education cluster include:

- Establish regular coordination meetings under the auspices of the proper authority using the INEE Minimum Standards as a guiding framework;
- Facilitate the inclusion of all stakeholders through the dissemination, and where necessary, the translation of all proceedings and materials;
- Identify a focal point to capture learning, distribute information and feedback input into the larger INEE Minimum Standard process

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[64] These Minimum Standards are available at: http://www.reliefweb.int/rw/lib.nsf/db900sid/LHON-66ZM7Z/$file/Education_Emergencies_INEE_Nov_2004.pdf?openelement. Page 78 of this document provides detailed guidance notes for each of the Standards.

4.1   The Inter-Agency Task Team on Education

In March 2008, the Inter-Agency Task Team (IATT) on Education published *Improving the Education Response to HIV and AIDS*. The Report drew from experiences of inter-agency coordination in the education sector in four countries: Jamaica, Kenya, Thailand, and Zambia.

The Report notes that across each of the four countries, establishing an HIV and AIDS Management Unit (HAMU) within the Ministry of Education was critical to a successful education sector response. A broader consultative body should also be established – an HIV/AIDS Committee – that includes both education officials and other stakeholders.

The nature of coordination with key external entities such as the National AIDS Authority (NAA), the MoH, the Ministry of Labour and the Ministry of Social Welfare varied substantially from country to country, for example, there was excellent NAA support in Jamaica but weak support in Thailand. In Kenya, the education sector's response was strong but its NAA did not have sufficient expertise to lend additional support.

Coordination mechanisms among external partners were diverse in terms of structures and approaches, but in all countries there was some kind of forum for coordinating the donor response within the education sector. Table 7 provides a brief overview of some of the coordination arrangements in the education sector in each of the countries studied and a brief overview of their composition and role.

Table 7: Overview of selected coordination arrangements in four countries
(Source: Adapted from IATT 2008:19)

Jamaica	Kenya	Thailand	Zambia
Education Donor Coordination Committee (EDCC): Meets monthly and brings together the MoE and key development partners. It is responsible for planning the education sector's response and for ensuring funding.	**Education Development Partners Group (EDPG):** Meets monthly. Every third meeting of the group takes place with the Permanent Secretary (PS) of the MoE. The EDPG establishes WGs on thematic issues.	**UN Theme Group on HIV and AIDS**: Coordinates the UN response under UNDAF. Education is discussed in this meeting when relevant.	**MoE sector plan:** Coordination takes place around the plan to which donors have subscribed. Mechanisms for coordination of the MoE sector plan include monthly meetings, a joint steering committee, and a JAR.
NAA – Education Sub-Committee: Represents a broad group of educational interests and includes representatives from NGOs, the private sector and government	**Education SWAp**: Formal coordination structures have been established, including joint planning and annual progress reviews. A formal committee to review the implementation of the HIV and AIDS sub-programme was established in September 2006.	**MoE:** Within the MoE, HIV and AIDS are coordinated as part of the sexuality education programme which involves a structured mechanism that brings together the various units in the ministry contributing to the response.	**Committee on Special Issues in Education:** (also known as the 'Equity' area). The Committee is chaired by the PS and tasked with HIV /AIDS, among other issues. At the time of the study, this committee had not met for some time.

Jamaica	Kenya	Thailand	Zambia
NAA – International Development Partners HIV and AIDS sub-committee: Looks at the education sector's response in addition to other issues.	I**nter-ministerial working group on OVC:** Involves all major partners, however, the MoE's participation in the group to date has been limited.	**HIV and AIDS Education Committee:** UNESCO is currently working on plans to assist the MoE in establishing this Committee with representatives from each Office of the MoE.	**Cooperating Partners Coordination Committee**: The DPs meet in these monthly meetings and HIV and AIDS are added as agenda items when necessary.
	AIDS Coordinating Units (ACUs): There are 3 units and they oversee the response in the education sector and link with other partners.		**NAA Technical Working Groups:** The MoE is represented on a number of these groups, namely, Information; Education; Care and Support; and ART.

4.2   Positive experiences of enhanced coordination in SWAp countries

- In Kenya and Zambia external partners were more positive about the scope of their own involvement and the strength of the coordination mechanisms;

- The SWAp process was highlighted as having enhanced donor coordination;

- It was also credited with having produced more formalised structures; contributed to the clarification of priorities (although this has not always translated in practice); contributed to better mainstreaming of HIV and AIDS in education; and provided a framework for discussing activities and funding;

- A critical gap which was highlighted in the SWAp contexts – but which was also found in other countries – is the lack of monitoring and evaluation of outcomes and impact and the absence of research (IATT 2008:20)

4.3   Challenges facing coordination of development partners
(IATT 2008:21)
- Coordination efforts among partners have still not resulted in adequate decision-making on a priority agenda around HIV & AIDS and education;

- In spite of joint action among sub-groups of DPs, lack of coordination and duplication of efforts by partners continues to be a substantial concern in all countries;

- DPs still push for specific agendas in spite of the commitments made to the 'Three Ones' and to national priorities;

- In non-SWAp countries, the response continues to have a short-term vision because of short funding cycles, thus raising serious concerns about sustainability.

5   COORDINATION EXPERIENCES FROM PEACE-KEEPING/ HUMANITARIAN SECTOR.

"*Constructing elaborate and intense coordination activity is counter-productive because it can obscure the fact that there is no coordinated policy amongst the various agencies involved in the response*"
(Reindorp and Schmidt 2002:4)

Humanitarian relief efforts, such as those which followed the 2004 Tsunami, rely on rapid coordinated inter-agency action. Coordination is particularly problematic in the humanitarian sector because there are many more (and much more diverse) actors involved than in other sectors, and because the large amounts of funding available for relief reduces incentives, and dampens the atmosphere for coordination (Telford & Cosgrave 2006). On the positive side, coordination is taken very seriously by the various international organisations (IOs) involved – UNICEF, OCHA, UNHCR, ICRC – and evaluations of coordination tend to follow soon after the event, meaning that lessons are drawn promptly from successive disasters. Lessons from the 2004 Tsunami response are summarised below, but it is instructive to begin with an overview of efforts by the international humanitarian community to reform inter-agency coordination.

In the past, IOs and donors piloted 'Friends of' groups in an effort to improve coordination (Reindorp and Schmidt, 2002). Characterised chiefly by their small size, (7 donors in the case of UNHCR), their principal effect was to increase information available to other partners. However, their specific purpose, rules of conduct, composition, and accountability mechanisms were often poorly specified and there was little evidence to show that these groups resulted in joint strategies being adopted. Consequently, donors have not used such groups to address UN inter-agency relations.

Two international events defined the current approach to inter-agency coordination for humanitarian relief: the Interlaken Report (1998), and the Fribourg Forum (2000). The Interlaken Report concluded that in order for coordination to be successful it was necessary to:

- Reduce collision between relief mandates and initiatives;
- Strengthen civil society institutions;
- Reinforce spontaneous local bilateral responses;
- Remove inappropriate protocols that are obstacles to relief[65].

The purpose of the Fribourg Forum was to convene senior policy makers responsible for international humanitarian assistance in Europe and the NIS in order to obtain their support and commitment for enhanced coordination and cooperation in the provision of humanitarian assistance in the region[66]. The Fribourg Forum gave the opportunity to governments and international/regional organizations to present initiatives and programs to address the challenging crisis management situation as well as identify areas of concern calling for particular attention.

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[65] http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&DocId=100305
[66] http://ochaonline.un.org/Coordination/FieldCoordinationMechanisms/TheFribourgProcess/tabid/1392/language/en-US/Default.aspx

5.1   Employing an Inter-agency standing committee to facilitate coordination

Of the various IOs providing humanitarian assistance, the Office for the Coordination of Humanitarian Affairs (OCHA) has made some innovative reforms in recent years. OCHA has, with partners, developed a strategy called the Common Humanitarian Action Plan (CHAP), and has developed clear division of responsibilities. OCHA is the Secretariat for critical inter-agency coordinating mechanisms such as the **Inter Agency Standing Committee** (IASC)[67]. Described as "a unique inter-agency forum for coordination, policy development and decision-making involving the key UN and non-UN humanitarian partners"[68], IASC is led by the Emergency Relief Coordinator. A single Secretariat in OCHA serves the IASC and the ECHA. This arrangement ensures that parallel discussions in the two Committees are based on a common understanding of the problems and on effective decision-making processes.

OCHA has also developed relations with regional partners such as the European Union. The EU-OCHA Light Coordination Mechanism, for example, is a framework for sustained inter-action, at the policy and operational levels, between EU institutions and OCHA in Brussels, with direct impact on coordination and execution of field operations. The expectation of the LCM is that it will generate effective and complementary response to emergencies. Close coordination with national delegations in Brussels will promote coherence in decision-making and complementarity in accessing resources for UN relief operations[69].

5.2   The Cluster Approach to effective inter-agency coordination

OCHA produces Annual Evaluation Reports of inter-agency coordination of disasters. An evaluation of the Pakistan earthquake 2005 reported that a *Cluster Approach* "successfully provided a single and recognizable framework for coordination, collaboration, decision-making, and practical solutions in a chaotic operational environment" (OCHA 2006: 22)[70]. Successful employment of Health Clusters to help coordination at local level has been reported in the inter-agency response to the Myanmar Nargis cyclone disaster (Moszynski, 2008; PONJA 2008); in provision of health to the elderly (IASC 2007) Table 8 summarises 8 key actions that the IASC should take to maximise Cluster performance.

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[67] http://ochaonline.un.org/Coordination/MandatedBodies/InterAgencyStandingCommittee/tabid/1388/language/en-US/Default.aspx
[68] http://ochaonline.un.org/ochaLinkClick.aspx?link=ocha&DocId=100308
[69] WHO's Global Health Cluster for humanitarian health has a website at:
http://www.humanitarianreform.org/humanitarianreform/Default.aspx?tabid=75
[70] http://www.tsunami-evaluation.org/NR/rdonlyres/2E8A3262-0320-4656-BC81-EE0B46B54CAA/0/SynthRep.pdf

Table 8: Key Actions to maximise Cluster Group performance

8 key actions the IASC Working Group should undertake:

1. **Incorporate** the Cluster Approach in all IASC member's operations manuals, training materials, and partnership frameworks and ensure staff briefing and training is provided.

2. **Disseminate** the recently defined roles and responsibilities among Cluster Leaders and partners. Furthermore, consideration should be given to reviewing country level coordination arrangements with a view to mitigate duplication and overlaps between existing coordination structures and coordination activities generated by the Cluster Approach.

3. **Develop** Cluster Toolkits for policy guidance, joint assessment and planning formats, minimum standards and benchmarks, and other relevant tools and documentation to be made accessible through a common information system in support of the field-level application of the new approach. Practical guidelines on inter-cluster linkages and reporting mechanisms for government and national NGOs should be included.

4. **Refine** a cross-cluster coordination framework that ensures representation by all IASC members.

5. **Include** strategies for standard-setting, information management, and data analysis to support strategic decision-making.

6. **Facilitate** greater involvement by the international NGO representative organizations and enlist their participation in order to increase the predictability of the core cluster membership.

7. **Reinvigorate** high-level efforts to coordinate and partner with international financial institutions, and galvanize their support to the Cluster Approach.

8. **Explore** the potential for the new CERF to support early deployment of dedicated Cluster Coordinators, Information Officers, administrative support, and provide cluster specific seed funding to ensure a capacitated response.

5.3   Causes of weak coordination

The TEC synthesis Report has identified a number of causes of weak inter-agency coordination in the humanitarian sector (Telford & Cosgrave 2006):

- **Number of actors involved** - Proliferation of actors involved in the coordination effort plus large amounts of private funding available, meant that there was no interest in common services and made coordination "a hurculean task";

- **Insufficient funding** - Support and funding for coordination was often in short supply; there were no guarantees of immediate, start-up funding;

- **Inadequate skills and experience** - Lack of continuity, skills and experience among some senior UN coordinators posed problems (for example, poor meeting management skills). Their lack of personal authority denied OCHA the authority to coordinate;

- **Insufficient representation with INGO/NGOs -** INGOs did not appoint special liaison officers to deal with the large number of other agencies and the need to share information with them. NGOs were insufficiently represented in many coordination bodies and coordinated poorly among themselves;

- **Lack of consensus** - INGOs did not bring consistent consensus on important issues being discussed [i].

5.4 Recommendations for enhanced coordination

5.4.1 The TEC synthesis Report (Telford & Cosgrave 2006):

- **The importance of national coordination –** International agencies should respect and promote national coordination of all response activities. International coordination should be conducted as a component of national coordination. The membership, language(s), location, accessibility, priorities, authority and capacities of international coordination mechanisms should be determined accordingly;

- **Develop a coordination model** – The UN should play its mandated coordination role in improving linkages and coherence between the different disaster response actors by developing a coordination model that supports national coordination efforts, by ensuring that the complementary international effort is itself coherent – e.g. a model built around the IASC model;

- **Support States to develop expertise** - To ensure that agencies are allocated and carry out tasks appropriate to their capacities and funding;

- **Work through common coordination mechanisms** – Where appropriate, and with the support of multilateral agencies, states should establish, and international agencies should be prepared to work through, common mechanisms such as consortia and trust funds;

- **Invest more in the assessment capacities** of international agencies. Assessments should ideally be joint, involving national, local and international actors (p118);

- **Improved training** – Improvement of international coordination requires increased training, improved 'coordinator' rosters, the deployment of senior personnel beyond capitals to support local coordination, and greater involvement of NGOs;

- **Expand coordination** – Where appropriate, *integrated geographic coordination mechanisms* (not just sectoral or 'cluster'-based models) should be considered (p119).

5.4.2   Recommendations from Bennett et al, 2006:

1. **An international review and consultation should be undertaken** with international and local NGOs to develop new approaches to achieving: (a) adequate representation within coordination structures at all levels; (b) consensus that can be translated into common positions and a level of predictability on key issues; and (c) the extent to which a certification process can be introduced to assist governments and donors in choosing responsible NGO partners with whom to work.

2. **Ensure that sufficient priority is given to enhancing the coordination capacities of local as well as national government bodies**. This would include, for instance, deploying senior staff beyond capitals and helping to build the capacity of local authorities to utilise information systems such as HIC. Where large numbers of INGOs are anticipated, the deployment of a senior NGO liaison officer should be considered;

3. **Ensure effective, consistent and coordinated communication with recipient populations at all stages of the response** – and with a concerted effort to include women in the dialogue – should be prioritised. This should entail dedicated staff resources and tools, with efforts made toward reaching a communications protocol with the host government. A common strategy should be developed, including the use of public meetings, broadcast media, newsletters and posters;

4. **Provide and promote adequate leadership and coordination skills** – these should include the basics of how to maximise the output of meetings. These skills should be promoted by all agencies, forming part of the induction training for operational staff, along with standard operating procedures;

5. **Benchmark (gender-sensitive) indicators for coordination** should be developed, along with a simple monitoring and report-back system for the quality of coordination meetings;

6. **Strongly advocate and disseminate information** on the common services available to all actors: what they provide, how non-UN agencies can supplement capacities, and the purpose of the Humanitarian Common Services 'matrix'.
7. **Adequately resource** coordination efforts.

6   UN INTER-AGENCY REFORM: DELIVERING AS ONE[71]

In November 2006 a High-level Panel on UN System-wide Coherence in the Areas of Development, Humanitarian Assistance, and the Environment was convened in response to a growing realisation that UN funds, programmes, and agencies at country level were suffering from profound 'operational incoherence[72]. The problem had become acute. More than one-third of UN country teams included 10 or more UN agencies on the ground at any one time (14 UN agencies in Viet Nam, 18 in Tanzania, and 23 in Mozambique); this has led to incoherent programme interventions and excessive administrative costs; it also burdened the capacity of developing countries to deal with multiple agencies; and the normative and analytical expertise of non-resident agencies did not sufficiently support UN country team efforts.

The response from the Panel was a Report – *Delivering as One: Report of the Secretary-General's High-Level Panel* that put forward a series of recommendations to overcome the fragmentation of the United Nations[73].

The Report describes '4 ones':

> One Programme;
> One Leader;
> One Budgetary Framework;
> One Office.

Governments of eight *Pilot Countries* – Albania, Cape Verde, Mozambique, Pakistan, Rwanda, Tanzania, Uruguay and Viet Nam – have volunteered to become "One UN" pilots. A fifth 'One' – 'One Communication' – is evolving in several Pilot countries (eg Mozambique[74]). The Report also proposes that a *Resident Coordinator* (RC) must manage each Country Programme. The RC will be empowered to speak on behalf of the UN system, lead the country teams (composed of the representatives of United Nations system organizations present in the country) in shaping and allocating resources to the "One Programme" and hold members of the country team accountable for achieving the results/outcomes agreed upon in the "One Programme".

On 4-5 March, 2008, the United Nations Industrial Development Organization (UNIDO) hosted a high-level dialogue on United Nations System-wide coherence[75]. The meeting brought together top officials from governments, the Co-Chairs of the United Nations General Assembly Consultations on System-wide coherence, representatives from the "Delivering as One" (DaO) pilot countries and aid agencies, as well as senior officials from United Nations system organizations[76]. The main developments reported at this meeting were:

- *The Resident Coordinator* – In order to ensure that the RC is impartial (most RCs are also Resident Representatives of UNDP and since UNDP is the manager of the RC system, there is a perception of conflict of interest in this dual role), the UNDP has started to erect *institutional firewalls* by, among others, appointing UNDP Country Directors in a number of countries to assume responsibility for

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[71] http://www.undg.org/index.cfm?P=7
[72] http://www.undg.org/archive_docs/9021-High_Level_Panel_Report.pdf
[73] http://www.undg.org/archive_docs/9021-High_Level_Panel_Report.pdf
[74] UNEG Evaluation of the Pilot Initiative for Delivering as One Evaluability of UN Reform Process in Mozambique Evaluability Assessment Mission (29 January - 2 February 2008)
[75] http://www.undg.org/docs/8642/UNIDO-hosts-meeting-on-UN-System-wide-coherence.pdf).
[76] www.unido.org/fileadmin/media/documents/pdf/One_UN/SWC_Meeting_Summary_Final.pdf

UNDP programmes, thereby leaving the Resident Coordinator free to focus on his/her coordination responsibilities.

- *Agency HQs need to be flexible* – UNIDO noted their call for agency headquarters to provide more flexibility to the field, and said that a change in the "mind set" at headquarters was needed in this area. One way of improving the mindset might be to strengthen agency mobility policies to ensure the constant flow of staff, including senior staff, between headquarters and the field.

- *Less reliance on external consultants* – UNESCO commented that too much was being left to outside consultants and that more needs to be done by the UNCTs.

- *Commit fully to the gender agenda* – UNESCO also warned against the gender agenda falling victim to the process; gender needs to be recognized as bedrock of the development exercise.

- *Lack of consensus over role of specialised agencies* – WHO posed the question "Do you want us to give up being specialized agencies?" He answered this himself, in the negative, but noted that, in a sense, specialized agencies were being asked to do so at the country level. This may be acceptable, he noted, for some development issues, but not for others such as global health and security, or governance.

- *Ensure inclusiveness* – The agency representatives suggested that the role of the private sector and of civil society organizations should be taken into consideration in the preparation of the UNDAF, that the One Leader was a key element, and that the development of an effective Code of Conduct was a useful tool.

- *Specialised agencies are failing to harmonise business practices* – Pilot countries have reported that harmonizing the business practices and procedures of the participating United Nations organizations is proving difficult. Although the funds and programmes have increasingly harmonized their programme and project management guidelines and their administrative policies and procedures, the specialized agencies are continuing to apply a different "business model", i.e., operating modality, based primarily on policies and implementing rules adopted by their governing bodies.

Examples of simplified processes, Joint Programmes, and harmonised responses from three Pilot countries

The United Nations Evaluation Group is currently conducting an evaluation of the Pilots for Delivering as One. The evaluation process has three distinct phases:
1. An evaluability study to assess the extent to which the pilots are evaluable;
2. Self assessments and their synthesis;
3. Independent evaluation of the pilot initiative.

Evaluability studies have been completed for all of the 8 Pilots, with the last, Uruguay, published in October 2008[77]. These studies are the latest snapshot we have of progress made by the UN agencies through the Delivering One reform process to collectively provide more aid effective support to countries, either through simplifying procedures, joint work-planning, or harmonising processes that have led to reduced transaction costs and better support for the country. The following section summarises examples from three of these Evaluability Reports.

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[77]

www.uneval.org/papersandpubs/documentall.jsp?showAll=1&doc_source_id=0&doc_cat_source_id=1&doc_source_extra_id=0&doc_cat_id=32

In Viet Nam there are early signs of programmatic collaboration between agencies through joint programmes on AIDS, Avian influenza, the Joint Program on Kon Tum, gender, and youth programmes, as well as in the newly set up UN Communication Team. With regard to funding, there is support amongst a number of 'like-minded' donors to support the One Budget and One Plan Fund, rather than funding individual projects and agencies. However, the Evaluability Report also highlights a lack of common vision amongst the agencies that was impeding further advancement. The original 6 agencies[78] were agreed, but the 8 'specialist' agencies that joined later did not agree about the end product of the Delivering One initiative: the 6 original agencies were aiming towards 'One UN' while the specialist agencies were aiming more towards 'Delivering as One' (King and Tuinenberg 2008)[79].

In Tanzania a key feature of the Delivering as One (DaO) process is the formulation of Joint Programmes (JPs). The Tanzania Evaluability Report identifies seven JPs[ii]. Gains from these programmes include "greater involvement of and 'cross-fertilization' among agencies to address pressing problems" (for example, refugee hosting areas in North Western Tanzania through supporting the capacity of host communities and local government). Evidence of this is the broader range of UN agencies participating in humanitarian assistance (JP 6.1), and also the recent posting of a UNDP staff in the region (Norgbey et al 2008). Support for JP 6.2 – strengthening natural disaster preparedness – is also evident, with management efforts merging into one programme (e.g. UN consolidated assistance – 'speaking with one voice' – helped significantly the GOT's handling of an outbreak of Rift Valley fever in Feb 2007).

As with the experiences in Viet Nam, the Tanzania Report identified lack of consensus amongst the agencies over the vision of the DaO (Norgbey et al. 2008). However, a Non-Resident Agency Coordination Analyst was appointed in October 2007, indicating that the Regional Coordinator is committed to addressing NRA concerns. Tanzania is also starting to pilot 'functional clustering', where the focus is on co-location of resource centres, sharing procurement practices, and creating emergency coordination groups.

In Mozambique the Developing as One reforms are contributing to a simplified, harmonised, and 'joined-up' response. The UN Country Team (UNCT) is making efforts to align and simplifying UNDAF with GOM's Poverty Reduction Plan, PARPA II (Henry at al 2008). It is using national assessments rather than its own Common Country Assessment tool. An example of harmonised practices amongst all UN agencies is the adoption of harmonized approach to cash transfers to implementing partners (HACT), as well as electronic bank transfers (EFT). In the humanitarian sector, the UN Humanitarian Coordination Team has adopted a Cluster Approach and gained access to the Central Emergency Response Funds (CERF) – two humanitarian reforms designed to minimise erratic coordination. There are 11 Joint Programmes operating in Mozambique, and these are all funded through One Fund (Henry at al 2008).

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[78] Specialized agencies ar autonomous agencies linked to the UN by special agreements (e.g. WHO, FAO, ILO, UNESCO).
[79] **JP 1** Wealth creation, employment and economic empowerment (ILO, UNDP, FAO, UNIDO, WFP, IFAD and UN-HABITAT). **JP 2** Reduction of maternal and newborn mortality (UNFPA, WHO and UNICEF). **JP 3** Support to national response to HIV/AIDS (UNAIDS, UNFPA, UNDP) **JP 4** Capacity strengthening for development management (UNDP, UNICEF, UNFPA). **JP 5** Capacity building support to Zanzibar (UNDP, UNICEF, UNFPA, UNESCO, WHO, FAO) **JP 6.1** Managing transition from humanitarian assistance to sustainable development in Northwestern Tanzania (NWT) (UNHCR, UNESCO, UNDP, UNICEF, UNEP). **JP 6.2** Strengthening national disaster preparedness and response capacity (WFP, UNICEF, UNDP, FAO).

7   SUMMARY OF TOOLS AND MECHANISMS USED TO PROMOTE MORE EFFECTIVE COORDINATION

Table 8: Tools and mechanisms employed by IHP+ countries to promote coordination

Country	Code of Conduct	MOU	Other
Burundi	Yes	Yes	
Cambodia	No	No	
Ethiopia	No	No	Country Compact
Kenya	Yes	Yes	
Madagascar	No	No	Health Code
Mali	No	No	Roadmap
Mozambique	Yes	No	
Nepal	Yes	No	Statement of Intent
Nigeria	?	?	
Zambia	no	Yes	

Burundi – Burundi has drawn up a partnership framework/MOU **-** the *Framework for Collaboration among Health and Development Partners* - which it is hoped will enhance mutual coordination. This is due to be signed by the Minister of Health and AIDS Control, the Minister of Economics, Finance and Cooperation for Development, as well as by the development   partners[80].

Cambodia – In Cambodia there is no code of conduct or memorandum of understanding (MOU) between the DPs in the health sector, although the GOC acknowledges that formulating such an agreement would serve as an opportunity to clarify responsibilities and   roles,   and   standardize   and   harmonize   practices[81].

Ethiopia – The GOE is currently implementing a Harmonisation Action Plan with DPs. As part of this broad action, the health sector launched a sectoral harmonisation plan in 2005, and a *Code of Conduct to Promote Harmonization in the Health Sector of Ethiopia* was one output of this. The Code calls for "greater co-ordination of reports, analytical work, reviews and missions"[82]. According to the Ethiopia Compact, the GOE "favours sector-wide approaches…as a mechanism to plan and coordinate all resources flowing into a sector, including domestic revenues, support to the budget, project aid, and technical assistance".

Kenya – Kenya's Code of Conduct has recently been signed by some DPs, and it is intended to constitute the Kenyan Country Compact. Kenya also has a MOU between MOH/F   and   health   sector   DPs[83].

Madagascar – The Madagascan Parliament is currently in the process of adopting a new Health   Code   which   will   update   existing   health   regulations.

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[80] IHP+ Stock taking Report – Burundi, 2008:4
http://www.internationalhealthpartnership.net/pdf/02_BURUNDI%20_TSR_EN_FINAL.pdf
[81] IHP+ Stock taking Report – Cambodia, 2008:7
http://www.internationalhealthpartnership.net/pdf/03_CAMBODIA_TSR_EN_FINAL.pdf
[82] Ethiopian Country Compact Annex 4
http://www.internationalhealthpartnership.net/pdf/04_Ethiopia_IHP_Compact_August_2008_FINAL.pdf
[83] Report of the IHP+ Inter-Agency, Inter-Regional CHST Meeting, Lusaka, March 2008, p9

Mali – A Roadmap to reach agreement with DPs on key actions and the responsibilities of parties is being drafted for their consideration at a forthcoming meeting of the PRODESS monitoring committee.

Malawi – Malawi used a legal instrument - an Act of Parliament - to change the legal status of its NAC. This has allowed it to clarify its role, responsibilities, and governance arrangements in relation to the newly established Department of HIV and AIDS and Nutrition.

Mozambique – Mozambique has a Code of Conduct (the Kaya Kwanga Commitment) to guide its Partnership for Health Development. The objective of the Code is "to define the principles and mechanisms to guide, co-ordinate and facilitate productive relations between the MoH and co-operating partners"[84]

Nepal – Nepal and DPs signed a Statement of Intent in 2004 which is implemented by a Code of Practice for EDPs operational procedures.

Tanzania – A new coordination mechanism was established in 2006, the Tanzania National Coordination Mechanism (TNCM), which has evolved from the CCM and through the Prime Minister's Office, coordinates not just GF grants but PEPFAR and World Bank programmes as well.

Zambia – Zambia's IHP Stocktaking Report provides more detail about its coordination mechanisms than the other reports. The strengths of the MOU are that it:

- Engenders a sense of inclusivity;
- Encourages strict adherence to regular activities, agreed to in the MOU;
- Assures attendance at meetings - something not commonly seen with other line ministry Sector Advisory Groups;
- Provides confidence for dialogue to take place during meetings;
- Contributes to a more responsive MOH, which listens and takes appropriate action to comments and observations made by the DPs;
- Is more comprehensive than partners expect of a Country Compact, and consequently (a) is a preferred option by some DPs, (b) conversely, some DPs regard a CC as an additional administrative burden/cost.

With this added value, the experience in Zambia is that:

> "The MoU still serves as the best model for country leadership; especially so if the Zambian government was clear and precise on its operating principles. If this was done then all other signatories could follow suit. The wider stakeholder buy-in on the SWAps MoU should serve as strength around which to set the MoH on a path to become "result-oriented" in its activities in order to improve the health status of Zambians".[85]

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[84] Kaya Kwanga Commitment: a Code of Conduct to guide the partnership for health development in Mozambique, p2

[85] IHP+ Stock taking Report – Zambia, 2008:8

8 SUMMARY OF POSSIBLE OBSTACLES TO CHST MEETING THEIR COMMITMENTS

This final section of the review identifies various issues that might impede the effective coordination of national health.

8.1 Political obstacles

There is an increasing recognition that understanding the political dimension of health sector reform is key to effective implementation[86]. Understanding the political nature of reform - implementing a SWAp for example – leads to a more informed understanding of the likelihood of opposition to that reform. Respondents from Nepal interviewed for the External Review of the IHP, noted the fragile position of a senior MOH official as a factor that could impact negatively on effective coordination of DPs[87]. Whilst there are positive examples of effective positioning of NACs within the Office of President (Kenya), and the access to networks that can follow, coordination functions can suffer if a senior MOH presiding over that NAC finds themselves politically 'isolated' – as happened with the Mozambique NAC[88].

8.2 Accountability

The fifth 'element' of the Paris Declaration, accountability, underpins the IHP+. Reviews of NACs, however, comment on the absence in any NAC documentation, of reporting on the nature of relationships between NACs and Parliamentary Committees, or NACs and MOH[89]. The experience of the Tanzania NAC, TACAIDS, demonstrates that the trade off between speed and transparency is not always easy to gauge. An arrangement in Tanzania where the head of the Board is also the head of the Secretariat was set up to curb bureaucracy and to facilitate swift decision making for an "emergency" response. But this has resulted in some DPs calling for a review of this appointment in line with their own commitments to transparency and accountability, vis-à-vis the performance of TACAIDS[90].

8.3 Capacity constraints at sub-national level

At sub-national levels, although NACs lack capacity, they do not engage sufficiently with the non state sector as one way to strengthen that capacity deficit. In addition, Local Government Authorities are mandated to coordinate the response but have problems accessing resources to take up their coordination role with sectors and other partners.

Various examples of capacity constraints are cited in IHP+ Stocktaking Reports. They include: difficulties accessing and spending money for AIDS activities at district levels; lack of clarity on role and decision making structures; and limited capacity at all levels to plan, manage and coordinate AIDS activities. Both Uganda and Rwanda, for example,

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[86] Walford, 2007; Buse K., and Dickinson C. (2007) How can the analysis of power and process in policy-making improve health outcomes? Moving the agenda forward. Overseas Development Institute (ODI), HLSP Institute; Buse K., and Booth D., with Murindwa, Mwisongo, and Harmer (2008) Donors and the Political Dimensions of Health Sector Reform: The Cases of Tanzania and Uganda, ODI Working Paper 7
http://www.odi.org.uk/pppg/politics_and_governance/publications/GAPWP7.pdf
[87] Interviews conducted by the author for the External Review of the IHP+, 2008
[88] Dickinson et al 2008:6
[89] Dickinson et al 2008: 8
[90] Dickinson et al 2008:38

have highlighted capacity constraints in the coordination and management of their move to decentralisation, especially human resources. Examples of initiatives to strengthen sub-national capacity to manage AIDS activities are also cited in the literature – Tanzania's "Technical Facilitating Agencies" (TFAs) that support Local Government Authorities' (LGAs) capacity to plan and manage HIV and AIDS activities, for example[91].

8.4   Roles and responsibilities

Lack of clarity about partners' roles and responsibilities continues to dog efforts to coordinate the health response in many IHP countries. Many ministries and local government bodies remain unclear about their role in, and potential for, contributing to the national response. In Malawi, for example, "There is acknowledged lack of clarity between the roles and responsibilities of the OPC (Department of HIV and AIDS and Nutrition) and the NAC[92]. It is important to be clear what functions a coordinating body is expected to perform: requiring it to manage grants, for example, may distract it from its main role as a coordinator. Malawi's NAC was able to clarify its roles and responsibilities through legal instrument.

8.5   Civil society and the challenges of coordination

Civil society in the present context refers to a broad range of stakeholders, including patient groups; medical and health care associations; the media; health care workers; FBOs; advocacy groups; NGOs; youth organizations; women's organizations; large international NGOs (e.g. OXFAM, TAG); and grassroots or community-based organizations. With such a broad range of interests, coordination within this sector will be challenging. In Zambia, for example, the number of CSOs has increased 10 fold since the early 90s[93]. Box 4 provides a summary of challenges faced in this country.

Table 9: Coordinating CSOs in Zambia

(Source: Mundy et al 2008:4-5)
• **In Zambia, civil society has little experience of operating as a coherent sector, especially within the field of HIV;**
• **There are very few umbrella or network organisations that have strong decentralised systems for communication, consultation, feedback and democratic election of representatives;**
• **The fragmented and project-based nature of civil society initiatives makes effective service delivery within the context of the NASF 2006-10 difficult;**
• **Competition for resources, lack of integrated approaches, weak monitoring and evaluation (M&E) capacity, diversity and wide dispersal of CSOs make it difficult to create an interface between civil society and the national HIV M&E framework;**
• **The NASF 2006-10 is not explicit about the role of civil society, or the nature and conditions of engagement between NAC and civil society. This has led to some ambiguity about the appropriate role of civil society in the national response, potential areas of comparative advantage and opportunities for strategic partnership between sectors.**

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[91] Dickinson et al 2008:6
[92] Dickinson et al 2008:19
[93] Birdsall K., and Kelly K. (2007) Pioneers, partners, providers: The dynamics of civil society and AIDS funding in Southern Africa. Centre for AIDS Development Research and Evaluation (CADRE)
http://www.sarpn.org.za/documents/d0002809/Civil_society_Aids_CADRE_Jun2007.pdf

The Cambodia STR: "Ineffective regulatory mechanisms and weak coordination between public and private (including NGO) health services";

8.6   Quality of participation

Great efforts have been made by CSOs to push for representation in Country Health Sector Teams. Issues currently under discussion include whether or not civil society is formally regarded as an 'equal partner' by the other members of the country team; whether or not the civil society representative is perceived to be a legitimate representative by the civil society community; and whether civil society has sufficient time and resources to feedback to its community, decisions made at NAC meetings. Equally important to representation, however, is the *quality* of participation at meetings by civil society representatives. Early Tracking Studies of CCMs reveal that civil society participation was extremely limited. Various reasons are given: a lack of understanding of technical areas and the fact that initial proceedings were held in English (Mozambique); hierarchical institutions, a tendency for bilateral and multilateral donors to dominate discussion, and a sense of inferiority felt by civil society groups (Tanzania); and a sense by civil society that the 'real' decision were being taken away from the CCM (Uganda)[94]

As noted earlier in this report, there are some examples of good practice that will help to strengthen the quality of civil society participation, for example; the development of an institutional framework for NACC coordination with civil society, and a solid national election process for civil society representation on the CCM in (both in Kenya), and strengthened coordination structures such as the Nigerian National Council on AIDS, Kenya's ICC-AIDS and its new Steering Committee, and Uganda's Partnership Committee.

8.7   Health reporting and alignment

Studies of Health Management Information Systems in Uganda and Zambia report a lack of coordination of HIV/AIDS information flows. On the one hand, data on a country's HIV/AIDS response from its various sectors are reported through HMIS – managed by the NACs; on the other, health-related data (program, HR, surveillance) data are reported through HMIS managed by the MOH. In addition, the GF, PEPFAR, and the World Bank all have their own donor-specific reporting requirements. Three causes compound the problem: the proliferation of information systems that has resulted partly from donors' own priorities and accountability requirements; weak government coordinating structures for HMIS; and ill-equipped and under-financed NACs[95]. Other studies also report on how an insistence by some donors to follow their own priorities and behaviours is impeding effective coordination[96].

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[94] See Donoghue, Brugha, Walt and Ndubani (2005); Donoghue, Brugha, Walt, Pariyo, and Ssengooba (2005); and Donoghue, Brugha, Walt, Cliff, and Fernandes (2005) *op cit.*
[95] Oomman et al 2008:3
[96] Dickinson et al 2008.

9   CONCLUDING REMARKS

Literature on CHSTs is scant, particularly in academic journals. Most of what we currently know comes from work being conducted by 'think tanks' such as HLSP and CGD, and it is concentrated around NACs and CCMs. Consequently, this review has focused primarily on the experiences of these mechanisms. However, there have been a number of innovative attempts at coordination – Malawi's Partnership Forum, for example – although it is too early to determine their effectiveness. Just two high profile longitudinal studies of the effect of CCMs on health systems have been conducted since the turn of the century and are now, inevitably, out of date. Nevertheless, they provide important lessons on how not to coordinate a national response effectively – lessons which should be taken on board for future coordination efforts through the IHP. The IHP+ will shortly be commissioning a 3 year evaluation, and this would be a good opportunity for robust analysis of existing coordination mechanisms and processes at the national level.

Whilst it is not in the terms of reference of this review to provide recommendations for improving coordination, the authors' involvement in the recent Short-term External Review of the IHP+ provided access to approximately 100 respondents working with the partnership. From interviews and a review of IHP documents, it is possible to distil a number of general recommendations that might assist future coordination efforts. Annex D provides a Table showing the coordination 'baseline position' of IHP+ countries when they signed up to the IHP in September 2007; progress that these countries have made to mid-2008; and a final column with recommendations on how that country might supplement ongoing coordination efforts.

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ANNEX B: NATIONAL, DEVELOPMENT PARTNERS, AND HIV/AIDS COORDINATION BODIES AND MECHANISMS.

Country	National coordination body	DP coordination platform	HIV/AIDS coordination body	CCM	SWAp
Burundi	Concertation des Partenaires pour la Santé et le Développement (CPSD),	Groupe de Coordination des Partenaires (GCP)	Conseil National de Lutte contre le Sida (CNLS).	Yes	Yes
Cambodia	Technical Working Group for Health (TWGH)	Government-Donor Coordination Committee (GDCC)	Government-Donor Joint TWG for HIV/AIDS (GDJ)	Yes (CCC)	SWiM (options for full SWAp under review)
Ethiopia	Joint Core Coordinating Committee	Country Compact	HIV/AIDS Prevention and Control Office (HAPCO)	Yes	Yes
Kenya	Health Sector Coordinating Committee (HSCC).	Joint Interagency Coordinating Committee (JICC)	National AIDS Control Council (NACC)		Yes
Madagascar	N/A	Partners Committee	National Committee for the Fight against HIV/AIDS (NCFA	Yes	Yes (PDHSSP)
Mali	N/A	N/A	Supreme Council for AIDS Control (HCNLS)	Yes	Yes (PRODESS)
Mozambique	SWAp Working Group (GT SWAP)	SWAp Working Group (GT SWAP); Partners Forum	Conselho Nacional de Combate ao HIV/SIDA (CNCS)	Yes	Yes (Mature)
Nepal	*National Health Sector Coordination Committee* (NHSCC)	A *Health Sector Development Partners Forum* (HSDPF)	N/A	Yes	Yes
Nigeria	N/A	N/A	N/A	Yes	No
Zambia	Health Sector Advisory Group (SAG)	SWAp Working Group	National AIDS Council (NAC)	Yes	Yes (Mature)

ANNEX C: SUMMARY OF THE GOVERNANCE/STRUCTURE, COORDINATION, FUNCTIONS, AND STAKEHOLDERS INVOLVED IN SEVEN NACS

(Source: Adapted from Dickinson et al, 2008)

Country	Governance/structure	Coordination	Stakeholders	Function
Kenya National AIDS Control Council (NACC).	Established by Presidential Order and is located in the Office of President; 19 member Board, including reps from various ministries, private sector and civil society); Secretariat chaired by a Director appointed by President; 9 Provincial Officers; 70 District Technical Committees; 210 Constituency AIDS Control Committees.	Director of the NACC Secretariat chairs the Inter-agency Coordinating Committee (ICC) and the CCM; Steering Committee for ICC;CCM - works closely with but has independent functions to ICC	ICC Steering Committee - 17 members (4 DPs, 13 senior gov reps, civil society, and private sector)	NACC - strategic leadership; Secretariat - develops policy & guidelines and coordinates/monitors activities; ICC sets priorities for the national response in consultation with Monitoring & Coordination Groups;
Malawi National AIDS Commission (NAC)	An independent private trust and 'semi-autonomous'; Board (max 11 multi-sector members) and Secretariat; Malawi Partnership Forum (MPF) for HIV and AIDS District AIDS Coordinator (DAC) and Coordinating Committees (DACC)	Good communication between NAC and MoH; The NAC's NAF contributes to SWAp Program of Work; CCM - the Malawi Global Fund Coordinating Mechanism (MGFCC), chaired by the PS/MOH with NAC as secretariat.	pooled donor group - recent GF membership plus wider donor partnership reps. MGFCC - 20 members from gov, civil society, private sector and DPs.	NAC - core coordination functions (planning, expertise, capacity-building, M&E, grants management); Pooled donor group - action/communication forum with NAC and MOH/GOM. Stakeholder oversight of NAC's activities with an advisory role to the Board.

Country	Governance/structure	Coordination	Stakeholders	Function
	Pooled donor group - HIV and AIDS Development Group (HADG) and the MPF			
Mozambique National AIDS Council (CNCS)	Created by Ministerial Decree and located in Office of PM; Board (chaired by PM with MOH as VP) & Exec Secretariat. Board has 13 commissioners representing gov sectors, civil society, NGOs; Flexible 'apparatus' replace standard bureaucracy	SWAp - the main coordination forum for health sector - meets monthly; Partnership Forum; CCM - 2006 its role was folded into PF and health SWAp (whose membership consequently expanded). An example of how to 'rationalise' coordination	On the PF - DPs, civil society 'umbrella' group, chaired by CIDA and UNAIDS, and CNCS Exec Sec participate. Implementing partners (mainly civil society umbrella organisations) and is chaired by CIDA and UNAIDS (Vice Chair), and includes CNCS Exec Sec	CNCS provides leadership and political support for national strategy; Exec Sec has mandate to lead, catalyse, coordinate and monitor. DPs provide technical and financial support; civil society are major implementation partners
Nigeria National Agency for the Control of HIV/AIDS (NACA)	2006 Presidential Bill gives NACA legal authority, independent status;	Bill means coordination relationship now possible between NACA, State, and local levels; Agency Board (16 members) and management committee; CCM - roles of NACA and CCM are separate and do not overlap. NACA has a wider coordination role.	The Board includes MoH, Sec to Minister of Woman Affairs; and reps from two NGO, PLHIV, women and youth.	NACA performs core coordination activities; Board - leadership, facilitate development of partnerships, and funding
Rwanda National AIDS Control Commission (CNLS).	Located in Office of President; President, VP, 6 permanent commissioners; 26 staff Exec Secretariat; Structure replicated at local and district levels	The MOH co-chairs the Health Sector Cluster Group with the Belgian Cooperation and the HIV and AIDS cluster group with USAID; Immature SWAp; CNLS is represented on the	Wide representation (CNLS President reps the church, VP reps NGOs); Umbrella organisation rep on Board of CNLS	In addition to core coordination duties, CNLS has helped est. community umbrella organisations (e.g. Rwandan Network of PLHIV), and set up an umbrella organisation to encourage an AIDS response through private sector and parastatal firms to act as

Country	Governance/structure	Coordination	Stakeholders	Function
		CCM through the Executive Secretary.		coordinating and advocacy bodies.
Tanzania Commission for HIV/AIDS (TACAID)	Legal mandate to provide coordination for a multi-sectoral response, and located in Office of PM; Board of Commissioners comprised of 10 non-technical members; TACAID Secretariat of 30 staff Board headed by Exec Chair (who is also head of Secretariat - quicker response but raises Qs of accountability & transparency); TACAID uses Multi-sectoral AIDS Councils (MACS) to coordinate at local & district level; NGO-managed (CARE, AMREF) Technical Facilitating Agencies (TFAs) assist Local Gov Agencies (LGA) to strengthen their coordination capacity	In 2005, GOT combined CCM and existing national coordinating mechanisms into one - the Tanzania National Coordinating Mechanism (TNCM) Development Partners Group is main DPs forum - it has a sub-group for HIV/AIDS	TNCM - Chaired by the PS of the Prime Minister's Office; representatives include MOH & MOF, OOP, DPs, civil society, PLHIV, & private sector.	TACAID - implementation and steering functions; implements and manages TNCM
Uganda AIDS Commission (UAC)	Est by Parliamentary Statute, Commission; Secretariat appointed by President. UAC and its partners	The Uganda HIV and AIDS Partnership, established in 2002 as a UAC led multi-sectoral coordination mechanism, plays a central role. It has a Partnership Committee, a Partnership Forum and a	UAC is governed by a Commission of 10 members from gov, NGOs, & PLHIV. The Partnership comprises of 12 Self Coordinating Entities (SCEs) which has good representation (gov ministries,	UAC - core coordination activities: policy formulation, planning, M&E, mobilise resources, foster partnership relationships. UAC does NOT implement policy

Country	Governance/structure	Coordination	Stakeholders	Function
	established the HIV and AIDS Partnership in 2002 as a participatory and innovative multi-sectoral coordination mechanism. Coordination initiated by UAC is discussed through Technical Working Groups (TWGs) or established Subcommittees of the Partnership Committee.	Partnership Fund. The Greater Involvement of People Living with HIV and AIDS (GIPA) is one of the Partnership's major guiding principles. The National Coordinating Committee (NCC) of the GFATM fulfils the role of the CCM.	Parliament, local and district level partners, DPs, civil society including PLHIVs, the private sector and academia. NCC membership includes a similarly wide range of stakeholders.	

ANNEX D: PROCESSES, PROGRESS, AND RECOMMENDATIONS FOR FURTHER COORDINATION OF THE NATIONAL RESPONSE

Country	Coordination processes, mechanisms & documents - Sept 07	Progress towards further coordination mid - 2008	Recommendations for more effective coordination
Burundi	• Joint health sector review in Oct 07; • First health SWAp in development; • Sector coordination group (CPSD) established March 07; • NHDP 2006-10 and plan of action (2007-09) adopted; • MOU signed in Nov 2007.	• Mid-Term Expenditure Framework initiated; • Partnership framework for accelerated implementation of the NHP signed in February; • National Health Accounts development in final stage of development.	• Additional resources required to strengthen the CPSD.
Cambodia	• OECD/DAC pilot country implementing a Government Action Plan on Harmonization, Alignment and Results (HAR) • Established a high level Government-Donor Coordination Committee; • Replaced existing coordination mechanisms, at the sectoral level, with joint-donor TWGH.	• Health Sector Plan (HSP2) for the period 2008-15 being developed; • Health Sector Support Program 2 between DPs and MOH signed 17th July; • IHP related issues – including coordination of national response – discussed in Health TWG, Health Partners meeting, and Government-Donor Joint Technical Working Group on AIS.	• Encourage global health partnerships to engage more fully in country-level discussion; • Develop in-depth dialogue among DPs to support implementation of the HSP on subject areas agreed with MOH; • Use available resources to support tracking and coordination of activities; • Improve liaison between MOH and DPs, and among DPs; • Work towards implementing draft work plan outlining key coordination activities
Ethiopia	• A National Strategic Plan for poverty reduction (PASDEP) 2005-2010 geared towards reaching the MDGs. • The health chapter of PASDEP constituted the third Health Sector Development Plan (HSDP III).	• Well consulted and agreed HSDP III • Code of Conduct • Country Compact signed 27th Aug 2008.	• Meaningful CSO involvement in coordinating the implementation of the Country Compact will be essential to its success.
Kenya	• Strong MoU in place between MOH, MOF and most development partners; • Code of Conduct in place that contains many elements of a Compact; • NHSSPII, 2005-10.	• Ministry of Health re-constituted; • Development partners, and the private sector, are part of the Health Sector Coordinating Committee;	• Health Sector Coordinating Committee should ensure IHP is on the agenda for discussion at meetings; Important for the two health ministers to work closely together and avoid duplicating

Country	Coordination processes, mechanisms & documents - Sept 07	Progress towards further coordination mid - 2008	Recommendations for more effective coordination
			structures at local/district levels
Mali	• Mali's health sector has a 10 year social and health development plan	• PRODESS extended to 2011.	• N/A
Mozambique	• A mature SWAP in place; • Five Year Government Plan (2005 – 2009); • MOH developed Health Sector Strategic Plan for period 2007-2012)	• Meeting of SWAP DPs on the 8th of July with discussion of Compact/Health Strategic Plan and scale up on MDGs.	• Encourage dialogue between DPs and MOH through the Performance Assessment Framework currently being developed.
Nepal	• MOHP and DPs jointly formulated NHSP-IP for 2004-09; • MOHP and DPs agreed to work together under a shared vision and on agreed upon priorities;	• All DPs have signed up to health sector reform under government leadership; • Monthly health partners' forum	• Develop a mechanism and/or forum that will facilitate dialogue between civil society, private sector, MOH, and other development partners by, for example, expansion of Health Sector Development Partners Forum (HSDPF); • Incorporate civil society and private sector into the HSDPF; • Strengthen channels of communication between global level and in-country development partner reps and MOH. •
Zambia	• Vision 203, the Fifth National Development Plan (2006-2010); • National Health Strategic Plan (2006-2010); • A mature SWAP with well established structures and tools for SWAp management and Coordination (TWGH, MOH, PCC);	• Implementing its 3rd Health Sector Programme • Strong coordination mechanism and performance monitoring system • Annual Joint Sector Review • Review of MOU to identify weaknesses and gaps	• Foster further engagement and dialogue, towards understanding the factors that contribute to parallel behaviour towards in-country systems and processes by Cooperating Partners; • Equip MOH to lead, coordinate, M&E the DPs health sector response with a skill set of personnel able to manage outside their usual environment, and sufficient financial resources.

ANNEX E: TERMS OF REFERENCE

International Health Partnership and Related Initiatives (IHP+) Country Health Sector Teams: Background Literature Review

Background

The International Health Partnership and related initiatives (IHP+) has been developed to coordinate development assistance and increase investments in national health plans. The work is country driven, and country compacts are a critical feature of the International Health Partnership. Country health sector teams are of central importance to the development and implementation of agreements in country compacts. WHO has contracted a consultant to lead work to understand better the existing good practice in the work of country health sector teams, and to identify opportunities for disseminating good practice, and improving the effectiveness of country health sector teams.

These terms of reference are for literature reviews to underpin and support this work.

Deliverables

The deliverable of this consultancy is a report with four parts to it:

1. A summary of the current arrangements for country health sector teams in countries working on the IHP+ (i.e. who is on them, how they work, what sub-groups exist etc).
2. A summary of existing good practice and different aspects of effective national coordination in health and HIV/AIDS, including the positive experiences of civil society engagement. This should include role, composition, responsibilities, organizational structure and legal status of relevant existing coordination bodies.
3. A summary of the different tools and mechanisms (with examples) that currently exist to promote more effective coordination. This can include codes of conduct, memorandum of understanding, legal agreements etc.
4. A summary of the issues and obstacles to country health sector team members meeting their commitments as members of country health sector teams, and examples of effective measures taken to improve harmonization and alignment.

Country health sector teams are a new term. For the purpose of this work we are interested in teams, working groups, committees and coordinating bodies that function at the country level and bring together different sectors to work jointly on health or HIV/AIDS. These include government, WHO, World Bank, and UN country teams, bilateral development partners, civil society, private sector, and development partners with no country presence (e.g. GFATM and GAVI).

The sections in the report will inform consultation documents and be available as background documents for consultation with country health sector teams on current best practice and options for improving their effectiveness.

Methodology

The work should be drawn from a review of existing literature which should be fully referenced. Material on the following is a guide and is not comprehensive:

- IHP+ country stock taking reports (especially for deliverable 1)
- Reports on Global Fund to fight AIDS, TB and Malaria Country Coordinating Mechanisms

- Reports on UN reform, one UN, and moves to improve harmonization and alignment in UN support to countries
- Reports on the GAVI country teams (inter-agency coordination committee (ICC) or national health sector coordination body for health systems strengthening (HSS))
- Reports on coordination mechanisms in Sector Wide Approaches
- Reports on coordination mechanisms from other sectors (e.g. education, humanitarian responses, peace-keeping, UN reform pilots)
- Reports on National AIDS Councils
- Donor, international and multilateral agency reports on country coordination, alignment and harmonization in the health sector

Timeframe

The reports will be used to inform consultation documents and will be available as background material.

A total of 20 consultant days is allocated for this work.

The final report should be delivered by September 19. Sections 1, 2 and 3 should be delivered by September 9.

27 August 2008