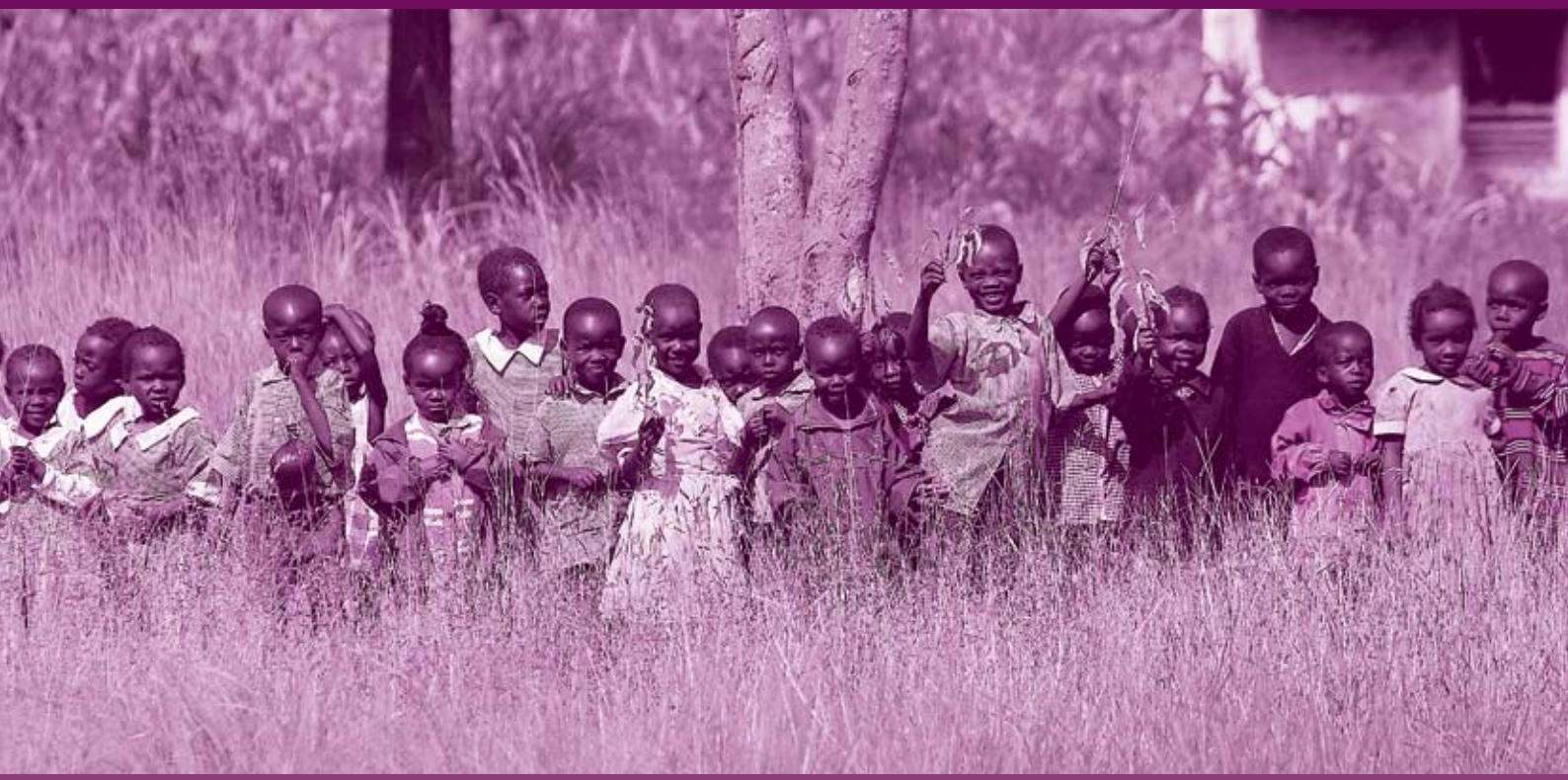
THE GLOBAL FUND IMPLEMENTER SERIES

COUNTRY COORDINATING MECHANISMS
HARMONIZATION AND ALIGNMENT



Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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List of terms and abbreviations

CCC	Country Coordinating Committee
CCM	Country Coordinating Mechanism
CNCS	National AIDS Council (Mozambique)
DFID	Department for International Development (UK)
EC	European Commission
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
JICA	Japan International Cooperation Agency
LFA	Local Fund Agent
M&E	monitoring and evaluation
MoH	Ministry of Health
NACA	National Action Committee on AIDS
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PMI	President's Malaria Initiative
SWAp	Sector Wide Approach
SWiM	Sector Wide Management
TACAIDS	Tanzania Commission for AIDS
TMAP	Tanzania Multisectoral AIDS Program
TNCM	Tanzania National Coordinating Mechanism
TB	tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

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To examine the extent to which Global Fund-supported activities and inputs were harmonized and aligned with those of other partners and in support of national objectives, systems and processes, case studies were conducted in **Cambodia**, **Mozambique**, **Nigeria**, and **Tanzania**.

Country Coordinating Mechanisms

Prior to the Global Fund, few countries had structures geared to coordinating responses across the three diseases. While most countries had National AIDS Committees, these were AIDS-focused, and lacked broad stakeholder involvement as well as proposal development expertise. For these and other reasons, including a lack of faith in the capacity of pre-existing structures and misconceptions that separate entities were a stipulation of the Global Fund (**Mozambique**), Country Coordinating Mechanisms (CCMs) were formed in each case. The CCMs of **Cambodia**, **Nigeria** and **Mozambique** were more typically established to deal exclusively with Global Fund grants. **Tanzania's** CCM was, however, directed to coordinate all national responses to the three diseases - encompassing Global Fund investments as well as those of other partners; this CCM was subsequently also tasked with responsibilities for other epidemics. Over time, **Mozambique's** CCM functions had largely been absorbed within the health sector-wide approach (SWAp) such that it no longer dealt with coordination, management and monitoring, and only met for outstanding matters, such as proposal development and grant negotiations. Alignment in this instance was felt to have gone as far as it could.

National Planning

Despite additional financing provided by the Global Fund, the strategic plans and programs of these countries were far from fully financed, such that fragmented implementation continued to present difficulties. While Global Fund proposals were perceived as broadly consistent with national strategic and program plans for the three diseases and, therefore, aligned with national objectives, there were difficulties with aligning implementation with national plans and cycles. Reasons included a lack of predictability of the sums and timings of Global Fund disbursements, which were attributed in part to the Global Fund's performance-based funding model. Furthermore, as countries managed greater numbers of Global Fund grants, the difficulty of aligning multiple plans increased, making it harder to work toward integration aims. Grant consolidation plans for the future were expected to ease some of these challenges.

Key stakeholders relevant to HIV/AIDS, tuberculosis (TB), and malaria were generally included as members of CCMs. This provided, in theory, opportunities for harmonization and integration. However, the country studies did not indicate that Global Fund investments had contributed

to integrating responses to the three diseases or suggest that this was either expected or desired.

Financial Arrangements

In **Cambodia**, cooperation between donors for sector-wide management of health had reduced the administrative burden on government and yet, donors continued to finance separate elements of the strategic framework. **Mozambique's** SWAp had resulted in donors channeling finances through the government's Health Sector Common Fund and the HIV/AIDS Common Fund; the Global Fund's participation in the scheme was welcomed and was reported to have encouraged the World Bank to follow suit. In **Nigeria**, where SWAps were not used, some donors pooled contributions while others did not. **Tanzania's** health sector employed a SWAp; however, the case study did not detail reports on the financing arrangements. The more demanding requirements of the Global Fund's performance-based funding model were generally reported to have hindered participation in pooled financing schemes. There were no signs that the performance-based model might be adopted by others.

Procurement

In most instances, finances were channeled through pre-existing systems for procurement, although there were exceptions. **Cambodia's** CCM had developed its own system. And while **Nigeria's** CCM mostly used established systems, independent agents were used for international procurement and commodity distribution within the country. In **Tanzania**, separate systems were established to organize procurement for NGOs. The rationale for alternative approaches generally stemmed from the perceived weaknesses of existing systems. However, there were no indications that newly established mechanisms were intended to be temporary or that plans were being considered to invest in and strengthen national systems.

Monitoring and Evaluation

National monitoring and evaluation (M&E) systems were used to some extent in all countries with the exception of **Cambodia**. The **Cambodia** CCM established its own M&E system for reasons of preference and necessity; while outcome indicators were common to all programs, process indicators for the Global Fund were distinct. In **Tanzania**, the CCM largely relied on national M&E systems, but was also establishing a separate facility to capture information required uniquely for Global Fund grants. Evidence of alignment emerged from **Nigeria**, where M&E systems, formats and synchronicity of reports for the Global Fund and other partners had been streamlined. **Mozambique** was also working to harmonize disparate requirements and a new list of health sector indicators was being developed to serve all parties.

The preliminary findings of the case studies suggest that the scope for harmonization and alignment may be greater in recipient countries with SWAps. Active involvement of Global Fund representatives, in terms of participating in and supporting SWAps as they develop, may be important to facilitate progress. The CCM in **Mozambique** represented the most progressive attempt at alignment to date. This experience is, therefore, particularly worthy of being closely followed. More generally, participants confirmed the need to track progress with harmonization and alignment toward sharing lessons learned and promoting the best outcomes.


Red Storm Rising
J. Rommel THE DESERT FOX
Social Psychology
STATISTICS

Harmonizing and aligning health investments is a challenge that predates the Global Fund. Countries supported by the Global Fund tend to share similar constraints: insufficient and unpredictable financial resources; fragile infrastructure and shortages of human and other resources. These factors – combined with the demands of managing multiple vertical programs – result in considerable difficulties for all concerned.

As piecemeal and short-term planning can lead to inefficiencies and undermine efforts toward sustainable development, the Global Fund has been advocating that opportunities be taken to complement national programs and strengthen health systems. It was understood that its substantial new finances could affect national processes and systems in a variety of direct and indirect ways. Case studies were conducted to examine the extent to which the Global Fund contributed to harmonized/aligned systems and processes, and the challenges faced therein.

Study Design and Methodology

This is one in a series of eight reports which examine the different aspects of the work of CCMs.

In summary, four country case studies were conducted by independent consultants to cover experience in **Cambodia**, **Mozambique**, **Nigeria** and **Tanzania**. In each case, following a desk review of relevant documents, consultants visited countries between September and October 2007 to interview CCM members and other stakeholders. A total of ten to twelve days (five to seven in country) was dedicated to each investigation.

Following a review of the composition and history of the CCMs, an account was taken of coordination systems and structures for the health sector as well as for HIV/AIDS, TB and malaria prior to the establishment of the Global Fund. The position and relationships of the CCM with respect to these entities was examined – particularly in relation to conducting national gap analyses and developing proposal plans.

The extent to which donors - including the Global Fund - worked together to coordinate inputs and invest in national systems and SWAps was also investigated. Areas of focus included pooled financing, use of national procurement systems and processes for M&E. Wherever challenges were mentioned, or recommendations emerged, these were documented.

In the context of this report, and in line with the Paris Declaration,[2] "harmonization" refers to a broad range of efforts, including seeking common arrangements, simplification of procedures, more effective division of labor and sharing analyses and information between development partners. "Alignment" refers to instances where development partners align their own strategies and policies with the recipient country's agenda, strategies, institutions and procedures and use and improve the recipient government's systems, thereby "*strengthening the partner country's sustainable capacity to develop, implement and account for its policies to its citizens and parliament.*"

[1] The Global Fund commissioned case studies, in six regions, 19 countries, across eight themes.
[2] The Paris Declaration, endorsed on 2 March 2005, is an international agreement in which more than 100 ministries, heads of agencies and senior officials, committed to actions and indicators to increase efforts in harmonization and alignment and managing aid for results. The Global Fund is a co-signatory to this declaration.

CAMBODIA

Background

Following years of upheaval during the 1970s and 1980s, **Cambodia's** efforts in the health sector were necessarily focused on reconstruction. By 1996, with relative political stability and donor support, planning began with the fundamental steps of dividing up the country into administrative units. Besides the regular development challenges, difficulties were faced due to the exodus of skilled health personnel during the former Khmer Rouge period. This made development efforts in **Cambodia** particularly dependent on external technical assistance.

Similar to many other countries, **Cambodia's** disease programs were (and remain) largely organized along vertical lines. Prior to the Global Fund, the National AIDS Authority brought together 12 ministries to coordinate the intersectoral response. The National TB Program was coordinated by the National Center for Tuberculosis and Leprosy Control, while the National Malaria Program was implemented by the National Center for Malaria. A technical group for health supported policy and program development in the broader health sector, while technical sub-groups for HIV/AIDS, malaria, and TB performed similar functions for the disease-specific programs. These technical groups included key donors that contributed to each programming area and were largely independent of one another. The only area of operational harmonization lay in linkages between laboratory services for HIV and TB. In recent years, the number of national NGOs working in the health sector had grown rapidly and largely as a result of donor support.

Country Coordinating Mechanisms

The CCM in **Cambodia**, known as the Country Coordinating Committee (CCC), was established to exclusively cater to Global Fund grants. Because of its large membership (29 members), a further sub-committee – the CCC Sub-Committee (13 members) – was formed. This sub-committee was constituted of the most influential members of the CCM and was reported to function as a technical working group to support CCM decision-making. The CCM was reported to liaise well with the national bodies for TB and malaria programs. The national technical working group on HIV provided inputs to and coordinated with the CCM. However, coordination of HIV/AIDS work between the CCM, the National AIDS Authority, and the National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases was said by some to be confused.

National Planning

Apart from Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ), which financed the CCM Secretariat, most major health sector donors (Japan International Cooperation Agency (JICA), European Commission (EC), the World Bank, the UK Department for International Development (DFID), the United States

Agency for International Development (USAID) and the French Embassy were represented on the CCM. These donors were closely involved in conducting the health sector review which led to the current health sector strategy and plan. Perhaps due in part to consistent donor involvement, Global Fund-supported programs were said to have been developed based on national objectives and plans for the three diseases. That said, it was noted that there was potential for overlap of Global Fund programs with those supported by USAID in certain provinces. Of greater concern, were reports that Global Fund programs may have undermined the Cambodian Equity Fund's efforts to provide comprehensive services for HIV/AIDS, TB and malaria in some referral hospitals. Further details were not provided; nevertheless, the suggestion appeared to be that the integration of Global Fund programs with other initiatives could have been better.

Financing Arrangements

The latest health sector strategic plan 2003-2007 adopted a sector-wide management approach (SWiM). As part of the arrangements, most multilateral and bilateral finances were channeled through the Ministry of Health. While the SWiM required donors to work under a common strategic framework and with mutually agreed management agreements, donors neither pooled funds nor contributed to common project implementation arrangements. Instead, the majority of donor finances were tied to project-based support. Consequently, the government's administrative burden to liaise with, and report to donors, remained considerable.

Procurement

Cambodia's national procurement system was spearheaded by the World Bank and the Asian Development Bank. This system was, however, perceived as inadequate for Global Fund-supported programs. The Ministry of Health's Under Secretary of Health, (and the CCM as a result), established a parallel system involving 26 people, including three international technical staff. While this new system had accelerated progress, there were no indications that the arrangement was temporary or that there were plans to improve the national procurement system so that it could be used in the future.

Monitoring and Evaluation

Cambodia's M&E system included outcome indicators which were used by all programs. However, the distinct process indicators for Global Fund grants led to the development of additional systems. There was no mention of plans to consolidate the two.

A review of national health programs in 2006 – including, but also going beyond Global Fund investments – marked the first multi-stakeholder approach to program evaluation, such that those involved in supporting or implementing separate programs came together to review one another's efforts. This was stated to have contributed to increased mutual accountability.

Challenges

Separate funding channels and vertical programming were reported to be major barriers to coordination.

MOZAMBIQUE

Background

Prior to the inception of the Global Fund, considerable efforts had been made towards a SWAp for health policy and programming. Various committees and partner forums were initiated to advance harmonization and alignment efforts.

Historically, the National Health Directorate (MISAU), had coordinated efforts in the health sector and for the three diseases. While it was not clear if the two were related, following the introduction of Global Fund-supported programs, this Directorate was split into two bodies, the Directorate for Health Promotion and Disease Control (which covers the three diseases), and the Directorate for Curative Services.

The Department for Endemics and Epidemiology was also responsible for managing communicable diseases including HIV/AIDS, TB, and malaria. This Department had program managers for each of these diseases. The National AIDS Council (CNCS) led the multisectoral HIV/AIDS SWAp at the national level, while its representatives coordinated interventions at the provincial level. The report did not provide further information as to the division of labor, and/or any problems with these multiple arrangements.

Country Coordinating Mechanisms

At the time when **Mozambique** first applied for Global Fund support, applicants were under the impression that the Global Fund required a newly constituted and separate CCM dedicated exclusively to managing its grants. This contributed to establishing a CCM independent of national bodies and processes. It was subsequently clarified that **Mozambique** had the flexibility to change the arrangement to better suit its needs.

By 2004, **Mozambique** had made considerable progress with the health sector SWAp and the multisectoral SWAp for HIV/AIDS; donors financed the common funds for the health sector and HIV/AIDS. It was at this juncture that CCM members and partners felt that the CCM should no longer function in isolation. Work toward a plan to identify existing bodies and systems that could take over the CCM's functions began. In 2006, this plan was finalized and approved.

The coordination, management, and oversight functions of the CCM were integrated into the SWAps. The CCM still existed, but with a much lighter remit than before, convening for less-frequent events such as developing Global Fund proposals, handling the review process, and resolving grant-related issues. In part, this transition was achieved by securing the participation of CCM constituencies within national coordination bodies for health and HIV/AIDS. For instance, non-government representatives were made official members of national coordination bodies. Those interviewed felt that the process of harmonizing and aligning CCM functions had gone as far as it could.

National Planning

Global Fund activities were reported to be consistent with strategies for the health sector (2001-2010), TB (2008-2012), and malaria (2006-2009). The process for applying for Global Fund support, the lengthy documentation and the unpredictability of the outcome, coupled with requirements for information were said to hamper efforts in coordinating planning. In 2007, following a delay in disbursements, (only a fraction of the anticipated US$ 50 million was forthcoming), health programs faced disruptions to implementation. By December 2008, the situation had been rectified, with the Global Fund having disbursed more than US$ 40 million to the Ministry of Health. There were conflicting reports as to whether this delay had or had not led to a formal request to the Global Fund to simplify its procedures. Nevertheless, it was noted that there were similar disbursement delays from other development partners in 2007, including the lead donor of the health SWAp, the EC. Part of the difficulty, as far as the Global Fund was concerned, lay in the Ministry of Health (MoH) not processing a disbursement request, without which the Global Fund could not release funds. The situation was reported to have since improved with greater attention to procedures and follow-up on all sides.

Financing Arrangements

A group of 19 donors and the government, referred to as the Progam Aid Program, created an agreement to conduct joint reviews to assess progress toward the national poverty reduction strategy. This agreement included promoting the use of country systems and providing financial support through a general budget.

The Global Fund participated fully in both Common Funds – PROSAUDE (Ministry of Health) and the National AIDS Council. The Global Fund utilized country-owned accounting systems, despite the fact that these were stated to be sub-optimal and awaiting improvement. The Global Fund continued to require – as it does for all countries – the PR to send data on utilization of financial resources to accompany each disbursement request. The Global Fund's participation in this finance mechanism was viewed positively. Indeed, this step was said to have motivated the World Bank to follow suit.

During a meeting in Namibia in 2007, CCM members learned that the Global Fund also contributed to pooled funds in Malawi. This led to a provisional agreement between CCM members in **Mozambique** and Malawi to work toward a “lessons learned” document, and to request the Global Fund to provide guidelines for such situations. However, at the time of the study, there was no evidence of follow-up by the CCMs or by Global Fund Secretariat staff.

Procurement

Programs supported by the Global Fund were deemed to be fully aligned with national systems; all purchasing occurred through the mechanisms used by the MoH and the National AIDS Council.

Monitoring and Evaluation

The MoH and the NAC produce M&E data and reports in various areas which donors utilize to assess programmatic performance over a period of time. A Common Annual Review is conducted once a year (with a lighter mid-review process halfway through the year), with the participation of the Global Fund. As part of the common review process in 2008, the Global Fund (via the Local Fund Agent, or LFA) was responsible for undertaking an on-site data verification exercise of some key indicators on behalf of the Ministry of Health and all development partners.

In response to problems which remained unclear but which were reported to be due to Global Fund requirements for information on programmatic performance and system difficulties with the same, the CCM wrote in November 2006:

"*It is recommended that the Global Fund further aligns its procedures with the existing structures in* ***Mozambique*** *and fully adheres to the Memorandum of Understanding by respecting and accepting the monitoring mechanism agreed for the Health and HIV/AIDS Sectors, and by avoiding requests for additional information about the performance of these Sectors.*"[3]

While the sequence of events was unclear - and possibly unrelated - the Global Fund, in collaboration with other development partners, created a single list of health sector-specific indicators to be used by all parties in monitoring performance.

Challenges

Some believed that the disbursement delays which occurred in 2007 were not solely a result of insufficient progress toward meeting targets, but also due to high staff turnover at the Global Fund Secretariat. The insufficient briefing of new Fund Portfolio Managers was said to have undermined progress.

An experiment whereby the in-country DFID representative represented the Global Fund was met with mixed feelings. Some felt that a still-greater Global Fund presence was required in country to articulate policy positions. Delays in clarifying matters of strategic importance were felt to have contributed to the aforementioned interruptions in disbursement, as well as to have hampered progress with harmonization and alignment.

NIGERIA

Background

Constitutionally, the local government is responsible for primary health care; the state government is responsible for secondary levels of care and provision of technical guidance, while the federal government is responsible for tertiary levels of care, policy formulation and technical guidance to the state level. At the time of this report, **Nigeria** had not engaged in a SWAp for health.

The HIV/AIDS, TB and malaria programs each had specific institutional frameworks and structures. HIV/AIDS was organized within the National Agency for the Control of AIDS, while TB and malaria remained within the Public Health Department of the Federal Ministry of Health.

The Country Coordinating Mechanisms

The CCM was established as a "stand alone" body to focus entirely on Global Fund grants. The CCM was reported to have established linkages with the Office of the President for Millennium Development Goals, the National Tuberculosis and Leprosy Control Program, the National Primary Health Care Development Agency, the National Workplace Policy and Program in the Federal Ministry of Labor, the Federal Ministry of Finance, as well as others. The basis of these collaborations and the outcomes, however, were not made clear.

Initially, the CCM was dysfunctional, with a large and unwieldy membership, many committees and a lack of clarity as to its functions. The CCM, therefore, ran into problems exercising normative functions, getting collaboration from development partners and local bodies and made no progress toward the larger aspirations of harmonization and alignment. The difficulties were such that all of the first grants fell considerably short of meeting their

[3] The CCM in correspondence related to the Request for Continued Funding (the Phase 2 of Round 2 requests) to MISAU, Nov 2006.

targets and were threatened with cancellation. This crisis contributed to extensive reforms and technical assistance, following which the CCM assumed its role.

National Planning

A health sector gap analysis was conducted at the national level by a technical committee headed by the World Health Organization (WHO). Study participants said that the presence of development partners on the CCM led to synergies in developing national strategies and plans for health. The HIV/AIDS response was led by the National Action Committee on AIDS (NACA). NACA, as well as the technical working groups of the malaria and TB programs, worked closely with the CCM at the time of Global Fund proposal development to align responses.

Donors collaborated over apportioning responsibilities and demarcating geographical areas for interventions among themselves. However, references were still made to programming and stakeholders operating independently, in a "piecemeal" manner, without coordination and with occasional duplication of effort.

Financing Arrangements

Donors had formed a "Donor Partnership Group" which included donor partners as well as the UN system. Some donors had pooled their contributions and others had indicated their readiness to do the same; the participation of the Global Fund in this regard was not made clear.

Procurement

Programs supported by the Global Fund largely used national procurement systems. International procurement went through the same agents used by government (Crown Agents and IDA). Once products were purchased, they were stored within government central medical stores. Other agencies, including the Christian Health Association, assisted with distributing products within the country. It was not clear whether the involvement of additional groups was necessary to increase absorptive capacity or represented a lack of faith in existing distribution systems.

Monitoring and Evaluation

Collaboration between development partners resulted in a national M&E plan for HIV/AIDS. This prompted memoranda of understanding between NACA, development partners and civil society organizations to collaborate on harmonizing and aligning activities related to HIV/AIDS. This M&E plan was also used by the Global Fund. A common malaria M&E plan was in place, and deliberations on a single TB M&E plan were said to be ongoing. Furthermore, donors participated in joint reviews of progress with Global Fund grants by virtue of their membership on the CCM.

Reporting formats and timings were streamlined with no duplication of requests for information by national or development partners. However, difficulties with obtaining reliable data were mentioned alongside shortages of manpower and skills, throwing the quality of the resulting data into question. A working group of the oversight committee of the CCM was reported to be directly involved with building capacity through providing technical assistance and material resources. Tracking tools or automated "dashboards" to indicate progress toward indicators were also being developed.

Challenges

Difficulties with aligning finances and programming had occurred due to a lack of synchronicity with the budgeting cycles of donor governments. However, development partners were working on a strategy to overcome the problems. There was no specific mention of the Global Fund in this regard. The major obstacle to harmonization and alignment was felt by some study participants to lie in weaknesses in communication between the PRs and the CCM, such that the CCM's ability to be informed was jeopardized.

TANZANIA

Background

Before the 1990s, the relationship between the Tanzanian government and development partners had soured, partly due to reforms demanded by donors and international financial institutions. It was reported that donors felt that the government was not delivering, while the government perception was that donors were interfering too much in their policies. This situation improved after 1995

under President Mkapa, leading to an environment that encouraged partners to explore ways of harmonizing and aligning investments. Concrete steps were made, including various agreements and strategies to restore local ownership of aid and to promote local leadership in designing and executing programs. The development partners also formed a consortium (Development Partners Group) to engage with government through a single channel and with "one voice". SWAps had also been initiated in various sectors, including health, to promote public/private partnerships in development.

Various structures were responsible for overseeing health programming. TB and malaria programs were administered by overseeing bodies within the Ministry of Health; while the multisectoral HIV/AIDS response was coordinated by the **Tanzania** Commission for AIDS (TACAIDS). Other than the SWAp, there were no formal systems to interface between these diseases and minimal involvement of non-government partners in the response to malaria and TB.

Country Coordinating Mechanisms

The CCM in **Tanzania**, the Tanzanian National Coordinating Mechanism (TNCM), was mandated to oversee coordination of all programming for the three diseases. Its remit, therefore, extended beyond Global Fund investments to include other initiatives (e.g., the President's Emergency Plan for AIDS Relief (PEPFAR), the Presidential Malaria Initiative (PMI) and the **Tanzania** Multisectoral AIDS Program (TMAP). At a later date, this CCM was also tasked with coordinating the response to other epidemics. The TNCM guidelines encompassed responsibilities for coordination across public and private sectors; civil society organizations; bilateral and multilateral agencies; harmonization of the Global Fund, PEPFAR, PMI and TMAP, among other programs; and to ensure that Global Fund-supported programs were captured in the Mid-Term Evaluation Framework.

Overlap between the functions of the CCM and other bodies was reported to be minimal, while the linkages between other national bodies that work on HIV/AIDS, and the health SWAp were stated as being particularly good.

National Planning

Tanzania had adopted a SWAp for planning. Prior to the Global Fund, national strategies for HIV/AIDS, TB, and malaria existed and formed the key references to guide nationwide programs. TB and malaria programs were largely vertical and there was little programming coordination between the three diseases.

Despite the CCM's mandate to coordinate nationwide programming for the three diseases, there was no evidence of joint planning between programs supported by the Global Fund, PEPFAR, PMI and TMAP, or with efforts to capture Global Fund grants in the evaluation framework. However, information sharing had improved through the concurrent presence of key stakeholders as members on the CCM and on coordinating bodies for health and the three diseases. An instance of successful harmonization was reported: following joint deliberations, the former policy of subsidized insecticide-treated bed nets was changed in favor of free distribution. Upon agreement, the new policy was adopted by all relevant parties.

Financial Arrangements

An independent monitoring group comprised of development partners and the government was established to assess progress in harmonization and alignment of aid. Development partners also formed a consortium called the Development Partners Group to engage with government through a single channel. This group worked with the CCM and the health SWAp. However, parallel funding and project implementation was still said to be the norm.

Procurement

The Ministry of Finance, one of the PRs, used national procurement systems, while the non-government PRs used systems outside the public sector. Although the NGO arrangement undoubtedly constituted a parallel system to the one already in place, it was felt that this helped increase absorptive capacity and, therefore, accelerated program implementation. Indeed, the non-

government PRs were reported to have a considerably better performance record than the government PRs. Furthermore, most CCM members interviewed stated that government systems did not lend themselves to efficient management of non-government actors. An additional outcome of the new system stemmed from the fact that prior to its formation, the national procurement system was viewed as a “closed shop”. The involvement of new actors and systems was felt to have led to greater accountability in procurement.

Monitoring and Evaluation

The Global Fund relied upon existing M&E systems for reporting. However, study participants said this approach was weak and in need of strengthening. The CCM was in the process of developing an automated tool, referred to as the “Executive Dashboard”, to capture information required for Global Fund grants. There were no indications of expanding this tool to accommodate information on programs funded by other development partners.

A joint review for HIV and AIDS programs took place in 2006. While this collaboration was considered to represent progress in harmonizing efforts towards M&E, it was pointed out that the CCM had yet to develop guidelines for systematic reviews or for identifying gaps.

Challenges

Study participants felt that weaknesses in the CCM's capacity limited progress in harmonization and alignment of information sharing. It was pointed out that the CCM lacked the ability to conduct analyses to identify areas of overlap or opportunities for linkages and synergies. The CCM's capacity was limited to activities concerning Global Fund grants. It was not yet able to extend to other programs. Consequently, programs and finance arrangements largely remained independent. A further constraint was reported: CCM members from civil society had poor knowledge of national processes and opportunities for efficiencies such that their ability to significantly influence progress toward harmonization and alignment was questioned.

The limitations of time and reliance on interviews for information meant that the case study findings rarely went into depth and often raised more questions than they answered. Given the complexity of the subject, these reports should be considered as preliminary feedback.

Country Coordinating Mechanisms

Few countries had pre-existing structures geared to coordinating responses across the three diseases. While most countries had National AIDS Committees, these were AIDS-focused and tended to lack broad stakeholder involvement and proposal development expertise. For these and other reasons, including lack of faith in the capacity of pre-existing structures, expediency and misconceptions that separate entities were a stipulation of the Global Fund, CCMs were established anew in each case.

To minimize duplication of effort and improve country ownership and alignment, the Paris Declaration discourages creating parallel structures or project implementation units to manage aid-financed projects and programs. These case studies showed interesting results in this regard: while the CCMs in **Cambodia** and **Nigeria** formed linkages with, but otherwise remained independent of, national coordination structures, other CCMs had forged more substantial relationships. The fact that CCMs had taken different paths indicated an appreciation that the responsibility for defining CCM constructs lies with countries. In the instance of **Tanzania**, the CCM was given additional responsibilities, presumably because this CCM was perceived to be functioning well or because there was no other structure better positioned to take on the tasks. The reasons for changes in **Mozambique** were different. Here, and in line with the philosophy that guides the Paris Declaration, it was deemed best to transfer certain functions of the CCM to existing bodies and mechanisms. It is too early to draw conclusions in terms of the benefits of the different arrangements.

National Planning

Despite the new finances provided by the Global Fund, none of the countries had fully financed strategic plans. This resulted in continued difficulties with fragmented programming. Study participants said that Global Fund proposals were broadly consistent with national strategic and program plans for the three diseases. However, it was not possible to tell whether such statements were based on anything beyond a superficial match at the level of shared objectives and targets. Despite the fact that early Global Fund grant cycles were difficult to anticipate and proposals were often rapidly put together, Global Fund applications were considered to be aligned with national objectives. Indeed, any other finding would have represented a serious cause for concern.

Reports of poor communications and coordination between programs for HIV/AIDS, TB, and malaria were common and may be due to many factors. Apart from shared histories of vertical programming, the scope for program intersections and synergies is fairly narrow. It is hard to tell whether

the single reference to a link between the TB and HIV/AIDS programs at laboratory level in **Cambodia** represented a unique example or whether attention to programs was uneven across the case studies. Either way, there was no indication that Global Fund investments had contributed to integrated responses across the three diseases or suggestions that this was either expected or desired. That said, in each of the case studies, communications between stakeholders of the three diseases was reported to have improved by virtue of their membership on CCMs.

Difficulties were expressed, however, in relation to aligning the implementation of Global Fund-supported programs with national plans and cycles. Reasons included a lack of predictability of the sums and timings of Global Fund disbursements which, in turn, were linked to the Global Fund's performance-based financing model. Furthermore, as countries managed greater numbers of Global Fund grants, the difficulty of aligning multiple plans increased, making it harder to work toward integration goals. Increasing predictability of Global Fund cycles as well as grant consolidation steps may ease some of these challenges in the future.

Financial Arrangements

While all countries reported some degree of collaboration between donors to pool funds, the common experience appeared to be tied funding with the usual transaction costs for countries. Some participants voiced support for the performance-based financing model of the Global Fund. This approach was occasionally reported to impede participation in pooled financing schemes. However, there were no indications that the Global Fund was more difficult to work with than other development partners. There were also no indications that donors were attempting to identify and adopt a single standard by which all could operate or, indeed, that countries had uniform aspirations as far as financial arrangements were concerned.

Procurement

Most countries used pre-existing systems for procurement, although there were exceptions. The rationale for alternative approaches was generally based on perceptions of weaknesses of existing systems. However, there were no indications that newly established mechanisms were intended to be temporary, indicating missed opportunities to align investments. The Tanzanian instance, however, whereby a new procurement system was installed to service the non-government sectors, illustrated that having more than one system can allow for valuable in-country comparisons and lead to better outcomes all round. Alignment in this instance may not have been the better option.

Monitoring and Evaluation

With the exception of the CCM in **Cambodia**, national M&E systems were generally used for some data while separate processes were also required to capture information unique to Global Fund grants. There were some indications of CCMs and the Global Fund Secretariat working actively to support harmonization and alignment. The Global Fund Secretariat and **Mozambique** were working on health sector-specific indicators to be used by all parties to monitor the health sector's performance in the future. And in **Nigeria**, CCMs provided technical and material support for M&E systems, including formatting and synchronizing reports for the Global Fund and other partners to streamline processes.

Donors occasionally participated in joint program reviews. These were perceived to be useful and foster a climate of mutual accountability. The ability of CCMs to contribute to national-level diagnosis as well as influence planning appears to depend on many factors including analytic capacity and the ability to sway influence.

These case studies suggest that the scope of CCMs to contribute to harmonization and alignment may depend in part on the existence and degree of advancement of SWAps in recipient countries. The direct involvement of the Global Fund in terms of participating in and supporting SWAps as they develop appears to be important to facilitate progress. It may prove worthwhile for the Global Fund to anticipate closer involvement and policy support for countries using SWAps. Given that the **Mozambique** experience represents the most progressive attempt at alignment, this is particularly worth following closely. More generally, participants confirmed the need to track progress with harmonization and alignment toward sharing lessons learned and promoting the best outcomes.

A number of recommendations for CCMs on how to improve harmonization and alignment emerged from this study, as outlined below:

- Establish guidelines and plans to fast-track implementation of Global Fund grant consolidation.
- Align Global Fund start dates with country planning cycles.
- Explore ways to simplify Global Fund documentation and to examine the possibility of existing national strategy/plan documentation being submitted as proposals in the future.
- Emphasize that countries can establish CCMs as they see fit, as long as they operate within the fundamental principles stated in the CCM guidelines and also meet Global Fund minimum eligibility requirements.
- Train and sensitize CCM members to identify and proactively support country harmonization and alignment needs/plans.
- Establish Global Fund guidelines for countries to identify capacity gaps and use Global Fund finances to strengthen weak national systems.
- Establish Global Fund guidelines and lessons learned toward supporting SWAps and participating in pooled donor financing arrangements

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David J. Winters
CCM Manager

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Chemin de Blandonnet 8
1214 Vernier
Geneva, Switzerland

+ 41 58 791 1700 (phone)
+ 41 58 791 1701 (fax)

www.theglobalfund.org
info@theglobalfund.org

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