Strengthening the National HIV/AIDS/STI/TB Council (NAC) and Supporting Strategic HIV Prevention, Care and Mitigation Activities within the National HIV/AIDS/STI/TB Framework, Zambia (STARZ)

A SYNTHESIS OF INSTITUTIONAL ARRANGEMENTS OF NATIONAL AIDS COMMISSIONS IN AFRICA

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SECTION 1: A SYNTHESIS OF INSTITUTIONAL ARRANGEMENTS OF NATIONAL AIDS COUNCILS/COMMISSIONS IN SEVERAL AFRICAN COUNTRIES

Introduction

This paper presents a synthesis of institutional arrangements and issues currently facing National AIDS Councils/Commissions (NACs) in 2007. In this paper the term National AIDS Council or Commission or NAC is used to describe a stand-alone institution, independent of a government ministry, and usually comprising a governance body (the Board) and an operational body (the Secretariat), which, taken together form the National AIDS Council or Commission (NAC). The paper is based on a process of literature review and informant interviews with agency-based and NAC staff and independent consultants familiar with NAC issues. Common features and emerging themes, identified through analysis of the country-specific data, are described below in relation to NAC institutional set up, structures, financing, and harmonisation and alignment. The paper is accompanied by a summary table (page 14) on institutional set up in all of the countries reviewed plus the remaining SADC countries (20 countries in total), and twelve country annexes. The information contained in the country annexes represents a snap shot of current institutional arrangements and issues as of October 2007. The countries reviewed include: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe. The terms of reference and agreed questions for the review can be found at Annex 1 and 2 respectively. Annex 3 provides a reference list of country, regional and global documents and websites reviewed during the compilation of this paper. Annex 4 contains a list of abbreviations. In addition, and following the drafting of this paper, HLSP has established a resource guide on this topic, details of which can be found at http://www.eldis.org/go/topics/resource-guides/hiv-and-aids/key-issues/national-aids-commissions.

Background to establishment of National AIDS Councils/Commissions

During the early years of the epidemic, national responses were largely driven by Ministries of Health (MOH) which also spearheaded the development of sector responses with other line ministries. However, soaring prevalence rates and international recognition of the multi-sectoral nature of HIV and AIDS called for emergency international and national responses involving the mobilisation of sectors beyond health. Ministries of Health did not have the authority and mandate to direct other ministries involved in the response and in the late 1990s there was generally a move to extract the leadership of the response from MOH and establish stand alone semi-autonomous National AIDS Councils/Commissions tasked with leading and coordinating the national response. The funding conditionality for the World Bank Multi-country AIDS Programme (MAP, established 2000) requiring the establishment of a high level multi-sectoral coordinating body provided a major impetus for the establishment of NACs.

In 2003, the UNAIDS Three Ones Principles—one action framework, one coordinating authority, one monitoring and evaluation system—were identified for concerted AIDS action at country level, including coordination of the HIV and AIDS response. The Principles have endorsed the centrality of the NAC in the national response as the “One national AIDS coordinating authority”. The principles were not presented to countries as prescriptive global blueprints. Early on it was acknowledged that their application should result in adaptations appropriate to each country, and the situations and institutions concerned. The UNAIDS guiding principles recognise there are different ways in which they can be used to bring together self-coordinating entities, partnerships and funding mechanisms for concerted action. This is certainly the case in the twelve countries reviewed, while in all of them the NAC is regarded as the ‘One’ national coordinating authority.

Since the identification of the Three Ones Principles, the environment in which African NACs operate has become increasingly complex and challenging. Scaling up processes to achieve universal access targets to prevention, treatment and care have placed increasing demands on NACs to deliver on their mandates. The importance of partnerships for HIV and AIDS-related action is ever increasing. All countries reviewed have significantly improved access to, and coordination of, financial and other resources, and there is a growing diversity of funding mechanisms and a substantial increase in funding. While extremely positive for national responses, this does increase the scope of work required to ensure effective use of aid and domestic resources for HIV and AIDS. The increased demands on NACs, and their central position in the national response, means that clarity in roles and relationships, and enabling political, legislative, policy and institutional environments, are more important than ever.

The institutional set up of National AIDS Councils/Commissions

Common features

A number of common institutional features have emerged during the process of this review which demonstrate some uniformity in the way NACs have been set up. For example:

- *NACs are young institutions*. Eleven out of twelve of those reviewed are under ten years old. Nine out of twelve have been established since 2000. Lesotho's NAC has only been operating since March 2006.
- *There is a predominant NAC model in place*. The institutional set up of a NAC comprises a governance body or Board of Commissioners—most often referred to as the National AIDS Commission/Council—and an operational Secretariat that supports the Commission.
- *Positioning in wider public administration system.* Most of the NACs reviewed are positioned under the highest political office in the country (nine of twelve), the Office of the President (OoP) or equivalent—a principle agreed by the African Union and endorsed by UNGASS. Reasons given for this positioning include a) enhanced political clout for the NAC; b) NAC neutrality in order to carry out its role of coordinating multiple sectors and ministries and c) demonstration of political commitment.
- *Similar legal frameworks.* All the NACs reviewed have been, or are in the process of being, set up by an Act of Parliament or Presidential Decree. In nine out of twelve cases the NACs have been set up as autonomous or semi-autonomous organisations and several NACs have put in place a flexible apparatus which allows for the contracting of staff at market salaries, breaking away from traditional civil service pay scales.
- *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 "Multisectoral 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.

Despite some commonalities in institutional set up, the country annexes highlight the diversity of approaches being taken up by NACs to adapt their structure and function within the *existing* institutional set up, to better suit their local conditions and strengthen the national response. For example, the NAC in Malawi has recently changed its legal status from a private trust through a new Act of Parliament. The new Act clarifies the NAC's roles, responsibilities and governance arrangements vis-à-vis the newly established Department of HIV and AIDS and Nutrition, which is also under the Office of the President and Cabinet. Kenya's NAC has been undergoing restructuring since an institutional review in 2004 and is in the process of strengthening the governance function of the Board along the lines of a private sector model with Commissioners in possession of requisite skills and competencies.

Emerging themes

A number of key issues regarding the institutional set-up emerged during the course of this review:

Position of NAC under the OoP: No studies have systematically reviewed the impact, or influence, of being positioned under the OoP on the effectiveness of the NAC or the national response. However, evidence from this review suggests that the power, authority and credibility of NACs appear not to be based on their position in the wider system, but are partly dependent on the personalities and relationships between key individuals. These relationships can be politically based and dependent on the prevailing political context. Critical success factors include a) personal commitment and dynamism of senior members of the Secretariat to drive NAC's agenda forward, b) the political connections of the Chair of the Board and, therefore, ability to "get things done" and c) the personal relationship between senior members of the Secretariat and the President or PS in charge (as cited in Tanzania and Rwanda).

Our review found cases where the positioning of the NAC under the OoP has brought benefits and some unintended consequences. For example, in Kenya positioning under the OoP has been cited as important in linking and networking across sectors, and for supporting the recent successes of the mainstreaming agenda. In Mozambique coordination functions have been problematic because of political obstacles caused by an increasingly isolated President who is Chair of the Board of Commissioners.

Similarly, positioning under the MOH has also brought benefits and consequences. It was cited that access to leadership and decision-makers is a key issue and this can vary, regardless of positioning. For example, in Zambia, the NAC falls under the Ministry of Health. The Minister of Health is also the Chairman of the Cabinet Committee on HIV and AIDS and, as such, is regularly called upon by the President to report on issues related to HIV and AIDS.

Legal framework and the institutional set up: NACs derive their authority from their legal framework. Clear institutional arrangements and legal status have emerged as important for NACs to effectively deliver their mandates, including coordination and resource mobilisation. Where institutional arrangements have been confused (e.g. Malawi), or legal status is outdated (e.g. Malawi) or absent (e.g. Nigeria), effective coordination is compromised and making the NAC's role operational has been more problematic. The revisions of the legal mandate in Malawi and the restructuring of the NAC in Kenya demonstrate the need to put in place clear, robust and transparent institutional arrangements, alongside legal status. The NAC in Kenya has re-focused on its role and is demonstrating success in resource mobilisation again.

Paradoxically, the Act of Parliament which sets up the NAC, and provides it with the legitimacy and mandate to operate, can also impose a rigidity that makes it difficult to change the institutional set up. Any major change to the mandate of a NAC involves going back to Parliament and revising or renewing the Act – a cumbersome and lengthy process. Potentially this could have implications for the future when NACs might need to be more flexible with their set up, their mandate and their organisational structures.

Capacity to plan, manage and coordinate HIV and AIDS activities at decentralised levels. All the countries reviewed have identified capacity development requirements at sub-national levels. Capacity constraints have challenged coordination of AIDS activities at sub-national levels. A number of countries (e.g. Kenya and Rwanda) have, or are in the process of, removing the provincial tier of AIDS coordination structures in order to focus more on the community level. However, challenges persist at lower levels. These include: difficulties accessing and spending money for AIDS activities at district levels; lack of clarity on role and decision making structures; limited capacity at all levels to plan, manage and coordinate AIDS activities. There are numerous initiatives to strengthen sub-national capacity to manage AIDS activities such as Tanzania's

"Technical Facilitating Agencies" (TFAs), which are funded by the World Bank and operate at regional level to support Local Government Authorities' (LGAs) capacity to plan and manage HIV and AIDS activities. Funding for the TFAs will cease over the next two years but informants are concerned about whether sufficient capacity will be in place in LGAs for the TFAs to phase out.

Governance, structure and functions of National AIDS Commissions

Common Features

The function and structure of the NAC varies from country to country but there are some commonalities and specific observations across the countries reviewed. These include:

- *Board size and composition:* Typically, a Board of Commissioners is quite large with between 15 and 30 members. Of the countries reviewed Rwanda has the smallest Board with eight members. Commissioners are either elected by their constituencies or, more usually, appointed by government for a fixed term, renewable on the basis of performance. Most Boards are highly representational and include Commissioners drawn from government, faith based organisations, civil society including PLHA and donors. Details on representation criteria were not found by the review team but the dominant notion is that a representative Board ensures greater involvement and mobilisation of selected stakeholders.
- *Frequency of Board meetings*: Boards of Commissioners tend to meet irregularly – quarterly meetings being the exception not the norm (Botswana), with the majority of Boards managing to meet twice a year.
- *Use of advisory coordination mechanisms to inform the Board*: Countries such as Uganda, Kenya and Malawi have set up Partnership Forums or Committees which provide wider stakeholder oversight of the NAC and play an advisory role to the Board, particularly on policy issues.
- *Civil society representation:* It is clear that NACs are committed to ensuring civil society is represented in national and sub-national coordination mechanisms. All the NACs reviewed included civil society representation on Boards and, where they exist, on Partnership Forums / Committees. Civil society is also consistently represented in newer and strengthened coordination structures, for example the Nigerian National Council on AIDS, Kenya's ICC-AIDS, and its new apex Steering Committee, and Uganda's Partnership Committee. However, beyond these structures, the review found it challenging to source information about how NACs are seeking to strengthen civil society representation.
- *Function of NACs*: There is a lack of published documentation that distinguishes the specific functions of the Board vis-à-vis the Secretariat[1], but information on the functions of the NAC as a whole is easily available. NACs are expected to perform a set of "core" functions which 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. These functions 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. In reality many of these functions are undertaken by the Secretariat rather than Board. In

[1] See Tanzania Country Annex which attempts to do this and the Nigeria Country Annex which specifies the respective roles of the Board and the Secretariat as detailed in the new Act of Parliament.

some cases such as Kenya, it is the Secretariat which is mandated to lead on functions traditionally under the auspices of the Board, such as policy development. Notably absent in any NAC documentation on functions is any reference to stated role, interactions and lines of accountability between NACs and Parliamentary Committees on HIV and AIDS. Country level documentation on formalised relationships between NACs and MOHs is also scarce.

- *Grant Management Functions:* Most of the NACs reviewed, including Lesotho, Mozambique, Malawi, Namibia, Kenya, Nigeria, Rwanda and Tanzania are performing grant management functions, often with the help of contracted Fund Management Agencies (Lesotho, Malawi, Kenya and Tanzania, forthcoming Mozambique). Although outside the "core" functions, NACs have been effective in putting in place structures (such as the harmonised PMU for Global Fund and WB MAP funds in Rwanda and under development in Tanzania) and staff to handle grant disbursements. In the case of Mozambique, Malawi and Kenya, these functions are not new but have been part of the history and legacy of NACs and this tradition has endured.
- *Salary independence:* Although details are scarce, NACs are operating a salary structure independent of the civil service in around half of the countries reviewed (Lesotho, Malawi, Kenya, Tanzania, Mozambique, Zambia and some staff in Zimbabwe)[2] enabling greater flexibility in the terms and conditions of recruitment and in incentives to attract the right staff. Despite the departure from civil service pay scales, capacity within the NAC at central level was consistently cited by informants as a constraint.

Emerging Themes

A number of key issues regarding the governance, structure and functions of NACs emerged during the course of this review:

Functionality of Boards of Commissioners: Boards of Commissioners were initially set up for two reasons a) to provide a broad based partnership forum of stakeholders involved in the national response and as an important mechanism for promoting multi-sectoral cooperation and b) to ensure good corporate governance practice, similar to that of a private sector Board which ensures that an organisation operates within its legal mandate and works efficiently towards meeting its objectives. From this review it is clear that Boards are facing challenges in meeting these objectives primarily because performing the dual role of representation and good governance requires different skills sets and different types of representation. The review found that success and effective Board functioning is mainly dependent on personalities rather than any characteristics in their configuration. There is an emerging debate around the value of a separate Board structure with Tanzania considering rationalising NAC structures and merging the Board and the Secretariat function. Malawi also reviewed the Board in conjunction with the drafting of the new Act of Parliament.

A number of issues have been specifically cited:

1. Commissioners are appointed into a role that they may find difficult to fill. For example, many Commissioners are non-technical so leading on and endorsing technical policy decisions is problematic. Many lack financial or accountancy expertise, so leading on governance, transparency and performance issues can also be problematic. This is compounded in cases where there are still conflicts of interest (such as Tanzania) where the Chair of the Commissioners is also the Director of the Executive Secretariat. However opportunities presented by the drafting of new legislation, such as in Malawi and Nigeria,

[2] It is possible that independent salary structures are being applied in some of the other countries in this review, however, information was not available or forthcoming on this issue. For example, the new Act of Parliament in Nigeria gives powers to the Board to determine terms and conditions of service for NACA employees, but information did not become available on whether this is being applied.

are allowing debates on Board membership. In Nigeria six of the sixteen members are now selected for their skills and experience.

2. Irregular meetings and different levels of seniority among the Commissioners affect the Board's ability to function well, with senior Commissioners often not being available to attend meetings and delegating to more junior staff without the power to make decisions.
3. Large Boards tend to have high transaction costs and limited effectiveness.

Delivering mandated core functions: There is evidence that some NACs are still experiencing problems with delivering their core mandate to lead and coordinate a multisectoral response, especially mainstreaming HIV and AIDS in other sectors. Many ministries and local government bodies remain unclear about their role in, and potential for, contributing to the national response. At sub-national levels, AIDS committees often lack capacity, and remain focused on specific health related AIDS activities insufficiently involving the non state sector. Local Government Authorities may have the mandate but have problems accessing resources to take up their coordination role with sectors and other players. This situation is compounded by earmarked off budget funds for AIDS, the existence of which can act as a disincentive for sectors to incorporate AIDS activities into their usual line of business. For mainstreaming processes to effectively tackle AIDS, strong national ownership, technical capacity and accountability structures are required, but often NACs operate without the mandate to hold line ministries to account for their part in the national response.

Delivery of core or non core functions: For some NACs core business has always included a grant management function, a function that NACs perform well and that takes place alongside coordination and mainstreaming functions. Some NACs have actively sought out this role and "captured" funds from other organisations such as MOH. Some donor informants indicated that they perceive this involvement in implementation, through the management of grants, as a distraction from delivering on the core business of coordination and mainstreaming. However donor behaviour in this area can be contradictory - providing funds to support pooled funding mechanisms that channel grants to civil society under the NAC, whilst also calling for greater focus on core functions or coordination.

Civil society representation and participation: It is apparent that NACs are committed to civil society representation and all the NACs reviewed included civil society representation on Boards, Country Coordinating Mechanisms (CCMs) and Partnership Forums / Committees where they exist. However, beyond these structures, it was more difficult to source much information about how NACs are seeking to strengthen civil society representation. In the African countries reviewed civil society is large and diverse and there are challenges in ensuring comprehensive participation and legitimate representation. Some examples of good practice emerged. For example Kenya is developing an institutional framework for NACC coordination with civil society and has completed a robust national election process for civil society representation on the CCM. New and strengthening coordination structures are consistently including civil society representation, for example the Nigerian National Council on AIDS, Kenya's ICC-AIDS and its new apex Steering Committee and Uganda's Partnership Committee.

Financing the National Response

Common features

The financing of the national HIV and AIDS response is country-specific, but there are some commonalities and specific observations across the countries reviewed. These include:

- *Links between AIDS and national budgeting processes.* As relatively new organisations NACs are still working to define their role, and to integrate AIDS in national planning and

budgeting processes. Some NACs are having success in this area. For example in Kenya the National HIV and AIDS Action Framework (NAF)[3] is used for setting priorities for government HIV and AIDS spending in the Medium Term Expenditure Framework (MTEF) and annual budget cycle. In Tanzania a code for AIDS was first included in the MTEF three years ago and the NAF guides the government's allocation of resources to HIV and AIDS under the MTEF. In other countries, such as Uganda, the NAF is not yet directly linked to government budget allocations and not integrated into national budgeting processes.

- *Significant increases in financing.* All the countries reviewed have experienced a significant increase in external financing of the national response over the last few years. In addition the majority of funding is provided by external donors. For example, in Uganda 85-90% of funding is provided by donors.
- *Common major donors.* Ten out of twelve countries receive substantial resources from PEPFAR. All twelve are receiving grants from the Global Fund. Most have World Bank (WB) MAP programmes. The exceptions include Uganda, where the WB is providing funding through a social fund credit, and Kenya where a new WB credit for HIV and AIDS will go to the WB Board at the end of June 2007. The majority of external financing for HIV and AIDS comes from these three donors. For example, in Tanzania 80% of donor financing is from PEPFAR, WB and GF. One notable exception to this is Botswana, where the government is a major funding source.
- *Diverse financing mechanisms*. The countries reviewed all exhibit a multiple range of external financing mechanisms, including disease target specific programming (GF), discrete projects, co-financing, pooled or basket funding and direct budget support (DBS). These mechanisms are becoming increasingly diverse with new initiatives under development, such as pooled funding in Nigeria and the WB considering moving towards DBS in Rwanda and maybe Tanzania. Zambia has a joint financing arrangement for the financing of the coordination function of the NAC and separate joint financing arrangements for support to civil society through the Zambia National AIDS Network (ZNAN) and the Churches Health Association (CHAZ).
- *NAC involvement in resource allocation*. The review attempted to assess NAC involvement in the allocation of funds to support the NAF. However, in reality it appears that there is no uniform pattern and the role of NACs in allocating funds is inconsistent. Respondents and documents interpret the allocation of funds in different ways and the extent to which NACs have authority over the allocation of funds (over and above their own budget) is unclear. However, some NACs are mandated to undertake resource disbursement (eg Malawi, Tanzania, Kenya, Nigeria) and those with a grant management function are allocating resources as part of this role.

Emerging Themes

Initiatives and mechanisms to support alignment of development partner funding to NAF priorities. There is increasing cooperation between NACs and donors with a growth in mechanisms to further align external funding to NAF priorities. These activities were viewed as very positive by NAC respondents and clearly contribute to the fulfilment of their core mandates. One of the earliest examples of pooled funding is the Partnership Fund in Uganda, which was set up in 2002. Other countries have extended this concept beyond funding coordination activities. In Mozambique the majority of government and external donor funding is disbursed through the Common Fund to finance an annual operational plan. The GF grants have been integrated into the Fund and the World Bank is due to follow. This is a pioneering example of how a vertical funding mechanism can be adapted to better fit with country systems whilst also supporting NAF priorities. Malawi has a similar pooled funding mechanism, which also includes the GF and the WB. Malawi NAC coordinates the allocation of pool resources to priority areas according to annual workplans, while

[3] The countries reviewed use slightly different terminology to refer to the common national HIV/AIDS Action Framework developed and coordinated by NAC. For the purposes of this document the abbreviation NAF is used throughout.

Tanzania has a Memorandum of Understanding annexed to the NAF which agrees that donors will only support activities stated in the strategic framework. Initiatives are underway to develop new mechanisms both in countries where harmonised funding is weaker (eg two new pool funding mechanisms in Nigeria, WB and DFID co-financing in Kenya), and to strengthen existing initiatives (eg WB considering moving to DBS in Tanzania).

Planning and sustainability of external financing. Although the GF has entered pooled funding arrangements in Mozambique and Malawi, it still tends to operate as a vertical funding programme based on multi-year funding commitments with no follow-on funding guarantees. PEPFAR, by far the largest funder in six of the countries, manages its funding outside of government frameworks through cooperating partners and contractors. PEPFAR only commits funds on an annual basis with overall future support being dependent on favourable decisions in Congress (although in May 2007 President Bush announced his intention to double the initial $15 billion five year commitment). The political basis of this support makes it difficult to predict the long term financing of the single biggest source of funds for HIV and AIDS and also makes country planning processes vulnerable to decisions made in Washington. Additionally, although PEPFAR and national governments agree that support should be based on the priorities outlined in the NAF, the practical reality is that PEPFAR/USG remains largely external to harmonisation and alignment processes, and this undoubtedly presents coordination challenges for NACs. MAP was the first programme to offer African countries substantial, long-term funding to support HIV programmes of national scale and coverage. Many of these programmes are now approaching the end. With the WB updating its HIV and AIDS strategy for Africa over the next five years and beyond, the future of continued World Bank support is not certain.

Financial sustainability is a significant issue especially in the context of universal access targets and increased pressures associated with scale up. Donor planning and funding cycles often do not correspond to strategic planning and budgeting cycles at country level. They present challenges to NACs working to coordinate resource allocation against the NAF and identify gaps and shortfalls to inform resource mobilisation, especially in an environment where substantial external resources are being used to purchase ARVs.

Harmonisation and Alignment

Common features

The harmonisation and alignment of the national HIV and AIDS response is country-specific, but there are some commonalities and specific observations across the countries reviewed. These include:

- *Alignment of national development instruments with national AIDS strategies and plans*: In all of the twelve countries reviewed there are links between the NAF and wider national development plans, most often the Poverty Reduction Strategy Paper (PRSP), National Development Plan (NDP) or equivalent. Where development cycles allow (eg Kenya, Uganda, Tanzania and Zambia) the NAF has been developed within the broader framework of the PRSP/NDP. Integration of HIV and AIDS tends to be stronger in more recently developed PRSPs/NDPs, for example the new Malawi Growth and Development Strategy has HIV and AIDS and Nutrition Disorders as a pillar and includes HIV and AIDS as a cross cutting issue in its themes. In Zambia, the HIV Chapter of the Fifth National Development Plan is the National AIDS Strategic Framework (2006-2010). There are indications that the next generation of PRSPs (eg Kenya, Rwanda, Nigeria) will align with strategies as set out in the NAF.
- *Formal linkages between NAC and actors in Ministries of Finance/Economics/Planning (MOFP)*: Typically details are scarce on relationships between the NAC and actors involved in national level planning and budgeting. UNAIDS/WB/UNDP have been active in mainstreaming AIDS in PRS processes and recent reports highlight that close relationships

and regular dialogue between NAC and MOFPs, and input at crucial times to the PRS development cycle, are critical success factors in getting budgets allocated across sectors for HIV and AIDS. From the NACs reviewed, all appear to be working hard to align more with national processes and some NACs are actively seeking to develop relationships (eg following restructuring Kenya's NACC has increased the profile of HIV and AIDS in core government processes).

- *Alignment of MOH and multi-sectoral HIV and AIDS policy and strategy*: There is evidence of alignment between MOH and HIV policies and strategies (Rwanda, Tanzania, Mozambique, Nigeria and Zambia) and all countries, often with development partner support, are seeking to strengthen convergence between priorities in the NAF and health sector strategic plans.
- *NAC-led development partner coordination mechanisms:* All twelve countries have established development partner coordination mechanisms (eg Harmonisation Task Force in Kenya, Donor Coordination Group in Nigeria, HIV and AIDS Cluster in Rwanda, Cooperating Partners Self-Coordinating Group in Zambia). These fora can involve wider stakeholders, such as the Uganda HIV and AIDS Partnership and the Partners Forum in Mozambique.
- *Commitment to harmonisation and alignment with development partners:* As we have seen in the Financing section above, there is increasing cooperation between NACs and development partners with a growth in mechanisms to further align external funding to NAC/NAF priorities. All twelve countries reviewed currently have, or are planning, pooled funding, co-financing, common funding or programme funding arrangements. Nigeria was one of the first countries to review and domesticate the Global Task Team recommendations in line with the country context.

Emerging Themes

Substantial players outside the harmonisation and alignment agenda. Informants frequently mentioned that substantial players remaining outside the harmonisation and alignment agenda challenge NACs' coordination mandate. At least three of the countries reviewed identified donor behaviour (following their own priorities and agendas, and still using their own systems despite global commitments to the Rome and Paris Declarations), as a key obstacle to alignment with country needs and systems. USG, including PEPFAR, was mentioned most frequently. Within this context, concerns were also raised about operationalising the Three Ones, in particular monitoring and evaluation where not all stakeholders provide the required data.

Rationalisation of coordination structures and mechanisms. At least three of the countries reviewed have made efforts to rationalise and streamline systems and processes by removing parallel mechanisms. Both Tanzania and Mozambique have sought to increase the efficiency of coordination mechanisms by aligning the CCM with existing coordination structures. In Tanzania the CCM and the existing coordination mechanism were recast to form one Tanzania National Coordination Mechanism which is responsible for coordinating all resources aimed at scaling up AIDS, TB and malaria responses. In Mozambique the role and function of the CCM has 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 there is greater neutrality between representatives. In both these contexts the CCM no longer exists solely for the purpose of developing and overseeing GF proposals. Malawi is also considering aligning the CCM with other health and HIV and AIDS accountability structures. Strong government leadership, together with a joint focus on results and outcomes, and communication and trust between government and development partners, have led Rwanda to rationalise management and procurement systems. Coordinated by CNLS, a GF Project Management Unit manages both the five GF programmes and the WB MAP. The Government of Rwanda has also instigated a Coordinated Procurement System to create a common pooled fund for the provision of ARVs. GF and PEPFAR contribute to the pool.

Concluding Remarks

This review has attempted to provide a snapshot of the status, characteristics and key issues of NAC institutional set ups in twelve African countries, with some limited information on the rest of the SADC countries. Notable from the review is the constant adaptation of the NAC model to better suit local circumstances. NACs can learn from each other and need to ensure that the experiences of adaptation and reforming action is documented and disseminated to peers and to the international community. This review represents one of the only multi-country syntheses of NACs to date. We hope the information contained in the review can be shared, expanded and used widely to promote lesson learning for the future.

Every effort was made in the limited time available to the research team, to contact each NAC reviewed, to ensure the accuracy, reliability and completeness of the information included. However, responses were not received from some NACs so this study remains a work in progress. Readers are invited to contact the authors of this report named below with comments and related information or documentation. Please also contact the authors if your institution would be interested in helping to finance an expansion of the present review in terms of country coverage and/or scope of material:

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SECTION 2:

SUMMARY TABLE OF INSTITUTIONAL SET UP FOR NATIONAL AIDS COUNCILS/COMMISSIONS IN SEVERAL AFRICAN COUNTRIES – October 2007

NAC with year established	NAC established by Act of Parliament/ Presidential Decree	NAC situated under Office of President or equivalent	NAC has independent or semi -independent status	NAC set up has Board of Commissioners and separate Secretariat	NAC has coordinating structures at sub-national levels	Roles and functions of NAC documented and defined	NAC also involved in grant management functions	NAC contracts out grant management functions	NAC staffing pay scales independent of civil service	NAC has pooled donor funding instruments for HIV and AIDS	Evidence of rationalisation of coordination structures and mechanisms e.g. CCMs merging with NACs; joint GF/WB PMUs
Angola 2003/2005[4]	Cabinet Decree	Commiss'n under OoP; Tech body under MOH	Part of the MoH		✓		✓		Civil servants		
Botswana 1999	✓ Pres Declaration	✓		✓	✓	Strategic plan					
Democratic Republic of Congo 2004	✓[5] Pres. Decree	Text says OoP but in practice MOH	✓ But fully financed by the WB	✓[6]	✓ Provincial yes, still working on Districts	✓	✓ (MAP)		All on WB contracts	GF R3 $113m with UNDP as the PR	NAC ED is CCM Chair

[4] 2003- Angola established *La Commission de Lutte Contre le SIDA et Grandisn Endemics*. The President was the coordinator and the 14 Ministers were the members. The Commission had a technical committee which was formalized in 2005 as *L'Institute Nationale de Lutte Contra le SIDA*, under the MoH.

[5] Programme Nationale Multisectoriale de Lutte contre le SIDA (PNMLS), with a Comité Nationale Multisectoriale de Lutte contre le SIDA (CNMLS) as the governing board.

[6] Chair is MoH. Includes representatives from 33 institutions and approximately 30 individuals.

Shading indicates a non-SADC country

A synthesis of institutional arrangements of NACs in several African countries—May 2008

NAC with year established	NAC established by Act of Parliament/ Presidential Decree	NAC situated under Office of President or equivalent	NAC has independent or semi -independent status	NAC set up has Board of Commissioners and separate Secretariat	NAC has coordinating structures at sub-national levels	Roles and functions of NAC documented and defined	NAC also involved in grant management functions	NAC contracts out grant management functions	NAC staffing pay scales independent of civil service	NAC has pooled donor funding instruments for HIV and AIDS	Evidence of rationalisation of coordination structures and mechanisms e.g. CCMs merging with NACs; joint GF/WB PMUs
Kenya 1999	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Lesotho 2005	✓	✓	✓	✓	✓	✓	✓	✓ Crown Agents, in house for two years	✓ Five year contracts		
Madagas-car Committee 2002	Pres Decree	✓	✓	Chair is Pres, plus Executive bureau	✓ By the decree but not very functional, except at the commune level, there Local Committees	✓	✓ (MAP and GF-TB/HIV) GTZ, French Cooperation fund, UNDP		✓ Some, but not all		✓ Exec Sec of NAC is Vice Pres of CCM

NAC with year established	NAC established by Act of Parliament/ Presidential Decree	NAC situated under Office of President or equivalent	NAC has independent or semi -independent status	NAC set up has Board of Commissioners and separate Secretariat	NAC has coordinating structures at sub-national levels	Roles and functions of NAC documented and defined	NAC also involved in grant management functions	NAC contracts out grant management functions	NAC staffing pay scales independent of civil service	NAC has pooled donor funding instruments for HIV and AIDS	Evidence of rationalisation of coordination structures and mechanisms e.g. CCMs merging with NACs; joint GF/WB PMUs
Malawi 2001	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Mauritius 2002/2006[7]	Cabinet Decision	OoPM		Dir. is Chair of Comm. for Drug Control 30 People with CSOs and PS		✓[8]			All Civil Servants, with top up		No CCM yet,
Mozam-bique 2000	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Namibia 2004	Cabinet Decree	MOH			✓	✓	✓	Did use NEDICO for two years, but now within			
Nigeria 2000	✓	✓	✓	✓	✓	✓	✓		✓		

[7] There have been only 3000 known cases of HIV in Mauritius since 1987, when tracking first began. The NAC was established in 2002 and the Secretariat in 2006.

[8] TORs are clearly defined but need updating.

NAC with year established	NAC established by Act of Parliament/ Presidential Decree	NAC situated under Office of President or equivalent	NAC has independent or semi -independent status	NAC set up has Board of Commissioners and separate Secretariat	NAC has coordinating structures at sub-national levels	Roles and functions of NAC documented and defined	NAC also involved in grant management functions	NAC contracts out grant management functions	NAC staffing pay scales independent of civil service	NAC has pooled donor funding instruments for HIV and AIDS	Evidence of rationalisation of coordination structures and mechanisms e.g. CCMs merging with NACs; joint GF/WB PMUs
Rwanda 2001	✓	✓	✓	✓	✓	✓	✓				✓
South Africa	✓ Act	✓ Off of Dep President, daily interaction with MOH	Mixed Funded by Dept of Health	✓ About 16 sectors represented + 7 gov. depts.	✓ Provincial AIDS Councils and District level	✓	✓ Coordinates GF grants and there is a dormant Trust		Civil servants	Mostly Dept of Health, until Trust is activated	CCM is the Resource Manage-ment Committee. Some members of the Council are the same
Swaziland 2001	✓ Act	OoPM	✓	✓ Councillors	✓ RAMSHAC C	✓[9]	✓ PR for GF and other small grants		✓		
Tanzania 2001	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓[10]

[9] defined by the Act, but then further, however, NERCHA (National Emergency Response Council On HIV and AIDS) is further developing the NAC strategy that stipulates coordination

[10] A new coordination mechanism was established in 2006, the Tanzania National Coordination Mechanism (TNCM), which has evolved from the CCM and has some legal derivation under the Prime Minister's Office and coordinates not just GF grants but PEPFAR and WB programmes as well.

NAC with year established	NAC established by Act of Parliament/ Presidential Decree	NAC situated under Office of President or equivalent	NAC has independent or semi -independent status	NAC set up has Board of Commissioners and separate Secretariat	NAC has coordinating structures at sub-national levels	Roles and functions of NAC documented and defined	NAC also involved in grant management functions	NAC contracts out grant management functions	NAC staffing pay scales independent of civil service	NAC has pooled donor funding instruments for HIV and AIDS	Evidence of rationalisation of coordination structures and mechanisms e.g. CCMs merging with NACs; joint GF/WB PMUs
Uganda 1992	✓	✓		✓	✓	✓				✓	
Zambia 2002	✓	MOH	✓	✓	✓	In draft			✓	✓	
Zimbabwe 1999	✓	MOH	✓ Parastatal	✓	✓	✓			✓	✓	

SECTION 3

COUNTRY ANNEXES

3.1 Country Annex: Botswana

National AIDS Council (NAC) and National AIDS Coordinating Agency (NACA)

1. Establishment of NAC and the institutional setting

HIV was fist identified in Botswana in 1985. The country responded with many of the preliminary infection control programmes found in other countries, such as ensuring blood safety. The first medium term plan on HIV and AIDS was introduced in 1989 and the National AIDS Policy was launched in 1993. The second medium term plan, from 1997 onwards, broadened the national response to a multisectoral response. The National AIDS Council was established through a Presidential directive in 1999. The Presidential directive does not define the mandate, level of authority or autonomy of NAC, but it does indicate that the National Coordinator, heading up the coordinating agency (NACA), is at Permanent Secretary level and it makes the NAC like an extra Ministerial Department, with the shared leadership of the Ministry of the State President (Presidential Affairs and Public Administration). NACA is its Secretariat. The current National Coordinator has been in post for three years.

2. Governance and Structure of NAC

The NAC, as a Board, has representation of the public sector, with most Ministries represented by their Permanent Secretaries, the private sector through the Botswana Business Coalition on AIDS (BBCA), NGOs/CSOs, representatives from all the NGO networks, and representatives from local authorities. The Board includes more than 50 people. The President is the Chair of the NAC and the Minister of Health is the Vice Chair. The NAC is scheduled to meet four times per year, and it is generally the practice that it meets regularly. There is a newly established website for the Botswana national AIDS response and minutes of the Council meetings may be available on the website once it is more fully operational.

Selection to the Council is facilitated by NACA. NACA proposes to government who should be on the Council. NACA reports that it tries to get a broad selection of candidates, to ensure comprehensive representation. In their recommendations, they are looking for quality, commitment and expertise. According to NACA, the present Council selection system is working well, but it does not accommodate everyone. NACA is currently reviewing the size and composition of the Council to help it be more efficient and effective.

While it is generally accepted in Botswana that the level of authority of NAC, as chaired by the Head of State, is effective and satisfactory, it is not without challenges. There is still some confusion between NAC and NACA. Everyone needs to understand their roles and appreciate the role of NACA as the coordination agency. Some look at NAC as advisory to government. NAC cannot make any binding decisions on government. It is reported that sometimes NACA makes a decision, but it cannot hold NAC accountable. Similarly there is a question about the extent to which NAC can hold NACA accountable. NAC and NACA do have the authority of the President, which facilitates their work, but there are still some grey areas. For instance, the historic roots of the AIDS response in the Ministry of Health still cloud the lines of authority. Fortunately, it is reported that there is a high level of mutual respect and that the various players are trying to tackle these issues in a cordial way. Regardless, without an Act of Parliament or other legislation, there is no real statutory power, and this is viewed as problematic.

3. Functions of NAC and NACA

The mandate of NAC is leadership and policy, strategic and technical direction for the national response, at a high level. The NAC does not deal with administrative matters. The core functions of NAC include the oversight of NACA, policy direction, strategic guidance and resource mobilisation. NAC defines the priorities of the national response.

The mandate of NACA is an extension of the NAC. NACA is responsible for communicating to all the implementing partners the direction given by NAC. NACA facilitates partnerships and builds capacity. NACA is responsible for the M&E of the national response. NACA handles the necessary administrative issues. NACA also plays a key role in the mobilisation and allocation of resources, including the mobilisation of funds from the Ministry of Finance (MoF). While NACA is not a funding agency per se, it does have influence over the disbursement made by the MoF and the GFATM. NACA is not an implementing agency.

Over time the understanding of the core functions of NAC and NACA has been improving. NAC and NACA have been very successful with providing strategic direction and with M&E, but less successful with policy formulation. It was reported that NACA needs to do more at the sector level and that partnerships are still an issue. The tracking of resources is also problematic. NACA has not yet fully decentralised. There are District Multi-Sectoral AIDS Committees (DMSACs) under local government, but these are not yet fully integrated within the NACA structures.

To carry out these core functions, NACA has a staff of 80. These are organised around three directorates: Programmes, Ministerial Management, and Behaviour Change, with M&E being handled by the epidemiology unit: a post which is unfilled at the moment. While this structure has been viewed as generally adequate, there is an expressed need to transfer the decentralised structures into NACA. There is also a proposal to make changes to the mix of management and technical skills, to include strategic planning and research. The National Coordinator has also lodged a request for a Deputy.

The staff at NACA are largely civil servants, but there are some staff seconded from partners, such as the African Comprehensive HIV/AIDS Partnership (ACHAP). PEPFAR facilitates recruitment of particular skills on a contract basis, because the processes and bureaucracy within government do not facilitate the hiring of additional staff. The government finds it challenging to operate in an emergency mode. However, efforts have been made, for instance, the requirements for the procurement of goods and services have been relaxed enough to help meet the need of expediency. NACA can now use their own small tender board.

4. Financing the national response

NACA is perceived as a credible lead agency able to exert influence over sector policies and plans and public sector resource allocations. The formal and informal relationship between the NAC/NACA and the Ministry of Finance is well established and collegial. NACA is trusted to do disbursement, but its capacity is still an issue. There is a system in place for tracking resources, but NACA reports that resource tracking should not be part of core business; it is sending that function back to MoF. NACA would like to rely more on joint planning to do budget allocations and then look at accountability.

NACA does get funding directly through the national budget to finance NACA structures and operations. It is reported that this financing could be more efficient if it went directly to the Sectoral Ministries for the purposes of mainstreaming. At present, it is reported that everybody comes to NACA for money and that this is an area that should be streamlined.

Botswana has the following major sources of funding:
GFATM- R 2, $18m
PEPFAR- received $73m in 2007. $93m expected for 2008

ACHAP- $113m for five years (2001-2005). This timeframe was extended as the expenditure rates were low.

5. Harmonisation and Alignment

Broader development frameworks

HIV is integrated in the Botswana National Development Plan (NDP) and it is aligned with the national AIDS strategic framework (2003-2009).

Alignment of HIV and AIDS and Health Sector

The relationship between the NACA and the MoH is improving. It is reported by NACA that at the level of top leadership it is fine, but there is turbulence at the operational level. It is explained that MoH has been working on the response to HIV for a long time, but they may not be the best at delivering things like behaviour change. Most of the health responses, such as treatment, PMTCT and VCT, are in the national health plan as well as the national AIDS plan. In terms of resources, the MoH is beginning to feel the strain, as the budgets for other diseases are diverted to HIV related services.

In terms of the alignment of AIDS and health systems, this is an area that Botswana is still working on. Most of the M&E systems were patient oriented in the health sector. NACA is less interested in patient data, but NACA does recognise the need to respect confidentiality while making sure the HIV information flows. NACA and MoH are agreeing on indicators, which is the basis for the whole system.

Harmonisation and alignment between government and development partners

There are several fora in which the GOB meets its development partners. In 2006 they revived the Partnership Forum and placed UNAIDS as the secretariat for that Forum. At present there is the Madikwe Forum, which is a forum in which the GOB meets partners to discuss the funding and direction of ACHAP. PEPFAR has its own structure to review and agree on the COP. Partners also meet through the HIV sub-committee of the CCM. The various fora could be better aligned. The NACA would like to enhance accountability on the part of the development partners. They want to make sure they know how the money coming in is being utilised and they want more say into how activities are prioritised and where the money is used.

Harmonisation and alignment of governance structures

At this stage in Botswana, the CCM is like an additional structure. It was explained that it came about as a result of the GFATM, but no synergies have been established yet. The CCM is just a structure for the GFATM, but NACA has initiated discussions to look at greater harmonisation.

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3.2 Country Annex: Kenya

Kenya National AIDS Control Council (NACC)

1. Establishment of NACC and the institutional setting

Since the late 1980s Kenya's HIV and AIDS response had been led by the Ministry of Health (MoH), which established the National AIDS and STDs Control Programme (NASCOP). The forward thinking Parliamentary Sessional Paper "AIDS in Kenya" (No. 4, 1997) proposed the establishment of a national body to coordinate a multi-sectoral national response to HIV and AIDS. The National AIDS Control Council (NACC) was subsequently established in 1999 through a Presidential Order in legal Notice No. 170 of the State Corporations Act. As a corporation under the State Corporations Act, NACC has the same degree of autonomy and operational independence as commercial state corporations. The legal notice mandates NACC to "provide policy and a strategic framework for mobilizing and coordinating resources for prevention of HIV transmission and provision of care and support to the infected and affected in Kenya".

The Secretariat, set up in 2000, was initially located in the MoH, but was soon moved to the Office of the President (OP). With a new Government in 2003, a Cabinet Committee on HIV and AIDS was set up to provide political leadership and high level oversight. NACC is now in the process of implementing its second National HIV and AIDS Strategic Plan (KNASP), 2005-2010 with a new HIV and AIDS Monitoring and Evaluation (M&E) Framework.

2. Governance and structure of NACC

At the national level the NACC structure comprises the NACC Council/Board and its Executive Secretariat. The Board, chaired by the President's appointee, has 19 (plus 7 additional) members including Permanent Secretaries from a wide range of Ministries and senior representatives from the private sector and civil society. Work is currently underway to review and strengthen the Board.

Within the OP the NACC is currently under the Minister for Special Programmes. The Minister appoints the Director of the Secretariat, who reports to an Executive Committee. This Committee is chaired by the chair of the Board and provides guidance and corporate direction to the Board while advising the Secretariat. The NACC structure also includes AIDS Control Units (ACUs) in line ministries and government departments which seek to coordinate and mainstream AIDS with limited funds direct from NACC.

Since 2003 NACC has been restructured at the sub-national level with a community level focus. The Provincial AIDS Control Committees (PACCs) set up in 1999 have been replaced with 9 provincial officers to coordinate and supervise activities at regional levels. The original District AIDS Control Committees (DACCs) have been replaced by 70 District Technical Committees (DTCs) which coordinate at district level and provide technical support to the 210 Constituency AIDS Control Committees (CACCs). The DTC is chaired by the District Commissioner who reports to the Office of the President through the Provincial Commissioners.

Following an institutional review in 2004, the Board restructured the Secretariat to renew focus on NACC's original policy, strategy and coordination mandate. A new team of senior and middle management has been recruited through a national competitive process with the flexibility of contracting staff on market salaries. Emphasis has been placed on performance management, financial management, fiduciary risk management, and monitoring and accountability.

The Director of the Secretariat chairs the Inter-Agency Coordinating Committee (ICC) for HIV and AIDS which is the primary forum for deliberating on AIDS policies and strategies, including coordination and review of the National Strategy. It has broad stakeholder membership including

senior representatives from Government, civil society, the private sector and development partners. The Board receives progress reports and recommendations for policy action from the ICC. There is also a new NACC apex Steering Committee for the ICC to set priorities annually for the national response, based on the recommendations from the annual Joint AIDS Programme Review (JAPR), which are reviewed and prioritised by the Monitoring and Coordination Groups (MCGs) in a fully consultative process. Development partners comprise four of the seventeen members of the Steering Committee, with key sectoral government departments, CSOs and private sector representatives making up the rest.

3. Functions of NACC and the Secretariat

The NACC is responsible for strategic leadership of the national response playing an important role in policy making processes and the strategic agenda. The Secretariat has a mandate to develop policy, guidelines and strategies for mobilising and supporting a multi-sectoral response alongside coordinating and monitoring all activities in support of the National Strategy. The Secretariat also fulfils an advocacy and communication function. Alongside mobilising resources, the 1999 Legal Notice No. 170 included the provision of grants to implementing agencies as a mandated function.

Between 2001 and 2005, under the World Bank funded financed Multicountry AIDS Programme (MAP), grants were channelled to community-based projects and other non-state HIV and AIDS interventions through the NACC structure, including at that time PACCs, DACCs and CACCs. A financial management agent (FMA) was used to disburse and manage funds according to NACC approved proposals. The new World Bank project "Total War on HIV and AIDS (TOWA) Project" will go to the Board at the end of June 2007. It also includes grant awards to civil society, public sector, private sector, and research institutions. The Call for Proposals will go forward within the framework of the Steering Committee - endorsed priorities for the response for the forthcoming year (see para 2 above). A FMA will be appointed and NACC has two separate functions – a grant accountant for disbursement and an internal auditor who reports to the Board.

4. Financing the national response

KNASP, as it is reviewed annually in the JAPR, provides the framework for setting priorities for Government HIV and AIDS spending in the Medium Term Expenditure Framework (MTEF) and annual budget cycle. NACC works closely to mainstream HIV and AIDS in the Government budget cycle and MTEF and has increased the profile for HIV and AIDS in core governance processes. The NACC and the MoH have a joint budget allocation within the MTEF ceiling in as far as the NACC budget for its operations comes within the ceiling set for health. The ACU allocations of non-health line ministries are routed through NACC, who is encouraging ministries to also budget and bid for additional resources to mainstream HIV and AIDS internally and externally across their sectors. Any additional resources come from Ministerial allocations within their own sectoral ceilings.

NACC uses the KNASP financing framework to coordinate the allocation of resources to priority areas. All development partners are encouraged to cooperate with this NACC-led mechanism. Donor funds account for the largest portion of HIV expenditure with many development partners contributing to the HIV and AIDS response. The new World Bank TOWA Project will be co-funded with DFID and provide support through the NACC. The total credit is for US$80 million over 4 years, plus a further US$33 million from DFID. Funding will strengthen NACC's role in governance and coordination and support program implementation. The Joint UN System Action Plan for HIV
and AIDS in Kenya, which will be supported by DFID, provides technical assistance to the implementation of the KNASP and the TOWA Project through the UN system. DFID is also entering into a partnership with the Swedish International Development Agency (Sida) to strengthen the coordination between civil society and the Government, which is also functionally linked to the TOWA Project.

PEPFAR more than doubled its allocation to Kenya between 2004 and 2006 to around $208 million in Fiscal Year 2006. PEPFAR funding is managed separately from NACC and other channels of US Government support – CDC, Department of Defence, and USAID – work closely with their principal cooperating partners and contractors. Global Fund (GF) channels its support through the Ministry of Finance, as Principal Recipient, to the MoH and civil society, and is therefore engaging with both NACC and Ministry fora. NACC is among the implementers of the GF Round 2, Phase 2 grant. A Global Fund/Principal Recipient Coordination Unit (GF/PRU) has been established within the Ministry of Finance.

5. Harmonisation and alignment

Broader development frameworks

The purpose of the KNASP includes operationalising the Government's commitment to fight HIV and AIDS set out in the Economic Recovery Strategy for Wealth and Employment Generation (ERS), 2003-2007, which in Kenya is the national poverty reduction strategy. The KNASP has been developed within the broader framework of the ERS, and the Ministries of Planning and Finance have indicated that they intend, in the context of developing ERS2, to ensure that the AIDS response is mainstreamed into national planning and budgetary processes and monitoring and evaluation systems. Over the past three years, the Government has been linking and harmonizing all of its economic and development instruments, including the ERS, the annual Public Expenditure Review (PER), the MTEF and the national monitoring and evaluation system. However, as health and AIDS are linked as one sector in the MTEF budget ceilings, and the ERS is supported by the MTEF, current ERS monitoring reports have grouped AIDS with the health sector rather than reflecting AIDS as a cross-cutting issue.

Alignment of HIV and AIDS and the Health Sector

In the MoH, NASCOP leads on management and implementation of the clinical/bio-medical aspects of HIV and AIDS. HIV is being increasingly integrated into core health service provision (tuberculosis, reproductive health services and antenatal care) with the National Health Sector Strategic Plan (HSSP) 2005-2010 guiding the health sector response. NASCOP was involved in preparing both the KNASP and the draft Health Sector Strategic Plan, with the HSSP being prepared after the KNASP. Continued closer integration of NASCOP with HIV planning and budgeting processes within the MoH led MTEF cycle will enable more coherent planning and upscaling of Government of Kenya budget commitment to the HIV and AIDS response. This year (2007) the Government has made a significant budget commitment for Antiretrovirals (ARVs) (approx $7 million), in part because of strengthened NASCOP engagement in the MoH budget process.

Work is ongoing to strengthen the links between MoH and NACC, especially in strategic planning. The KNASP includes strengthening collaboration between the health sector response to HIV and AIDS and KNASP as a planned result by mid 2006. Objectives are for the health sector HIV and AIDS strategy to explicitly include KNASP priorities and for effective participation of the health sector in KNASP processes.

The national monitoring and evaluation framework and database is managed by NACC and linked to M&E subsystems at NASCOP, MoH. The framework was jointly developed with stakeholders including the MoH. NACC and MoH continue to collaborate to ensure coordination with the one national framework.

Harmonisation and alignment between government and development partners

It is acknowledged that harmonising and aligning development partner activities with the KNASP and strategic priorities remains a challenge. Multilateral institutions and international partners are increasing efforts to align their support to national strategies, policies and systems. The planned

World Bank TOWA project co-funded with DFID, and linked to UN and SIDA support, will facilitate NACC allocating available resources to strategic priorities in a more structured way. The NACC led Harmonisation Task Force is the main forum for coordination with development partners

Since 2002 an annual Joint AIDS Programme Review has been held to monitor and assess progress in the national response while highlighting strategic issues and priorities. It is a national inclusive mechanism involving development partners which serves to promote consultation and coordination. The JAPR is being fully decentralised to district level in 2007.

Harmonisation and alignment of governance structures

The role and responsibilities of the Country Coordinating Mechanism (CCM) used to be undertaken by the ICC for HIV and AIDS (also ICCs for TB and malaria). A separate CCM was established to allow the ICCs to discuss policy and strategy more broadly. The CCM continues to work closely with the ICCs, which lead on planning and budgeting for GF proposal preparation. As the Chair of the ICC, the Director of the NACC Secretariat is a member of the CCM and reports to the CCM on issues related to the GF. The Chair of CCM is the Permanent Secretary, Ministry of Health and the Vice Chair is a NGO representative.

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GF: www.theglobalfund.org/programs/countrysite.aspx?countryid=KEN&lang=en
NACC: www.nacc.or.ke
PEPFAR: www.pepfar.gov/press/81596.htm
http://gateway.nlm.nih.gov/MeetingAbstracts/102231732.html#

3.3 Country Annex: Lesotho

National AIDS Commission (NAC)

1. Establishment of NAC and the institutional setting

AIDS was declared a national disaster in Lesotho in 2000. At that time, a multi-sectoral approach was emphasised and a policy framework and Medium Term strategic plan were developed. A coordinating authority, the Lesotho AIDS Programme Coordination Authority (LAPCA) was created in 2001 as a government department of Cabinet. LAPCA was not well resourced with staff or money and there were doubts about its ability to carry out its mandate without a legal instrument.

Following the Abuja Declaration by the African Ministers of Health, which endorsed the concept of the 3 Ones in 2003, the Government of Lesotho (GOL) decided to establish the National AIDS Commission (NAC) with enabling legislation. The process took a long time as there was a need to assess LAPCA to see if it could become the Secretariat. Once it was established that it could not, there was the issue of creating a new entity and crafting a Bill.

In 2004 Lesotho qualified for GFATM Round 2. The GFATM offered support for capacity building but as there was not yet one national coordinating authority, the establishment of NAC became a condition to access the grant. By mid 2004 GOL advertised for the position of CEO of NAC, while they were still working on the legislation. They hired a CEO in Jan 2005, which coincided with stakeholder consultations on the Bill, but by the time the CEO was hired there was still no legal framework. Therefore, the legislation on the coordination authority was fast-tracked, with a decision to deal with the other outstanding issues later. The National AIDS Commission Act was signed into law on 19 September 2005.

There was no specific model that was followed in the establishment of NAC, rather it was a combination of best practices from other countries.

2. Governance and Structure of NAC

The mandate of NAC is to coordinate the national HIV&AIDS response overall. Specifically, NAC is to develop the policies and strategies to guide the response, to mobilise the stakeholders to participate in the response, to mobilise resources, and to conduct M&E including research. The NAC Act created a corporate body, as a parastatal, reporting to the Office of the Prime Minister, with a Board for governance, policy-setting and strategic direction. The Board is the ultimate authority. The Board is made up of five Commissioners: the Chair is independent, the rest of the Commissioners have a portfolio: health, legal, finance and administration, stakeholders/partnerships. These are appointed from the HIV&AIDS Forum (see below). Other Board posts are advertised to get submissions. An evaluation team evaluates applicants and proposes three for each position. The Commissioners are then selected and ratified by the Prime Minister.

NAC was granted autonomy in the NAC Act. It is the custodian of the National HIV&AIDS Policy, which was authorised by the Cabinet, through the Cabinet Sub-Committee on HIV and AIDS. The Cabinet Sub-Committee is advisory to the PM—anything that is to go to Parliament has to go through the Cabinet Sub-committee. NAC is the Secretariat for the Cabinet Sub-Committee as well.

NAC meets a minimum of four times per year, but currently it is meeting monthly as it only started at the end of March 2006.

Two other organs of the structure which supports the national AIDS response are the HIV and AIDS Forum and the Secretariat. The HIV&AIDS Forum has representation from local stakeholders (from 14 organisations, including faith-based organisations (FBO), people living with HIV and AIDS (PLHA), youth, women, NGOs, private sector, sporting bodies, public sector (Health, Local Government, Finance and Education), and Houses of Parliament (2)). The Chair of the Board also chairs the Forum. The Forum provides recommendations on policies and strategies and provides a list of candidates for the Commissioners positions. The Forum meets quarterly and has been meeting regularly.

The Secretariat is the third organ. It is headed by a Chief Executive Officer (CEO), who serves as the Board Secretary.

NAC and its Secretariat have no relationship to the civil service. They have separate operational policies and procedures. The annual budget for operations and grant-making goes through Parliament, but NAC can also independently mobilise funding, as a government agent. The Act provides for the NAC to create an HIV Fund, but this has not yet been established.

The level of authority that NAC reports to has been generally satisfactory. However, it is reported that it can be difficult to report outside the Commission because the PM is not very accessible. Therefore, reporting is often to the Cabinet Sub-Committee. There were regular sessions with the Sub-Committee until Cabinet was dissolved in November 2006. Elections were held in February. 2007, but political issues meant the Cabinet was only reconstituted late in 2007.

3. Functions of NAC

In Lesotho, NAC describes itself primarily as a technical leader. It sees its primary role as making sure that there is clear national policy and strategic direction. It is the custodian of the national HIV&AIDS policy and plan, and both of these documents are in place. The policy and plan are the key instruments to guide the response. There is also an M&E framework and a coordination framework. NAC aims to guide the national response and to mobilise technical and financial resources, which are then to be accessed by implementing partners. NAC seeks to ensure that the guidance and capacity building are provided.

The biggest challenge NAC faces is that it is a new organisation.

1) NAC has no track record. It has had to start from scratch. Stakeholders have needed to gain confidence. Lesotho started with the 3 Ones, but the level of commitment and buy-in is still a challenge. NAC perceives that more advocacy is needed.
2) There is a challenge with MOH. It is perceived that MOH sees NAC taking over part of their mandate. As a result, NAC reports that MOH is not reporting relevant information and data to NAC.
3) There is limited capacity of implementing partners. They are challenged to absorb the funding that exists, let alone scale up implementation. NAC is still at the early stages. The first year was the inception phase. It has now actually begun implementing its mandate. It is rolling out and operationalising tools. NAC has produced the first integrated annual plan, but it now faces the challenge of getting partners to report in the quarterly forum.
4) There is also a challenge with the M&E framework. For those who are funded by NAC, it is relatively easy to collect data, but for those who receive funding elsewhere, they don't want to give data to NAC. As yet, there are no MOUs with donors, though these are being developed.

NAC is headed by a CEO, on a four year contract. There are three Directors at NAC: 1) Policy, Strategy and Communications, which includes M&E, research and advocacy, 2) Stakeholders Coordination and Support, including the coordination and technical support units, 3) Finance and Corporate Services, including finance, grants management, administration, Human Resource, and management information systems (MIS). There is also the office of the CEO, which houses the corporate set up, including internal audit. There is a total of 64 staff, with 10 field officers at district level, who are complemented by data officers on a shorter term arrangement to establish the M&E systems. Of the full complement of 64 staff, 47 are currently in place.

At present, this organisational structure is viewed by NAC as appropriate for carrying out the core functions, especially leadership and management. Technical skills, such as policy analysis, advocacy, impact mitigation and mainstreaming are limited. There is a need to build competence in HIV and AIDS issues, as the staff were generally hired for their skills in management and coordination. For example, the current CEO has a BA in economics and an MBA. His career has been in private sector management, not in government, nor in dealing with HIV&AIDS. While he has experience with development, environment and social issues, he has no prior practical experience with HIV&AIDS. Furthermore, these staff are all on contract. There is a challenge of new staff coming from different work environments. There is the need to establish a work culture appropriate to the nature of the work.

4. Financing the national response

As NAC is a relatively new organisation, it has not yet achieved the necessary credibility nor proven that it can exert influence over sector policies and plans and public sector resource allocation. According to key informant interviews, there is still some doubt about NAC's ability to carry out the mandate, but the necessary instruments are in place, therefore the onus is on the Secretariat to prove itself.

Lesotho is considered a middle income country, with significant royalties coming from water and diamonds only. Otherwise it is a low income country and poverty levels are high.

The NAC budget does include GOL funding and, therefore, funding requests and reports go through the Ministry of Finance (MoF). Reporting on the MDGs also goes through the MoF, as MoF is accountable for attaining the MDGs.

NAC funding through the national budget goes to NAC directly and for the sub-national structures, decentralised government is where the funding for district level is channelled. There are District HIV and AIDS Committees that are responsible for planning for community level committees and capacity building, and funding for these activities can come through NAC.

There is a virtual basket fund for those who have resources to contribute. At this point, they do not put money into a pooled fund, but they have to report collectively through NAC. The USG and Irish Aid are keen to get money in the basket and thus it is a work in progress.

Lesotho has GFATM funding from Rounds 2 ($29 million), R5 ($40 million), and R7 ($33 million). Ministry of Finance is Principal Recipient in all cases.
There is Millennium Challenge Account funding for health sector infrastructure.
The EU is providing €10m for OVC over 5 years, through UNICEF.
There is also funding from UNDP, DFID, Irish Aid, UNAIDS and the USG through the US Embassy and USAID, however the USG is using its own partners, ie PSI, and not channelling any money through government.

5. Harmonisation and Alignment

Broader development frameworks

There was a policy framework for HIV&AIDS and a medium term strategic plan developed in 2001. Since then they have not been updated. There have been efforts to align national development instruments such as PRSPs, MTEFs with the national AIDS framework and / or AIDS sectoral plans, but this has yet to be fully accomplished.

In the Lesotho Country Vision 2020, HIV and AIDS is identified as a priority. In the MDGs HIV and AIDS is the first priority goal and national planning strategies do include HIV and AIDS.

Alignment of HIV and AIDS and Health Sector

The MoH has its own plans with regard to HIV&AIDS. These plans now have to be reviewed and aligned with the new NAC. Each sector needs to refine plans accordingly, but with the multi-sectoral approach, all sectors have been part of the planning of AIDS strategies, therefore, it is easier to focus on mainstreaming of HIV&AIDS and to link back to sectoral operations. There are challenges related to various sectors being at cross purposes, especially the relationship between the MoH and NAC. Furthermore, it is reported that there are challenges with conflicting personalities, but these challenges could be overcome through involvement and consultation, negotiation and finding of common ground. There is a shared vision of the need for partnership. There is a perspective that the health sector should carry on with health interventions and NAC should concentrate on the non-health interventions. It is the experience of NAC that funding forces cooperation as well, ie NAC chairs the *Know Your Status* national programme, so MOH is obliged to follow along.

Harmonisation and alignment between government and development partners

There is a coordination framework, which includes the role of donors and development partners. This is the broader framework in which all partners work in Lesotho.

There are currently no pooled funding arrangements for NAC but there are donors interested in establishing such a mechanism.

Harmonisation and alignment of governance structures

There is a CCM in Lesotho. It is composed of representatives from the public sector, the private sector, civil society, and development partners. It has 26 members, the Chair is from the MoH and the Deputy Chair is a person living with HIV&AIDS.

The history of the GFATM in Lesotho has been challenging. The background is that the first application was done through LAPCA. LAPCA was supposed to be the PR, but it did not have sufficient capacity and time, and was later dissolved. MoF became the PR for HIV, with the intention that when NAC was put in place, it would take over the responsibility. NAC is ex officio on the CCM, a strategic position. A small GFATM coordinating body was taken on board by NAC, when NAC was established. The GFATM coordinating body reports directly to NAC. With NAC as PR, NAC could not be a member of CCM, due to conflict of interest, thus complicating the issue. With a transition from MoF to NAC as a PR, it was thought that the coordination office should be transferred under MoF, but it appears that this was fraught with personal issues, related to appointment of a NAC Director. Relations deteriorated but are being repaired now.

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3.4 Country Annex: Malawi

Malawi National AIDS Control Council (NAC)

1. Establishment of NAC and the institutional setting

The Government of Malawi established the National AIDS Commission (NAC) in July 2001 with the mandate to lead and coordinate the national response to the HIV and AIDS. NAC was set up by a Trust Deed, rather than an Act of Parliament. In this way it could operate as an independent private trust in the Office of the President and Cabinet (OPC). According to the Constitution, whilst NAC is 'closely linked' to Government it is semi autonomous. NAC is the successor to the National AIDS Control Programme (NACP), which was based in the Ministry of Health (MoH). Malawi developed its first HIV&AIDS National Strategic Plan (2000-2004) which incorporated a multi-sectoral approach. NAC is now implementing the second strategic plan – the National HIV and AIDS Action Framework (NAF) 2005-2009.

2. Governance and structure of NAC

Following an institutional review, the current NAC structure became operational in January 2004. It comprises a NAC Board and a Secretariat. The Board has multi-sectoral, broad representation with a maximum of eleven members selected by the President following nominations from more than 30 key constituencies. The President also appoints the Chairman. It meets four times a year. As a private trust NAC appoints staff on terms of service independent of the limitations in the public service. In accordance with the human resource capacity constraints inherent in Malawi, the Secretariat has faced difficulties both with attracting the appropriate calibre of staff and more recently with staff turnover.

Prior to the 2004 election Minister of State was responsible for HIV&AIDS. The Vice President was the chair of the Cabinet Committee for HIV&AIDS. Following the election the President himself became the Minister of State for HIV&AIDS. The Department for HIV and AIDS and Nutrition was established in the OPC to upgrade OPC's leadership role. The Principal Secretary reports to the Chief Secretary of the OPC. The new OPC Department is seeking to champion mainstreaming of HIV and AIDS policies and advocacy activities throughout the public sector. There is also a Parliamentary Committee for Health which includes HIV and AIDS. This Committee has no direct connection into Cabinet.

The Malawi Partnership Forum (MPF) for HIV and AIDS was constituted in 2006 as a forum for wider stakeholder oversight of NAC's activities with an advisory role to the Board. It meets bi-annually. The wide group of stakeholders represented broadens the constituencies with direct oversight of NAC's work beyond the membership of the Board and includes some stakeholder groups not on the Board, for example development partners and the UN. The MPF has an executive which reports to the general assembly of the Forum.

A new Act of Parliament has been drafted to clarify roles and responsibilities. The OPC (Department of HIV and AIDS and Nutrition) is responsible for policy formulation and the NAC is responsible for technical leadership and coordination. Indications are that it will include NAC's legal status and associated governance arrangements, and so provide for a clear demarcation of responsibilities and a single line of HIV and AIDS coordination.

There is a new focus on empowering and decentralizing the national response to district assemblies and enhancing the response at the community level. The 1998 Local Government Act gave Assemblies the mandate to lead local development, which includes HIV and AIDS. NAC is currently determining how best to support the Assemblies and is reviewing the roles of the District

AIDS Coordinator (DACs) in the Assembles and related committees, including the multi-sectoral District AIDS Coordinating Committees (DACCs). The DACs and DACCs were established to manage and implement the HIV and AIDS response. Annual HIV and AIDS District Implementation Plans (DIPs), containing integrated work plans for the districts, are to be funded by NAC.

3. Functions of NAC and the Secretariat

NAC is mandated to lead and coordinate the national response, which includes planning, providing technical expertise and building capacity, mobilisation and disbursement of resources, and monitoring progress. New legislation on the mandate and role of NAC is anticipated as part of the forthcoming Act of Parliament. The role of NAC as presented in the 2001 Constitution NAC includes:

- Facilitating development of national HIV and AIDS policy
- Facilitating policy and strategic planning in sectors
- Guiding the implementation of the National HIV and AIDS Action Framework
- Advocacy and social mobilization on HIV and AIDS in all sectors at all levels
- Building partnerships among all stakeholders in the country with regional and international linkages
- Development of 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
- Overall monitoring and evaluation
- Identification of HIV and AIDS research priorities

In addition to core coordination functions additional functions have been performed, such as the development of health promotion materials. Furthermore NAC has been involved in grants management since 2003 when a Grants Facility was established in the Secretariat to engage, contract and support the nongovernmental (civil society), public and private sectors. In 2004 financial management was contracted out to a Financial Management Agency (FMA), which is responsible for both direct implementing partners and sub-grantees. Grants disbursements to district based grantees and sub grantees has also been contracted out to NGOs acting as umbrella organisations. The FMA contract expired in June 2007 and the grants management unit within NAC has taken over the grants management function.

4. Financing the national response

Malawi has a very high dependence on external financing with many development partners contributing to the HIV and AIDS response. In the 2003-2008/9 period the amount committed by donors is over 90% or 75% of funds committed and projected so far according to NAC (NAF 2005-2009) and the UN respectively. The two largest external funders are the World Bank and the Global Fund (GF). The WB MAP programme is for $35m 2003-2008. Under Round 1 (2003-2008) the GF commitment is US$178, followed by $84 million in 2005 under Round 5 (OVCs and health systems strengthening). For Round 7, Malawi was awarded $36 million for HIV. There are only two Principal Recipients, NAC and the Ministry of Health (MoH). As PR, NAC also channels funds to the MoH.

Pool funding development partners fund the Strategic Management Plan 2003-2008 (SMP) and implementation of the NAF, while others operate outside the SMP and are less directly linked to the NAF. NAC coordinates the allocation of pool donor resources to priority areas according to annual workplans. Some partners fund the annual workplan as discrete donors (eg CDC and UNDP) while others channel funds through other mechanisms. This is separate from the pooled

funding arrangements in support of the health SWAp, which also includes the Global Fund but not CIDA who do not fund the Health Sector directly.

Pool partners collectively represent the largest source of funding for NAC and include the Government, Global Fund, World Bank, DFID, CIDA, Norway/SIDA. The pooled funds are channelled through the Grants Facility to all sectors with an umbrella mechanism supporting sub-granting to community based organizations and NGOs. This is one of the main channels for moving resources to communities through District Assemblies.

The government is also providing extra resources in terms of recurrent expenditure to all public sector bodies. Since the 2002/03 budget the Government has created an HIV and AIDS budget line for each ministry and department. Line ministries aim to allocate 2% of their annual budget for HIV&AIDS related activities.

5. Harmonisation and alignment

Broader development frameworks

Following the completion of the Malawi Poverty Reduction Strategy (MPRSP), the Government has developed the Malawi Growth and Development Strategy (MGDS) as the overarching strategy for Malawi for the period 2006/07 to 2010/2011 fiscal years. The MGDS, which is principally MPRSP II, presents a policy framework that articulates issues related to both economic growth and development. The MGDS includes HIV and AIDS issues as a cross-cutting issue in its themes, which include social protection and social development. It is also the final 6th pillar of the strategy (HIV and AIDS and Nutrition Disorders).

The forthcoming national social protection framework aims to address root causes of poverty and vulnerability, with impact mitigation as the key focus of the programme in relation to HIV and AIDS. There are established links between NAC's NAF and wider development strategy. NAC sits on the National Technical Committee on Social Protection.

Alignment of HIV and AIDS and the Health Sector

The MoH leads the health sector bio-medical response to HIV and AIDS and established an HIV and AIDS Unit in 2003. Essential services in the Essential Health Package (EHP), implemented through the Health Sector Wide Approach (SWAp), include prevention and treatment of HIV and AIDS. Strong communication exists between the NAC and the MoH, although collaboration can be thwarted by capacity constraints especially in the MoH. The NAC's NAF contributes to the overall goal of the SWAp Program of Work and lessons learnt from the process of pooled funding for HIV and AIDS activities through NAC have greatly assisted in successfully developing pooled funding plans for the health SWAp. However until recently NAC has provided its funding as a discrete budget line in the Health SWAp. There are plans for this to change in the new Malawi Financial Year that starts July 1st 2007 when "Pool to Pool" financing will begin. MoH will also be re-costing the Essential Health Package which includes updating the package with new HIV interventions and this should also mitigate vertical programming to some extent.

NAC has an HIV&AIDS Monitoring and Evaluation (M&E) plan which was adopted in 2003 and revised in 2007. The Ministry of Health collects a more comprehensive set of HIV&AIDS related data for the purposes of its HMIS. Some of these MoH indicators have been incorporated into the NAC led system. Efforts to further integrate the M&E systems of NAC and MoH have been somewhat challenged by adding more layers of coordination in the decentralisation process.

Harmonisation and alignment between government and development partners

Malawi has made progress in harmonising and aligning development partner activities with the NAF and its strategic priorities. Good partnership arrangements are in place, in particular the pooled donor group (with recent GF membership), the wider donor partnership represented by the HIV and AIDS Development Group (HADG) and the Malawi Partnership Forum. Each of these groups has an important advisory role to play within the national response. Some donors, due to their own government requirements, are not able to join the pool and channel funds through NAC, and may require another set of data collection over and above the NAC and MoH systems to fully respond to their own reporting requirements.

The Memorandum of Understanding (MoU), which guides the relationship between the Government and the pool partners, has been in operation since 2003. UNDP and CDC have not pooled their funds but are also covered to some degree by the MoU although they are no full signatories. The pool donors meet together with an annually rotating chair to provide a forum for the group and to act as a communication channel with NAC and government.

The SMP 2003-2008, which guides the implementation of the NAF, is a useful tool for fostering harmonisation. It aims to represent a common understanding of the expected results, outputs, impacts, performance measurement and reporting amongst key stakeholders including NAC and pooled development partners. The SMP forms the basis of the MoU, which is being reviewed and updated to bring it in line with government processes and to focus more widely on harmonised finance, procurement, review and reporting arrangements.

Harmonisation and alignment of governance structures

The roles and responsibilities of the GF Country Coordinating Mechanism are undertaken by the Malawi Global Fund Coordinating Mechanism (MGFCC), which is chaired by the Permanent Secretary, Ministry of Finance. NAC functions as the secretariat. As the MoH and NAC are also GF PRs, due to the potential for conflict of interest with this arrangement, MoF now chairs this forum. There are around 20 members of the MGFCC, including representatives of government, development partners, UN, civil society, NGOs, FBOs, private sector, research and academic institutions. Increasing alignment of the MGFCC with the other Health, HIV and AIDS accountability structures is under consideration and lessons are planned to be shared with Mozambique

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3.5 Country Annex: Mozambique

Mozambique National AIDS Council (CNCS)

1. Establishment of CNCS and the institutional setting

The HIV and AIDS campaign had been led since its inception in the late 1980s by the Ministry of Health (MOH). The MOH established the National Programme for Combating AIDS which developed a broad education-based awareness programme with wide participation of civil society and NGOs. The MOH led a multi-sectoral response with government, NGOs and donors in the development of the first National Strategic Plan to combat HIV and AIDS in 1999. The plan proposed the establishment of an Inter-Ministerial AIDS Commission – the CNCS – with the responsibility to coordinate a national multi-sectoral response. The CNCS was created in 2000 by a Ministerial Decree (10/2000 23rd May 2000). The Decree also established the CNCS Secretariat to serve as the operational body for the coordination of the national response. The CNCS is currently positioned under the Office of the Prime Minister.

2. Governance and structure of CNCS

At a national level, the CNCS's institutional framework comprises a Board and Executive Secretariat. The CNCS Board is chaired by the Prime Minister and the Minister of Health is the Vice President. There are 13 commissioners on the Board representing government sector ministries, NGOs and civil society representatives. The Executive Secretariat has an established office in Maputo and a provincial nucleus in each province. The Executive Secretariat was established under exceptional administrative, financial and personnel management conditions. Standard civil service procedures have been set aside for a more flexible apparatus which allows for the contracting of staff at market salaries, the design and implementation of a "purpose built" financial management and programme monitoring system, and an openness to measures to improve effectiveness including hiring in functions as needed.

3. Functions of CNCS and the Executive Secretariat

The CNCS provides leadership and political support for the national strategy and plays an important role in policy-making processes, supervising, evaluating and giving direction in the administration and implementation of multi-sectoral programmes. The Executive Secretariat has been given the mandate to lead, catalyse, coordinate and monitor all activities in support of the National Strategy. CNCS spearheads the non-medical government efforts and is responsible for developing, allocating and managing budgets. This is done primarily through the operational HIV and AIDS Common Fund. Approximately 80% of external donor funding (including Global Fund grants) and 65% of the State budget allocated to the CNCS is disbursed through the Common Fund. The Executive Secretariat has financial officers at central and provincial level to facilitate the management and implementation of the fund. Since 2004 it has awarded over 1200 grants to local groups. Development partners are currently working with CNCS to provide a system that will outsource the management of grants.

4. Financing the national response

In April 2006, the Mozambican government and seven principal donors and funding agencies - Canada, Denmark, UK, Ireland, Sweden, the World Bank and the Global Fund signed a Memorandum of Understanding creating a Common Fund for disbursing assistance for HIV and AIDS. Under this agreement, the development partners channel their financial aid through the Common Fund account managed by the CNCS. The Fund may only be used to finance the CNCS Annual Operational Plan. The CNCS has discretion to use the money to implement anything within

the plan, and the Memorandum states "Common Fund partners may not earmark funds for any specific objective".

The seven partners promise to provide their aid "in a way that is aligned with Mozambican instruments, processes and systems of financial management". They also commit themselves to eliminating unnecessary bilateral procedures (such as reporting requirements), and to "mounting joint missions, undertaking joint analysis, using joint procedures, and reducing the number of visits and overlapping activities".

Currently, no UN Agencies working in HIV and AIDS in Mozambique contribute to the CNCS Common Fund. The World Bank, willing in principle, is currently operating outside the fund due to challenges in adapting its internal regulations to the MOU.

A number of donor governments provide funding and other support to address Mozambique's HIV and AIDS epidemic, including the United States, the United Kingdom, the European Union, France, Belgium, Canada and Ireland. DFID provided over US$4 million in 2006 to directly support HIV and AIDS activities including almost US$1 million to the CNCS. This is in addition to the financial support provided through budget support and common funding mechanisms in the Ministry of Health and the Education Common Fund.

Mozambique is one of the 15 focus countries for PEPFAR. U.S. bilateral aid for Mozambique was $37.5 million in FY2004; increasing to $94.4m in FY 2006.

The World Bank has approved $55 million (2003-2008) in funding to support the HIV and AIDS Response Project. As part of its regional HIV and AIDS Treatment Acceleration Project, the World Bank has also approved $60 million in funding to expand access to ART in Mozambique, Ghana and Burkina Faso of which Mozambique receives $20.8m (2004-2007).

5. Harmonisation and Alignment

Broader development frameworks

The Strategic Plan for the Health Sector (PESS 2001-2005-2010) was approved by the Mozambique Council of Ministers on 24 April 2001. The PESS became the basic strategy document for government and external partners to work towards a common vision. The Plan was drafted concurrently with the first Action Plan for the Reduction of Absolute Poverty (the PARPA), the Mozambican Poverty Reduction Strategy Paper (PRSP). Because of their simultaneous launch, the PESS is generally consistent with the PRSP which includes a commitment to respond to HIV and AIDS albeit through education and health related activities, and within broader government policy.

Alignment of HIV and AIDS and Health Sector

Within the PESS framework, the Ministry of Health has drawn up a National Strategic Plan for HIV and AIDS (PEN II) which was approved by the Council of Ministers in 2004 and covers the period 2005 to 2009. Non health sector HIV and AIDS policies, such as education, are the responsibility of CNCS, which is operating its own separate pooled fund and National Strategic Framework for HIV and AIDS (NSF). The NSF and the PEN II are aligned. PARPA II objectives and indicators have also been developed based on the NSF.

Harmonisation and alignment between government and development partners

The MOH and its partners signed a Code of Conduct in 2000 and a revised Code in 2003, setting out the principles and guidelines for collaboration between the MOH and its developing partners and defining the leadership role of the government through the increased use of country based systems and planning cycles. The main coordination forum for the health sector is the Health

SWAp (SWAp Saude) which meets monthly to review progress made in implementing the PESS. The main coordination forum for the multi-sectoral response to HIV and AIDS is the Partners Forum which was established in 2003 as the forum for dialogue between the CNCS and its partners and meets monthly to review progress made in implementing the PEN II. The Partnership Forum is comprised of partners providing technical and financial support to the response and implementing partners (mainly civil society umbrella organisations). It is chaired by CIDA and UNAIDS (Vice Chair) and includes the Executive Secretary of the CNCS. A Code of Conduct and Terms of Reference exist which define the principles, mechanisms and regulate the functioning of the Forum.

Rapid progress has been made over the past two years in harmonisation and alignment in HIV and AIDS. Most partners have significantly changed their ways of working in order to reduce the risks of duplication, incoherence and diversion of scarce CNCS resources away from its core business. The integration of Global Fund grants into the Health Common Fund (the Prosaude) and the CNCS Common Fund represents a pioneering example of how a disease specific funding mechanism can be adapted to better fit with country systems whilst also supporting the objectives of the PEN and the PESS. The World Bank is due to follow suit.

Harmonisation and alignment of governance and coordination structures for HIV and AIDS

The existence of a Country Coordinating Mechanism solely for developing and overseeing Global Fund proposals has always been contentious in Mozambique. Given the existence of a Sector Wide Approach in health and the PF for HIV and AIDS, stakeholders questioned the need for another coordination mechanism. In August 2006, a solution was agreed to fold the role and function of the CCM into the PF and the Health SWAp. As a result, the membership of the PF and the Health SWAp has expanded to ensure that all CCM members are represented and participate in both fora. Under this arrangement the CCM has become a "virtual" group that meets on an ad-hoc basis to carry out core functions – mainly preparing and appraising GF proposals and convening ad hoc meetings on topics that warrant special attention (such as mitigation of conflicts of interest).

Informants for this review have indicated that the Mozambique model is a useful example of how coordination structures can be rationalised. Informants have also suggested 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.

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3.6 Country Annex: Namibia

National AIDS Committee (NAC)

1. Establishment of NAC and the institutional setting

Namibia launched the National AIDS Control Programme (NACP) under the Ministry of Health and Social Services in 1990, shortly after Independence. Under this programme, a short term, emergency response plan was developed and awareness and prevention campaigns were advocated. By 1992 the first Medium Term Plan was developed for 1992-1998. The First medium term plan has a focus on NACP coordinating and managing HIV patient care and prevention activities. The NACP was based at the Ministry of Health and Social Services, but supported activities implemented by other ministries and NGOs. A review of the first Medium Term Plan was conducted in 1997. The review found that extensive awareness campaigns had had good effect, that political commitment was clearly articulated and that management structures were in place. The review, however, recommended that there should be further development of programme management, more targeted communication interventions and multi-sectoral involvement should be strengthened. To address these recommendations, in the second Medium Term Plan (1999-2004), the National AIDS Co-ordination Programme (NACOP) was formed, replacing the NACP, though still housed under the Ministry of Health and Social Services. Under the third Medium Term Plan (2004-2009) it was agreed that further strengthening was required to build the capacity to plan, coordinate and monitor the national and local responses. Therefore, the National AIDS Council (NAC) was established to provide national leadership, the National Multi-Sectoral AIDS Co-ordination Committee (NAMACOC) was established to oversee coordination and overall implementation of the response, the National AIDS Executive Committee (NAEC) was established and is responsible for the implementation of the decisions of the NAC, and various other committees for sectoral, technical and regional advising were created.

2. Governance and Structure of NAC

The NAC was established by a decree of Cabinet in 2004. Below Cabinet, NAC is the highest policy decision making body on matters related to HIV&AIDS. Membership on the NAC includes nine Ministers, 13 Regional Governors, the Director General of the National Planning Commission Secretariat and the Permanent Secretary for the Ministry of Health and Social Security (MoHSS), who serves as the Secretary to NAC. The Chairperson is the Minister of , Ministry of Health and Social Security with the Minister of Regional and Local Government and Housing as Deputy Chair. NAC is responsible for initiating and approving policy for an expanded response to the commitment for the regional and sectoral response and ensures sustained political commitment and broad support for the programme. Each Minister is responsible for his/her own sector's HIV&AIDS resource mobilisation, ensuring that the budget is sufficient for the implementation of the sector's commitments in the national plan, at all levels.

The National Multi-Sectoral AIDS Co-ordination Committee (NAMACOC) is similar to the NAC, but the membership is at Permanent Secretary level, including the PSs from 13 Ministries, the OoPM and the National Planning Commission. There are also Undersecretaries from 13 regions and 18 representatives from 16 organisations, including FBOs, the private sector, NGOs, youth, cooperating partners and various other CSOs. The specific responsibilities of the NAMACOC include the coordination and overall implementation of the national and multi-sectoral response, advising NAC on policy issues, providing leadership on sectoral and regional implementation, and resource management.

The Secretariat to both the NAC and the NAMACOC is the National AIDS Executive Committee (NEAC), which is a committee of over 30 people, including representatives from five Ministries, the OoPM and the National Planning Commission, six representatives are designated from CSOs, plus the UN, the Partnership Forum and the Directorate of Special Programmes, MoHSS, with

other co-opted Advisers from the Directorate as well. NEAC is responsible for the implementation of the decisions of NAC and NAMACOC, covering all components and all sectors. NEAC meets to coordinate the detailed implementation of the multi-sectoral response. It monitors the detailed progress toward outcomes and outputs of each component of the third Medium Term Plan, and it resolves implementation issues, referring to NAMACOC when appropriate. The NEAC is supported by the Expanded National AIDS Response Support Division within the Directorate of Special Programmes, within the Department of Health and Social Welfare Policy, within the MoHSS, therefore the effective coordination of the national HIV&AIDS response is embedded within the MoHSS.

Both the NAC and the NAMACOC are scheduled to meet every six months, with a provision for extra-ordinary meetings. In practice, NAC and NAMACOC do not meet very regularly, but the NEAC, which meets monthly, is more consistent.

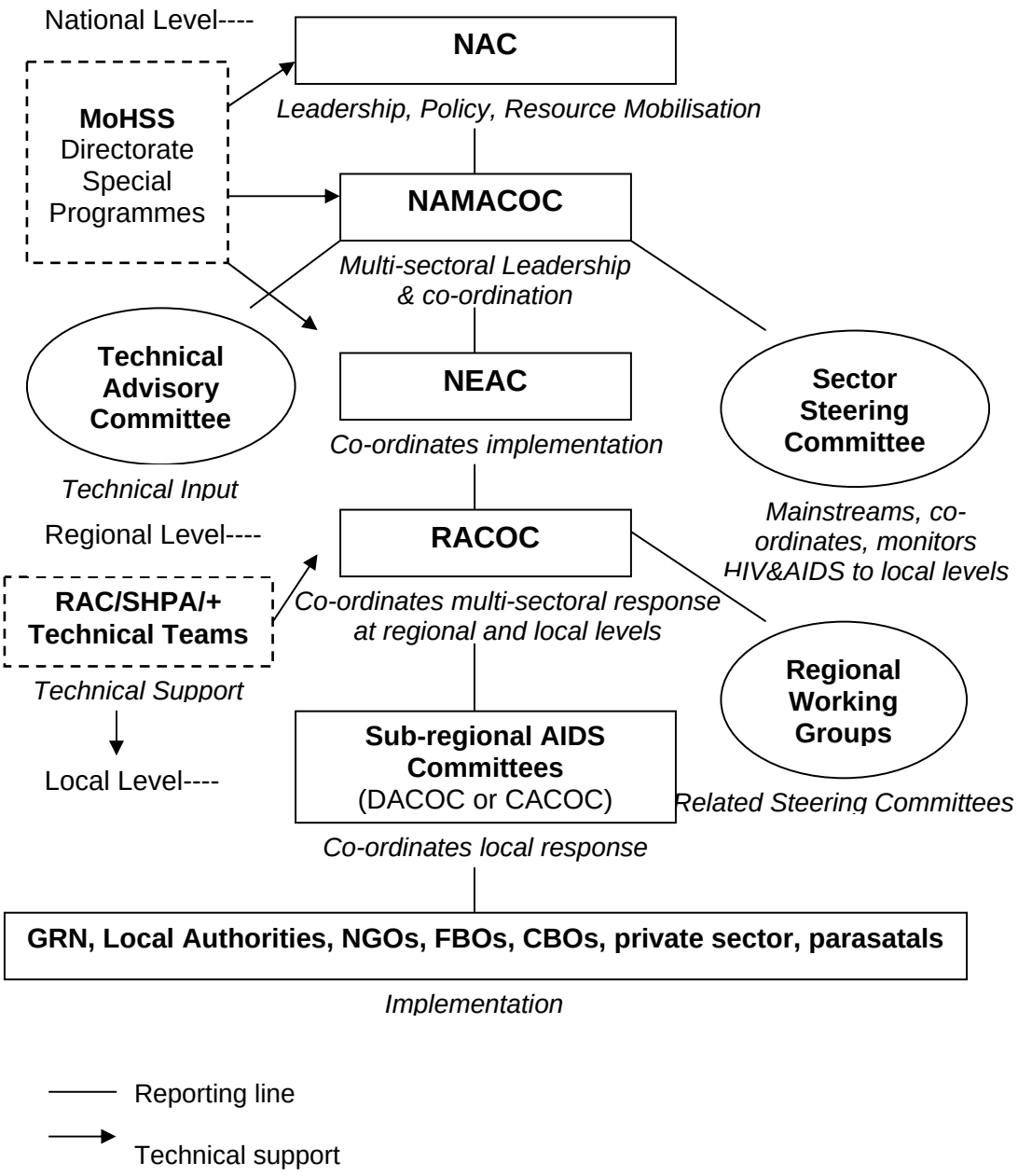
Civil Society representation is significant on both NAMACOC and NEAC, indicating that civil society does have space to participate in planning and implementation as well as policy formulation and governance. Namibia National AIDS Support Organisation (NANASO) is the umbrella for civil society. It works with MoHSS and it plays a part in the selection of CSOs to be represented on NAMACOC. NANASO has a seat on NEAC.

3. Functions of NAC, NAMACOC, NEAC and the MoHSS Directorate of Special Programmes

The core functions of the various committees which have been established to oversee and coordinate the national response to HIV&AIDS in Namibia are outlined in the organogram below. According to the Government of Namibia, “the breadth of activities required to overcome this epidemic means that no one person can be expert in all aspects of the response.” At national and regional levels, technical expertise and interventions are coordinated through specific posts within the Directorate of Special Programmes. To support the Directorate, Technical Advisory Committees (TACs) have been established to pool expertise from various stakeholders and implementing partners.

In 2002, Cabinet approved the creation of a new Directorate within MoHSS. The Directorate of Special Programmes was created to design, manage and direct policy development, strategic planning, resource mobilisation, coordination, facilitation, monitoring and evaluation of the national response across all sectors. The Directorate includes HIV&AIDS, TB and malaria. The Directorate has two divisions, one focusing on the health sector response and the other on the multi-sectoral response. The Directorate has 48 civil service posts, but a full complement of 161 staff, including the seconded and contract staff, ie CDC, PEPFAR, GF PMU, and specific programme staff for VCT, TB, and malaria, supported by donors such as the European Commission and GTZ.

Figure 1: Organogram of the National AIDS Co-ordination Programme



For the purposes of this comparative paper, NAC is similar to a Cabinet Committee on HIV&AIDS, NAMACOC and NEAC are similar to a Board or Council and the functions of a Secretariat fall to the Directorate of Special Services within the MoHSS.

The current organisational structure is perceived to be appropriate on a day to day basis for carrying out the core functions, including the leadership, managerial and technical skills. Given the combination of civil servants, contract staff and seconded staff, there have been few problems with recruitment and retention, however, there has been a relatively minor problem with poaching from government and across the partners. While it is generally felt that the everyday functioning of the Directorate is fine, what is missing is effective leadership at the higher level, which is felt to be faceless at the present time.

Informant interviews revealed that with the national HIV response falling to the MoHSS, the Minister chairing NAC and the PS Health chairing NAMACOC, the multisectoral response is impeded—as the Minister cannot delegate to other Ministries. When the review was done of the 3rd MTP these issues came out in Cabinet. The Minister of Health at that time is now the Deputy PM. While she was Minister, she was well respected and she could make things happen. Now she has moved and the current Minister of Health is viewed as relatively junior, matters have become more difficult. NAC meetings and NAMACOC meetings are said to rarely happen. It was reported that there has been only one recently, which was to approve the National HIV Policy, and that was poorly attended. It was expressed by members of the Directorate that there was a desire to have the functions of NAC taken to the Office of the Prime Minister or to the National Planning Commission, which reports to the President, as it is viewed that this would give NAC more authority. It was recommended that NAMACOC should go to the Secretary to the Cabinet as they are the overall supervisor of all the PSs.

4. Financing the national response

In Namibia, it is expected that the financing of the national response must be shared by government and all sectors of society. In addition to the national commitment to finance the response, many international partners have given support and continue to pledge support to achieve specific results. The coordination of resource mobilisation and tracking rests with the Resource Mobilisation and Development Cooperation sub-division of the Directorate of Special Programmes in the MoHSS.

The Namibian 2nd National Development Plan (NDP2) includes a strategic goal of combating HIV&AIDS and, as such, there is an expectation that each Ministry will adequately plan and budget for their contribution to the national response. Each PS, as the controlling officer, has the responsibility for ensuring that their Ministry's workplan and budget appropriately finance the mainstreamed local responses within every constituency, within the mandate of the Ministry. As a result, the national response is funded directly through government, both at Secretariat level as well as implementation. Resources flow through all relevant Ministries and they flow to sub-national levels through local government structures.

As part of the second Medium Term Plan and the NDP2, the private sector was also strongly encouraged to partner with GRN in the fight against HIV&AIDS. A "Menu of Partnership Options" was compiled in 2002 to canvass for support from and enhance partnership with the private sector.

Other significant funding sources include:

1. The Global Fund Round 2 (2004-2009) was awarded for all three disease areas for a total of $114m (Namibia also received Round 5 funds for TB and Round 6 funds for malaria)
2. PEPFAR allocated $67m for 2007

5. Harmonisation and Alignment

Broader development frameworks

In addition to the Medium Term Plans which guide the HIV&AIDS response, Namibia has an overall Vision 2030, has developed a series of National Development Plans, and is currently developing the 3rd NDP. Vision 2030 addresses HIV&AIDS as a cross-cutting issue within each sector, with greater depth in the section on Population, Health and Development. The strategies in Vision 2030 highlight the need for leadership at all levels, a multi-sectoral approach, the promotion of policies to combat stigma and discrimination, the inclusion of HIV&AIDS in all development plans, a greater understanding of the impact of HIV&AIDS on all sectors, and an enhanced ability to monitor impact.

Alignment of national development instruments such as PRSPs and MTEFs with the national AIDS framework and / or AIDS sectoral plans is currently weak, but the Directorate is working on improving such alignment. Similarly, although the 3rd MTP indicates that all Ministries should be mainstreaming HIV&AIDS into their plans, the Directorate finds it needs to work harder on that, especially for Regional and Local Govt.

Alignment of HIV and AIDS and Health Sector

Because the management of both the health sector response and the multi-sectoral response falls under the MoHSS, there is a high level of coordination and alignment between HIV&AIDS and health. Components of the national AIDS framework are widely integrated into broader national health policies and strategies. Currently, health issues related to HIV&AIDS are fully aligned within the MoHSS health information and M&E systems, but the Directorate is trying to develop these systems so that they are better able to capture the necessary data for the multi sectoral response.

Harmonisation and alignment between government and development partners

There are a number of coordinating forums establishing the relationship between the Government of Namibia and development partners, including the Partnership Forum and the UN Theme Group on HIV&AIDS. At present there are no special pooled funding mechanisms between the Directorate and the cooperating partners/donors. The European Commission does have a project focused on capacity building at the Directorate, but it ends in 2008.

Harmonisation and alignment of governance structures

The Namibia Country Coordination Mechanism for HIV/AIDS, TB and Malaria (NaCCATuM) is the body responsible for the coordination of GFATM money in the country. NaCCATuM is at NANACOC level with some of the same people serving on both. The PS Health is the Chair. NaCCATuM appears to be working well at present. Historically, some members were not very active, but now it functions better because the Directorate encouraged those members to participate more actively. The Directorate, as Secretariat to NaCCATuM, held a retreat with GFATM facilitation to help NaCCATuM members understand their role better.

It is reported that the process of applying for the Global Fund was instrumental in bringing all the partners together in an effort to prioritise and plan. The Directorate is the PR for the GFATM and disburses funds to more than 30 sub-recipients. The Directorate also disburses PEPFAR/CDC funds.

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3.7 Country Annex: Nigeria

National Agency for the Control of HIV and AIDS: NACA

1. Establishment of NACA and the institutional setting

In 1997, the Government of the Federal Republic of Nigeria, through the Federal Ministry of Health (MoH), adopted the National Policy on HIV and AIDS and STI. In January 2000, the President established a Presidential Committee on AIDS (PCA) comprised of Ministers from all sectors, with the President serving as Chairperson. At the same time the National Action Committee on AIDS (NACA) was established to coordinate a multi-sectoral response to HIV and AIDS. Nigeria's first HIV and AIDS Emergency Action Plan (HEAP) was approved in 2001 for a three-year period. Currently the Nigeria HIV and AIDS National Strategic Framework (NSF) 2005-2009 is being implemented.

The National Policy on HIV and AIDS and STI was revised in 2003, to become the National Policy on HIV and AIDS, in recognition of the importance of a multi-sectoral effort to control the spread of HIV and AIDS and mitigate its impact. The new Policy included an institutional framework suitable for the multi-sectoral and multi-level approach and stated "*The Federal government of Nigeria shall constitute a permanent statutory body or agency that derives its power from legislation to replace the presently existing National Action Committee on AIDS. … The State and local governments shall constitute similar statutory agencies at their respective levels for the management of the response to the epidemic at the levels".*

In April 2007 a new Presidential Bill (2006) was adopted which replaced the NACA with the National Agency for the Control of HIV and AIDS (hereafter referred to as NACA or the Agency). NACA is supervised and controlled by the President. The Bill provided the new Agency with legal authority and independent status. As stated in the NSF, the pre-existing institutional arrangements did not allow for an effective coordination relationship between NACA and entities at State and Local levels. Prior to the new Bill NACA, as a federal coordinating body, was not able to exercise full control in coordinating State and Local level HIV and AIDS activities due to the semi-autonomous status of States in Nigeria and the lack of legal status. The new legislation has provided NACA with the authority and mandate to work with these levels and Federal Line Ministries and Departments.

2. Governance and Structure of NACA

The new legislation established the Agency, a Governing Board (the Board) for the Agency, a Management Committee for the Agency and a National Council on HIV and AIDS. The Board is mandated to not meet less than three times in each year and has 16 members appointed by the President. These include: the Chairman; the Director General (DG) of the Agency; six members selected for their skills and experience; representatives of the Federal MoH, the Secretary to the Government of the Federation and the Federal Ministry of Woman Affairs; two NGO representatives; and representatives of PLHA, women and youth. The Board is currently formulating a capacity building programme for its new membership

The National Council on AIDS comprises the DG as Chairman and delegates from States, the Federal Capital Territory (FCT) and representatives of other stakeholders. It is responsible for: coordinating all HIV and AIDS intervention programmes in the Federation including assessing progress at Federal, State and local levels; the provision of technical direction and; stakeholder cooperation.

The DG of the Agency is appointed by the President and reports to the Board. The Board's powers include making rules for the appointment of Agency employees, including determining terms and conditions of service. The Management Committee, responsible for the management of

the Agency, comprises the DG and heads of Department of the Agency. The Board has requested NACA to review its organisational structure in light of the new legislation and in accordance with the goals and objectives of the NSF.

Nigeria is a three tier federal system, with a Federal Government, 36 semi-autonomous State Governments and 774 Local Government Areas (LGA). The HIV and AIDS coordinating institution at the State and local levels are the SACAs and LACAs respectively. The NSF recommends the SACAs to be situated under the State Governors Office and LACAs under the LGA Chairman's Office to enable them have the political authority to coordinate the muti-sectoral response.

Approximately eight SACAs have completed the legal process of becoming multi-sectoral State Agencies. NACA has provided all states with guidelines on State Agency structure. SACAs are developing three to five year multi-sectoral State HIV and AIDS Strategic Plans (SSPs) with several states having already launched their SSPs. All the SSPs have the same eight objectives as the NSF but with state specific targets and interventions. In addition some LGAs are looking to develop their own long-term planning tools.

3. Functions of NACA and the Board

The new legislation includes functions of the Agency and its Board. The functions which the Act mandates the Agency to perform include:

- Plan and coordinate activities of the various sectors in the National Response Strategic Framework
- Facilitate the engagement of all tiers of government and all sectors on issues of HIV and AIDS prevention, care and support
- Advocate for the mainstreaming of HIV and AIDS interventions into all sectors of the society
- Formulate policies and guidelines on HIV and AIDS
- Support HIV and AIDS research in the country
- Mobilise resources and coordinate equitable application for HIV and AIDS activities
- Provide and coordinate linkages with the global community on HIV and AIDS
- Monitor and evaluate all HIV and AIDS activities in the country
- Facilitate the development and management of the policies and strategies of all sectors to ensure the human, financial and organisational resources to support the successful execution of the national HIV and AIDS response programme
- Facilitate collaboration for the management of HIV and opportunistic infections

In addition NACA is the manager of the World Bank MAP project (see section 4) including grant management and drug procurement. The new Bill includes provision for the Agency to establish one or more funds into which donor payments may be credited. The Agency shall disburse these funds to ministries, States and other organisations for executing HIV and AIDS activities and programmes.

Functions of the Board include:

- Provide leadership and advocacy for the prevention and control of HIV and AIDS, and provide intergovernmental and multi-sectoral coordination
- Facilitate the formation and development of national and international partnerships and collaboration
- Facilitate funding for effective dissemination of information and counselling against HIV and AIDS infections and care and support for PLHA throughout the Federation
- Review the extent of implementation of the NSF
- Determine the overall policies and guideline of the Agency, including its financial and operating procedures, and ensure their effective implementation

4. Financing the national response

The budget for the Government resource allocation to the national response is defended in the National Assembly, with approved allocations based on the defence and other parameters including competing needs and the resources envelope. There is a Debt Relief fund, which has been committed to MDG targets, and the Government finances part of the treatment programme including drug procurement. The Government expenditure, through NACA, was approximately US$15.6 million from 2000 to June 2005. In 2006, US$9.2 million was allocated to NACA and for HIV and AIDS program activities in other sectors.

Work to align the planning, financial and reporting cycles with the NSF is ongoing. The NSF recommends a resource mapping exercise and the development of a resource framework to ensure equitable distribution and targeting of resources. A recommendation from the GTT domestication process was the development of annual action plans at all levels. Based on information from stakeholders, including objectives, activities and funding sources in relation to NSF priorities, a national draft plan was produced in 2006. All AIDS related activities and finance were aggregated to inform the national plan.

The main external funders of the national response are PEPFAR, the World Bank and the Global Fund (GF). Other development partners funding the response include USAID, DFID, CIDA, UN Agencies, JICA, EC and Irish Aid. External AIDS funding amounts to over US$300 million per annum. When compared to the burden of the HIV epidemic (the third highest HIV positive population in the world), external funding to Nigeria has not been as extensive as other countries in Sub-Saharan Africa. However, major partners including the WB are looking to develop new programmes and funding is likely to double over the next year.

A World Bank Multi-country HIV and AIDS Program (MAP) loan of US$90.3 million was approved Nigeria in 2001 (as the HIV and AIDS Program Development Project) to contribute to implementation of the HEAP. Serviced by a National Project Team (NPT), a five year HIV and AIDS Fund (HAF) was established to provide support to NGOs and organizations/groups engaged in HIV and AIDS programmes and activities. In addition the project aims to expand the public sector response and 17 Federal line Ministries have benefited. In May 2007 the World Bank approved additional financing of US$50 million to help finance costs associated with scaling up the project from 14 to 35 states.

The GF has to date approved US$74.4 under Rounds 1 and 5. This includes US$30 million for the scale up of comprehensive HIV and AIDS treatment, care and support, under Phase 1, Round 5, with the NACA as the Principal Recipient (PR). PEPFAR has been increasing its annual support to Nigeria's comprehensive HIV and AIDS prevention, treatment and care programmes – from $70.9 million in Fiscal Year (FY) 2004 to approximately $163.6 million in FY2006.

5. Harmonisation and alignment

Broader development frameworks

The National Economic Empowerment and Development Strategy, NEEDS (2004), is Nigeria's poverty reduction strategy. There are complementary SEEDS plans at State level. The NEEDS makes explicit links between poverty and ill-health, including HIV and AIDS, and acknowledges the potentially devastating impact of HIV on socio-economic development. Strategies include increased capital budgetary allocations, through recent debt relief agreements, to social, infrastructure and other key sectors, including HIV and AIDS related activities. These broader development frameworks integrate with the NSF, and the next generation of national and state strategies being developed will align with strategies as set out in the NSF and SSPs.

Alignment of HIV and AIDS and the Health Sector

In the Federal MoH the National AIDS and STI Control Programme (NASCP) leads the response. The Health Sector HIV and AIDS partnership facilitates the establishment of development partner support to the health sector. Although the national Health Sector Strategy for HIV and AIDS was developed subsequent to the NSF, it is now nested within the NSF.

The Nigeria National Response Information Management System is the national M&E system developed to monitor the HEAP and now being revised and expanded to ensure it reflects the monitoring requirements of the NSF. Training and software provision to state level was concluded at the end of 2006. NNRIMS also derives data from the Patient Management Monitoring System (PMM) for tracking patients on ART.

Harmonisation and alignment between government and development partners

Government and development partners are committed to harmonisation. Nigeria was one of the first countries to review and domesticate the Global Task Team (GTT) recommendations in line with the country context.

The Donor Coordination Group (DCG) is recognized as a Constituency Coordinating Entity within the Nigerian HIV and AIDS partnership. It started in April 2004 as an informal information-sharing forum for HIV and AIDS donors in Nigeria. Membership is on an institutional basis. The group is open to all bi-lateral and multilateral donors and foundations, directly providing financial resources to the HIV and AIDS response in Nigeria and adhering to the Terms of Reference. Most of the administration of the DCG is handled by the secretariat based in UNAIDS. A NACA representative attends DCG meetings as an observer.

There are currently two pooled funding mechanisms under development:

(1) To support the Global Fund CCM secretariat. DFID and USAID are co-funding a jointly agreed workplan to fund the secretariat. DFID will channel its funds through UNDP, who will have oversight responsibility for implementation of the plan. USAID has a system which enables them to transfer funds to the CCM against the jointly agreed workplan, rather than pooling funds.

(2) To support NACA in its coordination and monitoring function. Partners are currently working on the design of a joint funding mechanism for pooling funds through one account in NACA. NACA is leading a Task Team, with DFID, the World Bank and CIDA, to undertake the design.

Harmonisation and alignment of governance structures

The CCM and the NACA are separate entities. The CCM is chaired by an elected representative and the NACA is represented on the CCM. Also as a PR, NACA is represented on the PR sub-group. Following reform in 2006, the CCM is seen as an effective and well governed structure with 2 members elected by each constituency. A Programme Coordinating Committee comprising the CCM chair, PRs and SRs meets regularly. There is no sense that the roles of the NACA and CCM overlap and NACA is widely recognised as the agency with a wider coordination role.

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3.8 Country Annex: Rwanda

Commission Nationale de Luttre Contre Le SIDA (CNLS)

1. Establishment of the CNLS and the institutional setting

Prior to 2001, the Ministry of Health's National AIDS Control Programme led the national response to HIV and AIDS in Rwanda. The Government launched its multi-sectoral response to HIV and AIDS in 2001 by establishing the National AIDS Control Commission (CNLS) through Presidential decree N°02/01 of 16/03/2001. CNLS sits under the political tutelage of the Office of the President, and under the technical supervision of the Ministry of Health (MOH) which has had a Minister of State for HIV and AIDS and Other Epidemics established since 2002. The Minister of State for HIV and AIDS and Other Epidemics serves as the CNLS representative to Government and the National Assembly. There is no apparent formal reporting structure between the MOH and CNLS.

The Office of the President is the institution charged with assisting the executive arm of government and is headed by a Minister of State and a Director of Cabinet. CNLS is one of seven special commissions that have been set up under the Office of the President and charged with addressing specific issues of national concern. Line ministries are also involved in the multi-sectoral response, most notably the education, defence and youth sectors.

2. Governance and Structure of CNLS

The current Commission is relatively small (previously 19 members), comprising a President, a Vice President and six fixed commissioners. Members are appointed by Presidential Order upon decision taken by Cabinet for a three year term, renewable once on the basis of performance. Commissioners are selected on the basis of representation with the current President being a Bishop and the Vice President representing the NGO community. Other Commissioners represent constituencies from PLHA, medical and private sectors. The Commission meets irregularly, approximately twice a year.

The Executive Secretariat is the administrative and technical arm of the CNLS. It is headed by the Executive Secretary and is composed of 26 staff and three departments: administration and finance; planning, coordination and monitoring and evaluation; and social mobilisation (see organogram dating 2005 overleaf).

Under the Government of Rwanda (GOR) decentralisation policy, the structure described above is meant to be replicated at the provincial and district levels through Provincial and District AIDS Coordinating Committees with provincial structures responsible for the coordination of various initiatives at provincial level and district structures playing a more prominent role, being involved in formulating sector plans, ensuring implementation, monitoring and evaluation and reporting back to CNLS. CNLS has been active in establishing 106 District AIDS Coordinating Commissions. Whilst these structures exist, they are less established than the national CNLS with many District AIDS Coordinating Committees amounting to one or two officers coordinating the response and monitoring and evaluation data reporting. From all accounts, the decentralised structures suffer from serious capacity constraints.

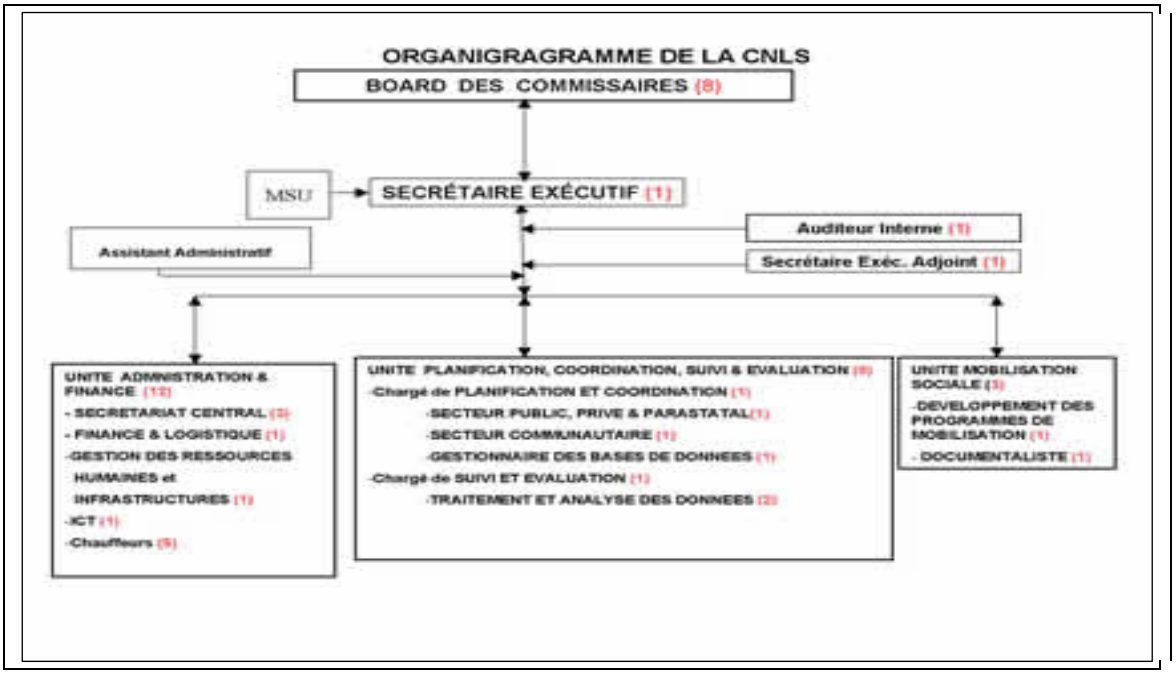

Figure 1: Organisational structure of CNLS (source: website www.cnls.gov.rw)

3. Functions and role of CNLS and the Executive Secretariat

CNLS is entrusted with:

- Assisting the GOR to determine and implement National AIDS Control Policies
- Serving as an organ for coordination of national strategies and the preparation of action plans for institutions involved in matters of AIDS control
- Sensitising the population to mainstream activities of AIDS control, integrating them into their day to day activities, taking into account priority strategies highlighted in the national policy
- Mobilising funds for AIDS control both nationally and internationally
- Sensitising and mobilising support from the country's higher authorities in the fight against HIV and AIDS.

Since 2002 CNLS has promulgated three major policy instruments orienting action against the epidemic:

1. The National Strategic Framework 2002-2006.
2. The National Multi-sectoral Plan 2002 – 2006 (operational plan of NSF)
3. National M&E Plan 2002-2006

CNLS has been active in establishing focal points for HIV and AIDS within each ministry, using CNLS as an umbrella structure within which focal points could be supported. Assessments suggest this is not happening beyond the Ministry of Health, Ministry of Defence, Ministry of Education and Ministry of Youth, Sports and Culture which have each developed their own sectoral policies and programmes on HIV and AIDS.

CNLS has also been active in supporting the establishment of a number of community umbrella organisations (e.g. Rwandan Network of PLHA) to act as coordinating and advocacy bodies. An umbrella organisation responsible for marshalling a response to AIDS through private sector and parastatal firms has also been established. Members of these umbrella organisations are represented on the Board of Commissioners of CNLS.

The MOH, supported by the Minister of State for HIV and AIDS and other major epidemics plays a key role in the fight against HIV and AIDS. Responsibilities include:

- Implementing the policy of the GOR as proposed by the CNLS
- Supervising and evaluating the implementation of the policy
- Proposing updates and adaptation of national policies
- Coordinating HIV and AIDS actions at the political level

The MOH has developed a national programme for treatment, care and support. This is being achieved through the Treatment and Research AIDS Centre (TRAC) which is under the MOH and has been in place since 2001.

Finally, the CNLS is proactive in managing funds for Global Fund programmes and the World Bank MAP. Under the auspices and coordination of the CNLS, a semi autonomous structure, the Global Fund Project Management Unit (PMU) has been established which manages five Global Fund programmes and the MAP. According to the Secretariat this has been put in place for administrative reasons only and CNLS hosts the unit on behalf of the MOH.

4. Financing the national response

There are two main sources of funding for HIV and AIDS in Rwanda.

1. "Internal" financing which consists of the GOR budget contribution, HIV and AIDS solidarity funds and some private sector initiatives. In 2006, the Government of Rwanda budget contribution was earmarked at 1% of the national budget to fight HIV and AIDS, distributed to several ministries involved in AIDS activities. The total national expenditure for HIV and AIDS in 2005 is given at $23,128, 571. This is expected to increase in 2007 to around $27.7m (Rwanda Government MTEF).

2. "External" sources of funding still account for the majority of funds for HIV and AIDS. The most significant sources of external funding come from three sources:

- The World Bank MAP ($30.5m through 2003-2008). Financial and technical assistance to CNLS supports programme coordination, capacity building and monitoring and evaluation.
- PEPFAR ($227m through 2004-2007)
- The Global Fund (total approved HIV and AIDS $88.2m (of which $56.6m 2004-2009, and $31.6m 2007-2009) and HIV/TB grant of $14.6m)

5. Harmonisation and alignment

Broader development frameworks

Rwanda's Vision 20/20 document outlines the key objectives that need to be attained for Rwanda to become a middle income country by 2020. These long term goals include addressing HIV and AIDS through human resource capacity objectives. The PRSP (currently under revision) also includes HIV and AIDS as a cross cutting issue and makes reference to the GOR's National Multisectoral Plan. No targets are set within the 2002 PRSP but informants confirm that current revisions to the PRSP are in line with revisions to the forthcoming National Strategic Framework for HIV and AIDS.

Alignment of HIV and AIDS and the health sector

Rwanda has a Health Sector Strategic Plan 2005 -2009 (HSSP) which includes an embedded HIV and AIDS component whose logical framework cover some of the main categories of the National Strategic Framework and targets four main outputs. There appears to be a good convergence

between the priority action areas in the National Strategic Framework and the outputs envisaged in the HSSP. An assessment of donor coordination in AIDS in Rwanda (2005) suggests that although donors refer to the PRSP in defining HIV and AIDS strategies to be supported, few explicitly aligned their support with the priorities defined in the National Strategic Framework and operational plan.

Harmonisation and alignment between government and development partners
As part of the Vision 20/20 and the PRSP, the GOR in collaboration with donor partners have put in place a framework for aid coordination, harmonisation and alignment at national and sector level. Within this context, sectoral clusters and cross sectoral clusters have been created in a bid

to harmonise development assistance while adequately responding to national priorities. The MOH co-chairs the Health Sector Cluster Group with the Belgian Cooperation and the HIV and AIDS cluster group with USAID. The HIV and AIDS Cluster meets quarterly and seeks to enhance the effectiveness and efficiency and mutual accountability of HIV and AIDS programmes as well as improving coordination among donors and the alignment of their programmes of support to national policies.

Unlike some other countries in sub Saharan Africa, Rwanda has few pooled funding mechanisms in place for the health sector or for HIV and AIDS. Rwanda is at the early stages of a Sector Wide Approach (SWAp) for health, an approach promoted by the UK DFID and based on their successful experience of the SWAp in the education sector.

Since 2004 the Government of Rwanda has instigated a Coordinated Procurement System (CPDS) to pool resources from donors in order to create a common fund for the provision of ARVs. The CPDS is headed by a Resource Management Commission (RMC) which is comprised of senior government officials (the Minister of Health is the President), senior donor representatives, and local and international implementer agencies. To manage the coordination of this mechanism effectively, the chair and senior members of the CPDS are also members of the CCM and actively participate in decisions made by CPDS structures in relation to Global Fund programmes.

Other attempts to improve coordination between government and development partners include the Three Ones initiative which, in the case of Rwanda, has been redefined as “the Three Ones for the Big Three”. This is an attempt to unify efforts in the fight against HIV and AIDS, Malaria and TB, the 3 “ones” through one government executing authority (GoR), one synergistic monitoring and evaluation plan for the three diseases, and one strategic plan for three epidemics.

Harmonisation and alignment of governance and coordination structures

CCM: The CCM and the CNLS, although similar in representation remain separate in Rwanda with a clear mandate between the two entities. The CCM is formed according to the rules and regulations established by the Global Fund. The recent change in Chair of the CCM due to conflicts of interest (the Chair of the CCM was the Minister of Health, also a Principal Recipient of a GF grant) is testament to Rwanda’s commitment to ensure the CCM functions transparently and efficiently. CNLS is represented on the CCM through the Executive Secretary.

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3.9 Country Annex: Tanzania

Tanzania Commission for AIDS (TACAIDS)

1. Establishment of TACAIDS and the institutional setting

Tanzania started to address HIV and AIDS through the National AIDS Control Programme (NACP) based at the Ministry of Health (MOH) in 1985. TACAIDS was established in 2001 in response to a) President Mpaka's announcement that AIDS in Tanzania was a disaster requiring an emergency response, and b) recognition that HIV and AIDS required a multi-sectoral response and the MOH had no authority to direct other ministries. TACAIDS is legally mandated (through Act 22 of 2001) to provide strategic leadership and to coordinate and strengthen efforts of all stakeholders involved in HIV and AIDS. Under the Prime Minister's Office, TACAIDS is listed as an independent department/parastatal and is mandated to plan, regulate and control its affairs independently but within the government system.

2. Governance and Structure of TACAIDS

The Act which established TACAIDS provided for the appointment of a governing Board of Commissioners. The current Commission is comprised of ten, mainly non technical members representing youth, media, faith based and professional organisations and the private sector. Commissioners are appointed for a three year period and can be eligible for re-appointment. The Board is headed by an Executive Chairman who is also the Chief Executive of the TACAIDS Secretariat. This arrangement was set up initially to curb bureaucracy and to facilitate swift decision making for an "emergency" response. More recently, there have been calls (mainly from donors) to review the appointment of the Chair of the Board of Commissioners, to ensure better transparency and accountability vis-à-vis the performance of TACAIDS.

To support the Commission there is a full time secretariat of about thirty staff involved in policy, planning, monitoring and evaluation, research and management information systems; advocacy, IEC; finance, administration and resource mobilisation; internal audit and public relations. The senior management group of TACAIDS consists of five Directors reporting to the Chief Executive. The Directors come from various backgrounds and have diverse work experience from both public and private sectors. All are responsible for management of departments with their own budgets and staff. The Chief Executive of TACAIDS Secretariat leads the national response and reports to the Prime Minister's Office, the mission of the latter being to ensure, supervise and monitor the implementation of government decisions.

TACAIDS only exists at national level but uses existing regional and district structures—Local Government Authorities (LGA)—to mainstream AIDS into district level programmes, mobilise resources for HIV and AIDS activities and coordinate HIV and AIDS responses through Multi-sectoral AIDS Councils (MACs) established at all levels. In addition, Technical Facilitating Agencies (TFAs) have been established at regional level (using World Bank MAP funds) to provide financial and technical support to LGAs to strengthen their capacity to coordinate, plan and manage HIV and AIDS activities. TFAs are largely managed by NGOs such as CARE or AMREF and are currently not integrated into regional and local government structures. TFAs will be phased out by 2009. By then, it is expected that LGAs will have sufficient capacity to take over the functions of the TFA.

3. Functions of TACAIDS and the Secretariat

The core functions of TACAIDS and the Secretariat are detailed below in Box 1. In addition to these core coordination functions, a number of additional functions exist that are not detailed in Box 1. Examples of these are:

- Some implementation functions around the coordination of the national response. For example, implementation of advocacy activities (advocacy with ministries involved in the response on the need for effective coordination)
- Steering functions for certain funds (for example, the World Bank's MAP)
- Implementation and management of a new coordination mechanism (established 2006), the Tanzania National Coordination Mechanism (TNCM), which has evolved from the CCM and has some legal derivation under the Prime Minister's Office and coordinates not just GF grants but PEPFAR and WB programmes.

These additional functions have been incorporated into the existing TACAIDS institutional structure. TACAIDS has always resisted the development of parallel structures for specific donor funded programmes. As such, there is no separate PMU, and the steering of TMAP funds rests with the Director of Finance and comes under the direction of the Director of Policy and Planning. A Global Fund focal point has been established as part of the Directorate of Policy and Planning.

Box 1: Functions of TACAIDS and the Secretariat

Overall Functions of TACAIDS	Functions of the Secretariat
To formulate policy guidelines. To develop a Strategic Framework for planning of all HIV and AIDS control programmes and activities within the overall national strategy. To foster national and international linkages among stake holders through proper co-ordination of all HIV and AIDS control programmes and activities within the overall national strategy. To mobilize, disburse and monitor resources To disseminate and share information To promote research, information sharing and documentation To promote high level advocacy and education To monitor and evaluate all on-going HIV and AIDS activities To coordinate all activities related to the management of the HIV and AIDS epidemic in Tanzania as per National Strategy To facilitate efforts to find a cure, promote access to	To provide essential technical and administrative support for the Commission To implement the decisions of the Commission To co-ordinate activities of stakeholders To manage the operational funds of the Commission by preparing annual budget and programmes To provide relevant data for information, education and communication activities of the Commission and to develop HIV and AIDS data bank To monitor and conduct relevant evaluations on all on-going HIV and AIDS activities Liaise with stakeholders with the view to regulating and coordinating the levels of internal and external resource mobilisation. To publish periodic reports of the Commission's activities and other materials on HIV and AIDS

Overall Functions of TACAIDS	Functions of the Secretariat
treatment and care, and develop vaccines To protect human and communal rights of people infected and affected with HIV and AIDS To promote positive living among people living with HIV and AIDS To advise the government on all matters relating to HIV and AIDS control To identify obstacles to the implementation of HIV and AIDS, prevention and control policies, programmes and ensure the implementation and attainment of programmes, activities and targets. To promote all activities related to the prevention and control of HIV and AIDS epidemic in particular regarding the following: - (i) health care and counselling of HIV and AIDS patients (ii) the welfare of the bereaved orphans and survivors of HIV and AIDS victims (iii) the handling of social, economic, cultural and legal issues related to the epidemic	To carry out any other functions that may be assigned to it by the Commission towards achieving the goals and objectives of controlling HIV and AIDS in Tanzania[11].

4. Financing the national response

The HIV and AIDS budget in Tanzania accounts for 10% of the national budget (increasing tenfold in the past five years). A specific code for HIV and AIDS in the MTEF was introduced three years ago and is used by the public sector to budget for HIV and AIDS. Public Expenditure Reviews are conducted every year to assess government expenditure on HIV and AIDS. Donor funds account for 90% of the yearly budget on HIV and AIDS. 90% of HIV and AIDS funds in Tanzania come from Development Partners. 80% of these funds come from three significant sources:

1. The Global Fund $108.5m (of which $5.4m 2003-2008, and $103.1m 2005-2010; HIV and AIDS grants alone with a further $83m from a TB/HIV/AIDS grant)
2. PEPFAR $309m allocated through to end 2006
3. World Bank MAP $70m (2004-2008)

TACAIDS has significant influence on WB funds through the Public Sector Fund (through line ministries) and the Community HIV and AIDS Response Fund (handled through the TFAs). PEPFAR funding is managed completely separately from TACAIDS. GF funds are routed through the Ministry of Finance (which is Principal Recipient). TACAIDS is a sub recipient on one grant but has no real leverage on GF funds more generally (although TACAIDS controls the proposal development process). Funds from TMAP are channelled to LGAs and TACAIDS has limited allocative influence on these.

A Health Sector Wide Approach and a corresponding basket funding mechanism have been created in Tanzania but are not yet fully functional. Donors continue to channel funds outside of these mechanisms, including for HIV and AIDS through basket funding, budget support and project support.

[11] ibid.

CIDA is considering AIDS sector budget support as a way of financing district AIDS related activities through earmarking block grants for this purpose. Other donors could be interested in this mechanism but scope for large investments is limited due to the nature of the source of funds, with GF and PEPFAR unlikely to go down this route and future World Bank investments possibly being channelled as Direct Budgetary Support.

As well as TACAIDS coordinating the various activities of all the financing mechanisms, a key task is ensuring the regular monitoring of financial flows and that funds are properly allocated and disbursed taking into account the overall balance of the different strategies of the national response. The identification of shortfalls and mobilization of additional resources is closely connected to this task.

The National Multisectoral Strategic Framework (NMSF) guides the government allocation of resources under the Medium Term Expenditure Framework (MTEF) to targeted HIV and AIDS interventions. TACAIDS liaises with the Ministry of Finance so that the Guidelines for the Preparation of Medium Term Plan and Budget Frameworks ensure line ministries, regions and local government authorities include HIV and AIDS control activities in their MTEFs/budgets.

5. Harmonisation and Alignment

Broader development frameworks

Tanzania is currently implementing its second five year PRSP. Its outcome focus aims to foster collaboration among all sectors and the strategy mandates that all public and private sectors and institutions mainstream HIV and AIDS as a cross cutting issue. The National MultiSectoral Strategic Framework 2003-2007 (NMSF) is aligned with the PRSP.

Alignment of HIV and AIDS and Health Sector

Informant interviews have confirmed that a great of deal of effort is being made to ensure that current revisions to the NMSF are being developed in tandem with revisions to the National MoH HIV and AIDS strategy. The National HIV and AIDS strategy will inform the next National Health Policy, due 2008. In addition, the MOH monitoring and evaluation information on HIV and AIDS is coordinated by TACAIDS in line with the one national monitoring and evaluation framework.

Harmonisation and alignment between government and development partners

There are a number of coordinating forums establishing the relationship between the Government of Tanzania and development partners. The Development Partners Group is an umbrella entity addressing donor support in development cooperation. A sub-group on HIV and AIDS is established that helps coordinate the response to HIV and AIDS with the government and has facilitated harmonisation and alignment of national priorities including resource mobilisation. A number of thematic technical working groups support the sub-group on HIV and AIDS offering technical support to specific sectors.

A unique feature of the relationship between government and development partners in Tanzania is the existence of a MoU annexed to the NMSF which agrees that development partners will only support HIV and AIDS activities stated in the NMSF. In addition, Tanzania has led a process to develop the Joint Assistance Strategy in which HIV and AIDS is a key theme.

Harmonisation and alignment of governance structures

In 2005, the Government of Tanzania combined the CCM and existing national coordinating mechanisms into one. As such, the CCM was replaced by the Tanzania National Coordinating Mechanism (TNCM). The TNCM is taking the expanded role of coordinating all national and

international resources aimed at scaling up AIDS, TB and Malaria (see fig 1). TACAIDS acts as the Secretariat for the "recast" CCM. The TNCM is Chaired by the PS of the Prime Minister's Office and representatives include Ministers of Health, Finance and the Office of the President, development partners, civil society representatives including PLHA and academia and private sector organisations.

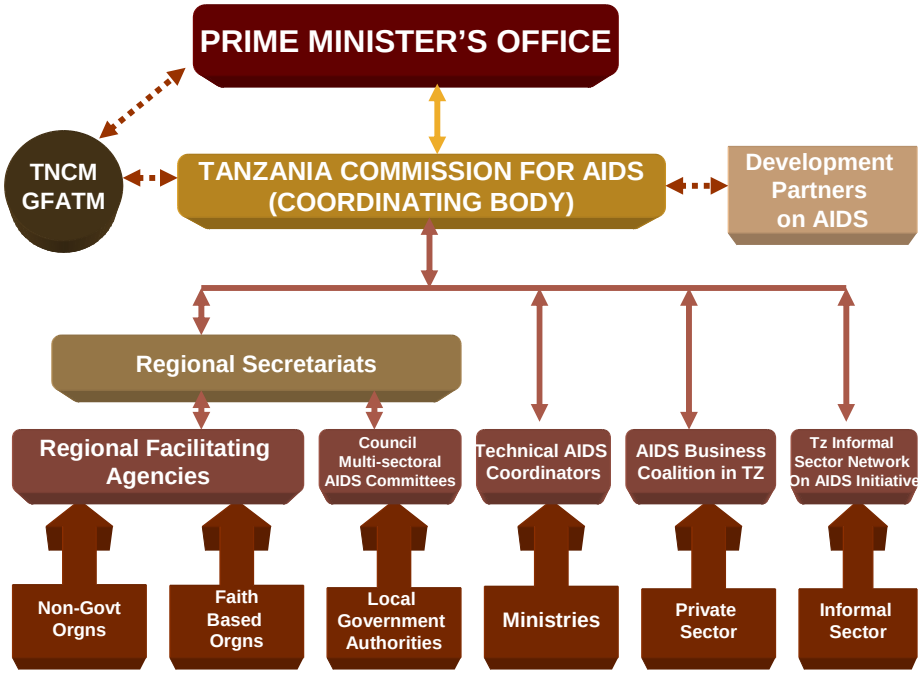

Figure 2: Coordination structures for HIV and AIDS in Tanzania

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3.10 Country Annex: Uganda

Uganda AIDS Commission : UAC

1. Establishment of UAC and the institutional setting

The early response to HIV and AIDS in Uganda was led by the health sector, with the Ministry of Health (MoH) establishing the first AIDS Control Program in Sub-Saharan Africa in 1986. The Uganda AIDS Commission (UAC) was formed in 1992 as the central coordinating authority of the multi-sectoral HIV and AIDS response. Its mission was to provide overall leadership in the coordination and management of an effective HIV and AIDS national response. UAC was established by Parliamentary Statute No 2 of 1992, which situated it under the Office of the President. Uganda's response to the epidemic, led by President Museveni, is well known for its high political commitment at various levels. HIV and AIDS has been declared a national emergency in Uganda.

2. Governance and Structure of UAC

The UAC is a corporate body governed by a Commission (Board). The Board is composed of ten members appointed by the President and drawn from the government and non-government sectors, including representatives of PLHAs and individuals selected for their outstanding expertise and commitment. The UAC Secretariat (UACS) is headed by a Director General appointed by the President, who is also the Chief Executive and Secretary to the Board. The role of the Secretariat is to implement the Commission's decisions and to advise on all technical matters relating to the role of UAC. The structure of the UACS hinges on three Directorates: Policy, Advocacy and Knowledge Management which houses the National Documentation and Information Centre (NADIC); Planning, Monitoring and Evaluation; and Finance and Administration.

In response to the need for strengthened coordination and scaling up of the national response, UAC and its partners established the HIV and AIDS Partnership in 2002 as a participatory and innovative multi-sectoral coordination mechanism (see section 5 for further information). The Partnership provides policy and technical guidance to the UAC and facilitates its coordination role. All issues concerning the coordination and management of the response initiated by UAC or other stakeholders are discussed through Technical Working Groups (TWGs) or established Subcommittees of the Partnership Committee. The Commission meets regularly to receive and discuss technical and policy issues from stakeholder consultations through the Partnership Structure.

Uganda has recognised capacity constraints in the coordination and management of the decentralised response, especially weak human resources. AIDS Task Forces exist at municipal, district, sub county, parish and village levels with Government and NGO membership. They work to provide leadership, coordination and ensure participation. HIV and AIDS Strategic Plans and AIDS Focal Point Officers (FPOs) are also present in many districts, with the FPOs being ad hoc appointments and not part of the public sector staffing structure.

3. Functions of UAC and the Secretariat

The UAC spearheads processes for setting national priorities and policy formulation and is responsible for overall policy and oversight of the national response. It is not mandated to engage in direct implementation and is expected to provide strategic leadership within agreed policy and programme parameters. In 1997 the first Five-year National Strategic Framework (NSF) for HIV and AIDS was developed with Uganda now implementing the second National Strategic Plan 2007/8 – 2010/11 (NSP). The mandate of the UAC was to oversee, plan and coordinate AIDS

prevention and control activities throughout Uganda. This mandate has been translated over the years into the following key function areas:

- Guide policy formulation and establishment of programme priorities
- Take the lead in national planning and monitoring
- Spearhead advocacy for HIV and AIDS activities
- Identify obstacles to the national response
- Mobilize and monitor resource allocation and utilization
- Foster linkages among partners
- Gather and disseminate information
- Promote HIV and AIDS related research

4 Financing the national response

The majority (85-90%) of funding for the national response is provided by external donors with Government funding providing between 7-8% of total budget. External funding is a combination of pooled funding through the Partnership Fund (see section 5), project support (eg GF, PEPFAR) and poverty reduction budgetary support (PRBS). Increasing budgetary discipline, with pressure to adhere to sector ceilings, affects the balance between project aid and general budget support. Some development partners including USAID do not provide direct funding to the Fund but provide support to identified coordination and management priorities.

The main funders are PEPFAR ($170 million 2006), Global Fund (GF) (Round 3, Phase one $70m approved), and the World Bank MAP ($50m 2001-2006), with the UN and bilateral agencies providing additional funding. Despite the national response budget growing in the last four years from about $40 million in 2003/4 to nearly $170 million in 2006/7, financial constraints were caused by the suspension of GF support in 2005 and failure to obtain Round 6 funding. In addition the World Bank switched from HIV and AIDS-specific funding to a more general social-fund credit at the end of MAP-I in 2006. GF support was reinstated in 2005 once certain conditionalities were met.

Meeting the goals and targets in the new NSP will require a doubling to tripling of the resources available to $340 million in 2012 (low funding scenario) or $512 million (high funding scenario) with a renewed focus on aligning development partner funding to NSP priorities. Stronger engagement of various sectors in the response is needed, especially in budgeting, resource allocation and planning of funds in line with NSP. Currently the NSP is not directly linked to Government budget allocations and not integrated into local government, sectoral and national budgeting and planning processes. While decisions about resource allocation remain with each line Ministry, the Ministry of Finance and Economic Development (MoFPED) does take HIV and AIDS and its consequences into account when assessing sectoral plans and budget bids.

5. Harmonisation and alignment

Broader development frameworks

The new NSP was developed within the context of Uganda's Vision 2025 and the Poverty Eradication Action Plan (PEAP). The UAC and its partners have made significant progress in forming links between the AIDS response and the PEAP, which identifies HIV and AIDS as a cross cutting issue hindering the achievement of national development targets. The PEAP reinforces the critical role of MoH in HIV and AIDS prevention, care and treatment and the important role played by Ministry of Labour Gender and Social Welfare in the social aspects of HIV and AIDS mitigation. It mandates all public sectors to factor in HIV and AIDS in their development planning. The Office of the President and Ministry of Finance and Economic Development have mainstreamed HIV and AIDS into planning processes, but other sectors remain challenged by mainstreaming with obstacles cited including the absence of an AIDS budget line from MoFPED.

However, structures are in place in the line Ministries including AIDS Focal Points, sector working group meetings and strategic plans in most sectors.

Alignment of HIV and AIDS and the Health Sector

The MoH has been a major implementer of Uganda's national response since the 1980s and continues to lead the health-sector response. The entire AIDS budget falls under the health sector budget. As in many countries, efforts to link the policy and programming initiatives of UAC and MoH are ongoing. Within the health sector an annual joint process reviews progress against Health Sector Strategic Plan (HSSP) targets and a SWAp supports the implementation of the HSSP. Support is received either through the Government budget, to districts or through project modalities. For HIV and AIDS tracking and reporting, the MoH AIDS Control Programme reports on the health related aspects of the national response, but not the non-health aspects. Harmonisation between the national level HIV M&E framework and the sector M&E frameworks is ongoing.

Harmonisation and alignment between government and development partners

There are good examples of harmonisation and alignment in the AIDS response, primarily as a product of budget support or sector support but also through information sharing and involvement in policy dialogue. However individual partners continuing to work independently through project and programme support has led to some fragmentation.

The Uganda HIV and AIDS Partnership, established in 2002 as a UAC led multi-sectoral coordination mechanism, plays a central role. The AIDS Development Partners are a key constituency of the Partnership, although it provides representation and information sharing for wider stakeholders. The Partnership aims to:

- Minimize duplication
- Maximize potential for synergies, harmonization, learning and peer support
- Pool efforts for scaling up the response

The Partnership structures are the Partnership Committee, the Partnership Forum and the Partnership Fund. The Partnership comprises of 12 Self Coordinating Entities (SCEs) which include Government ministries, Parliament, local government and district level partners, development partners, civil society including organisations representing PLHAs, the private sector and academia. The Greater Involvement of People Living with HIV and AIDS (GIPA) is one of its major guiding principles.

The Partnership Committee (PC)
The PC functions outside of the UAC structure as a consultative body. It is constituted of elected representatives from the 12 SCEs with some constituencies having permanent seats, including UAC, UNAIDS, and the Ministries of Health, Finance, Gender, Labour and Social Development. It meets monthly and sets the agenda for the update, implementation, and monitoring of the national strategic framework, while harmonising policies, programmes and plans and spearheading resource mobilisation.

The Partnership Forum
The annual Forum, first held in October 2002, brings together all members of the SCEs to review progress and set priorities for the following year. The Partnership Forum is the highest representational body of key stakeholders and makes major programmatic decisions on the national response that have a significant impact on a critical mass of the partner constituencies.

The Partnership Fund
Established in 2002, the Fund covers coordination costs of the SCEs and key coordination activities of the UAC. It is a flexible source of small grants for essential coordination and related

activities. The pooling of funds has set a precedent for common ownership of the strategic response as well as increased transparency and accountability. The three main donors are DFID, DCI and the Norwegian Embassy with Denmark being the most recent member of the Fund. The PC makes spending decisions which are administered by UAC.

The Partnership mechanism supports UAC in its coordination role and is key to ensuring proper allocation and participatory governance of funding. The partnership system helps the UAC to focus on it key functions of planning, M&E, policy guidance, advocacy, managing strategic information and facilitating access to resources.

Harmonisation and alignment of governance structures

The National Coordinating Committee (NCC) of the GFATM fulfils the role of the CCM in Uganda. The NCC membership includes representatives of the UAC, various line Ministries, local government and local authorities, district health services, civil society organisations (NGOs, FBOs, PLHAs), private sector, development partners, UN Technical Agencies and academia. The NCC is chaired by the Permanent Secretary & Secretary to the Treasury, MoFPED, with the MoH serving as Secretary. The MoFPED is the Principal Recipient of GF funds.

The Uganda AIDS Commission established the National AIDS Documentation and Information Centre (NADIC) in 1994 to serve as a clearinghouse for HIV and AIDS information in the country.

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PEPFAR: www.pepfar.gov/press/81648.htm
WHO: www.who.int/countries/ug/en/

3.11 Country Annex: Zambia

National AIDS Council (NAC)

1. Establishment of NAC and the institutional setting

In Zambia, the National AIDS Council (NAC) was established by an Act of Parliament in 2002, with a mandate to coordinate and facilitate the multisectoral response to HIV and AIDS. NAC is a statutory body of the MoH, though it does have the authority to act outside the Ministry. NAC is not embedded in the civil service. Staff are hired on performance-based contracts with various durations.

The NAC is "a body corporate with perpetual succession and a common seal, capable of suing and being sued in its corporate name, and with power, subject to this Act, to do all such acts and things as a body corporate may by law do or perform. "

2. Governance and Structure of NAC

The highest authority on HIV&AIDS in Zambia is the Cabinet Committee on HIV&AIDS. The Cabinet Committee, chaired by the Minister of Health, reports to the President. The Cabinet Committee is scheduled to meet twice a year.

The Minister of Health also has the authority and responsibility to appoint a 15 person Council. Membership on the Council includes:

(a) Permanent Secretaries in the Ministries responsible for—
  (I) community development and social welfare;
  (ii) education;
  (iii) health;
  (iv) sport, youth and child development;
(b) a representative nominated by each of the following organisations or bodies:
  (i) Network of Zambian People Living with HIV and AIDS;
  (ii) Zambia Network of Non-governmental Organisations on HIV and AIDS;
  (iii) Forum for Youth Organisations;
  (iv) religious organisations;
  (v) General Nursing Council;
  (vi) Medical Council of Zambia;
(c) a representative of the Attorney-General;
(d) a representative of the media sector;
(e) a representative of a traditional healers' association; and
(f) two persons from amongst members of the public.

The Chair of the Council is also appointed by the Minister and at present is a representative from a religious organisation. The Council is further organised into four committees, which co-opt members from the HIV&AIDS community, at large, in addition to the Council members. The committees are Research and Ethics, Human Resources and Administration, Finance, and Programmes. The Council and its committees each meet at least four times per year.

The Council is supported by a Secretariat. The Council is responsible for recruitment and performance appraisal of the Director General (DG). The DG manages the Secretariat and serves as the Secretary to the Council.

The role of the Council is to provide policy direction and oversight on the functions of the Secretariat. The Council makes sure that policies are carried out in line with vision and mandate.

3. Functions of NAC

The functions of the Council are to coordinate and support the development, monitoring and evaluation of the multi-sectoral national response for the prevention and combating of the spread of HIV, AIDS, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB.

a. support the development and coordination of policies, plans and strategies for the prevention and combating of HIV, AIDS, STI and TB for health and other institutions concerned with the prevention and combating of HIV, AIDS, STI and TB;

b. advise the Government, health institutions and other organisations on the policies, strategies and plans to prevent and combat HIV, AIDS, STI and TB;

c. ensure the provision and dissemination of information and education on HIV, AIDS, STI and TB;

d. develop a national HIV, AIDS, STI and TB research agenda and strategic plan which shall include the quest for a cure for HIV, AIDS as one of the research priorities;

e. support programmes relating to prevention, care, and treatment of HIV, AIDS, STI and TB;

f. mobilise resources to promote and support identified priority interventions including research in areas related to HIV, AIDS, STI and TB;

g. provide technical support and guidelines to health and other institutions involved in the—

(i) prevention and treatment of HIV, Aids, STI and TB; and

(ii) care and support of persons infected with or affected by HIV, AIDS, STI and TB;

(h) collaborate with other research institutions in relation to HIV, AIDS, STI and TB;

(i) Undertake such other activities as are conducive or incidental to its functions under this Act."

The NAC Secretariat is responsible for the day to day implementation of the functions of the Council. In that regard, it can be described as technical leader, a facilitator, a networking hub and a coordination agency. It is responsible for the development and dissemination of the National AIDS Policy (2004), National AIDS Strategic Framework (2006-2010), and the Operational and M&E Plans that complement the framework. NAC is responsible for the coordination and monitoring of the multi-sectoral response.

4. Financing the national response

There are significant funds coming into Zambia to both coordinate and implement the national response. NAC is not a funding agency, but it is a recipient of funds from a Joint Financing Arrangement (JFA), as well as direct funding from various bilateral and multilateral partners.

For the implementation of the response, PEPFAR is by far the largest donor, contributing over one billion USD to Zambia to date. These funds are largely channelled through USG partners and have a heavy focus on the health sector response. This has been effective in getting over 140,000 Zambians on treatment for HIV. There has also been support to NAC, with a focus on strengthening the M&E systems. But more emphasis will be placed on coordination, as the USG has recently signed on to the JFA.

The Global Fund is another significant partner, as is DFID and as has been the World Bank. DANIDA is planning a large HIV programme at present. These partners have had foci on the civil society response and the coordination of the response.

- Zambia has GFATM funding for HIV from Rounds 1 ($92 million) and 4 ($253 million)
- PEPFAR resources were $216 million in 2007
- UN resources planned for Zambia in 2008 total approximately $9 million
- There is also funding from DFID, Irish Aid, Sida, the Royal Netherlands Embassy, and other bilateral partners.

The Government is also making a substantial contribution to the HIV and AIDS response. The GRZ's strategy is to mainstream the budgetary allocations for HIV and AIDS within the allocations of the Ministries. For instance, the Office of the President is allocated ZMK 25,000,000 for HIV and AIDS awareness under General Administration. For the Ministry of Mining, programme 8 is wholly on HIV and AIDS prevention with a budgetary allocation of ZMK 215,000,000. The Auditor General's Office has ZMK 45,000,000 for HIV and AIDS mitigation and the Ministry of Energy has ZMK 99,000,000. For the Ministry of Health, all provinces have their own allocations for HIV and AIDS and in some cases with STI and TB.

There is also a Sector Wide Approach (SWAp) in the health sector to finance health activities, and many donors are looking at joining DFID and EU in providing direct budget support (DBS). With the completion of HIPC and the debt relief that Zambia enjoyed in 2006, there are some who are putting pressure on the Ministry of Finance to use more of the GRZ resources to fund the social sectors, including HIV and AIDS. There are preliminary efforts in place to develop an AIDS Trust Fund, but it seems likely that such an innovation will be some years off. Efforts to measure and track all the financial resources coming to Zambia fro HIV&AIDS have been fraught with challenges.

5. Harmonisation and Alignment

Broader development frameworks

In 2006, Zambia developed its fifth National Development Plan (FNDP). HIV&AIDS was fully integrated into all the chapters of the FNDP and there was a chapter dedicated to HIV&AIDS. The HIV&AIDS chapter became the National AIDS Strategic Framework (NASF). The organs established to monitor the implementation of the FNDP are Sector Advisory Groups (SAGs). The HIV SAG has been slow to get started, but it is now in place and will be meeting twice a year. The SAGs are all convened together once a year to report back to the Ministry of Finance and National Planning (MoFNP), the custodians of the FNDP. At the most recent “All-SAG” meeting, it was clear that more work needs to be done on the mainstreaming of HIV&AIDS into the various sectors, as few reported on HIV in the “All-SAG”.

Alignment of HIV and AIDS and Health Sector

Although NAC is part of the MoH, it works relatively autonomously. The offices are separate and interaction is limited. Historically, however, the HIV response in the country was more fully integrated into the MoH, as the National AIDS Control Programme. There are still posts within the Ministry that have a focus on HIV&AIDS, both for treatment, as well as prevention activities which require health interventions, such as PMTCT, prevention and treatment of STIs, and male circumcision. Thus there is an established and on-going integration of HIV and health. The National Health Plan includes an HIV section, with a focus, where appropriate, on the health sector response. Likewise, there are references to the health sector response in the NASF.

Harmonisation and alignment between government and development partners

There are several ways in which the development partners have facilitated their harmonisation and alignment with NAC. In Zambia, a joint assistance strategy (JASZ) has been developed that outlines which partners will play a role in the HIV&AIDS sector and which of those with be the lead partners on behalf of other donors. This has reduced transaction costs for both the GRZ and the collective of the donors. Additionally, the development partners have formed a self-coordinating group, which meets very regularly, once a month. NAC is represented at these meetings, and the lead partners follow up with the NAC DG after each meeting. Another key area is in the financing of NAC. There are now nine partners who are signatories to the JFA. This has streamlined NAC's financial relationships with the donors.

Harmonisation and alignment of governance structures

There is a Country Coordinating Mechanism (CCM) in Zambia, which is separate from the NAC, though they do include many of the same players. The CCM includes Permanent Secretaries from key government institutions (MoE, MoH, Gender and the MoFNP), research and educational institutions, CSOs, FBOs, PLHA, bi-lateral partners, and UN agencies. The chair is from the University of Zambia. Originally it was the PS from the MoH, but the MoH is a PR and therefore it was deemed that there was a conflict of interest. NAC serves as the Secretariat to the CCM.

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3.12 Country Annex: Zimbabwe

National AIDS Council (NAC)

1. Establishment of NAC and the institutional setting

In Zimbabwe, the National AIDS Council (NAC) was established by an Act of Parliament in 1999, with a mandate to coordinate and facilitate the multisectoral response to HIV and AIDS. NAC is a parastatal of the MoH, though it does have the authority to act outside the Ministry. Because it is a parastatal, it is not embedded in the civil service. Staff are hired on three year performance-based contracts.

Zimbabwe was the first African nation to introduce an AIDS Levy and a national AIDS Trust Fund. These were important innovations and provide a level of support and continuity in an era of uncertainty in Zimbabwe.

2. Governance and Structure of NAC

The NAC Board reports to the Minister of Health. The Permanent Secretary for the MoH is an ex Officio of the Board, as is the Chief Executive Officer (CEO) of the Secretariat. There are 14 Councillors, including the CEO and the PS. The Councillors are appointed by the President on advice of the Minister of Health. The Councillors represent all sectors, including the president of the NNPLHA and the president of the Confederation of Zimbabwe Industries. To ensure representational functions, Board members come from organisations that are representative, ie big businesses. There is also a representative from indigenous entrepreneurs, to help compensate for the prior lack of Private Sector involvement.

The role of the Board is to provide policy direction and oversight on the functions of the Secretariat. The Board makes sure that policies are carried out in line with the vision and mandate of NAC. They also monitor the performance of the CEO. The Board is scheduled to meet four times a year, and in practice it does meet quite regularly. The minutes are circulated among the Board and to the Minister, and resolutions are disseminated by press conference after the meeting.

It is reported by the Secretariat that the level of authority of NAC has been satisfactory. It is described as having “no limiting leash, no one says don’t do this or don’t do that.” But there are other Ministries that do not feel compelled to report to NAC on their HIV&AIDS activities. The Act stipulates that they should, but the NAC is currently working on a Statutory Instrument to enforce the Act. With regard to the resource mobilisation mandate, this is stipulated under the Act. NAC has been able to pursue resource mobilisation independently.

3. Functions of NAC

NAC describes itself as a facilitator, a networking hub and a funding agency, with funding coming through the AIDS levy. The core functions of the NAC are: 1) to coordinate the multi-sectoral response, 2) to ensure the Strategic Framework is in place and oversee the operationalisation of the framework, 3) M&E, and 4) Resource Mobilisation. NAC has been able to carry out these core functions reasonably well. There was an initial framework which expired in 2005. The new framework is from 2006-2010, and it includes the relationship and function of the sub national levels, with 10 Provincial AIDS Coordinators, and 95 District AIDS Coordinators.

The core functions of NAC have changed over time. When NAC started, there was plenty of money, and much of the implementation was done through NAC. However, this created competition with other players. Now NAC is doing much less implementation, rather, it is focusing

on the coordination of the implementers. For example, to support OVC, there is a national body, with a fund within the Ministry of Labour and Social Welfare (MoLSW). This national body assists in paying school fees and providing other appropriate support. The money for this fund comes from the AIDS Levy and goes to the MoLSW for them to disburse. For ARVs, there is an arrangement with UNICEF, whereby funds go to UNICEF for them to procure the drugs. The drugs are delivered to the MoH to administer.

As a result of these changing functions, NAC is now better able to coordinate the national response, for example by mapping HIV activities in all the districts. NAC has ascertained that coverage is reasonably good in areas where there are CSOs operating. Some areas report that they don't have CSOs to cover them, so NAC is trying to ensure better coverage in those districts.

There are 300 staff in total, organised in six directorates: Finance, Human Resources and Administration, Internal Audit, M&E, Information and Communication, and Operations/Programming. There are 50 staff in Harare. The 95 district offices include staff in both accounts and programmes. At provincial level there is an office, which includes M&E, Programmes, IT, Accounts, a secretary and drivers. Generally, all these staff of NAC are funded through the AIDS Levy.

The economic situation (8000% inflation) makes for high staff turnover, therefore NAC is always inducting new staff. The CEO of NAC has been in post for 3+ years. He has a background as a medical doctor and public health specialist, and he also has an MBA. Many staff are going from NAC to CSOs, which seem to pay people in hard currency. In an effort to curtail this, NAC has been liaising with partners to have the partners support posts within NAC using hard currency. Currently there are about 30 posted supported that way. Various national coordinators—OVC, gender, BCC, advocacy and Provincial M&E posts—are all supported in some way by the UN.

The organisational structure is judged by the NAC itself to be appropriate to carry out the functions of NAC. It is strong in coordination and M&E. Resource mobilisation is handled through the Communication and the Operations units, with oversight from the CEO.

4. Financing the national response

The NAC is funded from a 3% AIDS levy on all income and corporate taxes. The funds generated from the AIDS levy go into the National AIDS Trust Fund, as legislated in 1999. The funds are collected by the Zimbabwe Revenue Authority (ZRA) and every month the ZRA transmits the allocation directly into the NAC account. The AIDS levy is also used to fund key areas of implementation, as outlined above. Disbursements of the AIDS levy are transparently recorded on the NAC website.

Although NAC is funded out of the AIDS levy, the current economic situation in Zimbabwe has created challenges for the on-going financing of NAC. The official exchange rate is Z$30,000 (Oct. 2007) per USD. NAC is funded at a level of 10 million Z$/year. This level is sufficient for the payment of salaries, but when NAC needs to purchase things from outside, there is not enough left to pay salaries. Even though salaries for NAC staff are three times higher than the civil service, and the salaries are adjusted regularly, NAC has had to replaced 50 of 95 district coordinators and all the Provincial coordinators in the past year.

NAC is generally perceived as a credible lead agency, able to exert influence over sector policies and plans and public sector resource allocations, though it has taken time to achieve that position. When NAC was initially assessed in 2002 by the Global Fund for the role of Principal Recipient (PR), it failed the capacity test, but now has been accepted as the PR for Phase 2 of Rd1 and Rd 5, which are both currently running. NAC is also chairing the common fund. NAC is starting to work with Line Ministries to ensure that they all have HIV&AIDS focal persons, and NAC is conducting advocacy for the Line Ministries to develop sectoral policies and plans. They have been having some success with the Ministries of Mines and Agriculture.

5. Harmonisation and Alignment

Broader development frameworks

The guiding document for Zimbabwe is ZUNDAF- It provides a framework for common planning and it provides common targets. There are various other development strategies and plans, which include HIV indicators. These are based on the MDGs and other targets that have been developed by NAC.

Alignment of HIV and AIDS and Health Sector

NAC is part of the MoH. As such, the National Health Framework includes an HIV section. This overlaps with the HIV Framework, as developed by NAC. NAC and MoH engage the same stakeholders, who make sure that the targets are harmonious and aligned. The NAC targets are based on the Universal Access (UA) targets. The MoH now needs to revise its targets to include the UA targets.

Regarding the alignment of health and HIV systems, Zimbabwe is not doing as well as it could. There are currently separate M&E systems for HIV and health. The HIV system is multi-sectoral, encompassing more than the health system. As custodians of UNGASS, the health indicators come from the MoH.

Harmonisation and alignment between government and development partners

In 2002, many donors withdrew their support, but it was reported that now these donors have noted the humanitarian crisis and are coming back in to help. In light of the AIDS levy and in the context of the economic situation, NAC expressed a view that they didn't need cash, but rather in kind contributions, like drugs. DFID, CIDA, Sida and Irish Aid are in a pooled funding arrangement (the Expanded Support Programme). This fund has pledges of $40m over three years, with $15m already in the account. There is also funding that comes from UNDP, through three UN agencies for implementation: UNFPA for BCC, UNICEF for ARVs, and UNAIDS for capacity building in management, coordination and M&E. The UN also supports some staff members. NAC would like them to widen their support.

Harmonisation and alignment of governance structures

There is a CCM in Zimbabwe, which is separate from the NAC, though they do include many of the same players. It includes key government institutions (MoE, MoH, Ministry of Social Welfare and Ministry of Local Government), CSOs, FBOs (the Zimbabwe Association of Church-Related Hospitals), other umbrella bodies, PLHA, bi-lateral partners, and UN agencies. The chair is the MoH and he is said to be very committed. It is reported that the representation function is more formal within the CCM than the NAC. NAC is a member of CCM, but now that NAC is a PR, they also report to CCM.

Documents

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ANNEX 1

Terms of Reference: Review of Institutional Arrangements of National AIDS Commissions

Background

In Zambia the National AIDS Council (NAC) was established by an Act of Parliament in 2002. The Act placed the NAC under the Ministry of Health. The Director General of the NAC (Dr. Chirwa) has requested technical support from the DFID STARZ programme to develop his understanding of the governance, structure and functioning of NACs in selected countries.

Purpose

The purpose of this technical support is to undertake a desk review and analysis of coordinating bodies for national multi-sectoral HIV and AIDS responses in approximately ten countries. The review will mainly focus on institutional and governance arrangements; existing and changing functions, roles, responsibilities and coordination. The advantages, disadvantages and challenges of different country arrangements will be considered. The data will be presented for interpretation by the Zambia NAC. The STARZ programme has not been requested to make recommendations specific to the Zambian situation based on the information collected.

Methodology

Ten countries will be reviewed for their relevance to Zambia (including geographical proximity) and the significance of their arrangements for the Zambian context. Five of these countries will be "focus" countries and examined in more depth on the basis of interesting changes that are known to be taking place with the NAC in the context of the themes we have identified (governance, functions, harmonisation and alignment and financing) The countries selected for general review are: South Africa, Namibia, Uganda, Rwanda, and Nigeria. The countries selected as focus countries are: Mozambique, Kenya, Malawi/Rwanda, Botswana and Tanzania. These have been selected on the following basis:

- Botswana: Middle Income Country and requested by Zambia
- Tanzania: Harmonisation and alignment of NAC/CCM
- Kenya: MoH/NAC relationship; decentralised NAC at district and community level, known alignment between PRSP/MTEF/NSF
- Mozambique: NAC/CCM Harmonisation and alignment; pooled funds for NAC; extensive grant funding undertaken by NAC and staffing structure to reflect this
- Rwanda:

The desk review will use, as a basis, a series of questions grouped around key themes (see attached). These questions will guide the collection of information. Technical support will be provided by HLSP AIDS Specialists and an experienced researcher with a Masters degree in public health. The team will use a combined approach of collecting and collating existing published and unpublished information and conducting semi-structured interviews with both development partners and government staff, where possible. Existing HLSP and STARZ networks will be used and support will be requested from DFID Zambia the Health, HIV and AIDS Adviser. The team will coordinate with UNAIDS as appropriate.

Output

The main output of the review will be a report which will include:

An executive summary
- A commentary and brief analysis presenting the NAC's arrangements in the countries reviewed organised by key themes
- Annexes summarising the arrangements in each of the countries reviewed

Tables and frameworks will be used where appropriate to present the information in a user friendly manner.

Inputs and Timescale

16 days (Jackie Mundy and Clare Dickinson) plus 8 days for researcher (Janet Whitelaw-Jones). Other costs envisaged are communication costs for liaison between the review team and structured interviews.

Final report to be delivered by the end of June 2007.

Reporting Arrangements

The review team will report directly to Elizabeth Serlemitsos, and through her to the NAC DG (Dr Chirwa) and DFID (Jane Miller). All correspondence will also be copied to Jake Ross, who will be responsible for briefing the HLSP Africa Regional Director as appropriate. Clare / Jackie will provide a fortnightly email update of progress to Elizabeth Serlemitsos and will seek her inputs as appropriate.

ANNEX 2

A Synthesis of Institutional Arrangements of National AIDS Commissions

Questions to Guide Information Search

1 Governance Issues

a) What is the legislation (Act of Parliament?) which created the NAC? (find a copy where available and possible)

b) Has the legislation been amended since its creation? If so, how and why?

c) Does the legislation clearly define the mandate, level of authority and autonomy of the NAC? Can you specify each?

d) What is the organization's position in the public administrative structure and to which body does the organisation report to? (e.g. does it sit under and report to the Office of the President or some other equivalent? Is it embedded in the MoH?)

e) Does a Board of Commissioners/Councillors exist? How many people is it? Who sits on the Board and how are they appointed?

f) What is the role of the Board? (e.g. representation, ensuring good governance practice)

g) How often are they scheduled to meet? Does this happen in practice? Are minutes of meetings available on websites?

h) What sectors, civil society and interest groups (e.g. people living with HIV) are represented in the governance arrangements of the NAC and how effective is their representation? (if available – how are they selected, how do they feedback to their constituencies?)

i) What structures or systems are in place, or being put in place, to ensure fair representation?

j) Has the level of authority that the organisation reports to been satisfactory? If not, describe why and the challenges present.

k) Has the level of autonomy defined in the legislation facilitated or hindered the organisation's ability to carry out its mandate? Please describe

2 Functions

a) How does the NAC describe itself - technical leader, a facilitator, a funding agency, a networking hub?

b) What are the core functions of the NAC?

c) Has the NAC been able to carry out these core functions (national and sub-national levels)? If not, why not?

d) Have the core functions changed since the creation of the NAC? How is the NAC responding to new demands (e.g. grant management and disbursement, taking on CCM functions) and is it changing its organisation and governance structure as a result?

e) If the NAC is changing its functions in practice, how are these affecting the organisation's ability to fulfil its coordinating role? Are new functions perceived to give the NAC more clout/traction (e.g. the handling of money)?

3 Structure and Staffing (lower priority)

a) Does an organogram of the NAC exist? (if yes, find a copy)

b) Is the organisational structure appropriate for carrying out the core functions, including the leadership, managerial and technical skills? (technical skills could include policy analysis, advocacy, impact mitigation, mainstreaming)

c) Have any specific measures been put in place to deal with issues of staff recruitment and retention? (e.g. revised salary structures, contracted staff or civil servants? moving HR management outside of the public service)

4 Harmonisation, Alignment and Financing

a) Is the NAC perceived as a credible lead agency able to exert influence over sector policies and plans and public sector resource allocations?

b) Is there any information available on the formal and informal relationships between the NAC and actors in ministries of finance/economics/planning?

c) Does the NAC get funding directly through the national budget? How are the NAC structures (national and sub-national levels) being financed?

d) What is the role and relationship between the NAC and the MoH in the national response? How does this impact on the ability of the NAC to coordinate with the MoH?

e) How are components of the national AIDS framework represented in broader national health policies/strategies?

f) How do AIDS and health related systems align with each other? (e.g. how does the MoH M&E framework interact with the HIV M&E framework?)

g) Is there any alignment of national development instruments such as PRSPs, MTEFs with the national AIDS framework and / or AIDS sectoral plans?

h) Is there a CCM in the country? What is the relationship between the CCM and the NAC? Pros and cons? Is this relationship changing and if so, how?

i) Are there any unique features of the relationship between the NAC and the cooperating partners/donors? E.g. pooled funding arrangements for AIDS, capacity building of NACs etc.

j) please note any additional unique circumstances or key issues that related to the situation in this country.

ANNEX 3

Review of Institutional Arrangements of National AIDS Commissions

Documents and Websites Reviewed

COUNTRY SPECIFIC

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ANNEX 4

Review of Institutional Arrangements of National AIDS Commissions

Abbreviations

ACHAP	African Comprehensive HIV/AIDS Partnership
ACU	AIDS Control Unit
ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti retro-viral
BBCA	Botswana Business Coalition on AIDS
CACC	Constituency AIDS Control Committee
CCM	Country Coordinating Mechanism
CEO	Chief Executive Officer
CIDA	Canadian International Development Agency
CNCS	Mozambique National AIDS Council (Inter-Ministerial AIDS Commission)
CNLS	Commission Nationale de Luttre Contre Le SIDA (Rwanda National AIDS Control Commission)
CPDS	Coordinated Procurement System
CSO	Civil Society Organisations
DACC	District AIDS Control Committee
DAC	District AIDS Coordinator
DBS	Direct budget(ary) support
DCG	Donor Coordination Group
DCI	Development Corporation Ireland
DFID	Department for International Development, UK
DG	Director General
DIP	District Implementation Plan
DMSAC	District Multi-Sectoral AIDS Committees
DTC	District Technical Committee
EC	European Commission
EHP	Essential Health Package
ERS	Economic Recovery Strategy
FBO	Faith Based Organisation
FCT	Federal Capital Territory
FMA	Financial Management Agent
FPO	Focal Point Officer
FY	Fiscal Year
GF	Global Fund
GF/PRU	Global Fund/Principal Recipient Coordination Unit
GFATM	Global Fund for HIV and AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV and AIDS
GOB	Government of Botswana
GOL	Government of Lesotho
GOR	Government of Rwanda
GTT	Global Task Team

HADG	HIV and AIDS Development Group
HAF	HIV and AIDS Fund
HEAP	HIV and AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
ICC	Inter-Agency Coordinating Committee
JAPR	Joint AIDS/Annual Programme Review
JFA	Joint Financing Arrangment
JASZ	Joint Assistance Strategy, Zambia
KNASP	Kenyan National AIDS Strategic Plan
LACA	Local AIDS Coordinating Area
LAPCA	Lesotho AIDS Programme Coordination Authority
LGA	Local Government Area/Authority
M&E	Monitoring and Evaluation
MAC	Multi-sectoral AIDS Council
MAP	Multi-country HIV and AIDS Program (World Bank)
MCG	Monitoring and Coordination Groups
MDG	Millennium Development Goal
MGDS	Malawi Growth and Development Strategy
MGFCC	Malawi Global Fund Coordinating Mechanism
MOF	Ministry of Finance
MoFNP	Ministry of Finance and National Planning
MoFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MOHSS	Ministry of Health and Social Security
MoLSW	Ministry of Labour and Social Welfare
MoU	Memorandum of Understanding
MPF	Malawi Partnership Forum
MPRS(P)	Malawi Poverty Reduction Strategy (Paper)
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
NACA	National Agency for the Control of HIV and AIDS
NaCCATuM	Namibia Country Coordination Mechanism for HIV/AIDS, TB and Malaria
NAC	National AIDS Commission/Council
NACOP	National AIDS Coordination Programme
NACP	National AIDS Control Programme
NADIC	National Documentation and Information Centre
NAEC	National AIDS Executive Committee
NAF	National HIV and AIDS Action Framework
NAMACOC	National Multisectoral AIDS Coordination Committee
NANASO	Namibia National AIDS Support Organisation
NASCOP	National AIDS and STDs Control Programme
NASCP	National AIDS and STI Control Programme
NASF	National AIDS Strategic Framework
NEEDS	National Economic Empowerment and Development Strategy,
NGO	Non governmental organisation
NMSF	National Multisectoral Strategic Framework

NNRIMS	Nigeria National Response Information Management System
NPT	National Project Team
NSF	National Strategic Framework for HIV and AIDS
NSP	National Strategic Plan
OP/OoP	Office of the President
OPC	Office of the President and Cabinet
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PACC	Provincial AIDS Control Committee
PARPA/II	Action Plan for the Reduction of Absolute Poverty/II (ie, PRSP)
PCA	Presidential Committee on AIDS
PEAP	Poverty Eradication Action Plan
PEN II	National Strategic Plan for HIV and AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PESS	Strategic Plan for the Health Sector, Mozambique
PF	Partnership Forum
PLHA	People Living with HIV and AIDS
PMM	Patient Management Monitoring System
PMU	Project Management Unit
PR	Principal Recipient
PRBS	Poverty Reduction Budgetary Support
PRSP	Poverty Reduction Strategy Paper
PS	Permanent Secretary
RMC	Resource Management Commission
SACA	State AIDS Coordinating Area
SAG	Sector Advisory Group
SCE	Self-Coordinating Entity
SEEDS	State Economic Empowerment and Development Strategy
Sida	Swedish International Development Agency
SMP	Strategic Management Plan
SR	Sub-recipients (of Global Fund)
SSPs	State HIV and AIDS Strategic Plans
STARZ	Strengthening AIDS Response in Zambia
STI	Sexually Transmitted Infection(s)
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TFAs	Technical Facilitating Agencies
TMAP	Tanzanian Multi-country HIV and AIDS Program
TNCM	Tanzania National Coordinating Mechanism
TOWA	Total War on HIV and AIDS
TRAC	Treatment and Research AIDS Centre
TWGs	Technical Working Groups
UAC	Uganda AIDS Commission
UNAIDS	United Nations Agency for HIV and AIDS
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
USAID	United States Agency for International Development
USG	United States Government
WB	World Bank
WHO	World Health Organisation
ZRA	Zimbabwe Revenue Authority

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