## International Health Partnership and Related Initiatives (IHP+)

# Country teams:
# Building on good practice and looking to the future

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This report draws upon interviews and written contributions from over 60 people in IHP+ countries and development agencies and an extensive literature review including a paper prepared by Andrew Harmer, a consultant for the DFID Health Resource Centre. It is accompanied by an inventory of tools for country team working.

**Summary**

The IHP+ was launched in 2007 as a commitment "to work effectively together with renewed urgency to build sustainable health systems and improve health outcomes in low and middle income countries".[1] Country teams are the key country level mechanism that can drive this ambitious agenda to improve the coordination of international assistance in support of national strategies to deliver health outcomes. This paper provides a summary of the current status of country teams in IHP+ countries and outlines good practice from their structures and ways of working. It draws on an extensive literature review and interviews and written inputs from over 60 respondents currently working, or with experience of working, in country teams.

The most effective, established country teams are in countries with a high level of national government leadership in the health sector and national leadership for improving aid effectiveness across all sectors. They are involved in national planning and review processes and develop single results frameworks which link to national poverty reduction strategies. They have clearly defined objectives and membership which includes civil society, and occasionally involves the private sector if not on a regular basis. They tend to have a sophisticated structure of working groups on technical and cross cutting issues to delegate work to, are linked to or oversee a pooled fund or sector budget support arrangement, and have some mutual accountability mechanisms in place.

[1] IHP+ Global Compact, 2007

## 1. Country teams in IHP+ countries

The guidance note on the 'Development of a Country Compact' highlights three elements of a country team. Firstly the range of stakeholders that should be involved. A country team is the team of government, multilateral and international agencies, donors, civil society and private sector stakeholders that is trusted with developing, implementing and monitoring a countries IHP+ compact. Secondly the guidance note outlines the key elements of a country compact which are the responsibilities of a country team to support the country: development of one single country health plan, one single results framework, one single policy matrix, one single budget, one single country-based appraisal and validation process for the country health plan and in some instances, one single fiduciary risk management/mitigation framework with a shared procurement and financial management procedure that should be aligned with country systems. Thirdly the guidance states that "the most important aspect of the Compact is the process of in-country development, building trust and common systems and ways of working. This process should be seen as inclusive and meaningful engagement of all partners and stakeholders (including civil society and private sector) is needed to achieve of the MDGs." The country team is an important mechanism to promote this inclusiveness.

The terminology of "country team" is new but the concept of a multi-stakeholder group which jointly coordinates action in the health sector is not new. Countries with SWAps have been evolving coordination mechanisms for some time. The IHP+ guidance states that ares should build on these existing mechanisms. Many of these existing teams are now determining what additional "IHP+" tasks they are taking on, and how.

## 2. Country team organization and responsibilities

Almost all IHP+ countries have a country team of some description but their responsibilities and membership vary. Some may not consider themselves as teams but rather as informal groups. They vary considerably with regards to their leadership, membership, working structures and processes, frequency of meeting, and range of responsibilities.

There are three levels of organization of country teams:

1. the established highly defined teams. These have generally evolved from the longest existing SWAp mechanisms and have a clear and defined group of representatives with strong government leadership, a defined supporting structure with good links to national process, effective use of working groups and regular (usually monthly) meetings (e.g. Mozambique, Cambodia, Zambia, Ghana, Mali and Burkina Faso).
2. the existing team. These have many but not all of the elements of more established teams in place. They usually have clear membership, although maybe not of all stakeholders, and leadership maybe lacking or inconsistent. They have some but not all of the following in place: links to national process, use of working groups to conduct work, and oversee pooled or sector funding arrangements. Meetings maybe less frequent and their agreed ways of working may be old and in need of renewal, or new and still bedding in (e.g. Nepal, Burundi, Ethiopia, Kenya).

3. the emerging or ad hoc team. These do not have a clearly defined team but government and development partners meet on an ad hoc basis when issues need addressing. They may be in the process of establishing a team (e.g. Madagascar, Nigeria, Benin).

This categorisation is an assessment of the degree of clarity and organisation of the structure and processes of the country team. It is not a rigorous assessment of the performance or effectiveness of the teams. It gives some indication of the likelihood of a team to be able to fulfil its objectives on the assumption that an effective team will have put key structures and processes in place. There is no single criteria that can be used to demarcate the categories but there are a collection of key indicators which taken together can indicate the functionality of the team. The key indicators that the team has shared objectives and has developed linkages and structures to be able to pursue its objectives and conduct its work include: clarity of objectives of the team, the level of definition and inclusiveness of memberships, the frequency of meeting, the links to national development process, oversight of sector or pooled funding and the use of working groups to conduct detailed work.

## Country teams Current Status[2]

| Country | Monthly meeting | Quarterly / biannual meeting | Dev Partner group | Working Groups | Document | Joint Review Process | Pooled fund / SBS | Civil society in CHST | Private sector in CHST | Formal Mutual Accountability Mechanism |
|---|---|---|---|---|---|---|---|---|---|---|
| **Burundi** | Yes | | | Yes | PF, TOR, MOU | Yes | | Yes | | Within annual review |
| **Cambodia** | Yes | | Yes | Yes | No | Yes | Pooled | Yes | | National PD survey |
| **Ethiopia** | Yes | | Yes | No | Compact, Manual | Yes | Pooled | Yes | | Independent Group |
| **Kenya** | | Yes | Yes | Yes | COC | Yes | SWAP | Yes | Interest | Plan within annual review |
| **Madagascar** | Planning | | Yes | Yes | | Yes | Planning SWAP | | | |
| **Mali** | Bi-monthly | | Yes | Yes | | Yes | SBS, SWAP | Yes | Interest | |
| **Mozambique** | Yes | | Yes | Yes | Compact, MOU, COC | Yes | GBS, Pooled | Yes | | National PD Survey |
| **Nepal** | | Yes | Yes | | SOI | Yes | Pooled | INGO group | | |
| **Nigeria** | | | Informal | Informal | | | | | | Donor group reports annually |
| **Zambia** | Yes | | Yes | Yes | MOU, TOR | Yes | Basket, SBS and GBS | Yes | Interest | |
| **Benin** | | Biannual | Yes | | | Yes | | | Interest | |
| **Burkina Faso** | | Yes | Yes | Yes | | Yes | Basket Funding | | Interest | |
| **Ghana** | Yes | | Yes | Yes | TORs, COC | Yes | Pooled, SBS | Yes | | Harmonisation action plan annual report |

Meeting frequency is taken from key documents and represents scheduled rather than actually taking place
MOU – Memorandum of Understanding, COC – Code of Conduct, TOR – Terms of Reference, PF – Partnership Framework, SOI – Statement of Intent
Pooled – a pooled funding arrangement, GBS – General Budget Support, SBS – Sector Budget Support, SWAP (without financing mechanism)

[2] Sources: Country stock taking reports prepared for Zambia IHP+ meeting February 2008, Country Health Sector Tem Literature Review by Andrew Harmer, HLSP, available country documents and interviews.

Established highly defined teams

The more established teams, for example Burkina Faso, Cambodia, Ghana, Mali, Mozambique and Zambia have clearly defined responsibilities vis a vis national bodies and other coordination mechanisms, use working groups to jointly find solutions to problems, link aid effectiveness in the health sector to national development processes, and review their on-going aid effectiveness and aim to constantly improve it. These teams have evolved over a period of time through the development and oversight of a health SWAp with pooled funding or sector budget support mechanisms. There is strong leadership from the Ministry of Health for the SWAp and the team, and this is linked to higher level government leadership for national development and poverty reduction.

Burkina Faso has the committee to follow up the National Health Development Plan (PNDS) and a committee to follow up the health elements of the national action plan for the poverty reduction strategy (PAP). The latter meets quarterly and includes external development partners, civil society and private sector associations. There is also a sub-group which includes partners to the common basket funding arrangement and many technical working groups. There is a single results framework for the health sector that is linked with a sub-set of indicators in the PAP.

Cambodia has a Technical Working Group for Health which is one of 19 groups that make up the overall development dialogue. Unusually for such a well organised structure the TWGH does not have TORs but it is clearly understood by all partners. The TWGH meets monthly, includes civil society, and is a good mechanism for information exchange and reporting. It is supported by a smaller TWGH Secretariat, comprised of representatives of key stakeholders, which also meets monthly and conducts more substantive business.

The Ghana Health and HIV & AIDS Group lists its five objectives as: (i) to conduct a coherent and coordinated policy dialogue, (ii) to participate actively in decision making on the direction of policies and strategies concerning health and HIV & AIDS, (iii) to monitor commitments made by different stakeholders, (iv) improve the harmonization and alignment of development partners towards government budget, priorities, systems and procedures in order to ensure the efficient implementation of the sector strategy, and (v) to work towards improving predictability of funds.[3] The sector group TORs outline the relationship between the health and the HIV and AIDS sub-sectors, the mechanisms for development partner coordination and representation with one voice, a clearly defined process of annual planning and joint reviews, and a requirement for an annual report on implementation of a harmonisation action plan.

There is strong government leadership of donor coordination in Mali which dates back to the development of a sector programme in the early 1990s. The five year PRODESS II social and health development plan is the common frame of reference for all country interventions. There is a structure of monitoring, technical and steering and regional committees with defined and distinct tasks and responsibilities. They all include civil society and meet at defined intervals (the most frequent is every

[3] Terms of Reference, Health, HIV and AIDS Sector Group, June 2008

two months). There is strong government leadership for harmonisation including a secretariat chaired by the Ministry of Finance which overseas harmonisation across all development assistance.

The Mozambique compact states that the main objective is “to set out a framework for increased and more effective aid, coupled with more efficient and effective government management and stewardship of that aid, in order to permit Mozambique to make faster progress towards the Health Millennium Development Goals (MDGS).” It complements and builds on the existing Memorandum of Understanding (2008), Code of Conduct with Development Partners (2003), Code of Conduct with NGOS (2006) amongst other pre-existing agreements. The Mozambique team meets monthly, has 26 partners, including civil society, and has 10 working groups. A key sub-group includes the contributors to the PROSAUDE common fund.

The Zambia Health Sector Advisory Group (SAG) has developed out of the long standing SWAp established in 1993. The team has three functions: (i) to support Government ownership and leadership for the National Health Sector Plan and encourage strong Ministry of Health led coordination; (ii) promote coordinated sector-wide policy dialogue and technical support on strategic issues in health with MOH, the cooperating partners (CPs) and all stakeholders; and (iii) ensure that the support of CPs to health is increasingly provided to GRZ in a regular, predictable, harmonized and coordinated manner.[4] The SAG outlines its working practices in a Memorandum of Understanding which includes preference for basket or pooled funding, an organised cooperating partner group with a single representative voice, a harmonisation progress annual report and a clearly defined process of annual planning and joint reviews. The SAG has technical working groups and sub-committees.

Existing teams

There is a group of countries with existing country teams which include many, but not all, of the attributes of the highly defined teams. These include Burundi, Ethiopia, Kenya, and Nepal. They all have joint annual review processes and some kind of pooled funding, budget support, or an intention and process to start such a financing mechanism. Their agreed ways of working may be old and in need of renewal, or new and still bedding in. They may also be in the process of responding to political changes in the country. They rarely have mutual accountability mechanisms.

Burundi has a relatively new and rapidly maturing coordination system and in 2008 the Government and Technical and Financial Partners to the health sector signed a Partnership Framework. In 2007 the government established the Consultative Structure of Partners for Health and Development (CPSD) to “facilitate the coordination of technical, material and financial support for the implementation of the National Health Development Plan (PNDS) to achieve the national objectives and the Millennium Development Goals reflected in the PRSP and in the priority action plan (PAP) of the Government”.[5] The CPSD meets monthly and includes civil

[4] Memorandum of Understanding (MOU) between the Government of the Republic of Zambia/ Ministry of Health and Cooperating Partners, April 2006

[5] Partnership Framework Between The Government of the Republic of Burundi and the Technical and Financial Partners in the Health Sector, 2008.

society. In 2007 it started a process of joint annual reviews and in 2008 set up 4 thematic working groups. The CPSD has just undertaken a review of its performance and is aiming to continue strengthening in 2009.

The Ethiopia compact builds on the pre-existing Health Sector Development Programme Harmonisation Manual (HHM) which outlines the Central Joint Steering Committee as the key coordination mechanism which "decides, guides, oversees and facilitates the implementation of HSDP." It is also "a forum for dialogue and consultations on overall policy, reform and institutional issues of the health sector between the Government, development partners and other stakeholders."[6] The government demonstrates strong leadership through a clear framework of annual planning and joint reviews, and has expressed a preference for sector budget support or pooled funding for the health sector. The compact makes provisions for an independent mutual accountability mechanism, but there are no regular technical or cross cutting working groups.

The Kenya Health Sector Wide Approach Code of Conduct, agreed in 2007, outlines the principles of cooperation and the objective "to ensure that ownership, alignment and partnership is taking place inline with the Paris Declaration in the Kenyan health sector SWAp."[7] The Code of Conduct outlines the common management arrangements, the government's preference for financing through sector budget support, annual planning and monitoring processes and the role of the Health Sector Coordinating Committee. It is scheduled to meet monthly although political turmoil and changes in government in 2007 and 2008 have disrupted this. Civil society is a member of the HSCC. In Kenya at present the SWAp is not a financing mechanism but a mechanism allowing all partners to cooperate under certain principles.

In Nepal the Health Sector Development Partners Forum (HSDPF) is a government led group including donors and multilaterals which is scheduled to meet quarterly and comprises government, multilaterals and bilateral donors with a provision to include civil society and private sector. There are monthly External Development Partners meetings and the 2004 statement of intent highlights a division of labour between partners. There is a regular process of national planning and joint annual review meetings. There is a not an existing structure of technical working groups but some elements of mutual accountability in the annual aide memoire produced in the joint annual review.

Emerging or ad-hoc teams
A small number of countries have emerging, ad-hoc or informal coordination mechanisms. These include Benin, Madagascar and Nigeria. In these countries there are occasional informal meetings to promote information sharing and coordination which provides a platform to build on. However they rarely have clearly defined objectives for the country team, regular meeting schedules or terms of reference for the team.

Benin is putting in place some foundations for joint working. The country coordinates joint annual reviews which brings together the key partners. A selection of external

[6] Health Sector Development Programme Harmonisation Manual (HHM), Federal Ministry of Health, Ethiopia 2007
[7] Kenya Health Sector Wide Approach Code of Conduct, 2007

development partners have endorsed the objective of establishing a SWAp and are working on it. They have monthly donor coordination meetings and coordinate to speak with one voice in meetings with Ministry of Health.

Nigeria does not have a defined country team and the highly decentralized federal political system and low aid dependency suggests a team would have different objectives and challenges to other IHP+ countries. There are signs that there is a willingness and opportunity for more formalized coordination: the Ministry of Health recently held a Health System Forum, some development partners are exploring SWAp mechanisms at state level and are starting meetings of an informal external development partners group. There is experience of joint working, for example around Malaria, that could be built upon.

Madagascar is in the process of establishing a team, defining objectives, membership and working methods. The government started to lead joint annual reviews of the health sector in 2007. These are held biannually and bring together government, external development partners and civil society. There are plans to increase the coordination mechanisms through establishing a monthly meeting between government and external development partners. There is an existing division of labour between the principle partners, World Bank, UNICEF and GTZ.

Country teams in Sector Wide Approaches

The literature on health SWAps devotes little attention to the country team type entities that did or did not exist. This suggests that while various teams, groups or committees have existed in different countries, that their full potential as a means to improve coordination and sector dialogue has not been realised. Zambia and Ghana are two IHP+ countries with long standing SWAps which have a country team with clarity of objectives, membership and working processes and structures. The literature on Bangladesh and Uganda, two other countries with long standing health SWAps, suggests a mixed picture on team working. A 2007 study of the Uganda health SWAp referred to efforts that had been taken to considerably reduce the number of working groups because there had been a "very intricate and complex net of working groups and similar processes".[8] Studies of the Bangladesh health SWAp in 2006 and 2007 highlighted the need for regular effective coordination meetings between the Ministry of Health and Family Welfare and external development partners.[9][10] The Bangladesh health SWAp has a history of well organised, inclusive annual reviews, utilising external consultants to analyse progress and make recommendations. These have provided a forum for dialogue that until more recently has not been supplemented with more regular meetings. In the absence of regular coordination meetings it was difficult to build longer term relationships and jointly address issues.

## 3. Elements of effective country teams

[8] Claes Ortendahl, The Uganda health SWAp: new approaches for a more balanced aid architecture, 2007

[9] Howard White, The Bangladesh Health SWAp: Experience of a New Aid Instrument in Practice, 2007

[10] Bangladesh Health, Nutrition & Population Sector Programme, Annual Programme Review 2006

Effective country teams require strong government leadership, well organised external development partners, inclusive participation and a well organised mix of health and non-health expertise to be able to address complex issues of building health systems and achieving health outcomes. This section looks at these issues, while the next section looks at how country teams structure themselves to conduct their business.

Strong government leadership is essential

Government leadership is critical and good practice suggests four key elements of leadership that are essential for country teams. Firstly the government needs to exercise its political leadership for both improving health and for improving the coordination and effectiveness of international assistance for health. Strong government led processes for the delivery of all international assistance at the national level both demands and reinforces country team working. In Cambodia, Tanzania and Mozambique the country team reports to a higher level entity of government and development partners. In Zambia the Joint Assistance Strategy of Zambia working group issued generic terms of reference for the development partner sector groups and required the health sector, among other sectors, to use as a basis for sector group terms of reference. In Mali the national health plan was redrafted (PRODESS II) to harmonise it with the governments Poverty Reduction and Growth Strategy Paper (PRSGP). In Madagascar the Ministry of Health is currently leading a process to establish a country team. Secondly political leadership from the ministry of health, led by the minister, but reinforced by other senior ministry officials and regional health leaders is vital to ensure a consistent and coherent message is conveyed to all development partners.

Thirdly an effective country team needs clear technical leadership from the government articulated in national health strategies, national plans and in the technical decisions that need to be taken to guide implementation. This technical leadership is particularly important in the discussions of working groups on technical issues that report to the country team. Finally there are key events in the annual work of a country team for which government leadership is essential including setting of national strategies, leading (annual) planning processes, leading joint reviews, and operationalising mutual accountability mechanisms.

Effective country teams have a strong core team and larger inclusive events

Most IHP+ countries have country teams which include government, international organisations, bilateral donors and civil society representation or participation but few, if any, include private sector. There are differences in the size of the team, and in many countries the team is not really a team but a gathering of many stakeholders once or twice a year.

Effective country teams have a manageable sized entity that is the core decision making team that meets on a regular basis. Participation in this is usually based on representation of a group, for example of external development partners or of civil society. These teams are usually between 20 but rarely more than 30 organisations represented. In Mozambique the Health Partners Group includes all partners in the SWAp (22 agencies, civil society, international NGOs and local NGOs). In Nepal the Health Sector Development Partners Forum has 18 members of various government ministries and external development partners with a provision for civil society and

private sector participation. In Cambodia the TWGH has 74 members. This size is useful for information exchange and communication mechanism but less so for dialogue and decision making. It is supported by a TWGH Secretariat comprised of six representatives of key stakeholders, which also meets monthly and conducts more substantive business and then feeds back to the full TWGH. This mechanism enables the largest country team to delegate work to a sub-group. Most country teams also make use of annual planning and joint review events to engage a much larger and broader set of stakeholders. In Ghana the bi-annual Health Summit and in Ethiopia the Annual Review Meeting bring together a much larger set of stakeholders including broad civil society and professional associations.

<u>Meaningful civil society engagement in IHP+ country teams</u>.
The IHP+ Guidance note states that the in-country process of developing a compact "should be seen as inclusive and meaningful engagement of all partners and stakeholders (including civil society and private sector) is needed to achieve of the MDGs." Respondents to this study suggest that the experience is mixed and that while civil society is generally represented in country teams that their participation in developing compacts has been limited.

There are two methods that civil society uses to determine representation in country teams, CCMs and NACs. Firstly through umbrella organizations that represent their members on the team. In Cambodia MEDICAM is a CSO umbrella organization with 130 members and in Kenya HENNET is a forum for NGOs working on health in Kenya. Secondly civil society representation is organized through a selection process, as in Zambia where civil society representation in the HIV and AIDS Working Groups is organized through a selection process developed by civil society and overseen by UNAIDS as an independent organization. In some countries civil society representation is nominated by government and can lack legitimacy or ability to speak independently as representatives of the community.

Many contributors to this study reported that while civil society is often represented in country teams that their meaningful engagement is limited by lack of access to information, fear or reluctance to speak independently to represent the communities concerns and lack of capacity to engage fully. Despite these general concerns civil society representatives have engaged meaningfully that can be built upon in country teams.

Firstly civil society representatives are engaged in national coordination mechanisms. In Kenya HENNET is a signatory to the Code of Conduct agreed in 2007 and engages in the discussions for the preparation of the health SWAp.[11] NGOs are active members in many countries in the working groups that are responsible for technical issues. In Zambia civil society participates in the monthly policy meetings and in the annual consultation meeting with all parties. In Cambodia MEDICAM is an active participant in sub-working groups and has links on its website to their work.[12] In Mozambique civil society representatives participate in the joint annual review and in Nepal civil society is increasingly being invited to join key events and

[11] http://www.hennet.or.ke/sublink.php?SubLinkID=c41c8ec8c9e4991ec242dc18691231e8&LinkID=0c3c8322b833376d737f14a98a77d998
[12] http://www.medicam-cambodia.org/

has been actively involved in consultations around the IHP+. Civil society (international and national) are represented in the coordination mechanisms in Mali. Finally in many countries civil society plays a vital role in the national health forums or joint annual reviews. In Zambia and Ethiopia a broad range and large number of civil society organisations are engaged in these national events and outline the work that they do and advocate to government on issues where they feel more attention and resources are required.

There are a number of examples of training courses available for civil society representatives to engage in national planning and budgeting, medium term expenditure frameworks and in building capacity to effectively consult with and represent their community. GTZ's BackUP initiative provides support and training to civil society representatives and NGOs like Treatment Action Group also run training programmes for civil society representatives engaging in these national processes.

Private sector engagement in country teams

There are few examples of meaningful private sector engagement in country teams but in some countries there is recognition on the part of government and other partners of the need to engage the private sector and openness to start engaging. Their potential contribution to the country team is significant given the role of the private sector in delivering health care in all IHP+ countries. In addition the private sector often brings an ethos of fostering innovation and problem solving which would be valuable to a country team. One example of the openness to engage the private sector is in Kenya where associations of hospitals and doctors are beginning to be recognised and their representatives have been included in some meetings. Similarly in Mali the government is considering including the private for profit sector in the coordination mechanisms. In Nepal prominent individuals linked to the private sector and included in joint annual review process, but not necessarily as formal representatives of the private sector.

Good external development partner organisation and representation is vital to the country team

In most IHP+ countries there are a large number of multilateral and bilateral donor agencies. This brings significant transaction costs to government requiring the time to coordinate and conduct dialogue with each. External development partners have begun to reduce the transaction costs through organised development partner groups which speak with one voice representing a consensus view. In Kenya the Development Partners in Health in Kenya (DPHK) meets monthly and WHO acts as a secretariat while the chair rotates. Benin has monthly donor coordination meetings and the group aims to speak with one voice. Nepal External Development Partners (EDPs) meet monthly with a rotating chair, and Madagascar is in the process of establishing a monthly development partners meeting. In Cambodia the health partners meet monthly two weeks before the TWGH to coordinate a common position with WHO playing a convening and coordinating role.

The most formalised external development partner coordination mechanisms are in those countries with long standing SWAp mechanisms. These offer models of how the external development partners in IHP+ countries could improve their coordination, work to have a single consensus voice in country teams, and reduce the number of active donors if the field is overcrowded. In Tanzania, Zambia and Ghana the

external development partners are led by a troika, a team of three representations from different agencies. They rotate on an annual basis, provide leadership to the external development partners and represent their consensus view in country team meetings. These troika usually include a mixture of bilateral donors and multilateral organisations. In each of these countries there is a documented terms of reference for the organisation of the group. In Zambia the Netherlands and Sweden have worked together to take forward the EU Division of Labour by the Netherlands providing funding as a silent partner in a process that will be phased out with Sweden assuming the sole role. In Ghana the UK is represented by the Netherlands. In Tanzania the Development Partners Group for Health (DPGH) includes 21 bilateral and multilateral agencies of which there is a three person troika leadership, 16 active partners who contribute to sub group working and two delegating partners. An additional contribution of the DPGH is the production of a single Joint Country Assistance Strategy which brings together all the technical and financial support of the agencies in one strategy which follows the framework and priorities of the governments national strategy. This is a useful coordination tool as well as a means of identifying and challenging non-aligned projects.

The UN Delivery as One process provides another model for improving development agency coordination and therefore streamlining participation in country teams. The key elements of the UN Delivering as One pilots are: one programme, one budgetary framework, one leader and one office. This has led to increased harmonisation and a common UN approach in Mozambique and Madagascar. In Madagascar the development of the UNDAF (2008 – 2011) was used to define a division of labour between UN agencies. The key features of relevance to a country team are the organisation of a group of agencies around one programme, with one budgetary framework and one leader. This is similar to the development partner groups with a single voice and a single country assistance plan, and if adopted elsewhere would increase the level of coordination and organisation of development agencies, as well as increasing alignment behind national strategies and plans.

Coordination and organisation of development partner participation in country teams requires at least one agency with the capacity and skills to lead, facilitate and coordinate. In many countries the WHO is looked to for this role. In Cambodia WHO plays a strong role in coordinating, chairing groups and representation in the TWGH and the TWGH Secretariat. In Zambia WHO is part of the troika that leads all development partners. WHO is not always equipped with the necessary capacity to fulfil this role. UNAIDS performs this function for coordination of agencies involved in tackling HIV and AIDS. UNAIDS mandate and role is largely devoted to leading and facilitating coordination between different UN agencies in the Joint UN Team on AIDS and country staff are allocated to the task with practical tools to use. These include tools for building Joint UN Teams on AIDS, tools for assessing team performance, and tools for conducting joint annual reviews. UNAIDS has used these tools in Zambia to facilitate improved coordination among UN agencies and other development partners.

Engaging GFATM and GAVI to participate in country teams

According to most respondents GAVI and GFATM are rarely as members of the country team because of their lack of local representative and the lack of a formal communication line between the team and their secretariats in Geneva. Most

respondents suggest that they would benefit from much greater communication and information exchange with GFATM and GAVI because of the significant volume of grant finance they provide.

One example of a country team engaging the funds was the appointment of a part time person in Mozambique to liase with the GFATM with funding from DFID. The liaison person did not act as a representative of the GFATM in country, but played a communication role with the GFATM secretariat to clarify information (in both directions) to enable issues to be addressed and GFATM grants to flow more smoothly. This role is probably not a long term solution as a well functioning CCM and CCM secretariat can take this responsibility, but it is a useful model for countries addressing short term coordination and communication issues.

Country team expertise and skills

An effective country team needs highly skilled people with the right experience, skills and expertise to be active country team members. It also requires a larger pool of expertise to draw upon from a range of health and other disciplines for country team work.

Country teams, whether they oversee compacts, SWAps or CCMs usually have their members identified primarily as the representative of particular organisations with a (financial) stake in the health sector. The criteria for appointing country representatives are primarily as a representative of an agency rather than as a member of a country team. In Ghana and Zambia this issue has been partially addressed through the selection process of external development partner representation in the health sector team. The representative is chosen using criteria for their expertise and level of country knowledge, and these are written into the Terms of Reference of coordination agreements. The intention is to ensure that external development partners representation brings technical expertise and knowledge of the country before they engage in complex coordination and policy processes. These mechanisms do not provide a guarantee but should over time raise the quality of representation.

The two principle models used by external development partners to contribute additional skills and expertise to the work of the country team are firstly through making staff available to participate in working groups and task teams and secondly through establishing a dedicated unit of expertise. Development partners in Mozambique and Tanzania both use the former model by contributing staff to other working groups. In Tanzania there is a pool of 16 active partners who participate in sub-sector groups like human resource for health, monitoring and evaluation, pharmaceuticals, malaria, HIV and AIDS and maternal, newborn and child health. In Mozambique this model is used to enable the country team to draw upon essential non-health skills including linking health sector planning and budgeting with national planning cycles and medium term expenditure frameworks. In the second model, used in Bangladesh, the development partners which contribute to pooled funding support the Health Programme Support Office located in a World Bank office with staff employed by the Bank so that it could draw upon their expertise. This has

reported pros of engaging wide World Bank expertise and cons of being seen to be too dominated by one agency.[13]

Documentation of country teams working arrangements
Countries use various documents to codify their agreements on ways of working. Burundi, Mozambique and Zambia have Memorandum of Understanding which outline the objectives, principles, scope and key commitments of joint working. Kenya has a Code of Conduct which covers these same point. Mozambique has a Code of Conduct which covers agreements about behaviours of the partners. Burundi has a Partnership Framework which outlines the overall framework of agreement, and a Terms of Reference for the country team. Zambia also has Terms of Reference for the country team. Ghana has Terms of Reference to cover the overall objectives, principles, scope and key commitments of joint working of the health and HIV and AIDS groups. Ethiopia has a Harmonisation Manual. From this confusing collection two points of good practice can be emphasised. Firstly that a coordination document developed through a process of discussion and negotiation involving all stakeholders is more likely to be owned, respected and adhered to. Secondly that the title of the document is not that important because their contents are broadly similar. Key contents include the objectives of the overall partnership and of the country team, statements of the governments and the development partners roles and responsibilities, the scope of the arrangement, the key working arrangements (e.g. planning and annual review processes) and commitments by the parties. The more advanced country teams include mutual accountability mechanisms and an annual process for reviewing commitments.

## 4. Key structures of country teams

Effective country teams require effective structures in which to conduct their work and to link them to broader national development processes. This section focuses on four key structural elements for effective country teams. Firstly it highlights the important links between the country team and broader national development processes and coordination bodies. Secondly it focuses on links between country teams and other health and AIDS coordination mechanisms including CCMs, NACs and Inter-agency Coordinating Committees (ICC) for immunisation. Thirdly it explores the working groups and coordination secretariat used by successful country teams to conduct their work. Finally it looks at good practice in mutual accountability mechanisms.

Country teams need to be well integrated into national planning, budgeting and development assistance coordination mechanisms
Country teams are part of a larger network of which includes national governments and parliaments, national budgeting and planning processes, and high level aid coordination mechanisms. Established country teams have effective links with these development processes to locate health planning and budgeting within national planning and budgeting cycles. They also have links with other country sector teams to enable them to address cross cutting issues including public financial management and procurement, human resources for health, and finally to link aid

[13] Howard White, The Bangladesh Health SWAp: Experience of a New Aid Instrument in Practice, 2007

effectiveness measures into nationally led aid effectiveness measures. In Cambodia the country team is one of 19 technical sector working groups reporting to the Government Donor Coordination Committee (GDCC). In many countries like Mali the health plan (PRODESS II) was drafted to fit into the national Poverty Reduction Strategy Paper and has been extended to align with the new Poverty Reduction and Growth Strategy Paper. In Mozambique and Tanzania the country team identifies a set of core health indicators that are integrated into the national development plan alongside indicators from other sectors. Mozambique has a highly developed aid coordination architecture that combines leadership from the top with strong mutual accountability processes.[14] In Burkina Faso the National Health Plan (PNDS) links to the national poverty reduction strategy and the Committee for Poverty Reduction Strategy, which meets quarterly, reviews the implementation of the health component of the poverty reduction strategy. A sub-set of the 20 indicators in the PNDS are included in the Poverty Action Plan. Countries with strong national leadership for aid effectiveness have stronger health sector teams and reporting mechanisms for the health sector teams. The Cambodia aid effectiveness report for 2007 draws upon reports provided by the different sector groups, including the health working group.[15] A key element of this is that the health sector team has an accountability line to a national development coordination group. This good practice is mutually reinforcing and has ensured higher attention is paid to harmonization and alignment when there is top level national government leadership and coordination.

Coordination with other health sector coordination mechanisms

Many countries have multiple mechanisms to coordinate national and international assistance within the health sector, including Country Coordination Mechanisms (CCM) for GFATM grants, an interagency coordination committee (ICC) for GAVI grants and the National AIDS Committees (NAC) coordinating the HIV and AIDS response. There are few formal methods used for ensuring these multiple coordination mechanisms are themselves coordinated. In many countries there are informal means of coordination and communication between the mechanisms and in a few countries there are attempts to formalise a link. In some countries the respondents noted that there is reasonable communication between the country team and the CCM or ICC because many of the same people sit on both. In Burkina Faso representatives of the country team are also members of the CCM and the ICC, acting as a conduit for coordination. The oversight mechanism for the pooled fund in Burkina Faso, into which GAVI contributes, is another means of coordination between ICC and the country team. In Nepal reports for GAVI are included in the joint annual health sector review and there is an informal monthly lunch meeting between the country team, the CCM and the National AIDS Council.

Few countries have formalised the relationship with cross representation or formal reporting arrangements, and none have attempted to reduce the number of coordination mechanisms although some are considering it. In Cambodia the TWGH and CCM recently formalised a relationship so that the TWGH will play a role in the approval process for proposals prepared for the GFATM by the CCM. In Mozambique the country team defined a clear division of labour whereby the CCM is

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[14] Handley, G. Mutual Accountability at the Country Level: Draft Mozambique Country Case Study. Centre for Aid and Public Expenditure, ODI. 2008

[15] The Cambodia Aid Effectiveness Report 2007, Cambodian Rehabilitation and Development Board Council for the Development of Cambodia

charged solely with preparation of applications to the GFATM. In a number of countries cross representation and communication is achieved through the chair of one group sitting on another. In Zambia UNAIDS chairs the finance committee of the CCM and provides a link to the health sector group as a member of if. In Cambodia WHO plays a role as the lead development partner in both the health and the AIDS groups. In Nigeria there is a different situation to other countries in that there is an effective CCM and ICC but the absence of an effective country team.

<u>Country teams have large responsibilities and need working groups and coordination secretariats to assist in fulfilling them</u>

The most established country teams delegate detailed technical tasks to working groups. These groups are usually led and chaired by government representatives, often with a civil society or external development partner co-chair. They conduct a significant amount of country health sector business and are the key mechanism for the country team to bring additional health and non-health expertise from the stakeholders. There are two types of working group. Firstly there are technical health working groups like immunisation, HIV, Malaria, TB. Secondly there are cross cutting health systems working groups like human resources, health financing, monitoring and evaluation, gender and aid effectiveness working groups which look explicitly at improving harmonisation and alignment.

The number of working groups varies but is typically between 10 (e.g. Mozambique) and 20 (e.g. Kenya). Zambia has a number of sub-committees and technical working groups which prepare reports for the SAWG or directly for government committees. Burundi has recently established five working groups and Burkina Faso has a range of sub-sector working groups. In Mozambique, a government official and development partner co-chair working groups on diverse issues such as drug procurement, audit and financing, human resource planning, priority disease response, maternal health, gender etc. The monitoring and evaluation working group is currently working on revising the indicators for the national results framework (PAF). Many IHP+ countries have sector budget support or pooled funding arrangements that bilateral donors, the World Bank and UN agencies use to finance the health sector. In these countries there is usually a sub group or sub-committee of the country team which oversees this funding arrangement. Mozambique and Zambia both have such arrangements to oversee pooled funding.

Evidence from CCMs and NACs suggests that an adequately staffed secretariat is essential to support the working of country teams. The secretariat is required to prepare meeting agendas, documents and minutes. Some ministries have a department for international cooperation and some appoint people within a department of planning. Ministries of Health typically have coordination staff either in a dedicated coordination office (e.g. Department for International Cooperation in the Ministry of Health in Cambodia) or as one of the functions that oversees planning and programming (e.g. Ghana or Zambia). Cambodia has a more elaborate and multi-stakeholder secretariat. The Technical Working Group for Health operates as a coordination mechanism with 74 official members. It is supported by the smaller TWGH Secretariat which comprises of 6 government representatives, WHO, the lead bilateral donor, an NGO and the lead multi-lateral donor. The TWGH Secretariat facilitates the work of the TWGH and prepares for the monthly TWGH meetings.

Health sector teams are experimenting with a range of mutual accountability mechanisms

The Paris Declaration and the IHP+ emphasize mutual accountability as a key part of the development partnership. The literature suggests few mechanisms for mutual accountability. Mutual accountability is one part of the accountability picture at the country level which also includes domestic accountability of governments to their citizens (through parliaments etc.) and joint accountability of all partners to deliver results towards achieving the health MDGs. It is important that mutual accountability reinforces and supports domestic accountability, and does not usurp it.[16] Mutual accountability mechanisms are useful for recognising and celebrating achievements and progress as well as being a mechanism to highlight and address unmet commitments. Sharing information about progress and success breeds more progress and success.

The mechanisms that have been used to promote mutual accountability include:

1. Frequent country team meetings encourage better information flow and enable achievements to be recognised and built upon;
2. External development partners develop a joint assistance plan which follows the framework and heading of national health plans or poverty reduction strategies, and brings together all their support to government in one document. This is a useful tool for peer pressure to ensure support is aligned, as well as for government to see clearly the extent to which partners are aligning their support. Tanzania uses such a plan.
3. Incorporate agency specific aid effectiveness commitments within the joint annual planning and review process and include these commitments in the annual review. Burundi does this and Kenya is preparing to do this.
4. Develop agency specific aid effectiveness commitments and review them annually within the country team.
5. Establish an independent monitoring group to review achievement of commitments and / or review the reasons behind unmet commitments. Ethiopia's compact plans for this.
6. Contract an independent assessment of adherence to commitments by an external organisation (e.g. NGO or research institute). Tanzania has done this.
7. Link into national Paris Declaration implementation annual review processes and report health progress to national aid coordination bodies. Mozambique does this.

Mutual accountability is new and can be a threat because it can involve highlighting and addressing underperformance. Countries which have a range of different tools seem to make more progress than others which invest all their mutual accountability efforts into one mechanism. In Tanzania some of the mechanisms that are used include: the Joint Assistance Plan of all external development partners which acts more like a peer review accountability mechanism, the annual report by the Health Partners Donor Group on performance, and an external independent evaluation of development partners efforts overall (not just the health sector). Combined with regular meetings with the Ministry of Health this enables issues to be picked up in many different ways. The Ethiopia country compact outlines a clear set of country

[16] Handley, G. Mutual Accountability at the Country Level: Draft Mozambique Country Case Study. Centre for Aid and Public Expenditure, ODI. 2008

level commitments for government and development partners. The compact also includes a provision for establishing an independent monitoring group to review the reasons why obligations are not met report annually. The Mozambique compact allowed each agency to identify the agency specific steps that it would take to increase alignment, which allows agencies to identify realistic steps recognising the different limitations on how far they can go to harmonise or align. These actions are time bound which provide the basis for accountability.

## 5. Good practice in country teams key areas of work

This section outlines some of the key examples of good practice that country teams in IHP+ countries demonstrate in the process of developing national plans, reviewing progress of national plans and developing and operationalising a single results framework.

Country teams contributing to national planning process

Contributing to national health strategies and to annual health plans is a key responsibility of country teams. It is vital that there is a clear process for country team participation to ensure a coordinated and smooth functioning process. The Ethiopia country compact states that "Development Partners will participate in national health planning and budgeting processes as set out in the calendar of the Joint Budget and Aid Review (JBAR) and of the Harmonisation Manual". In Ghana the Terms of Reference for the Health and HIV and AIDS Sector Group outlines the meeting formats for the health and HIV and AIDS sub-sector groups. The Ministry of Health leads health summits and HIV and AIDS summits twice a year in April/May and October/November. The April/May summit provides a forum for debate of the results of the annual sector performance review and the October/November summit focuses on the programme work for the following year. Both summits are prepared by a committee of government, civil society and development partners. The Ministry of Health of Zambia also plans and leads two annual Sector Advisory Group (SAG) meetings on a similar basis with one focusing on reviewing progress and the second devoted to future planning. The Ministry of Health of Zambia also leads an Annual Consultative Meeting to discuss the draft Annual Action Plan and Activity Based Budgets. The Code of Conduct for the Kenya Health SWAp also outlines a role for the Health Sector Coordinating Committee to review and endorse revisions of the Annual Operational Plans, draft MTEF for the health sector and draft budget.

Country team role in joint annual reviews

Joint reviews are a critical element of the work of country teams to review progress and improve the management for development results. UNAIDS have developed guidelines for undertaking reviews of the national AIDS response and OECD has guidelines for conducting joint evaluations. In IHP+ countries there is good practice on conducting joint reviews which could be usefully brought together and expanded on in guidelines for undertaking a joint review in the health sector. Clear Terms of Reference covering the objectives and scope of the review and agreed to owned and by the stakeholders in advance of the review are developed in Ghana under the leadership of the Ministry of Health. The overall review process is overseen by a committee of the various stakeholders. In Burundi a sub group of the CBSD oversees the process of preparing for the annual review. Madagascar started

conducting joint reviews in 2007, Benin conducts joint annual reviews, and has biannual sector reviews with some private sector people invited to key meetings.

Joint annual review processes and events are used by many IHP+ countries as an opportunity to include a wide array of civil society and private sector stakeholders. Ethiopia holds an Annual Review Meeting and Ghana the summit. Some IHP+ countries use the joint annual health sector review process to review the joint working and aid effectiveness. The Zambia HIV and AIDS team has incorporated the Country Harmonisation and Alignment Tool into their joint review to strengthen joint working. In Burundi the 2008 annual review included a review of the functioning of the CPSD, and in Kenya the joint annual review will also cover adherence to the Code of Conduct.

Country teams work to develop and improve single results framework

The Paris Declaration commits signatories to align country programming with an effective country performance assessment framework and to rely as far as possible on partner countries results oriented reporting and monitoring frameworks. Many IHP+ countries have put in place one single joint results framework and others are developing one. Delivering results is a core business of country teams and countries like Mozambique and Kenya have established monitoring and evaluation working groups and Burundi has a health information system working group. Many, but not all, IHP+ countries have accessed support from the Health Metrics Network to assess their health information systems and plan improvements.

Another key element of good practice is the linkage of health results frameworks to national development frameworks. Tanzania has a clear results framework which cascades down from the national poverty reduction strategy. Data and results are also being used at district level to shape programming and guide resource allocation. Within the IHP+ countries, Mozambique has one single national results framework (PAF) with 40 indicators in 7 thematic areas. Five of the indicators from the single health results framework are included in the overall PAF. The monitoring and evaluation working group is currently revising the indicators to address the ones that are less measurable. Other countries with single results frameworks, like Mali, are currently revising the indicator set to make it smaller, more manageable, and more measurable while countries like Zambia are working to improve the linkage of the results framework to inputs and goals in the national strategy.

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## Annex 1: Country team working consultation record

The following people kindly gave time and opinions through an interview or written input into this study.

| | |
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| Jane Miller | DFID Nigeria |
| Nastu Sharma | World Bank Health Specialist, Nepal |
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| Mr. Stierle | Programme manager, Health Sector Support Programme (MoHP/GTZ) |
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| Anna Guthrie | UK DFID |
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