# International Health Partnership and Related Initiatives (IHP+)

# Options for strengthening country team working

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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 draws upon a good practice document and is accompanied by an inventory of tools for country team working.

## 1. Summary

Country teams are at the forefront of an ambitious agenda in the IHP+ to take forward the Paris Declaration in the health sector to improve coordination of national and international resources for health outcomes. This is a challenging change management agenda within and between many large bureaucracies. IHP+ raised the political leadership on this agenda but did not significantly change the incentives for country teams. This paper suggests a number of key actions that can be taken to help country teams rise to the challenge. Firstly it looks at the need for focused team-building of the country team to develop a shared objective, strong government leadership, participation that includes core in-country staff and virtual membership and contributions from many others outside the country. Secondly it highlights the need to get the structures right for the country team, including positioning within national processes, relationships with other coordination mechanisms, and internal working structures and mutual accountability mechanisms. Thirdly it highlights the need for the strengthening of incentives for development agency staff.

The single overarching message is that development partners must signal clearly to staff that the challenge of meeting the MDGs require that they work in country teams to jointly address issues and build strong country-led health systems in preference to through stand alone projects and bilateral dialogue with government. The top recommendations are:

1. IHP+ countries and all national and external development partners should build or strengthen country teams using specialist team building or change management expertise (p. 12 and 17).
2. IHP+ countries must ensure full political and technical leadership for their country teams. Without this effective country team working will not develop (p. 12).
3. External development partners should establish, if it does not exist, an external development partners group which operates on the basis of one leader, one plan and one budgetary framework. Donors should reduce the number of active voices in country teams (p. 12).
4. All country teams should establish a process to fully include civil society participation in the team (p.12).
5. All country teams should establish a process to fully include private sector participation in the team (p.12).
6. Country teams should develop a framework for increasing electronic working methods and virtual team working that enables organisations and individuals not based in a country to contribute to the team (p. 12).
7. Country teams and organisations like GFATM and GAVI should review how to strengthen their involvement as virtual team members (p.12).
8. Country teams work effectively to locate health sector development planning into national planning and aid effectiveness processes and establish working groups to delegate tasks to (p. 18).
9. Country teams and some other health and AIDS coordinating mechanisms like CCMs should review their responsibilities with a view to merging or redefining their roles and relationships as appropriate (p. 18).
10. All development partners ensure that country staff have clear annual targets for their contribution to the work of country teams and are recruited to contribute skills to the country teams (p. 20).

11. WHO develop new tools to enable country teams working including a team self-assessment tool (p. 21).
12. IHP+ partners should resource a website which is a platform for sharing good practice, ideas and accessing tools (p. 23).

## 2. Current status of country teams in IHP+ countries

Some country teams in IHP+ countries are well established with a clear purpose and structure, some are functioning effectively with scope for strengthening, and some are in the process of being established.

Established highly defined teams

The more established teams, for example Burkina Faso, Cambodia, Mozambique, Ghana, Zambia and Mali, 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 long 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.

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 Kenya, Nepal, Ethiopia and Burundi. 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.

Emerging or ad-hoc teams

A small number of countries have emerging, ad-hoc or informal coordination mechanisms. These include Nigeria, Benin and Madagascar. 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. Madagascar is in the process of establishing a team, and currently conducts joint review meetings. Nigeria too has opportunities with the government recently holding a national Health System Forum and the exploration of SWAp mechanisms at state level. Nigeria poses a particular challenge for country teams because the federal-state structure which highly decentralised responsibility for health financing suggests that national level country teams would be divorced from the state level at which the majority of financing and coordination needs exist.

**Country teamss Current Status**[1]

| 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 | | | | | | |
| **Zambia** | Yes | | Yes | Yes | MOU, TOR | Yes | Yes | Yes | Interest | |
| **Benin** | | Biannual | Yes | | | Yes | | | | |
| **Burkina Faso** | | Yes | Yes | Yes | | Yes | Yes | | Interest | |
| **Ghana** | Yes | | Yes | Yes | TORs, COC | Yes | Pooled, SBS | Yes | | |

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
Pooled – a pooled funding arrangement, GBS – General Budget Support, SBS – Sector Budget Support, SWAP (without financing mechanism)

[1] Source: 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.

## 3. Country team responsibilities in IHP+

The guidance note on the 'Development of a Country Compact' 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." Country teams are the entities that achieves this. It's key responsibilities include: supporting the national government in the 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.

Country teams in countries with long standing SWAps perform many of these functions already, or are working towards them. The vision for country teams of the future is that they bring together all the relevant stakeholders to undertake these responsibilities, thereby increasing the health outcomes achieved with improved coordination of national and international resources.

## 4. Team building for successful country teams

An effective needs clear, agreed objectives, strong leadership and defined and inclusive membership as its basis. It requires that external development partners bring a range of necessary skills and expertise, organise themselves well to reduce transaction costs, and are represented by individuals with sufficient authority to participate in decision making. Finally effective country teams needs to establish clear modes of communication that increasingly involve using web-based platforms, video and teleconferences to engage virtual team members in joint working. An essential part of team-building is codifying all these elements in some core documents.

### Leadership of country teams

Government leadership is critical for the successful performance of country teams. Government, and in particular the Ministry of Health, has the responsibility for delivering health care to its citizens and enabling them to attain the highest level of health possible. Government therefore leads country teams. The countries with the strongest country teams (for example Mozambique and Cambodia) have had sustained government commitment to improving the health of the population as well as leadership of efforts to improve aid effectiveness in all sectors for development assistance to the country. The vision, drive and commitment of a determined government and minister of health is invaluable and irreplaceable. However it takes more than the leadership of one individual to enable country teams to perform well.

Government leadership is critical and the 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 country teams reports to a higher level entity of government and development partners. 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 effective country teams 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 country teams. Finally there are key events in the annual work of country teams for which government leadership is essential including setting of national strategies, leading (annual) planning processes, leading joint reviews, and operationalising mutual accountability mechanisms.

Country team membership and participation

IHP+ Compact Guidance suggests that country teams should include the involvement of government, civil society, private sector, multilaterals and donors because they are the key stakeholders in the process of improving country health systems to achieve health outcomes. There are four key areas of participation in country teams that require further efforts to improve participation and efficiency. Firstly many country teams need to work more to ensure the meaningful engagement of civil society and the private sector in country teams. Secondly, other development partners make valuable contributions but can do more to improve their own coordinated contributions. Thirdly the agencies not represented in countries can improve their participation as virtual team members. Finally all country team members need to ensure the team can call upon individuals with sufficient delegated authority when needed for important decision making.

Country teams would benefit from increased civil society participation

There is much work to be done in most countries to increase the participation and level of engagement of civil society in country teams. This includes formal membership in country teams, and active participation in meetings, working group, annual planning and review. This has recently started to happen in Nepal where civil society has been actively consulted in IHP+ working processes. This also includes the development of a set of commitments made by civil society to be incorporated into country compacts which outline the measures they will take as members of country teams that they will be held accountable for, in the same manner that government and external development partners are making commitments. Neither of the first two compacts (Ethiopia and Mozambique) include a section on civil society commitments that outline what civil society will be accountable for. The IHP+ Guidance on Civil Society Engagement in Country teamss paper outlines the key roles that civil society can play and expertise and knowledge that it can contribute.

Country teams would benefit from increased private sector participation

There is even more work to be done in most countries to increase the participation and level of engagement of private sector in country teams. This includes formal membership in country teams, and active participation in meetings, working group,

annual planning and review. This has recently started in some countries but is at a very limited level. This suggests that the full scope and potential of the private sector to deliver health services to people is not being tapped into, and its entrepreneurial problem solving capacity is not being utilized. Neither of the first two compacts (Ethiopia and Mozambique) include a section on private sector commitments that outline what private sector will be accountable for.

Multilateral, UN and bilateral donors should rationalize their coordination and representation to country teams

External development partners participation in country teams is strong. A critical area of unfinished work in the harmonisation and alignment agenda is to reduce the transaction costs on government of multiple external development partners by improving their coordination and representation as a group, and reducing when necessary the number of partners. External development partners must ensure that they have a well coordinated group and a system of representation that enables them to be represented by a single voice with a consensus voice in country team meetings. In Ghana, Tanzania and Zambia a troika system operates with three development partners representing and leading their colleagues, with the three being this years, last years and next years representatives acting together to ensure continuity and provide a single, consensus voice. A well coordinated group should also establish a clear division of labour between partners that will maximise their comparative advantages and reduce excessive time spent by multiple partners all performing the same tasks.

The UN Delivering as One reform pilots offer a useful model that if applied to the broader external development group could significantly improve harmonisation, alignment and mutual accountability. There are four key features: one programme, one budgetary framework, one leader and one office.[2] The most relevant elements to the coordination of external development partners in country teams would be one programme, one budgetary framework and one leader. In practice countries external development partners are already organising like this in Tanzania where they have one leader (through the troika but led by one leader), and one programme. In Tanzania the external development partners developed a plan that incorporates all support and projects in a framework that follows the governments national plan and shows non-aligned support.

Global Funds can contribute to country teams as virtual members

Country team members would like to have more communication from and interaction with the global funds like GFATM and GAVI which do not have a country presence. In particular country teams seeking to integrate GFATM and GAVI grants into existing joint planning and review processes and shared funding mechanisms need clarity on what GFATM and GAVI can and can't support and through what channels. While this information is readily available at headquarter level there is uncertainty at country level. GFATM and GAVI can address this by becoming virtual members of country teams and including their own agency specific commitments for inclusion in country compacts. GFATM and GAVI should become virtual team members by nominating headquarters member of staff to participate by email and teleconference in any relevant working groups or by utilising their network of institutional partners

[2] http://www.undg.org/?P=7

who are represented in country (often through UN) to act as a communications channel. Virtual membership would enable improved communications, facilitate easier involvement of GFATM and GAVI in country led efforts to improve alignment, for example on developing national plans or pooled financing mechanisms, and would enable GFATM and GAVI to contribute their own commitments to improve their aid effectiveness alongside other development partners in annual plans and compacts. Integration of the CCM with other teams (see later section) would improve communication and participation automatically.

Country teams need core members with sufficient delegated authority

The country stock taking reviews note that country team decision making is impeded by the various levels of delegated authority of country representatives of external development partners. Country teams need their members to be empowered to participate in decision making and to be able to follow through on them. External development partners can ensure a sufficient level of delegated authority through four means. Firstly the organisation of all external development partners into a single group with a single voice on country teams using rotating representation is an opportunity to make delegated authority a criteria for selection. Secondly external development partners need to ensure country representatives are empowered to make resource allocation decisions and participate in joint decision making, or agree to be represented as a silent partner by another agency with a higher level of local representation. Thirdly country teams should require membership of the team to only come with a guarantee of delegated authority. Finally, and as a measure of last resort, country teams should develop an annual calendar of key decision making events and external development partners should ensure headquarters representation or advance communication to ensure participation at the right level of authority.

Country teams need a resource of expertise in health and other disciplines to tackle the key development issues

Country stock taking reports and respondents highlight the lack of country knowledge or relevant skills as an issue impeding team working. Country teams have important responsibilities that require the right mix of skills, knowledge and expertise to be at their disposal, either from within their membership or in a dedicated unit. They require public health and health systems specialists as well as economists and governance experts to help address cross cutting issues like civil service reform, public financial management, human resource management and to locate health planning and budgeting in national expenditure and budgeting processes. However country team members are not usually recruited to fill an expertise gap but rather as the nominated representatives of an agency. Some countries, like Bangladesh, create a unit of staff dedicated to taking forward team working, housed by the World Bank. In other countries like Mozambique this expertise is provided by various external development partner representatives participating in working groups. External development partners need to improve their ability to mobilise their non-health expertise, either from in country or from regional and headquarters, to contribute to country teams and their working groups.

Country teams need a solid leadership core with extended virtual team members working together through web and electronic media.
Effective country teams need at their core a set of key consistent members who operate with a high level of mutual trust to collectively lead the team. Personal relationships, stability in membership and frequent interaction are vital to this core. Most country teams have this core group comprising between 20 and 30 representatives of different constituencies and sectors. The effective teams use annual and semi-annual national meetings of a wide range of stakeholders, and working groups, to promote broader participation and engagement beyond the core country team. This core team needs to be supplemented with the expertise and work of a wide range of people from in country and from development partners who need to mobilise additional expertise, often from outside the country. Country teams need to develop clear and agreed principles and arrangements for communications between all members to ensure smooth working. This is particularly important to bridge the potential gap between the core in-country team with virtual members in districts of the country or located in offices elsewhere in the world. Virtual team working will require extensive use of web-based platforms, email, teleconference and video conference to conduct their business. In particular working groups should use web-based (password accessible) working space to share and work on drafts and enable electronic discussion and debate. A particularly useful tool is annually agreed calendars of key working events to enable country team members and contributors to prepare the time to make their contributions.

The process of codifying team objectives, membership and ways of working is useful to ensure ownership by all stakeholders
Most IHP+ country teams have a written and agreed framework document covering their working objectives, working arrangements and commitments. Documenting and codifying the working arrangements of country teams are a vital process of ensuring there is full ownership and support. The documents used include compacts, memorandum of understanding, terms of reference code of conduct, partnership framework and statement of intent. A clear lesson from IHP+ countries, and countries with established SWAps, is that an inclusive process of developing and agreeing the key elements of the documents is important for ensuring that all partners have buy-in and are more likely to adhere to the commitments and agreements of ways of working that are codified within them. Country teams without such documentation should use the process of developing their compact to clarify and document their objectives, membership, ways of working and key commitments.

**Recommendations for Team Building**

Building effective country teams require an investment of time by all stakeholders to agree the objectives and scope of the team, its membership and participation and its ways of working. It is recommended that the following measures are taken to enable IHP+ country teams to strengthen their way of working:

1. IHP+ countries and all national and external development partners undertake a team building process to strengthen their country teams using specialist team-building or change management expertise. The precise objectives and scope will vary according to the country context and the needs of the country teams. This will develop shared objectives, membership, team working

processes including virtual membership by non-resident members, working groups, determine the skills needed to tackle key issues and the communications principles and methods that will be used. For the more advanced existing country teams this will be an opportunity to refine and improve team working. IHP+ partners should make resources available or establish a global call down contract for country teams to be able to receive specialist team-building and change management expertise.

2. IHP+ countries must ensure full political and technical leadership for their country teams. Without this effective country team working will not develop.
3. External development partners should establish, if it does not exist, an external development health partners group which operates on the basis of one leader, one plan and one budgetary framework. It will ensure experienced, highly skilled representation of all the development partners by a single voice utilising the rotating leadership troikas method used in Tanzania, Ghana and Zambia. It should develop a single joint assistance plan which brings together all external development partners support to the health sector in one plan that follows the framework and priorities of the national health strategy. The group should develop an agreed division of labour for providing support to working groups and a process for reducing the number of external development partners. Donors should reduce the number of active voices in country teams by taking forward measures like the EU Division of Labour in the health sector in over represented countries. This should benefit government by reducing transaction costs and benefit the external development partners by freeing up time they spend duplicating each other to devote to improving country team working.
4. All country teams should establish a process for civil society to have meaningful involvement in country teams and to bring their skills, experience and perspective to bear in the working groups.
5. All country teams should establish a process for private sector to have meaningful involvement in country teams and to bring their skills, experience and perspective to bear in the working groups.
6. Country teams and organisations which contribute significant funds for health but do not have a country presence, like GFATM and GAVI, should review their role with a view to becoming virtual members.
7. Country teams should develop a framework for increasing electronic working methods and virtual team working that enables participation from individuals and organisations not based in the country. This should include developing clear communication principles to enable country teams to include “virtual team members” who are not resident but participate in regular communication and dialogue.
8. Country teams should agree a minimum level of delegated authority that is required from members and external development partners should work separately and together to ensure that their collective representation has delegated authority for decision making and collective follow up on agreements.
9. Country teams should agree a process for self-assessment of their performance on a regular, possibly annual, basis to measure their progress and improvements in team working and identify future areas for strengthening.
10. WHO has a strong role to play in country teams as the UN member state organisation with a mandate for health, in particular norms, standards and

technical advice. At country level it is respected for its technical advice in public health, and is looked to for leadership and coordination. WHO country offices should develop a clear strategy for their leadership and coordination role, in dialogue with other development partners, adequately resource country offices to fulfil this role, and develop tools to enable country level staff to lead or facilitate country team building and team self assessment exercises. A UNAIDS country office provides a good model for this leadership and coordination role with staff dedicated to coordinating and facilitating, including facilitating national planning and review processes, and leading assessments of UN Joint AIDS teams. UNAIDS have developed tools for this work.

## 5. Effective Structures for a successful country teams

Effective country teams require effective structures in which to manage and 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 country teams and broader national development processes and coordination bodies. Secondly it focuses on the need to reduce duplication within countries, such as with donor health groups 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 options for introducing 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 picture of national entities which includes primarily national governments and parliaments, national budgeting and planning processes, and high level aid coordination mechanisms. Country teams need to have effective links with these development processes and other country sector teams to enable them to locate health planning and budgeting within national planning and budgeting cycles, to address cross cutting issues public financial management and procurement, and public administration and human resources for health, and finally to link aid effectiveness measures into nationally led aid effectiveness measures. In Cambodia the health 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 teams identifies a set of core health indicators that are integrated into the national plan alongside indicators from other sectors. Countries with strong national leadership for development and 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.[3]

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

Links between country teams - CCMs, NACs and other health coordination mechanisms

There are too many unconnected or duplicating coordination mechanisms in the health sector at the country level. Governments and development partners should reduce the number of coordination mechanisms and integrate the existing ones better together with clear responsibilities, thereby saving valuable transaction cost time. The most critical mechanisms to be integrated are CCMs, ICCs and NACs. There will be greater opportunities to improve harmonisation and alignment to achieve health outcomes if the coordination mechanisms for grants from single agencies are integrated with the coordination mechanisms for multiple grants and loans. There are two options for tackling country team and CCM links. The first option is to merge both entities into one entity and the second is to maintain separate entities while clearly defining a reporting relationship between them.

The GFATM founding Framework Document encourages countries to build CCMs based on existing coordinating mechanisms.[4] In practice most countries established new coordinating mechanisms for CCM grants, a situation that is now reinforced by the GFATM issuing strict guidance on minimum standards for what it accepts as a CCM for funding purposes. The GFATM can accept applications from merged entities as long as they can demonstrate the same level of participation (by the agreed set of constituencies), transparency (in particular of decision making over grant sub-recipients) and accountability (including for results and conflict of interest policy). The main benefit of merging country teams and CCMs would be the opportunity to bring the GFATM financing, a significant proportion of international development assistance to the health sector, into one coordinated planning, implementation and monitoring framework between government and development partners and thereby maximise opportunities for improving effectiveness. Additional benefits would include reducing transaction costs of coordination time in country, reduced barriers to tackling underlying issues that affect SWAps and GFATM grants, and providing a framework for better aligning all support with national government priorities and processes.

The two main obstacles to merger are the vested interests in countries health sector teams and CCMs which may fear losing control over, and access to, resources, and the institutional inertia linked to a reluctance to radically change existing structures for fear of threatening eligibility for GFATM grants. The participation of civil society and private sector is a key issue to address given that their participation in CCMs is mandatory for grant eligibility and stronger than in country teams. Merger would benefit country teams by bringing these constituencies in. The GFATM could incentivise a merger by issuing CCM eligibility guidance which includes as its preferred option the receipt of grants from CCMs that are merged with country teams. This could be piloted in IHP+ countries before larger scale roll out.

The second option for defining a reporting relationship between the two entities is less challenging. The most logical relationship is for the CCM to maintain its membership and be re-cast in a role that reports to the country team, in the way that has been defined in Mozambique. This option would involve recognition that the

[4] http://www.theglobalfund.org/documents/TGF_Framework.pdf

country team has a broader remit covering the whole health sector, often oversee pooled funding or sector support, and includes a policy advisory function, while the CCM focuses on overseeing the application for and implementation of finance for AIDS, TB and Malaria from one source. There are a number of opportunities and precedents for this because many country teams oversee a SWAp and have a sub-group comprising development partners which contribute to pooled fund or sector budget support, and this group has responsibility for overseeing this financing arrangement. The CCM could become a similar sub-group, or be merged with an existing relevant sub-group. It would require less structural re-negotiation than a full merger and would bring most, if not all, of the benefits.

This option is similar to the linkage that already exists in some countries between the country team and the ICC required in each country for eligibility for GAVI funding. Given the vast workload of a country team and its need to delegate, there are considerable benefits to be gained by CCMs and ICCs existing as working groups reporting to country teams.

Another key relationship for the country team is with the National AIDS Commissions (NACs). They have different roles. NACs are multi-sectoral national entities that guide national AIDS strategy development and implementation and mobilise multi-sectoral action in country. In this situation it would not be appropriate for it to merge with or report to the country team but there is a strong need for the two entities to communicate well together. This is important in countries where the country team is responsible for health and HIV and AIDS (like Ghana) but also where there are separate health and HIV and AIDS teams (like Cambodia).

A blueprint for the relationships between all national and international coordination entities is not possible or useful because of the specific histories and permutations that exist in different countries. There are some basic principles that should be followed. Firstly, a country team should not usurp the national role of domestic bodies to set strategy and policy, implement plans and coordinate domestic stakeholders. A country team should respect the primacy of these national entities, including NACs, and define its relationship to support them. Secondly one coordination mechanism to bring together national and international development partners to coordinate international assistance for health is better than two and therefore the country team relationship with the CCM, and in some countries the ICC, needs to be addressed.

Country teams in large federal states

Country teams will take on different structures in large countries with a high level of decentralisation of health policy and financing to sub-national level, as is the case in Nigeria. In countries like Nigeria where international development assistance for health is a very small proportion of total health resources the role of a country team is further complicated. There are four key issues. Firstly that there is still a need for a national country team as this is where national policy and strategy making is driven and that without a national team there is a risk of geographical inequities. Secondly that a sub-national health sector team will be an important coordination mechanism in countries where the state has responsibility for health care financing and resource allocation, and where external development partners work closely with the state level administration to coordinate delivery of international assistance. The possible

exploration of sub-national SWAps in Nigeria is one such example. Thirdly the other issues of team-building, leadership, membership, structure and efforts to improve mutual accountability would be equally relevant in sub-national, state level health sector teams as at country level. Finally the relationship between a country team and state team will be critical and ensuring adequate cross representation, probably at the level of chairs of the country teams, will be vital.

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

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 expertise from multiple stakeholders and with different specialists. For example in Mozambique the monitoring and evaluation working group is refining the set of national indicators to be less and more measurable. There are two types of working group. Firstly there are technical health working groups like immunisation, HIV/AIDS, 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. All country teams should consider establishing a mixture of working groups and delegate defined tasks to them. The relationship with the HIV/AIDS working group is a vital one to ensure clarity and good coordination on as these often have their own status and statutes. In Ghana there is one overall Health and HIV/AIDS working group with two sub groups – one on health and one on HIV/AIDS.

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. External development partners too need to dedicate human resources to coordination, improving their division of labour and their aid effectiveness measures. WHO usually fulfils this role, along side its normative and technical functions. It is instructive to compare the resourcing of this coordination function with UNAIDS country offices where more human resources are deployed for these functions. This suggests that in many countries at present the external development partners in general, and particularly WHO, are not allocating sufficient human resources to fulfil this function.

Mutual accountability

'Governments do not yet seem to have realised the full political leverage of the IHP+ global compact to challenge development partners on their ways of doing business.'[5] Mutual accountability at the country level is one mechanism for this. Country team mutual accountability needs to be seen as part of the wider accountability picture which also includes domestic accountability of governments to their citizens (through parliaments etc.), development partner accountability to their parliaments and governing boards, and joint accountability of all partners to deliver results towards

[5] IHP+ External Review, 2008

achieving the health MDGs. It is important that mutual accountability reinforces and supports domestic accountability, and does not usurp it.

Mutual accountability is the process through which multiple partners make commitments of what they undertake to do, and subsequently hold each other accountable for meeting those commitments. The commitments need to be owned, measurable, time bound, and reviewed. Mutual accountability mechanisms are excellent for recognising and celebrating success (thereby establishing a virtuous cycle) as well as the standard view of highlighting unmet commitments. Countries are experimenting with a range of mechanisms that include:

1. Frequent country team meetings with space on the agenda to report achievements since previous meeting;
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. 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.

Good practice suggests that finding mechanisms that can highlight the positive achievements, incorporate peer review mechanisms, and use agency developed and owned targets is critical. It also suggests that utilising a mixture of mechanisms has a reinforcing effect which increases the attention on agencies that make commitments to keep them as they are aware that there are a number of ways in which they may have to report that they have not kept them.

**Recommendations for improving the structure for effective country teams**

1. Governments and development partners should ensure that country teams work effectively to locate health sector development planning into national planning processes, work with other sector teams to address cross cutting issues and report to national development assistance coordination bodies on their progress in taking forward the Paris Declaration commitments.
2. Country teams, CCMs and other health and AIDS working groups should review their responsibilities with a view to merging or redefining their roles and relationship. GFATM should issue clear guidance on how it will accept

proposals from country teams. The choice between the merger and reporting options should be according to local context and need. Similarly the country team and ICC should ensure that the ICC has a clear link to the country team. If there is both an existing ICC and immunisation working group then they should be merged. IHP+ partners should make available resources for professional change management consultancy support for countries that intend to streamline their coordination mechanisms.

3. Country teams should establish a range of technical (disease specific) and cross cutting working groups on the key issues they need to address (like public financial management, procurement, human resources) and that they are linking health sector issues and efforts to address these issues to the work of other country sector teams who focus on these issues across all areas of government. All country teams should have a monitoring and evaluation working group.
4. Country teams put in place a number of mechanisms for mutual accountability to celebrate success and drive improvements in aid effectiveness.

## 6. Incentives and systems to support and encourage country team working

All organisations represented in country teams need to signal very clearly that working jointly with others in country teams is the primary mode of dialogue and coordination with government and other partners. This is particularly important for government staff who lead country teams and set the agenda and tone for coordinated working, both the substance but also in terms of an inclusive team that ensures full participation of civil society and private sector. It is also very important for the staff of development agencies which wield significant financial leverage. At present the incentives are still mixed and some agency staff have the option to prioritise their agencies projects over country team joint working. This section focuses on maximising the incentives and minimising the disincentives that influence the work of individuals and agencies in participating in country teams and working within them to jointly tackle issues. A critical area of incentives for participating in country teams are the procedures and staffing practices which influence how human resources are deployed. There are critical disincentives linked to the difficulty and time required to work jointly when agencies face intense pressure to disburse resources and demonstrate results quickly. Thirdly it outlines some of the key issues country teams are grappling with that are experienced as contextual disincentives.

Incentives and disincentives for country team working

There are considerable existing incentives for country team working that are demonstrated by the longer established SWAp mechanisms in operation in countries like Ghana, Tanzania, Zambia, Uganda and Bangladesh. The key incentives include very clear policy agreement at high levels of agencies as codified in the Paris Declaration, the development of new tools and aid instruments to enable joint working, training courses and staff promotion and selection practices, and individuals' intrinsic belief in the need for improved coordination because it is 'common sense'.

The following disincentives act against the incentives to contribute actively to a country team, or reduce the incentives to work within a country team to jointly tackle obstacles: (i) participating in country teams requires a significant time investment for

less certain returns than managing single projects, (ii) channelling resources through national systems is too high risk, (iii) different agency requirements for procurement and public financial management make pooled funding difficult, (iv) the need to ensure development partner visibility and attributable results, (v) strong pressure to demonstrate quick results, (vi) organisational incentives that reward quick design and agreement of new project or loan, (vii) organisations disbursement schedules. This correlates well with the perverse incentives identified in a 2005 ODI study which also notes that mixed incentives can create obstacles for the pursuit of harmonisation objectives.[6] The absence of new tools to support country team building, team assessment, and conducting key tasks like annual reviews also acts as a critical disincentive.

Longer term options for mandating country team working

Incentivising country team working in the longer term could involve more formal mechanisms or requirements for a country team to exist. The options include formally requiring a country team which reaches certain minimum standards to enable eligibility for funding or formally requiring a country team to perform certain tasks (for example validation of a national strategy) without setting minimum requirements for the composition and functioning of the team.

The GFATM model combines both, requiring a minimum standard of CCM as well as its endorsement of proposals. The Education Fast Track Initiative requires endorsement of a country education plan by the country's Local Donor Group, to signal to bilateral and multilateral financiers that the plan is investment-ready. The Delivering as One UN Reform approach requires joint working within the UN family using UN rules and guidance to require it. It is a model for how external development partners can organise but less relevant as a model for mandating a country team.

The interviews for this work suggest that requiring a country team to perform particular tasks would be the effective incentive because there would be little appetite in countries to meet formal minimum standards of a country team in the absence of a significant financial incentive (vis the GFATM). Even if the IHP+ health strategy validation work is concluded the experience of the Education Fast Track Initiative is more relevant, although replacing the local donor group with the country team.

**Recommendations for putting in place incentives and systems to encourage country team working**

The OECD publication on 'Incentives for aid effectiveness in donor agencies'[7] summarises good practice from 10 development agencies in four categories linked to basic principles of good change management:

1. leadership and management (including commitment, communication and organisational culture);
2. staffing (including recruitment and posting, training and development, and reward and recognition);

[6] de Renzio et al, 2005
[7] The guidance addresses bilateral and multilateral agencies.

3. policies and procedures;
4. budgeting and reporting (including performance monitoring and evaluation, and linking the budget to results).

It includes a self-assessment tool that a development agencies can use to assess the incentives within the agency and develop an action plan to address them. All international development agencies are recommended to review and adopt the good practice examples and conduct the self assessment tool.

To further strengthen country team working all country team members should:

1. commit to ensuring that their country staff prioritise working with government to undertake a team-building process to establish effective country teams as their primary instrument for improving health outcomes. IHP+ countries and all national and external development partners should use a professional team building process to strengthen their country team. The precise objectives and scope will vary according to the country context and the needs of the country team. This will develop shared objectives, membership, team working processes including virtual membership by non-resident members, working groups, determine the skills needed to tackle key issues and the communications principles and methods that will be used. For the more advanced existing country teams this will be an opportunity to refine and improve team working. IHP+ partners should make resources available or establish a global call down contract for country teams to be able to receive specialist team-building and change management expertise to support them in establishing or renewing their country team.
2. Ensure that the heads of external development partner, NGO and civil society offices, their lead health staff and other technical experts have clear annual targets for their contribution to the work of the country team. These should be included in annual performance reviews.
3. Ensure that all new health specialist recruitments to country offices in IHP+ countries are made based upon job description and terms of reference which explicitly includes participation in and contribution to the country team inline with division of labour agreements with other external development partners.
4. Ensure that staff in IHP+ countries can access training in the skills required for effective country team working. WHO should roll out its Harmonisation and Alignment toolkits to its staff and other development partners in IHP+ countries. The UNAIDS Country Harmonisation and Alignment Tool can also be used by country teams. Agencies that do not have training courses on implementing the Paris Declaration commitments should develop them or share existing courses with other agencies.
5. Development partners should make resources available to ensure that civil society representatives in IHP+ countries can also access the same training.

WHO should lead the development of new tools to support country team working. These include:

1. Developing guidance and good practice on how to conduct a joint annual review of the health sector. It would include good practice and checklists for conducting reviews that all countries can select from. Some good practice includes agreeing terms of reference, appointing an oversight working group

and putting in place a clear calendar of inputs required. This should draw upon the work developed by UNAIDS on conducting HIV/AIDS annual reviews, and could be done with OECD as part of the health as a tracer sector work. It should draw on the experience of a few volunteer countries and could be facilitated by external consultants.

2. Developing a self-assessment tool for country team working. This tool would enable a country team to assess the key elements of their structure, process, and outputs of team working, to identify areas for improvement and develop an improvement plan. It could be run as a stand alone exercise or as part of the annual review process. It should draw upon the work developed by UNAIDS on assessing HIV/AIDS teams, and could be done with OECD as part of the health as a tracer sector work. It should draw on the experience of a few volunteer countries and could be facilitated by external consultants.
3. WHO should work with OECD to develop good practice document on mutual accountability mechanisms that are used by country teams and that are used to ensure country team accountability to national development coordination mechanisms. This would ensure health sector experience of mutual accountability can learn from, and feed into, broader OECD work on mutual accountability

Civil society representation in the IHP+ at global and country level should develop guidance on civil society responsibilities and sample commitments that civil society can contribute for inclusion in country compacts.

<u>Disincentives for country team working include the obstacles to making progress on key relevant Paris Declaration commitments</u>

Improving country team working requires weakening the disincentives or tackling them head on.[8] Disincentives are often perceived by individuals as given constraints that cannot be addressed. These are related to the broader areas of Paris Declaration commitments which are not about team working, but are the focus of the teams efforts to improve coordination. Action in four key areas would remove disincentives and demonstrate progress and the ability of a country team to perform joint work.

Firstly country teams should prioritise establishing and refining a single results framework and national health information systems. This would enable government to take greater ownership of its achievements and issues, and put in place a government led reporting system that would also enable donors to be able to demonstrate results and mobilise additional resources. IHP+ already has results based financing and monitoring and evaluation working groups. However at present not all IHP+ countries are accessing support from the Health Metrics Network or necessarily linking it with country compacts and the IHP+. IHP+ Core Team and HMN should ensure that all IHP+ countries are accessing HMN support, and consider developing a framework for accrediting health information systems capacity and performance that all partners can rely upon.

[8] Harnmeijer and Bijlmakers, 2008

Aligning with national public financial management and procurement systems

Many country stock taking reports and country team members report that a key constraint to joint working is the difficulty of setting up pooled funding or sector budget support arrangements when different agencies require different standards for public financial management and procurement. This is a key disincentive as well as an obstacle to implementing the Paris Declaration commitments to use to the maximum extent possible national financial management and procurement systems. IHP+ partners could address this obstacle at a global level by building on the PEFA work. WHO and World Bank should work with OECD which has expressed willingness to make its Joint Venture for Procurement available as a platform to help unblock procurement issues in countries negotiating pooled funding arrangements. Bilateral donors as members of OECD and represented on the governing boards of the World Bank, UN and Global Funds should use these positions to seek harmonisation of standards.

Aligning application and reporting requirements

Country respondents report the significant transaction costs of developing proposals for grants, in particular from the GFATM, and to a lesser extent from GAVI, and for subsequently preparing agency specific progress reports. The work of the IHP+ working group on validation of national strategies, the GFATM exploration of accepting National Strategy Applications, and GAVI work identifying minimum components for validation of National Health Plans and immunisation plans will be welcomed as an opportunity to both ensure better comprehensive planning and reducing transaction costs. [9] Further work on identifying how countries can prepare standard progress reports that are accepted by all funders and not agency specific would bring additional benefits.

Harmonisation of funding channels

Many bilateral donors, UN agencies, GFATM and World Bank provide support more than one project, grant or loan to a country for improving health outcomes. These development partners should check their own portfolios of support to IHP+ countries and take measures to harmonise their own multiple financing channels to reduce transaction costs for country governments.

## 7. Encouraging cross country lesson learning on country team working and good practice to implement Paris Declaration commitments in the health sector

Countries and development partners have innovated and utilised a wide range of tools and mechanisms to improve their ability to deliver health outcomes by improving the effectiveness of international assistance. Much of this is undocumented, or not easily accessible in one place. IHP+ partners should resource a website which is a platform for sharing good practice and enabling country team members to share ideas and access tools. IHP+ countries should be invited to document good practice and showcase them in a launch event to give the website profile. The website should be a useful and accessibly facility to store and share country compacts, memorandum of understanding, codes of conduct, terms of

[9] http://www.theglobalfund.org/documents/board/18/GF-B18-04_ReportPSC.pdf and http://www.gavialliance.org/resources/2._IHP_update.pdf

reference, team working documents, mutual accountability tools and other tools and guidelines that are useful.

A good practice website for country team working and Paris Declaration commitments could be developed with OECD using the health as a tracer sector webpages:

- developed with OECD following the model of the Management for Development Results website and communities of practitioners.
- linked to the http://www.aidharmonization.org/ website which focuses on harmonisation and alignment.
- linked to http://www.accrahlf.net/WBSITE/EXTERNAL/ACCRAEXT/0,,contentMDK:21756134~pagePK:64861884~piPK:64860737~theSitePK:4700791,00.html This website was set up for the Accra High Level Form on aid effectiveness.
- linked to http://amp.developmentgateway.org/index.do an aid management and effectiveness website

There would be clear benefits of working with the OECD on the website to enable the health sector to benefit from linkages with other Paris Declaration implementation experience. Linkages to other aid effectiveness websites could be put in place and key web-based document libraries shared to reach wider audiences.

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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.

| | |
|---|---|
| Emeline Saunier | DFID Burundi |
| O'Leary Dr - Michael | WHO WR Cambodia |
| Paul Whelan | WHO Cambodia |
| Toomas Palu | World Bank Health Specialist, Cambodia |
| Ali Forder | DFID Ethiopia |
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| Michael Mills | World Bank Health Specialist, Kenya |
| Tony Daly | DFID Kenya |
| Tonia Marek | World Bank Health Specialist, Mali |
| Lubna Bhayani | World Bank Health Specialist, Madagascar |
| Dr Humberto Cossa Sr | World Bank Health Specialist, Mozambique |
| Neil Squires | DFID Mozambique |
| Cesar Mufanequico | Mozambique AIDS Treatment Access Movement (MATRAM) |
| Ramesh Govindaraj | World Bank Health Specialist Nigeria |
| Jane Miller | DFID Nigeria |
| Nastu Sharma | World Bank Health Specialist, Nepal |
| Susan Clapham | DFID Nepal |
| Shanta Lall Mulmi | Executive Director, Resource Centre for Primary Health Care |
| Ms. Ugochi Daniels | UNFPA Representative a.i Nepal |
| Mr. Stierle | Programme manager, Health Sector Support Programme (MoHP/GTZ) |
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| Mr. Solomon Kagulula | WHO Zambia |
| Catherine Sozi | UNAIDS Zambia |
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