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Ministerial Leadership Initiative

ASPEN GLOBAL HEALTH AND DEVELOPMENT
AT THE ASPEN INSTITUTE

IMPROVING COUNTRY CAPACITY FOR AID COORDINATION:

EXPERIENCES FROM FIVE MLI COUNTRIES

Ministerial Leadership Initiative for Global Health

ISSUE BRIEF

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Front Cover: *Ethiopia's Health Minister, Dr. Tedros Adhanom Ghebreyesus (far right), listens to staff during a weekly meeting of the Federal Ministry of Health in Addis Ababa. Photo © Dominic Chavez*

IMPROVING COUNTRY CAPACITY FOR AID COORDINATION:
EXPERIENCES FROM 5 MLI COUNTRIES

Ministerial Leadership Initiative for Global Health

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RESULTS FOR DEVELOPMENT
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Acronym List

ACU: Aid Coordination Unit

CAFSP: Health Financing and Partnership Support Unit of Senegal

CPAP: Country Program Action Plan

DACO: Office of the Vice-President, Development Assistance Coordination Office , Sierra Leone

DPCU: Development Partner Coordination Units

FMoH: Federal Ministry of Health, Ethiopia

FTE: Full-time Equivalency Assumptions

GDP: Gross Domestic Product

HMIS: Health Management Information System

IHP+: The International Health Partnership

INGO: International Non-governmental Organization

M&E: Monitoring and Evaluation

MLI: Ministerial Leadership Initiative for Global Health

MoF: Ministry of Finance

MoH: Ministry of Health

MoHP: Ministry of Health and Population , Nepal

MoHS: Ministry of Health and Sanitation, Sierra Leone

MOU: Memorandum of Understanding

NGO: Non-governmental Organization

ODA: Official Development Assistance

OECD: Organisation for Economic Co-operation and Development

OECD-DAC: The OECD Development Assistance Committee

PNDS: National Program for Health Development of Senegal

PRODESS: Health and Social Development Program of Mali

SWAp: Sector-wide Approach

SWC: The Social Welfare Council of Nepal

TORs: Terms of Reference

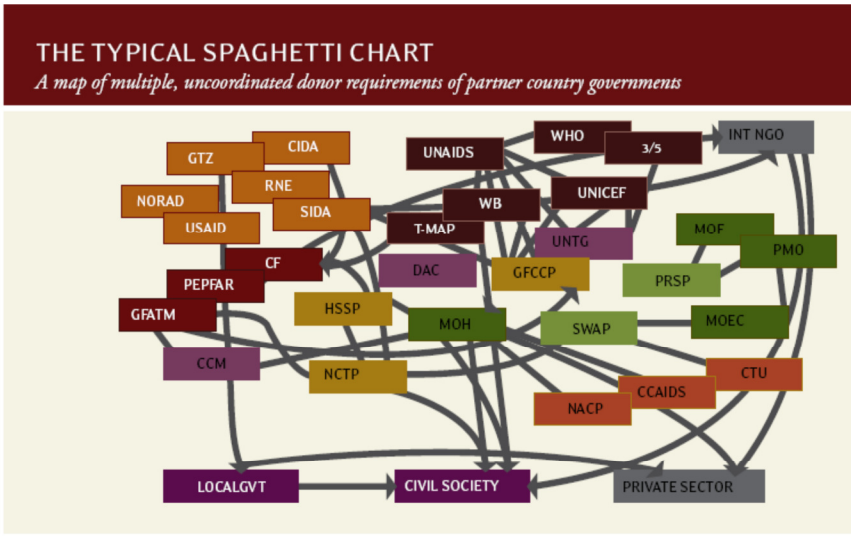
WHO: World Health Organization

I. Background and Context

Development assistance for health, which intends to boost a country's social and economic development, has risen dramatically in the past decade, after stagnating in the 1980s and 1990s. The increase in aid and the proliferation of donors have created a new, and largely fragmented, funding landscape that recipient countries must navigate. The OECD Development Assistance Committee (OECD-DAC) estimates that bilateral and multilateral donors contributed $15.6 billion for health in 2007 (10.9 bilaterals and 4.7 multilaterals), resulting in an annual development assistance growth rate of 17% between 2000 and 2007, but only 10% when measured between 1980 and 2007. It is important to note that the increases in multilateral contributions in aid between 2002 and 2007 were largely due to the creation of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), which committed $8.3 billion (cumulative total) over this. [1]

Sub-Saharan Africa, the largest recipient of development assistance since 1999, received almost half of the total development assistance in 2006-2007. Managing this complex aid flow (with many partners, each with specific requirements and modes of operation) and ensuring that aid results in concrete and desired health outcomes is a significant challenge for countries. For example, it is estimated that on average many developing countries receive over 800 new projects annually, host more than 1,000 monitoring missions, and prepare and present 2,400 quarterly progress reports.[2] Both development partners and country officials alike recognize the inefficiencies and unnecessary transaction costs involved in aid coordination, and are seeking solutions to mitigate the unintended consequences resulting from the mushrooming of development assistance projects.

At the global level, efforts to align and harmonize development partners have shaped the Paris Declaration of 2005 and the Accra Agenda for Action of 2008 (see Text Box F). These international agreements codified the principles of aid effectiveness, which are: a) country ownership; b) alignment; c) harmonization; d) managing for development results; e) mutual accountability. The International Health Partnership (IHP+) built upon these agreements and seeks to better harmonize development aid around a country-led national health strategy.[3] IHP+ partners with countries to develop Country Compacts that detail specific commitments for governments and their development partners and holds both parties mutually accountable for results.[4]



From a presentation to the CSIS Commission on Smart Global Health Policy, June 10, 2009, CSIS, by Joy Phumpahi, World Bank

Although the tenets of aid effectiveness are promising, implementing these practices and fully shifting the coordination responsibility to ministries of health (MoH), tasks ministries' staff with new challenges. Ministries must accommodate a range of aid modalities spanning from multi donor budget support to

[1] Measuring Aid to Health, November 2009, fact sheet at (http://www.oecd.org/dataoecd/44/35/44070071.pdf)
[2] African Development Bank and African Development Fund. Bank Group Action Plan on Harmonization, Alignment, and Managing for Results, April 2006, and the OECD - DAC Survey on Monitoring the Paris Declaration, 2006.
[3] International Health Partnership (IHP+) website.
[4] Aid for Better Health- What Are We Learning About What Works and What We Still Have To Do? OECD.
[8] The Paris Declaration on Aid Effectiveness (2005)and the Accra Agenda for Action (2008), OECD. http://www.oecd.org/dataoecd/30/63/43911948.pdf

vertical projects targeting high visibility diseases, not all of which are diseases which constitute a high burden for the country. Ministries must continuously balance donors' priorities with their own and with the larger, systemic health sector needs.

The range of aid approaches that country governments must accommodate include:

Figure 1.2

The Paris Declaration for Aid Effectiveness and the Accra Agenda for Action

In 2005, over one hundred Ministers, Heads of Agencies and other Senior Officials came together to discuss and identify actions to significantly increase efforts in aid harmonization, alignment and managing aid for results with a set of actions and indicators to be monitored. **The Paris Declaration** is an international agreement that clearly identifies key areas for improvement and fundamental principles of partnership commitment necessary for success in aid management reform, including:

1. Ownership
2. Alignment
3. Harmonization
4. Managing for Results
5. Mutual Accountability

At the Third High Level Forum on Aid Effectiveness in Accra in September 2008, donors and developing countries endorsed the **Accra Agenda for Action**. This includes new ambitious commitments by development partners and developing countries to accelerate the process of achieving the Paris Declaration's pledges.[8]

- **Multi-donor budget support or general budget support**: aid channeled to a country's budget, allowing the ministry of finance (MoF) to allocate the funds to the MoH based upon priorities in their national development strategy, and using national procurement and accounting procedures. Usually this type of arrangement requires a clear sector policy, supported by the following: a) a formalized government-led process for donor-coordination at sector-level; b) a sectoral medium-term expenditure program and annual budget that clarifies the expected level of available internal and external resources and how these resources will be used in pursuit of sector policy; c) a performance-monitoring system that measures progress towards the achievement of policy objectives and targets results; d) an effective funding mechanism that provides flexible and predictable funding in support of sector policies; f) an agreed process for moving towards harmonized systems for reporting: budgeting, financial management and procurement; and g) a client consultation mechanism.[5]

- **Sector budget support**: aid channeled directly or earmarked to the health sector and designated to achieve specific MoH program goals. The mechanisms can take the form of parallel financing, pooled financing, health sector budget support, or a combination; in order to be effective, however, a harmonized system of reporting, budgeting and financial management and procurement must be in place.

- **Project-based support**: aid provided to activities which are well defined, narrow, short-lived, and have stand-alone management arrangements independent from the government.

- **Program-based support**: is a hybrid approach in which flexible assistance is provided to support the comprehensive health sector strategy or a specific government health policy. It involves a high level of country leadership, donor coordination, and use of government systems. Program-based support can include general or sector budget support or Sector-wide Approaches (SWAps).

[5] Report of a Technical Consultation on Building UNFPA and WHO Capacity to work with National Health and Development Planning Processes on Reproductive Health, Geneva 2005 at http://www.who.int/hdp/publications/unfpa_who_fullreport.pdf

Figure 1.3

Aligning these multiple aid approaches with country government health priorities requires well developed capacity to manage aid flows together with a new type of planning and monitoring. Some countries have responded to this complex charge by creating aid coordination units or ACUs to track the range of development partner initiatives in the health sector and to ensure that aid is well-aligned and coordinated with the country's overall health plan and other partner initiatives. Although the creation of these units suggests an appetite for better coordination within developing countries, units are often hindered by the same problems that affect ministries of health at large including, a lack of coordination between government agencies, a lack of communication and leadership skills to coordinate development assistance among civil servants, and a lack of financial resources to fully carry out the coordination functions that were intended. There is potential for these units to learn from one another as they scale up operations and identify strategies to overcome some of the challenges they are facing.

Key Definitions

Aid effectiveness: the impact that aid has in reducing poverty and inequality, increasing growth, building capacity, and accelerating achievement of the Millennium Development Goals set by the international community.*

Alignment: donors base their overall support on partner countries' national development strategies, institutions and procedures.

Budget support: the financial contribution to the overall budget and conditionality is directed towards policy measures that relate to the overall budget priorities.

Development Partners: all international partners which contribute with funds or in kind to the development assistance.

Donor: all international partners and private sector which commit funds toward a country on the base of an agreed, formal agreement with the government of that country.

Donor coordination: eliminating the duplication of efforts and rationalizing donor activities to make them as cost-effective as possible.

Parallel Financing: financing mechanisms that enable donor funds to bypass government budgets and flow directly to projects.

Donor harmonization: harmonization among donor practices in terms of financial management, procurement and monitoring, in order to be efficient and be able to build and or strengthen country's own systems.

Joint or Pooled financing: combining donor funds for certain activities or general budget support to the government.

Sector support: aid targeted at a specific component of the government's budget, such as the health sector, often without conditionality

Specific budget support: financial aid targeted at supporting a particular sector or sectors, with conditionality relating to only the supported areas

The World Bank Data at http://data.worldbank.orgA Critical Assessment of Aid Management and Donor Harmonization in Ghana, AFRODAD*

The Questionnaire

This issue brief is based on the findings from a questionnaire administered to Ministry of Health staff in the five Ministerial Leadership Initiative for Global Health (MLI) countries: Ethiopia, Mali, Nepal, Senegal, and Sierra Leone. The original objective of the questionnaire was to inform the Ministry of Health and Sanitation in Sierra Leone about the set-up of development assistance coordination for the health sector in other countries. However, through the process of data collection and analysis, it became apparent that the results of the study would have wider interest and potential application in other MLI countries, and beyond.

The questionnaire collected information on issues related to the organization and management of aid coordination activities within the MLI countries, including the ways countries have chosen to define the roles and responsibilities of units in charge of coordinating aid activities, and the advantages and disadvantages of these types of arrangements. This work provides a number of practical examples for ways that developing countries can turn global principles of aid harmonization and alignment into concrete action on the ground.

II. Methodology

The findings and recommendations in this issue brief are based on a self-administered questionnaire to ministry of health staff in the five MLI countries. The objective of the data collection was to provide a window into the aid coordination issues and challenges ministries are facing as well as to identify the approaches ministries are using to organize and manage aid. The design of the questionnaire was based on the principles of aid coordination and harmonization as presented in the introductory sections as well as a review of literature on aid efficiency and effectiveness published by OECD, WHO, World Bank, and African Forum and Network on Debt and Development. Feedback was received on the initial draft of the questionnaire from MLI country representatives and staff and was incorporated into the final questionnaire.

The questionnaire included both multiple choice and open-ended questions and was provided in both French and English for the Francophone and Anglophone countries, respectively. The study questions targeted the following issues:

- the positioning of health aid coordination activities within government structures
- the financial mechanisms through which aid is channeled to the health sector
- the roles of donor aid coordination units within different MLI countries
- the strengths and weaknesses of the current arrangements and the more general aid environment
- the challenges countries face in their efforts to coordinate aid assistance

This questionnaire, the first of its kind within the MLI program, was completed by officials from the departments of planning within the five MoH. Based on a review of the literature, this seems to be the first questionnaire administered to the staff of ACUs. As an initial look into ACUs, the survey revealed a wide array of operational information, but the findings also suggest that there are a number of more in depth questions that could inform aid coordination approaches. A selection of these questions is listed in Annex 3.

MLI followed the questionnaire with several rounds of clarification questions for the staff members responsible for aid functions within their countries. During the course of the survey, it became apparent that further inquiry into methods for supporting leadership within ACUs was needed. Information around how ACUs collaborate with regional and district health units could build on the questionnaire's findings by posing further operational lessons for building political momentum for aid coordination and coordinating aid in decentralized systems. See Annex 2 for the questionnaire.

III. Key Findings

Development Assistance in MLI Countries

This section provides a brief overview of the scale of development assistance for health in terms of concessional loans and grants received by the MLI countries and the number of development partners and NGOs that are operating in the health sector.

All five MLI countries have between 10 and 20 active donors each providing over half a million US dollars per year to the health sector. Senegal, with 14 active donor partners, has the highest official development assistance (ODA) per capita and the highest gross domestic product (GDP) per capita among the MLI countries. Nepal, with 15 active donor partners, has the lowest ODA per capita (see

Figure 3.1 below). Figure 3.2 reflects the number of local and international NGOs and their relation to each country's population.

Figure 3.1: Number of multilateral, bilateral and global organizations such as Global Fund, Bill & Melinda Gates Foundation, etc. that are currently contributing or committing over $500,000 USD per year to the health sector

Country	Number of active donors contributing >$500K per year to health sector*	Contribution to the health sector 2008 (net ODA per capita in current US $)**	GDP per Capita 2008 (in current US $)
Ethiopia	10	41	345
Mali	10-20	76	691
Nepal	15	25	427
Senegal	14	87	1,042
Sierra Leone	12	66	341

Source: *Information from the survey* and Information from OECD/World Bank Database***

Figure 3.2: Number of National and International NGOs active in the health sector

Country	Number of Local NGOs*	Number of International NGOs*	Country population 2008 (WDI)**	Population Per NGO
Ethiopia	>1000	>30	80.7	78,000
Mali	200	20	12.6	57,000
Nepal	50	40	28.8	320,000
Senegal	50	10	12.2	204,000
Sierra Leone	20	40	5.6	93,000

Source: Questionnaire and World Bank Database***

Mali has more NGOs per capita than the other MLI countries. Ethiopia has the second largest number of NGOs per capita, while Nepal has the lowest number of NGOs per capita.

Agreements that govern relationships with development partners

All five MLI countries have established Legal Agreements and/or Memorandums of Understanding (MOUs) with their development partners. Three of five MLI countries (Nepal, Mali, and Ethiopia) have IHP+ country compacts, and Senegal and Sierra Leone are currently in the process of finalizing their country compacts. An IHP+ compact is a time bound agreement in which development partners agree to follow country health sector strategies and work within a clear results-focused harmonized framework.[6] In addition, Mali, Nepal and Senegal have Sector Wide Approaches (SWAps) governing their health sector development support.

Flow of development partner funds to the government

In an attempt to avoid constraints in health system capacity, donors rely on a number of different aid instruments to implement development assistance. All five MLI countries receive funds through health sector budget support and vertical projects from their development partners. Three of the five MLI countries (Mali, Nepal and Senegal) receive funding through multi-donor general budget support provided by development partners, and two of five MLI countries (Ethiopia and Nepal) have health sector pool fund arrangements.

[6] http://www.internationalhealthpartnership.net/CMS_files/documents/ihp_compact_guidance_note_EN.pdf

Figure 3.3

Ministry of Health	Multi-sector budget support	Health sector budget support	Off-budget Pool fund	Vertical project support
Ethiopia		Y	Y	Y
Mali	Y	Y		Y
Nepal	Y	Y	Y	Y
Senegal	Y	Y		Y
Sierra Leone		Y		Y

Source: Questionnaire

Organization

This section examines the structure and function of ACUs within each of the MLI countries. It includes descriptions of the scope and responsibility of ACUs within each nation, as well as some of the challenges they face in donor coordination.

Location of Development Partner Coordination Function within Ministries of Health

The aid coordination function is housed within established ACUs within the planning departments or planning units in all five MLI Ministries of Health. In some countries the team responsible for development partner coordination is not specifically named an "aid coordination unit," but in this paper ACU refers to whichever team or group is tasked with coordinating development assistance for health.

Figure 3.4

Location of ACUs within MLI Ministries of Health	
Ethiopia	Resource Mobilization Directorate and Policy and Planning Directorate, General Planning and Financing Directorate
Mali	Planning and Statistics Unit for the Ministries of Health, Social Development and Promotion of Women, Children andthe Family
Nepal	Policy Planning and International Cooperation Division, Ministry of Health and Population (MoHP)
Senegal	National Health Planning Unit (CAS/PNDS), MoHP
Sierra Leone	Directorate of Planning and Information, Liaison Office, MoHS

Who is leading the ACU?

In all five MLI countries, the management of the ACU is not considered a full-time role. Heads of ACUs are responsible for a range of other functions (e.g., general oversight of planning). In Mali the head of the ACU is the Director of Planning and Statistics. In Nepal the head of the team is the Chief of the Policy, Planning, and International Cooperation Division in the Ministry of Health and Population (MoHP). In Senegal, the head of the ACU is responsible for coordination with technical and donor partners and the planning, monitoring, and evaluation of the National Program for Health Development (PNDS). Every two months the head of the Senegal ACU represents the MoH in a health development partners meeting, (currently led by the WHO). In Ethiopia, the unit is attached to and jointly managed by two directorates: the Policy and Planning Directorate and the Resource Mobilization Directorate.

Number and status of personnel working in the ACU

The ACUs in four of five MLI countries are staffed by three to nine people. But in countries with weak or insufficient capacity the unit gets external support either on a medium- to short-term basis. Thus "the staff" is a mix of public servants, local consultants and international representatives. This is the case in Sierra Leone. In Mali, donor coordination activities are spread across approximately 60 full-time and part-time staff, many of whom are part of the governmental Planning and Statistics Unit which supports the Ministries of Health, Social Development, and Promotion of Women, Children and the Family. Most of the staff in Mali who work on health sector aid coordination also have other responsibilities.

Ethiopia and Sierra Leone have decentralized health systems, which require aid coordination to be carried out to some extent at the different levels of their health system. In Sierra Leone, the coordination is in theory still carried out from the headquarters at the MoHS by the ACU unit comprised of two full time staff and an assistant. However, much of the development partner projects' financing is channeled directly to the regional and local levels without passing through the MoHS. It is not clear if there are any coordinating units within the local government structures and if so, how they coordinate with the central government.

In Ethiopia most development partner coordination and monitoring occurs at the federal level through a joint team between: (1) the Directorate of Policy and Planning and Resource Mobilization and (2) the NGO Coordination and Project Appraisal Units of the Federal Ministry of Health (FMoH). The two directorates involved in aid coordination assist the FMoH in mobilizing resources by conducting resource mapping and gap analysis, working with development partners to disburse funding, tracking the level of funding committed by different development partners , monitoring and following the rate of fund utilization and liquidation, and preparing periodic reports on agreed upon formats and disseminating to users. The NGO Coordination and Project Appraisal Unit is responsible for coordinating the health NGOs registered in Ethiopia. The unit performs project appraisal before implementation using a standard format and evaluation criteria to ensure that each project is in line with national government policies and strategies, the health sector development plan and other rules, regulations and proclamations. It is the responsibility of the Directorate of Policy and Planning and Resource Mobilization to follow up on NGO implementation activities at the federal level.

The Resource Mobilization Directorate has seven staff fully engaged in monitoring NGO and development partner activities at the federal level. There are no resource mobilization directorates at the regional level. At this level many development partners work directly through local NGOs and independently track their work. If development partners choose to channel their regional funding through the FMoH, then the ministry tries to track local activity, but because of limited staff capacity, central coordination activities focus on the large NGOs and the federal level. The Bureau of Finance and Economic Development, which is part of the Federal Ministry of Finance and Economic Development, also has a great role in registering, mapping and monitoring NGOs' work at the regional level to ensure an equitable distribution of resources that meets the needs of priority program areas in collaboration with the Regional Health Bureaus. Overall, donors are better monitored and coordinated than NGOs in Ethiopia.

One way to assess the demands facing ACUs is to look at the number of local and international NGOs in relation to the number of personnel in the ACUs (translating the ACU personnel into full time equivalents). The table below provides some estimates of the workload per full time person in the coordination units of the MLI countries. While the questionnaire did not specifically ask about the number of hours staff dedicates to NGO coordination activities, the authors made full-time equivalency (FTE) assumptions based on the responses received about the number and status of personnel working in ACUs. Based on this analysis, Ethiopia seems to be the most overwhelmed by the number of NGOs per FTE. However, since Ethiopia has a decentralized system in which district councils and district teams

provide some supervision of NGO activities, a share of NGO coordination is handled outside the central FMoH level.

Figure 3.5

Country	Number of Local and International NGOs	Total Number of Staff at headquarters	FTE	Average NGOs per FTE
Ethiopia	1,030	7	5.95 (85%)	173
Mali	240	60	18 (30%)	13
Nepal	90	4	2.4 (60%)	37
Senegal[7]	60	9	N/A	N/A
Sierra Leone	60	3	3 (100%)	20

Countries in which the regional and district levels are involved in strong coordination efforts may have less need for centralized coordination activities. However, this survey did not review the efficiency and effectiveness of central, regional and district coordination units. In addition, the FTE measure can be deceptive as sometime even the full time staff members that are supposed to be dedicated to donor coordination are involved in other activities.

In addition to civil servants, the ACUs often receive support from international fellows and other technical assistance to help them carry out their activities. For example, Senegal and Mali receive regular support from international partners. Other countries like Sierra Leone get support on a more ad hoc basis. While the ad hoc support offers some value, the countries report that it can also cause instability, inefficiencies, and a lack of knowledge transfer and ministry ownership.

Roles and Responsibilities of ACUs

Decision-making within the ACU

Negotiations regarding aid coordination activities between development partners and governments are largely handled "outside" the ACUs' core teams. The ACUs primarily provide administrative (and in some cases, analytic) support for the decision-making processes. Decision-making typically follows one of two main approaches. In Mali and Nepal, decisions are made through committee consensus. In Mali, the steering committee for the 10 year health plan is responsible for decision-making. In Nepal, directives are issued jointly by the National Planning Commission and the Ministry of Finance. The health secretary also chairs a forum to build consensus between the Ministry and its external development partners. In the second approach, used by Ethiopia, Senegal, and Sierra Leone, the decisions are made by officials at higher levels than the ACUs.

The primary decision-maker(s) or decision-making body for the ACUs varies by MLI country:

- Ethiopia: The ACU unit director and the Director and Assistant Director of Policy, Planning and Finance General Directorate
- Mali: The committees and other bodies for the Health and Social Development Program (PRODESS) (e.g., Monitoring Committee; Technical Committee; Steering Committee; Facilities' Evaluation Day; Regional Steering, Coordination, and Evaluation Committee of PRODESS; and Health Districts' Council Circles)
- Nepal: The Chief of Policy Planning and International Cooperation Division under the guidance of the Health Secretary
- Senegal: Cabinet for the Minister of Health

[7] This measure is not applicable for Senegal because the ACU only works with technical and financial partners (e.g., bilateral, multilaterals, projects, and initiatives), not NGOs.

- Sierra Leone: Health Minister and Chief Medical Officer for MoHS but local government can decide on its own about development assistance without significant consultations with MoHS. The MoF has direct oversight of local government.

Participating in health sector planning activities

The ACUs in Nepal, Senegal, Ethiopia, and Mali actively participate in the development of health sector strategic planning and budgeting. For example, Mali's ACU and associated committees are involved in coordination and facilitation of sectoral strategies and national plans in addition to the development partner coordination function. In Nepal, the ACU engages with the Ministry of Finance on the negotiation of bilateral donor agreements and with the Social Welfare Council on the negotiation of agreements with NGOs.

In Ethiopia, the ACU is jointly overseen by the Policy and Planning Directorate and the Resource Mobilization Directorate, which has the effect of blending development partner harmonization and coordination activities with broader health sector activities. This is not the case in Sierra Leone as the strategic planning and the budgeting process do not typically involve the ACU.

Registration and licensing of NGOs

All five MLI countries have a process for registering NGO activities, which is performed by ministries other than health (see below). Ethiopia has also established a process for licensing NGOs to ensure certain pre-defined standards are met. The MoHS in Sierra Leone is also working with other ministries to define the documentation requirements and licensing criteria for NGOs and other actors.

The parties responsible for NGO registration and licensing in the MLI countries are:

- ***Ethiopia:*** Newly established, inter-governmental Charity and Society agency responsible for NGO licensing and registration. The FMoH (through the ACU) is responsible for collaborating with and providing necessary support to the inter-governmental agency in the issuance of registrations and licenses for health sector activities.
- ***Mali:*** The Ministry of Territorial Administration and Local Government authorizes NGOs to work in certain areas. According to their areas of focus, the NGOs are also required to sign relevant agreements and partnerships that are sector-specific. The Planning and Statistics Unit is responsible for managing all data related to NGO involvement in the areas of health, social development, and the promotion of the family.
- ***Nepal:*** The Social Welfare Council (SWC) and Ministry of Women, Children and Social Welfare are responsible for approving and coordinating international NGOs. International NGOs are not permitted to implement programs directly and must instead work in conjunction with local NGOs. District Administration Offices under the Ministry of Home Affairs are responsible for the NGO registration and regulatory process. Local NGOs can seek an affiliation with the SWC, but do not need its approval to carry out activities. Currently, new guidelines are being developed to better regulate the operation of international NGOs and to strengthen monitoring, check for financial irregularities, and increase international NGOs' accountability. The MoHP (through the ACU) is responsible for collaborating in this process, although the MoHP cites collaboration with the SWC as one of its challenges.
- ***Senegal:*** The ACU is not responsible for the registration and licensure of NGOs. It is the Health Financing and Partnership Support Unit (CAFSP) at the MoH, in collaboration with the Ministry of Social Development, that is responsible for the coordination with NGOs.
- ***Sierra Leone:*** Office of the Vice-President, Development Assistance Coordination Office and Ministry of Planning and Economic Development are responsible for registering NGOs. The MoHS (through the ACU) is responsible for providing necessary support to the registration process.

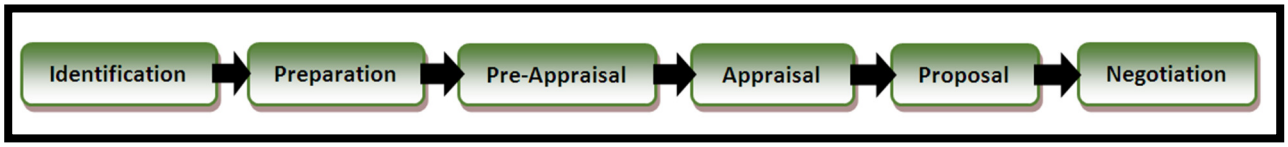
Summary of ACU Functions	Health Sector Planning	NGO Registration and Licensing	Drafting MOU and NGO Agreements	Mapping and Monitoring NGOs	Monitoring NGO Deliverables	Monitoring Deliverables of Bi/Multilaterals	Program/Project Evaluation	Tracking Development Partner Financial Contributions
Ethiopia	X	Performed by ACU and Intergovernmental Charity and Society Agency	X	X	X	X	X	X
Mali	X	Performed by the Ministry of Territorial Administration and Local Government	X	X		X	X	X
Nepal	X	ACU and Performed by Social Welfare Council and Ministry of Women, Children and Social Welfare						X
Senegal	X	Performed by Health Financing and Partnership Support Unit			X		ACU monitors health sector plan overall	X
Sierra Leone		Performed by ACU and Development Assistance Coordination Office under the Vice President and the Ministry of Planning and Economic Development		X	X			X

Figure 3.6

Drafting and negotiating Memoranda of Understanding (MOUs) and other agreements with NGOs

ACUs in two countries, Mali and Ethiopia, have some responsibilities for supporting the drafting and negotiation of MOUs or other agreements with NGOs. In Mali the ACU is involved throughout the process of project approval by supporting the identification, preparation, and negotiation of agreements and financing conventions for health sector programs and projects involving UN agencies, NGOs and other charities. The ACU in Mali also has a broader responsibility for monitoring and evaluating the projects/programs of the health sector, which is an asset for integration and broader coordination. In Ethiopia, the ACU assumes a larger role on behalf of the FMoH and is involved in preparing the missions in conjunction with development partners of their activities, pre-appraisal, appraisal, proposal review and the actual negotiation process, making critical decisions on the final use of development funding, activities and disbursements.

Figure 3.7: Stages in preparing an MOU, or any other type of agreement with different development partners:



Mapping and monitoring NGO and donor activities

Mapping and monitoring of NGOs is a core function of most ACUs. Three out of five MLI countries' (Ethiopia, Mali, and Sierra Leone) ACUs are involved in mapping and monitoring activities of NGOs. The MoHP in Nepal is not responsible for geographically mapping the activities of international NGOs - this function is carried out by the Social Welfare Council. The Social Welfare Council also coordinates the donors; however the MoHP does monitor the status of donor activities. In Senegal it is the CAFSP at the Ministry of Health, in collaboration with the Ministry of Social Development that maps and monitors NGOs' activities. In Ethiopia, the Bureau of Finance and Economic Development is highly involved in resource mobilization and works with the regional health bureaus to monitor NGOs' activities. Although Sierra Leone has a mandate to track data on NGOs, it has not succeeded in tracking them closely. Four countries - Senegal, Mali, Nepal, and Ethiopia - are tracking the level of funding received by different NGOs. Mali, Nepal, and Ethiopia also monitor NGOs' spending.

Most ACUs are not directly involved in mapping and monitoring donor's activities. Mali and Nepal are the only MLI countries in which the ACUs are responsible for mapping where donors are contributing. They also monitor donor funding arrangements and they track the status of donors' activities against a set of indicators. The ACUs in Mali, Nepal, and Senegal regularly meet with the main donors. In addition, Nepal monitors the spending levels of donor funds that are recorded by the government.

Liaison Function

Most MLI countries have a liaison function between the MoH and other ministries or national offices involved with coordinating development assistance, and the MLI survey findings suggest that ACUs often take on this role in addition to a broader liaison function outside of the government. In Nepal, the ACU provides coordination with development partners, between the many divisions within the MoHP and with the Department of Health Services. In Ethiopia the ACU

supports NGOs to liaise with health care providers (public and private). Mali reports that its ACU acts as a liaison and interface between the MoH and development partners.

Monitoring of deliverables from NGOs

Monitoring of NGOs' deliverables is carried out in all MLI countries, although the degree to which the ACUs perform this function varies. The countries reported that they monitor NGO activities through a variety of mechanisms: tracking a defined set of indicators, reports provided by NGOs, and through reports provided by MoH project managers/units. Senegal, Sierra Leone and Ethiopia reported that they actively follow-up with NGOs to assess the status of their deliverables.

The way that the organizations' activities are captured and reported, however, varies. In Ethiopia the indicators are defined in the comprehensive health sector plans but to a certain extent the sub-sector indicators are tracked through reports from NGOs at the sub-national levels.

Nepal relies on the program and project units to collect this information which is also a part of the joint annual review process.

Senegal, Sierra Leone and Ethiopia reported that they actively follow-up with the development partners to assess the status of their deliverables. However given that Ethiopia has more than 1000 NGOs involved in assistance there may be challenges to attempting to carry out this work at the central level. In Mali some information is actively collected by the ACU while some NGOs submit information directly to the unit. Mali has integrated a system of monitoring into ongoing activities in the health sector.

Monitoring the deliverables of the Multilateral, Bilateral and similar agencies

Most ACUs are not fully charged with the function of monitoring the status of donors' agreed-upon deliverables. Rather, monitoring usually takes place within the donors' project units. The donors do not usually actively update the ACUs on the status of their deliverables, especially when it comes to the flow of funds and disbursements. Rather, the agreed upon deliverables tend to be discussed between the donors and higher level MoH officials or sometimes the updates on donor activities take place in development partner meetings. However, development partner meetings are often not attended by MoH representatives or the representative who attends the meetings is not senior enough to contribute to the discussions.

The ACU in Ethiopia, however, has a strong role in monitoring development partners at the federal level. In fact it is mandated to impose sanctions if the program or project agreements are not respected.

Among the five MLI countries, Mali seems to have the ACU that is most involved in working with other health policy units in policy planning and monitoring of donors. In Sierra Leone, the donors are reporting either to higher level MoH leaders/units or during the development partner committees, which are not necessarily attended by MoH. However, it is important to note that Sierra Leone's recent effort to implement a free care initiative led to a heightened level of MoHS and development partner collaboration, and more reporting on development partner activities.

Program and project evaluation

Two out of five ACUs – in Mali and Ethiopia - are actively involved in the evaluation of development partner activities. Ethiopia is involved in the evaluation of NGO activities using health management information system (HMIS) indicators. Before new projects receive a green light, the ACU in

Ethiopia makes sure that the proposals align with the health policy goals as outlined by the health sector development plan and other government frameworks.

In Mali, the planning unit participates in monitoring and evaluation (M&E) of plans and agreements of donors and NGOs. Mali also produces an annual program performance report which highlights projects in the health sector.

In Senegal, the ACU organizes annual policy reviews and conducts monitoring and evaluation for its health sector plan.

In Sierra Leone, the ACU has not yet introduced a comprehensive M&E system. Instead, each program/project has its own indicators and evaluation system.

Tracking financial contributions of development partners

All of the MLI countries are involved in tracking commitments and expenditures of development partners' programs; however, this function is usually shared between financial management units and ACUs. Three out of the five ACUs – Mali, Nepal, and Senegal- reported that they track and monitor the flow of funds from donors more closely than the flow of funds from NGOs.

The table below shows the extent to which ACUs in the MLI countries monitor different types of donor and NGO spending. All five ACUs monitor overall spending by development partners. Ethiopia, Nepal, and Mali undertake more detailed monitoring of types of spending by development partners. At the time of data collection for this study, Sierra Leone did not have mechanisms in place for tracking specific types of development partner spending.

Figure 3.8

Donor and NGO Expenditure Monitoring	Overall spending	Spending on core activities	Capital expenditures	Administrative activities
Ethiopia	X	X	X	X
Mali	X	X	X	X
Nepal	X	X	X	X
Senegal	X	X	X	
Sierra Leone	X			

Source: Questionnaire

Obtaining sufficient and high quality financial information from development partners is often a challenge. For example, in Sierra Leone much of the information that is needed by the ACU is not reported regularly or in sufficient detail. The ACU has a mandate to collect information on commitments and expenditures from both NGOs and donors. However, the ACU uses three systems that are not closely coordinated and are often incomplete for recording information reported by the NGOs, private sector, and major development partners. The result is that information often is incorrectly recorded. This has led to many activities going unreported, including the construction of new clinics and hospitals that the government is not aware of.

Several MLI countries are now using electronic financial management systems to monitor commitments and expenditures. Nepal uses a standardized electronic financial management system in the Financial Comptroller General's Office, who passes information on to the MoHP. Nepal established an electronic annual work plan and budget system in 2009. Mali and Ethiopia also use electronic tracking systems.

Tracking the expiration of development partner support

Most ACUs do not define tracking the expiration of development partner support as one of their functions. Most donor aid is time limited and needs to be discussed and renegotiated periodically. Yet most of the ACUs are not actively involved in the renewal process or in formulating exit strategies or transition plans. Although this is discussed during the joint annual reviews with development partners, the ACUs are not usually a part of this process.

IV. Strengths & Accomplishments

Description of Strengths

Nepal, Mali, Ethiopia and Senegal characterized the strengths of their ACUs as their focus on coordination and alignment. They have national plans that describe needs, gaps and commitments. Nepal reported that its IHP+ national Compact has helped with coordination efforts. They also highlighted their new online Financial Reporting System which has real time links to focal points in more than 70 of the 75 districts in Nepal.

Mali's and Ethiopia's ACUs seem to benefit from their participation in broader health sector activities, both as a mode for learning and for coordination. In Mali, the team emphasized their involvement in the planning process, both at the technical level (through studies) and at the policy level (through analysis and coordination of the plans and programs), as well as their involvement in the monitoring and evaluation of other activities in the ministry.

The strength of Ethiopia's ACU was described as the unit's focus on the handling and appraisal of the Country Program Action Plan (CPAP) and project proposals, and in supporting NGOs with the planning and implementation of their activities. Ethiopia also highlighted the tools it uses to collect and input data from stakeholders.

V. Challenges

Description of weaknesses

The most commonly reported challenges that ACUs face are inadequate skills and staff capability. Specifically, MLI countries cited a lack of technical expertise and knowledge about health issues. They also cited insufficient support staff for field work and difficulties with the work environment, such as inadequate offices and lack of information systems and databases.

Other internal challenges include weak record keeping systems and inadequate monitoring and tracking of financial and other resources, in part due to a lack of routine reporting by NGOs and donors.

Some of the main external challenges reported by the ACUs include the need for MoH coordination with other ministries and agencies. Countries also cited budgetary and resource constraints and competing demands (e.g., a multitude of activities and new initiatives).

VI. Lessons Learned

As countries and development partners work together to implement better aid coordination practices, the lessons from this review of the aid coordination practices in the five MLI countries impart useful technical lessons applicable to the ministries of countries interested in improving aid coordination. As the table below shows, each country's ACU has strengths and weaknesses.

Figure 6.1

	Strength	Challenge
Ethiopia	**ACU has a strong role in handling the Country's Program Action Plan and supporting the planning and implementation of NGO activities.**	**The ACU has a low ratio of FTE to DPS and NGOs in the country.**
Mali	**The ACU is well integrated into health sector planning and evaluation--the inclusion of the ACU in the health sector planning unit offers advantages like better M&E of development partners agreements.**	**Mali does not yet receive any support to a pooled fund.**
Nepal	**Nepal has attracted a growing number of donors to participate in its Joint Financing Arrangement and is in the process of creating a Joint Technical Assistance Plan between collaborating development partners.**	**The ACU finds it challenging to coordinate NGO registration in conjunction with the Social Welfare Council and the Ministry of Women, Children and Social Welfare.**
Senegal	**The ACU actively participates in health sector planning and monitors the status of development partners' work in the sector.**	**The ACU does not coordinate NGO activity.**
Sierra Leone	**Recent efforts for pro-poor health reform have increased collaboration and reporting between the MOHS and development partners.**	**The decentralized health system complicates coordination on the central level since regional units are also involved in managing DAH.**

Experiences gathered from the MLI countries indicate the need for clearly defining roles, responsibilities, and resources within ACUs, in addition to practically enabling ministry staff to carry out their aid coordination duties by helping them to develop the necessary skill sets. From these experiences, we can identify the following recommendations:

Support ACU staff

- Ensure that staff have the adequate skills to carry out the TORs of the ACU
- Provide opportunities for ACU staff to learn continuously and have exposure to strategic planning, budgeting, and reform initiatives, so that they have a good understanding of the broader health systems context
- Country governments and donors should set aside funds to ensure that ACU staff has the resources needed, including staff, office facilities, opportunities for training and the appropriate authority to effectively perform their duties. If governments and donors are committed to coordination, then the needs of ACUs should be taken seriously.

Strengthen ACU relations with Key Stakeholders through an Open Communication and a Consultative Approach

- Provide access to information and communications systems to enhance ACU functionality
- Ensure that the role and activities of the ACU are clearly communicated to the various stakeholders - MoH, NGOs, private sector and donors
- Establish clear methods for development partners to interact with the ACU
- Ensure that strong communication and clear responsibilities are defined between the coordination unit within the MoH and other national units functioning in different ministries. There must be clear roles related to who is monitoring development partners and how information should flow among the system actors.

Create an Organization Structure and Clear Objectives that Enable Good Governance

- Assign a senior MoH leader as chair of an aid coordination oversight committee as a means of strengthening the governance of the ACU
- Establish which coordination activities can be carried out at the sub-national level and which ought to be a part of the mandate of a national ACU
- Regularly include a representative from the ACU in partner meetings
- The inclusion of the ACU in the health sector planning and evaluation unit of the Ministry in Mali provides distinct advantages for coordination such as better M&E of development partner agreements

Accountability and Transparency

- Development partners and NGOs should provide any information on expenditures and project status requested for aid coordination purposes in a timely and open manner.
- The information compiled about development partner and NGO commitments, disbursements, deliverables and performance should be made available to all stakeholders including other government ministries, civil society

Knowledge Sharing

- Seek to learn from other countries and global best practices in aid coordination
- Seek lessons from outside of the health sector

While the results of this survey have provided a strong technical foundation for understanding the mechanics and potential value of ACUs, a number of outstanding questions remain that warrant further consideration. A commonality among MLI countries, particularly for Ethiopia and Sierra Leone, is a decentralized health system, or a system that is moving toward decentralization. Coordinating aid in a decentralized context requires working with regional and local units which are heavily involved in managing health sector funds. A key question of aid coordination is how to harness the potential of development assistance across a country's numerous regions and effectively tie these disparate activities together and monitor them against larger health sector objectives. For a country like Sierra Leone, this is particularly challenging as financial and aid decisions are made centrally, but funds must flow to local governments for management.

Another unanswered question is the importance of leadership within ACUs. The results suggest that coordination units cannot effectively fulfill their role if they do not have the support of senior leadership and possess highly motivated and skilled leadership within the unit itself. More evidence and best practices are needed for how to encourage the buy-in of high level leadership and how to build leadership capacity within ACUs.

Additionally, the survey revealed that countries' ACUs have different levels of collaboration with regional or district level units. Further study could help reveal what operational policies have been most effective in harmonizing coordination activities throughout the health system.

Annex 1

Selected Indicators for MLI Countries					
	Ethiopia	**Mali**	**Nepal**	**Senegal**	**Sierra Leone**
Out-of-pocket health expenditure (as a % of private health spending)	**81%**	**99%**	**91%**	**79%**	**59%**
Total gov't expenditures as a % of total health spending	**58%**	**51%**	**40%**	**56%**	**31%**
External resources for health as a % of total health expenditures	**44%**	**20%**	**18%**	**21%**	**31%**
Per capita total expenditure on health (current US$)	**9**	**34**	**20**	**54**	**14**
ODA received in 2008 (USD million)*	**3196**	**907**	**687**	**998**	**358**

World Development Indicators, 2007
**Development Aid at a Glance: Statistics by Region, OECD www.oecd.org/dac/stats/regioncharts*

Annex 2: Donor Coordination Questionnaire

This survey was administered to policy and planning staff in MLI's five partner health ministries. In many cases, multiple staff members collaborated on the survey, and one complete response was provided to the MLI secretariat by each country. Respondents provided further clarifications upon request and had the opportunity to verify the findings for their respective countries.

Section 1: Purpose of Development Partner Coordination Units (DPCUs)[8]

1) What kinds of activities does the donor coordination unit carry out?

Section 2: Roles and Responsibilities of DPCUs

2) Who manages the DPCU?
3) What is the role of the DPCU? (Select Yes or No)
    a. Register NGO activities
    b. Register donor activities
    c. Continuous mapping where NGOs are acting
    d. Continuous mapping where donors are contributing
    e. Give general assistance to NGOs
    f. Give general assistance to donors
    g. Monitoring NGO deliverables
    h. Monitoring donor deliverables
    i. Contribution of evaluation of NGOs' activities
    j. Contribution of evaluation of donors' activities
    k. Specific monitoring of the status of activities (indicators) with each NGO
    l. Specific monitoring of the status of activities (indicators) with each donor
    m. Support the monitoring of the funding arrangements (partially only)
    n. Track the level of funding support provided by different donors
    o. Track the level of funding support received by different NGOs /charities
    p. Monitoring the expenditures made by different NGOs' /charitable
    q. Monitoring the expenditures made by different donors
    r. Meet regularly with the main NGOs
    s. Meet regularly with the main donors
    t. Act as a liaison between the Ministry and the NGO /charity community
    u. Act as a liaison between the Ministry and the donor community
    v. Act as a liaison between MOH and other Ministries
    w. Organize meetings between the ministry team and NGOs
    x. Organize meetings between the ministry team and donors
4) Who makes decisions in the DPCU?

Section 3: Organization of DPCUs

5) Is the donor coordination unit a standalone unit or is part of a larger unit? (Select Yes or No)
    a. MOH formal units (established)
    b. Other ministry units
    c. Temporary arrangements
6) What is the name of the department under which the DPCU exists?
7) How many coordination units do you have?
    a. MOH formal units (established)
    b. Other ministry units
    c. Other ministries

[8] For the purpose of the Questionnaire, Development Partner Coordination Units (DPCUs) was used in place of Aid Coordination Unit (ACUs).

d. Temporary arrangements

8) How many national non-governmental organizations (NGOs) are working in the health sector?
9) How many international NGOs (INGOs) are working in the health sector?
10) How many people work in the DPCU?
    a. Total
    b. From how many departments?
11) Who makes up the DPCU? (Select Yes or No)
    a. Public servants
    b. Local consultants
    c. International development partner representatives
12) How many development partners are active in your country?

Section 4: Financing

13) How is the DPCU supported? (Select Yes or No)
    a. Government subventions
    b. Donor subventions
    c. Employees are on the payroll
    d. Other sources (employees receive bonuses or other incentives)
14) How are the DPs' Health Funds channeled through your country? (Select Yes or No)
    a. Direct vertical projects of the DPs
    b. Pooled fund vertical projects
    c. Pooled fund general budget support (earmarked general budget support)
    d. Health sector budget support
    e. Multi-sector budget support
    f. Technical assistance
    g. Other
15) What type of budget support are the DPs providing? (Select Yes or No)
    a. Multi-budget support
    b. Health sector budget support
    c. Pooled fund budget support
    d. Other
16) What are the contractual arrangements that govern the relationship with the DPs in your country?
17) How do you make decisions in terms of funds allocation and reallocation? (Select Yes or No)
    a. We make consensus decisions through our regular meetings (e.g., monthly meetings)
    b. The chair of the meetings makes these decisions after consultation
    c. The director of the unit makes these decisions
    d. Other
18) Do you monitor the expenditures by different donors/NGOs?
19) For what kind of donor/NGO projects/activities do you monitor the expenditures? (Select Yes or No)
    a. Overall spending of the projects
    b. Core activities of the projects
    c. Capital expenditures of the projects
    d. Administrative activities of the projects
    e. The government budget associated with the projects
20) Please specify how you link donor/NGO expenditure monitoring with your donor coordination activities (Select Yes or No)
    a. Expenditures are monitored by the office of financial management

b. We only request the confirmation of the committed amounts and not the details of the expenditures
c. Expenditures are monitored by the office of financial management
d. We have separate monitoring and reporting systems

21) Who pays for the donor coordination unit activities? (Select government sources, donors or private foundations/investors)
    a. Top ups
    b. Unit has a budget
    c. Technical assistance
    d. Logistics

Section 5: Strengths and Accomplishments

22) What do you consider to be the strengths of the DPCU?
23) How would you rate the efficiency (time/money/outputs) of the donor coordination activities?
24) How do you monitor the activities that have to be accomplished by different donors/NGOs? (Select Yes or No)
    a. Through indicators
    b. Donors/NGOs reporting the accomplishments
    c. Project managers/units reporting the accomplishments
    d. Other
25) Do you have a comprehensive health sector plan which comprises most of the donors/NGOs activities?
26) Does the plan have output and/or outcomes indicators?
27) How did you establish the indicators? (Select Yes or No)
    a. They are project indicators
    b. Through several meetings in which we discussed and agreed upon indicators
    c. Other
28) Are there certain elements of your donor coordination activities that you would like to highlight or describe further?

Section 6: Challenges

29) What do you consider to be the weaknesses of the DPCU?
30) What do you consider to be the major/important internal challenges for the unit?
31) Do you monitor the flow of funds (incoming) from donors/ NGO activities?
32) Are the funds entering regularly (as scheduled)?
33) Do you know when different donors' and international and national NGOs' support will expire?
34) Do you map the duration and expiration of donors' and NGOs' support?
35) How is the MOH planning to respond to the phasing out/expiration of donors' and NGOs' support?

Annex 3: Questions for Further Study

A number of in-depth questions for further study emerged after analyzing the findings from this initial survey. These include:

1) How is leadership within ACUs fostered and rewarded? What challenges do ACU leaders face?
2) How do countries with decentralized health systems enable ACUs to work with lower level health facilities? For example:
    a. How does the ACU in Sierra Leone coordinate with local government bodies?
    b. How do Nepal's district officials use and benefit from the country's new financial tracking system? How are the system's focal points identified?
3) How are donor deliverables monitored? And how is their progress shared with other stakeholders?
4) How can ACUs better track NGO activity both federally and at lower levels of the health system?
5) How are new software technologies used to monitor donor commitments, expenditure and progress? Do DPs input information into these systems or do ACU staff members input data that they have already aggregated?
6) How can ACUs be better incorporated into Joint Annual Reviews?
7) What are the standards and metrics for licensing NGOs?
8) Have ACUs ever posed sanctions or repercussions on DPs or NGOs for not complying with their commitments? If so, what is the process for formulating and enforcing these?

ABOUT MLI

The Ministerial Leadership Initiative for Global Health (MLI) works with ministries of health in Ethiopia, Mali, Nepal, Senegal, and Sierra Leone to advance country ownership and leadership in three inter-related policy areas: health financing to ensure sustainable health care for all; donor alignment to ensure that donors work together to support country-led priorities; and reproductive health because the health of women is central to the health and stability of communities and nations. MLI, a program of **Aspen Global Health and Development at the Aspen Institute**, works in partnership with the **Results for Development Institute**. MLI is funded by the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation.

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