

**NATIONAL AIDS COMMISSIONS AND COUNTRY COORDINATING  
MECHANISMS: PERCEPTIONS OF FUNCTIONING OF THE TWO NATIONAL  
HIV GOVERNANCE STRUCTURES IN LESOTHO**

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## **DECLARATION**

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature:

Date:

## **ABSTRACT**

A number of countries in sub-Saharan Africa are recipients of major international investments for HIV. Funding has required that different governance structures be established, with the creation of independent Country Coordinating Mechanisms (CCM) for the oversight of Global Fund grants in country, and National AIDS Commissions (NAC) have been established as part of the World Bank Multi-country AIDS Programme (MAP) for coordination of national HIV efforts. In addition UNAIDS and SADC have endorsed the concept of one national coordinating authority. The NAC in Lesotho reports to the Office of the Prime Minister and its structure and function is governed by statute. The CCM has broad stakeholder representation and functioning is determined by Global Fund guidelines. The Global Fund is by far the largest donor to HIV programmes in Lesotho, with current potential funding amounting to USD 100 million. This study seeks to determine perceptions of members of the two HIV governance structures in Lesotho on their respective roles, reporting lines, responsibilities, levels of tension and integration of HIV in developmental agendas, through the administration of a pre-tested questionnaire to CCM members and NAC management in Lesotho.

Lack of clarity on the roles and functions exists for both CCM and NAC, with each group more likely to consider their own body as being more representative and having a clear and defined mandate. Strong disagreement exists on the extent of NAC functions beyond the classic coordination, advocacy and communication role, with NAC viewing their role as extending into direct programme implementation and management of funds. While the National Composite Policy Index for Lesotho indicates inclusion of HIV in broad developmental and health agendas, there is little tangible evidence of this being practically implemented. The structure and functioning of both NAC and CCM largely limits the inclusion of HIV into national developmental programmes. While the status quo of NAC reporting to the Office of the Prime Minister is supported, NAC members were significantly more likely than their CCM counterparts to want CCM to report to them. Not surprisingly, levels of tension between these two bodies is demonstrated in this study.

In spite of one-third of respondents desiring the creation of a single oversight body for HIV, this study argues for the maintenance of two structures but that NAC should limit itself to its original intended mandate of coordination, that practical interpretation of the universal NAC role of "coordination" be developed, and that internal NAC performance measures be adopted which are subject to periodic external review. Furthermore CCMs should be formally established by Ministerial decree or proclamation, and each body should have formal representation of the other in their membership. Membership of both NAC and CCM should include non-HIV developmental role players in the country. CCMs must also systematically report on Global Fund activities to NAC, so that NAC can fulfil its coordination function. Improved reporting to the public by both bodies on summarised indicators via the media is also recommended.

## **OPSOMMING**

Die doel van die studie is om die verskillende persepsies van die verskillende fonds-administreringsliggame in Lesotho te bepaal ten opsigte van onderskeidelike rolle, lyne van rapportering, verantwoordelikhede, moontlike spanningsvlakke en die integrasie van MIV agendas.

'n Vraelys is gebruik om data in te samel; data is verwerk en aanbeveling ter verbetering van die situasie in Lesotho word gemaak.

## INTRODUCTION

Many countries in the world which are burdened by the HIV epidemic are dependent on international assistance and support. Organizations such as UNAIDS, the World Bank Multi-Country AIDS Programme (MAP) and the Global Fund to Fight AIDS, TB and Malaria (GFATM) play a crucial role in supporting the implementation of programmes at the country level. These international organizations have influenced the creation of governance structures at the country level. In 2003, UNAIDS developed a set of guiding principles for improving country responses to HIV which became known as the “Three Ones” and included (1) One national strategic plan, (2) one national AIDS coordinating authority and (3) one agreed country level monitoring and evaluation.

With regard to the second of the three-ones, many countries were urged to by UNAIDS and the World Bank, to comply with one coordinating authority, and have subsequently established these. Typically a national AIDS coordinating authority (NAC) consists of a governing council and a secretariat and derives its authority from government, from its own competence and from recognition of its importance by national stakeholders. While this one coordinating authority typically drives the one strategic plan and one Monitoring and Evaluation (M&E) system, the form of the NAC differs from country to country. The *UNAIDS Report on the Global AIDS Epidemic (May 2006)*, recognizes the shortcomings of these NACs and highlights four main challenges (1) fostering leadership and commitment, (2) establishing the legal and policy framework, (3) developing structures for engagement of stakeholders and (4) building partnerships with international development agencies. The GFATM, as a second major role player in the international HIV field, requires, as a pre-requisite to funding, an independent governance structure which represents all stakeholders in the country and locally mirrors the GFATM Board structure in Geneva. This independent grant oversight body is known as the Country Coordinating Mechanism (CCM). Given the need for its independence and that the NACs are often government initiated para-statal, the CCM and NACs are separate bodies in most countries while remaining the same body in a few examples such as South Africa. South Africa has however now initiated the process of separating out the two bodies consistent with the approach by other countries.

It should be noted that CCMs have a specific and well defined function, namely to oversee aspects of Global Fund Grants in country, while NACs have a much broader role, mainly to ensure appropriate co-ordination of national HIV programmes. Global Fund grants are often the major source of HIV programme funding in many countries. The presence of two different governance bodies can create role confusion and create tension. Importantly the establishment of AIDS focused NACs (and CCMs) may have decreased the probability of integrating HIV and AIDS into countries broader developmental agendas which would represent a major step backwards in the global fight against HIV.

This study seeks to assess the perceptions of CCM and NAC members in Lesotho on their respective roles, reporting lines, responsibilities, levels of tension and integration of HIV into developmental agendas.

## **LITERATURE REVIEW**

### **Background and disease profile**

SADC countries constitute only 3.7% of the world population but 40% of those living with HIV and AIDS. Given the extensive poverty and developmental needs in SADC countries, there has been a shift from a health focus on HIV to incorporation into a larger developmental agenda during the last decade. This has resulted in an increased mobilisation of a multi-sectoral and cross functional response for HIV.

Multi-sectoral responses, increased global HIV interventions in the region e.g. GFATM and US Presidents Emergency Plan for AIDS Relief (PEPFAR) and large international developmental initiatives (e.g. MAPS of the World Bank) have all resulted in a shift of HIV coordination from national Ministries / Departments of Health to distinct national HIV coordinating structures. Increased funding has required increased coordination. This coordination has not been established without a fair degree of confusion relating to responsibilities, role clarification and integration of HIV in national developmental agendas.<sup>15</sup>

With a population of 1.9 million people and a 2003 estimate of 320,000 people living with HIV, Lesotho has an adult HIV prevalence rate of 28.9% and at least 100,000

AIDS orphans out of a total population of 185,000 orphans. The 2003 TB prevalence rate is 588 per 100,000, one of the highest in the world. Recent studies including the 2004 Demographic Health Survey have revised the HIV prevalence downwards (23,2%) and the TB prevalence rate upwards (+/-700). In spite of the downward HIV revision, Lesotho retains its position as having the third highest adult HIV prevalence in the world.<sup>10</sup>

Prevalence is higher in urban than rural areas and only 19% of those in need of treatment access it. Insufficient human resources and sexual behavioural norms are the biggest barriers to prevention, treatment and mitigation.<sup>17</sup> In contrast with a relatively high adult literacy (81.4%), life expectancy is 39.3 years and 56.1% of the population survives on less than USD 2 a day. Lesotho ranks 149 out of 177 in the Human Development Index Ranking.<sup>14, 17</sup>

### **The Global Fund and Country Coordinating Mechanisms**

The GFATM states that their purpose is to “attract, manage and disburse additional resources through a new public private partnership that will make a sustainable and significant contribution to the...mitigation of HIV/AIDS, TB and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals (MDGs)”.<sup>4</sup>

Principles of the GFATM include the financing of programmes which reflect national ownership, partnership, complement and build on existing programmes and should be consistent with national strategic plans. Furthermore GFATM financed programmes should be linked to broader national development efforts such as Poverty Reduction Strategies and Sector wide approaches (SWAps). Countries which receive Global Fund grants are required to establish a governance and oversight structure known as Country Coordinating Mechanisms (CCM). Functions of the CCM include:

- i. Coordinating the submission of proposals to GFATM for funding
- ii. Select organisations to function as Principle Recipients in country of Global Fund monies.
- iii. Monitor the implementation of activities approved by GFATM



- iv. Approving any changes to the programmes
- v. Evaluate the performance of these programmes
- vi. Ensure linkages between GFATM funded programmes and national developmental priorities and programmes such as poverty reduction strategies and SWAps.
- vii. Ensure transparency, inclusiveness and accountability

The structure of the CCM should include election of a Chair and Vice Chair, and recognising national customs and differences, the GFATM recommends that countries attempt to include the following stakeholders in CCM membership:-

- i. Academic sector
- ii. Government
- iii. NGOs
- iv. People living with HIV, TB and /or malaria (absolute requirement)
- v. Private sector
- vi. Faith based organisations
- vii. Multilateral and Bilateral in-country partners.

The academic, private, faith based, NGO and people living with diseases should constitute a 40% minimum of membership. <sup>4</sup> CCMs therefore represent GFATMs commitment to local ownership and partnership / collaboration in decision making. <sup>6</sup> Various models exist for management of grants under CCMs, with each model representing different forms of management of the CCM oversight function, such as:

- i. Public sector models (Indonesia)
- ii. NGO/Faith Based Organisation models
- iii. Donor basket funding models (Mozambique)
- iv. UNDP models (Myanmar)
- v. Non-health model (Lesotho) <sup>7</sup>

### **CCM Principles and performance**

With regard to the operationalisation of the principles of the CCM, six minimum requirements are stipulated:-

- i. CCM members representing the NGO sector must be selected by their own sectors based on a documented, transparent process, developed within each sector
- ii. The GFATM requires all CCMs to show evidence of membership of people living with and / or affected by the diseases
- iii. CCMs are required to put in place and maintain a transparent, documented process to solicit and review submissions for possible integration into the proposal
- iv. CCMs are required to put in place and maintain a transparent, documented process to ensure the input of a broad range of stakeholders, including CCM members and non-members in the proposal development and grant oversight process.
- v. CCMs are required to put in place and maintain a transparent, documented process to nominate the Principle Recipient and oversee programme implementation
- vi. When the PRs and Chair or Vice Chairs of the CCM are the same entity, the CCM must have a written plan in place to mitigate against this inherent conflict of interest.<sup>5</sup>

The CCMs are key to the GFATM principle of local ownership and participation in decisions making. CCMs should be central to the grant development process and grant oversight. In 2005, the GFATM commissioned research on the performance of CCMs which found that:

- i. 66% of CCMs included those living with the diseases
- ii. More than 50% had documented transparent processes for nominating PRs and overseeing their performance (i.e. complied with both)
- iii. 43% had transparent and documented process for obtaining wide input in proposal development processes and grant oversight
- iv. 75% had more than 40% membership from non-government sectors
- v. 33% of all members were women
- vi. 42% had documented terms of reference / by-laws etc
- vii. Government representatives were most satisfied with CCM functioning and NGO sector were least satisfied.

Recommendations of that study included developing CCM self assessment tools, in depth audits and reviewing guidelines for civil society roles in CCMs.<sup>11</sup>

### **The Global Fund and CCM in Lesotho**

Lesotho has been awarded the following GFATM grants from the various rounds / calls for proposals:-

- i. Round 2 HIV USD 29 million
- ii. Round 2 TB USD 5 million
- iii. Round 5 HIV USD 40 million
- iv. Round 6 TB USD 6 million
- v. Round 7 HIV USD 33 million

These are potential windows of funding, dependent on grant performance within the five year grant cycle and in keeping with the principles of “performance based funding” utilised by the GFATM. Lesotho is however a long way in implementing Round 2 (completion mid 2009). Round 5 is in its second year, Round 6 in its first and Round 7 is still to be initiated.

The Ministry of Finance and Development Planning was appointed by the CCM as the Principal Recipient of all grants therefore being responsible and accountable for financial and programmatic management. The grant activities are implemented by the Ministries of Health and Education, NAC and a number of NGOs.<sup>7,9</sup>

In addition the World Bank has made available a USD 5 million grant over the past four years for technical support to the grants in Lesotho. This has encompassed Grant management support, behavioural change communication, civil society implementation support as well as direct technical assistance to the Ministries of Finance and Health.

The Lesotho CCM is structured in a manner which allows wide representation of stakeholders. Membership is constituted with 32% of membership from the public sector, 24% NGO, 20% multilateral and bilateral partners, 8% from the PLWHA sector, 12% from the private sector and 4% from the academic sector.<sup>1,8</sup>

### **The World Bank HIV Response in Africa**

The World Bank intensified its HIV response in 2001 with the initiation of the MAP, with its aim being to scale up prevention and to prepare countries to respond adequately to the epidemic. The MAP addressed 4 main issues:-

- i. Strong government response
- ii. Institutional arrangements at the country level to respond to HIV
- iii. Increase community participation and local ownership
- iv. Enhancing a multi-sectoral response.

The MAP initiation strongly prompted and influenced the developments of NACs in response to the above. The World Bank review of the MAPs in 2006 stated that the initiative had been a success due to the following:-

- i. Increase in donor funding – 2240%
- ii. MAP activities integrated into NAC functions – 59%
- iii. NACs that coordinate MAP and GFATM – 38%

The review indicates that MAP has addressed country needs as “all data sources concur that MAP has helped build strong political leadership (and) has helped create an institutional environment at national...levels in which the national HIV response can thrive”.

The MAP programme has developed a Results Scorecard and Generic Results Framework. These consist of a set of indicators and amongst other outputs, will attempt to align reporting requirements between major partners, especially GFATM, World Bank, UNAIDS and PEPFAR. <sup>20</sup>

The MAP is also viewed as at least a 15 year commitment to Africa for HIV. To date 29 countries have benefitted. The World Bank believes that during the first part of MAP, and emergency response occurred and also that political and institutional responses were developed. The second phase scaled up prevention and treatment and the third phase would focus on specific high risk groups. Challenges that have emerged from the MAPs include, amongst others, linkages with other diseases and

managing the institutional architectural complexity of HIV. The Bank remains committed to its course on HIV in Africa 2007-2011 and will provide USD 250 million per year for HIV initiatives. The next few years builds upon 4 pillars of action:

- i. Focussing the response on evidence based strategies
- ii. Scaling up multi-sectoral and civil society responses
- iii. Increased Monitoring and evaluation
- iv. Harmonising donor collaboration

The last pillar seeks to ensure that all partners work together and function within the concept of the “three-ones”, described below. It is however accepted that HIV is a poverty and developmental issue, and must be continued to be viewed as such and future action must enhance the integration and delivery on all of these issues. <sup>20</sup>

### **National AIDS Commissions (NAC)**

Early on in the HIV pandemic, national responses to HIV were largely driven by national health departments. In the late 1990s it became increasingly evident that the response required more active involvement of other sectors as well as the perception that Health departments were too medically orientated. In 2002, a Commonwealth Regional Health Community Secretariat meeting from East, Central and Southern Africa defined the roles of NACs, and this was supported by UNAIDS (as one of the three-ones) and the World Bank in support of its MAP initiative. <sup>2</sup>

With regard to the establishment of NACs, some have been established by Act of Parliament, and some by Presidential or Ministerial proclamation. National Coordinating Authorities in SADC are mostly referred to as National AIDS Councils, Commissions or Committees. <sup>15</sup>

SADC guidelines suggest the establishment of NACs by statute in order to ensure legal standing of NAC. Most are housed within the officer of the Head of Government but although this can promote the overall multi-sectoral coordination mandate, Heads of Government are usually too busy to direct and lead national HIV efforts related to NAC. Locating NACs within Ministries of Health may hamper multi-sectoral efforts. NACs are statutory bodies, served by secretariats. In some countries the

secretariat are seconded, in others they are direct employees. SADC guidelines indicate the technical capacity requirements of policy development, advocacy and monitoring and evaluation.

Membership varies considerably between SADC states and adequate representation on NACs and hence input into policy formulation remains a challenge. Funding is usually available for NACs from state resources, although many use their position to leverage additional external resources. In reviewing the functions of NACs, SADC guidelines refer to possible confusion of roles when these are not clearly defined. (e.g. becoming involved in implementation rather than coordination). Suggested functions include:

- i. Development of HIV policy
- ii. Advocacy
- iii. National Strategic frameworks for HIV
- iv. Facilitate and support role players
- v. Coordination of multi-lateral and international partners
- vi. Partnership building
- vii. Resource mobilisation (resource allocation only in partnership with Ministries of Finance)
- viii. Human Resource Capacity development
- ix. Harmonisation of HIV policies and programmes
- x. Integration with developmental programmes such as Poverty Reduction Strategy Programmes (PRSP) and Medium Term Expenditure Frameworks (MTEF).
- xi. HIV research
- xii. Monitoring and evaluation <sup>15</sup>

Typically a NAC consists of a governing council and a secretariat and derives its authority from government, from its own competence and from recognition of its importance by national stakeholders. While this one coordinating authority typically drives the one strategic plan and one monitoring and evaluation (M&E) system, the form of the NAC differs from country to country. <sup>18</sup>

NACs have experienced some difficulties in fulfilling their mandates. Problems include the following:

- i. Governance: confusion over their legal status, political appointees as Commissioners of Boards, Commissioners expected to have governance and representation mandates. NACs perceived as government / public sector.
- ii. Staffing: inadequate or inappropriate, depletion of staff from government departments (mostly health) to NACs
- iii. Functions: Confusion of coordination versus implementation role
- iv. Roles and responsibilities: Conflict with other bodies, duplication with CCM, existence of many coordinating authorities<sup>2</sup>

NACs have largely failed in a key functional area – namely mainstreaming HIV in other government departments, mostly through lack of expertise in this area. Government departments are therefore often unclear of their role.<sup>2</sup>

Local government could play a significant role and the developmental requirements for local government coordinating HIV responses and integrating HIV with local development has been recognised by the South African Local Government Association (SALGA). In reality many NACs have failed to support local government in this endeavour<sup>2, 16</sup>

Less than half of African countries have some form of linkage between PRSP and NACs, in addition less than 20% of NACs have costed their strategic plans. A detailed costed strategic plan with linkages to MTEF, PRSP etc is considered critical to success.<sup>2</sup>

NACs have been initiated partly through the World Bank Multi-Country AIDS Programme (MAP) criteria which requires the existence of NACs for the rapid disbursements of funds. New structures set up have been largely driven by governments and have developed levels of bureaucracy, political interference, poor accountability, and a lack of a performance driven culture, consistent with other government departments. Alternative organisational and operational models need to be investigated.<sup>2</sup>

The Global Task Team appointed in 2005 made the following recommendations regarding NACs:-

- i. NACs should lead and multilateral and bilateral agencies should follow.
- ii. UNAIDS must support the capacity of NACs to deliver
- iii. Multiple stakeholders and donors should convene under the umbrella of the NACs
- iv. The GFATM, World Bank and UNAIDS must support efforts to clarify the relationship between NACs and CCMs. <sup>18</sup>.

The *UNAIDS Report on the Global AIDS Epidemic (May 2006)*, recognizes the shortcomings of these NACs and highlights four main challenges:

- i. Fostering leadership  
The degree and depth of stakeholder engagement may be a proxy measure of leadership. The Asia Pacific Leadership Forum which has bolstered support to political and civil society leadership in 33 countries is considered a best practice example.
- ii. Establishing the Legal and Policy Framework  
In order to provide NACs with sufficient responsibility and government seniority, founding legislation is imperative. The legislation must be formulated in a way that ensures that NACs are active and well-functioning. NACs must follow this up with developing appropriate policies which will drive further legislation necessary for a countries fight against HIV. Examples of the importance of carefully constructed legislation include Zambia where the CEO could bypass the Commission and report directly to Cabinet, and Mozambique where the NAC was established only by Ministerial Decree eventually rendering the NAC ineffective.
- iii. Developing Structures for stakeholder engagement  
This has been largely driven by the NGO sector. Countries need to develop country appropriate structures to enhance this.
- iv. Building partnerships with international development agencies  
Problems in the past have included donor driven agendas (not country), high transaction costs due to donor requirements, donors funding specific projects rather than continuous programmes. The Global Task Team recommended that GFATM should clarify their role and the presence of CCMs vis a vis National AIDS



Commissions, the World Bank should focus on health system sector strengthening i.e. role clarification between the different multilaterals. <sup>18</sup>

### **The NAC in Lesotho**

The Lesotho NAC was established by the National Aids Commission Act of 2005.

The functions of the NAC as described in the Act are:

- i. Establishment of policies, strategies and priorities for the national response.
- ii. To monitor implementation of the national HIV strategies and plans
- iii. To coordinate the scaling up of innovative efforts
- iv. Facilitate development of communication strategies
- v. To encourage non-discrimination
- vi. To develop, together with the Ministry of Health, guidelines on medical and other procedures that carry the risk for HIV transmission
- vii. Facilitate the provision of accessible and affordable counselling and testing
- viii. HIV Advocacy
- ix. To develop a national HIV monitoring and evaluation system
- x. To develop resource mobilisation strategies
- xi. To mobilise financial and technical resources for HIV from government, donor community and the private sector
- xii. Facilitation of HIV research
- xiii. To provide strategic direction for core –streaming HIV into national policies and programmes
- xiv. To functionally and geographically map out the scope of HIV interventions in the country.
- xv. To coordinate, monitor and supervise all activities relating to HIV and AIDS.

The structure of NAC includes a Board of Commissioners consisting of five people appointed by the Prime Minister for a period of five years, namely a Chairperson, a legally qualified individual, a finance / management qualified individual, a health related qualified person, and a person nominated from the HIV Forum. The meetings and affairs of the Board of Commissioners is regulated by the Act.

A Secretariat is established for the administration and implementation of strategies and policies of the Commission. The Secretariat is headed by a Chief Executive Officer who appoints the staff of the Secretariat. The administrative functions of the Commission are determined by the Act.

A Forum of 14 people is appointed consisting of government, private sector, NGOs, sporting bodies, faith based organisations, PLWHA, women, youth and the academic sector. The functions of the forum are:

- i. To provide a coordination platform
- ii. To encourage harmonisation of the national HIV response
- iii. To provide a communication channel
- iv. To advise on policy and implementation
- v. Advocacy and human rights promotion
- vi. To encourage constituencies to submit annual action plans.

The Forum currently meets four times a year, its legislative minimum.

The Act further creates an HIV and AIDS Fund into which all government funds for the Commission shall be paid. Auditing and accounting procedures are stipulated in the Act. <sup>12</sup>

In 2006 the NAC launched the National AIDS Policy as well as its National AIDS Strategic Plan (2006-2011). The NAC is responsible for coordinating the multisectoral response to HIV in the country, articulated in the Strategic Plan.

### **Coordination of national HIV initiatives**

At an International Conference on AIDS and STI in Africa (ICASA) in Nairobi 2003, a recommendation was accepted to adopt the principle of the “Three ones”:

- i. One national coordinating authority for HIV but which would function within a broad integrated multi-sectoral mandate
- ii. One country level Monitoring & Evaluation system
- iii. One agreed HIV framework and strategy

All SADC states have adopted the three ones.<sup>15</sup> The three ones are seen as the main tool for the coordination of the national HIV response and strategy. The strategy must be practically articulated into a national action plan which details roles of partners, costs, results and funding sources. The monitoring and evaluation system should contain targets representing outcomes of strategies and activities in the National Strategic Plan (NSP) and Action Plan.<sup>15</sup>

The intention of UNAIDS is that the three-ones is not a “set blue-print” but is a mechanism for optimising roles and relationships in the HIV field at country level. An effective NAC is imperative and effectiveness can be enhanced by a formal / legally binding mandate, broad democratic oversight and national ownership.<sup>19</sup> Unfortunately, UNAIDS does not provide specific guidelines on how to practically implement these requirements / principles.

Coordination ensures and facilitates the scaling up of national HIV responses. In all SADC countries, NACs are given this responsibility and are expected to engage partners and donors to determine mechanisms to harmonise donor activities in-country to national HIV efforts – thus donor activities must be present in the NSP.<sup>15</sup> A number of proclamations to ensure improved integration between international and national partners have emerged in recent years. These have included:-

- i. The Monterrey Consensus of the International Conference on Financing for Development (2002): multilateral and bilateral donors work in partnership with national governments to mobilise resources for development
- ii. Rome Declaration (2003): Committed donor countries, host countries to harmonise their policies and procedures for donor funded development
- iii. Paris Declaration on Aid Effectiveness of the Organisation for Economic Cooperation and Development (OECD) (2005) This aims to “scale up more effective aid” by developing systems and policies to enhance donor funding flow, accountability and improving HIV integration into broader developmental agendas and programmes.
- iv. The appointment of a Global Task Team (GTT) on Improving AIDS Coordination among Multilateral Institutions and International Donors: - their recommendations were aimed mainly at multilateral donors and resulted in a division of labour between

the different agencies to enhance coordination, a Technical Support Plan and GIST (Global Joint Implementation Support Team) <sup>15, 18</sup>

Coordination Challenges have also included different donors having varied reporting systems. The GTT in 2005 raised the following key challenges to effective coordination:-

- i. Burden of transacting and accounting separately with each donor to fulfil the requirements of these donors.
- ii. Lack of collaborative efforts between the donors with duplication of effort
- iii. GFATM requirements for a governance structure (CCM) has, in some cases, been perceived as a parallel HIV coordination body.
- iv. HIV funding into countries can sometimes flow through multiple entry points
- v. Accountability is skewed towards funding partners, not towards communities
- vi. Lack of sharing of information
- vii. Insufficient coordination. <sup>15</sup>

The GTT has recommended that joint programming of UN agencies through UN Theme groups should attempt to harness the collaborative and complimentary nature of different organisations including GFATM and the World Bank. A consideration has emerged for streamlining and pooling of all donor funding through NACs although it is recognised that this would require close collaboration with Ministries of Finance. <sup>18</sup>

### **HIV responses and integration of HIV with broader developmental agendas**

Integrating HIV into sectoral programmes can be difficult given that HIV programmes are often arranged vertically (eg OVC, ART etc). SADC guidelines suggest “flexibility” of programming. The issue of integration of HIV within broader developmental agendas is measured within the National Composite Policy Index (NCPI). The 2005 NCPI for the Lesotho UNGASS report indicated progress 2003-2005 with increased implementation of national programmes such as PMTCT, ARV roll out, services for orphans and vulnerable children but programmes such as workplace policies and life skills education falling short of the national commitments. The Government of Lesotho had committed itself to a national integrated programme

of action, this commitment being renewed in 2003. This commitment included acknowledging the need for multi-sectoral coordination. These integration initiatives are evident from:-

- i. Inclusion of HIV in the countries Vision 2020 paper
- ii. Inclusion of HIV in the Poverty Reduction Strategy Paper
- iii. Inclusion of HIV in the Common Country Assessment
- iv. Endorsement of the Greater involvement of people living with HIV (GIPA) and inclusion of Lesotho National People Living with HIV and AIDS (LENEPWHA) in bodies such as the CCM.

Challenges remain in multi-sectoral coordination, improving accessibility to essential services and expenditure of government funds allocated to HIV. In addition the practicality of implementing HIV in an integrated manner within this broader developmental initiative is not demonstrated.

The AIDS Programme Effort Index (API) completed for the 2005 UNGASS report indicates improvement in efforts to enhance policy development, strategy and programme outcomes from 2003 to 2005. In 2006, under the management of the NAC, a national policy, a costed strategy (2006-2011) and national monitoring and evaluation plan has been developed.<sup>14</sup>

While the NCPI and API reflect the inclusion of HIV in broader developmental programmes, the implementation mechanisms for this are not described or evident.<sup>14</sup> Interestingly, the 2005 UNGASS report for India contains NCPI results which includes a requirement that every department in government should demonstrate integration of HIV in their departmental plans. Integration is enhanced by the National AIDS Committee having formal representation from public, private and civil society sectors. The National AIDS Control Board has representation from government, NGO and academic sector. While the last mentioned deals with multi-sectoral issues in India, it is still HIV focused.<sup>13</sup>

England, in his 2006 Lancet article argues that NACs have not improved multisectoral coordination and should be replaced. He puts forward a case for

treating HIV like any other disease and to focus on reducing prevalence. NACs should play a greater role in funding and managing HIV funds, but there should be performance management of them, and it should be ensured that they report to a committee of key stakeholders. The problem of political interference is also raised and a further suggestion is to allow the private sector to run NACs although reporting to a multiple stakeholder committee. <sup>3</sup>

## **METHODOLOGY**

### **Hypothesis**

The establishment of two national HIV coordinating structures in Lesotho has created levels of tension, lack of role clarification and reporting responsibilities and a perception of decreased integration of HIV within broader developmental agendas.

### **Aim**

To determine perceptions of members of the two HIV governance structures in Lesotho on their respective roles, reporting lines, responsibilities, levels of tension and integration of HIV in developmental agendas.

### **Objectives**

- i. To determine CCM and NAC members perceptions of their own and each others governance bodies mandates and functions
- ii. To determine CCM and NAC members perceptions of integration of HIV with other health issues
- iii. To determine CCM and NAC members perceptions of integration of HIV with broader developmental agendas
- iv. To determine CCM and NAC members perceptions of ideal reporting mechanisms for each governance body
- v. To assess perceptions of CCM and NAC members on integrating and improving the synergy of the two governance bodies.
- vi. To determine CCM and NAC members perceptions of the level of functioning of the “Three-Ones” in Lesotho
- vii. To determine CCM and NAC members perceptions of the levels of tension which exist between the two governance bodies.
- viii. To make recommendations based on the findings of this study

### **Method**

A literature review determined the terms of reference, legislation and mandates for the establishment and institutional arrangements of the various NACs as well as the roles and mandates of CCMs. This research is a quantitative descriptive research design. A questionnaire consisting of both closed and open ended questions was

circulated to all members of the Lesotho CCM, their alternates where they were the main attendees at regular CCM meetings, and the top three levels of the NAC (representing the management of the NAC). The questionnaire was pre-tested on a smaller sample of individuals who were not members of either body, but who had enough knowledge and interaction with both bodies to make beneficial comments on the original questionnaire. Subsequent to the pre-testing, adjustments were made to the questionnaire. The submission of questionnaires was followed up by telephonic interviews or face to face interviews where clarity of responses was required.

Permission was obtained to conduct the study from the Chairperson of the CCM (the Principal Secretary of Health and Social Welfare for Government of Lesotho) and the Chief Executive of the National AIDS Commission.

Data was collated and analysed using the EPI-INFO 6 statistical programme. The chi squared test of significance was used to determine statistical associations. The use of a questionnaire is subject to all the limitations of such a measuring instrument including recall bias and organizational bias. Objectivity was improved by including multi-sectoral agencies in the study population (as members of CCM).

## **RESEARCH FINDINGS**

### **Response rate**

The response rate was 67%. The response from CCM members was higher than that from NAC (73% versus 60%). One questionnaire was discarded for being incomplete and one for being submitted after the final submission date. A total of 37 responses were included in the study analysis.

### **Mandates, representation and functions**

A total of 64.9% of members agreed that the legal mandate for the establishment and functioning of the CCM was reasonably or fully clear, with a similar proportion (67.5%) agreeing that the role and purpose of the CCM was reasonably or fully defined and clear.



A larger proportion of respondents agreed that the legal mandate for the establishment and functioning of the NAC was reasonably or fully clear (91.9%), with 67.6% stating that the role and purpose of the NAC was reasonably or fully defined and clear.

CCM members were more likely to state that their own (CCMs) mandate and role was clear than their NAC counterparts (OR = 5.4,  $p = 0.016$  Fisher exact and OR 9.5,  $p = 0.0045$  Fisher exact). Almost all (91.9%) agreed that the legal mandate of NAC was clear, but NAC members were far more likely to state that their role and functioning was clear compared with CCM counterparts (100% vs 45.5%,  $p < 0.001$  Fisher exact). A total of 78.4% of respondents agreed that CCM and NAC structures were representative of all stakeholders. Each group considered their own body more representative – more CCM members than NAC members considered CCM adequately representative (86.4% vs 66.7%, not significant), while more NAC members than CCM members considered NAC adequately representative (100.0% vs 63.6%,  $p = 0.008$ ).

With regard to CCM and NAC functions, respondents' results are included in Tables 1 and 2 below. There was no significant difference in the responses of NAC and CCM members on CCM functions. In spite of CCM also overseeing GFATM TB grants in Lesotho, more than 40% of respondents did not see HIV/TB harmonisation efforts as a function of CCM.

Whilst NAC functions of national coordination, partnership and advocacy appear largely undisputed, differences of opinion between NAC and CCM members on NAC functions are evident in management and financial issues. NAC members were far more likely than their CCM counterparts to see a role for themselves in disbursements of funds (66.7% vs 13.6%, OR = 12.67,  $p < 0.001$ ). Similarly, NAC members were more likely to see one of their roles as management of implementers (93.3% vs 40.9%, OR = 20.22,  $p = 0.001$ ).

**Table 1: Functions of CCM**

<b>Function</b>	<b>Agree (%)</b>	<b>Disagree (%)</b>
Appoint Principle Recipients	100.0	0
Monitor and evaluate implementation of GFATM activities	94.6	5.4
Oversee financial monitoring / disbursements of GFATM activities	91.9	8.1
Ensure linkages with national development	86.5	13.5
Evaluate performance of GFATM grants	75.7	24.3
Prepare proposals for GFATM	75.7	24.3
Harmonise HIV/TB efforts	59.5	40.5

**Table 2: Functions of NAC**

<b>Function</b>	<b>Agree (%)</b>	<b>Disagree (%)</b>
Monitor all HIV programmes	100.0	0
National HIV communication	100.0	0
Harmonise HIV efforts	100.0	0
Ensure linkages with national development	100.0	0
Develop partnerships	97.3	2.7
Formulate HIV strategy	94.6	5.4
Advocacy	91.9	8.1
Formulate HIV policy	89.2	10.8
Mainstream HIV into line Ministry functions	89.2	10.8
Coordinate multilateral partners and institutions	86.5	13.5
Mobilise all national funds for HIV	67.6	32.4
Manage implementers	62.2	37.8
Disburse all national funds for HIV	35.1	64.9

Responses to open ended questions on how to improve clarity of the functions and mandate of CCM included:-

- i. Improving technical capacity within CCM to enable them to provide the required technical support, coordination and leadership role in the targeted areas.
- ii. Allocate specific responsibilities to each CCM member for oversight / monitoring
- iii. Ensuring that all representatives are committed to full attendance and participation at CCM meetings
- iv. Leadership, disseminate information
- v. Ensure full representation of all stakeholders, strengthen civil society participation, active participation of all members.
- vi. Stop being reluctant to criticize government
- vii. Align with other national programmes
- viii. Improve understanding of mandate of all stakeholders, regular orientation of CCM members about their roles and responsibilities
- ix. Define critical agenda items, more involvement of CCM members in preparing agendas for CCM meetings
- x. Demonstrate how members undertake constituency report back.
- xi. Clarify roles compared with NACs and clarify legal status of CCM

Responses to open ended questions on how to improve clarity of the functions and mandate of NAC included:-

- i. Improve their leadership
- ii. Coordinate, advocate and provide overall strategic direction
- iii. Clarify NAC role and purpose - stop trying to manage and control
- iv. Strengthen their relationship with key role players like other government Ministries
- v. Report publically on utilization of resources
- vi. Public choice of Commissioners and CEO
- vii. Establish better system to track implementation, and implementing organizations to register with NAC
- viii. Improve advocacy function
- ix. Disseminate information to all stakeholders and create understanding of mandate
- x. Link HIV with gender, TB, reproductive health etc.
- xi. Improve coordinating, harmonizing and resource mobilization role
- xii. More support from government
- xiii. Improve representation

### **Integration of HIV with other health issues**

Only 18.9% of respondents agreed that HIV was reasonably or fully integrated into other health issues in Lesotho. A total of 83.8% of respondents agreed that the structure of NAC did not enhance this integration, with a further 89.2% agreeing that the functioning of NAC also did not enhance integration. There was no difference between NAC and CCM member's opinions on this. In contrast, only 48.6% and 45.9% of respondents stated that CCM structure and functioning respectively, did not enhance integration. NAC members were far less likely to agree that CCM functioning enhanced integration of HIV with other health issues (33.3% vs 68.2%, OR = 0.23,  $p = 0.037$ ).

Suggestions to improve coordination with other health issues included:-

- i. Include private sector health facilities in CCM and NAC
- ii. Ensuring that HIV and health are integrated into livelihood projects, economic and social issues etc and implementing organizations to demonstrate linkages prior to approval of funding
- iii. Lesotho needs a renewed health development strategy that integrates HIV, TB, food security etc
- iv. NAC should lead TB / HIV collaboration - HIV Strategic Plan should include TB
- v. CCM should have more systemic approach to HIV – ensure agenda contains collaboration
- vi. Raise focus of TB in CCM
- vii. Improve NAC / MOHSW relationship and collaboration at operational level

### **Integration of HIV with broader developmental agendas**

Less than half of respondents (45.9%) felt that HIV was reasonably integrated into national development issues, with NAC members more likely to believe this than their CCM counterparts (OR = 4.29,  $p = 0.037$ ). Similarly they were more likely to agree that the structure and functioning of NAC enhanced this integration (OR = 5.33,  $p = 0.018$  and OR 6.80,  $p = 0.0075$  respectively). Less than a third of respondents agreed that CCM structure and functioning enhanced this integration (29.7% and 32.4% respectively). There was no statistically significant difference between CCM and NAC members opinions on this component (CCM members were

as likely as NAC members to agree that their structure and function did not enhance integration).

Suggestions to improve the integration of HIV within the broader developmental agenda included:-

- i. Facilitate development of integrated project proposals and improved funding and reporting for integrated proposals
- ii. Project implementers must adhere to national policies and strategies to offer integrated services
- iii. Clearer policy / strategy around integration and more flexible institutional arrangements which work across issues and sectors
- iv. Stop treating HIV as vertical programme - increase understanding of multi-sectoral response and context of HIV
- v. HIV is seen as entry point to fund unfunded development issues – need to focus on these development issues and include HIV within them.
- vi. Broader representation of other national initiatives on NAC
- vii. CCM – have standing agenda item on integration to address critical gaps
- viii. Align activities with MDGs and strategies to developmental priorities

### Reporting mechanisms

Responses on which body the CCM and NAC should ideally report to are included in Table 3.

**Table 3: Perceptions of ideal reporting lines for CCM and NAC - %**

Body ideally reported to	CCM – %	NAC – %
No-one (fully independent)	37.5	-
Prime Minister's Office or committee of Cabinet	25.0	75.0
Ministry of Health and Social Welfare	-	5.0
Ministry of Finance and Development Planning	2.5	5.0
CCM	-	2.5
NAC	30.0	-

Other	5.0	12.5
<b>Total</b>	<b>100.0</b>	<b>100.0</b>

With regard to the ideal NAC reporting line, the majority of respondents agreed with the current status quo (Prime Minister's Office or Cabinet subcommittee). There was no significant difference in opinions on this with 86.6% and 68.0% of NAC and CCM members respectively having this opinion.

Differences of opinions emerge on the reporting lines of CCM. None of the NAC responses indicated the current status quo (Fully independent), while 60% of CCM members chose this option. The majority of NAC responses favoured CCM reporting to NAC in some form (73.3%) in contrast to 3.8% of CCM members who chose this option. NAC members were therefore considerably more likely to choose this option. (OR = 68.75,  $p < 0.001$ , Fisher exact).

Suggestions under "other" included reporting to parliament for CCM and public accountability and report back for both CCM and NAC with a suggestion of quarterly media led reporting back to the public.

### **Improving integration of NAC and CCM**

Just over one-third (35.1%) of respondents considered it a viable option to integrate the CCM and NAC into one body. NAC members were far more likely to have this opinion than their CCM counterparts (60.0% vs 18.2%, OR = 6.75,  $p = 0.009$ ). Of those suggesting a unification of the two bodies, 53.8% suggested a disbandment of CCM with either no change to NAC or including CCM members on the NAC Board. Other suggestions included reducing CCM functioning and expanding CCMs role on NAC, changing NAC mandates to include TB, or limiting CCM functioning to TB allowing NAC to assume oversight of HIV GFATM grants.

For respondents who stated that the two bodies should remain separate, suggestions for improving coordination between each other and between HIV and national development programmes included the following:-

- i. Making NAC and CCM inform a larger in-country stakeholder body (34.9%)

- ii. Establish a national development coordination structure (32.5%)
- iii. More formal partnership forums or stakeholder forums (21.0%)
- iv. Constituting CCM from existing in-country bodies
- v. Constituting NAC from existing in-country bodies
- vi. Both submitting quarterly reports to community bodies for public scrutiny

When cross referencing the suggestion that there should be one body, with earlier responses, those who viewed NACs role and purpose as clear and defined were significantly more likely to want one integrated body (52% vs 0%,  $p = 0.001$ , Fisher exact). Similarly those who believed that NAC had a role in disbursing funds (a controversial opinion) were also more likely to want one integrated body (OR = 21.11,  $p < 0.001$ ).

#### **Level of functioning of the “Three-Ones”**

A total of 54.1% of respondents felt that one national strategy was reasonably or fully functional, 32.4% felt that one national coordinating authority was functioning well and 45.9% agreed that the monitoring and evaluation system was reasonably well or fully functional. There was no significant difference in opinions of respondents of the two groups.

Suggestions to improve the functioning of the three-ones are included in the following table:-

**Table 4: Suggestions to improve the functioning of the Three-Ones.**

<b>Three Ones</b>	<b>Suggestion</b>
One HIV Strategy	Implementing partners to demonstrate linkages in their activities to the strategy Annual review of framework More active participation of line Ministries
One coordinating structure	Delineation between coordination and control Acceptance and recognition of NAC by all role players NAC to ensure more inclusiveness and less power Rationalise the large NAC staff structure

	<p>Increased coherence between NAC and CCM</p> <p>Support NAC in their mandate</p> <p>NAC to take over CCM functions</p> <p>Review necessity of NAC – other developmental issues do not follow this approach</p> <p>NAC to be more collaborative</p>
One Monitoring and Evaluation Plan	<p>NAC must actively seek data (not be passive)</p> <p>Capacity building of local staff in M&amp;E unit</p> <p>Strengthen districts to collect quality data</p> <p>Include TB in national M&amp;E framework</p>

### Levels of tension between NAC and CCM

Respondents were asked to grade the degree of tension between the two bodies on a scale of 1 – 10. A total of 63.9% of respondents indicated a higher level of tension (score 6-10). There was no difference in opinions of members of CCM and NAC.

Suggestions to decrease levels of tensions included:-

- i. Clarifying roles, responsibilities and reporting lines
- ii. Clear delineation of functions
- iii. Ensuring that NAC coordinated rather than controls
- iv. Allowing NAC to be a full member of CCM, and attends all CCM meetings
- v. Allowing NAC to assume a leadership role on CCM
- vi. Increased dialogue and transparency
- vii. Changing reporting lines
- viii. Facilitating collaboration at a “higher level”



## DISCUSSION

### NAC and CCM mandate and functions

The legal mandate of the NAC in Lesotho appears to be almost fully accepted by respondents (91.9%), a result expected given the promulgation of a detailed National AIDS Commission Act by parliament in 2005. This Act complies with SADC guidelines in terms of functions allocated to the NAC as well as the reporting line (to the Prime Ministers Office). In spite of this, there appears to be less agreement on the role of NAC with only two-thirds of respondents agreeing that this was reasonably or fully clear. A review of the functions of NAC, as solicited in the questionnaire may indicate the reason for this. All functions of the NAC listed in the questionnaire were agreed by > 85% of respondents as being core functions with the exception of functions relating to funding and management of implementers. This, coupled with the responses to open ended questions on improving the clarity of functioning of the NAC indicates a dislocation between the role of coordination versus the role of implementation, with a number of respondents stating that there should be clarity on the coordination role of NAC. SADC guidelines identify this as being a core risk in role confusion of NACs. In addition, when NAC manages implementers or manages the disbursement of funds to implementers, they may not only lose the focus on their core mandate of coordination, but may place themselves in direct competition with other implementing partners such as the Ministry of Health or umbrella NGO organisations.

It is additionally noted that the Act, although it allocates the function of resource mobilisation for HIV to NAC, it did not foresee a role in direct management of implementers or to act as a fund disbursing agency. The principle role of NACs, either through international or regional guidelines, or through legislation creating NACs, is one of coordination of HIV activities at a national level. Coordination as a function is however not defined. When functions of NACs are diversified to assume management roles, levels of staffing and bureaucracy increase. Interestingly, Lesotho, with a population of less than 2 million people has, in terms of staff, one of the largest NACs in Africa with over 55 staff. The size of the NAC and the difference recorded in clarity of legislation versus functioning may be a direct result of the management of implementers and disbursement of funds.

A CCM exists in Lesotho as it is a recipient of GFATM funds. The requirement to establish CCMs as a prerequisite to funding is driven partly by a desire to ensure that funds are not wholly managed by government, to ensure participation of NGOs thus driving a local ownership agenda and the inclusion of multilateral and bilateral partners to maximise synergy of action and enhance overall accountability of funds. While CCMs are constituted in accordance with GFATM guidelines and minimum requirements, unlike NACs, they are not constituted by statute, proclamation or decree, and are thus not founded on a legislative framework like NACs. This is reflected in the fewer number of respondents who stated that the legal mandate of CCMs was adequately clear. The establishment of CCMs thus may not only place them in conflict with organisations such as NAC, but also with other national coordinating bodies which may exist in a particular country.

The CCM functions included in the questionnaire were taken directly from GFATM guidelines. Lesotho is a recipient of HIV and TB grants from the Global Fund, yet 40% of respondents did not see collaboration of the two diseases as a CCM function. Given the fact that no other collaborative body exists outside of the Ministry of Health, this response is surprising and may well be a reflection of the “lower status” afforded to TB within the wider HIV, TB and Sexually Transmitted Disease arena. The fact that NACs focus only on HIV is considered a problem given the very high co-infection rates between the two diseases. An adequate HIV programme in sub-Saharan Africa cannot be managed without due cognisance of TB and vice versa. The vertical approach of NAC with regard to HIV is considered a draw back. A quarter of respondents did not agree that CCM should prepare proposals for submission to GFATM. While this is a well known function of CCMs, responses to open ended questions indicate only a reservation that proposals should be drawn from the National Strategic Plan on HIV. This observation is supported in the light of the requirement of one national plan to drive HIV activities in-country.

### Representation

The CCM is widely representative by Global Fund standards. While a minimum 40% membership of NGOs, Academic, PLWHA and private sector is required by the GFATM, the Lesotho CCM has a membership of 48% from these constituencies. The size of the CCM (26 members), makes it more representative than the NAC

Board of Commissioners (5 members). GFATM requirements for a transparent and documented process to appoint members from broader constituencies also results in a more representative structure than NAC Commissioners appointed directly by the Prime Minister. NAC does however enhance its representation through its Forum, but unlike the CCM which meets and debates issues on a monthly basis, the Forum meets quarterly (its legislative minimum). A review of the functions of the Forum and the Board, as detailed in the NAC Act, indicates that the major substantive decisions are made by the less representative Board. NAC respondents were more defensive of the adequacy of their own representation than CCM members. The requirements of the GFATM regarding CCMs enhance participation, local ownership and representation. NACs could be well served in emulating GFATM processes on representation.

#### Integration with health and development

The National Composite Policy Index included in the Lesotho UNGASS report describes the inclusion of HIV issues in broad developmental issues such as the Poverty Reduction Strategy and the Vision for the country for year 2020. While HIV indicators exist in both these documents, there is little tangible evidence of how HIV is practically included within these far reaching developmental initiatives. At best, the CCM should enhance TB / HIV collaboration by virtue of the fact that it provides oversight to Global Fund grants for both diseases. In addition, the Lesotho Round 6 grant provides specifically for HIV /TB collaborative activities. The responses from members included in this study indicate a strong awareness of the lack of integration, with over 80% of respondents agreeing that the NAC structure and function did not enhance integration of HIV with health issues. This may well indicate the HIV focus in NACs at the expense of allied health issues such as reproductive health, TB and Sexually Transmitted Diseases. An appropriate response to HIV must include integration with other health issues and the current structure and functioning of NACs do not enhance this need. This is a significant draw back with the current arrangements of NACs.

GFATM proposals are detailed and follow a set format distributed by the GFATM at the time of a proposal call. While a proposal will focus on one of the three diseases, the CCM must demonstrate integration with a number of developmental issues such

as national health sector development plans, national disease control strategies, national monitoring and evaluation plans, developmental frameworks, Millennium Development Goals, Health System strengthening, national health system priorities, common funding mechanisms, and sustainability. While this should enhance integration of GFATM funded HIV or TB activities with broader developmental agendas, in reality this aspect is not revisited after approval of a proposal, nor does any mechanism exist at CCM to continuously monitor this integration during the life cycle of the grant. Neither CCM nor NAC are structured or function in a manner to integrate HIV within broader health and developmental agendas in a practical manner.

Harmonisation, alignment and integration are items high on the agenda of international donors and UN agencies with a number of declarations and policy statements being issued since 2002. These declarations are more likely to improve the integration between different funding agencies and in Lesotho at least, there is little evidence of practical implementation of a declaration such as the Paris Declaration which requires improvement of HIV integration into broader developmental agendas and programmes. The United Nations bodies have however created in-country structures such as UN Theme groups on HIV which are widely representative and include many in-country development role players. However even with these structures, agenda are largely driven within a vertical programmatic HIV response. They do however serve a useful purpose in aligning donor funding in countries which do not have a Sector Wide Approach (SWAp) mechanism for donor funding. While NACs are structured and function within a vertically driven HIV programme agenda and CCMs respond to their oversight function requirement on a programme by programme basis (i.e round by round), HIV will not be appropriately integrated into broader national developmental initiatives.

#### Reporting Mechanisms and possible integration of NAC and CCM

Accepted SADC guidelines on NAC reporting options make a case for NAC reporting directly to the office of the Head of Government. This provides independence, sufficient authority and should allow HIV to function across sectoral lines. This could however raise two main problems. The first is the usual functioning of the Office of a Prime Minister or President, with competing priorities and pressures of work. This

may result in a NAC with insufficient access to the Head of Government and thus the NAC not being managed to the degree as expected in the SADC guidelines. The second issue is the lack of autonomy of NAC in terms of responding to political imperatives. While NACs report to a Prime Minister or Cabinet Minister, they will be viewed as organs of the State. GFATM requires autonomy of the CCM with a minimum membership of 40 % from non-governmental in-country role players to ensure that funding management and oversight is not dominated by government. This requirement is supported and precludes NACs assuming the role of CCMs while they operate as organs of state. In Lesotho, the NAC in its current form cannot assume the functioning of the CCM as it would fail on the minimum requirements of the GFATM on representation and reporting lines.

The majority of respondents agreed with the status quo for the reporting line of NAC, while the majority of NAC respondents wanted CCM to report to them. This highlights the conflict in roles with NAC viewing their role as an organisation to which all HIV role players report. This places NAC expectations again within the management arena which is in conflict with their necessary role of coordination. If NACs are already struggling to coordinate and integrate HIV functions at a national level, should they also be attempting to manage implementing partners? Given the responses to the open ended questions, it is precisely this issue which appears to cause conflict and dissension. An interesting suggestion was that mechanisms be put in place to enhance public accountability for both NAC and CCM, and consideration should be given to including “summary indicators” in the monitoring and evaluation plan which could be reported on quarterly to the public through the media.

The finding that the majority of respondents who want the creation of one body are NAC members who view their role as broad, is not surprising. Thus NAC members who believe that their role extends to management of implementers and disbursement of funds are more likely to want CCM disbanded and to assume their functions. CCM members in this study appear more content with the existence of NAC (a legislative given) than NAC is of CCM (an international funding given). The expectation of NAC roles appear to be at the source of much of these opinions and conflicts.

NACs, as organs of government also appear to have inherited bureaucratic approaches to structure and functioning. England's opinion in the Lancet of contracting NAC functioning to a private sector organisation is an interesting suggestion but may be at the expense of maintaining strong continued government involvement. Whatever the institutional arrangement, private sector principles and a performance driven culture must be inculcated into NAC functioning. Emulating GFATM principles of performance based funding could serve NACs well. Wherever possible, existing in-country structures should be utilised where they fulfil NAC and CCM representation and functional requirements.

### Three- Ones

The responses in this study indicate that only 32-54% of members believe that the three ones are fully or reasonably functional. Lesotho has a National Strategic Plan, yet only 54% of members viewed this as an adequate "one" HIV framework. National Strategies must be articulated further into costed action plans, be integrated across sectors and be reviewed (and amended) on a regular basis. The fact that less than a third of respondents were of the opinion that one national coordinating body was functioning well is indicative of the problems with NAC functioning highlighted earlier. Lesotho has now developed a single integrated Monitoring and evaluation system which needs to be distributed. Maintaining this as a stand alone HIV monitoring tool will not enhance integration of HIV with TB and other developmental issues. HIV efforts within countries would be well served by organisations such as UNAIDS developing practical implementation guidelines on the three-ones. The World Bank has included increased monitoring and evaluation support for their future MAP activities.

### Levels of tension

The study reveals levels of tension between the two bodies as expected. Clarifying roles and responsibilities, delineation of functions and more integrated functioning between the two bodies would improve levels of tension. The tension in Lesotho between the two bodies is consistent with that reported elsewhere, with the Global Task Team in 2005 stating that GFATM, World Bank and UNAIDS should support efforts to clarify the roles of the two bodies. While clarity does exist on the roles and functioning of each body, little documentation is apparent in clarifying the relationship

between the two bodies. This is a body of work which should be urgently undertaken by international development and funding partners.

## **CONCLUSION AND RECOMMENDATIONS**

The hypothesis of this study was that the establishment of two national HIV coordinating structures in Lesotho had created levels of tension, lack of role clarification and reporting responsibilities and a perception of decreased integration of HIV within broader developmental agendas. The results of the study indicate tension, disagreement and confusion of roles such as management and fund disbursement for NAC and lack of uniformity in opinion between the two on the ideal reporting line for the CCM. The structure and functioning of both NAC and the CCM limit integration of HIV with other health and broader developmental issues in Lesotho.

Should CCMs and NACs exist? The GFATM requires an oversight body for its funded programmes in the form which is not a government organ and is inclusive of all role players. This requirement appears to be fair and reasonable. The principle of the “three-ones” requires a single HIV coordinating body at a national level. The ideal reporting line (Prime Ministers Office) and the appointment of Commissioners by the Prime Minister renders this body as an organ of state. The requirement of a single coordinating body by bodies such as the World Bank MAP is also a fair and reasonable requirement to ensure synergy and coordination of action.

Both bodies exist in Lesotho and need to continue to exist. Specific recommendations to decrease tension and enhance integrated functioning include the following:-

- i. International support organisations such as UNAIDS should assist NACs by providing guidelines on the practical interpretation of the universal NAC role of “coordination”
- ii. NACs should not function as managers of implementing agencies or as a direct disburser of funds

- iii. NACs should maintain small staff complements, have internal performance measures and be subject to periodic external review
- iv. CCMs should be chosen by transparent mechanisms as required by the GFATM but should be formally established by Ministerial decree or proclamation, thus providing the CCM with a national legal status
- v. Membership of NAC and CCM should take cognisance of existing in country coordination bodies.
- vi. CCMs should be represented on NAC Boards, and NAC should be full members of CCMs.
- vii. NACs should review representation on their Boards to include a wider stakeholder group
- viii. Membership of both NAC and CCM should include non-HIV developmental role players in the country
- ix. Both organisations must establish mechanisms to review the role of their projects and programmes within the broader developmental agenda. UNAIDS and the World Bank can assist in this regard.
- x. The CCM must remain as independent and not report to any in-country body. However both NAC and CCMs could report to other development coordination bodies if they exist.
- xi. CCMs must report on GFATM activities to NAC, so that NAC can fulfil its coordination function and ensure that one monitoring and evaluation framework is populated and reported upon.
- xii. Both CCM and NAC should report on summary activities on a regular basis to the public through the media.
- xiii. Consideration must be given to including at least TB into the NAC mandate and ensuring that TB is given the focus it deserves within CCM agendas.
- xiv. In keeping with the recommendation of the Global Task Team, the GFATM, UNAIDS and the World Bank should assist in refining the roles of the CCM and NAC and should, as a start, solicit research or an assessment of the functioning of and relationship between these two bodies in various countries.



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