THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria

GHANA

Country Coordinating Mechanism

A Case Study

Conducted by Dr. Pol Jansegers

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The consultant, Dr. Pol Jansegers accepts sole responsibility for this Ghana CCM case study documentation undertaken from 26 November to 5 December 2003 on behalf of the Global Fund to Fight AIDS, Tuberculosis and Malaria. The selection and interpretation of the findings as presented in this documentation are solely those of the consultant and do not necessarily reflect the views of The Global Fund.

31 December 2003

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ABBREVIATIONS & ACRONYMS

AIDS	Acquired Imunodeficiency Syndrome
ARV	Antiretroviral
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CEDEP	Centre for the Development of People
Cedis	national currency (1 US Dollar = ± 8,550 Cedis)
CHAG	Christian Health Association of Ghana
DANIDA	Danish International Development Agency
DCU	Disease Control Unit
DFID	Department for International Development
FBO	Faith Based Organization
GAC	Ghana AIDS Commission
GARFund	Ghana AIDS Response Fund
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHANET	Ghana Network for PLWHA
GHS	Ghana Health Services
GSMF	Ghana Social Marketing Foundation
HIV	Human Immunodeficiency Virus
KPMG	international Audit Company
LFA	Local Fund Agent
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MAP	Multisectoral AIDS Project
MLGRD	Ministry of Local Government and Rural Development
MOE	Ministry of Education
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
NMCP	National Malaria Control Programme
NTCP	National Tuberculosis Control Programme
PHD	Public Health Department
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PMU	Project Management Unit
PR	Principal Recipient
PSI	Population Service International
PSU	Private Sector Unit
SWAP	Sector Wide Approach
TB	Tuberculosis
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations' Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations' Children's Fund
USAID	USA International Development Agency
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation
WR	WHO Representative

EXECUTIVE SUMMARY

The CCM in Ghana was established within a very short period to meet the conditions to submit a proposal to the Global Fund. The signatories of the proposal submitted for Round 1 automatically became members. Representatives from other sectors were co-opted subsequently.

Composition and functioning

- The CCM, at the time of submission of 3rd round proposals, had 53 members. There are plans to reduce the membership to 30.
- The Government, and more particularly the Health Sector, continues to have a strong presence in the CCM and to take the lead in the in-country GFATM processes.
- There are no clearly defined criteria for membership and internal regulations to govern the functioning of the CCM. A 'Bylaws Task Team' is in the process of developing CCM Bylaws.
- The Ministry of Health (MOH) is the Principal Recipient (PR), and the chairmanship of the CCM is with the Chief Medical Advisor of the MOH.

Strengths of the CCM

- Decision making is carried out in a democratic way and there is a strong sense of ownership among all CCM members. The development partners and civil society consider the CCM as an opportunity to strengthen the public-private partnership.
- Participation in the development of project proposals was all-inclusive for all three rounds, but was maximized in the 3rd round through the nation wide advertisement of the call for proposals in printed media.
- The establishment of technical teams for the review of proposals and for the provision of technical support in implementation.
- Integration of the GFATM supported projects in Ghana into existing national programmes and the use of existing Government mechanisms to manage and monitor them.

As compared to the public sector and development partners, the involvement of civil society, including People Living with HIV/AIDS (PLWHA) and private sector, in the functioning of the CCM appears to be still relatively weak. The challenge is now to strengthen non-public sector involvement, in order to expand the national response to HIV/AIDS, Tuberculosis and Malaria. The ongoing development of bye-laws for the CCM, as well as a better organization and representation of the civil society and private sector in the CCM should work in that direction.

1. INTRODUCTION

This report describes the Country Coordinating Mechanism (CCM) in Ghana. It is based on a review of the composition and functioning of the CCM in Ghana. The purpose of this review was to document the process for the establishment of the CCM and its functioning as well as to document the lessons learned in what has worked and not worked in operationalising the Principles of the Global Fund on public-private partnership.

The CCM reviews leading to case study documentation was conceived in response to requests from CCMs to share early experiences and lessons learned by CCMs. The Secretariat also found it timely during the second year of its functioning to find out the level of understanding by the CCMs of their mandate and responsibilities with regard to implementation, monitoring and evaluation of Global Fund approved grants at country level. More specifically, the Secretariat undertook reviews of the CCMs in selected countries:

- to have information on how specific CCMs function and on their understanding of their mandate,
- to identify and document processes that work in operationalising the Global Fund principles of public-private partnership,
- to highlight areas for improvement/strengthening to reach the goal of a public-private partnership fully engaged in the planning, implementation and monitoring of Global Fund grants.

The scope of work and the selection of CCMs for the review and case study documentation were done in consultation with a number of partners such as the International HIV/AIDS Alliance, UNAIDS, WHO, and GTZ. The review in Ghana was funded by the GTZ BackUp Initiative. UNAIDS provided in-country support through the UNAIDS Country Coordinator. The documentation of the lessons learned and experiences of the CCM in Ghana will be shared with CCMs in other countries, especially those that are in the process of establishing themselves.

Documentation design and methods

This case study documentation of CCMs is based on a rapid qualitative review comprising of discussions with Global Fund Secretariat staff, review of all existing background information, guidelines, studies/reviews completed at country level and of information about ongoing studies by partners, as well as country field visits organised with support from UNAIDS.

The assessment mission in Ghana was carried out from 26 November to 5 December 2003. The case study documentation was constrained due to unexpected reduction in number of days because of a national holiday. In addition, a meeting was called by the Prime Minister, for all institutions and organizations working in the Health sector, from 2 to 4 December. These circumstances made it impossible to have individual meetings with the various CCM members and other stakeholders. Therefore, most of the interviews were done in group meetings, organized with the various groups of CCM members, eg. development partners, NGOs, the Bye-laws task team, etc. Those group discussions were less time consuming, but provided also less opportunity than individual meetings to cross-check the respondents' views and statements.

Fortunately, meetings with some individual stakeholders could still be held on 2 and 3 December. (Annex 1; list of people met and interviewed)

The purpose of the interviews and discussions in Ghana was to explore the process of the establishment and evolution of CCM structure, roles and responsibilities of CCM members, the challenges of broad multi-sectoral ownership, and how the CCM has worked to ensure equal participation particularly of non-government actors. In addition, the facilitating factors as well as the impediments to this equal participation were analysed. The extent to which the CCM was able to fulfil all required responsibilities, not only in proposal development but equally in implementation oversight, monitoring and evaluation was also reviewed. Based on this, recommendations to strengthen the capacity of CCMs to fulfil their mandates have been made.

The country visit concluded with the focus group discussion for the presentation of the consultant's findings and the rapid needs assessment, on the 4th December. The meeting took the whole morning, and was attended by an impressive proportion of the CCM (Annex 2: list of participants).

GFATM in Ghana

Ghana participated in all 3 GFATM rounds, but proposals were approved only in the 1st and 2nd round. The malaria proposal, rejected in the first round, was re-worked, taking the GF comments into account, and approved in the 2nd round. The CCM plans to resubmit the 3 proposals rejected in the 3rd round. Table 1 summarises the status of the grants in Ghana.

Table 1 : Summary report on the status of approved GFATM grants[1]

Rnd	Disease Component	Total Yr. 1 & 2 Budgets (USD)	Total Lifetime Budgets (USD)	Grant Agreement Signature Date	Amount Disbursed to Date (USD)	Status 1
1	HIV/AIDS	4 965 478	14 170 222	12/12/02	1 676 499	2nd dis.
1	Tuberculosis	2 336 940	5 687 055	12/12/02	1 482 520	3rd disburst.
2	Malaria	4 596 111	9 356 933	3/07/03	886 150	1st disburst

Ghana has one of the best implementation records of GFATM supported projects. For example, it was the first country in the world to fulfil the conditions for disbursement, and hence the time lag between the signature of the grant agreement (12/12/02) and the disbursement of funds from GFATM (6 January 2003) was extremely short. It was also one of the first 6 countries to which funding for the 2nd quarter was released. An indication that progress and financial reporting had been found to be in keeping with GFATM procedures. The disbursement for the 3rd quarter was already made in November, 2003 for the Tuberculosis component, to date, 3rd quarter disbursements have been made to only 2 countries in the world.

[1]Please refer to website: www.theglobalfund.og for more information on status of GF approved grants

2. FINDINGS

2.1 Establishment of the CCM

Several CCM members reported that the Country Coordination Mechanism (CCM) in Ghana was established 'in a hurry'. They attributed this firstly to the very tight deadlines for the development of the first proposal to the GFATM and secondly to the GF requirement that proposals must be developed and submitted through a multi-sectoral partnership mechanism.

The Government of Ghana invited a group of people with expertise in HIV/AIDS, Tuberculosis and Malaria to participate in the proposal development for the GFATM first round of call for proposals. The invitation was conveyed to the various categories of stakeholders recommended by the GFATM to be part of the CCM: public sector, civil society including NGOs, faith based organizations (FBO) and persons living with HIV/AIDS (PLWHA), private sector, academic institutions and development partners. Those interested, responded to the invitation and attended several meetings, during which the proposals were developed.

This group automatically became the "CCM" and the date of its first meeting, 19 February 2002, was considered the date of its creation. The minutes of this first meeting confirm that this group of participants decided that a number of other stakeholders should also be CCM members: "*It was agreed that those in attendance should form a core of the CCM, with additional representation from Ghana Society for Prevention of TB, CHAG*[2]*, Wisdom Association (PLWHA), Coalition of NGOs in Health, GHANET, and private sector representatives, MLGRD, MOFA and MOE."* [3] It was this 'expanded' group (except for those mentioned in footnote 2, here below) who signed the Proposal document that was sent to the GFATM Secretariat, as "CCM members".

2.2 Composition of the CCM

Membership

The CCM in Ghana is chaired by the Chief Medical Officer of the MOH. The WHO representative is the Vice-Chair.

There are no established criteria for the CCM membership. The group of 40 'members' who signed the 1st round proposal was considered the CCM, until the second round proposal was developed. In that 2nd proposal (July 2002), it was mentioned in Section II that "*The composition of the CCM has changed with the*

[2] CHAG, abbreviation of 'Christian Health Association of Ghana is a very special national NGO, founded in 1967 and active in the field of health services provision. In fact, according to their annual report 2002-2003, CHAG runs 140 health institutions, mainly in the rural parts of the country, and provides health care to an estimated 35-40% of the national population! Several of the NGO's health institutions have been designated centers of good practice by the Government, and are sites for training of health professionals. This NGO has so far been only moderately involved in GFATM related activities, and could certainly become a more important partner.

[3] However, neither the Ghana Society for Prevention of TB, nor GHANET, nor MOFA subsequently attended CCM meetings.

addition of the following new members: Project Concern International-Ghana, VASS Medical Foundation, Malaria Consortium, Rotary Club, Ghana, Ghana Association of Private Voluntary Organizations in Development (GAPVOD)". All signed the proposal except GAPVOD nor did it attend any CCM meeting. Likewise the Rotary Club appeared only once on the list of participants, immediately after the signing of the proposal but did not attend any other meeting. The total number of members also appears to have changed from one proposal submission to the next. (Annex 6: comparative list of members)

The list indicates that a number of constituencies are represented by more than one person. These double (indicated as XX in table 3, hereunder) or triple (XXX) memberships are the following:

Table 3: Double and triple memberships in CCM

GFATM Round	1st	2nd	3rd
MOH – Private Sector Unit	XX	XX	XX
GHS – Public Health Division (*)	XX	XX	XX
Ghana AIDS Commission	XX		
Ghana Social Marketing Foundation	XX	XX	XX
WHO	XXX	XX	XXX
UNAIDS			XX
UNFPA			XX
USAID			XXX
DFID			XX
DANIDA			XX

(*) both CCM contact persons are from the PH Division, one of them is the CCM Secretary

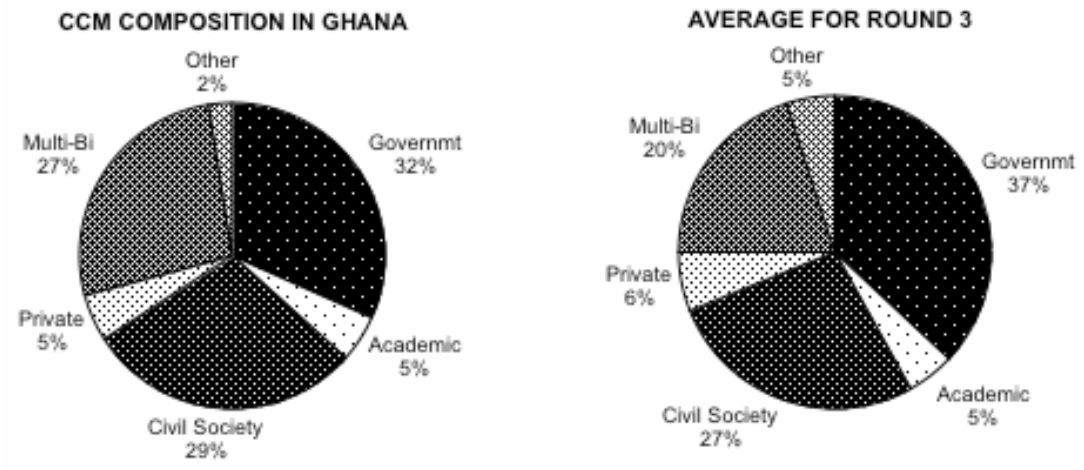
The various members from the Ghana Health Service, i.e. the Public Health Division, the Disease Control Unit and its 3 Programmes concerned (HIV/AIDS, Tuberculosis and Malaria) have been considered here as different 'constituencies'. Some of those interviewed rightly argued that with 6 representatives from GHS and 3 additional members, the representation from the MOH in the CCM is very unbalanced.

The gender balance of the CCM evolved to a more marked male dominance: the M/F ratio went from ± 1.5/1 in the beginning to 2/1 for the most recent member list.

Composition

All groups recommended by the GF are represented in the CCM. If constituencies are considered rather than persons, there is an almost equal share among the public sector, the civil society and the development partners, as illustrated in the pie chart. The comparison with the average distribution in the countries, which submitted proposals for round 3, is shown in the pie-chart at the right[4].

[4] Ref.: "Country Coordinating Mechanisms (CCMs): Analysis of CCM composition for Round 3", The Global Fund to fight AIDS, Tuberculosis and Malaria, October 2003



Note: 'Civil society' includes national and international NGOs, FBOs and PLWHA

There are plans to reduce the number of CCM members to a maximum of 30 as is stated in the draft bye-laws document, which is currently under development. The composition proposed is equal allocation of 6 seats for the 5 following groups:

- Government Health Sector (including academic institutions),
- other-than-Health public sector,
- civil society, including FBO and PLWHA,
- private sector,
- and development partners.

2.3 Governance - Organization

Internal regulations – Bylaws

There are no clearly defined internal regulations to govern the functioning of the CCM. Despite this, the CCM, as an instrument for proposal development and for overseeing the implementation of approved projects, has been working very well, mainly due to the commitment of a core of leading officials, primarily from the Health Sector and the development partners.

A first attempt to develop internal regulations was made towards the middle of 2003. This document specifies the CCM organizational structure[5], composition, terms of reference, etc. In this document, the essential roles of the CCM are defined, but no criteria for membership, or other ways of functioning were mentioned. (Annex 6)

In August 2003, the CCM created a 9-member team 'Bylaws Task Team', headed by the Private Sector representative, to undertake the development of official bye-laws. (Annex 7: Task team membership). This team developed a preliminary draft 'CCM Bye-laws" document (Annex 8: CCM Bylaws), based on the GF "Guidelines on the

[5] The diagramme showing the organizational structure was still the same as in the Attachment # 5 of the Project Proposal for the first Round, submitted on 5 March 2002, which probably explains why the CCM secretariat, established within the Public Health Division of the Ghana Health Service, is not yet mentioned.

Purpose, Structure and Composition of Country Coordinating Mechanisms". The document is to be finalised and adopted at the next CCM meeting.

Modus operandi

- Meetings are held on a regular basis. In addition to the meetings held to review the various project proposals before submission, there have so far been 10 'regular' CCM meetings: 5 in 2002 and 5 in 2003. The meetings are called by the CCM Secretariat and Chair. The agendas are proposed by the CCM Chair and the 2 contact persons, both from the Public Health Division/GHS.

- A CCM secretariat has been established. The Administrative Assistant of the Public Health Department of the GHS is the secretary of the CCM, while continuing at the same time to function in his won capacity as administrative assistant. The secretariat has, more recently, been strengthened through the appointment of two additional staff members. Despite difficult working conditions, the CCM secretariat functions very well. For example, minutes are available for virtually all meetings (Annex 7: meeting minutes), documents can be traced easily. E-mail is broadly used for communication and backed up by fax and telephone if necessary, etc.

Participation in decision making

- The CCM functions in a 'democratic' way, where each member has a voice. Representatives of all groups feel ownership, and none feels marginalized. Several members confirmed that the public sector has a strong leadership in the CCM but approved of this. As one representative of the civil society put it: "*If the CCM were not Government driven, it wouldn't work!*'. Government officials respond to this trust by providing complete transparency. For example "*Every CCM member has a copy of the disbursement plans.*"

- Though no voting procedures have as yet been used, it was reported that decision making is done by consensus as in the selection of Chair and Vice Chair. The Bylaws task team considers however developing "Procedures for election of officers" and "Voting Procedures". To make these procedures meaningful, a strictly defined list of members will be necessary.

- There has been regular participation in CCM meetings with an overall attendance rate of 53 % (Annex 9: meeting participation list). This could be attributed to the strong commitment of the 2 CCM focal persons who organize the meetings, but also by the generally strong sense of ownership of the CCM members. The substantial attendance fee paid to each member by the CCM Secretariat (200,000 Cedi = 23 USD) probably also plays a contributory role.

- Participation of the various partners in proposal development and implementation is organized in two distinct phases:
  1) **Submission of 'concept papers' for participation in the project proposals**. This procedure was more systematically used in the 3rd round. The call for proposals was announced in the national print media. As a result, more than 300 such concept papers were submitted (± 200 for HIV/AIDS, 40 for TB, and 70 for malaria).These were reviewed by the thematic task teams with

final selection and consolidation into one proposal done by the Joint Review Team for submission to the GFATM.

2) **Submission of plans of action.** Sub-recipients would be specifically identified at this second phase. Eventually, at this stage, new implementing partners could still be included to carry out some of the activities of the approved projects. For instance, home based care was part of the HIV/AIDS component, approved in the 1st round, to be carried out essentially by civil society. To start the implementation phase, and even after its onset, additional NGOs could still be co-opted to participate, as long as their action plans are in line with the planned and approved actions and budgets.
The main sub-recipients currently involved in the implementation of the various components are listed in Table 4:

Table 4: Sub-Recipients currently implementing GFATM supported projects

HIV/AIDS	Tuberculosis	Malaria
NACP	NTCP	NMCP
MLGRD	Anglican Church	Health Concern Ghana
CHAG	Ghana Society of Prevention of TB	Project Concern International
GSMF	Club Vision Ghana	Noguchi Research Center
FHI	CEDEP	Food and Drug Board
Several PLWHA Associations	Ghana Medical Students Association	CEDEP
	Noguchi Research Center	School of Medical Science

Technical teams

- During its first meeting, the CCM established: three Thematic/Technical Task Teams - one for each of the 3 components (HIV/AIDS, Tuberculosis and Malaria): a Joint Monitoring Team specifically for the purpose of proposal development; a Joint Review Team for the harmonization of the 3 components of the proposal. The composition of those task teams was essentially done by auto-selection and by area of expertise. The 3 technical task teams have been repeatedly called upon, not only for the selection of concept papers for the development of proposals, and of action plans for approved proposals, but also for the follow-up of the implementation of the respective projects.

  There was no consensus among those concerned about the extent to which each individual Technical Task Team member should be involved in monitoring activities in the field. Many Task Team members, however, thought that the time needed for appropriate monitoring is incompatible with the availability of most CCM members, because of their other duties.

  Several other Task Teams were established later, some permanent, such as the Monitoring and Evaluation (M&E) Task Team, which replaced the initially created Joint Monitoring Team, and others limited in time and scope. The task teams can invite one or more experts in the related areas, even non-CCM members, to its meetings. The list of task teams, with their dates of creation, number of members is shown in Table 5.

Table 5 : Task teams established in the CCM

Task Team	Date	members	Chair	Coordinator
HIV/AIDS	19/2/02	11	GAC	UNAIDS
Tuberculosis	19/2/02	7	Ghana Medical School	GHS/DCU
Malaria	19/2/02	8	Noguchi Research Centre	WHO
Establishment of mechanisms for proposal review and endorsement	17/9/02	5		
Monitoring & Evaluation	23/1/03	5		
Advert development (for inviting concept papers)	2/4/03	5		
Visit of Global Fund Director	12/8/03	10		
Bye-laws for CCM	12/8/03	9	Private sector	
Performance Monitoring	12/8/03	8		

2.4 Institutional set-up and linkages

The Ghana CCM was set up as an independent body, without institutional links to related institutions such as the Ministry of Health, the Ghana Health Service[6], or the Ghana AIDS Commission. At the time of its establishment, it was clear for everybody that the Government should take the lead for the development and the management of Global Fund supported projects. In the first CCM meeting on 19 February 2002, it was decided unanimously that the Chief Medical Officer of the Ministry of Health be "*nominated as the **Chairman of the CCM***".

In the same first CCM meeting, several entities were proposed for the role of ***Principal Recipient***: MOH, WHO, UNFPA, UNDP and GARFund (the Ghana AIDS Response Fund), but no decision was then taken. The document submitted to the GF on 5 March 2002, however, specified that "*The existing financial management arrangement of the health account […] will be used to administer funds received from the Global Fund."* It was only in the meeting of 2 August 2002, that the MOH was confirmed in its role of PR.

UNICEF was initially proposed as the ***Local Fund Agent*** and would have performed that role effectively but could not be accepted by the Global Fund. Subsequently, in the CCM meeting of 2nd August 2002, Price Waterhouse Coopers was selected among 3 auditing firms and their contract has been extended based on their reselection during the normal LFA renewal process.

Coordination with national programmes and structures

Ghana has a long standing positive experience in public-private partnerships. It is one of the few African countries where the SWAP approach is being implemented

[6] The Ghana Health Service is the operational arm of the MOH, where National HIV/AIDS, Tuberculosis and Malaria Control Programmes are located.

effectively[7]. This facilitated the integration of all 3 components of the GF supported projects into the existing programmes as illustrated by the following:

- criteria for the selection of proposals specified that:
  - project proposals need to be based on the existing national strategic plans
  - all proposals are supposed to take national priorities into account
  - they should address eventual gaps in national programmes
- no new structures were created for the management of approved projects: all are managed by the existing programme structures.

The will to integrate is also obvious in the field of project monitoring. The CCM was definitely assigned the role of overseeing the implementation of the projects i.e. monitoring the financial management as well as the attainment of stated objectives, but *routine* monitoring, including that of the sub-recipients, is undertaken by the respective national programmes, and their data used by the CCM to appreciate progress of implementation. The M&E plan for malaria (Annex 4) perfectly illustrates this policy: its first heading reads: "*Description of Existing M&E System*", and the document further explicitly states: "*[Monitoring] will draw on the existing information and reporting systems of partners…*"

This integration into the respective national programmes is further illustrated by the fact it was always the 3 national programme managers concerned (HIV/AIDS, TB and Malaria), and not the respective Task Team Chairs, who reported during the CCM meetings to report on project implementation progress.

Some CCM members were of the opinion that that the 'end of year review' of the GF funded projects, scheduled in January 2004, would somehow duplicate the 'Annual Performance Review' of the MOH, and that such duplication should be minimized in of interest mainstreaming of M&E activities. They said, *"In order not to jeopardize integration*, *the CCM should not take over tasks of existing Government mechanisms"*. The challenge here will be to ensure that activities carried out by civil society and other non-public partners, are duly taken into account.

But integration has not always been successful. As shown in Table 5, the Ghana AIDS Commission (GAC) is the Chair of the HIV/AIDS Task Team. As a "*supra-ministerial body placed directly under the Chairmanship of the President of the Republic*"[8], the GAC has four main roles in HIV/AIDS national programming:
1) policy development, 2) supervision and 3) coordination of the national response, and 4) resource mobilization. Despite these crucial roles in the national response to HIV/AIDS, and despite its leading role in the CCM's HIV/AIDS Task Team, the GAC does not seem to play a very visible role in GF related activities. The attendance rate of the GAC in CCM meetings so far was only 50%, and the Director-General did not attend any of the regular meetings. In a meeting with the consultant on the last day of the mission[9], the Director-General was of the opinion that the GAC should indeed

[7] Currently, 4 development partners participate in a SWAP mechanism with the Ministry of Health: the World Bank, the Netherlands, Danida and DFID. JICA, the Japanese development agency, is considering joining soon.
[8] Ref. "Ghana AIDS Commission", by Prof. S.A. Amoa, Director-General of the GAC. (Editorial in a special edition on HIV and AIDS of the "Step" magazine
[9] The GAC did not attend any of the meetings organized in relation with the present assessment, because of other commitments.

play a more important role. In particular, he thought, the GAC should have shared the role of Principal Recipient with the MOH, because it has a legal backing for resource mobilization, and has experience in managing broad partnership funding in the field of HIV/AIDS (the GARFund, managed by the GAC and financed by 4 development partners, i.e. the World Bank, DFID, USAID and WHO, is comparable to the MOH's SWAP). This tension over the control and use of resources has played a role in the level of commitment of the GAC to the CCM activities.

3. Strengths of the CCM

Three factors played a critical role in Ghana's success with GFATM supported projects:

1) the Government's genuine commitment to upscale the national response to the 3 diseases;
2) to utilize public-private partnerships for that purpose and
3) the government's technical expertise in project management.

Other determining factors such as strong integration and coordination, the Government's will to involve civil society, and exceptional records with project implementation, are the logical consequences of these factors

Integration into national programmes and existing systems

- The strong integration of GFATM funded projects into the existing national programmes has already been highlighted. No management structures have been duplicated for the purpose of overseeing the implementation of these projects. Monitoring of project implementation is very much mainstreamed in Government services: based on the routine monitoring structures of the Public Health Sector, and overseen by the CCM. Finally, progress and financial reporting is done in a satisfactory way.

Process to ensure public-private partnership

- There is a true public-private partnership at the basis of GF supported project development and implementation. Though the process is clearly Government, more specifically Health Sector-driven, the civil society and development partners participate fully through the CCM, and generally trust the Government's management capacity and approve the Government being in the drivers' seat.

  Civil society participation was effective in all 3 rounds: in the first 2 rounds, through the participation of selected NGOs and other non-public partners in the development and selection of proposals; in the 3rd round through the submission of concept papers following nation wide announcement of call for proposals in the print media. Their true participation was further assured by the possibility to submit action plans for the implementation of the approved GFATM funded projects.

- All CCM members interviewed confirmed their strong feeling of ownership and partnership. They generally feel empowered by their CCM membership. The sense of ownership of Health Sector and development partners is expressed by their attendance rates at CCM meetings: an average of 70% for the former (close to 80% if only MOH/GHS is considered!), 71% for the latter. The overall attendance

rate is 53 % (Annex 10). The CCM is seen as an opportunity to still improve links between public and private sectors.

Strong management expertise

- The Government of Ghana's – and more specifically the MOH's – expertise in project and financial management led to rapid grant signing followed by immediate implementation of GF funded projects: Ghana was the first country in the world to fulfil the conditions for disbursement, and hence to receive funding from GFATM (in January 2002). It was also one of the first 6 countries to which funding for the 2nd quarter was released, hereby showing that progress and financial reporting had been found appropriate. Disbursement for the 3rd quarter was already made for the Tuberculosis component, in November, 2003. So far, 3rd quarter disbursements were made for only 2 countries in the world.

This implementation success tends to be attributed primarily to the Government's good management capacity and know-how. Building on that success, the CCM should now further strengthen non-public sector participation and maximize public-private partnerships, in order to expand the national response to HIV/AIDS, Tuberculosis and Malaria to all layers of the society, and to the most remote areas of the country. That will certainly entail capacity building of non-public sector partners, and ensure that they have a strong voice in the CCM decision making process.

4. Challenges for strengthening CCM

Membership and participation in CCM

- So far, several constituencies are represented by more than 1 person (the most recent list of members has 52 names, for about 40 constituencies). In addition, the representatives from certain constituencies often vary from one meeting to another. The result is that there are very often 'new faces' in CCM meetings, representation by sometimes quite junior staff, and most importantly, a lack of continuity.[10]

  Partnerships reach their maximum efficiency when not individuals, but groups or constituencies are involved. Therefore, it is important that a group's representative is legitimate and recognized by that group, and that there is a continuous two-way communication between the representative and his/her constituency. When representatives change too often, partnership links are weakened. Having one steady representative and a system to allow a process of democratic rotation after a fixed period of time is necessary to facilitate true participation, consistent communication, and to ensure effective partnerships.

  Some practical consequences for the CCM are the following:

  – while allowing sufficient flexibility, membership needs to be stabilized, based on specific criteria developed by the CCM

[10] The same fact was experienced by the consultant during this mission: looking at the lists of participants in the various group meetings, it was impossible to say who were CCM members, and who were not (the most extreme illustration of this was the participation of *five* WHO staff members in the meeting for multilateral development agencies, cf. Annex 11). That is the reason why Annex 2 lists the '*Persons representing CCM member constituencies*', rather than '*CCM members*'

- Those CCM members representing groups of several entities (such as umbrella-NGOs or associations of PLWHA, private sector,…) need legitimacy and recognition from their group. For instance, through broad based election or designation by a core group of leaders. That recognition will then be further strengthened by regular back and forth communication between the group and its representative.

- Although the civil society is well represented the CCM in terms of number, the NGOs do not seem to be organized optimally for an effective representation in the CCM. Umbrella-NGOs have been created, but have along way to go to establish credibility. For example the Coalition of NGOs in Health, created in 2000, and Ghanet, an umbrella-organization for NGOs working in the area of HIV/AIDS and do not yet seem to have acquired the strong credibility and representation needed for acceptance. The CCM should find ways to strengthen the involvement of civil society: Their average attendance rate of CCM meetings, so far, was only 32% though this has improved in 2003: 40%, against 23% in 2002). There is only one member private sector member in the CCM. Measures are however under way to strengthen private sector representation.

- Public sector participation in CCM is rather unbalanced: 10 are from the Health sector, 4 from other Government sectors (that is approximately 23 and 9 %, as compared to respectively 16 and 21 % for the average of other countries in the 3rd round[11]. The non health Government representatives are also much less regular in attending CCM meetings: on average 45%, against 70% for the Health Sector. The involvement of the Ghana AIDS Commission (GAC) in CCM activities does not reach the level expected by several stakeholders.

- Currently all the members of the CCM are based in the capital city. It is essential if the CCM is to meet the real needs of people in the communities all over the country, consideration should be given to include members from outside the capital city.

Bylaws

The development and adoption of bylaws by the CCM would definitely contribute to its smooth functioning and provide an opportunity to settle some differing views on a number of issues, such as:

- Rotation of CCM chairmanship
- decision making by consensus or secret voting
- independent secretariat or one within the MOH, etc.

The adoption of bylaws should also include clear criteria for CCM membership, and a clearly defined process to improve meaningful participation but it must be pointed out that the distribution proposed in the draft bylaws document might well contribute to a certain imbalance among the CCM members. It mentions indeed that "not more than 6 members will be selected from each of 5 main groups:

[11] Ref.: "Country Coordinating Mechanisms (CCMs): Analysis of CCM composition for Round 3", The Global Fund to fight AIDS, Tuberculosis and Malaria, October 2003

- Public Sector (other than Health, and including academic institutions)
- Public Health Sector
- Civil society
- Private sector
- Multilateral/Bilateral development partners

This, in fact, would imply that the reduction of the number of members would be borne essentially by the civil society and the development partners, since these groups currently have respectively 12 and 11 members, and would each be reduced to a maximum of six.

More realistic timelines

A strong plea was made by several leading CCM members, for less time pressure for proposal development and for the provision of clarifications to the GFATM for proposals. They thought that it is essential to have sufficient time, not only for the development of the proposals and subsequent action and disbursement plans, but also for the implementation of the approved projects, 'at the pace of targeted communities'. It was however brought to the attention of the stakeholders that, as far as time pressure *during project implementation* is concerned; the pace of implementing projects was primarily determined by the work plans developed in the planning documents, and that less ambitious planning would automatically reduce time pressure.

Provisional issues related to understanding of GFATM procedures & guidelines

The GFATM guidelines themselves have sometimes been criticized for lack of clarity. Generally, CCM members were of the opinion that the principle of "building the boat while sailing" is acceptable, but sometimes felt somehow 'insecure', because of a perception of 'changing rules'.

There is a certain amount of frustration due to the limited understanding of the process of proposal approval/rejection and of the respective roles of the GFATM Secretariat and the Technical Review Panel in that process. This frustration was recently aggravated by the publication of Board Decision on proposal approval before the CCM was officially notified. All this shows the necessity for the GFATM Secretariat to provide the CCMs and other stakeholders in the various countries with clear information and clarification on processes.

5. Review of needs and technical support

Capacity building

The needs expressed by several CCM members in group and during individual meetings, and in the debriefing meeting at the end of the mission were essentially related to the necessity of making sufficient resources available – or allowing sufficient budget flexibility – for the following:

- Capacity building in project management, for national NGOs and especially for CBOs, but also for small businesses of the private sector. Several CCM members were of the opinion that the lack of human capacity had in fact been the *only* barrier, so far, to achieving full public-private partnerships. But they also added that competence is growing fast, since the initiation of training activities. They stressed the importance of capacity building for sustainability and to increase absorptive capacity in the country. Even when the usual 'brain-drain' of trained staff is taken into account, the final result of training is most often still positive. Therefore, capacity building needs priority attention – and budget!
- To improve the representation of umbrella-organizations through the strengthening of their overall coordination and management capacity and through improving legitimacy and recognition of the various groups' representatives. This concerns the private sector, as well as umbrella-NGOs and organizations representing several associations of PLWHA).Audits of the various sub-recipients, once completed will provide information of their technical and capacity building needs.

6. Recommendations

6.1 To the GFATM Secretariat:

To reconsider the time pressure put on countries for proposal development and for providing clarifications on proposals prior to approval. The forms and instructions for the submission of proposals are not always clear and the amount of information requested is often substantial and not easy to find. The request to use a genuinely participatory approach for the development of the project proposals also tends to slow down the pace of work. Unrealistic, tight deadlines are often being met at the expense of good quality work and effective, broad-based participation of all CCM members.

6.2 To the CCM:

- To finalize and officially adopt the bylaws for the CCM, in particular concerning: The criteria for CCM membership, including details of constituency representation in the CCM, alternative representation and rotation modalities;
- To help national NGOs organizing themselves better, improving their coordination and strengthening their representation in the CCM. This should include institutional and human capacity building, and if necessary, material resources enhancement, as in the case of PLWHA associations. Primarily international development partners should be encouraged to provide assistance in this area.
- To facilitate strengthening of technical expertise and management capacity building of communities living with the disease for their effective participation in CCMs and for proposal development, and for programme implementation, monitoring and evaluation.
- To establish a mechanism for the submission of decentralized proposals, particularly from the civil society which will facilitate their inclusion but at the

same time avoid several hundreds – or thousands – of small, dispersed proposals, which will be impossible to consolidate. Decentralized vetting, selection and consolidation may also be helpful in this process.

- To advocate and encourage participation of the private sector in the CCM, and their involvement in project development and implementation.
- To encourage governments and bilateral/multilateral partners to ensure that resources are available and systems in place for a functioning CCM Secretariat as well as to support members to attend meetings and for their feedback and consultation with their constituencies.

In conclusion, the CCM in Ghana should pursue its policy of integration and mainstreaming of GFATM supported projects and continue to take advantage of existing national mechanisms and structures for its own functioning. The CCM has provided the opportunity to further strengthen the tradition of public-private partnerships and to strengthen existing structures of the various partners instead of duplicating them. Examples range from using the findings of the Annual Performance Reviews of the MOH for its own yearly evaluations, to helping the civil society in the creation or strengthening of umbrella-organizations, or assisting PLWHA associations in building their management capacity.