THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria

Rwanda

Country Coordinating Mechanism

A Case Study

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The consultant, Dr. Pol Jansegers, accepts sole responsibility for this Rwanda CCM case study documentation undertaken from 30 October to 8 November 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.

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ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANSP+	Association Nationale de Soutien aux Personnes Vivant avec le VIH/SIDA (National Association to Support PLWHA)
APELAS	'Association du Privé et des Entreprises dans la Lutte anti-SIDA' (Private Sector Association to Fight against AIDS)
ARV	Antiretroviral
CAMERWA	Centrale d'Achat des Médicaments Essentiels du Rwanda (Purchasing Centre for Essential Drugs)
CCM	Country Coordinating Mechanism
CDLS	'Comité de District de Lutte contre le SIDA'
CNLS	'Commission Nationale de Lutte contre le SIDA' (Multisectoral AIDS Commission of Rwanda)
CPLS	'Comité Provincial de Lutte contre le SIDA'
DFID	Department for International Development
DSS	Direction de Soins de Santé
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IMPACT/FHI	Implementing AIDS Prevention and Care Project/Family Health International
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MAP	Multisectoral AIDS Project
Minecofin	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOS	Ministry of State for HIV/AIDS and Related Diseases
MSF	Médicins Sans Frontières
NGO	Non-government Organisation
PACFA	Prevention and Care of Families Against AIDS
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PMU	Project Management Unit
PNILT	Programme National Intégré de lutte contre la Lèpre et la Tuberculose (National Leprosy and Tuberculosis Control Programme)
PNLP	Programme National de Lutte contre le Paludisme
PR	Principal Recipient
PSI	Population Service International
RNYC	Rwanda National Youth Council
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
TRAC	Treatment and Research on AIDS Centre
UNR	Université Nationale du Rwanda
VCT	Voluntary Counselling and Testing
VCTI	"Voluntary Counselling and Testing" Intégré
WB	World Bank
WHO	World Health Organisation
WR	WHO Representative

Executive Summary

The CCM in Rwanda was set up in January 2002, primarily because it was a condition for the submission of proposals to the GFATM and is characterised as follows:

- The CCM has 33 members representing all the relevant sectors.
- More than 50 % of the CCM members are extremely motivated and fully committed to the successful implementation of the GFATM approved grant proposals. Advocacy and other measures are under way to strengthen the participation of the less active members.
- The CCM functions through a Secretariat and a well established governance process with management tools and technical panels.
- The CCM has played an effective role in the formulation of project proposals, but is aware of the need to strengthen the capacity of civil society, for proposal writing as well as for implementation and monitoring of the projects.
- Attempts to integrate management and monitoring structures into existing ones have not always been successful: new structures were created, some of which at least partly overlapped with existing ones.

- ***Strengths*** of the CCM are:
  - Strong Government commitment and support from the Office of the President provides credibility of the CCM.
  - Governance processes which facilitate true participation
  - The participatory process of decision-making has led to a strong feeling of ownership by all members, who feel *"useful and respected*".
  - The creation of technical panels to review proposals.
  - The willingness and cooperation of both multi-and bilateral development partners to provide technical assistance to CCM members as and when needed. The synergetic effect of public-private partnership is thereby shown to be effective
- ***Challenges*** for strengthening CCMs and for the implementation of GFATM supported – and other – projects are those related to:
  - Limited human capacity particularly among NGOs and people living with the diseases has resulted in difficulties in their participation in proposal development and could lead to the slowing down of implementation by the sub-recipients.
  - Communication among members, especially those representing the civil society and their constituencies would need to be further developed and formally established.
  - Not all members participate regularly at CCM meetings and this could in the long run affect the inclusive partnership in the decision making process.
  - Roles and responsibilities of PR and Chairperson and lines of reporting between the CCM and related structures are still not understood.
  - GF procedures are not clearly understood by CCM members and the Principal Recipients.

In general, the Global Fund has, through the CCM in Rwanda, brought partners together and provides an opportunity through these (almost) all-inclusive partnerships to accelerate the control of the three diseases particularly that of HIV/AIDS prevention and care.

1. Introduction

1.1 Rationale and purpose

This report describes the Country Coordinating Mechanism (CCM) in Rwanda. It is based on a review of the composition and functioning of the CCM in Rwanda. The purpose of this review was to document the process of 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 Rwanda 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 Rwanda will be shared with CCMs in other countries, especially those that are in the process of establishing themselves.

1.2 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 and on-going at country level followed by country field visit.

During the eight-day country visit from 30th October to 8th November, 2003, documents were reviewed**,** and individualised interviews and focus group discussions with relevant stakeholders and members of CCMs were conducted. (Annex 1: List of people met and interviewed; Annex 2: list of documents). The purpose of these interviews and discussions was to explore the process of the establishment and evolution of CCM structure, roles and responsibilities of the members, to identify issues related to ensuring broad multi-sectoral ownership and equal participation particularly of non-government actors. 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 a debriefing session with the CCM and a rapid needs assessment. Due to conflicting demands imposed by governmental meetings, this debriefing session was limited in time and in participation. It therefore did not allow for a more in-depth discussion on technical needs with all members of the CCM.

1.3 Status of GFATM approved grants in Rwanda

The proposal on HIV/AIDS/TB focusing on Integrated Voluntary Counselling & Testing ("VCTI") submitted for Round 1 by the Rwanda CCM was approved by the Board.
A Program Grant Agreement between the GFATM and the Ministry of Health was signed on 10 April 2003, and the first disbursement made in May 2003. Rwanda was one of the first countries to start implementation, which continues to be on schedule, as planned.

The Global Fund Board, on the recommendation of the Technical Review Panel, approved two proposals for Round 3: *Decentralisation of HIV/AIDS prevention*; and Controlling Malaria in Rwanda.

Table 1: Status of GFATM approved grants[1]

	GFATM Round	**Grant agreement signed**	**5-year maximum (USD)**	**2-year approved maximum**	**Funds disbursed**
HIV/AIDS/Tuberculosis	1	10/4/03	14,641,046	8,409,268	2,111,992
Decentralisation of the overall management of people living with HIV/AIDS	3	/	56,676,465	14,890,735	0
Controlling Malaria in Rwanda	3	/	17,676,240	13,045,301	0

The total budget for the 3 projects is close to 89 million USD over two years, which, in comparison to the country's relatively small population of 6 million gives an indication of the importance of the grants for Rwanda.

[1] More information is available on: www.theglobalfund.org

2. FINDINGS

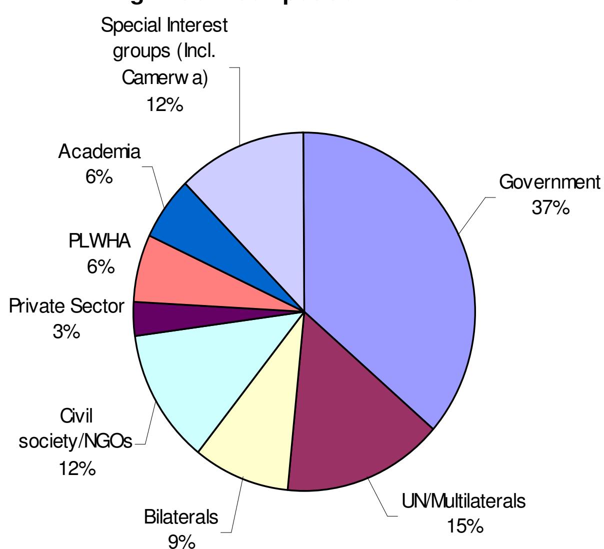
2.1 Establishment of the CCM and its composition

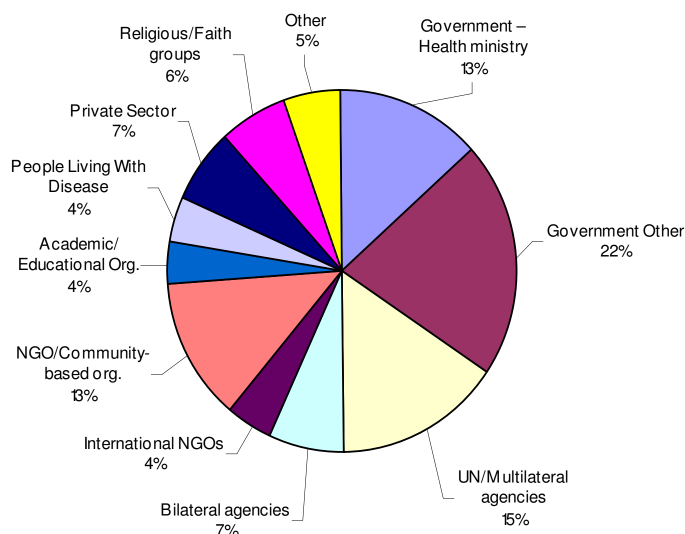
The CCM in Rwanda was set up in January 2002, primarily because it was a condition for the submission of proposals to the GFATM. The process was Government driven, and consisted of the co-option of institutions/organizations from the different constituency groups which were specified in the GF guidelines, with expertise in one or more of the three diseases. Criteria for membership were developed and adopted only in June 2003. (Annex 3: Membership in the CCM Rwanda).

The CCM in Rwanda has 33 members.

- All recommended constituencies: Government, multi/ bilaterals, NGOs, private sector, People Living With HIV/AIDS, academic institutions: are represented in the CCM. Currently, the distribution of membership is as follows:
-

Category	Number of members
Government	12
UN/Multilaterals	5
Bilaterals	3
Civil Society/NGOs	4
Private Sector	1
PLWHA	2
Institutions of Higher Learning/academia	2
Special interest groups	4 (including Camerwa)
Total:	33





This distribution is in line with the average composition found in most countries in the region as shown in Figure 2 and 3: 37% Government; multi/bilateral agencies comprise roughly 24%. The membership has changed substantially over time. During the 1st round submission, the CCM had 23 members. The 3rd round proposal submission was signed by 26 CCM members. The membership list, which includes the latest member Camerwa (Centrale d'Achat des Médicaments au Rwanda) of 31 October, 2003 shows 33 members.[2]

- There is well balanced gender representation with a male to female ratio of approximately 1.5/1.
- Two constituencies, the Ministry of Finance and Economic Planning (Minecofin) and the community of People Living with HIV/AIDS, have a double membership. The ANSP+, an umbrella association for people living with HIV/AIDS, was initially representing this constituency in the CCM. More recently, through the efforts of the government, an official umbrella organization, "Réseau National des PVVIH" (National Network of PLWHA), with an elected chairman was created. This network is now also a member of the CCM. However, since ANSP+ is one of the 8 sub-recipients for the VCTI project, it kept its membership in the CCM.
  The Minecofin's double membership was to ensure that at least one of the representatives would be able to attend the meetings. This was found to be necessary since the Minecofin is the Vice-President of the CCM. This supposes of course that the replacement of a member unable to attend a meeting is admitted.
- The criteria for membership were approved in the CCM meeting of 26 June 2003. One of the criteria specifies that the membership is lost if a member misses two consecutive meetings. Although this rule apparently applies to several members (Annex 4: attendance at the last 5 CCM meetings), loss of membership was never mentioned in the meeting minutes. Five members attended none of those last 5 meetings, but are still included on the list of members of 31/10.

2.2. Governance and organisation

Leadership of CCM

The CCM is chaired by the Ministry of State for HIV/AIDS and Related Diseases (MOS) with two 2 Vice-Presidents: the Minecofin and the WHO Representative. The Vice-President takes over the duties of the President, when the President is on duty travel. The arrangement of having two Vice Presidents ensures that at least one of them will be present during the CCM meetings.

Modus operandi and support structure

- There is no formal agenda for meetings. But the CCM meets very regularly almost on a monthly basis. Eleven ordinary meetings were held in 2003.
- CCM meeting minutes are available for all meetings (Annex 5: CCM meeting minutes). The minutes are sent to all CCM members by electronic mail, usually together with the invitation for the next meeting. Since the meeting of 29/5, lists of participants are also routinely attached to the minutes
- The decision to establish a permanent secretariat to the CCM was taken at the beginning of 2003. Several development partners volunteered to contribute to its

[2] Lux Development (Luxemburg's bilateral development agency) was also accepted as a member, but is not yet included on that list.

functioning. Substantial material and financial resources were provided by WHO, which also accepted the responsibility for the recruitment of a permanent secretary. The recruitment process is, however, substantially delayed by the slow administrative procedures in the WHO Regional Office for Africa. Since August 2003, the duties of the Secretariat are being carried out by the Chief Advisor to the MOS.

Participation in CCM decision-making

- Decision making during meetings is done in a 'democratic way'. Every member has an equivalent vote. Only two or three CCM members were of the opinion that the *'weight'* of Government representatives made decision making somewhat un-democratic. But this was clearly due to the difference of authority and level of position of the various members and not to any regulation in that direction. In particular, civil society representatives expressed their satisfaction with the CCM functioning *"like a round table"*.
- Decisions concerning the location and staffing of the Project Management Unit of the VCTI and regarding the selection and recruitment of the PMU staff were also taken with the involvement of all members of the CCM.
- All CCM members interviewed declared that they had played an effective role in the project formulation process. This was confirmed even by those members whose proposals were rejected as being unsuitable at the country level before submission to GFATM. The NGO Forum, the national umbrella NGO created in 1999 was one of those affected by this decision. Their representative expressed acceptance of this measure and continued to play an active role in the CCM processes.

Communication with constituencies

Most of the CCM members interviewed recognised the importance of consulting their constituents and keeping them informed and involved in the decisions taken by the CCM. To facilitate consultancy and feedback, the Government took the initiative to create six umbrella-organizations over the last six months:

1) 'Bureau de Coordination' of 10 member-NGOs in the NGO Forum, which meets twice a month;
2) the 'Réseau National des PVVIH' (PLWHA) ;
3) the 'Comité interconfessionnel de coordination' for faith-based organizations;
4) APELAS for the private business sector;
5) the 'Government cluster on HIV/AIDS' comprising of the public sector;
6) the 'Cluster of development partners on HIV/AIDS' comprising of multi- and bilateral partners.

The last two are represented in the CCM by several of their individual members; the first 4 of these umbrella-organizations are CCM members. However, the umbrella-FBO and APELAS have so far attended only one meeting. The effectiveness of these mechanisms in ensuring feedback and consultancy process could not be confirmed. Some informants were of the opinion that there is still substantial work to be done.

Technical panels

In order to assist the CCM in reviewing and evaluating project proposals, technical panels of experts were created for HIV/AIDS and Malaria. Each of these panels with about 15 members included both CCM members and non-members. During the recent meeting of 24 October, the CCM gave more autonomy to these technical panels through the nomination of a President, Vice-President and a Secretary for each panel, and gave them the responsibility for appointing experts to their respective panels.

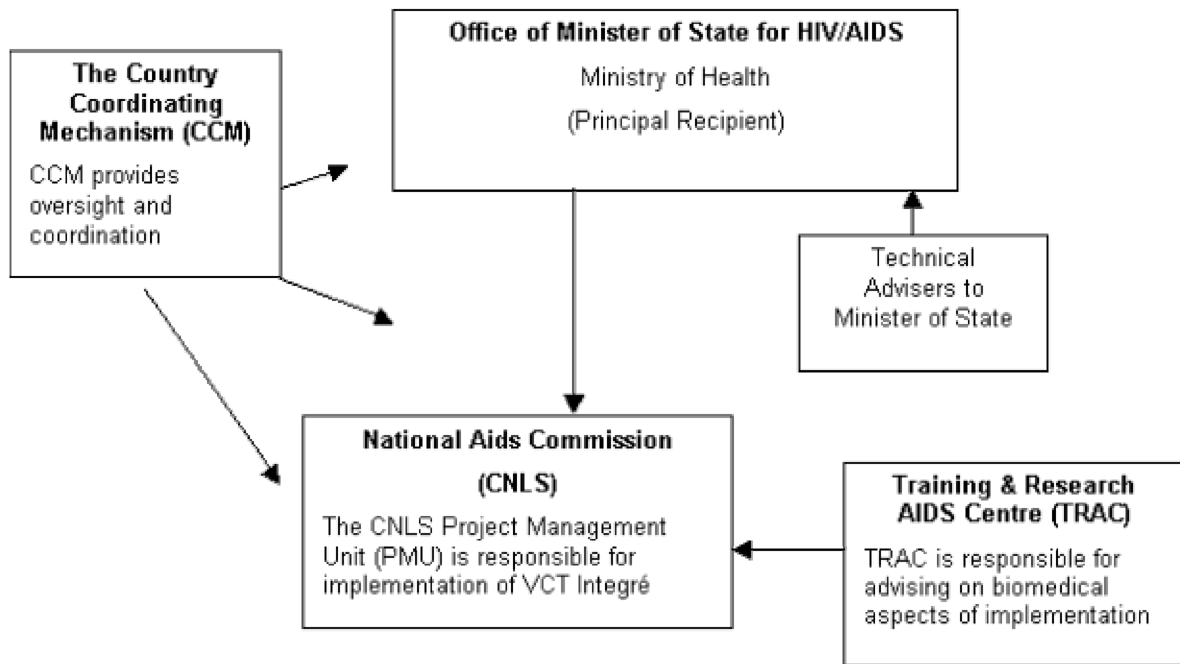
Management tools

An impressive set of management tools have been developed, and are currently available: Terms of Reference of the CCM (Annex 6: TORS), criteria for membership and list of members, composition of technical, post descriptions for CCM (Annex 3: Membership criteria) and PMU staff (Annex 7: TORS), procedures of the CCM (Annex 9), etc. These tools have been very useful for the practical organization of the CCM and PMU, and to determine their mutual relationships. Some of those interviewed expressed the need for the development of other tools, e.g. for financial management and to ensure the accessibility of these to sub-recipients, especially those at a decentralized level.

2.3 Institutional Arrangements for implementation of Global Fund approved grant: PR and PR-CCM relationship

The Rwanda Ministry of Health is the PR and leads the implementation of Global Fund supported activities of the *VCT Integré* programme through the office of the Minister of State for HIV/AIDS. However, the Minister of State has delegated management responsibility to the Project Management Unit (PMU) in the National AIDS Commission (CNLS), which reports to the President's Office. The semi-autonomous Treatment and Research AIDS Centre (TRAC) also has a vital advisory role with respect to the biomedical aspects of the programme. The institutional arrangements illustrated are summarised in the chart below.

Fig.4: Key Institutional Arrangements for
Global Fund VCT Integré Programme in Rwanda



Sub Recipients
The following eight organisations from both the public and civil society were identified as Sub-Recipients for the VCTI project:

1. The Treatment and Research on AIDS Centre (TRAC) responsible for the VCT, PMTCT and treatment of opportunistic infections of AIDS patients, and for the training in those areas of the medical staff in the Health Districts;
2. La Direction de Soins de Santé (DSS) ;
3. The Health Districts;
4. The 'Centrale d'Achat des Médicaments Essentiels du Rwanda' (CAMERWA) ;
5. The National TB and Leprosy Control Programme (PNILT) for testing and treatment in TB clinics;
6. The National Association For Supporting People Living With HIV/AIDS (ANSP+) for home based care and support, micro-credit projects and support to orphans;
7. The Rwanda National Youth Council (RNYC) for the mobilization of youth, in order to increase access to VCTI centres;
8. The National University of Rwanda (UNR).

CAMERWA is the purchasing house for drugs, tests, etc. Most of the implementing partners still need support in different technical areas, such as in project management, monitoring and evaluation, etc. Several development partners provide technical support to meet those needs, e.g. USAID and UN agencies are strengthening the TRAC, UNICEF supports the RNYC in the area of M&E, SIPAA, UNDP and FAO are working with ANSP+, etc.

In May 2003, the Local Fund Agent (LFA) found a conflict of interest in the MOS being at the same time the CCM chair and the PR, which resulted in the resignation of the MOS as CCM chair, and his replacement by the Ministry of Finance (Minecofin) as the interim chair. Though at later period, the MOS was re-established as both CCM chair and PR, while the Minecofin retained the position of second Vice-President.

The MOS does not, as yet, appear to be adequately equipped and staffed to take up its considerable responsibilities and work load. In addition, even if there is no conflict of interest, holding multiple functions, some of which are supposed to oversee others, is demanding and not always easy. For example, the MOS, as PR, is the recipient of the report prepared by the PMU, through the CNLS, of which the PR is the Vice-Chair, and eventually commented upon by the CCM, of which again the PR is the Chair.

The issue of lines of reporting was taken up by the Rwanda CCM during a CCM meeting, which resulted in the decision (Annex 5: item # 8 minutes 21/8/03 meeting) that *"…the PMU reports directly to the PR, and maintains communications with the Secretariat of the CCM"* is therefore an appropriate one. It would be useful to explicitly reflect this decision in the 'Terms of reference of the CCM – Rwanda', under item 4. 'Reporting'. (Annex 6)

2.4 **Institutional set-up and linkages with other related bodies**

Contradictory as it may sound, the CCM in Rwanda appears on organigram (Annex 10[3]: organigrams) as a quite loose entity, floating somewhere between the CNLS, the PMU of the Global Fund approved grants and the MOS. In practice, it is very well connected with all these units, as well as with most of the important actors in the field of HIV/AIDS, tuberculosis and malaria. The reason for this is multifold:

- The Minister of State is the President of the CCM, and Vice-Chair of the CNLS[4]. Through the Minister of State, the connection is made between the CCM and the technical units of the Ministry of Health: the Treatment and Research on AIDS Center (TRAC), the Programme National de Lutte contre la Tuberculose (PNLT) and the Programme National de Lutte Contre le Paludisme (PNLP);
- There is strong political commitment from top leadership. The Office of the President takes a keen interest in the functioning of the CCM. Both the Office of the President and PACFA ("Protection and Care for Families against HIV/AIDS"), an initiative of the First Lady's Office, are active members of the CCM;
- The Executive Secretary of the CNLS and MOS who have the responsibility for the PMU of the GFATM supported project, VCTI and the Executive Secretary of MOS are strong personalities and extremely motivated. They have developed a close collaborative process of working with each other;
- The coordinator of the PMU of the VCTI reports on a monthly basis to the CCM, and attends the CCM meetings as a non voting member.

[3] The 3rd diagramme was drawn from the step 2 assessment report of the PR, by the LFA, which is still in draft. This organigram contains an error, in that it links the Training & Research on AIDS Center (TRAC) directly to the CNLS instead of to the Office of the Minister of State.
[4] As such, the MOS represents the CNLS in the Cabinet of Ministers. The Chair of the CNLS is Bishop Kolini, but this seems to be rather an honorary position.

Some of the leading CCM members clearly stated that the CCM is not meant to have institutional links with other related bodies, since its primary roles are to supervise the development of GFATM supported projects, to coordinate and to monitor their implementation, but *not* to implement or manage them. During discussions, it became clear that the role of the CCM and its linkages to the various related bodies is not very clear to those involved. This is demonstrated in the organigram drawn by different partners. Each of these organigrams shows a different linkage to the CCM. The LFA, in its 1st assessment report, reported that the CCM's role was not sufficiently specified. Even if collaboration is currently excellent, it is recommended that the linkage of the CCM with other bodies, in particular the lines of reporting, be streamlined.

Harmonization and coordination with national fora, policies and programmes.
The government had proposed that the PMU established for the World Bank's Multisectoral AIDS Programme MAP be expanded to undertake the *management of the HIV/AIDS component* of the GFATM supported projects i.e. the VCTI. This proposal was accepted and adopted by the CCM. The World Bank did not agree to this arrangement since it was of the opinion that one PMU could not manage two important large projects at the same time. This led the CCM to establish a separate PMU. However both PMUs are integral parts of the CNLS, housed in the same building and have good working relationship through a "Comité de Collaboration". This Committee meets on a weekly basis. Through this close collaboration, the CNLS can support the CCM in the monitoring of implementation and in meeting reporting procedures.

The collaboration between the CNLS and the GFATM supported project is further facilitated through the Executive Secretary of the CNLS being a CCM member and the MOS, the CCM Chair. Despite this close collaboration, it must be pointed out that some management structures have been duplicated through the establishment of separate units each for the management of the World Bank's MAP, for the GFATM supported VCTI project, in parallel with the management structures within the MOH. The MOH management structures would have needed serious capacity strengthening it was given the responsibility to manage such large scale projects.

As a result, the responsibilities for the direct management of HIV/AIDS projects has shifted away from the Ministry of Health and the Ministry of State specifically created to deal with HIV/AIDS and related epidemic towards the CNLS, which is under the Office of the President. This, in itself, is of course not an issue, since it facilitates a more multisectoral approach for HIV/AIDS prevention and care action. In addition the CNLS is a strong and well functioning body. But further expansion of GF supported projects may still lead to the creation of the respective Project Management Units. The decision has already been made that the management of the malaria component of the GF 3rd round projects will be placed within the PNLP (National Malaria Programme). The decision concerning the management of the future ARV distribution project is still pending. However whether it is placed within the CNLS alongside the PMU of the VCTI or in the TRAC, it will still lead to setting up of additional management structures. This may not facilitate coordination, reporting, etc.

3. Strengths of the Rwanda CCM

Political commitment

- Strong political commitment and support from the highest authorities in the country, as shown by the active involvement of the Office of the President and by the First Lady's initiative, PACFA, has strengthened the position of the CCM within the country. This has also motivated the other members of the CCM and contributed to their active participation.
- All key positions – within the CCM, but also in related bodies such as CNLS or PMU of the VCTI – are held by very strong, competent and highly motivated individuals. Their regular attendance and full participation and that of other important constituents such as UNAIDS, USAID, PSI have made the CCM an important decision making body in the country.
- The creation of umbrella-organizations by the government has facilitated the true representation of civil society. One such example is the "Reseau National des PVVIH' (National Network of People Living With HIV/AIDS). This has contributed to making the CCM membership all inclusive and to improving and expanding public-private partnerships. Most of the members are highly motivated and participate actively in the meetings, even if these meetings are time consuming, and occasionally held on Saturdays, which is a public holiday in Rwanda. (Annex 4: Attendance at CCM meetings).

Governance processes which facilitate true participation

- **The development and use of a number of management tools** by the CCM: TORS, Criteria for Membership; Composition and Roles of Technical Panels; post description for CCM secretariat and PMU staff; Procedures for CCM functioning have all contributed to strengthening the organisation and functioning of the CCM;
- **The institutionalisation of exchange of experience and know-how between the two management units** through the creation of a "Comité de collaboration", which meets regularly, has facilitated implementation. The CNLS, of which the PMUs of both MAP and VCTI are integral members, is a strong and unifying body. This has also led to the CNLS to provide support to the CCM in coordination and reporting procedures etc.
- **The development of a regular reporting system** from the PMU of the VCTI to both the CNLS and the CCM. 'Flash reports' of 1 to maximum 2 pages are sent on a weekly and monthly basis (Annex 11: Flash reports). The PMU of the VCTI has just developed a reporting model to be used by the various sub-recipients, in order to facilitate the development of consolidated quarterly reporting.
- **Regular communication and sharing of minutes among all CCM members has contributed towards openness and transparency**. E-mail is routinely used for communication among all CCM members. It is rapid and imposes few constraints to its users.
- **The participatory process of decision-making** has led to a strong feeling of ownership by all members, who feel *"useful and respected*", and hence motivated to bring effective support from their constituencies. Decisions on priorities and other important issues are taken strictly collegially, each member having an equivalent vote. One of the usually less vocal members confirmed this

decision making process when he proudly said *“I can even challenge the Minister”.*

The willingness and cooperation of both multi- and bilateral development partners to provide technical assistance to CCM members as and when needed. For example:

- GTZ, UNAIDS, UNDP immediately offered to provide provisional arrangement while a secretary was being recruited for the CCM.
- GTZ, whose attention had been drawn to the urgent need for massive capacity building, immediately offered support, through fast mode mechanisms, for the training of trainers in project management. This also well demonstrates the advantage of synergetic action of public-private partnership where ‘stronger’ partners provide technical support to those in need.

This fast and immediate response from partners together with political commitment and effective CCM processes has facilitated implementation with the work-plan being implemented on schedule.

4. Challenges to strengthening the CCM

Guidelines and clarity on procedures

The GFATM guidelines themselves have from time to time been criticized for their lack of clarity. The recently developed ‘Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms’ has resolved most of the uncertainties concerning the CCM functioning.

- Due to the initial lack of clarity, but even more due to the flexibility built into the guidelines, the lines of authority and of reporting between the CCM with other related bodies, were sometimes interpreted in different ways by different partners. In particular, the guidelines on reporting from the PMU to higher levels create problems. For example where the positions of PR and CCM chair are filled by different persons, the CCM would not *automatically* be informed about decisions taken in the PMU, since the latter reports *directly* to the PR. The same situation is less likely, but could still occur when both positions rest with the same person or constituency as is the case in Rwanda. There is likelihood for the PR to *‘forget’* to function as CCM chair and share important information with the CCM.

- Lines of authority and reporting between the various institutions related to GFATM supported projects are still not understood (eg. PMU-TRAC, CCM-PMU, etc.). The dual role of the MOS, as both the PR (to whom the PMU has to report, through the CNLS) and the Chair of the CCM (which has to approve all major decisions of the PMU), is therefore crucial in the fulfilment of the CCM’s responsibilities.

Integration versus duplication of management structures

Attempts to integrate management and monitoring structures into existing ones have not always been successful and would need some reconsideration:

- The Government’s will to integrate the management of the VCTI project into the MAP PMU could not be realised because the World Bank was of the opinion that the MAP PMU did not have the capacity to manage two major project;
- Duplication of management structures between the PMU of the VCTI and the technical Departments of the Ministry of State has been created by the

establishment, within the PMU of 3 posts of Project Manager ("Chargé de Projet")[5], to *'monitor and evaluate the DSS and Health District component of the VCTI* to be implemented by the sub-recipients.(Annex 14: TORS). These technical units are under the direct line of authority of the MOS;

- To a certain extent, the CCM itself, at its creation, overlapped with then existing coordination structures, such as the Expanded Theme Group on HIV/AIDS. The functions of the latter were later taken over partly by the CNLS, and partly by the 'Donor cluster on HIV/AIDS' of the Development Partners Coordination Group, while the Theme Group on HIV/AIDS has again become *UN*TG, i.e. restricted to UN Agencies;
- If the practice of establishing new PMUs for other GF funded HIV/AIDS projects is continued, instead of strengthening existing management structures for example the TRAC for the distribution of ARV and other care for AIDS patients, the management structures for GF supported projects may become rather heavy[6]. This might further contribute to the existing imbalance of management between CNLS and MOS.

In summary, the development and implementation of GFATM supported projects have not favoured the mainstreaming of HIV/AIDS into the broader development agenda but have instead reinforced the vertical structure of related programmes. But from a *practical* perspective, GFATM supported projects have been an opportunity to create effective and (almost) all-inclusive partnerships through CCM, and have brought the various constituencies to accelerate and to take forward the HIV/AIDS prevention and care in the country.

The recent development by the Government, with the assistance of the Clinton Foundation, of an all-inclusive national plan, incorporating MAP, GFATM and other HIV/AIDS projects, may be an opportunity to re-think and eventually review the institutional set-up of the entire HIV/AIDS programme, in view of improved efficiency and coordination.

Attendance at CCM meetings

- CCM meeting attendance records indicate that not all CCM members attend the meetings regularly. Based on the attendance list, some CCM members: Ministry of Defence, Ministry of Education, Profemme, ANSP+ [7], and Cestral, the trade union group have never attended a meeting at least not since May 2003, when lists of participants became available. The faith based organizations and the private sectors do not have a positive attendance record either - their respective representatives have attended only one meeting. Even the WHO representative, despite being the Vice president has only participated in two of the last five CCM meetings.

[5] Three such positions were created in the PMU of the VCTI, each one to manage the GF projects carried out by a few sub-recipients: 1 for DSS and Health Districts, 1 for TRAC, PNILT and UNR, and 1 for ANSP+, NYC and Camerwa. Their terms of reference are attached in Annex 9

[6] Staffing needs for the PMU, as identified and approved by the CCM in its meeting of 26 June, are attached in Annex 14

[7] This is a surprising fact for ANSP+, which is one of the 8 sub-recipients for the VCTI project. It should be mentioned though, that the recently created 'Réseau National', an umbrella association of PLWHA – and thus including the ANSP+ -, attended 2 of the last 4 meetings.

- An additional issue is the rapid turn-over among the representatives of some constituencies for eg. PACFA, Réseau National, ANSP+. Advocacy and other measures are under way to promote regular meetings attendance of all CCM members. Some members, however, recommend that in order to sustain member's motivation to participate in meetings, an attendance fee should be paid.
- There seems to be a tendency to announce meetings with very short notice: 3 of the last 6 meetings were announced just the day before. This poses problems to the members to appropriately prepare the meetings, to read related documents in advance, etc.

Communication among CCM members

- Communication among members especially that representing the civil society – and their constituencies is not always optimal. The NGO Forum tries its best to remedy this situation through the establishment of a 'Coordination Bureau' of 10 member NGOs, who meet twice a month, while the 'General Assembly' of all 82 members meets once every 2 months.
- Though, communication among CCM members, although much facilitated by the extensive use of E-mail, is also subject to frequent breakdowns of telephone lines, computer equipment, etc.

A communication strategy to ensure consultation and feedback with constituencies would need to be developed.

Other practical issues

- **Slow recruitment procedures** have resulted in the critical post of permanent secretary of the CCM being vacant since the beginning of 2003. Though the duties of the Secretariat are being carried out in the interim by the Chief Advisor to the MOS[8] since her arrival in the country in August 2003, the CCM members see the need for a full-time permanent secretary. (Annex 13: TORS, CCM Secretary)
- While the CCM is aware of its responsibility for the mobilisation of additional resources for the fight against HIV/AIDS, tuberculosis and malaria, some of its members still seem to expect the Global Fund to bear the entire responsibility for ensuring sustainability. The international partners perfectly understand and assume this responsibility, as illustrated by their prompt intervention when unforeseen problems arise. Several additional initiatives focus on ensuring sustainability, such as:
  - a special Task Force for continuous resource mobilization, created by the Ministry of State;
  - the existing Development Partners Coordination Group, or 'Donor Cluster'.

[8] Position financed through USAID

5. Review of needs and technical support

The Implementation of the VCTI project is on track. Capacity building has been ongoing for a long time. But there is further need for capacity building in the following three areas:

Needs of sub-recipients

The sub-recipients will need substantial capacity building to implement and monitor the activities planned and to provide timely financial and activity reports. The TRAC, one of the 8 sub-recipients for the implementation of the VCTI project, responsible for the capacity building of medical staff in Health Districts, acknowledged that it is currently ill equipped to carry out the training activities. The MOS is of the opinion that the TRAC, which was recently reorganized and newly staffed, would need to be strengthened with long-term international technical assistance.

GTZ, has offered to assist the TRAC with an initial ‘training of trainers’. Other development partners, such as UNDP, UNICEF, USAID as well as the World Bank through the MAP have developed plans to support capacity building of the various sub-recipients.

Technical needs of members of the civil society

- Members of the civil society themselves recognise the need for skills building in project formulation. This was confirmed by the leader of the NGO Forum. Though they fully participated in the submission to all 3 rounds, it was clear that NGOs were, more than others, handicapped by the lack of capacity in proposal development. This, in addition to the tight deadline for project development and submission could have been the cause for skewed selection of project proposals - leading to around 85 % Government beneficiaries in both the 1st and 3rd round).

  An important human resource strengthening project was initiated by the DFID funded initiative *Support to the International Partnership against AIDS in Africa* Though the focus of this project is on decentralized Government structures, such as provincial and district AIDS commissions, it will also provide support to NGOs, PLWHAs and Faith Based Organizations in several countries in Africa. The project will offer training in project management and coordination, financial management, monitoring and evaluation, report writing as well as in other related programme areas. The project, to be implemented by Action Aid, was substantially delayed in Rwanda, but is now set to start before the end of 2003.

- The need explicitly mentioned during the individual meetings and the debriefing meeting was that the CCM should be provided with sufficient resources for its own functioning. Since the CCM is aware of the fact that no *additional* budget can be made available for that purpose, some members proposed that sufficient flexibility be allowed for budget (re-)allocation for the grants approved. Another possibility would be for the government to consider supporting the functioning of the CCM.

Due to strong Government commitment, the implementation of the activities will probably take place as planned in spite of the weak infrastructure and limited human capacity especially at the decentralised levels of implementation. However, as the UN Resident Coordinator very eloquently put it: “*We need to close the gap between commitment and capacity to deliver.*” Development partners, bilateral as well as multilateral, have a crucial role to play in that process.

6. Recommendations

To the Global Fund:

- To further clarify the guidelines concerning the CCM role, responsibilities and functioning, while allowing sufficient flexibility for adaptation to each individual situation and country;
- To allow sufficient flexibility in budget (re-)allocation for capacity building of sub-recipients and of civil society members of the CCM in implementation, monitoring and evaluation, when the need for capacity building had initially been under-estimated in the proposal submitted;
- To encourage governments and bilateral/multilateral partners to ensure that resources are available and systems in place for logistical support to the CCMs, to support members to attend meetings and for their feedback and consultation with their constituencies;
- To encourage the various development partners to coordinate and harmonize the financial, management, monitoring and evaluation as well as reporting systems of the programmes they support in the country.

To the CCM:

- To clarify and formalize lines of authority and reporting between the CCM and related management and coordinating bodies;
- To announce CCM meetings and send related documents in a timely way, in order to allow appropriate preparation of the meetings by all members;
- To review the list of CCM members, on the basis of their assiduity in attending the meetings, while avoiding double membership for the same constituency, and eventually reconsider the need to have a double Vice-Chairmanship (keeping the membership to a minimum is useful when a 2/3 quorum is required for valid voting or other important decision making);
- To take all necessary measures for capacity building of certain CCM members and/or sub-recipients for the formulation of project proposals, and for the implementation, management and monitoring of approved projects. To call on international development partners (UN and others) for assistance in this area;
- To promote and develop a two-way communication strategy between CCM members and their constituencies: members consulting their constituents, and providing regular feedback to them;
- To ensure that guidelines and management tools are easily accessible (as far as availability as well as comprehension are concerned) for decentralized sub-recipients and other actors (e.g. health districts).