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Review of Health Partner Engagement with the Ministry of Health, Mozambique

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Abbreviations

ACA	Joint Annual Review
CCC	Joint Coordination Committee
CCC-A	Enlarged Joint Coordination Committee
CCS	Health Coordination Council
DNPO	National Directorate for Planning and Budgeting of the MOF
FP	Focal Partner
FPT	Focal Partner Team
G-19	Group of 19 Development Partners
GOM	Government of the Republic of Mozambique
GTM	Medicines and Logistics Working Group
H&A	Harmonisation and Alignment
HOC	Head of Cooperation
HOM	Head of Mission
HPG	Health Partners Group
HRH	Human Resources for Health
IHP+	International Health Partnership Plus
M&E	Monitoring and Evaluation
MISAU	Ministry of Health (of Mozambique)
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium term Expenditure Framework
NGO	Non Governmental Organisation
PAP	Programme Aid Partners
PARPA	Poverty Reduction Strategy
PELF	Strategic Plan for Pharmaceuticals
PES	Economic and Social Plan
PESS	Health Sector Strategic Plan
PFM	Public Finance Management
SBS	Sector Budget Support
SWAp	Sector-wide Approach
TA	Technical Assistance
UNICEF	United Nations Children's Fund
WG	Working Group
WHO	World Health Organisation

1. Executive Summary

The primary purpose of this assignment was to review the Health Partner Group (HPG) functions and structure in order to maximise effective engagement with MISAU. This is covered in section 3 of the report.

1.1 Capacity issues at HPG and WG level

Mapping of skills gaps at HPG and Working Group (WG) level was not possible in the intended way, partly for time reasons but mainly because the Aid Effectiveness Working Groups are still incipient structures at formation stage. WG co-Chairs interviewed for this assignment were of the opinion that a more fundamental problem than capacity at WG level was weak capacity at the level of the counterparts - MISAU departments and units - with whom development partners (DPs) are attempting to engage in the WGs. It was therefore suggested that improved focus on institutional capacity building, including improved understanding of MISAU capacity gaps should receive greater attention by DPs.

There is consensus that WGs have a potential to improve engagement and capacity building matters as long as they are able to reorient their attention from technical matters to a focus on aid effectiveness.

The **technical capacity** of the 6 WGs comes from two sources: one source is MISAU staff and advisors based within MISAU who participate in the WG. Another source of skills are the representatives of each of the agencies active in the WG. This pool of skills is occasionally supplemented by bringing in additional skills, through either inviting experts already based in the DP country offices or through contracting in technical assistance for specific tasks that each group may require (see Annex 4). The following points have been made on the issue of enabling greater access to key skills to the HPG and its Aid Effectiveness Working Groups:

1. There are considerable **variations** in both the **access** to technical skills by each WG as in the perceived **importance** that WG Chairs and co-Chairs attribute to the need for the WG to access additional technical skills. In most cases this was linked to **different levels of consolidation of each Working Group** in terms of defining membership, adopting standard working practices or achieving the required clarity of mission among its members. On this note an initial **recommendation** is for Chairs and co-Chairs to take the lead in **systematically mapping** essential skills needed and to compare these with the pool of available technical skills, as a means to **establish any perceived capacity gaps**.
2. The **primary option** for addressing capacity gaps at Working Group level should be to **draw from the pool of skills** (staff & advisers) **already available at the DP agencies** that make up the WG. However, it is important for any such arrangements to **be formalised and made explicit** in order to take account of the fact that technical capacity within DPs can change rapidly. By formalising these arrangements WGs would become better prepared to deal with eventual changes to the skills mix pool linked to changes at the DP level.
3. If or when DPs are unable to mobilise staff or advisers already available to their country offices, or should that support prove insufficient in terms of continuity of engagement is when **the option of contracting in additional skills might be**

considered. Should this option be favoured one would expect attention being placed on the following matters:

- a. The contracting option should be discussed within the FPT and communicated formally to the HPG and to the MOH Chair of the WG in order to avoid any misinterpretations about the purpose of bringing in one new person to the WG.
- b. It is recommended that 2-3 year contracts (with the required probation periods) should be preferred to shorter, one year contracts in order to foster continuity of advice by the contracted advisers as well as to strengthen engagement and institutional memory within the WG.
- c. Within the perspective of 2-3 year contracts the HPG might consider full time or part time contracts depending on the needs. Part time advisers were generally seen by co-Chairs interviewed as a better option than full time advisers or than the setting of a “technical secretariat” type of structure. The main justification given was that the inputs of the advisers would be required only at specific moments in the annual planning cycle and that a part time adviser would be more acceptable to some WG Chairs, for whom a full time adviser or a “technical secretariat” might look like an unnecessarily “heavy” arrangement. In any case, it would seem appropriate to discuss the modalities with the respective WG Chair.
- d. Co-Chairs expressed the view that advisers supporting the WG should reside in Mozambique and be (or soon become) functional Portuguese speakers.
- e. Clear TOR should be developed for the contracted advisers, and these should include, among others, an effort to better map out capacity gaps at the level of the MOH in any key areas, with a view to helping the HPG take a more proactive role in dealing with the said MOH capacity gaps, as mentioned earlier.

Other suggestions made in the body of the report to improve the workings of the HPG and the WGs for improved information sharing, greater focus on harmonisation and alignment and improved policy engagement and dialogue include renewed efforts towards:

- Professional management of the HPG and WG structures, including more effective working practices and systematic management of meetings and relationships;
- Explicit commitment by agencies taking up the roles of FP and co-Chairs to provide the required time and resources to their staff;
- Improved election procedures and stronger induction of members of the HPG and WGs for them to practice division of labour;
- Effective delegation of responsibilities to DP staff who volunteer for these positions by HPG members based on trust and effective delegation of responsibilities;
- Improved focus of HPG and WGs on capacity building at the level of MISAU counterparts through improved mapping of skills needs and gaps and more effective targeting and mapping of long and short term TA.

1.2 Is there interest in a TA pool fund?

A second purpose of this assignment was to identify, on a very preliminary basis, the interest of MISAU in the creation of a TA pooled fund, and to identify the potential utility of such a fund in increasing MISAU capacity to respond to priorities defined through CCS, CCC and Working Group recommendations. This is covered in section 4 of the main report.

The assessment contained in Section 4 suggests that there is indeed an interest on the part of MISAU for the establishment of a TA fund available to MISAU. However, it is recommended that before going down that route the HPG should take a more proactive stance and role in resolving TA coordination matters linked to DP practices through a more systematic assessment of TA-related issues and options. The HPG is also encouraged to use existing structures such as the Working Groups to better, jointly assess TA needs through improved focus on institutional capacity building at MISAU level. Undertaking clear steps towards greater coordination, harmonisation and alignment of TA delivered to MISAU is an integral part of the SWAp that seems to be long overdue.

2. Introduction

2.1 Background

In order to keep this report to the required length specified in the TOR, most background information and some of the analysis can be found in the annexes. For background to this assignment readers are referred to Annex 1 for the full TOR. An assumption has been made throughout the report that the primary stakeholders and potential beneficiaries of this report – the health Development Partners of Mozambique and their government health counterparts - are all familiar with the institutional arrangements governing the Mozambique health SWAp.

2.2 Objectives and report structure

The primary purpose of the assignment was to review the Health Partner Group functions and structure to maximise effective engagement with MISAU. This is covered in section 3 of the report.

Specific objectives included:

- To identify the set of skills and competencies that should be available to the HPG, in order to effectively perform HPG's oversight function;
- To consider the current skill and competency profile of HPG against the demands placed on the various HPG structures (including Working Groups) and determine whether there are key areas of competency that need to be strengthened;
- To develop terms of reference for whole or part time inputs to maximise the effective skill profile if this is considered necessary;
- To assess whether this mechanism can improve institutional memory in the HPG for it to provide technical and coordination support to the MISAU;
- To identify mechanisms for mobilising additional skills in support of effective HPG engagement, whether this be drawing upon broader skill sets already available in country within agencies, contracting in additional support for specific areas, or creating whole or part time posts to provide specific skills, which might be mobilised by partners working in the sector.

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2.3 Approach to the assignment

In accordance with the scope of work (see Annex 1) the consultant:

- a. Conducted a desk review of experience in other SWAp countries, highlighting different models of donor organisation, drawing on existing evidence of what works well and issues and challenges for effective coordination of development partner support to health. A summary of issues identified during the desk review, the list of documents used and the names of the key informants who provided additional information on country specific coordination arrangements are included as Annex 3.

- b. Reviewed HPG functions and structures and assessed whether they are fit for purpose. This was conducted through:
- Consultation with Health Partners, firstly through an email questionnaire sent 2 weeks before the visit to Maputo in order to map the main issues and to guide the interviews to be held subsequently with each development partner in Maputo. 13 questionnaires were received from 11 agencies represented in HPG. The questionnaire has been included as Annex 5.
 - Person to person interviews were held with health partners, MISAU senior officers and some advisers currently providing technical support to MISAU. The list of persons met is included in Annex 2.
 - Consultation with government officers to determine the perceived characteristics of effective health partners and the effectiveness of existing coordination arrangements.
- c. Reviewed current HPG capacity and competence and the time demands placed upon key roles (notably working group co-Chairs). This was attempted through individual interviews with most Chairs and Co-chairs from the “aid effectiveness” Working Groups.
- d. Identified demand within MISAU for the creation of a TA pooled fund, and considered whether and how such a fund might be used in order to increase MISAU capacity to respond to demands emerging from CCS, CCC and Working Group recommendations. To achieve this the consultant:
- Met with members of a newly constituted TA task force led by WHO. This group attempted to map out main TA being provided by development partners to MISAU: They used a questionnaire for this purpose but the response was limited and the time available too short for the mapping to be sufficiently complete.
 - Met with senior MISAU officers to explore demand for and views on pooled TA.
 - Met with several advisors delivering TA to MISAU in order for the consultant to better understand TA provision within MISAU and capacity issues.

2.4 Limitations of the assignment

The reviewer had to appraise coordination arrangements within a relatively short period of time (7 working days) by interviewing a sample of key informants, which allowed for only one interview with most of them. This did not always allow for time to cover all the issues in sufficient depth or to explore and appraise possible options with informants in terms of improving coordination arrangements or assessing the demand for TA within MISAU. A two pronged approach might have worked better for the consultant to deliver a more rounded assessment of issues and options, and more consensus on the options, by first doing a diagnosis of key issues and then exploring options for improvement with each informant. This was not possible in the short time available. The timing of the visit to Maputo, which coincided with the annual meeting of the Conselho Nacional de Saude also limited the availability of senior MISAU staff to meet with the consultant.

The issues mentioned above also limited the assessment of demand for a TA pooled fund, particularly in the absence of a map of TA being currently delivered by health partners to MISAU. As explained earlier the mapping that was attempted by the TA task force produced limited results (few questionnaires were returned) and the assessment of needs could only be superficially done by the consultant in the time available. The willingness of agencies to fund a notional TA pool fund was also superficially explored and limited by the fact that agencies could not be presented at this stage with a sample of options for their appraisal.

These limitations have been taken into account at the time of suggesting next steps to take forward the issues and options discussed in the main body of the report.

2.5 Acknowledgements

In spite of time pressures the reviewer would like to thank all busy MISAU officers, health partners and advisers who found time to meet with him. In addition to all the persons listed in Annex 2 the reviewer would like to acknowledge the support received from Ferdinando Almeida, Etelvina Mahanjane, Marco Gerritsen, Hilde de Graeve and Neil Squires for arranging the agenda of meetings at short notice.

The consultant is also indebted to the following persons for providing additional information and documentation on other health SWAps: Catriona Waddington (HLSP) on Ethiopia; Mark Pearson (HLSP) on Malawi; Clare Dickinson (HLSP) on several countries, Liva Sorman Nath (SIDA Bangladesh) and Ulrika Hertel (SIDA Uganda) on Uganda; Andrew Jennings and Shahrukh Safi (AusAID Bangladesh) on Nepal and Bangladesh, Shoko Sato (JICA), on Cambodia.

3. Review of Health Partner Group functions and structures

3.1 Summary of coordination arrangements and progress to date

Within a relatively short time Mozambique has developed a well established Sector Wide Approach (SWAp) which brings together 26 different partner agencies in support of the national strategic plan for health (PESS). A number of partners supporting the SWAp provide their support through a pooled funding instrument, called PROSAUDE, with some donors providing their aid as Sector Budget Support (SBS). A Memorandum of Understanding governs the relationship between government and development partners engaged in PROSAUDE, and a code of conduct governs the engagement of all partners who are supporting the SWAp. Mozambique is a signatory to the International Health Partnership (IHP+) and has an IHP compact, which reaffirms the commitment of all partners to increasingly harmonise and align their support with nationally defined priorities.

The main objectives of all DPs operating within the Mozambique health SWAp are to, increasingly:

- a. Improve the quality of the dialogue on health between government and its partners;
- b. Harmonise donor assistance modalities with government systems through a Sector-Wide Approach (SWAp), advocating for increased commitment to the Paris Declaration on Aid Effectiveness;
- c. Ensure that partner programmes are in line with the declared Government Strategy and Policy as much as possible;
- d. Work to align donors' funding and reporting cycles with those of Government;
- e. Strive for consensus amongst all partners on key issues relating to the Health Sector in Mozambique;
- f. Coordinate the position of partners in all official communication with MISAU;
- g. Reduce the transaction costs for MISAU in the management and coordination of external inputs.¹

The reason for outlining these objectives at this point is because all coordination arrangements and linked capacity issues discussed in this report should support the attainment of these objectives among all health development partners.

3.1.1 The Health Partner Group and related structures and mechanisms

The Health Partner Group (HPG) represents all development partners supporting the Mozambique health sector. The HPG is led by a Focal Partner (FP) which is the elected partner agency who leads policy dialogue with the Ministry of Health (MISAU). Currently the focal partner is elected for a 2 year mandate. The FP works within a troika structure – with a vice focal partner, who is either the out-going FP, or the incoming focal partner. A second vice Focal Partner is one of the UN agencies, with this role being allocated on a rotational basis. In addition to the Troika, the Focal and vice focal partners are supported by a Focal Partner Team (FPT), which is an informal structure created to provide advice to the Focal Partner. The FPT includes a coordinator (normally contracted by the Focal Partner), who ensures effective and regular communication between partners and between HPG and government. Other

¹ Taken from the TOR of the Health partners Coordination Framework, version August 2007.

members of the FPT (referred to as FPT+), include the chairs of the Working Groups (see below) and a representative of the US Government agencies (USAID and CDC) an arrangement made to reflect the size of USG support.

The **Health Partner Group (HPG) meets on a monthly basis** and brings together all agencies funding activities in the health sector, as well as including representatives of civil society (NAIMA & MONASO). Meetings between the HPG and government are formalised through structures which are described in the Memorandum of Understanding. Key meetings include:

- A **monthly joint coordination meeting (CCC)** involving the Permanent Secretary and Directors of MISAU with the FPT;
- **Open CCC meetings** (known as “enlarged CCC” or “CCC Alargado” (CCC-A) when all partners are invited. Periodicity of CCC-A is not set and depends on need as perceived by either DPs or MISAU. An important CCC-A meeting takes place every year at the time of the joint annual review (ACA) when the review report prepared by the external consultants and MISAU members of the team, is presented;
- In addition, two **sector coordination committee (CCS)** meetings are held every year. These are chaired by the Minister of Health and comprise his/her cabinet, selected provincial health directors (on a rotating basis) and the representatives from development partners active in health, including some Heads of Mission/Heads of Cooperation (HOM/HOC). The forum endorses key reports and recommendations (such as those emerging from the joint annual reviews), and informs development partners of significant issues or decisions relating to health sector policy, especially focusing on MOH Annual Operation Plans (known as the PES) for the following year.

3.1.2 The Aid Effectiveness Working Groups

Engagement between MISAU and Health Partners also occurs at both policy and technical level through **Working Groups**. There are 6 working groups formally linked to the SWAp structures known as the “Aid Effectiveness Working Groups” (hereafter Working Groups (WG). These have been recently reduced from 10 pre-existing working groups. The 6 newly constituted WGs are:

- (i) **Public Financial Management** (hereafter PFM WG) covering financial management and audit issues but also those relating to the health budget preparation and approval);
- (ii) **Monitoring and Evaluation** (hereafter M&E WG) covering planning, investments, monitoring and evaluation;
- (iii) **Human Resources for Health** (hereafter HRH WG);
- (iv) **Medicines & Supply Chain Logistics and Management** (hereafter Med&L WG);
- (v) **National Health Services** (hereafter HS&P WG) covering national health services and programmes;
- (vi) **Engagement with NGOs** (hereafter NGO WG).

These WGs are expected to have an oversight function. Each WG has a Chair – who is normally a director from the Ministry of Health, and a co-Chair, represented by one of the DPs. The co-Chair positions are appointed on a voluntary basis – and depend upon agencies allowing their representative sufficient time to take on the

role. The amount of time individuals have for the tasks can vary considerably. In addition to these aid effectiveness working groups there is technical support delivered through other working groups working directly with MISAU staff to support technical aspects of policy development and implementation. However, **for the purpose of this review, the focus will be on the “aid effectiveness” Working Groups.**

3.2 Capacity to engage effectively at HPG level

To discuss capacity issues for HPG and WGs to effectively engage with MISAU a simple analytical framework is used in this report. This framework assumes that effective capacity transfers and engagement are a result of the following components.

Table 1: Simple analytical framework to analyse capacity issues

Analytical framework to analyse capacity issues		
	Development Partner Level HPG & WGs	MISAU level WGs
The “right” people	<ul style="list-style-type: none"> Do FP and Co-Chairs have the time and resources available to them to perform their role? Do they know what is expected of them? Do they have the right attitudes and skills in networking and coordination? 	<ul style="list-style-type: none"> Do MISAU Chairs have time and resources to perform their role? Do they know what is expected of them? Do they have the right attitudes and skills in networking and coordination?
With access to the right skills	<ul style="list-style-type: none"> What are the essential technical and related skills necessary, particularly at WG level? Do WG have access to those skills, and how? 	
Using appropriate structures for engagement	<ul style="list-style-type: none"> Do the existing structures have clear & realistic TOR? Do structures use the right dynamics to approach their role systematically and effectively? 	

In order to cover these areas in the analysis the consultant looked first at issues concerning DPs (firstly addressing HPG and then WG issues as this was the main focus of the assignment) and then looked briefly at similar issues at the level of MISAU.

3.2.1 Issues identified at HPG level

The HPG is the primary coordination structure for health DPs (the HPG TOR have been included in Box 1 below).

The following issues emerged during interviews with health DPs, MISAU officers and in the questionnaires that 13 members of the HPG (from 11 agencies) submitted to the reviewer.²

² To keep matters short and simple issues relating to various HPG structures (HPG meetings, CCC, CCC-A, FPT, etcetera) are discussed together in this section.

Using appropriate structures for engagement: perceived effectiveness of HPG meetings

- 1) The widely held views are that existing coordination structures are sufficient but that the real issues is **poor compliance with existing partnership arrangements** on all sides (DP & MISAU). For example it was suggested that:
 - a) There is a **formal rather than a practical focus on H&A** issues, with little discussion about specific targets that individual agencies should meet to improve their H&A track record.
 - b) There is **insufficient or unsystematic sharing of information** among DPs, for example, about their plans or about the TA that they are providing to MISAU. The perception was shared by several DPs and confirmed by a couple of national directors, that there are too many person to person contacts between some DPs and MISAU officers that should better take place at the level of working groups and that should be shared more openly with other DPs.
 - c) A **disproportion between the technical capacity of some agencies** and the number of areas where they expect to be active or to be briefed by their peers was also reported. The opinion was expressed that too much time in HPG meetings is taken to explain to other DPs issues that are either too complex or too specific (thus being more appropriate for discussion at working group level) or, simply, issues that interested persons could learn about by reading available documents or by approaching WG co-Chairs individually instead of 'wasting everybody else's time' (to paraphrase the statements made by some interviewees).
 - d) Some DPs interviewed were of the opinion that **discussion on PROSAUDE matters** should use the Prosaude designed channels and **should not take a prominent role at HPG level** (this assumes that it currently takes up too much time within HPG). Any Prosaude matters that are useful for non-Prosaude DPs to be aware of can and should be brought into HPG as points of information.
 - e) There is a perception that there is often **confusion about what it means to reach consensus when complex matters are discussed**. For example, the difference between DPs trying to reach consensus towards presenting a common position to MISAU was seen as necessary in a SWAp, but this was said to be often confused with expecting all DPs to reach consensus on the issue itself. This was seen as difficult, impossible and often unnecessary.
 - f) The point was made that options for **consensus on complex matters should be discussed first at the levels of WG** (or at least the DPs from that WG) **in close consultation with the FP**. It was said that under the SWAp having a different opinion on a matter does not entitle a health DP to make that position known to MISAU or to take separate action from the one agreed in plenary.
 - g) While the important role of WGs is often emphasised some **Co-Chairs of WGs felt that they are often by-passed by their own peers** at HPG or FPT level on specific matters. The point was made that WG co-Chairs should have a leading responsibility to analyse and provide guidance on matters relating to their areas of remit, including the management of difficult situations that may emerge over time. In other words, WG co-chairs were requesting the trust of the HPG and the close collaboration of the FPT in dealing with any ongoing or emerging issues relating to the remit of the WG.

- h) Other specific issues linked to WG roles and functioning will be discussed later – the points above relate to how the HPG and FPT should strive to enforce and respect the principle of division of labour and apply it to the WGs and their co-Chairs.
- 2) There is a perception that while **coordination arrangements between HPG and other sectors or coordination groups** have improved, there is still some way to go. Apart from improving information sharing and coordination, a key objective of these stronger links should be to ensure that key issues that affect the health sector, whether systemic matters or any emergencies or crises, are properly presented, analysed and discussed at the right levels. In this way any issues that are beyond the scope of the MISAU or the health partners have greater chance of reaching the right ears and being resolved.³ For example:
- a) **At the level of HOM/HOC.** This should be the primary responsibility of the FP and of the co-Chair of the WG where the issue under discussion falls. Key forums where these matters might be discussed would include G-19, PAP and CCS, as Appropriate.
- b) **At the level of the MOF** and or the DNPO, where the PFM WG and the FP should raise the profile of health financing, PFM and budget issues, particularly those emerging in the Joint Annual Reviews.

The right people

- 3) It was acknowledged by most interviewees that the FP role can easily become **almost a full time job** in such a dynamic environment as the Mozambique health SWAp. Therefore, the agency taking up the role of FP should be prepared to devote sufficient time and resources for the incumbent to play the FP role effectively, **ensuring that the HPG and its related structures become professionally managed.**

Minimum resources to be committed would include (i) the time for the FP to attend and prepare for meetings and (ii) the funds necessary to finance the position of HPG Coordinator. While these requirements have been honoured by agencies taking up the FP role in recent years it was suggested that **this should be made explicit in the TOR for the Health Partners Coordination Framework documents.** It was also suggested that the Head of Cooperation/Mission for the incumbent agency should also be made aware of these needs and formally agree to them before formally accepting the responsibility of becoming FP.

- 4) It was suggested that **better internal division of labour at the level of the FP team** should be further explored. Suggestions included:
- a) Making one of the vice FPs **take responsibility for preparing, coordinating and managing the information sharing part of HPG meetings**, ensuring that this is done efficiently and that it does not take more than the required time.⁴

³ There are several examples of recent bigger or smaller “crises” and issues where it is important for the health partners to present issues in the right light to their development agencies. Incomplete or biased analysis of these issues within high level coordination structures outside MISAU can cause considerable harm to the credibility of MISAU and its HPG.

⁴ In Bangladesh, for example, the HPG equivalent (known as Health Consortium) is adopting a practice of allowing 3 minutes to each agency for information sharing during consortium meetings, and to require that any information item requiring more than 3 minutes be circulated in advance through a one-pager information sheet through the Consortium Secretariat.

- b) It may be better for **the FP to delegate the chairing of HPG meetings** in order to better maintain a balance between the effective chairing of the meeting and the need for the FP to intervene whenever necessary (but under the leadership of the Chair of the meeting). One of the Vice FPs or another person with good facilitation skills within the HPG group could be asked by the FP to take the Chair.
- c) It was suggested that **the FPT+ should undergo induction training** around the time when the FP and the WG co-Chairs take up their positions (see more later under 2.3 on co-Chair elections) and get some external facilitation support for improving the work dynamics of the FPT and the management of meetings, with a view to better follow up key HPG matters. Induction could take place through a working morning or a working day every 2 years or as and when a new FP is elected.

With access to the right skills

- 5) In the Mozambique SWAp context the best way to ensure HPG and FP access to the right skills would be to strengthen the effectiveness and competence of the Working Groups (as discussed later) and to enable effective team dynamics within the FPT+. Part of those dynamics could be greater use of the Huddle workspace among the HPG members to share information effectively without overloading meetings with lots of nitty gritty information.

Box 1: The HPG TOR

Health Partner Group Terms of Reference

Purpose: Sharing of information, obtaining updates from and preparation for CCC meetings and review progress on the Health Partners Monitoring Matrix

When: Monthly meetings, prior to the Steering Committee meetings

Who: All interested Health Partners' nominated representatives

Chair: FP or VFP (in absence of FP)

Agenda: Set jointly by FP and VFP (with inputs from FPT+. Meetings minuted.

The Health Partners Group is an opportunity for partners to obtain an update on developments and share information with others. The meetings will promote discussions on process and technical health issues and the HPG is the key group for preparing donor input to the CCC. The Health Partners Group will receive regular feedback from the co-chairs of the WG's and will delegate tasks to WGs where appropriate. The creation of ad hoc task forces can also be decided upon when indicated. The Health Partners Group may also propose tasks for the FP and VFP to take forward. Extra-ordinary meetings of the Health Partners Group can be called as necessary, but should avoid becoming routine. It is expected that the meetings of the Health Partners Group will be held at the offices of the Focal Partner during the period of his/her tenure.

The Health Partners Group will develop an annual work plan, which will be directly linked to removing key bottlenecks for progress on the sector Economic and Social Plan (PES) and the Health Sector's Performance Assessment Framework (Health PAF). The work plan will be monitored regularly, in the form of a "Health Partners Monitoring Matrix" and a Quarterly Implementation Matrix. This plan will commence each year when the new Health Partners' Focal Partner and Vice-Focal Partner(s) take up their roles. The monitoring matrix should serve as the guiding tool for all Health Partners Group meetings and should be used to monitor partners' contributions and progress.

3.3 Capacity to engage effectively at Working Group level

The six aid effectiveness working groups were still in formation stage at the time of the consultants visit. Each was at a different stage in its development in terms of adapting the generic TOR that had been circulated in 2010⁵, defining their membership or preparing their annual plans. The consultant discussed these matters with the Chairs and co-Chairs of the WGs and attempted on that basis to do a preliminary mapping of skills needed and whether available, but the mapping could not be completed fully. This has been reflected in a summary table included as Annex 4.

3.3.1 Situation analysis

The following observations were made in relation to the current status of the aid effectiveness working groups.

Using the right structures

The reviewer had access to draft or final TOR from 4 out of 6 WGs (see summary Table in Annex 4 on current status of Aid Effectiveness Working Groups). The TOR reflect an important effort made by both MISAU and DPs to reorient the work of the WGs and make it more systematic. The level of progress across WGs was mixed at this relatively early stage. A read across the TOR of WGs reviewed and the interviews held with Chairs and co-Chairs suggest that attention should be paid to the following matters.

- 1) The Aid Effectiveness Working Groups have the potential to become a **main hub for harmonising approaches by DPs to support MISAU** in the areas of their remit. WGs have many advantages over the HPG meetings in terms of size, focus and skills mix to analyse specific issues. Engagement at the right level is clearly a key goal underpinning the six reconfigured WGs and, generally speaking, this is captured in the TOR. What is captured less in the TOR, however, is how the new focus will be achieved and how WGs can move from being technically focussed (as the remit has been so far) to a greater focus on aid effectiveness. All co-Chairs interviewed acknowledged that this will require additional efforts and that for the WGs to realise their full potential they should be more **professionally managed**. The following suggestions can be made.
 - a) One suggestion is for each WG to **map out key stages during the planning cycle** when their involvement will be required, so that WG members are able to plan for and allocate time to fulfil their duties at that time. Forecasting may be easier for WGs like PFM, M&E and Medicines and Logistics WGs whose inputs can be predicted around key events such as ACA, CCS or budget cycle. This practice would help to develop appropriate work routines in the WGs that would help the aim of maintaining institutional memory among its members and ensure that newly elected co-Chairs are clear about their duties and allocate time to the WG at the right times. For improved institutional memory it would be useful to ensure that in all WGs the following information is available to members and is regularly updated:
 - i) Mapping which members of the HPG community have skills that are important to the group or access to other useful skills within their agencies;⁶
 - ii) Mapping and discussing TA needs, TA requests and TA being provided;

⁵ General TORs: Aid Effectiveness Working Groups in Health. Draft 2010 (date unknown).

⁶ Improved skills mapping would be very useful and could be done by using the lists of essential skills shown in Annex 4.

- iii) Standardising reporting by Co-Chairs to HPG;
- b) Another suggestion would be to **improve division of labour at WG level**, with some members from each constituency (MISAU, DPs, NGOs) taking responsibility for specific sub-areas within the WG's remit. Thus, for example, the M&E WG which tends to have a very broad remit may chose to allocate some members to each of the sub-areas assigned to the group, for example, investments, preparation of the ACA or preparation for the CCS, to mention just 3 key sub-areas for this WG. Whether or not this example is appropriate, the principle of division of labour should prevail. Co-Chairs did raise the issue that some members in the WG simply "sit and listen" so the workload tends to concentrate always on the same few.
- 2) Since a key purpose of the WGs is engagement, support and oversight, the **membership of WGs may become an issue as current membership is generally very large**, perhaps too large for certain issues, in particular sensitive ones, to be discussed comfortably. Aware of this fact, some co-Chairs are already using a kind of "executive" smaller group where policy dialogue and discussion of sensitive matters is more likely to happen without the MISAU feeling that it is being put on the spot. Another possible improvement might be to enforce the principle that a single person from one agency should not be part of more than one or maximum two working groups (allegedly some HPG members figure in 3 or even 4 WGs) and that they should participate actively and provide time to the group. Just "*sitting*" in *some* meetings of the WG is unfair to other members and defeats the purpose of the aid effectiveness WGs.
- 3) **Capacity building of MISAU directorates would seem a key objective** that few WGs seem to discuss or acknowledge in the TOR. Efforts to **more systematically map TA** being delivered to those directorates should be part of that focus, together with a better understanding by DP members of the capacity gaps at MISAU level. This would increase the effectiveness of engagement and the chances that capacity gaps are addressed at each level. Would MISAU and the HPG consider this a worthy exercise?
- 4) Another area where WGs could make a difference is in **strengthening the links with the HPG group** (as argued in the previous section) through more systematic reporting arrangements. Likewise, WGs should develop a higher profile and more effective information sharing links with WGs from related sectors (PAP) and with the Heads of Mission. The objective should be that when health matters are discussed at those levels the right people from both the MISAU and DP side can provide additional information and analysis.
- 5) Finally, WGs should contribute to **reducing unnecessary transaction costs linked to poor working routines** within the HPG group. A key cause of higher transaction costs is excessive email traffic, where all members are copied on matters that a member or MISAU and or HPG should first share with their co-Chair, not with all members of the WG or the HPG. This situation is particularly serious when MISAU officers who are members of the WG are also copied in these unnecessary exchanges. Information sharing is fine but should be effectively implemented.

The right people

- 6) At the moment the prioritised skills for the co-Chair position are mainly technical. However, interviews suggested that strong **facilitation and networking skills**, as well as the **ability to work effectively in a group** are as, if not more, crucial. In other words, just being technically competent may not be enough for a person to become co-Chair

- 7) The **process through which co-Chairs of Working Groups are elected deserves further attention** in order to achieve greater internal consistency within HPG and across WGs and to enable better fit with arrangements at the HPG level. For example:
- a) Some WGs mention how the Co-Chair will be elected (eg. HRH) while others do not (eg M&E). **The process of co-Chair election** should become explicit and homogeneous to the extent possible.
 - b) Some WG TORs suggest that the co-Chairs will be elected either by the members of the WG or by the Chair of the WG who would then seek approval from WG members (as in HRH WG). This is potentially risky since **before being accepted the potential WG co-Chair agency should be approached for it to provide sufficient guarantee that it will allocate the time and the resources necessary for the person from that agency to do the job**. In this case it would seem more appropriate for someone from the HPG (perhaps the exiting co-Chair) to approach the Agency of the incoming co-Chair rather than expecting a person from MISAU to do it.
 - c) The **timing of the election of co-Chairs** for the 6 WGs is also important given that (as recommended elsewhere) co-Chairs should receive induction to be helped into the job and to work effectively within the FPT+ structure. This would suggest that the election of co-Chairs should probably take place around the same time as the election of the FP, to enable the induction of all WG co-Chairs and FP to be done at the same time (for cost and for other reasons).

3.3.2 Capacity Issues at Working Group level

In this section we review capacity issues at Working Group level i.e. whether WGs have access to the necessary technical capacity to engage with the Ministry of Health, with other parts of the Government of Mozambique or with higher level aid coordination structures (such as the G-19). Since the Aid Effectiveness Working Groups are the chosen means for the HPG to engage with the Government of Mozambique the issues discussed in this section are not different from capacity of the HPG as a whole.

The technical capacity of the 6 WGs comes from two sources: one source is MISAU staff and advisors based within MISAU who participate in the WG. Another source of skills are the representatives of each of the agencies active in the WG. This pool of skills is occasionally supplemented by bringing in additional skills, through either inviting experts already based in the DP country offices or through contracting in technical assistance for specific tasks that each group may require. This has been partly covered in Annex 4.

While Annex 4 has attempted to list the critical skills necessary within each group it has not achieved a mapping of the available skills as was initially intended. This has been due in part to the impossibility of mapping the skills available within a large number (close to 30) of development agencies or within the pool of advisers based in MISAU, in a week's time. A second reason why the analysis could not be completed was because the Chairs and co-Chairs of Working Groups needed more time to consider what the crucial skills for each WG are and how/where these could be made available to the WG.

While a more thorough skills mapping would have made our analysis easier it is not an impediment to briefly analyse capacity issues at Working Group level and to provide a few suggestions for improving any identified skills gaps, as follows.

1. The analysis undertaken suggests that there are considerable **variations** in both the **access** to technical skills by each WG as well as in the perceived **importance** that WG Chairs and co-Chairs attribute to the need for the WG to access additional technical skills. In most cases this was linked to **different levels of consolidation of each Working Group** in terms of defining membership, adopting standard working practices or achieving the required clarity of mission among its members⁷. An initial **recommendation would be for Chairs and co-Chairs to take the lead in systematically mapping essential skills needed and to compare these with the pool of available technical skills, as a means to establish any perceived capacity gaps**. These capacity gaps should then be discussed at FPT level to look at possible ways to bridge these gaps within available agencies.
2. The opinion of this reviewer, and that of most WG Chairs and co-Chairs met, is that the **primary option for addressing capacity gaps at Working Group level should be to draw from the pool of skills (staff & advisers) already available at the DP agencies that make up the WG**⁸. However, it is important for any such arrangements to be formalised and made explicit in order to take account of the fact that technical capacity within DPs can change rapidly. By formalising these arrangements WGs would become better prepared to deal with eventual changes to the skills mix pool linked to changes at the DP level.
3. If, or when, DPs are unable to mobilise staff or advisers already available to their country offices, or should that support prove insufficient in terms of continuity of engagement, is when **the option of contracting in additional skills might be considered**. Should this option be favoured one would expect attention be placed on the following matters:
 - a. The contracting option should be discussed within the FPT and communicated formally to the HPG and to the MOH Chair of the WG in order to avoid any misinterpretations about the purpose of bringing in one new person to the WG.
 - b. It is recommended that 2-3 year contracts (with the required probation periods) should be preferred to shorter, one year contracts in order to foster continuity of advice by the contracted advisers as well as to strengthen engagement and institutional memory within the WG.
 - c. Within the perspective of 2-3 year contracts the HPG might consider full time or part time contracts depending on the needs. Part time advisers were generally seen by co-Chairs interviewed as a better option than full time advisers or than the setting of a “technical secretariat” type of structure. The main justification given was that the inputs of the advisers would be required only at specific moments in the annual planning cycle

⁷ By clarity of mission we mean the points made earlier in the report about generating an understanding of how an “aid effectiveness” working group should be different from a “technical” working group in terms of focus and day to day work practices and routines.

⁸ For example, the skills base available to the PFM WG would change significantly should agencies like the World Bank take a more proactive involvement in that WG., as might be the case as per its work, as it was suggested to this consultant.

and, therefore, these would not justify a full time position⁹. An additional reason given was that a part time adviser would be more acceptable to some WG Chairs, for whom a full time adviser or a “technical secretariat” might look like an unnecessarily “heavy” arrangement. In any case, it would seem appropriate to discuss the modalities with the respective WG Chair.

- d. Co-Chairs expressed the view that advisers supporting the WG should reside in Mozambique and be (or soon become) functional Portuguese speakers.
- e. Clear TOR should be developed for the contracted advisers, and these should include, among others, an effort to better map out capacity gaps at the level of the MOH in any key areas, with a view to helping the HPG take a more proactive role in dealing with MOH capacity gaps, as mentioned earlier in this report.

3.4 Conclusions

The mapping of skills gaps at HPG and Working Group level has not been possible in the way it was intended. However, options for accessing additional skills have been discussed (see 3.3.2) for HPG and WGs to access additional capacity in key areas. Most co-Chairs were of the opinion, as is the consultant, that improved focus on institutional capacity building within MISAU, including improved understanding of capacity gaps at MISAU by DPs are fundamental issues for increased and improved engagement between MISAU and its development partners.

Working Groups have the potential to improve oversight, alignment, harmonisation, capacity building and policy dialogue as long as they are able to reorient their attention from technical matters to a focus on aid effectiveness. Specific **suggestions** that the consultant has provided for HPG and WG to improve their engagement with the Government of Mozambique and with other aid coordination structures include:

- Professional management of the HPG and WG structures, including more effective working practices and systematic management of meetings and relationships;
- Explicit commitment by agencies taking up the roles of FP and co-Chairs to provide the required time and resources to their staff;
- Improved election procedures and stronger induction of members of the HPG and WGs for them to practice division of labour;
- Effective delegation of responsibilities to DP staff who volunteer for these positions by HPG members, based on trust and effective delegation of responsibilities;
- Improved focus of HPG and WGs on capacity building at the level of MISAU counterparts through improved mapping of skill needs and gaps and more effective targeting and mapping of long and short term TA.

⁹ On the other hand a DP might choose to opt for a full time position and use it to support more than one sector or more than one area relevant to the agency, like public finances, procurement, etcetera.

4. On the creation of a TA pooled fund for MISAU

4.1 Objective and approach

A second objective of this assignment is to identify the interest of MISAU in the creation of a TA pooled fund, and to identify the potential utility of such a fund in increasing MISAU capacity to respond to priorities defined through CCS, CCC and Working Group recommendations. Within this context the consultant attempted to approach the task in three stages:

- (i) A mapping of TA to better understand current provision and identify main providers of TA to the MISAU;
- (ii) Interviews with a few members of the HPG (mainly co-Chairs and FPT) and a sample of MISAU staff (mainly at the level of Directors and Deputy Directors -see people met in Annex 2) to explore MISAU interest in a pooled TA fund and DP willingness to fund it.
- (iii) Should there be an interest in a pooled TA fund the consultant was asked to look at possible options for delivering such TA.

In the absence of an available TA map, a newly constituted TA task force led by WHO attempted to map out TA using a simple questionnaire that was distributed to DPs. However, the time available for TA mapping, the complexity of TA matters at the level of MISAU and the limited DP response rate all resulted in a very incomplete picture. It was therefore not possible for the consultant to arrive at a meaningful picture of TA being currently delivered. The willingness of agencies to fund a notional TA pool fund was also superficially explored and limited by the fact that agencies could not be presented at this stage with a sample of options for their appraisal.

This section contains the main points deriving from the assessment of the willingness of MISAU to have access to a TA fund. They have been written with a view to suggesting some steps to be undertaken should the HPG and MISAU decide to take the consideration of a TA fund further.

4.1.1 *Interest in a TA pool fund for MISAU*

The interviews held at MISAU to explore the interest in the TA fund (see Annex 2 - people met) revealed that there is a different understanding of what a TA fund would be and would do for MISAU. For example:

- 1) Some directors in MISAU spoke of a TA fund in relation to HRH. Their expectation would be that a TA fund would enable MISAU to contract (mainly) specialist doctors to staff certain (mainly tertiary) health facilities and/or to teach and train medical specialists in existing medical training centres or hospitals. The point was made by the consultant that this is not, strictly speaking, a TA fund but a form of financial assistance that would require a different type of assessment to that usually performed for a TA fund. In fact, if such financial support is perceived as necessary by MISAU it should be probably best financed through the Prosaude and be part of the existing national HRH plan. This form of financial aid is not covered in this report.
- 2) Other MISAU officers (DPC, DNS) expected a TA fund to enable MISAU access to additional skills for specific analysis of emerging issues (short term TA) or to enhance capacity transfers to specific MISAU departments or units (by accessing longer term TA). While these forms of TA already exist, the advantage of the TA fund would be to give greater autonomy to MISAU in

deciding what was needed and when, thus reducing the need for MISAU to ask for DP support each time a need is identified. It was pointed out that such an arrangement would have at least two additional advantages for MISAU:

- a) It would provide an incentive for MISAU to better assess technical capacity gaps in different parts of MISAU since there would be a mechanism for MISAU to address some of those gaps through the TA fund; and
- b) It would enhance better planning and forecasting of TA needs that might transform into annual or six-monthly TA plans.

MISAU officers recognised that while there is a lot of TA available to the Mozambique health sector, existing TA suffered from several limitations in terms of alignment and harmonisation. For example, the impression by most MISAU officers interviewed is that existing TA tends to be quite DP driven, particularly in the case of short term TA where considerable duplication is perceived to exist. Longer term TA through advisers placed at and reporting to MISAU was perceived as being, generally, better harmonised with MISAU working patterns, although it was mentioned that some DPs have quite a number of long term advisers placed at either central or provincial levels not based at MISAU offices and who do not report to MISAU managers;

4.2 Moving towards improved TA coordination by HPG and MISAU

Exploring the interest in a TA fund is challenging in a context of poor coordination, alignment and harmonisation of TA practices. The following points would seem relevant to improve the current situation:

1. **Improved coordination of TA to MISAU is important and long overdue.** There is a perception among MISAU and DPs that the launch of a TA fund is a secondary issue when compared to the more urgent need to improve coordination of TA delivered to MISAU. It was mentioned that TA coordination is a key output of the H&A agenda of all DPs represented in the HPG. Poorly coordinated TA is a recurrent discussion within MISAU and HPG, particularly when issues relating to capacity building and capacity development of MISAU units and departments are raised in annual reviews and other reports. .
2. **Some technical assessments have been made but a framework for TA coordination does not yet exist.** In spite of the perceived importance of, and references to, TA coordination in many SWAp-related documents¹⁰, there have been few systematic attempts by the members of the health SWAp to approach the issue of TA coordination. In fact, some studies undertaken as far back as 2002 discussed TA coordination only as part of the assessment to move towards TA pooling, which has led some interviewees to believe that the only or the main approach to improve TA coordination may be to pool TA. For whatever reasons, the Mozambique SWAp has made at best timid or short lived attempts to improve TA coordination. These attempts have resulted in improved information sharing about TA practices among SWAp partners and, in some cases, improved coordination of certain forms of TA being delivered, as in the case of long term advisory positions funded by DPs within MISAU, but a framework for improved TA coordination and for mechanisms to implement it, continue to be lacking.

¹⁰ These include the Kaya Kwanga Code of Conduct; the Prosaude MOU; or the Terms of reference for the Sector-wide Approach in Health between Ministry of health in Mozambique and Co-operating partners, among the main ones.

3. **Improved TA coordination is possible, and TA pooling is not necessarily the best option.** Reviews of TA coordination in various countries and settings¹¹ establish a clear difference between TA coordination – an end in itself for improved TA effectiveness and capacity building, and TA pooling – just one of the options available to improve TA coordination and to fund and procure it. Even TA pooling adopts different forms in different countries in terms of its scope (is the objective to pool all forms of TA or just TA in support of selected areas?) or scale (will most partners abide by the proposed model or just some of them?) Are donors prepared to pool resources to serve a single procurement arrangement? In any case, the important point to be made is that it is possible to improve TA coordination in a SWAp without resorting to TA pooling.
4. **It is possible to improve some aspects of TA coordination using existing structures.** While we are recommending a more systematic assessment of options for improved TA coordination later in this section there is quite a lot that HPG could do to improve TA coordination using existing structures and mechanisms. For example:
 - a. There is considerable scope for **improved information sharing on TA plans and practices at Working Group level**, as discussed in section 3 of this report. This would be greatly facilitated by increased focus on capacity issues affecting the MISAU counterparts with whom the WGs interact. It is important to bear in mind that the first and most important step towards improved TA coordination is to do a joint assessment of capacity gaps and TA needs to overcome those gaps.
 - b. Working Groups might also consider **mapping the TA that various agencies deliver within the remit of each working group**. Such mapping may reveal important lessons, such as the tendency for MISAU and DPs to focus on technical skills gaps linked to specific diseases and programmes while the area of institutional development of MISAU may be receiving much less attention.
 - c. In terms of more harmonised TA provision, it is perfectly possible for a DP or a small group of them to **put in place a TA fund for MISAU using models that have been tested in other countries**. One such model that has been successfully implemented in countries like India and Pakistan is a “resource facility” model¹² whereby a TA contractor procures TA to the MOH following rigorous needs assessment and market practices. While these models may not resolve all TA coordination issues they may resolve some of these and provide examples of mechanisms that other DPs may like to imitate or join.
 - d. **Mapping of existing TA is not a necessary step or a first step to look at coordination matters.** An assessment of TA coordination with a view to developing improved coordination arrangements need not and probably should not begin with a TA mapping exercise.¹³ In any case, the TA

¹¹ For example, the author undertook a review of TA in the context of Health SWAps for the Health Partners Group of the Bangladesh Health SWAp in 2006. This report was made available to the Focal Partner and to Dr Hilde de Graeve (WHO) during the visit to Mozambique. It contains a detailed review of issues and options as well as a list of the main literature on the subject.

¹² A resource facility model consists of a contractor funded by one or more DPs who sets an office for TA needs assessment and provision at the country level. Contractors are selected through tendering. One such example is the technical Resource Facility funded by DFID and AusAID in Pakistan.

¹³ We should differentiate TA mapping in the context of improved TA coordination arrangements within a SWAp (the focus of this section of the report) and TA mapping in the context of the work and areas covered by the six Aid Effectiveness Working Groups. As has been said (in section 3 of this report) the

mapping should not precede the much more crucial assessment of TA coordination problems and issues, as it will be those problems and issues that improved coordination arrangements should address. On the other hand, TA mapping can be very useful once the framework for the analysis of TA and for improved coordination options is being developed.

5. **It would be desirable for the HPG to make a visible effort to improve TA coordination and to do it in a systematic manner.** TA coordination issues will continue to affect the impact of many interventions by DPs and will continue to impose transactions costs on both DPs and MISAU. For these reasons the partners in the Mozambique SWAp are encouraged to further explore options for improved TA coordination, and to do it in a systematic and professional manner. The following is a very simplified framework for approaching TA coordination in a context like the Mozambique health SWAp.

Stage 1. Recognise the problem of lack of TA coordination. There needs to be a concerted effort by both MISAU and the HPG to recognise that lack of TA coordination is a problem and that there is a mutual desire to further investigate the issues and appraise the options for improved coordination.

Stage 2. Plan an assessment of issues and options for improved TA coordination. A small task force within the HPG (liaising as necessary with MISAU) could be delegated the responsibility of looking into the matter and to draft Terms of Reference for a more systematic review of issues and options, which should probably be done through contracted TA. Key responsibilities of the Task Force would include:

- To define what will be meant by TA in the context of the assignment. Short and long term TA often pursue different (yet complementary) objectives, and it is not the same TA delivered for the HPG group than that delivered to MISAU. Similarly, there is a need to clarify that assistance provided by staff based in the offices of DPs (including the UN agencies) would not be usually considered TA for the purposes of the review;
- To define the approach to the task and draft the TOR for additional analysis;
- To review, assess and adapt to the SWAp context the analysis undertaken (by external consultants) and the proposals stemming from it;
- To provide guidance and support to the contracted consultants;
- To keep the Focal Partner and MISAU informed about progress;
- To help prepare an implementation strategy by adapting recommendations made by external consultants.

latter should be a primary responsibility of each Working Group as part of the process of better understanding capacity gaps and targeting of capacity building efforts within MISAU.

Stage 3 – Implement the assessment of TA issues and options. It is suggested that external TA should be contracted to undertake the analysis. The review team should best **combine a national and an international consultant** and should approach the topic through pre-defined steps, as follows:

- **National Consultant.** A national consultant is a preferred option for collecting detailed information from DPs and from MISAU, whether or not a mapping of TA is undertaken. A national consultant would also be in a better position to provide further support to the TA task group to take forward recommendations. The national consultant should have a good understanding of the Mozambique health sector and of donor practices in relation to TA delivery¹⁴.
- **International consultant.** This person should bring depth of analysis and experience with TA delivery in an international context.
- **The external assessment would be undertaken in 3 main steps:**
 - Step one would be the initial visit (international and national consultants) to assess issues, needs and expectations of MISAU and HPG, and to design the more detailed data collection tools (key areas for support; short or long term TA; willingness of DPs to fund, and preferred modalities for funding; etcetera);
 - Step 2 would involve data collection. Most of this might be done by the national consultant combining some structured data collection tools with more informal interviews. On the basis of that information, the reviewers would present a draft analysis combined with a desk based options appraisal for further discussion with partners;
 - Step 3 would involve the discussion of the options for improved coordination with HPG and MISAU prior to making final recommendations. This step would involve work in country by both consultants.

4.3 Conclusion

In conclusion, there seems to be an interest on the part of MISAU for the establishment of a TA fund available to MISAU. However, it is recommended that before going down that route the HPG should take a more proactive stance and role in resolving TA coordination matters linked to DP practices through a more systematic assessment of TA-related issues and options. The HPG is also encouraged to use existing structures such as the Working Groups to better, jointly assess TA needs through improved focus on institutional capacity building at MISAU level. Undertaking clear steps towards greater coordination, harmonisation and alignment of TA delivered to MISAU is an integral part of the SWAp that seems to be long overdue.

¹⁴ The main reason for recommending the use of a national consultant instead of using an existing person from the HPG or MISAU is the time and concentration of effort that will be required. Members of HPG may not have such availability.

5. Annexes

Annex 1: Terms of reference

Increasing the effectiveness of Health Partner Engagement with the Ministry of Health, Mozambique: Review of Health Partner Group functions and structure to maximise effective engagement with MISAU.

Background:

1. Mozambique has a well established Sector Wide Approach (SWAp) which brings together 26 different partner agencies in support of the national strategic plan for health (PESS). A number of partners supporting the SWAp provide their support through a pooled funding instrument, called PROSAUDE, with some of those donors providing their aid as Sector Budget Support (SBS). A Memorandum of Understanding (annex 1) governs the relationship between government and development partners engaged in PROSAUDE, and a code of conduct (annex 2) governs the engagement of all partners who are supporting the SWAp. Mozambique is a signatory to the International Health Partnership (IHP+) and has an IHP compact, which reaffirms the commitment of all partners to increasingly harmonise and align their support with nationally defined priorities (to the extent that their procedures allow).
2. The Health Partner Group (HPG) is led by a Focal Partner (FP) (which is the elected partner agency who leads the policy dialogue with the Ministry of Health (MISAU). Currently the focal partner is elected for a 2 year mandate. The FP works within a troika structure – with a vice focal partner, who is either the outgoing FP, or the incoming focal partner. A second vice focal partner is one of the UN agencies, with this role being allocated on a rotational basis. In addition to the Troika, the Focal and vice focal partners are supported by a Focal Partner Team. The focal partner team includes a coordinator (normally contracted by the Focal Partner) – who ensures effective and regular communication between partners and between HPG and government. Other members of the Focal Partner team, which is an informal structure created to provide advice to the Focal Partner, include the chairs of the Working Groups (see below) and a representative of the US Government agencies (an arrangement made to reflect the size of USG support).
3. The Health Partner Group meets on a monthly basis and brings together all agencies funding activities in the health sector, as well as including representatives of civil society (NAIMA – a network of international NGOs, and MONASO – an HIV/AIDS network organisation which participates only infrequently). Meetings between the HPG and government are formalised through structures which are described in the Memorandum of Understanding. Key meetings include a monthly joint coordination meeting with the Permanent Secretary and Directors of MISAU with the FP team (meeting known as the CCC). There are also open CCC meetings when all partners are invited. In addition there are two large formal meetings between health partners and MISAU chaired by the Minister of Health, known as the CCS (sector coordinating committee) – which review sector progress and discuss future plans.
4. Engagement between MISAU and Health Partners also occurs at both policy and technical level through **Working Groups**. There are 6 formal working groups (recently reduced from 10 working groups) which have an oversight function – these focus on: audit and financing; monitoring and evaluation; engagement with

NGOs; Human Resources for Health; Medicines/pharmaceuticals and logistics; and National Health Service Issues. Working Groups have a Chair – who is normally a director from the Ministry of Health, and a co-Chair, represented by one of the development partners. The co-Chair positions are appointed on a voluntary basis – and depend upon agencies allowing their representative sufficient time to take on the role. The amount of time individuals have for the tasks can vary considerably. In addition to these oversight working groups, there is technical support delivered through other working groups working directly with MISAU staff to support technical aspects of policy development and implementation. However, **for the purpose of this review, focus on Working Groups should be on those which have an oversight function** and which engage with MISAU at Director level.

5. The Health Partner Group capacity comes from the representatives of each of the agencies active in the HPG and is occasionally supplemented by contracting in technical assistance for specific tasks. Health partners themselves are a diverse group with varying levels of expertise in the health sector, with some bringing public health expertise, and others policy, planning or administrative expertise. There has been no formal mapping of health partners competencies in order to assess whether the collective skill set is sufficient to meet the varied demands of effectively engaging with MISAU. The majority of HPG members stay between 3 to 4 years in post, so institutional memory is a challenge.
6. At the Health Partner retreat, in February 2011, a series of questions were asked of the competencies and skills required by health partners collectively in order to maximise the effectiveness of engagement with MISAU (annex 3). These terms of reference aim to help the Health Partner Group better understand the skill set needed to effectively engage with MISAU, considering the current demands in terms of both skills and time commitment made on health partners and the need for technical and coordinating support within MISAU. These terms of reference will also consider potential modalities for mobilising the right balance of skills and competencies to maximise the impact of health partners in their engagement with MISAU – to ensure that they are able to effectively deliver the oversight function. Key areas of competency where additional capacity may be needed and where the review will focus include: audit/financing and public financial management; monitoring and evaluation; procurement and logistics planning; medicines.
7. Capacity constraints within the Ministry of Health also impact on the quality and effectiveness of MISAU and partner interaction. A limited number of staff with multiple responsibilities can often result in insufficient time being available to take forward priorities agreed in the CCS, or CCC or in the Working Groups. Whilst some agencies have sought to strengthen MISAU capacity by placing long term TA within the Ministry, and whilst some task, such as the annual evaluation of sector performance are contracted out to consultants, the approach to TA within the Ministry in order to enhance MISAU capacity has not been systematic. The previous Minister of Health stated clearly that TA should either be very task focused and time limited, or should be clearly capacity building with a clear objective of skill transfer, a lack of staff within MISAU often hinders ability to build internal capacity. A proposed solution to short term capacity constraints is a TA pooled fund, controlled by MISAU – and an objective of these Terms of Reference is to assess whether there is interest in and demand for the creation of such a pooled TA system within MISAU. This should consider whether such a fund could be used to improve MISAU's interaction with health partners, by improving capacity to implement priorities and recommendations which emerge from CCS, CCC and working group decisions. If a need for a pooled TA fund is

confirmed by MISAU, then the consultant will also need to identify donor partners who would be willing and able to contribute to the fund.

Purpose:

8. The primary purpose of this assignment is to review the Health Partner Group functions and structure to maximise effective engagement with MISAU.

Specific objectives:

- To identify the set of skills and competencies that should be available to the HPG, in order to effectively perform HPG's oversight function;
 - To consider the current skill and competency profile of HPG against the demands placed on the various HPG structures (including Working Groups) and determine whether there are key areas of competency that need to be strengthened;
 - To develop terms of reference for whole or part time inputs to maximise the effective skill profile is considered necessary;
 - To assess whether this mechanism can improve institutional memory in the HPG; To provide technical and coordination support to the MISAU;
 - To identify mechanisms for mobilising additional skills in support of effective HPG engagement, whether this be drawing upon broader skill sets already available in country within agencies, contracting in additional support for specific areas, or creating whole or part time posts to provide specific skills, which might be mobilised by partners working in the sector.
9. A second purpose is to identify the interest of MISAU in the creation of a TA pooled fund, and to identify the potential utility of such a fund in increasing MISAU capacity to respond to priorities defined through CCS, CCC and Working Group recommendations.

Scope of Work for Mozambique visit

10. The consultant will:

- e. Conduct a desk review of experience in other SWAp countries, highlighting different models of donor organisations, drawing on any existing evidence of what works well and issues and challenges for effective coordination of development partner support to health.
- f. Review HPG functions and structures and assess whether they are fit for purpose by:
 - Consultation with Health Partners to establish functions of key partner and government interaction, and identify skill and competency areas which might enhance the quality of policy dialogue.
 - Consult with government, to determine the perceived characteristics of effective health partners, identifying if possible technical competencies which MISAU feel would enhance partners ability to engage effectively in key areas of policy formulation and planning.
- g. Review current HPG capacity and competence and the time demands placed upon key roles (notably working group co-chairs).
 - Determine the time demand on key structures and determine the key competency sets that are needed to effectively perform these functions. To explore current mechanisms for mobilising expertise, whether through

contracting of consultants, or drawing down skills from other members of partner agencies teams.

- h. If additional technical expertise is considered necessary, the consultant will develop terms of reference and identify the likely time requirement for key roles and functions – developing where appropriate person specifications which might help enhance the quality of HPG engagement with MISAU
 - Review technical capacity which might be available in partner agencies that can be called down (e.g. audit and financial management expertise) – and consider whether agencies could commit to provide a firm commitment of time for these individuals in support of HPG business.
 - Identify agencies which might have capacity to either second in, or recruit additional identified technical expertise, and consider the modalities which might be used for this – whether through local or international recruitment, or from existing capacity in country offices
- i. Identify demand within MISAU for the creation of a TA pooled fund and to consider whether and how such a fund might be used in order to increase MISAU capacity to respond to demands emerging from CCS, CCC and Working Group recommendations. Within this context the consultant should:
 - Identify MISAU interest in a pooled TA fund and if desired, how it might function and where it would be located within the MISAU structure.
 - Identify which donor partners would be interested in or able to finance such a TA pool, and their views on how such a pool might improve joint work between MISAU and partners.
 - Define outline terms of reference for a pooled TA fund.

Timeframe:

11. The consultancy will take place in April 2011. A draft report will be submitted by the end of April 2011 and the consultant will submit a revised report 1 week after receiving comments from DFID on the first draft.

Output:

12. A Report (maximum length 10 pages, plus annexes) highlighting current capacity, competencies and time demand placed on HPG to fulfil its key functions. The report should identify key areas, roles and competencies where partners consider additional capacity may be needed. The report should present an option appraisal of different models for strengthening HPG capacity, considering drawing down existing in-country capacity, contracting in specific skills, or creating posts that would fit within existing HPG structures in a defined way.

Inputs and skills required:

13. Up to 16 days for a consultant with a background in health systems, an understanding of SWAs and of development partner organisational structures in other countries.

Reporting

14. The consultant will report to Neil Squires, DFID Mozambique

Annex 2: Persons Met

Date	Name	Agency
09 March & 07 April	Neil Squires	DFID
Sunday 10 April	Consultant arrives in Maputo	
Monday 11 April	Laura Rose	World Bank
	Ferdinando Almeida	HPG Coordinator
	Marco Gerritsen	Netherlands & Focal Partner
	Elias Kwame Ferdinando Almeida Etelvina Mahanjane Marco Gerritsen	TA Task Force
Tuesday 12 April	Catarina Regina	SDC, Co-Chair M&E WG
	Geert Haghebaert Bela Matias	European Union
	Emanuele Capobianco	UNICEF, Co.Chair Health Services and Programmes WG
	Pilar de la Corte Molina	UNFPA
Wednesday 13 April	Leen Jille	Unicef, Co-Chair Medicines & logistics WG
	Hilde de Graeve	WHO, Co.Chair HRH WG, TA Task Force
	Celeste Kinsey Jonas Chambule	Canada, Co-Chair GFA WG Member, GFA WG
	Alvaro Alonso	Adviser, HRH MISAU
Thursday 14 April	Polly Dunford	USAID
	Etelvina Mahanjane	DFID
	Patricia Guzmán Pilar de la Corte	UNFPA
Friday 15 April	Nandy Heurtaux Katarina Plankaert	Netherlands, member GFA WG FICA, member GFA WG
	Marco Gerritsen	Netherlands & Focal Partner
Saturday 16 April	Mindy Hochgesang	CDC, Adviser, M&E MISAU
Monday, 18 April	Luisa Panguene	Directora Nacional Adjunta, (Training), DRH, MISAU
	Celia Gonçalves	Directora Nacional Adjunta, DPC, MISAU
	Jorge F Manuel Tomo	Permanent Secretary, MISAU
	Neil Squires, Bridget	DFID
Tuesday 19 April	Martinho Dgedge	Director Nacional DRH, MISAU
	Silvia, Adeline	GFATM Unit, MISAU
	Americo Assane	Adviser to the Minister, MISAU

Date	Name	Agency
	Mouzinho A O Saide	Director Nacional, DNSP, MISAU
	Neil Squires Marco Gerritsen	DFID, ex-FP Netherlands, Focal Partner
Wednesday, 20 April	De-Briefing with Health Partners Group	Netherlands Embassy
Thursday 21 April	Consultant leaves Maputo	

Annex 3: Review of experience with strengthening coordination in other countries with a health SWAp

Approach

The TOR required the consultant to “conduct a desk review of experience in other SWAp countries, highlighting different models of donor organisations, drawing on any existing evidence of what works well and issues and challenges for effective coordination of development partner support to health”.

Therefore, the consultant conducted a desk review of health SWAPs gathering documentation from his own materials, the Internet and from various colleagues.¹⁵ He also interviewed, in person or by phone and email several colleagues in order to get additional information from the focus countries.¹⁶

The countries covered in the desk review were **Bangladesh, Malawi, Mozambique, Nepal and Uganda. Cambodia and Ethiopia** were also included in the review as while **Cambodia** does not strictly speaking have a health SWAp but rather a Swim (sector wide implementation) and **Ethiopia** does not have a SWAp but uses donor coordination structures (including those from the IHP+) that are perceived as effective models to be learnt from.

Outcome of the desk review

The desk review revealed that while countries implementing a health SWAp use similar coordination frameworks the ways in which each country applies and adapts the framework to its own needs and circumstances vary considerably. This makes cross country comparisons a challenging task in terms of identifying the pros and cons of each approach. For example:

- 1) All countries have a **forum where all health DPs** meet, usually on a monthly basis, in order to: share information; pursue their H&A agenda, using a Code of Conduct or similar; and prepare for higher level engagement with the MOH, usually through some sort of higher level coordination arrangement where their DP representatives or focal partners meet with a small group from the MOH.
- 2) Several countries have created a **Secretariat** to support the coordination of the sector programme. However, while in Mozambique and Bangladesh the secretariat is an informal structure funded by and working for the health DPs only, the SWAp Secretariat in Uganda is a formal structure of the SWAp and is located in and managed by the Directorate of Planning of the MOH. This distinction is important in terms of how the information among SWAp partners is managed. While it might be tempting to assume that the Uganda model represents a more inclusive and harmonised arrangement with greater government ownership, this is not necessarily the case. As said earlier, it is simply the result of the specific circumstances applying to the Uganda SWAp and its basket funding mechanism.
- 3) In all health SWAPs reviewed **DPs select their representatives** on an annual basis or, increasingly (Bangladesh, Mozambique probably soon) every two years. It is usually the selected “focal” partner (FP) who is engaged in the top level coordination meetings between a few senior officers of the MOH and the focal partner. In all health SWAPs a co-Chair or vice-Chair of the DPs is also selected

¹⁵ I am indebted to the following colleagues for their help in gathering relevant documents: Catriona Waddington (HLSP, on Ethiopia); Mark Pearson (HLSP, on Malawi); Clare Dickinson (HLSP – several countries), Ilva Sorman Nath (SIDA Bangladesh) and Ulrika Hertel (SIDA Uganda, on Uganda), Andrew Jennings and Shahrukh Safi (AusAIDS, on Nepal and Bangladesh), Shoko Sato (JICA, on Cambodia).

¹⁶ Catriona Waddington (phone & email); Mark Pearson (email); Clare Dickinson (email); Shoko Sato (email); Andrew Jennings and Shahrukh Safi (in person); Ilva Sorman Nath and Ulrika Hertel, by email.

to support the FP. In some health SWAps a third DP supports the FP. However, significant differences were observed in terms of:

- a) The **degree of autonomy delegated to the FP** in selecting which issues to address with the MOH;
 - b) Whether there is a **clear division of labour** between the Focal Partner and the team supporting him/her – in general, the division of labour was not explicit or clearly made. A general comment was made that there tends to be over-concentration of tasks in the person of the FP, which was often perceived as a disincentive to become FP.
- 4) Wide variation was observed in the mechanisms used by different health SWAps to coordinate with the main government stakeholders such as the Ministry of Health. For example, most Health SWAps have defined an “**apex level**”, “**inner circle**” or “**executive**” where a selected number of DPs (the Focal Partner and one or two vice-partners) and of MOH officers (a few selected directors plus a Director General Health or Permanent Secretary, or similar) meet on a regular basis. In Mozambique this would be the FP team, in Bangladesh the HNPSP Coordination Committee or the JCCC in Ethiopia. The main areas of responsibility of this apex body relate to sector programme coordination, follow up of important matters and, where necessary, discussion of sensitive issues. They are meant to be the main communication channel between DPs and the Ministry, and viceversa, on all SWAp related matters. In general this body is not perceived as a good instrument for policy dialogue as the agendas tend to be dominated by issues linked to the areas of responsibility mentioned above.
- 5) The issue of **how to engage in policy dialogue** between the DPs and the MOH has received a lot of attention in recent years and would deserve a separate chapter in a more thorough review. Suffice to say for the purposes of this desk review that the following issues are being reported in several countries:
- a) Countries usually define a **joint meeting where all the health DPs and nominated officers from the MOH** are invited to attend. In Bangladesh this would be (is supposed to be) the quarterly HNP Forum and the policy dialogue following the Annual Programme Reviews. In Cambodia this would be the monthly meetings of the Technical Working Group – Health (TWG-H in the summary table). In Mozambique this would be “CCC Alargado” and the meetings where the results of the ACA reports are presented.¹⁷ The general characteristic of these meetings is that while they can provide a certain momentum and could be used for information sharing they are often too large for effective time and people management. They are increasingly perceived as too large for meaningful policy dialogue. As a result these meetings are increasingly questioned (particularly by the government but also by DPs) because of their high opportunity and transaction costs (esp. vis a vis their limited perceived usefulness), and because the large number of DPs willing to raise issues with the Ministry tends to focus on negative aspects (the things that are not working as well as they should) and thus can put the government officers on the defensive.
 - b) The main event where most countries discuss policy issues is around the **Annual Joint Reviews** of the programme or of the strategic or annual plans. In some countries (Bangladesh) these reviews are implemented by external consultants while Mozambique, Cambodia and Malawi use a mix of external

¹⁷ The CCS that takes place twice a year in Mozambique would not be included in that category because it is supposed to be attended by HOC/HOM from the main development partner agencies, even though this is not usually the way it happens as discussed elsewhere in the main report.

consultants and national senior staff from the MOH. While these annual reviews are necessary they are not always perceived as effective in terms of engaging in meaningful policy dialogue because, yet again, there tends to be a focus on what is not working well rather than on what is working better.

- c) Since the planned joint meetings are not very effective in terms of engaging in policy dialogue what would be the alternatives to these large meetings described above? Are there any alternatives in use? This reviewer could not find any examples that seem to work better than the mechanisms described above. Only in Mozambique the newly constituted **Aid Effectiveness Working Groups** might become an effective forum for policy dialogue, because these meetings are attended by fewer people who have more technical expertise or share a specific interest in one particular area (say, M&E or financial management). The main difference between these “aid effectiveness” working groups in Mozambique and the standard technical working groups that exist in many countries is that the former are expected to help MOH and DPs deal more effectively with overarching systemic issues that act as barriers to effective policy implementation and service delivery (see main body of this report for more on this). However, it is too early to say if these promising working groups will enable improved programme results and more effective policy dialogue because they have only been in operation (with their new TOR) for less than 6 months.
 - d) In sum, the issue of how can DPs engage in constructive policy dialogue with their government counterparts remains an unresolved issue in all health SWAs reviewed by this consultant,
- 6) Most health SWAs have defined the **main functions** of coordination arrangements by stating the objectives being pursued and by identifying the main tasks that should be done to attain those objectives. **In general, there are 3 main functions that coordination arrangements should facilitate:**
- (i) Effective sharing of information among partners and with the government;
 - (ii) Regular review of alignment and harmonisation principles and targets linked to the annual planning cycle of the sector plan; and
 - (iii) Engagement in constructive policy dialogue.

This is reflected in the slide shown below taken from a recent review of the Bangladesh health SWA coordination arrangements.

The Objectives	The Functions
<ul style="list-style-type: none"> • Promote DP Coordination • Promote coordination with GOB • Promote coordination with Civil Society & other actors • Promote interest and solidarity of its members • Promote transparency with the DP community • Promote transparency between DPs and GOB • Serve as rallying point for policy dialogue with GOB • Promote best practices in DP assistance • Promote effectiveness of aid through improved coordination of TA • Promote aid effectiveness through policy engagement on key technical issues 	<ol style="list-style-type: none"> 1. Share information effectively 2. Align with GOB and harmonise your processes 3. Engage with the GOB in positive policy dialogue <p>Nº 3 cannot happen without effective 1 and 2</p>



- 7) On the basis of information gathered from key informants most **coordination arrangements suffer from the following problems**, particularly when the SWAp has reached a certain level of maturity:
- a) **Poor compliance** with existing partnership arrangements and mechanisms on all sides, DPs and MOH, which often results in ineffective information sharing and in insufficient focus on defining specific H&A targets for each agency that are regularly and rigorously monitored.
 - b) Many sector programmes report a disproportion between the **capacity of agencies and the level of ambition in terms of being involved in monitoring and influencing the sector programme**. The example often quoted was of an agency having a single person responsible for health at the country office who may not have a health background or who may be responsible for other sectors or for more than one country.
 - c) The problems of “**many meetings, big agendas, poor dynamics and time keeping, limited introspection and unclear decisions**” are also reported to explain why coordination arrangements do not necessarily result in the expected improvements in information sharing, alignment, harmonisation or policy dialogue.
 - d) Linked to the previous two points is the often reported **unclear, ineffective division of labour among DPs** that results in focal partners having to do a full time job in addition to their agency-related responsibilities. Some countries have made significant efforts to better distribute the coordination workload by expanding the size of the Focal Partner structures into a Focal partner team (from a single individual to a “troika, as in Mozambique and Uganda), and by relying more on working groups to analyse complex issues before these reach the forum of development partners or the SWAp coordination meetings (Uganda, Mozambique). However, improved division of

labour does not resolve per se technical capacity issues that may affect the focal partner or its group.

- e) In sum, coordination has improved but remains insufficient and constant efforts are needed to keep coordination mechanisms alive and effective.
- 8) The literature reviewed and the key informants interviewed did not provide much information about the **ways in which groups of development partners and/or working groups access additional expertise to engage with the government** on technical discussions or policy dialogue. The most common approaches seem to be to either use available skills available within country offices of the DPs¹⁸ or, when that approach was not feasible, to contract in expertise from external consultants on a need basis using resources from individual development partners. However, the point was made that a more critical issue was to ensure that the government itself (the Ministry of Health in particular) had access to those skills (staff, staff advisers or consultants) so that the same analysis could become available to both government and development partners. No examples could be found of positions being created at the level of DPs to advise either the DPs or the Working Groups.

¹⁸ This seemed to be by far the most common approach. For example, an economist or financial management specialist working in, say, Public Finance or Education sectors would be asked for help with analysis of documents coming from the health sector.

	Bangladesh	Mozambique	Uganda	Ethiopia	Cambodia
Is there a health SWAp? How many years running?	<ul style="list-style-type: none"> • Yes • (1998) 13 years 	<ul style="list-style-type: none"> • Yes • 2001 (10 years) 	<ul style="list-style-type: none"> • Yes • ?_?_? 	<ul style="list-style-type: none"> • No – but good coordination arrangements with DPs 	<ul style="list-style-type: none"> • Not quite, but there is great focus on H&A through sector wide management known as Swim. • At least 8 years
What is the main coordination mechanism among DPs?	<ul style="list-style-type: none"> • The HNP Consortium of DPs 	<ul style="list-style-type: none"> • The Health Partners Group (HPG) 		<ul style="list-style-type: none"> • Not sure if it has a formal name, but health partners meet separately. 	<ul style="list-style-type: none"> • Health Partners meeting (HPM)
How often does it meet?	<ul style="list-style-type: none"> • Monthly. More if necessary 	<ul style="list-style-type: none"> • Monthly 		<ul style="list-style-type: none"> • Monthly?? (not sure – being revised at the time of this snapshot. 	<ul style="list-style-type: none"> • Monthly
Is there a Secretariat linked to the DPs? What is its main role? How funded?	<ul style="list-style-type: none"> • Yes - for last 6 months only. One person • Admin support to Chairperson • TBD – so far SIDA 	<ul style="list-style-type: none"> • Yes – for last 2 years – 1 person (called FP Coordinator) • Admin support to Focal Partner Team; Gatekeeper for access to information 	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • NO – the TWG-H Secretariat is not linked to HPM but to TWG-H (see later)
Is there a Secretariat linked to the SWAp? Where located? How funded?	<ul style="list-style-type: none"> • Not formally– but Planning Wing of MOHFW is ad hoc, de facto coordination 	<ul style="list-style-type: none"> • No 	<ul style="list-style-type: none"> • Yes • In Planning Dpt, MOH • Basket fund 	<ul style="list-style-type: none"> • ?? 	<ul style="list-style-type: none"> • Yes, the TWG-H Secretariat, but this is more of a top coordination committee - see later

	Bangladesh	Mozambique	Uganda	Ethiopia	Cambodia
Is there an internet based information access point? How open or close is access to it?	<ul style="list-style-type: none"> • Yes, a blog managed by GiZ • Open to DPs only - 	<ul style="list-style-type: none"> • Yes . Huddle Workspace managed by Coordinator • Password 		<ul style="list-style-type: none"> • ?? 	<ul style="list-style-type: none"> • ??
What is the main coordination arrangement between Gov and DPs?	<ul style="list-style-type: none"> • HNPSP Coordination Committee • Forum around APR for "policy dialogue" 	<ul style="list-style-type: none"> • CCC monthly 		<ul style="list-style-type: none"> • JCCC – a sort of executive with 50% MOH (but mainly Director Planning) and 50% DP (about 5, elected for their skills) 	<ul style="list-style-type: none"> • The TWG-H Secretariat – in reality a top coordination committee of 7 MOH senior staff, 3 DPs + 1 NGO
How often does it meet? How is Gov represented? How are DPs represented?	<ul style="list-style-type: none"> • Monthly • Sec. Health; DGHS; DGFP; Joint Dir.; Some line dir. • Chair DP + World Bank. Proposed change to Troika ie Chair + 2 Co.Chairs 	<ul style="list-style-type: none"> • Monthly • Perm Sec Health, Directors • Focal Partner Group: FP + New or exFP + UN rep 			<ul style="list-style-type: none"> • Monthly, before the large TWG-H meeting • 7 senior officers • 3 DPs: WHO (chair), 1 bilateral, 1 multilat. • 1 NGO rep
Is there provision for larger meetings between all DPs and Gov? How often? Do they take place? Is CS/NGO represented?	<ul style="list-style-type: none"> • Yes. HNP Forum. Quarterly • No, except at APR • No 	<ul style="list-style-type: none"> • Yes – CCC "alargado" (enlarged joint coordination group), meets more or less quarterly, and CCS (supposed to be attended by HOM/HOC) that meets twice in a year • Yes • Yes 			<ul style="list-style-type: none"> • Yes, the TWG-H, meets monthly, it's a a large meeting, 1 monographic topic selected for each meeting
Are there Working Groups (Gov + DP) in place? Are they formally linked to the SWAp/ coord. Mechanism? What is their main role?	<ul style="list-style-type: none"> • No • No • Technical & sub-sector coordination • No – hardly ever 	<ul style="list-style-type: none"> • Yes, both technical and 6 WGs called "Aid Effectiveness" for oversight: • Yes (the 6 "oversight" WGs) • Oversight + additional analysis • Yes 		<ul style="list-style-type: none"> • Yes, mainly technical • Not linked to upper structures • Technical • No 	<ul style="list-style-type: none"> • Yes, they are known as Sub-TWG-H - ,mainly technical • Seldom, and not in a pre-defined manner • Seldom, and not in a pre-

	Bangladesh	Mozambique	Uganda	Ethiopia	Cambodia
Do they regularly report to higher level coordination structures?					defined manner
How are skills gaps addressed among DPs to better engage with Gov?	<ul style="list-style-type: none"> Ad hoc, usually by hiring TA and on occasion from within agencies. 	<ul style="list-style-type: none"> Ad hoc, usually by hiring TA and on occasion from within agencies. 		<ul style="list-style-type: none"> N.A. ?? 	<ul style="list-style-type: none"> Not any specific mechanisms defined
What are the sector or programme review arrangements? External team or mixed?	<ul style="list-style-type: none"> Annual Programme Review External, followed by Aide memoir DP + Gov 	<ul style="list-style-type: none"> Joint Annual Review (ACA) Mixed – Gov TL and external team 			
Is there a FORMAL mechanism for Coordination of TA to MOH? How about for DPs?	<ul style="list-style-type: none"> No Yes – the Consortium meetings – DPs fund it as per resources available 	<ul style="list-style-type: none"> No Yes – the HPG and FPG - DPs fund it as per resources available 			<ul style="list-style-type: none"> No Through information sharing, but not systematically done.
Any interesting features?		<ul style="list-style-type: none"> GFATM used to be a pooled funder – it was asked to leave the pool due to unpredictable behaviour and lack of interlocution capacity due to no country presence 		<ul style="list-style-type: none"> Ethiopia to become pilot for GFATM to operate through national plan 	

Annex 4: Review of progress and skills in the aid effectiveness working groups

Working Group & remit	Formation Stage & any issues detected	WG expected Inputs & role in relation to health SWAp	Essential Skills Requirements	Issues on access to essential skills
<p>Public Financial Management</p> <p>Covers financial management and audit, including issues relating to the health budget preparation and approval)</p> <p>Note: TOR of this WG were not available to the consultant.</p>	<ul style="list-style-type: none"> • TOR drafted twice – too technically focused? Final version not yet approved • It is yet to be defined how various roles will be performed, such as: coordination, representational role; analytical support: oversight and follow up with GOM & HPG • Membership extremely open – may become an issue given sensitivity of areas to be covered. Is there need to formalise a smaller “executive” for engagement with GOM? • Different areas have different counterparts at GOM level – the wide remit requires good division of labour within WG members to support co-Chair. 	<ul style="list-style-type: none"> • PES implementation, and whether this reflects agreed allocations and PFM issues raised at any level of SWAp mechanisms • PFM aspects linked to ACA • Budget execution, pre and post Parliamentary approval • Review of PROSAUDE audits and other relevant audits within MISAU • Crucial role to keep PROSAUDE partners involved and to feed back to non PROSAUDE partners on matters of their interest 	<ol style="list-style-type: none"> 1. Financial management in public sector & SISTAFE 2. Audits and management reports 3. Budgeting & resource allocation 4. Health financing, pooling, aid instruments 5. Procurement 	<ul style="list-style-type: none"> • They access skills in audit from auditors based in 2 agencies (Irish Aid and ??). They also contract in some support as/when needed. Jointly this may represent about 50 person/days per /year. Has to be mainly Mozambicans • Co-Chair feel a full time adviser position not justified better to continue with current approach. • Greater involvement of WB in this WG could improve access to skills but WB staff are themselves very stretched out.
<p>Monitoring and Evaluation</p> <p>Covers planning, investments, monitoring and evaluation</p> <p>Draft TOR and membership of WG available to consultant</p>	<ul style="list-style-type: none"> • The person who played the co-Chair role within SDC left in April. It is not clear if SDC has relevant skills in house to lead this crucial WG • TOR are quite detailed in terms of areas to be covered, but the specific plan of work (what inputs are required at what point in time) would need better definition. 	<p>These are extensively defined in the TOR – the following is a summary:</p> <p>Planning/M&E</p> <ul style="list-style-type: none"> • Preparation, dissemination, interpretation and follow up the annual joint reviews and CCS • Monitoring frameworks (health PAF, health PARP, etc; • Engage in the policy dialogue 	<ol style="list-style-type: none"> 1. Health planning and monitoring cycle in MISAU 2. Sector & programme monitoring and evaluation 3. Investments planning & expenditure monitoring 	<ul style="list-style-type: none"> • The group uses skills available within agencies that are part of the group. • Chair and Co-Chair when interviewed did not perceive that additional skills were necessary, although the mapping of these skills had not been done. • The notion of contracting

Working Group & remit	Formation Stage & any issues detected	WG expected Inputs & role in relation to health SWAp	Essential Skills Requirements	Issues on access to essential skills
	<ul style="list-style-type: none"> The scope of this WG appears very broad and mixed. There are overlaps with other WGs, as in the area of investments with the PFM WG. There is no mention to how the co-Chair will be elected. The membership is very large, perhaps too large to enable engagement with MISAU. We suggest this be reduced or an "executive" of the WG be created. 	<p>regarding the health sector planning, and prioritization processes (Annual PES, MTEF, BdP)</p> <ul style="list-style-type: none"> Dissemination of results of technical studies and reviews to improve planning and to minimize duplication of work. <p>On investments</p> <ul style="list-style-type: none"> Assist MISAU in the process of developing the Health Network ensuring consistency with PESS, PES and MTEF; Help build institutional capacity in MISAU to plan, implement and manage investments; Encourage the active participation of the provinces in investment plans; help establish an Infrastructure and Equipment Information subsystem. 		<p>something like a professional technical secretariat had not been discussed. Initial reactions were that this would not add value and that it would easily invade the competences of the MOH.</p> <ul style="list-style-type: none"> It was however accepted that the management of the WG could be improved through improved preparation of WG meetings.

Working Group & remit	Formation Stage & any issues detected	WG expected Inputs & role in relation to health SWAp	Essential Skills Requirements	Issues on access to essential skills
<p>Human Resources for Health</p> <p>Covers all HRH related areas: planning, management, training and development</p> <p>TOR and membership available to consultant</p>	<ul style="list-style-type: none"> • TOR finalised in April. The WG has introduced a Secretariat based in MISAU • Would this group encompass issues about capacity building of MISAU staff or about helping to map TA? • We suggest a review of the ways for electing the co-Chair as explained in main report. • The membership is very large: does this enable engagement with MISAU? We suggest a smaller executive of the WG might help to better engage on policy dialogue. • Strong leadership from National Director HHRR, but see comments 	<ul style="list-style-type: none"> • The main HHRR areas where the group will focus are well defined. • What is less defined is the way in which the group will ensure <u>oversight and focus in aid effectiveness in those areas</u> ie how this group is different from a technical WG. For example: how will H&A targets be set for those DPs supporting HHRR? Is there a need for a TA policy focusing on capacity building and on capacity building transfers? How and when will the implementation of the HHRR plan be discussed, and follow up of findings and recommendations from ACA and other reviews? 	<ol style="list-style-type: none"> 1. HRD and capacity building 2. HR Management and Planning 3. Performance management of managerial and service delivery staff. 	<ul style="list-style-type: none"> • In the interviews held the Chair was clearly against the idea of a professional Secretariat of any sort. He considered that MISAU, WHO and other members of the WG had enough skills to oversee implementation of the HHRR priorities.
<p>Medicines & Logistics</p> <p>Covers all areas linked to Drugs (procurements and supply chain management) and commodities</p> <p>TOR and membership available to consultant</p>	<ul style="list-style-type: none"> • Draft TOR available, not yet approved by MISAU • TOR suggest the group is an "enlarged forum" yet the Co-Chair clearly understands that the WG should be the primary coordination arrangement and the main space for policy dialogue between MISAU and DPs in the crucial 	<p>These are clearly defined – still, an annual calendar of key events for the WG to consider might be useful. The defined areas are:</p> <p>Annual Planning: approve 6 monitor annual action plan of GTM; discuss & approve relevant components of PESS</p> <p>Monitor and approve the integrated plan for procurement and delivery of medicines, including: needs</p>	<ol style="list-style-type: none"> 1. Drugs Supply Management Systems 2. Procurement rules at the GOM, Prosaude, etcetera 3. Annual budgeting procedures (PES, PELF) relating to WG remit 	<ol style="list-style-type: none"> 1. Skills currently available at co-Chair level provided through UNICEF 2. Mapping could not be completed but the view is several DPs (USAID, Clinton Foundation, JSI, among others) can contribute relevant

Working Group & remit	Formation Stage & any issues detected	WG expected Inputs & role in relation to health SWAp	Essential Skills Requirements	Issues on access to essential skills
	<p>area of medicines & medical supplies.</p> <ul style="list-style-type: none"> • Co-Chair admits it is hard for the group to change its technical orientation in practice • Quarterly meetings defined in TOR: is this enough? Given the large membership of the WG would it help if a small "executive" of WG met on a monthly basis. Important as all matters linked to medicines tend to be sensitive and MISAU may not like to be put on the spot in front of too many DPs. • WG is already helping mobilise needed TA through some DPs (esp USG) 	<p>assessment; resource allocation and financing through different financing sources; etcetera.</p> <p><i>Monitor activities linked to PELF:</i> O GTM irá acompanhar e monitorar os trabalhos realizados no Subgrupo, em conformidade com a implementação planificada do PELF.</p> <p><i>Monitoring visits to provinces as and when mutually agreed</i></p>		<p>skills at WG level.</p> <ol style="list-style-type: none"> 3. So the balance seems to be that there is sufficient competence, although the position of co-Chair held by UNICEF relies on continued funding for the position currently occupied by Co-Chair. 4. It was not perceived that a technical secretariat would be either acceptable to MISAU or would add value to the work of the group 5. New DFID adviser (soon to be) placed at WB seems to have relevant skills
<p>Service Delivery and programs</p> <p>Covering health services delivery and national programmes</p>	<ul style="list-style-type: none"> • The TOR have been drafted and membership is defined. Frequency of meetings is said to be monthly yet Chair (see later) says it is weekly?? • Co-Chair recognises that the shift from technical to oversight function is not yet there. • Chair is pleased with functioning of the Group. Explains he makes himself available every week for DPs to meet him. Is this too many? Is this technical 	<ul style="list-style-type: none"> • The objectives clearly point to the aid effectiveness function (coordinated policy dialogue; strengthen predictability, Harmonisation and sustainability; strengthen evidence and results based approaches). • However how these will be implemented in practice through a more systematic approach to how the meetings should be conducted and the agenda set is less obvious from the TOR. Perhaps this could be 	<ol style="list-style-type: none"> 1. Disease control interventions & Public Health 2. Knowledge of specific diseases 3. Harmonising and aligning national and global programmes with PESS & PES 4. Health services delivery, including integrated 	<ol style="list-style-type: none"> 1. Perception among Chair and co-Chair is that the WG currently has all the main skills required, and that when this is not the case TA can be easily accessed through DPs in the WG. 2. Perhaps some support might be needed to better define how to align and harmonise disease control interventions, as this area is not always well

Working Group & remit	Formation Stage & any issues detected	WG expected Inputs & role in relation to health SWAp	Essential Skills Requirements	Issues on access to essential skills
	<p>or oversight focus?</p> <ul style="list-style-type: none"> Chair suggests there is still too much one to one approaches by individual DPs to his Directorate on issues that should be discussed in WG 	<p>strengthened by ensuring that the agenda for all meetings contains those points?</p>	<p>delivery, local planning, etcetera</p> <p>5. HMIS and M&E issues linked to disease control interventions</p>	<p>understood among some DPs and MISAU officers from the DNS who are more familiar with vertical rather than horizontal interventions</p> <p>3. New GFATM Unit in MISAU perceived to be helpful to coordinate around 3 diseases.</p> <p>4. In conclusion the idea of technical secretariat not seen as relevant for this group.</p>
<p>NGOs</p> <p>Covers engagement with NGOs in health sector.</p>	<p>Not covered in this assignment</p>	<p>Not covered in this assignment</p>	<p>Not covered in this assignment</p>	<p>Not covered in this assignment</p>

Annex 5: List of Documents Reviewed

Mozambique

Terms of reference for the Aid Effectiveness Working Groups:

General TORs: Aid Effectiveness Working Groups in Health. Draft, 2010

TOR for the Working Group on Planning, Investments, Monitoring & Evaluation

TOR for the WG on he

Terms of Reference: Health Partners Coordination Framework. Undated.

Draft Discussion Note: Are we as effective as we could be? Health Partners Retreat, 2010.

The Kaya Kwanga Commitment: a code of conduct to guide the partnership for health development in Mozambique. 2001, revised 2003.

Terms of reference for the Sector-wide Approach (SWAp) in Health, Ministry of health of Mozambique and Co-operating Partners, Maputo 2007.

Terms of Reference – SWAp Coordinator – Mozambican Health Sector. Nov 2010.

Memorandum of Understanding. Prosaude II. Including Annexes. Maputo, July 2008

UN Mozambique. Capacity Assessment of the UN agencies in Health and related sectors in Mozambique. Dalberg. Final report, November 2009.

Vio, Ferricio. Management of expatriate medical assistance in Mozambique. *Human Resources for Health* 2006 **4** 26.

Cross Country Studies

HTSPE, UK. Aid Effectiveness Agenda: benefits of a European Approach.. European Commission, November 2009.

Bangladesh

HNPSP Pre-Appraisal Aide Memoir and Annexes XI and XII

HPNSDP Appraisal Aide Memoir Final

Partnership Arrangements between the Government of Bangladesh and Development Partners concerning support for the implementation of the Health, Nutrition and Population Sector Programme (HNPSP)

Joint Financing Arrangement. Bangladesh Health, Population and Nutrition sector Development Programme (HPNSDP 2011-2016). DRAFT March 9, 2011.

Overview of Task Groups, HNPSP, January 19 2010

HNP Consortium. Overview of Task Groups and Other Forums for Coordination between GOB-DPs, January 16, 2011

ERD, Aid Effectiveness Unit (AEU), A paper on LCG Working Groups Restructuring

ERD, LCG Sub-Group Guidelines

MOHFW, Planning Wing. Notification on the constitution of the LCG Group Health, 5 January 2011.

Job Description for the Secretariat for Health, Population and Nutrition Consortium, August 18, 2010

HNPSP Code of Conduct, Discussion paper, July 2010

HNPSP 2010. Annex 1 – List of the HNPSP Task Group members

ERD, AEU, Bangladesh Joint Cooperation Strategy 2010-2015. How to work more effectively together to deliver real development outcomes. June 2010.

Approved Terms of Reference, health, population and Nutrition Consortium Bangladesh.

HNPSP APR 2006, Main Report

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Multi-Donor Trust Fund Grant Agreement between People's Republic of Bangladesh and the International Development Association

Trust Fund Administration Agreement between (...) and the International Development Association concerning the Multi-Donor Trust Fund for the health, Nutrition and Population Support Program in Bangladesh (TF No. 070396). March 20, 2008.

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Wilkinson, D. review of the Technical Working Group – Health- ans its Secretariat. Department for International Cooperation, Ministry of Health. 11 February 2008.

Shoko Sato. Technical Notes on the structure of the Cambodia Sector Coordination Arrangements. Personal Written Cokmmunication. March 2011.

An Assessment of Progress under the Sector-Wide Management (SWIM) and recommendations to the MOH and Health Partners for improving Harmonization and Alignment in the Health Sector. Ministry of Health, March 2007.

Ethiopia

Technical Assistance Guideline for Ethiopia. Federal Ministry of Health, Government of Ethiopia, July 2009.

Pereira, Javier. Ethiopia: Aid Effectiveness in the Health Sector – Case Study. Action for Global Health. September 2009.

Terms of reference (TOR) for the Joint Core Coordinating Committee (JCCC) of the Health Sector Development Program (HSDP). Source and date Unknown.

Terms of references (TOR) for the Joint Consultative Forum (JCF) of the Health Sector Development Program (HSDP). Source and date unknown.

Terms of reference to take forward the Internation Health Partnership in Ethiopia. 2011.

Malawi

Pearson, M. Impact Evañluation of the Sector-wide Approach Malawi. Draft Report 12 Mar 2010. DFID Human Development Resource Centre.

GTZ. Human resources/Capacity Development within the Health Sector – Needs Assessment Study. Final Report, June 2007.

Carlsson et al. Malawi Health SWAp - Mid-Term Review. Ministry of Health, Malawi. 26 January 2008.

Nepal

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Code of Conduct for Partnership in Health. Ministry of Health, Nepal.

External Development Partners – Health Sector – Nepal. Terms of Reference: Chair and Co-Chair. Ministry of Health. August 8, 2006.

NEPAL: HEALTH SECTOR PROGRAM IMPLEMENTATION PLAN II (NHSP IP II)

Joint Annual Review (JAR), January 31-February 2, 2011. AIDE-MEMOIRE (draft for further discussion)

Joint Financing Arrangement. Nepal Health Sector Program II (NHSP 2). Draft.

NEPAL HEALTH SECTOR DEVELOPMENT PARTNERSHIP (NATIONAL COMPACT) between Ministry of Health and Population Federal Democratic Republic of Nepal and External Development Partners. September 2008

Tanzania

A Critical Assessment of Aid Management and Donor Harmonisation in Tanzania. A case Study. Afrodad, 2007

Wohlgemuth Lennart. Changing Aid Modalities in Tanzania. Center for African Studies • Göteborgs Universitet

Zinnen Véronique. Sector-Wide Approach (SWAp) and Health Service Delivery in Tanzania. For Task Team on Health as a Tracer Sector (TT HATS). January 2011.

JOINT ASSISTANCE STRATEGY FOR TANZANIA (JAST). Final Draft. May 2006. Government of the United republic of Tanzania.

Uganda

HEALTH SPENDING IN UGANDA THE IMPACT OF CURRENT AID TRUCTURES AND AID EFFECTIVENESS. Action for Global Health, April 2010.

Williamson, Tim and Moon, Samuel. Reinvigorating the pursuit of more effective aid in Uganda. ODI, September 2010.

Notes on structure and functions of the Uganda Health SWAp. Personal written communication by Ulrika Hertel, First Secretary/Senior Programme Manager Health Sector, Embassy of Sweden, Kampala, Uganda.

Zambia

Pereira, Javier. Aid Effectiveness in the Health Sector. Case Study. September, 2010. Action for Global Health.

Annex 6: Questionnaire for Health Partners Group

Mozambique Health Partners Group Review of Health Partner Group Functions and Structure to Maximise Effective Engagement with MISAU - April 2011

Questionnaire to map issues and guide interviews next week

Dear Colleagues,

- *This questionnaire attempts to help the reviewer, Javier Martinez, to map a few issues relevant to the work that he will begin on **Monday 11th April** in Maputo.*
- *It should not take you more than 5-10 minutes to respond to the questionnaire.*
- *You can also use the questionnaire to highlight any issues that you would like to discuss with the reviewer in person, next week.*
- *Any person(s) from your Agency who normally attends meeting of the HPG is entitled to respond. It would be preferable that there is not more than one person per agency replying to this questionnaire.*
- *While the information provided here will be used to map out certain aspects of the work ahead such information is not collected for statistical purposes and it will be treated as CONFIDENTIAL.*
- *Please send this questionnaire back to the consultant Javier.martinez@hisp.org AS SOON AS POSSIBLE, AND POSSIBLY NO LATER THAN FRIDAY 8TH APRIL 2011.*

Section A Data on respondent

This section is for coding purposes – it will not be shared by the consultant

1. Please write your name:
2. Name of your Agency:
3. Is your Agency a pool funder or SBS funder? Yes/No:
4. Your designation within your agency:
5. Years you have been involved in health sector in this Agency: Years
6. Years you have been involved in the Mozambique health sector: Years
7. What is your professional background BY TRAINING?¹⁹ :

Section B Skills needed to better engage with MISAU/GoM

1. The following skills have been listed in the TOR as the most crucial to better engage with MISAU/GOM in matters relating with the health sector plan. Please **tick the ones** that you consider most important and use the space below to include any that is/are not mentioned in the list and that you consider also very important.

- Audit:
- Fiduciary Risk Assessment:
- Public Financial Management:
- Sector/SWAp Monitoring and Evaluation:
- Procurement and logistics planning:
- Medicines:

¹⁹ Are you a doctor, a teacher, an economist, a journalist, a career diplomat, , etcetera - BY TRAINING?

- I think the following skills are also CRUCIAL to engage BETTER with MISAU (PLEASE WRITE):
-
-

2. In relation to the skills listed in the previous question: Does your agency have access to those skills on a day to day basis? For example, you may have people (staff/advisers) with those skills working in other sectors ... Please tick the boxes only if your answer is YES and briefly explain who possesses the said skills

- Audit:
- Fiduciary Risk Assessment:
- Public Financial Management:
- Sector/SWAp Monitoring and Evaluation:
- Procurement and logistics planning:
- Medicines:
- Skills that you included in Question 1: :
- Any comments you wish to add?:

-
-

Please expand on issues above if you want to:

3. How would you rate the performance of the HPG in achieving the following aims?

For each aim please assign a score according to the following scale:

- 0= no achievement;
- 1= some achievement, but highly insufficient;
- 2= some achievement and progressing well;
- 3= good achievement and sufficient progress;
- 4= excellent achievement and progress.

- a. Promote Development Partner (DP) coordination:
- b. Promote coordination with MISAU:
- c. Promote coordination with civil society and other actors:
- d. Promote transparency with the DP community:
- e. Promote transparency between DPs and MISAU:
- f. Serve as platform for policy dialogue with MISAU/GOM on health matters:
- g. Promote best practices in DP assistance:
- h. Promote the effectiveness and efficiency of aid in the HNP sector through coordination of Technical Assistance:

4. Among of the following statements which are the ones you AGREE MORE WITH? (Please tick):

- a. Alignment among HPG partners is weak and/or unclear:
- b. Alignment among HPG partners is strong and/or clear:
- c. We DPs currently achieve good leverage in policy dialogue with MISAU:

- d. We DPs do not achieve much leverage in policy dialogue with MISAU: .
- e. There is not really much policy dialogue between DPs and MISAU except around the Annual Review and/or CCS, and that IS INSUFFICIENT: .
- f. There is not really much policy dialogue between DPs and MISAU except around the Annual Review and/or CCS, and that IS ENOUGH: .
- g. There should be more regular, better structured policy dialogue between DPs and MISAU/GOM, particularly in relation to sector priorities: .

Any additional comments?

-
-

5. IF YOU FEEL that DPs are not achieving enough leverage with MISAU or engaging enough with MISAU on key issues please state what you think are the main reasons for it? (Please tick as many as you want)

- a. The HPG is not sufficiently linked to other parts of Government apart from MISAU, which results in certain systemic issues not reaching the top levels of GOM: .
- b. The HPG members do not work effectively enough with other parts of their own agencies to achieve greater results in other sector that have an impact in health: .
- c. The HPG tries to cover too many areas and/or its members have too many priorities encompassing the whole spectrum of the health sector: dispersion works against focus and leverage. .
- d. It would be good for DPs to prioritise between 3 -5 REALLY KEY policy areas, and to stick to these and to hold MISAU and ourselves the DPs accountable for these. .
- e. One problem is that the Focal Partner Group do not achieve much: they keep on raising the same issues and get reassuring commitments but main issues remain the same. .
- f. A key problem is we DPs lack technical skills in certain crucial areas and cannot really engage effectively with MISAU/GOM in those
- g. If you ticked (f) which technical skills are we lacking? .
- h. Any additional reasons? .

Section C HPG Meetings

1. Are you the person usually designated by your Agency to participate in HPG meetings?

(Yes/No) : .

2. Do you feel that HPG meetings are well PREPARED? Please answer in your own words and look at the list of issues that you may wish to consider in the footnote²⁰:

- Please explain:

-

3. What is your impression about the NUMBER OF TOPICS to be covered vis a vis the amount of time you have available to meet? For example, is the agenda too full, too empty or about right?

- Please explain:

-

²⁰ You may like to consider, for example, the following aspects: an agenda is circulated at least a day before the meeting; there is provision for reviewing points from earlier meetings and for feed back from other meetings such as CCC or from Working Groups; etcetera

4. Is there usually sufficient time to cover AT LEAST THE most important topics? If not, do you feel that some topics might require higher degree of analysis prior to the meeting?

- Please explain:

-

5. Do you think that, generally speaking, HPG members have the required skills to analyse issues discussed at the meeting? If not, are additional skills called upon as often as needed?

Please explain and provide examples if possible for us to explore when we meet:

-

6. Do you feel that WORKING GROUPS currently make a positive contribution to the HPG meetings and help the work and deliberations of HPG? Which working groups WORK BETTER in your opinion?

Please explain:

-

Section D Working Groups

1. Do you participate in any of the following Working Groups and, if so, in what capacity? (i.e. as Co-Chair, as Participant, etc). Please tick the ones in which you participate and state in what capacity

- Audit and Financing: .
- Monitoring and Evaluation: .
- Human resources for Health: .
- Engagement with NGOs/Private Sector: .
- Medicines and logistics: .
- National Health Service Issues: .

2. How would you define its functioning: (please tick)

- a. It is very quite well organised and meets regularly: .
- b. It is disorganised and seldom meets: .
- c. It feeds regularly information into the larger HPG: .
- d. It is not linked in a clear way to the HPG or to the SWAp coordination structures: .

3. If the performance of these working groups is, in your opinion, below acceptable standards or dysfunctional what would you consider to be the main reasons for it? (tick as many as you need)

- a. Lack of leadership by the GOM officers who are supposed to lead: .
- b. Lack of support or engagement from the members of the HPG who are part of these groups: .
- c. Turnover is too high, continuity and institutional memory are a problem for both MISAU and HPG members: .
- d. Lack of perceived usefulness of the WG by either the GOM or HPG members: .
- e. People are too busy with many things and the working group suffer: .
- f. Chairs, Co-Chairs or members do not have the required technical skills to analyse and make progress on the issues that are raised: .
- g. The specific TOR of the WG are not clear: .

- h. The specific responsibilities of Chairs and Co-Chairs are not defined. [redacted] .
- i. Any other reason? [redacted] .

Section E Anything you really want to share with this reviewer about the effectiveness of coordination arrangements and engagement with MISAU/GOM? Any examples from other countries where you have worked before?

Please explain:

-
-
-
-
-

Thank you very much for taking the time to answer these questions!

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