Pacific Regional HIV/AIDS Project

Review of National AIDS Coordination Mechanisms

in

Pacific Island Countries

Final Report

April 2006

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Annexes

ACRONYMS

CCM   Country Coordinating Mechanism
CBO   Community based Organisation
CDO   Capacity Development Organisation
CPG   Community Planning Group
GFATM   Global Fund for fight against AIDS, TB and Malaria
MDG   Millennium Development Goals
MoH   Ministry of Health
NAC   National AIDS Council
NCM   National Coordination Mechanism
NGO   Non-governmental Organisation
NSP   National Strategic Plan
PIC   Pacific Island Country
PRHP   Pacific Regional HIV/AIDS Project
SPC   Secretariat for Pacific Community
STI   Sexually Transmitted Infection
TB   Tuberculosis
TOR   Terms of Reference
UNAIDS   Joint United Nations Programme on HIV/AIDS
UNGASS   United Nations General Assembly Special Session on HIV/AIDS

1.0   Background

The Pacific Regional HIV/AIDS Project (PRHP) was designed in 2001 and commenced in November 2003. The project is funded by Australian government and works across 14 countries. It is implemented by the IDSS and Burnet in conjunction with the Secretariat of the Pacific Community (SPC), through what is known as the Franco-Australian initiative.

The project has 3 components, component 1 being implemented by the Secretariat of the Pacific Community, Component 2 and 3 being implemented by the AMC. Component 1 deals with the development and implementation of the second regional strategy and Component 2 deals with the strengthening of capacity to implement national strategies, and disbursement of grants to enhance responses at the local level through Community Development Organizations (CDOs) and other local non-Government Organizations (NGOs). Component 3 deals with project management and administration.

During the two years between the design of PRHP and the start of its implementation, there were significant changes in the HIV and AIDS situation and responses in some Pacific Island countries (PICs) targeted by the PRHP. For example, the number of newly detected HIV infections increased in some countries, whilst remaining stable in others. In addition, some of the countries that had developed national HIV/AIDS strategic plans through a previous AusAID-funded HIV/AIDS Strategic Planning project began implementing these plans. Within this context, it is important that PRHP captures the current HIV situation in partner countries to ensure that project activities address existing needs. Throughout 2004, PRHP staff visited partner PICs to introduce the project, engage stakeholders, and assess the HIV situation and response. PRHP also conducted a rapid assessment of National AIDS Committees (or equivalent) on their response to HIV in their country and identified capacity development needs of partners to enhance the response to the epidemic.

The Project has made significant progress in the implementation of the components. However it is seeking to review some of this progress in order to identify ways to strengthen its role in supporting the work of coordination of responses to HIV and AIDS in the fourteen PICs with which it is working. Specifically it is seeking to focus on capacity building and assessment of country needs in order to strengthen capacity to implement National Strategies.

The purpose of this Review was to inform PRHP's strategies to:
- Strengthen the capacity of National Coordination Mechanisms to coordinate, manage and monitor National Strategic Plans
- Strengthen the capacity of National Coordination Mechanisms to effectively manage technical assistance and other development initiatives in support of country partner-owned and led priorities
- Encourage a harmonised and collaborative national approach (NACs and CDOs) to coordinate the implementation of action/strategic plans

This report outlines the findings from this review and makes a number of recommendations to improve functioning and sustainability of National Coordination Mechanisms (NCMs) and proposes strategies for PRHP assistance to strengthen NCMs. Terms of Reference for the Review are at Annex 1.

1.1   Methodology

The review was undertaken during October 2005. The following methods were used to conduct this review:

- Review of documentation including PRHP reports, specifically situational analyses from twelve PICs, minutes of NCM meetings, other papers on country programs, national strategic plans; briefings from PRHP team members to attain knowledge on current capacities, structures and issues relating to PICs.
- Visits to a sample of PICs to more specifically assess the relationships between NCMs, CDOs and other key stakeholders, engagement of CDOs with NCMs, to assess capacity for management and coordination of the response in these countries. The following countries were selected on the basis that they represent different PIC categories based on country contexts, HIV incidence and functionality:
  - Solomon Islands – This has a well-functioning NCM model that can provide valuable lessons for other PICs.
  - Fiji – The NCM is functioning well on some levels, however coordination and collaboration with development partners needs to be addressed, which is an issue given the expanding HIV/AIDS epidemic.
  - Samoa – The NCM is not functioning effectively and the CDO is weak and the relationship has not promoted effective coordination.
- Additional consultations were held with delegates from a number of PICs who were attending the **Pan-Pacific HIV/AIDS Conference in Auckland, and a group session was held with CDO representatives during the conference.**
- Information collected was analysed and preliminary findings were presented at Pan-Pacific HIV/AIDS Conference in Auckland in late October 2005. Discussion from this session was also used in drafting this report.

The review was limited by the small number of country visits and the extent of consultation that was possible among delegates at the Auckland conference. This was intended as a rapid review of national coordination mechanisms and is therefore limited in its depth and breadth of analysis. However it does provide a general picture of these mechanisms and actions that the Project could take to strengthen these structures.

2.0   National Coordination Bodies

Two decades of experience in responding to the epidemic of HIV and AIDS show that the critical elements for managing an effective response are multi-sectoral planning and coordination, effective monitoring and the active engagement of all sectors. We know from this experience that the effort needed to scale up and intensify a national response requires a government led coalition which accommodates and coordinates all partners working within a national strategic framework. Since the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration in 2001, there has been an increasing focus on building national capacity to lead the response through development of national action frameworks and national coordinating bodies. Among the key targets for UNGASS are indicators on national commitment and action and this Declaration has committed countries to establishing and strengthening mechanisms for coordination by 2003. For UNAIDS, supporting the functionality of national coordination authorities remains a priority. By 2003, around 90% of countries surveyed by UNAIDS had created national multisectoral bodies to facilitate

coordination between government, private sector, civil society, people living with HIV and AIDS and vulnerable populations.

The types of national coordinating bodies reported in countries around the world are:
- National AIDS Commissions and Councils – these are usually the high-level bodies mandated by government to lead the response
- Government led partnership forums and working groups – these forums have been established to involve the broad range of stakeholders in policy and program development and implementation
- Expanded UN Theme Groups – these have evolved to include other stakeholders outside the UN system
- Global Fund Country Coordinating Mechanisms – this mechanism coordinates the design and implementation of Global Fund programs

These bodies may act as the sole forum for coordination in some countries but frequently there are multiple bodies working to coordinate different aspects of the response. Sometimes these efforts are coordinated but frequently they operate independently and separately from each other.

The effort globally to establish national coordination mechanisms looks impressive, however the existence of national coordinating bodies and strategic frameworks does not necessarily translate into effective response and action. We know that successful responses are due to central government leadership and political will, commitment and an ability to mobilise resources, and mechanisms to support strong partnerships between all sectors. Few countries have been able to achieve all of this.

Two key areas that have been highlighted as contributing to the weaknesses of national coordinating authorities are:[1]
- *Absence of strong mandates and support*. These bodies lack accountability, authority and legitimacy and overall leadership of response.
- *Absence of human resource capacity and/or management and institutional authority*. Capacity among national authorities for planning, resource mobilisation, coordination, information management and monitoring and evaluation is very limited. Low salaries, limited training and skills contribute to this constraint. Only 9% of countries surveyed had capacity for coordination.

Many of the constraints to effectiveness of coordinating bodies relate to the involvement and engagement of players. These are:
- Lack of central government agency support and funding
- Minimal engagement of non-health government ministries and a lack of cooperation between ministries
- Civil society organizations are not actively included in decision-making bodies
- Donor support is often fragmented, uncoordinated and operating outside of government systems

Other challenges relate to the operations of these bodies. These are:

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[1] UNAIDS The "Three Ones" in Action: Where we are and where we go from here. May 2005

- Difficulties in getting high level participation – most government leaders do not have the time to attend meetings
- Sectoral representatives often have unclear mandates from their sector and processes for consultation and feedback are not well developed
- There are limited mechanisms for reporting on, reviewing and monitoring the response
- Lack of adequate staffing and experienced personnel in Secretariats
- Political interference with appointment of personnel to these bodies

The role of the health sector in the response continues to be raised as an issue of concern in relation to coordinating the response. While the Health sector plays a central role in managing and coordinating the response to HIV in Pacific countries, in many other countries it has been reported that the Health sector is being increasingly marginalised through the establishment of a multisectoral response, resulting in friction and competition with NAC[2]. This has come about not only through the shifting of responsibility of managing the response from health to NAC, but is also due to the equal weight and responsibility being given to other sectors to become engaged in the response. While health is the technical agency on HIV for other government departments and sectors, it has often not been given any special status or control in relation to the NCM. This is creating significant tensions in some countries, especially around management and disbursement of funding for HIV programs.

In countries were HIV prevalence is low, Ministries of Health are usually managing and coordinating the response. However its role in overseeing the implementation of the response is often compromised by its lack of authority over other government agencies. Ways around this are to invest in Health Ministries the explicit authority to manage the coordination of the response. This occurs in Brazil where the Ministry of Health continues to manage the response and has developed an inclusive coordinating mechanism with a broad range of sector agencies. This country has achieved considerable success in its control of the epidemic.

Country Coordinating Mechanisms (CCMs) are partnership committees with broad stakeholder membership and are established in those countries which are in receipt of funding from Global Fund for fight against AIDS, TB and Malaria (GFATM). CCMs are designed as public-private partnerships to coordinate development of GFATM proposals and oversee the implementation of fund-supported activities. While there are a number of issues reported around governance, management, and representation in relation to the operations of CCM, an important issue is their relationship with NAC and the potential for duplication around roles relating to oversight of the HIV response. In many countries GFATM provides the major source of funding for the response and much of this funding is being managed through Ministries of Health. This has led to some friction between NAC and MoH around who manages funds and has oversight of their implementation.

Much of the impetus for coordination has been driven by funding and technical support provided by donors. However in some countries where there are significant number of players, the imperative for coordination has also have been driven by the large numbers of donors trying to interact with government, local NGOs and with each other at national and provincial levels. The establishment of coordinating mechanisms has also been driven by donor needs - an interesting comment on the Partnership Committee in Uganda, is, that it was created by donors as a way to get around the

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[2] Putzel J. Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal. May 2003

weaknesses of the Ugandan AIDS Commission "to coordinate programs and eliminate duplication and waste"[3].

Further, mechanisms for participation and engagement in the response are variable, with civil society often finding it difficult to have its voice heard and gaining meaningful representation on coordinating bodies. Similarly, funding from the increasingly crowded field of donor agencies has brought different reporting mechanisms and expectations in relation to government policy and direction.

While much of the literature is focused on the structure of national coordinating bodies, it is these processes that make coordination work. These include:
- Regular and joint planning processes
- Processes for review, monitoring and evaluation of activities
- Processes for making decisions about program direction and use of funds
- Processes for documenting and sharing information between agencies and across sectors
- Developing linkages between sectors and agencies working at national, provincial and district levels
- Processes for resource mobilisation and allocation

A recent report by Global Task Team on coordination stated that:
"*Coordination, alignment and harmonization are not ends in themselves, but rather means to achieve results on the ground*".[4]

2.1   Improving national responses – The 'Three Ones'

As the level of effort to respond to HIV increases among government and international agencies, the risk of duplication, overlap and fragmentation is increasing in many countries. In late 2003, UNAIDS introduced a set of guiding principles for national authorities and their partners. Known as the "Three Ones", these principles aim to coordinate national responses through clarifying roles and responsibilities, promoting an environment of cooperation among players in order to make best use of resources. These are:
- One agreed HIV/AIDS Action Framework that drives alignment of all partners
- One national AIDS authority, with broad based multisectoral mandate
- One agreed country-level monitoring and evaluation system

The "Three Ones" identify areas of improved responses, greater integration of efforts at country level including ways for donors to work together and in support of government responses. The principles outline a number of "suggested actions", recognising that each countries situation is unique, that there is no one template or formula that should be applied, and that responses need to be tailored to address the particular realities in each country.

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[3] Putzel J. Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal. May 2003
[4] UNAIDS. Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. June 2005. p. 12.

In an effort to improve the functioning and capacity of national coordinating bodies the following actions are suggested:[5]

- Ensure that the national coordinating body has support of highest level of government and that it has the budget, human resources and authority to do its job.
- Consider legislation, by-laws, terms of reference, guidelines and training so that national councils and secretariats have clear mandates, instructions and support for ensuring broad multisectoral participation.
- Make capacity building a top priority in national action frameworks, workplans and budgets and a top priority in negotiations for donor support
- Make fair wages and benefits, including good working conditions, top priorities when budgeting and negotiating for funding.

In line with these actions, donors are encouraged to harmonise their policies, procedures and practices, develop mechanisms to coordinate among themselves and with governments, devise ways to work with government policies and priorities, and to support national efforts to establish and strengthen national coordinating mechanisms and frameworks. The focus on building the human resource capacity is also highlighted as a critical area for donor support.

3.0   National Coordination Mechanisms in Pacific Island Countries

3.1   Overview of Response to HIV and AIDS in Pacific

HIV was first reported in a Pacific Island Country in 1984. At December 2004, 1028 cases of HIV including AIDS had been reported across Pacific Island Countries and Territories (excluding PNG). The highest number of reported infections are from Fiji, French Polynesia, Guam, Kiribati, New Caledonia. Prevalence rates of HIV are also relatively high in a number of PICs due to low populations. In this regard Tuvalu has a one of the highest rates of HIV among its small population.

Determinants of HIV transmission are: high rates of STIs and TB in the regions; poor health and social indicators; high rates of mobility between islands and throughout the region, including people moving around for work such as seafarers; young sexually active populations; gender relations and violence against women, cultural taboos and practices; limited economic opportunities and high unemployment and weak country economies. Further, as reported rates of infection are relatively low, HIV is not seen as a high priority for funding or program development.

The key challenges in addressing HIV and AIDS have been identified as:[6]

- Inadequate surveillance and monitoring capacity
- Difficulties with long distance communication
- Providing sustained leadership at all levels
- Lack of resources
- Culture as a barrier to prevention
- Lack of capacity in all aspects of HIV response

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[5] UNAIDS The "Three Ones" in Action: Where we are and where we go from here. May 2005
[6] Final Draft of Regional Strategy on HIV/AIDS (2004-2008)

- Difficulty in sustaining comprehensive national responses
- The need for coordination at national and regional levels
- Dealing with vulnerable groups
- Addressing stigma and discrimination
- Building capacity for treatment of those infected

It is evident that many countries in the Pacific initially responded to the threat of HIV and AIDS during the late 1980s and early 1990s, through the establishment of units within Ministries of Health, development of strategic plans and setting up national coordinating bodies. Much of the support for these responses came from WHO initially and then through support from an AusAID HIV/AIDS project which assisted in the development of a strategic planning process across 17 PICs. Through this project 12 PICs developed National Strategic Plans. These plans featured a multi-sectoral approach that included programs to prevent and control HIV/AIDS & STIs, however the plans did not include Millennium Development Goals (MDGs) and only a few included budgets and monitoring and evaluation plans[7].

Much of this early impetus to respond to HIV and AIDS has fallen away. Many countries have not committed the financial and human resources to sustain the momentum needed to implement their strategies and have not shown sufficient leadership to make HIV a national priority.[8] More recently however Pacific leaders endorsed the Pacific Regional Strategy on HIV/AIDS (2004-2008) and four PICs (Fiji, Kiribati, Tuvalu and Solomon Islands) have provided specific funding for the HIV response in their countries.

Most countries have also established national AIDS committees (NACs) to guide policies and program strategies. However, these committees have in general not performed well. In a situational assessment of the 1997-2000 Regional AIDS/STD Strategic Plan, it was reported that these committees have been hampered by infrequent meetings, lack of autonomy and lack of influential representation within the overall health sector, lack of secretariat support, unclear roles and responsibilities.[9] Kiribati was nominated as an exception with the establishment of a joint-committee on HIV/AIDS and TB made up of three members of Parliament and at least three people from the National Task force, a national NGO. This is seen as a demonstration of commitment at senior political levels to tackle the epidemic.

3.2   Overview of NCMs in Pacific

In this review of national coordinating mechanisms it is evident that majority of countries have a coordinating mechanism, that these are formal bodies with defined representation, and terms of reference. Twelve out of fourteen countries surveyed have some form of NCM. The form of these bodies varies across PICs. They include:

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[7] PRHP. Milestone 2 Report: HIV/AIDS situation and responses in twelve Pacific Island Countries Oct 2005.

[8] SPC. Franco-Australian Pacific Regional HIV/AIDS & STI Initiative: Situational and response analyses for HIV/AIDS & STI prevention, control, care and support services in Pacific region in relation to the components of the 1997-2000 regional AIDS/STD strategic plan. March 2004.

[9] ibid.

- National AIDS Committees or Councils
- Stakeholder forums and meetings
- Sub-committee or working groups
- Taskforces of government and civil society representatives
- Community Planning Group, a requirement for managing funding within countries receiving US government funding
- Country Coordinating Mechanism for GFATM funds

These committees are largely multi-sectoral in nature and all are led by Ministries of Health. The committees are also managed within Ministries of Health, and only a few have adequate secretariat support. There is limited engagement of other government agencies on these committees and processes for the involvement of development partners with these bodies have not been developed.

Other characteristics are summarised as:
- Three NCMs have legal status – Samoa, Cook Islands, Solomon Islands
- One country has a NGO-led NCM – Kiribati
- Ten countries have some form of strategic plan and a number are in the process of reviewing and updating their plans
- Most countries have a nominated HIV coordinator (from within MoH). One country (Fiji) has a Project Officer dedicated for HIV and AIDS. All other Coordinators have multiple responsibilities.
- CCMs in a number of countries are playing an active role in coordination
- Capacity Development Organisations (CDOs) are operating in 8 countries to support the NCMs

A table summarising these characteristics is attached as Annex 2.

3.3 Case Studies of specific National Coordination Mechanisms

3.3.1 Solomon Islands National AIDS Council

The coordinating mechanisms in Solomon Islands are:
- Solomon Island National AIDS Council - meets quarterly
- Intersectoral working groups – still being formed
- Stakeholders meetings – held six monthly

The national strategic plan was reviewed in 2004 through broad stakeholder input. The National HIV Policy and Multisectoral Strategic Plan 2005-10 was endorsed in early 2005. This Plan includes operational plans that are costed and which set out responsibility for each sector.

The NCM was endorsed by the Government of Solomon Islands as the Solomon Islands National AIDS Council (SINAC) in 2004. It has 31 members, which includes a large group of government, NGO and civil society representatives. Private sector is represented through the Chamber of Commerce. The SINAC has held four meetings since it was established in September 2004. It is chaired by Minister of Health.

The SINAC is supported by a number of Intersectoral Working Groups. These are:

- Behaviour and Sentinel Surveillance and Research
- Advocacy strategies with Youth, PLWHA, Gender and other Vulnerable Groups
- Legal and Ethical Issues, HIV Management Policy and Legislation
- Behaviour Change Communication (BCC): Information, Education and Communication (IEC) materials, Condoms, Media, Health Promotion and Risk Settings
- Counselling, Care and Treatment
- Monitoring and Evaluation and Planning

Further information on the structures and specific terms of reference is attached at Annex 3.
The SINAC is supported by Oxfam as the nominated Capacity Development Organisation (CDO). This arrangement is designed to assist with facilitation of meetings and manage the PRHP grant processes.

Stakeholder meetings have been established to bring together the range of players involved in implementing the response to HIV and AIDS. These meetings are held six monthly and are proving to be a useful forum for discussing issues and reviewing the program. These meetings are used for the following purposes: an opportunity for discussion, sharing and learning; debate and discussion on emerging concerns and topics; presentations on key activities and findings from surveys and research eg SGS studies; forum for raising awareness and assessing new approaches. Through discussions at these forums areas for policy development emerge. These issues are then referred to the relevant Intersectoral Working Group for further discussion and development.

Stakeholder meetings are usually structured in a workshop style to maximise participation through group discussion. Up to 40 people may attend these meetings.

The CDO Coordinator and Ministry of Health work closely to facilitate the processes for the meetings. The CDO was until recently providing most of the secretariat support to these structures and devising processes for stakeholder meetings. It is now expected that the Ministry will take over this role though its Secretariat.

The Secretariat will be responsible for organising and resourcing the meetings of SINAC, the stakeholder meetings and the intersectoral working groups. The Secretariat will be required to communicate with members on timing of meetings and facilitate some of the meeting processes. It will also be responsible for distributing minutes and papers for meetings in a timely way. An important part of the stakeholder forums has been the survey of response activity undertaken among implementing agencies. This has been undertaken by the CDO and may need to become a role for the Secretariat. The Project will need to support the MoH to identify capacity needs of the Secretariat to carry out these functions. This could be done by the CDO once the Secretariat is in place, given the excellent working relationship that exists between the CDO and MoH. This may mean that the CDO provides training and mentoring support for a period of time to develop these systems, processes and capabilities within the Secretariat.
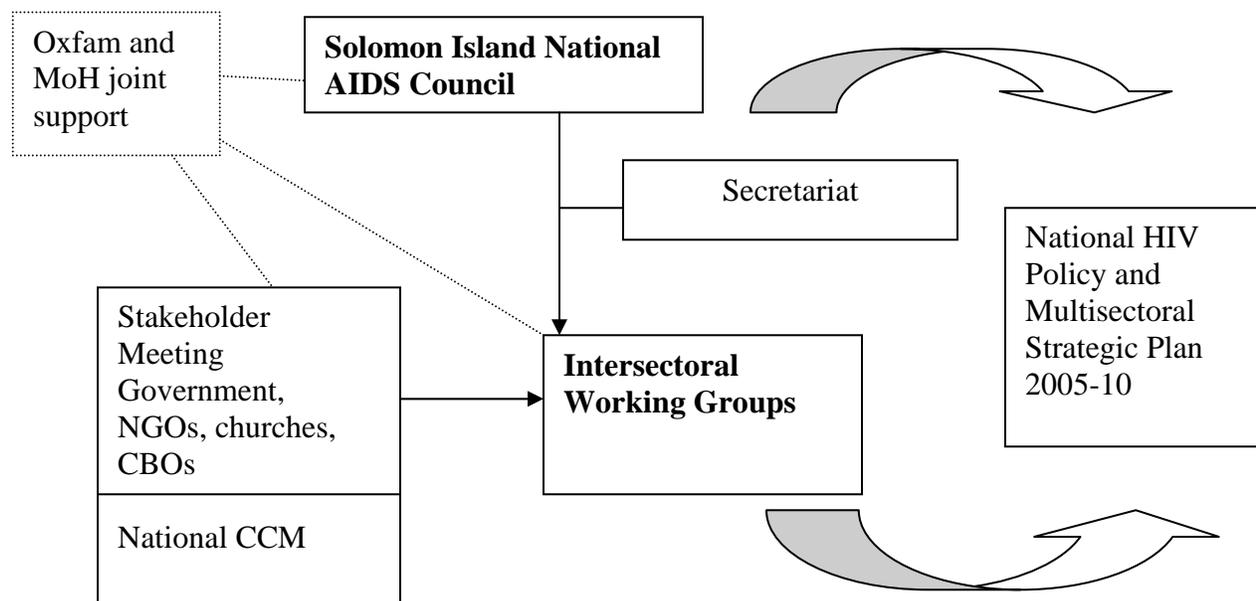
There are a number of strengths of this model:
- Processes are clearly established for the engagement of different levels of stakeholders and that each body has well defined terms of reference.
- The role of the CDO to support MoH to develop NCM processes has pushed forward the implementation of these structures and through this has increased the momentum for the response. Specifically the responsibility of the CDO Coordinator to facilitate these meeting has assisted to build this momentum.
- Developing processes for regular review of response activities through stakeholder meetings has increased the monitoring capacity of the SINAC. This process has also been enhanced by the CDO conducting a regular assessment of stakeholder activities through an NGO survey which is presented at the six-monthly meetings.
- The role of the CDO to build capacity of NGOs is reflected in their more active engagement in these processes – organizations are showing more capacity to develop and review their program initiatives.
- Stakeholder meetings are providing means for reviewing and developing priorities for program and linking problem analysis with strategy development and budgeting.
- International NGOs have begun to work more collaboratively, and are starting to coordinate activities and develop joint projects. This collaboration has been enhanced through their involvement in coordination processes.
- Efforts have been made to actively involve an HIV positive person on SINAC.
- National CCM developed to coordinate GFATM funds has become sub-committee of SINAC as one of the Intersectoral Working Groups.

There are also a number of weaknesses:
- The structures are driven by two key people who facilitate meetings, get people to attend, draft agendas and minutes.
- There is a lack of secretariat support and progress has been slow in getting approval for recruitment for positions.

- The churches are not active stakeholders.
- Processes of broad stakeholder engagement on all issues are time consuming and decision-making processes can be slow.
- Processes tend to rely on the participation of experienced and technically competent people, those with less knowledge and capacity can feel excluded.
- There is a lack of human resources available to participate in these meetings, especially with the number of meetings and the few people available to attend.
- Monitoring and evaluation systems have yet to be developed to capture the information being presented and discussed in the meetings.
- Donors are not participating in these structures and there is little evidence of coordination among the few agencies. There is also a limited working relationship with Ministry of Health as donor coordination is the responsibility of Planning.

Overall the structure is beginning to operate well. The Ministry has developed a good working relationship with key NGOs and there is strong engagement and active participation of Ministry of Health, and NGOs in the SINAC and stakeholder meetings.

There is however minimal involvement of other government agencies, although Ministry of Finance attends regularly and less participation of churches and private sector on the coordinating bodies. The processes for coordination of the response are primarily due to drive and commitment of two key individuals. This is potentially unsustainable unless it can be institutionalised through the secretariat and wider involvement of sectors.

3.3.2 Fiji National Advisory Committee on AIDS

The National Advisory Committee on AIDS (NACA) was established in 1987 by Cabinet to coordinate HIV and AIDS activities. The Committee was reactivated in 2001 after a long period of inactivity during 1990s. NACA was established with 20 members; however it is now a large body with up to 40 people representing different stakeholder groups. It functions as an advisory body under the Ministry of Health and is chaired by the Minister of Health.

Currently more than half of the members on NACA are from Ministry of Health. Its secretariat is within the Family Health Unit of the Ministry, there are six staff positions including a dedicated project officer position for HIV and AIDS.

There are six subcommittees of NACA: care and support; medical and STI; blood safety; IEC and Advocacy; ARH Taskforce; Research. These subcommittees meet monthly and they made recommendations to the NACA.

The NACA meets quarterly and its meetings are focussed on reviewing the implementation of the National HIV/AIDS Strategic Plan 2004-2006.

More recently there has been a reassessment of this body and legislation is being drafted to change the Advisory body into Council under Prime Minister's Department.

Fiji Council of Social Service is the nominated CDO, and its role is primarily to report on PRHP grants to the NACA and conduct training with NGOs.
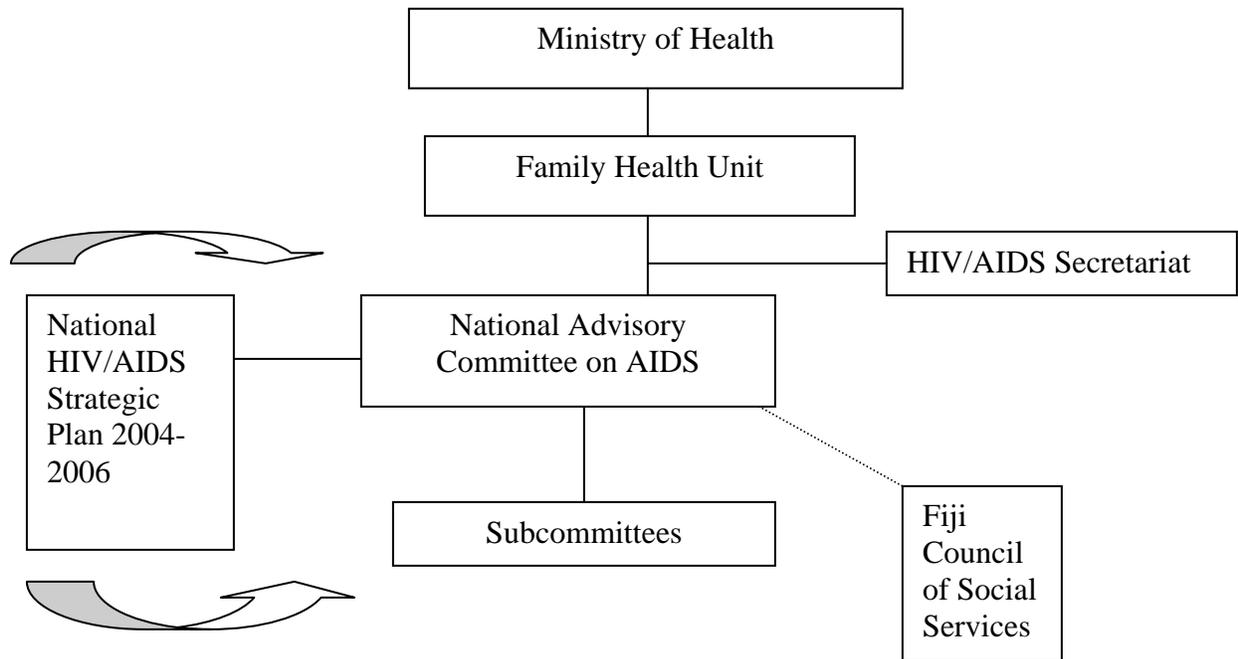
There are a number of strengths of this model:
- In Fiji support for a response to HIV and has been expressed by Great Council of Chiefs, Prime Minister and Vice President, giving greater authority to efforts of NACA.
- A parliamentary group has been established.
- Sub-committees are actively meeting and appear to be facilitating more engagement among implementing agencies. These groups are reporting on program activities, discussing issues, developing solutions and actively networking.
- The NCCM has been put under NACA as sub-committee to streamline its reporting.
- There is a good working relationship between Ministry and most NGOs.
- NACA is a large inclusive group allowing a diverse number of organizations to be represented.
- Department of Planning is represented on NACA
- People living with HIV and AIDS are represented on NACA

There are also a number of weaknesses:
- As a large body it is difficult for all representatives to participate effectively.
- Membership of NACA included 50% of Ministry of Health personnel.
- The Ministry of Health does not have authority to influence agency and sector plans even though these are included in the NSP. Agencies are not required to report on their activities to NACA.
- The processes for discussing and referring policy issues from the sub-committees to NACA are not well defined, resulting in some of these issues being discussed again in the larger body, rather than recommendations being referred for approval.
- There is an emphasis on reporting on implementation of activities rather than processes for review and monitoring of the NSP at these meetings.

- There is a lack of clarity about the coordinating role of the Secretariat within the Ministry as it is also responsible for implementation of HIV activities for health sector. The Project officer is responsible to facilitate meetings of NACA and provide some technical support to agencies, however this position is also actively engaged in a number of HIV related activities.
- While PLWHA are represented they need support to develop skills and confidence of their members (12 active members) to participate fully in meetings.
- There is little donor coordination, apart from UN Theme Group.
- The CDO is not engaged in supporting NACA – it is focused on management of grants and capacity building of NGOs.

The NACA functions well as a body to involve and engage players in the response. However it needs to be restructured to make it a more functional committee. Currently 50% of its members come from the Ministry of Health. Effectively it is operating as a vehicle for Ministry to coordinate its own activities. The Ministry may be better served to establish its own internal committee to monitor health sector activities.

NACA is also operating as a stakeholder forum and this should continue with broader input from donors, faith based groups, other government ministries. However, a smaller, higher level group is needed to make key policy decisions on behalf of the government. The moves to restructure NACA may address this issue.

NACA also need to focus its efforts more on relationship building, collaboration and monitoring processes to improve its operations. There are tensions within the Committee between government and NGOs. Part of the tension relates to areas of responsibility for implementation and more clarity is needed around stakeholder comparative advantage so that skills of NGOs and other government agencies can be better utilised.

The role of the NACA and its sub-committees to make decisions needs to be streamlined. The subcommittees are established as technical working groups to support NACA and should be used as such. These committees need to make recommendations to NACA rather than refer issues for further discussion.

3.3.3   Samoa National AIDS Coordinating Council

The Samoa National AIDS Coordinating Council (NACC) was established in 1987. Of its 20 members, 50% are representatives from non-governmental agencies, 8 are from government, one representative from the media and a representative of people living with HIV and AIDS. The Council is responsible for overall governance, strategic direction including policy advice and coordination of Samoa's National HIV/AIDS control programs and key stakeholders.

The Council is supported by a Technical AIDS Committee of 20 members, mostly section heads from the Ministry of Health, one representative from Education and one NGO. WHO is also on this committee.
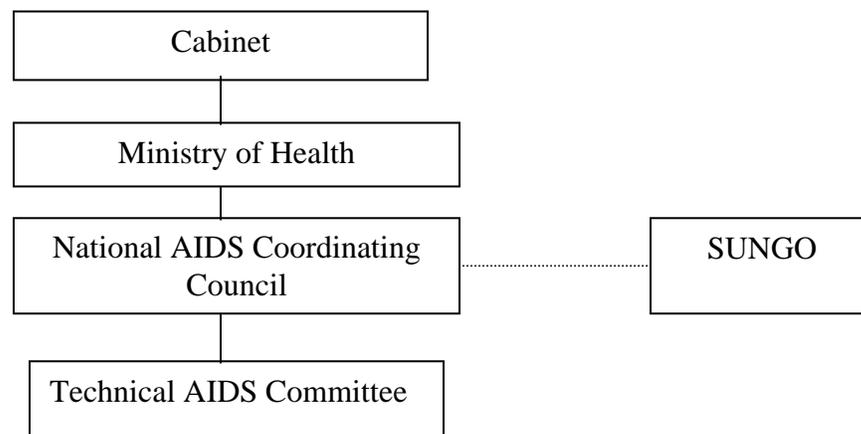
Samoa does not have a current HIV/AIDS strategic plan. It is in the process of developing a proposal for support to do this. However other national plans that include HIV and AIDS are National Health Plan and National Plan for Action for Women.

NACC has begun to be more active during 2005 – four meetings have been held this year. Factors attributed to this are the availability of funds through UNAIDS, GFATM and the PRHP grants and the requirement that NACC meets to approve these grants. Prior to 2005, NACC had not met regularly until 2003 when the NCCM was set up. The CCM is now combined with NACC.

NACC is currently chaired by CEO of Ministry of Health, however this is a recent change – the National Council of Churches was the chair for the last 2 years.

The CDO is SUNGO the Samoan NGO umbrella organization. This organization is a member of the Council and the CDO Coordinator has been active in providing secretariat support to the Council.

Secretariat for the Council is within the Public Health Unit of the Ministry, however there are no dedicated positions to support the administrative workload of Council meetings.

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The strengths of this model are:
- The Council has a well balanced group of members and has good representation form NGOs
- The Technical AIDS Committee is working well to support the Council with technical advice. Its members have good technical backgrounds and are experts in their areas.
- PRHP grant to NACC assists to support funding of meetings.

The weaknesses of this model are:
- Strained relationship between Ministry and NGOs
- Lack of clarity of the role of the CDO Coordinator and recognition of role of CDO in relation to supporting NACC
- Limited private sector involvement in NACC
- NACC is not resourced by government as a high level policy body on HIV and AIDS
- Lack of a current plan weakens the focus of NACC for coordination.

A number of the difficulties with NACC relate to relationships between players and how these players can work together. Partnerships between the Ministry and many of the NGOs are not strong. Although the NACC nominated SUNGO as the CDO to manage the PRHP grants, there is a lack of clarity around the role of CDO in relation to how it supports NACC. The Coordinator has been active in resourcing the Committee however some members are unclear about the role of the CDO and who the Coordinator should report to. There have also been some difficulties with the Ministry promoting and disbursing grants, access has been difficult for some agencies, and approval processes have been held up. This is also due to lack of clarity among members of NACC about the responsibility for PRHP grant funds. While it is clear that SUNGO manages these funds some members of NACC believe that NACC should control the funding.

It was also reported that Council members were reluctant to participate on the committee without receiving allowances, that these had been cut out with government cut backs and there has been some pressure to have these reinstated to increase participation.

The NACC has the potential to be an effective body, it is structured well and has good representation from stakeholders. There is a strong commitment from key people, especially in the Ministry to support an effective response to HIV. The difficulties appear to lie in how government and non-government can work together in partnership and processes for engagement.

4.0   Key Issues and Findings

4.1   Increased response to HIV and AIDS

It is evident that there has been a heightened response to HIV and AIDS in the Pacific region in the last three years. This appears to be due to the increased funding available through GFATM, the revived involvement of UNAIDS in the Pacific and the development of the Regional Strategy. The PRHP has also provided added impetus to this response through supporting coordination structures and building community capacity to respond and providing funding through a Grants Scheme. The regional focus on HIV and AIDS through GFATM, PRHP and UN Agencies has also promoted opportunities for more regional cooperation and collaboration through workshops, meetings and training programs.

At the country level there are also more players entering the field through increased donor funding prompting the need for better coordination. The 'three Ones' principles have been applied to varying degrees of efficacy.

It is also becoming evident that there is a readiness for greater engagement at political and community level in some countries, prompting more resources for HIV activities and support for coordination mechanisms. PRHP has supported community based response through the CDOs and the small grants programme. Increased technical support and capacity building through PRHP, UN agencies, other regional partners have also assisted to build this readiness and engagement. However the countries' capacity to develop a comprehensive national strategic plan, accountability and facilitation of its implementation and the monitoring and evaluation needs to be improved. The

CDOs, other NGOs and government representatives working through the NCM should ensure a coordinated response to HIV in all the Pacific Island countries.

4.2   Political support and leadership

Across the PICs there has been limited leadership on HIV at the central political level. It may be that the low prevalence of HIV in these countries does not bring enough urgency to the need for action at this level, however lessons learned from many other countries show the necessity for strong political commitment and leadership to control the epidemic.

There have been a number of initiatives in the Pacific to strengthen political leadership:
- Establishment of Asia-Pacific Leadership Forum to enhance leadership skills
- UNAIDS facilitated a regional workshop for leaders and Great Council of Chiefs
- Parliamentarians meeting in October 2004 in Suva which produced the "Suva Declaration" of commitment to act on HIV and AIDS
- Development of Pacific Regional Strategy on HIV/AIDS (2004-2008) with a key theme and actions on leadership
- Pacific Plan recently endorsed by Pacific Forum pledges resources to support the implementation of the Regional Strategy.

Political commitment is a key indicator of UNGASS to which most PICs have committed support and are required to report on their progress on these indicators regularly. SPC has recently completed a survey of PICs using the National Composite Policy Index to prepare the report on UNGASS indicators.

Stronger leadership and commitment is required to support NCMs, through resourcing these bodies and providing more direction for addressing the epidemic. There are few examples in the Pacific of strong government commitment. Fiji has demonstrated a strong response from the Great Council of Chiefs and recently the Prime Minister indicated the need for greater political commitment. It remains to be seen what impact the recent Pacific Forum will have on country responses and the level of political commitment, however the Forum and the Regional Strategy have placed HIV and AIDS as a priority issue for the region. While political leadership commitments have been demonstrated there is the added challenge to the bureaucracy to translate these commitments into action at the national level. The national government focal points working together with the CDOs and other NGOs should form the NCM that would be accountable for the national strategic plan for HIV and AIDS. Building the capacity of a NCM should address the capacity of all relevant stakeholders and institutions that will ensure an effective national response to HIV and AIDS.

There are opportunities for greater regional cooperation and collaboration around leadership through workshops at the regional and country level. UNAIDS has a mandate to focus on strengthening leadership responses and will continue to play a role here.

4.3   Structure of the NCM

As described earlier, there are a number of structures being used to support coordination of national responses. Most of these structures have been derived from organisational templates from other countries and based on multi-sectoral representation. It is evident however that a number of countries are modifying these templates to fit with the realities of their countries. Kiribati is an example of a different model of coordination that has stakeholder support and commitment. Solomon Islands have extended some of these structures to bring greater clarity to decision making processes and involve the maximum number of stakeholders. Fiji has established a broadly inclusive body to involve as many players as possible.

While a government endorsed and led mechanism is seen as international best practice, there are other structures that appear to be facilitating coordination. Of note are stakeholder meetings which provide the opportunity for all players to get together at regular intervals, discuss and identify policy issues and review progress on the national strategic plan. Similarly, technical working groups that have been set up to support a number of NCMs are providing the opportunities for sharing information, solving problems and improve working relationships between implementing agencies.

It is also evident that in countries were NCM are active this is due to interest and involvement of key individuals who can drive the processes for setting up meetings, communicating with key stakeholders and focusing the agenda and discussions. It is also important that sufficient human and financial resources are available to facilitate meetings. An active Secretariat is also a contributing factor to the success of NCMs.

It is the reality however, that many of these NCMs do not meet regularly. This appears to be due to: the lack of financial and human resources to support these bodies; the absence of clearly defined and understood roles and responsibilities for NCM members; the limited recognition of HIV as a serious threat in countries with low prevalence; the lack of dedicated secretariat staff available to support meetings; a limited recognition of the need to hold regular meetings and purpose of these meetings.

Getting the structures right is clearly an issue in some countries. The size varies across countries. Fiji for example, has established a large inclusive NCM with around 40 members which continues to grow whenever new organizations seek to participate. Other countries such as Vanuatu and Samoa have attempted to maintain smaller committees with designated representatives.

A key factor in all countries is the limited range of personnel who are available to participate on these bodies. Many of the same individuals are involved on committees at different levels and this can become time consuming and somewhat burdensome particularly when they already have busy schedules in their regular jobs. The other issue is that these committees may be established to deal with different issues, but when they require the same personnel to discuss these, it becomes somewhat duplicative of their time.

The involvement of People Living with HIV/AIDS on decision-making bodies is an important GIPA[10] principle. People with HIV/AIDS are included on NCMs in Samoa, Fiji, Solomon Islands

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[10] Greater Involvement of People Living with HIV and AIDS

and Kiribati. However, greater consideration is needed to support their active participation. People with HIV and AIDS report that they find it difficult to discuss some of the policy and technical issues and that they are often not given enough time and space within meetings to express their views.

Country Coordinating Mechanisms (CCMs) have been established to design and implement GFATM activities in 11 countries receiving funding. It is evident that these CCMs function because they receive funds from GFATM for CCM meetings and are also are required to meet to discuss GF project issues. In a small number of countries the CCM is the only functional NCM. These committees are largely established in parallel to existing NCMs, however some countries have integrated these with the NAC, as part of the main committee or as a sub-committee of the NAC. This appears to be an effective way to deal with the potential for duplication while still complying with GFATM requirements. It also means that the CCM reports to NAC bringing greater clarity to reporting and coordination responsibility. This can limit its role for broader program coordination. Further, it is accountable in the first instance to GFATM rather than to the government.

4.4   Governance

All NSP developed by PICs have been endorsed by government, however it is not clear whether the endorsement includes an institutional framework to support the implementation of these plans. Very few NCMs have legal status. We know from international experience that strong institutional frameworks are necessary to support national strategic plans. These frameworks need to outline structures for management of the response, and include mechanisms for coordination and monitoring and evaluation frameworks. Budgets and implementation plans that include responsibilities of each sector should also be included. Solomon Islands and Fiji has developed national strategic plans with activity and implementation plans that outline responsibilities of the sectors and include budgets.

Most of the structures that have been set up to support the NSP appear to have been developed within Ministries of Health as a way to coordinate the implementation of program activities and have been endorsed by Executive of these Ministries. As already stated these are multisectoral bodies and the Ministries are engaging with a broader range of players, including NGOs. However, it is not clear whether these bodies are an advisory forum to the Ministry which then makes the recommendations on policy to the government, or whether these bodies have the authority to make these policy decisions, independent of the Ministry.

The lack of legislation governing NCMs, means that there is a limited requirement to report at the highest political level, i.e. to Parliament, on the response. However, the endorsement of the NSPs should mean that there is some imperative to provide reports on progress and outcomes of these plans to the highest level. Where NCMs are working to coordinate implementation and monitor outcomes this should be sufficient provided that they are reporting on these at the political level.

UNAIDS suggests that strengthening national coordination bodies requires:[11]

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[11] UNAIDS 2005 ibid.

- Making "authority" real

This means that NCMs need to have good links with central government processes, that the ministries of planning and finance are involved and can ensure that adequate funds and human resources are made available to support the national coordinating body. This authority is most often supported through legislation and that the NCM is chaired by a senior person.

- Empowering the NCM

NCMs need to have terms of reference and by-laws that govern their operations. They also need to have broad representation from key stakeholders and clear guidelines for how to effectively represent their constituencies.

The effectiveness of NCMs is also compromised by the quality of participation and decision-making. Often the representatives on NCMs are not high level enough to make decisions on behalf of their agencies or they are unable to make decisions without extensive consultation with their constituents. It is also the case that some of these representatives don't have the mandate to represent particular groupings. For example, there are a number of different civil society organizations which are not part of umbrella organizations and can only represent their particular area. For example, church groups not affiliated with National Council of Churches.

To be effective NCMs need to have regular meetings, to have a clear purpose for these meetings and to have procedures that govern decision making and communication processes. A common issue reported by members of NCMs was lack of communication about meetings, lack of clear agenda and purpose, and limited understanding of their responsibilities as a member of the NCM. Few reported ever having received any orientation to the role of the NCM or training around governance.

A review of a sample of minutes of NCMs show that the meetings are used by members to actively review the NSP and discuss key issues of implementation. Commonly the NCMs are monitoring grant funding and activities, including GFATM funds and PRHP grants. The meetings are also being used to update members on the country's HIV situation, and in some cases the meetings are used for a detailed review of service delivery including development of IEC materials. There is not much evidence of active engagement in policy development. In some cases this is the domain of technical working groups, but how policy is endorsed by NCMs is not at all clear.

4.5   Role of Ministry of Health

The development of an early response to HIV and AIDS is evident in all PICs. This response was supported by WHO through its Global Programme on AIDS. This support led to the establishment of the National AIDS Control Programs within Ministries of Health and development of national plans in many countries around the world. This placed the Ministries firmly in the drivers seat for the response. While activities to address HIV and AIDS were largely centred around health initially, increasingly there has been more engagement with other sectors, especially churches, NGOs and CBOs for delivery of community based prevention. There is however very limited engagement of other government sectors in the response.

Much of the programmatic response to HIV is being supported by funding through GFATM and PRHP. GFATM is primarily supporting a health led response in many countries around the world

and in the Pacific has activated the Ministries to become more engaged. The establishment of CCMs to manage and coordinate the use of GFATM funds may have provided the impetus to reactive existing NCMs.

In all countries the Ministry of Health is responsible for the secretariat to NCM. In very few countries there is separate funding available for the work of the secretariat to the NCM. Where there is an expectation for secretariat support to the NCM, it is usually attached to designated positions in STI or public health units. Some Ministries have appointed HIV Coordinator positions however these are largely responsible for development and implementation of programs within health sector. Secretariat support to the NCM is an additional responsibility for that position.

There is a lack of clarity about the coordination role of these secretariats. As they are largely responsible for implementing HIV programs within the Ministry, this may make it more difficult to function as a coordinating body. While it is necessary for these units to be implementing the health response, it may limit the support for engagement of other sectors in program implementation. The challenge for these secretariats is how to step back, identify clear roles and responsibilities for each sector for implementation of HIV activities and devise the means for coordination of these activities, along with managing their own workload.

The Health sector is recognised as having the primary technical role in the response to HIV. This places it in an important position to lead the response. There is evidence that it is facilitating a broader response through bringing in other players and supporting their activities. However there is also evidence that this is proving to be difficult in some countries where government and NGO relationships are not strong, where there is competition between government agencies and where there is a lack of understanding about the need to engage different sectors to respond to the broader development issues of the epidemic.

Internationally there has been a move away from placing responsibility with Health in order to facilitate a multisectoral response through a broader range of sectors. While this move has lead to a more politicised response and greater involvement of other sectors, it has also marginalised the role of health in many countries.

UNAIDS notes that where national AIDS coordinating authorities are located within health they may lack authority over other ministries. To overcome this, UNAIDS provides three suggestions to strengthen national coordination authorities where health is the lead agency:[12]
- Give ministry of health the explicit authority and mechanisms for coordination
- Make the authority an independent entity with a strong mandate from highest level of government
- Have the authority associated with central agencies such as prime ministers office, planning, or finance ministries through reporting arrangements and participation on central agency meetings.

Clearly the Health sector is providing leadership for the response in PICs and attempting to be more inclusive of other sectors. Importantly it is ability of Ministry of Health to advocate for HIV and

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[12] UNAIDS. The "Three Ones" In Action: Where we are and where we go from here. May 2005 p.28.

raise issues at the highest level and get the necessary commitment from that level that will determine whether it is an effective agency to lead the response.

4.6   Partnerships between government and civil society

Partnerships between government and civil society are an important aspect of effective responses. For these to be effective, they require a good understanding of each other's roles and capacity and clear expectations of the relationship. In many countries government supports civil society to deliver programs at the community level because it has more credibility and connection with local communities. In the Pacific churches have well developed networks to the village level and governments appear to work closely with this sector and to a lessor extent with other civil society groups. The NCM should be the mechanisms by which a strong partnership between government and civil society is enhanced.

Partnerships between government and NGOs, particularly International NGOs with programs in PIC are variable. Many of these organizations receive funding outside of the country and although their programs fit broadly with the NSP they are primarily accountable to funding bodies elsewhere and have limited responsibility to NCMs. In general however, INGOs are working with NCMs, many are represented on these bodies and participating in technical working groups and other mechanisms to coordinate the response.

Engagement of the private sector is underdeveloped in most PICs although it is evident that this sector needs to strengthen its involvement in the response. The development of extractive industries such as fishing, logging, mining and plantation development in some PICs are associated with increased risks for HIV transmission and need to play a greater role in prevention. In some countries the Chamber of Commerce is represented on the NCM but this body does not have capacity or depth of membership to represent all private sector industries.

There are a number of excellent examples where sound partnerships have been developed between government and NGOs and where these relationships have improved the functioning of NCMs in those countries. Specifically in Solomon Islands, Kiribati and Tuvalu there are good relationship between government and NGOs.

- In Kiribati the response is coordinated by a NGO, the Kiribati HIV/AIDS Taskforce. This NCM has the endorsement of the government and government ministries participate actively in the meetings. The endorsement of this body to coordinate the response came from recognition that the government did not have the capacity or resources, however it has provided some support to this organization for its coordination activities. The Minister of Health also chairs the Taskforce.

- In Solomon Islands there is a strong working relationship between Oxfam (the Capacity Development Organisation) and Ministry of Health. Together they facilitate the NCM meetings and Oxfam is viewed by the Ministry as a collaborating partner in coordinating the implementation of the NSP. This has been made possible through the nomination of Oxfam as the CDO to provide support to the Ministry to strengthen the NCM. It has also been due to the provision of funding to enable this to occur.

In a recent presentation this partnership was highlighted. It showed how the understanding of

expectations and different roles that can make this partnership work.[13] These were:

- A recognition and understanding by government and NGO of the differences in organisational culture and values and how these can be managed in such as way to allow for complementarity rather than division
- NGOs can bring a greater understanding of the social impact of HIV to medical and public health paradigm of HIV
- Government and NGOs can deliver services in different ways – government can get services to communities through primary health care network while NGOs have networks in community settings and have greater access to vulnerable populations
- Working together is achieved through pooling of different expertise and qualities
- NGOs can often mobilise resources more quickly from different sources and have more flexibility in implementing programs

This partnership in Solomon Islands has also been due to committed individuals who have had the determination to make it a productive relationship. Through this, other NGOs are playing a greater role and the base for the response has been broadened.

Processes for examination of these partnerships are necessary to improve and strengthen responses. It is also clear that governments need to find ways to involve other players, particularly those with connections to vulnerable groups and who can readily engage with communities. These partnerships can take time to develop particularly where it requires new ways of working through collaboration and mutual responsibility.

4.7   Capacity for coordination

The capacity for coordination among NCMs is variable. Some of the structures established lend weight to more effective processes, especially where implementing agencies can get together and discuss their program activities, solve problems and learn from each other. Sub-committees, technical working groups and stakeholder forums provide the best means for this to happen. These meetings tend to be held more regularly as they are a means to sort out any difficulties in implementation. These smaller structures bring together people with similar backgrounds and expertise and can focus on issues relevant for their expertise and knowledge, rather than trying to deal with all issues in the larger group.

To be effective however members need to be able to participate fully in discussions with adequate knowledge and expertise. People living with HIV and AIDS report that they are sometimes unable to participate in technical discussions because they don't have enough clinical knowledge. The key areas reported for capacity building among NCM members were: monitoring and evaluation, technical skills in counselling, treatment, care, and advocacy. Other areas relate to governance and meeting procedures.

The lack of secretariat support to facilitate meetings is a constraint to effective coordination. Most secretariat support comes from within Ministries of Health and in some cases this administrative

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[13] D. Elima and G. Malefoasi. Government and NGO Collaboration in Solomon Islands. Presentation at Pan-Pacific HIV/AIDS Conference, Auckland 25-28 Oct 2005.

support is undertaken by very senior people who have very limited time to do this well.

4.8   Role of CDO and CDO Coordinator

PRHP has established Capacity Development Organisations (CDO) in Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. It is in these countries that the NAC Grant Program is operating[14] and Coordinators have been appointed to administer the grant process and work with the NCM to facilitate its role in management of these grants.

The CDO was selected by the NCM as the agency to administer the grants. All CDOs are non-governmental organizations with a level of capacity to manage funds and provide some technical support. In a number of countries the CDO is the umbrella NGO organization with a strong network of agencies. These organizations were selected on the basis of their networks, capacity to assist other organisations and a track record in working with other NGOs and managing projects.

In most countries where the CDO is funded, there is good engagement with the NCM. The minutes of NCM meetings show evidence of the active participation of CDO coordinator in preparing briefs, reporting on grants, and discussing grant proposals. In a small number of countries the CDO is also acting as the Secretariat to the NCM, preparing meeting agendas, communicating with NCM members, facilitating meetings processes and writing minutes. This can be a time consuming activity especially where the NCM meets regularly and can distract from other responsibilities of coordinating the grant process, assisting with development of grant applications and NGO/CBO training.

In Solomon Islands, the CDO Coordinator and Ministry of Health have worked closely together to facilitate meetings however much of the work of organising meeting and advising members of these meetings has fallen to the CDO Coordinator. More recently this position has been trying to withdraw from providing this administrative support in order to promote the Ministry to take more responsibility, as the Government of Solomon Islands has now allocated funding for a secretariat for SINAC.

Lack of clarity of the role of CDO Coordinator in relation to NCM has posed some confusion. The CDO is selected by the NCM and the Coordinator is appointed by the CDO to support the grant process. This position in some countries has also been made available to the NCM to support its processes, including facilitation of meetings in some countries, effectively operating as a secretariat. While the position is responsible to the manager of the CDO it is accountable to the NCM for some of the administrative processes. This relationship needs to be clarified so that the Coordinator, NCM chair and members of NCM are all clear about the reporting relationship and scope of the role in relation to resourcing the NCM. This should be done at the outset when the CDO is nominated by the NCM, through an agreement that articulates roles and responsibilities of both parties in relation to support that will be provided by the CDO Coordinator. This agreement should be reviewed regularly to see if it is meeting expectations of both parties. Training undertaken by the Project with both CDO and NCM representatives should also focus on this issue and provide the opportunity for the development of agreements on roles and responsibilities for both parties.

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[14] The PRHP NAC Grant Program is an annual allocation of funding, managed by the NAC with assistance of the CDO, to fund HIV and AIDS prevention and care activities identified as priorities in the NSP.

Skills of the CDO Coordinator are also an important factor in working with the NCM. These positions require capacity to work across all levels, negotiate with high-level government representatives, and have good liaison, networking, facilitation and presentation skills. It is clear that these qualities are a factor in the success of the partnership between the CDO and NCM in Solomon Islands. Training has provided good background for CDOs on capacity assessment, grant processes, project planning and management and in some technical areas. Developing these qualities may require a different approach, perhaps more coaching and mentoring of Coordinators, through the Project or through skilled people in country.

While CDOs in some countries have an active and facilitative role with NCM, in other countries they are only managing the grant process and reporting on these activities. The NCM is responsible for approving grants and advises the Coordinator of those grants that are successful. In small number of other countries, the CDO Coordinators appear to be struggling to find a way to work with the NCM, that their role and expectations of how they can assist the work of the coordinating body is unclear.

It is clear that each country has developed its own arrangements for how NCM and CDO will work together. The CDOs have been credited as helping to reactivate the NCMs through provision of grants and providing some secretariat support. They have also been credited with fostering an improved climate for implementation of HIV activities through capacity building programs with NGO and CBOs. NCM members report that there were now more players in the field and this was primarily due to PRHP and GFATM grants.

5.0   Conclusion and Recommendations

The Pacific is now receiving a much greater level of financial resources for the response to HIV and AIDS. Around USD30 million has been committed to fund activities across the Pacific since 2002.[15] At the recent Pacific Forum, leaders endorsed the Pacific Plan which provides an additional $12 million for implementation of the Regional HIV/AIDS Strategy. This increasing level of resourcing to address HIV brings pressure for more effective coordination with a growing number of players and broader focus for implementation. It also places considerable strain on the limited human resources available in these small island countries and the capacity to absorb this level of funding.

While HIV prevalence is still relatively low in this region, there is an opportunity for PICs to act before it is too late, to properly target areas of risk and vulnerability and use the experiences gained from other countries to make best use of these resources.

To do this however improved leadership by national governments will be key to strengthening responses in PICs and much more effort is needed to encourage greater commitment and ownership of national responses. Regional forums and workshops for leaders across the Pacific is one way to foster this and to build into existing networks and forums the urgent need for action on HIV and AIDS. Strengthening networks between leaders would also assist with sharing of experiences of national coordination mechanisms and offer a forum for exchange and information on NCM matters.

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[15] ADB US$8milion; AusAID A$12 million; NZAID US$5 million + NZ$2million for PRHP Grant Program; GFATM US$5 million

The PRHP will need to continue to work collaboratively with UNAIDS and SPC to achieve more action at this level. The development of a coordinated approach to deliver support in this area should be based on Regional Strategy with defined activities for each partner and mechanisms for review.

Recommendation 1

PRHP should provide support to NCMs to take leadership on HIV/AIDS in their countries. The project should work with UNAIDS and SPC to develop a combined strategic approach to strengthening NCMs to take leadership on individual country responses and resource Initiatives that support leadership strategies set out in Pacific Regional Strategy on HIV/AIDS". PRHP should therefore support and strengthen the national coordination mechanism that is accountable to the national response to HIV and in line wit the governments overall development plan as is already reflected in the commitment of most of the island governments to the MDGs.

- ***That PRHP work with UNAIDS and SPC to develop a combined strategic approach to strengthening NCMs to take leadership on individual country responses and resource leadership initiatives that support leadership strategies set out in Pacific Regional Strategy on HIV/AIDS.*** *Some of the ways that PRHP and partners can assist to do this is through:*
    - o *Joint visits and training of NCMs,*
    - o *Development of a coordinated strategy with UNAIDS and SPC to target leaders and key focal points in PICs*
    - o *Identifying key leaders and focal points from PICs to target for training*
    - o *Establishing and resourcing networks that can facilitate sharing and learning about national responses and specific country initiatives*
    - o *Conducting workshops and training on leadership for leaders and focal points across a number of countries*

Frameworks and structures for Coordination
In the light of the growing resources for HIV and AIDS in the Pacific there is a need for much stronger coordination at country level to develop plans that can make best use of these funds. A number of countries are now reviewing their National Strategic Plans to bring these up to date. Given the limitations that have been identified in relation to the earlier plans developed, these Plans will need to reflect the Regional Strategy priorities and develop monitoring and evaluation frameworks that include MDG and UNGASS indicators. Building on the situational assessments and training already conducted by the Project, a number of countries still require technical assistance and PRHP and SPC plan to continue to assist with these processes. As discussed earlier the plans should be costed and set out the institutional framework for coordination and a monitoring and evaluation framework for the response in each country.

The recent review of PRHP recommended that the Project place greater emphasis on responding more strategically to country needs, taking into account the different needs, human capacities, program capabilities and particular epidemics that exist in PICs. Not all countries may require a stand-alone NSP or multi-sectoral committee. The review suggests that HIV may be best addressed in smaller countries through its integration into national development plans linked to the Regional

Strategy and other planning frameworks such as population policies and frameworks to address MDGs.[16]

Through the situational assessments the Project has assessed to a large extent the country capacity for coordination, however it has not looked far enough into opportunities for integration with country development and planning frameworks. These assessments have also not closely examined the appropriateness of the structures in place and possible alternatives for coordination. In its annual Plan for 2006, the Project has identified processes for supporting the review and development of NSPs among larger countries and ways to assist smaller countries with the development of planning frameworks.

It is clear from international experience that the NCMs are a critical element of the response to HIV and AIDS. More importantly, however countries need to have the will and capacity to identify problems, set priorities and establish accountable systems to enable them to respond effectively. These bodies need to be multi-sectoral, have clear mandates and the authority to make decisions about how resources will be allocated and managed.

Across PICs the structure of NCM varies. It may be that each country has developed a structure that suits its realities and that the structure of NCMs will remain variable across these countries. Importantly it is its capacity to function as a coordinating body in each country that is the measure of its effectiveness. There appear to be a number of key elements that assist it to do this: the authority that the NCM has in relation to players and stakeholders; the level of secretariat support; clear terms of reference for its operations and membership including representation for people living with HIV and AIDS; regular meetings; and, active participation from representatives.

To achieve coordination, small island countries may need to focus on the opportunities that exist to bring players together rather than focusing on building structures that will be difficult to resource and maintain. As stated earlier there are a range of ways to achieve coordination and it is these processes that bring this about. These include: processes for planning, review and monitoring; forums that facilitate learning, documentation and sharing of information; networks and linkages between sectors and agencies; processes for managing resource distribution and allocation. It may be better for the Project to focus its efforts on building collaborative processes such as stakeholder forums and meetings with implementing agencies as the primary means for coordination, especially in those countries where it is proving difficult to support the functioning of high-level committees that receive little government recognition and support.

Among those countries where the NCM is a mandated government body and where it is functioning as an government–led oversight committee, greater clarity is needed around its role as a policy making body and how it accounts to higher levels of government. The Project needs to continue to work at strengthening the involvement of central agencies and improving the capacity of representatives to engage in decision-making and policy development.

In continuing to support structures for coordination, the Project should identify whether these bodies are the best means to continue to oversee the response to HIV or whether there are better ways to

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[16] AusAID. Technical Advisory Group Project Review: Draft Final Report. Sept 2005

facilitate coordination, such as stakeholder forums, or planning committees. In identifying mechanisms for coordination in each country, central agencies, such as Department of Finance, Planning and Prime Minister, should be consulted, particularly to ascertain their view of the NCM and the potential for their involvement in and support of these bodies.

The PRHP and all the partners working in HIV and AIDS in the region should develop joint work plan and programmes to support the capacity development of NCMs through a collaborative approach.

Recommendation 2

- ***That PRHP assist national governments and stakeholders identify best means for coordination of their action frameworks, recognising that these frameworks will differ depending on the size and extent of epidemic and resources available. Assessment should take account of networks currently operating and their capacity for coordination, and the opportunities to establish new processes to achieve improved coordination.*** *In doing this the Project should:*
    - o *Analyse current context including the national frameworks for action and responses to HIV, role of key stakeholders, existing mechanisms and networks for coordination, policy and legislative requirements needed to strengthen the NCM, and ways to improve relationships with central agencies and planning structures.*
    - o *Assist governments to develop action frameworks or NSPs that are linked to national development plans, that include MDGs. That annual implementation plans are developed from national strategic plans and are tied to annual budget cycles*
    - o *Assist governments to develop monitoring and evaluation frameworks based on national action plans and identify ways to strengthen monitoring capacity of NCM through use of surveys, workshops and existing networks among stakeholders*
    - o *Facilitate the establishment of stakeholder forums in PICs as a primary means to bring players together to coordinate response activities*
    - o *Where there is a working CCM responsible for global fund activities there is a need to clearly define the CCM roles and responsibilities to that of the NCM so that there is clear mandate as to who is accountable for the NSP development and its implementation.*

Recommendation 3

- ***That PRHP identify capacity development packages for each NCM based on the agreed structure and processes for coordination. These packages and written guidelines will be used to orientate the national CDO coordinator and NCM members to governance issues, roles and responsibilities of NCM representatives, reporting requirements, and meeting procedures. Additional support for people living with HIV to facilitate their participation on NCM should be provided.*** *In doing this the Project should:*
    - o *As part of the development of National Strategic Plans it is recommended that the process of development or up dating of the National Strategic plans be used as an opportunity to develop standard approaches for capacity development of both CDOs and NCMs. The NSP should have a component that address leadership and*

coordination under which activities spelling out capacity development plans for both NCM's and CDOs would be develop and implemented.

- o *Identify key people from NCMs to participate in capacity development workshops including CDO representatives, who can become resource people in country to support ongoing capacity development, training and orientation for NCM members*
- o *Develop specific capacity development packages to improve conduct of meetings and communication among NCMs, targeting secretariats and NCM members*
- o *Clarifying roles and responsibilities of NCMs including establishing procedures for regular meetings, HIV policy development, monitoring of national plans and activities and reporting on these.*
- o *Develop training packages on effective management of NCM role and responsibilities for NCM members, including how they can be more effective advocates among their constituents.*

Role of CDO

The 2006 review of CDOs should come up with a clearer understanding of how CDOS will assist the NCMs in the implementation of the NSPs. Clearly the position of Coordinator cannot manage the grant process and provide adequate support to the NCM. Where this is working well it tends to be at the expense of other CDO activities. The other important constraint is lack of clarity around accountability for CDO coordination role in relation to the NCM. While the NCM has been involved in the selection of the CDO in those countries where this arrangement is in operation, there needs to be clearer guidelines around how the position and agency should relate to the NCM. One way forward may be to locate the position of CDO within the institutional framework as the NGO support/coordination mechanism. This would give the CDO a stronger role as the key NGO representative and key partner in coordination of the response. It would also be useful for CDO and NCM to develop an agreement at the outset of the CDO nomination by NCM, that sets out roles and responsibilities of Coordinator in relation to the NCM, expected outcomes and reporting requirements. This agreement can then form the basis for performance assessment and bring more accountability to this arrangement.

An agreed work plan should also be developed that sets out how the CDO Coordinator will work with NCM and what the expected outcomes will be. The Coordinator should also provide a regular report to the NCM on these agreed activities.

More focus is needed on improving the skills of Coordinators in negotiation, liaison, networking, facilitation and presentation. These are personal qualities that may need to be developed through coaching and mentoring processes supported by the Project.

Areas for capacity building with NCMs were identified as: monitoring and evaluation, technical skills in counselling, treatment, care, and advocacy; governance and meeting procedures. The Project should provide resources to support the CDO Coordinators to facilitate training in some of these areas. However a number of these areas for training may be also available through UNAIDS, WHO, SPC, and other NGOs. The role of the CDO Coordinator should be to identify these possibilities and alert the NCM members to training opportunities in line with a capacity building plan.

In order that the NCM capacity development is linked with the development and up dating of the individual NSP (National Strategic Plans) it is recommended that the process follow the general format suggested in figure 2 illustrated below. By so doing the NSP updating and development exercise should be in itself a capacity development exercise.

Figure 2: Capacity development process
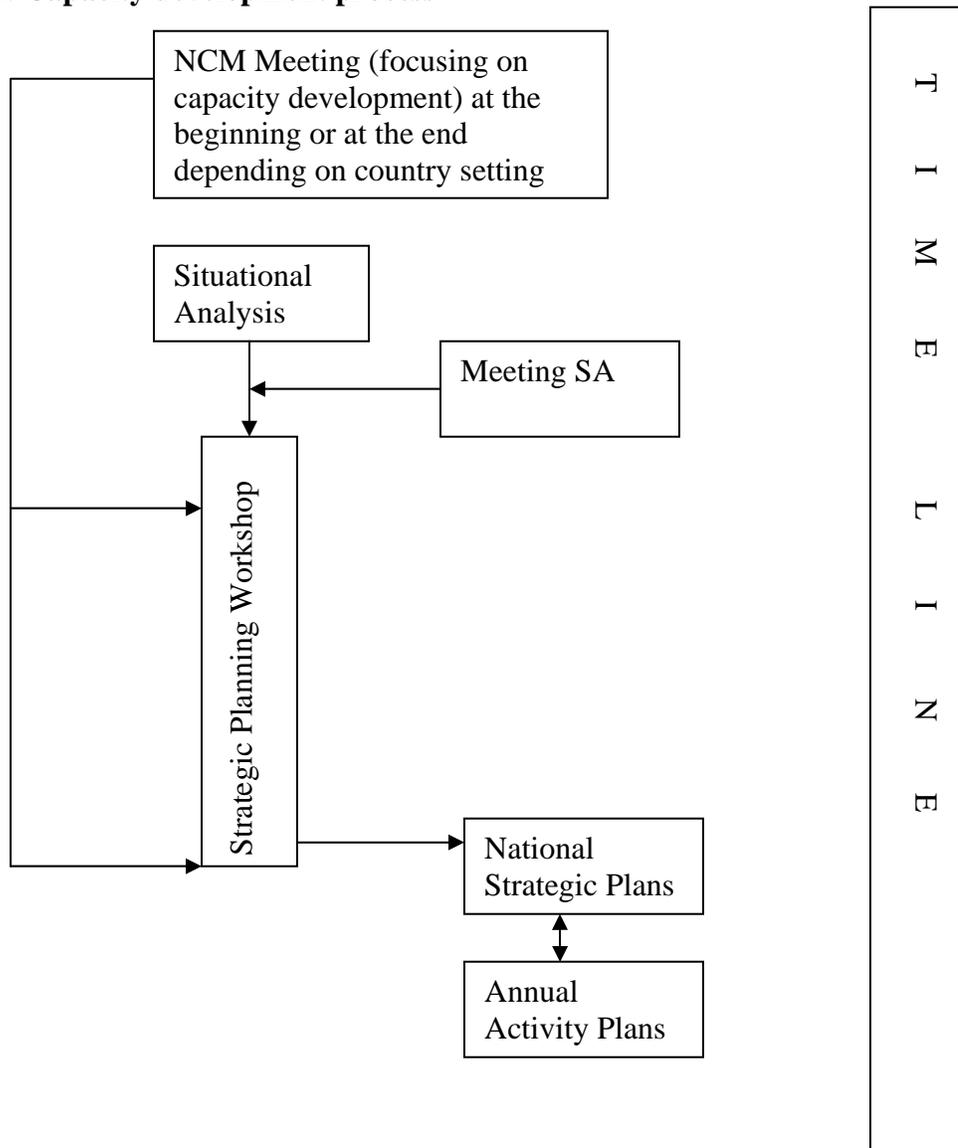
Recommendation 4

- *That PRHP assess the appropriate relationship for the CDO to work with NCM. This should be based on the capacity assessment of the NCM and set out clear responsibilities for how CDO will relate to the NCM, and the expected outcomes of this arrangement. This should be achieved by:*

o *Undertaking a capacity assessment of NCM and development of capacity building plan for the NCM as part of the NSP.*
o *Documenting and agreeing on roles and responsibilities of the CDO and Coordinator at the time of nomination of the CDO by the NCM*
o *Acknowledging the CDO in the institutional framework of the NCM as the NGO support/coordination mechanism.*

Recommendation 5: The planned PRHP review of CDOs in 2006 should clarify the relationships and roles of CDOs, other NGOs and the NCM at each country level.

- *That workplans for CDO Coordinator's role with NCM are devised and these are used as the basis for regular reporting and accountability. These workplans should be based on the capacity building plan developed with the NCM and the agreed roles and responsibilities for the CDO in relation to the NCM.*
- *Other such operational and implementation requirements should also be reviewed and guidance provided by the review to enhance implementation of priority interventions identified by the national strategic plan.*

Recommendation 6:
- *That PRHP identify ways to strengthen partnerships between government and NGOs through the strengthening of NCMs. This may be through collaboration on particular initiatives, identification of areas of comparative advantage; agreements on program implementation. In doing this the Project should:*
    o *Use the processes for negotiation of the CDO role in relation to NCM to identify ways to achieve a workable partnership between government and NGOs. It may also identify some of the barriers and ways to address these.*
    o *Highlight and promote the partnership successes in a number of countries and how these have facilitated stronger responses to HIV. This could be done through regional forums, networks and in workshops held with NCMs*
    o *Facilitate processes to bring together government and NGO sectors to discuss ways for greater collaboration eg. stakeholder forums that allow for review and learning can build better relationships among sectors. This could be done through the design and execution of the competitive grants process where the CDOs and Government representatives of focal points for HIV and AIDS get together through existing NCM and develop a national proposal for the competitive grants scheme. Such a proposal should identify the requirements for capacity development of the NCM which will be supported by PRHP.*

Role of Ministry of Health
In most cases Ministries of Health have lead the response to HIV and AIDS through existing STI and reproductive health programmes in most PICs. They have established programs and are providing the technical support. Because of the size of most countries in the region it is likely that these ministries will continue to have responsibility for the coordination of the response. While structures for coordination can be clarified and broader stakeholder involvement in these structures

can be accommodated, the role of health in managing a multisectoral response will need clarification. The areas for clarification are: its role as an implementing agency and how this responsibility can fit with a role of coordination; the internal structures to support the NCM; decision making processes and how these are followed through; its role and capacity to advocate with higher levels in the government, especially the prime minister's office and departments of planning and finance.

The NCM needs to be given the necessary authority to act on matters of HIV for the government and Health as the agency responsible must have suitable powers to engage other government departments in the response. This is best achieved through legislation, however there are other means to achieve this - through the endorsement by government of the institutional frameworks to support national plans, that clearly articulate the responsibility of the Ministry of Health to drive the response. Other ways to ensure this authority is to make the NCM an independent authority within the Ministry and ensure that it has support from the highest level of government, for example, the NCM being chaired by a senior person from prime minister's department. Another way is to ensure that the NCM is closely associated with oversight ministries, that there are means for dialogue with these ministries and the Ministry of Health and that they are represented on this body.

Recommendation 7:
- *That PRHP identify ways to strengthen the authority of the Ministries of Health and mechanisms for coordination of the response. In doing this the Project should:*
  - *Identify policy and legislative requirements for strengthening the NCM, including the Chair of the NCM and its membership*
  - *Use the processes for capacity assessment of NCM to clarify internal Ministry structures for support to NCM including role of secretariats, processes for decision-making and management of relationships between Ministries and other government agencies.*
  - *Where there is possibility of a secretariat identified to support the NCM there is a need to identify capacity building requirements to improve the operations of the Secretariats*
  - *Assist Ministries of Health to more clearly articulate and establish clearer ways to separate their responsibility for managing an implementation program to respond to HIV from their responsibility to coordinate and facilitate other sectors to respond.*

Recommendation 8:
- *That PRHP assist NCMs and Ministries of Health to assess their capacity for advocacy and develop ways and means for more effective dialogue within government. To do this the Project should:*
  - *Identify processes for linking Ministries with central planning and government decision making structures*
  - *Undertake advocacy training with NCM members*
  - *Assist NCM to access and use strategic information that will assist with advocacy efforts within government.*

Annex 1

Terms of Reference for NCM Review

Pacific Regional HIV/AIDS Project

Terms of Reference for
Review of National AIDS Coordination Mechanisms (NCMs)
in Pacific Island Countries

Purpose of the Review

The purpose of this Review is to inform PRHP's strategies to:

- ➢ Strengthen the capacity of National Coordination Mechanisms to coordinate, manage and monitor National Strategic Plans

- ➢ Strengthen the capacity of National Coordination Mechanisms to effectively manage technical assistance and other development initiatives in support of country partner-owned and led priorities

- ➢ Encourage a harmonised and collaborative national approach (NACs and CDOs) to coordinate the implementation of action/strategic plans

Background

The Pacific Regional HIV/AIDS Project (PRHP) was designed in 2001 and commenced in November 2003. The project works across 14 countries and is implemented by the Australian Management Contractor (AMC - IDSS and Burnet) and the Secretariat of the Pacific Community through what is known as the Franco-Australian initiative.

The project has 3 components, component 1 being implemented by the Secretariat of the Pacific Community, Component 2 and 3 being implemented by the AMC. Component 1 deals with the development and implementation of the second regional strategy and Component 2 deals with the strengthening of capacity to implement national strategies, and disbursement of grants to enhance responses at the local level through Community Development Organizations (CDOs) and other local non-Government Organizations (NGOs). While Component 3 deals with project management and administration

During the two years between the design of PRHP and the start of its implementation, there were significant changes in the HIV/AIDS situation and responses in some Pacific Island countries (PICs) targeted by the PRHP. For example, the number of newly detected HIV infections increased in some countries, whilst remaining stable in others. In addition, some of the countries that had developed national HIV/AIDS strategic plans through a previous AusAID-funded HIV/AIDS Strategic Planning project began implementing these plans. Within this context, it is important that PRHP captures the current HIV/AIDS situation in partner countries to ensure that project activities address existing needs. Throughout 2004, PRHP staff visited partner PICs to introduce the project, engage stakeholders, and assess the HIV situation and response. PRHP also conducted a rapid assessment of National AIDS Committees (or equivalent) on their response to HIV in their country and identified capacity development needs of partners to enhance the response to the epidemic.

To April 2005, PRHP staff members have visited 12 of the 14 partner PICs. Mile stone two of the AusAID reports describes the findings of the situation assessment visits to the first seven PICs – Cook Islands, Fiji, Kiribati, Republic of Marshall Islands (RMI), Nauru, Samoa and Tuvalu. The second part of the situation assessment report, covering the situation in Federated States of Micronesia (FSM), Niue, Palau, Solomon Islands, Tokelau, Tonga and Vanuatu will be completed once the final two PRHP partner countries, Niue and Tokelau, have been visited by PRHP staff in the first six months of 2005.

Significant progress has been made on the project implementation. It is now timely to focus on capacity building and assess country needs in order to strengthen capacity to implement National Strategies (Component 2 The 21 May 2005 PCC meeting resolved that PRHP conduct a rapid review to examine the relationship between CDOs and National Coordination Mechanism and critically analyse the capacity building needs and recommend strategies for strengthening national coordinating mechanisms.

Scope of Work

The findings of the review will inform PICs and PRHP's strategies to strengthen national HIV/AIDS coordination in partner PICs. Specifically the independent review will:

1. Assess the capacity of NCMs to coordinate, manage and monitor national strategic plans. This should be undertaken based on a clear understanding of individual country situation analyses, responses and key stakeholders.

2. Assess the capacity of CDOs to effectively build capacity of NCMs and NGOs to coordinate and implement HIV/AIDS strategies.

3. Review the relationship between the National Coordination Mechanisms and the CDOs and other NGOs and how this supports capacity building objectives.

4. Review the current process of capacity building of National HIV and AIDS coordination mechanism.

5. Identify ways that coordination for national responses to HIV/AIDS can be achieved in small island states.

6. Make appropriate recommendations of strategies to 1) enhance capacity building of national coordination mechanisms, 2) improve the coordinated implementation of national strategic plan priorities between the NCMs and CDOs and 3) improve PRHP's support in these areas.

Key Tasks

1. Undertake a documentation review and a briefing from PRHP team members to attain knowledge on current capacities, structures and issues amongst PICs.

2. Visit a sample of three PICs to focus the review, including broad engagement with NCMs, CDOs and other key stakeholders. The Consultant should advise on an appropriate review method.

   Sample countries have been selected on the basis that they represent different PIC categories based on country contexts, HIV incidence and functionality.
   - Solomon Islands – This has a well-functioning NCM model that can provide valuable lessons for other PICs.
   - Fiji – The NCM is functioning well on some levels, however coordination and collaboration with development partners needs to be addressed, which is an issue given the

expanding HIV/AIDS epidemic. Currently the CDO is relatively weak and the NCM and CDO are not coordinating well together.

- Samoa – The NCM is not functioning effectively and the CDO is weak and the relationship has not promoted effective coordination.

3. Consult with NCMs and CDOs from eight PICs during the Auckland conference.

4. Collect and analyse data that describes and assesses the:
   - type and range of coordination mechanisms that are operating in PICs;
   - specifics of the NCM – who is involved, how does it operate, how does it relate to government program and key stakeholders, what is its fit with other coordination mechanisms (CCM, NAC, SWAp, donor forums)
   - role of CDOs in facilitating coordination, capacity building and management of the national HIV/AIDS response and ways through which sustainability of CDOs can be achieved
   - interface between CDOs and NCMs and constraints and limitations of this relationship
   - factors that support or constrain the functioning of these mechanisms

5. Recommend strategies for:
   - Improved functioning and sustainability of NCMs
   - Strategies for PRHP assistance to strengthen NCMs

6. Present preliminary findings at the Pacific HIV/AIDS Conference.

7. Prepare a draft and final report.

ANNEX 2

Summary of National Coordination Mechanisms

Country	NSP	NCM	Secretariat	CDO	Comments
Cook Is	Yes 2004 - 2008	National AIDS Council –legislated in 1985, TORs, action plan	No MoH	Red Cross	NCM legislated
Fiji	Yes 2004-2006	NACA, 28 + members, TORs, budget, workplan, sub committees, meeting regularly	Yes – MoH Project officer	Fiji Council of Social Services	NCM not legislated. managed by MoH Parliamentary Committee established
Kiribati	Yes 2006-2010	HIV/AIDS Taskforce, 28 members, TORs, action plan, registered as NGO	Yes - Coordinator	Kiribati HIV/AIDS TaskForce	Not legislated Govt support
Marshall Is	In development 2005- 2008 MoH plan	Community Planning Group, TORs, limited participation of broader stakeholders	No MoH coordinates	No CDO	CPG set up as condition of US grant
Nauru	Yes, not endorsed	AIDS Taskforce – 4 members, not meeting regularly	MoH Health promotion	No CDO	NCM functions for specific activities such as WAD
Samoa	Proposal for development of Plan	National AIDS Coordinating Committee, 20 members, TORs, Technical AIDS committee	MoH - HIV coordinator	SUNGO	SUNGO – strained relationship with MoH
Tuvalu	Yes, NSP being revised - draft of 2006-2010, plan for 2001 endorsed	TuNAC, active to 2001, now functioning intermittently	MoH Red Cross, TANGO facilitate coordination and secretariat support	TANGO	Good relationship between MoH and NGOs
FSM	No, plan developed by MoH for grant	Community Planning Group – stakeholder involvement CCM for GF funds	HIV coordinator in MoH	No CDO	
Palau	Yes – NSP 2000 -2005	Community Planning Group	MoH HIV coordinator	No CDO	CPG set up as condition of US grant
Solomon Islands	Yes, endorsed plan 2003	National AIDS Council – SINAC Stakeholder meetings Technical working groups	MoH – funding for secretariat	Oxfam	NCM well supported by Oxfam Parliamentary Committee

Country	NSP	NCM	Secretariat	CDO	Comments
					established
Tonga	Yes – NSP 2001-2005	NAC – inactive CCM - active	MoH HIV coordinator	Tonga Family Health Association	CDO supporting CCM meetings
Vanuatu	Yes – NSP 2003-2007	National AIDS Council, TORs, 10+ members, not meeting regularly technical working groups and CCM – more active	MoH - 2 staff	Wan Smolbag	NCM endorsed by Govt Support from CDO – Wan Smolbag for coordination
Nuie	No	No	MoH - HIV Coordinator	No CDO	
Tokelu	No	No	HIV Coordinator	No CDO	

ANNEX 3

Solomon Islands National AIDS Council

SINAC – The Solomon Islands National AIDS Council:[17]

The Solomon Islands National AIDS Council (SINAC) is a multi-sectoral body. There is a secretariat and focal area working groups or response components attached to the SINAC. The diagram on page eight outlines the SINAC structure.

3.1. SINAC

The multi-sectoral SINAC is the overarching authority for the HIV/AIDS response in the country by stakeholders, partners and funding bodies. The role of the National AIDS Council is to give overall guidance, approval and accountability for HIV/AIDS policies, and prevention, treatment and care programs. The SINAC is to have a political articulation to parliament for policy and legislation, and systems of reporting to the Ministry of Health, stakeholders and parliament need to be established, potentially through a cross-party parliamentarian group.

3.2. Composition

The composition of the SINAC at the national level is multi-sectoral, and the nominated positions require commitment. The membership of the advisory board is to be made up of many government sectors, non-government organizations, representation of PLWHA, youth and women, the Trade Union, the Legal sector (lawyer and human rights specialist), UN organizations, the media and the private sector. The Minister of Health will chair the Solomon Islands National AIDS Council. The proposed members of the National AIDS Council are:
1. Undersecretary of Health Improvement
2. Undersecretary of Health Care
3. HIV/AIDS Unit Program Manager
4. PLWHA
5. Female and Male youth representatives from NGO/CBO
6. Women's representative from NGO
7. Media Association Director
8. Legal Adviser (lawyer or human rights specialist)
9. General Secretary of SICA - broad based Church leadership
10. General Secretary if the Full Gospel Association (SIFA)
11. Minister of Home Affairs
12. Minister of National Planning
13. Director of Health Planning
14. Representative of the Chamber of Commerce
15. General Secretary National Council of Women
16. Minister of Education
17. Head of National Referral Hospital (NRH) – CEO or Medical Superintendent
18. World Health Organization (WHO) Country Liaison Officer (CLO)
19. Country Director SCA

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[17] Excerpts from document prepared for government endorsement of SINAC. Aug 2004.

20. Country Program Manager World Vision
21. Director of SIPPA
22. Minister of Provincial Government
23. Ministry of Foreign Affairs
24. Oxfam Country Representative (CDO Representative)
25. Commissioner of Police and Prison Services
26. Medical Association / Medical Doctor
27. Chairperson of the Nursing Council
28. Trade Union Representative
29. Child Development Officer National Advisory Council of Children
30. Head of the Port's Authority
31. Advisory representatives from Component Working Groups when issues in their areas are being discussed

4. Terms of Reference – SINAC

The Terms of Reference (TOR) for the SINAC are to:

- Endorse standardized national messages for consistency
- Endorse standards for messages for behavioural change and communication
- Endorse IEC materials from all sectors
- Endorse training manuals used for e.g. VCT, care and support, behaviour change, peer education etc.
- Review and endorse policy and make recommendations to parliament
- Advise the Cabinet on HIV/AIDS related issues and advocate for related policy
- Ensure ethical standards and equity in service delivery within the health system for people living with HIV/AIDS (PLWHA)
- Advocate for and ensure the protection of human rights for PLWHA
- Endorse grant applications for HIV/AIDS made to the CDO for the Pacific Regional HIV/AIDS Program NAC grants program, to the GTFAM, and to other funding bodies
- Approve revisions to the NMSP
- Oversee the coordination and implementation of the NMSP
- Encourage the involvement of people living with HIV/AIDS and other vulnerable groups
- Promote and facilitate national partnerships and a multi-sectoral response
- Advocate for and mobilize resources
- Oversee the financial accountability of STI/HIV/AIDS related funds
- Meet on a regular basis and be supported by a secretariat and working groups. There may be the need to initially meet on a monthly basis

Initially the SINAC, as the multi-sectoral national AIDS authority, would not be a statutory body but endorsed by the Executive of the Ministry of Health. It is recommended that the SINAC move towards being established through an act of parliament with a formally endorsed mandate, and that it be integrated into and recognized by national health and development plans. The SINAC will be supported by a secretariat.

5. SINAC Secretariat

By early 2005, it is envisioned that the SINAC multi-sectoral advisory board will be supported under the health sector with a working secretariat, and an official coordinator for the SINAC (see page 11). The SINAC secretariat has been integrated into the structure of the HIV/AIDS Prevention, Treatment and Care unit with an approved ongoing budget. The terms of reference for the secretariat have been incorporated into the job descriptions for the positions in the HIV/AIDS unit to ensure that the secretariat is in a position to support the SINAC, component working groups and partners, and that its focus is multi-sectoral (see Annex 1). The secretariat is the coordinating body of the SINAC and terms of reference for the secretariat have been tailored to facilitate this role.

5.1 Terms of Reference for the Secretariat

The Terms of Reference for the HIV/AIDS secretariat are to:

- Facilitate a national multi-sectoral response with partners through communication and institutional strengthening (capacity building and skills transfer)
- Facilitate the translation of the NMSP at a provincial level
- Review, develop and revise the NMSP with partners
- Work closely with the Capacity Development Organization of the Pacific Regional HIV/AIDS project (Oxfam).
- Coordinate the National Multi-sectoral Strategic Plan
- Monitor the national response through the creation of a common framework and evaluate the National Multi-sectoral Strategic Plan (NMSP) with stakeholders across sectors
- Ensure that monitoring and evaluation data is collected, compiled and analysed against the NMSP
- Strengthen the capacity of provincial STI/HIV/AIDS coordinators to respond with other stakeholders to strengthen HIV prevention, care and treatment programs
- Ensure STI and HIV surveillance data is regularly collected and analysed, and strengthen ongoing surveillance programs
- Guide and support Behavioural Sentinel Surveillance (BSS) and HIV Sentinel Surveillance (HSS) activities and the Country Surveillance Program Director
- Coordinate and facilitate the multi-sectoral focal working groups attached to the SINAC
- Build and strengthen relationships with stakeholders, and create communication systems that are broad based and inclusive
- Identify research, training and resource needs
- Develop proposals for funding for a variety of donors and funding bodies based on the recommendations from the focal area working groups
- Support and expand the HIV/AIDS unit resource centre and IEC distribution
- Support the development of a BCC strategy with the focal area working group
- Ensure the participation of PLWHA and other vulnerable groups in program, planning and policy development at all levels
- Coordinate and support policy development
- Support the training of VCT counsellors and home based care workers, and coordinate

and monitor their work
- Monitor the quality assurance of VCT
- Facilitate communication between clinical management and home support teams
- Secretariat members will participate in all focal area working group meetings

The secretariat will facilitate a national multi-sectoral response through the coordination of the NMSP and by working closely with a range of stakeholders and partners, and the response components or focal area working groups.

6.0 SINAC Intersectoral Working Groups:

The working groups of the SINAC must have a multi-sectoral composition and have specific focal areas or response components. These working groups are action oriented and play an advisory role to the SINAC, and are supported through the SINAC secretariat. These working groups are to be inclusive and include PLWHA, youth, women, government and non-government organizations, the private sector, UN organizations and other stakeholders. Each focal area or component may have more than one working group. The focal areas for the working groups are:
- Behaviour and Sentinel Surveillance and Research
- Advocacy strategies with Youth, PLWHA, Gender and other Vulnerable Groups
- Legal and Ethical Issues, HIV Management Policy and Legislation
- Behaviour Change Communication (BCC): Information, Education and Communication (IEC) materials, Condoms, Media, Health Promotion and Risk Settings
- Counselling, Care and Treatment
- Monitoring and Evaluation and Planning

The focal area working groups respond to the identified needs from the SINAC, secretariat and other partners, they work with the Secretariat and report directly to the SINAC. The Secretariat SINAC coordinator will ensure communication and coordination between the members of the working groups. The objectives of these working groups will evolve and change with the needs of the epidemic; however some initial objectives have been created to guide the work and advisory direction of the working groups. It is envisioned that some of these focal area groups will have sub working groups due to the breadth of the focal topic areas.

6.1 ISWG for Behaviour Change Communication (BCC): Information, Education and Communication (IEC) materials, Condoms, Media, Health Promotion and Risk Settings
- Strengthen the capacity of the MOH and partner organizations to increase STI/HIV awareness, while creating an enabling environment for behaviour change.
- Provide support for the creation of a national multi-media education and awareness campaign for prevention, treatment and care.
- Ensure that templates for BCC materials is available to be adapted at a provincial level and with other vulnerable groups
- Provide advise to partners in the development of IEC and BCC materials

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- Increase the capacity of partners and the MOH to build networks through which to distribute information
- Support the development of a risk setting approach with partners to address an effective response to vulnerable groups
- Support the development of a national resource center
- Support and advise on the social marketing of condoms
- Ensure the involvement of PLWHA in prevention and BCC programs
- Review HIV related media and support the sensitization of the media through the media association

6.2 ISWG for HIV Counselling and Testing, Treatment and Care:

- Support the creation and expansion of networks of counseling, support and care services for PLWHA and for families and communities that are affected
- Advise on and ensure the expanded training of VCT counselors
- Advise on and ensure the supervisory, support and monitoring of VCT counselors
- Give advise in the development of VCT with rapid testing
- Ensure that all HIV testing includes voluntary informed consent and counseling
- Assist in the development of systems of referral for care and support into provincial areas
- Support the establishment and coordination of care, support and treatment teams at a national level and in provincial areas to meet the needs of PLWHA
- To work with those creating policy and protocols in the area of treatment, and other HIV management areas
- Provide advise to the SINAC on trade and drug procurement issues
- Support the development of clinical capacity to treat opportunistic infection and prescribe and monitor ART adherence

6.3 ISWG for Advocacy strategies with Youth, PLWHA, Gender and other Vulnerable Groups

- Support the development of HIV prevention, treatment and care strategies <u>with</u> youth, PLWHA and other vulnerable groups
- Ensure that cross-cutting issues are adequately integrated across all focal area working groups and in the NMSP
- Ensure that members from vulnerable groups are involved at all levels of the response
- Support the development of advocacy strategies with youth, PLWHA, women and other vulnerable groups

6.4 ISWG for Behaviour and Sentinel Surveillance and Research

- Provide advise to the SINAC on the Second Generation Surveillance system and its development
- Monitor the results of the Global Fund surveillance initiatives
- Review and support the improvement of data collection systems for STI/HIV/AIDS
- Provide advise on all HIV related research proposals and provide advise to the research and ethics committee when such research is being assessed

- Identify research areas based on the National Multi-sectoral strategic plan and give advisory support in the development of research proposals
- Strategize to increase and improve the collection of STI and HIV related statistics
- Ensure that systems are in place to protect HIV related statistical data
- Monitor the collection of STI data and review yearly compiled statistics at national and provincial levels
- Support the building of skills and capacity to mange and analyze STI and HIV/AIDS related data
- Ensure that data is regularly presented and communicated to partners
- Support the improvement in the delivery of STI and HIV services through increased clinical management, enhanced diagnosis and treatment, and through increased access to these services for youth, PLWHA and other vulnerable groups
- Support the development of links between research and surveillance data, and planning and the development of strategies for prevention

6.5 ISWG for Legal and Ethical Issues, HIV Management Policy and Legislation

- Strengthen the capacity of the SINAC and other stakeholders in the development of HIV management policy and protocols
- Advise and advocate on issues related to confidentiality and the rights of PLWHA

6.6 Monitoring and Evaluation and Planning

- Support the development of a monitoring and evaluation (M & E) framework for the NMSP
- Support the development of partners skills in monitoring and evaluation
- Ensure that M & E data is compiled and analyzed on an annual basis
- Support the annual review of data generated from all partners against the NSMP and assist to identify changing and ongoing priorities and gaps in the response
- Provide advise to the SINAC in HIV related planning
- Support planners to integrate HIV in national and provincial development plans
- Ensure that adequate links are made between M & E, research and surveillance data, and policy development and planning processes

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                          │           SINAC                 │
                          │ Solomon Islands National AIDS   │
                          │         Council                 │
                          │      Advisory Board             │
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SINAC
Solomon Islands National AIDS Council
Advisory Board

CCM – Global Fund

CDO Oxfam

SINAC Response Components
Focal Area Working Groups

SINACS – SINAC Secretariat

Behaviour and Sentinel Surveillance and Research

Legal and Ethical Issues, HIV Management Policy and Legislation

Counseling, Care, and Treatment

Monitoring and Evaluation and Planning

Advocacy: Youth, PLWHA, Gender and Vulnerable

BCC: IEC, Condoms, Risk Settings, Media and Health Promotion