MONITORING AND EVALUATION IN GLOBAL HIV/AIDS CONTROL—WEIGHING INCENTIVES AND DISINCENTIVES FOR COORDINATION AMONG GLOBAL AND LOCAL ACTORS

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Abstract: This paper discusses coordination efforts of both donors and recipient countries in the monitoring and evaluation (M&E) of health outcomes in the field of HIV/AIDS. The coordination of M&E is a much underdeveloped area in HIV/AIDS programming in which, however, important first steps towards better synchronisation have already been taken. In this paper, we review the concepts and meanings commonly applied to M&E, and approaches and strategies for better coordination of M&E in the field of HIV/AIDS. Most importantly, drawing on this analysis, we examine why the present structure of global health governance in this area is not creating strong enough incentives for effective coordination among global and local actors. Copyright © 2010 John Wiley & Sons, Ltd.

Keywords: HIV/AIDS; monitoring; evaluation; harmonisation; alignment; global; health governance

1 INTRODUCTION

The emergence of new powerful agencies targeting HIV and AIDS, most notably the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and the US President’s Emergency Plan for AIDS Relief (PEPFAR), has made possible an
unprecedented scaling up of efforts in prevention and treatment of the disease. However, a number of recent studies suggested that there are disparities between levels of funding raised globally for the control of HIV and AIDS and attention given to making ‘the money work’ in local settings (England, 2007; Schieber et al., 2007). Much of this implementation crisis is attributed to badly functioning or rudimentary national health systems, to weak domestic financial and resource management, to inefficient national systems for procurement of drugs and services and to a lack of infrastructure for their distribution to district and facility levels. Yet, it is increasingly acknowledged by most agencies operating in the field of HIV and AIDS that this implementation crisis is, to a large extent, also an outcome of insufficient coordination and harmonisation of policies and programmes between international agencies and other global initiatives.

In this paper, we discuss contemporary developments in global coordination of monitoring and evaluation (M&E) since we believe that this is an area where coordination efforts are still underdeveloped, and where momentum for enhanced global collaboration is gathering. In most of the literature and in health policy making, the term ‘M&E’ is a standard expression, suggesting that monitoring and evaluation activities form an inseparable entity. Monitoring and evaluation, however, are two quite different dimensions of global and local stocktaking in HIV/AIDS control as elsewhere. Monitoring refers to routine record keeping of project or programme performance; surveillance of morbidity, mortality and treatment rates and assessments of health facility performance. Evaluation refers to the assessment of overall achievements of health interventions, projects and programmes. Clearly, data and information gathered through monitoring may be used for the purpose of evaluation, where the aim is to improve programmes and health interventions and identify best practices. Monitoring and evaluation also differ with regard to the methods used for collection of information and data and, as a consequence, with regard to the costs involved in assuring rigour and completeness of data. Routine collection of patient data for monitoring purposes, for example, is relatively inexpensive, although great efforts are often required to maximise data validity and reliability. In contrast, large population-based surveys for longer-term evaluations of the effects of specific programmes and interventions in terms of outcome and impact are expensive and methodologically difficult.

Throughout most of this paper, we will still adhere to the commonly used terminology of M&E, simply because these two activities are conventionally combined and because evaluation is not possible without the continuous supply of sound information collected through monitoring. M&E aims to assess performance through providing measures of inputs, processes, outputs, outcomes and impact so as to improve programmes and control disease. However, some of the highest transaction costs imposed on national and sub-national implementation partners result from poor coordination of their external partners’ M&E processes and demands. This is the focus of our paper. Insufficient coordination of M&E requirements puts a high burden of transaction costs on those at the far end of the implementation chain, i.e. the district and facility managers, doctors, nurses, community health workers and other service-providers who are asked to provide critical quantitative and qualitative data for M&E reports (Koenig et al., 2006).

Assertions of the need for (Chan et al., 2010) and proposals on how to ensure more effective and synchronised M&E systems locally and globally are numerous (UNAIDS, 2006; World Bank Global HIV/AIDS Program, 2006). However, they fundamentally disagree on how, by whom and according to which mechanisms such coordination should take place. In this paper, we propose three arguments that are critical in any future global harmonisation efforts in M&E for HIV and AIDS control. First, coordination in the area of
M&E should not be seen as an aim in itself, but a necessary condition for bringing about an overall improvement of programmes. Current efforts towards greater coordination of M&E standards and systems often lose sight of this fundamental purpose. Secondly, there are various dimensions of coordination within the field of HIV/AIDS control. Coordination activities differ with regard to: whether they primarily target monitoring or evaluation; alignment (of donors with the recipient country) or harmonisation (among donors); and the level (global or national) at which coordination efforts are being undertaken. We unpack and analyse the different meanings that are commonly applied and propose a framework for M&E that aims to capture these differing levels of coordination and policy making within this field. Thirdly, increase in international donors’ and national actors’ motivations to effectively use these global coordination instruments will require changes in the current system of global health governance in which there are strong incentives for individual actors to ‘play alone’ rather than with others. In this respect, the recent paper by Chan et al. suggests a commitment on the part of most of the main global actors to greater coordination, as part of their joint aim for greater accountability (Chan et al., 2010).

Using our framework, we will show how incentives/disincentives for actors vary with regard to the various dimensions of M&E coordination, and how this variation influences the possibilities for improvement and success in terms of harmonisation and alignment between donors and recipient countries. We conclude that giving recipient countries a stronger role in steering coordination processes between global and national partners would increase the potential for realistic solutions to international coordination ‘problems’, which result from struggles over leadership and public goods that are intrinsic to the institutional landscape of global health politics.

2 GLOBAL COORDINATION FRAMEWORKS IN HIV/AIDS CONTROL

Efforts to bring about greater donor coordination, which included the need to rationalise and ‘accommodate the monitoring and accounting requirements of different agencies’, took shape in the mid 1990s in Sector-Wide Approaches (SWAs) to health (Cassels and Janovsky, 1998). These were a response to the project approaches that had dominated donor aid modalities for decades. SWAs were seen as an effective way to bring about enhanced coordination and alignment in the health sector, reduce transaction costs and avoid duplication (Hutton and Tanner, 2004). While lip-service was paid to the need for coordination of M&E, the reality was that much more emphasis in SWAs was given to the coordination of financing, to the neglect of evaluation performance and progress across the sector as a whole and to assessing the general impact of SWAs across countries (Garner et al., 2000; Martinez, 2006: pp. 6–7). Nevertheless, the lessons learned during the implementation of SWAs in diverse national settings have certainly given impetus to the various global coordination efforts outlined below. Since 2004, global actors have undertaken a variety of standard-setting activities in order to ensure a better coordination of aid institutions, especially as it applies in the complex field of HIV and AIDS control.

Important principles regulating the relationship between donor and recipient countries were enshrined in the 2005 Paris Declaration on Aid Effectiveness, an international agreement that has 130 signatories. The Declaration specifically calls for greater

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1OECD-DAC, High Level Forum, Paris Declaration on Aid Effectiveness, Paris, 28 February–2 March, 2005, accessible at: http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html, accessed 03/03/10.
harmonisation and alignment in development cooperation. It also stipulates that recipient countries should assume leadership and primary responsibility for ensuring coordination of all programmes and projects that are funded externally or through national budgets (ownership). Thus, national governments should also be seen as the focal point of all activities related to a synchronisation of M&E. The Declaration’s principle of mutual accountability furthermore implies that in any coordination effort such as coordination in M&E both donors and recipients should ‘jointly assess [...] mutual progress’.\(^2\) As a specific framework in HIV/AIDS control the ‘Three Ones’ Principles agreed by key international donors during a 2004 high-level meeting hosted by UNAIDS and the governments of the USA and the UK are by now forming the basis of most efforts towards donor coordination and harmonisation in the field of HIV and AIDS. The principles stipulate that any national AIDS response should be based on one agreed HIV/AIDS Action Framework that serves as the focal point for all partners; that there should be one National AIDS Coordinating Authority; and that donors should promote and adhere to one country-level Monitoring and Evaluation System.\(^3\)

A recent development has been a range of multilateral ‘compacts’ between donor and recipient countries such as the International Health Partnership (IHP), launched in late 2007 as a ‘Global Compact for Health’,\(^4\) and the 2007 Harmonisation for Health in Africa (HHA) Action Framework.\(^5\) The IHP is envisaged as a contract under which international donors commit themselves to collaborate more efficiently and align their activities with national health plans and priorities, while recipient countries are obliged to work towards enhanced efficiency and accountability of national health plans. However, as the first external review of the IHP (+ related initiatives) concludes, it is still too early to determine the extent to which both international donors and recipient countries will ‘sign up to Country Compacts that will commit them to concrete deliverables’ (Conway et al., 2008).\(^6\) So far, only four countries have signed Country Compacts (Ethiopia, Mozambique, Mali and Nepal). While the IHP+ inter-agency working group has developed a common framework for monitoring health systems performance and evaluating progress in countries, it remains to be seen to what extent this framework will become part of the Country Compacts.

All international principles and standards targeting policy coordination among aid donors, in particular the Paris Declaration, single out M&E as an area in which better coordination among international agencies is needed. Despite sustained efforts to strengthen M&E in the field of HIV and AIDS, ‘most HIV M&E systems are not fully functional’ (GTZ, 2007; UNAIDS, 2006). The global harmonisation of indicators for HIV/AIDS surveillance has been quite successful in the past few years, starting with the 25 globally accepted UNGASS indicators agreed in 2001 and, at present, through the efforts undertaken by the Global Fund in conjunction with other large global health initiatives (GHIs) (Global Fund, 2009). Most other areas of coordination of M&E, however, are still underdeveloped. The Global Fund lists ‘monitoring and evaluation systems’ among its seven biggest implementation problems (or bottlenecks) that are caused

\(^2\)OECD-DAC, High Level Forum, Paris Declaration on Aid Effectiveness, Paris, 28 February–2 March, 2005, accessible at: http://www.oecd.org/document/18/0,2340,en_2649_3236398_35401554_1_1_1_1,00.html, accessed 03/03/10.


\(^4\)http://www.internationalhealthpartnership.net/en/about, accessed 03/03/10.

\(^5\)http://www.who.int/healthsystems/HSS_HIS_HHA_action_framework.pdf, accessed 03/03/10.

\(^6\)See http://www.internationalhealthpartnership.net/pdf/IHP_External_review_2008_EN.pdf, accessed 03/03/10.
by health systems constraints (WHO, 2007: p. 27). Even though many countries have made moderate progress in improving their national M&E systems since UNGASS in 2001, the M&E requirements imposed on countries with very limited resources contribute to an overstretching of already weak health systems (UNAIDS, 2006: p. 9). The Global HIV/AIDS Initiatives Network which has conducted research on policy coordination in 14 countries, concluded in 2008 that ‘the coordination of monitoring and evaluation is poor in most countries’ (Spicer et al., 2010).

Various assessments of M&E coordination come to the conclusion that M&E often figures as an ‘add-on’ to projects and programmes rather than as an essential dimension of broader planning and implementation processes (Global Task Team on Improving AIDS Coordination, 2005: p. 12). What is often neglected is that coordination of M&E is a means to an end (i.e. better performance of programmes and improvement of implementation strategies resulting in health gains) and not just an exercise to satisfy a multiplicity of separate donors. In the following section, we specify the dimensions and levels where better coordination of M&E is needed to improve HIV and AIDS programmes at the country-level and debate different mechanisms that could contribute to such improvements.

### 3 DIFFERENT DIMENSIONS OF M&E COORDINATION

While principles and mechanisms of coordination among donors are largely debated on a global level, coordination itself takes place at country level. Such a differentiation makes it easier to identify the extent to which the various existing technical assistance initiatives (toolkits, task teams, groups etc.) and global frameworks are applicable to different dimensions of M&E. This can prevent a conflation of global and country-level requirements for M&E and, ultimately, provide a clearer vision of where and how improvements are possible. The term alignment refers to the process through which external actors aim to bring their agendas, priorities and programmes into line with the national priorities of their partner countries. M&E alignment, thus, is a critical component of country ownership. Its primary purpose is to reduce complexity and transaction costs for national implementation agencies, to enable countries develop a coherent and unified M&E framework and bring donors’ activities into line with national systems. Harmonisation, in contrast, refers to the relationships within the donor community, covering all activities through which external actors aim to synchronise their activities (globally and locally) and avoid duplication of or contradiction between priorities, processes and programmes. The primary strategy for harmonising M&E lies in the creation of a common pool of data and information that makes cross-country and cross-programme/initiative comparisons possible.

Among the major problems in the contemporary coordination of M&E is the fact that, inspired by the various global principles discussed above, donors’ coordination activities at country-level usually stop short of closing the (audit) circle and ensuring that the benefits of a more unified M&E strategy lead to better programme implementation on the ground. Donors have usually judged the benefits (or not) of harmonised M&E mechanisms in terms of their own accountability for how taxpayers’ money is spent. Thereby, negotiation of

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harmonised indicators and data collection is primarily to meet donors’ needs and not to provide information for implementing improvements in programmes at the country level.

A large 2009 review of interactions between global health initiatives and country health systems conducted by the WHO Maximising Positive Synergies Collaborative Group, for example, comes to the conclusion that GHIs tend to focus mainly on two dimensions of information—the coverage of health services and surveillance of specific diseases. They ignore the wider dimensions of surveillance related to the overall state of services and population health in general. GHIs are neglecting health information systems (HIS) in these broader areas simply because these are not immediately relevant to their mostly disease-specific work and investments (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009: p. 2157). Health information systems in many countries are also unreliable and incomplete (GHIN, 2009). The recent paper by Chan et al., which is co-authored by eight leaders of global health initiatives, does at least show an incipient recognition of the primary role of M&E systems, which is to improve programme performance in country (Chan et al., 2010).

Rather than seeing it as primarily a way of satisfying individual donors’ needs for data and information, M&E should be perceived as the primary mechanism for assessing the overall effectiveness and efficiency of programmes and interventions. Such assessments must include both individual actors’ contributions and the overall effects of foreign aid on the national HIV situation or the health system in general. As has been argued in the introduction, M&E is a framework for measurement and assessment that overlays all stages of a programme cycle (input, process, output, outcome, impact). Table 1 provides a framework that summarises the different areas where coordination is needed, the particular approaches that characterise coordination in these areas, as well as the primary strategies through which better coordination of M&E coordination should—ideally—be achieved.

Awareness of and commitment to improved coordination is rising among international donors and recipient countries. In the past few years, a variety of positive changes were already observable within the field of alignment and programme implementation, in the form of national action plans or frameworks for M&E. The technical assistance provided by the Global Monitoring and Evaluation Team (GAMET), for example, has reportedly resulted in improved national M&E systems in 19 countries. In Eritrea, Indonesia, Jamaica and Kenya, the GAMET team has helped establish M&E frameworks through a consultative process with domestic and external stakeholders. The UNAIDS Country Harmonisation and Alignment Tool (CHAT) that serves to map the relationships between all stakeholders involved in a national response to HIV/AIDS has so far been tested in a pilot study in seven countries (Botswana, DR Congo, Somalia, Zambia, Nigeria, Indonesia, Brazil) (Whynns and Lubis, 2007). The M&E Toolkit developed by the Global Fund together with other GHIs is also reported to have contributed to an improvement of national M&E systems (Global Fund, 2009). An attempt at coordination of M&E through the introduction of a collective M&E system is also being undertaken by the IHP+ at present.

However, despite these major efforts to turn global principles into effective practice, the various initiatives discussed above have, so far, remained selective interventions that lag far behind the aspirations of global and national agencies involved in HIV/AIDS control.

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Table 1. Framework for focus, approaches and strategies towards coordination in HIV/AIDS control

<table>
<thead>
<tr>
<th>Focus</th>
<th>Harmonisation (Input)</th>
<th>Alignment (in-country coordination process)</th>
<th>Result of M&amp;E coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>Donors harmonise activities among themselves through collectively agreed standards and procedures</td>
<td>Donors/external actors align their activities with partner country’s national strategies and technical capacities (e.g. by agreeing on one costed national HIV/AIDS plan)</td>
<td>Donors and partner countries develop a coherent and mutually agreed set of indicators for measuring the effectiveness/success of programmes</td>
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<tr>
<td></td>
<td>Donors agree on a division of labour, globally and at country-level</td>
<td></td>
<td>Recipient countries develop national health information system (HIS) and monitoring system</td>
</tr>
<tr>
<td>Primary strategies of M&amp;E coordination</td>
<td>Assessing individual external agencies’ performance against a mutually agreed set of indicators</td>
<td>Strengthening country’s capacity and mechanisms for M&amp;E</td>
<td>Strengthening M&amp;E dimension in all national implementation programmes</td>
</tr>
<tr>
<td></td>
<td>Avoiding of duplication of M&amp;E structures/facilities/reviews among donors</td>
<td>Working within national health information system</td>
<td>Strengthening national health information systems</td>
</tr>
<tr>
<td></td>
<td>Channelling resources of external actors into M&amp;E activities</td>
<td>Reducing numbers of indicators demanded by external agencies</td>
<td>Assessing the effects of all actors’ (national, international) activities on national health systems/specific health situation</td>
</tr>
<tr>
<td></td>
<td>Simplifying M&amp;E frameworks and procedures</td>
<td>Aligning of international partners’ M&amp;E plan or system with national AIDS framework, e.g. by using national indicators to measure results/progress</td>
<td>Assessing the system-wide effects of external actors’ interventions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Developing an evidence-based results framework for the national AIDS response</td>
</tr>
</tbody>
</table>
4 INCENTIVES AND DISINCENTIVES FOR COORDINATING M&E

The dilemma with regard to further coordination, particularly among global partners, lies in the fact that it is very hard for these actors to see incentives for collaboration and divisions of labour in an ‘anarchical’ terrain that is characterised by competition for visibility and leadership roles (de Renzio, 2004; Rogerson, 2005; Obser, 2007). Persistent problems of coordination in aid cooperation, such as the unwillingness of agencies to share information, knowledge and best practices, the continuous struggle for leadership, the difficulty to agree on commonly accepted norms and standards for policy-formulation and implementation or the overcrowding of certain aid areas are particularly relevant and visible in HIV/AIDS. Keeping in mind the multi-dimensionality and complexity of enhanced coordination in the field of M&E for HIV/AIDS control, it is difficult to imagine an M&E system that all stakeholders will buy into. A general challenge that affects M&E coordination is to strike a balance between fostering harmonisation and division of labour on the one hand and fostering excellence and innovation through a at least a minimum level of competition between individual agencies on the other. For external funding agencies, an integrated, collectively endorsed M&E system is less attractive because it implies significant investments in an area that brings little attributable value-for-money, that is value that can be easily communicated to domestic politicians, other stakeholders such as the domestic media and donor country taxpayers.

In fact, looking at the budget distribution of large global AIDS initiatives, it becomes apparent that M&E plays little more than a marginal role in their activities. The Global Fund, for example, cut down allocations to M&E from 5 to 3% between round 4 and 7, despite frequent statements regarding its importance.9 However, this may be because countries have not made requests for funding M&E in their applications. Of the 5.9 billion USD budget for the President’s Emergency Plan for AIDS Relief (PEPFAR) Operational Plan 2008, only around 10.6 million USD are allocated to enhance ‘strategic information and evaluation’ in PEPFAR focus countries (PEPFAR, 2008: p. 190). A 2009 study on investments in national M&E systems concluded that the median for actual spending on M&E at the national level was 1.8 per cent (Peersman et al., 2009: p. 89), despite the recent agreement among major global health initiatives that about 5–10 per cent of programme funds should be invested in data collection, monitoring, evaluation and operational research (Bennett et al., 2006, Chan et al., 2010).

Forty per cent of the countries included in the study by Peersman and colleagues reported that funding for M&E activities was provided exclusively by international sources. The study also concluded that, while most of the 185 countries for which the authors reviewed national M&E measures had reported a general endorsement of national M&E plans by all key partners involved in HIV/AIDS control, the actual harmonisation and alignment measures undertaken by these actors were far from optimal. Only 9 per cent of countries in the Caribbean and 24 per cent of countries in sub-Saharan Africa confirmed that alignment and harmonisation had been undertaken by all relevant agencies. The study also concluded that the fact that national M&E plans and systems are still underdeveloped is also strongly related to governments in recipient countries not taking full advantages of the funds available for improving M&E systems.

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9See the global expenditure target pie-chart for all funding rounds of the GFATM at http://www.theglobalfund.org/en/distributionfunding/, accessed 03/03/10 see page 8.
While the harmonisation of indicators and systems for monitoring between global health actors appears to be the most successful area of M&E coordination so far, alignment of monitoring systems between donors and recipient countries seems to be a much more difficult undertaking. Particularly where national HIS are weak, it is sometimes convenient and less costly for donors to set up their own monitoring systems using their technical capacities and staff, rather than engaging in long-term and expensive capacity building to establish robust and sustainable national data collection systems. In Kyrgyzstan, for example, a study on global health initiatives’ effects on HIV/AIDS control in the country concluded that, since comprehensive measures to establish a common M&E system for the country have just begun, GHIs are retaining their parallel data reporting systems based on the requirements of the individual agencies. The results of parallel monitoring and reporting systems are that, for example, donors do not promote or do not follow a single approach for registering clients, recording activities and impact of interventions which, in some cases, leads to a double-counting of clients by implementing agencies.

The case of Zambia illustrates how, even in cases where national HIV/AIDS M&E systems have been established, donors still adhere to additional indicators and different reporting formats, arguing that the time-frame for individual donors’ reporting requirements is too tight in order to allow for delays in reporting by the MoH (GHIN, 2009). The added importance of the Zambia case study is that it included sub-national data collection, which illustrated the top-down nature of coordination problems, where PEPFAR was reported to be circumventing district coordination structures and working through stand-alone parallel M&E systems which it had established. In general, there remains the far-reaching problem that, even where core donor agencies such as the Global Fund or the World Bank have agreed on common standards, indicators and procedures for monitoring of HIV control, the vast number of implementing partners (such as civil society organisations—CSOs) are not willing or capable of following these standards and procedures.

Harmonisation of evaluation principles and standards appears to be the least successful and most problematic area of M&E coordination. In other words, getting agreement among donors on the standards to assess the effectiveness of programmes and interventions, both disease-specific and in terms of the overall health situation is difficult. It is not surprising that donors are reluctant to buy-in fully to stronger collaboration and mainstreaming in evaluation, since where an assessment aims to measure downstream effects and impact, it is less likely to be able to directly attribute effects to an individual agency’s actions. In general, donors are mainly interested in evaluation if (a) it serves to assess a country’s performance in using donor funds and, as a consequence, its eligibility for further funding and assistance or (b) if the evaluation is in a position to demonstrate the direct positive effects of individual donor activities and funds on improvements in disease control or the larger health system. Table 2 summarises our own evaluation of possibilities for progress in the different dimensions of M&E coordination specified in our framework.

Disincentives for cooperation are at play where the motivation of country-level stakeholders to cooperate in the alignment of M&E standards is concerned—particularly in cases where M&E is strongly connected to performance-based funding and

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11Ibid, p. 34.
accountability. Firstly, improvements in M&E imply more accurate and therefore constraining mechanisms of accountability for national governments and implementing agencies. This puts governments under increased pressure to account for how funds were used, show transparent results and verifiable progress. As such, a reduction in complexity would be counter-intuitive for those national authorities who struggle to live up to the expectations of the international community in their performance. Secondly, some authors suggest that recipient governments sometimes support parallel reporting and M&E systems in order to play off individual donors against each other and to promote competition between them (Buse and Walt, 2006). Others argue that weak coordination among donors makes it easier for recipient governments to ‘achieve the aid allocation they desire’ (Bigsten, 2006: p. 123) and to ensure sustained funding and donor commitment.

Better harmonisation among donors could also imply, as Acharya suggests, that recipient country government autonomy would decrease in the face of stronger and more coherent donors’ agendas (Acharya et al., 2006: p. 14). It is therefore no surprise that the 2006 Global Corruption Report on Health attaches great importance to improved coordination, particularly among donors, in order to avoid the sometimes welcome confusion about the origins and use of funding that facilitates corruption by recipient governments and implementing agencies. Where M&E mechanisms are weak, the report claims, falsification of records is much easier for corrupt agencies (Transparency International, 2006; see also Transparency International, 2008).

The disincentives discussed above are counter-balanced by strong incentives on the part of all actors to reduce the transaction costs implied by weakly coordinated M&E efforts. All major agencies involved in HIV/AIDS control have, to some extent, expressed their interest in improved coordination of M&E and many of them are participating in joint initiatives to turn their commitment into reality. However, the current global health architecture reduces the motivation of individual agencies to pool resources and curb such transaction costs—costs that are borne primarily by recipient governments. There are two important reasons for the gap between coordination commitments ‘on paper’ and the lack of concrete realisation of these commitments in day-to-day practice. First of all, there is the perennial problem of the public good character of knowledge, once it is made publicly available. This problem applies particularly to M&E, since this dimension of global policy-making is all about sharing facts, statistics, indicators and best practices.

A 2007 comparative study on the funding practices of PEPFAR, the Global Fund and the World Bank MAP in Mozambique, Uganda and Zambia, for example, concluded that, even though PEPFAR had the most comprehensive system to collect financial data and monitor the disbursements of funds, it did not share most of its data with other key agencies. Considering that information on the use of funds and their effects on improving

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harmonisation (donors)</td>
<td>Relatively easy; most progress made</td>
<td>Very difficult; least progress made (greatest disincentives for donors but high transaction costs for recipient countries)</td>
</tr>
<tr>
<td>Alignment (donor-recipient)</td>
<td>Relatively difficult, particularly if national HIS is weak or when some powerful donor agencies remain outside alignment structures</td>
<td>Relatively difficult—if evaluation not harmonised across donors, high transaction costs caused for recipient countries through duplication</td>
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</table>

Table 2. Progress in different dimensions of M&E coordination
programmes are critical to M&E, such practices severely obstruct coordination efforts in this field (Ooman et al., 2007: p. xiii). Obviously, enhanced coordination of M&E efforts in harmonisation, alignment and programme implementation calls for the creation of a common resource pool accessible to all actors involved in global and local policy-making. However, sharing data and information with others within a global M&E facility often involves high transaction costs for those offering data and provides opportunities for free riding.

The second major reason for the gap between rhetorical commitment and reality is the problem of leadership. Coordination of standards for measuring performance is difficult where there is no one agency endowed with managing and supervising this process. Regarding leadership in harmonisation efforts between donors, the 2005 Recommendations of the Global Task Team singled out UNAIDS as the ‘focal point’ for all activities related to M&E (GFATM, 2005; UNAIDS, 2005: p. 2). However, current efforts to agree on a division of labour between different agencies already indicate that an agreement on any such lead agency for the broad health sector might be difficult. Global actors and bilateral donors are reluctant to even partially give up their control over budgets and policies and hesitate to take on lead functions since they involve ‘substantial incremental costs’ (Shakow, 2006: p. 4). They also fear the risk of free-riding by other institutions who may, for instance, take advantage of a well-functioning national HIS without, however, sharing in the massive costs for technical support to establish such a system.

With regard to leadership and alignment in HIV and AIDS, national AIDS councils and commissions are generally perceived to be the main coordinating structures, bringing together all relevant external and national agencies and actors, and managing coordination and alignment efforts between them. Assessments of the reality of national AIDS commissions, however, frequently conclude that their independent status in national HIV/AIDS is, in many cases, weak and their steering capacity in national HIV/AIDS policies and implementation low (Dickinson et al., 2007; Hongoro et al., 2008; Morah et al., 2009; Spicer et al., 2010).

5 IMPROVING COORDINATION OF M&E—A GLOBALLY OR NATIONALLY DRIVEN PROCESS?

It is widely assumed that struggles of individual agencies to take the lead in harmonisation will result in a counter-productive politicisation of coordination efforts and further aggravate already existing power struggles among the numerous agencies involved in the field of HIV and AIDS. UN agencies and the large AIDS initiatives, however, have already begun to negotiate various agreements on global labour divisions in terms of harmonisation, aiming for a fair share of ‘lead’ for everyone (UNAIDS, 2005; PEPFAR et al., 2006). Paradoxically, if such initiatives proliferate, we could again be confronted with a counter-productive effect of duplication and fragmentation rather than a unified response that aims to cover all actors (bilateral, multilateral, public, private, small, large) in a country-level response to HIV and AIDS. An independent review on the IHP+ conducted in 2008, for example, concluded that many of those interviewed for the review were still sceptical regarding the value added of the Partnership, particularly in countries where measures towards harmonisation and alignment for the improvement of aid effectiveness had already been under way (Conway et al., 2008: p. 1; see also Pereira, 2009).
Various suggestions have been made for how the present structure for monitoring and evaluating global aid for HIV and AIDS could be altered in order to create new incentives for cooperation among international and national actors. However, there seems to be considerable disagreement both among global stakeholders in AIDS governance and independent observers regarding the potential direction and shape such changes should take. Several authors report that leadership in this area by any one global health actor seems either unlikely or unfeasible due to different reasons. Bennett et al. (2006) conclude that the unwillingness of single global health actors to shoulder investments in evaluation alone requires multi-stakeholder institutional frameworks (Bennett et al., 2006: p. 80). Some authors suggest that, despite its role as the major institution in global reporting and monitoring, WHO’s position vis-à-vis recipient countries who can exert political pressure on WHO’s leadership increases the likelihood that ‘monitoring and evaluation can be distorted’ (Murray et al., 2004). Others, however, contend that WHO should take the lead in ‘democratic, transparent coordination on all aspects of international health’ (Silberschmidt et al., 2008: 1483). They suggest the creation of a ‘Committee C’ of the World Health Assembly, thereby ensuring the greatest possible representation and input of state and non-state actors in debates on coordination.

In terms of harmonisation of M&E data at the global level, Murray et al. have suggested the creation of a ‘new, independent, health monitoring organisation’ (Murray et al., 2004). Though not specific to HIV/AIDS, the creation of the Health Metrics Network in 2004 and the establishment of the Institute for Health Metrics and Evaluation in 2007 were envisaged as such independent health monitoring bodies (AbouZahr and Boerma, 2005). The Health Metrics Network’s primary task lies in enhancing ‘the availability, quality, dissemination and use of data for decision-making’,12 while the Institute for Health Metrics and Evaluation aims to develop an on-line global data bank that is freely available to everyone (Murray and Frenk, 2008). It is still too early to assess the legitimacy and outreach of these newly created institutions within the global health community. These initiatives—which include financial and operational input from different public and private actors—may be critical steps towards collectively financed yet independent M&E bodies that assemble and analyse information on national health systems and make data publicly available to both global and national decision-makers. However, there is a real risk that the establishment of a single institution (based in the ‘north’ and) globally responsible for country-level data, will itself become just another top-down initiative.

The 2005 Global Fund Study on ‘Harmonisation of Global Fund Programmes and Donor Coordination’ concludes that primary emphasis has to be put on national leadership and strong governmental responses to the coordination of national and international activities (GFATM, 2005: p. 18). Such findings suggest that all globally managed efforts towards enhanced coordination must fail if they are not supported by strong leadership at country level. Successful examples of M&E initiatives at country-level include Moldova, where a national M&E unit was established within the Ministry of Health. The Unit provides the only M&E system in the country and is based on a national set of indicators agreed upon by all major stakeholders.13 A number of multilateral and bilateral efforts are also geared towards country-based solutions for enhanced coordination, such as the IHP+, the BACKUP initiative by GTZ or the HHA Action Framework. These efforts are driven by the

belief that, without sustained and broad capacity building at national level, all global efforts towards a better coordination of M&E will inevitably place an additional burden on already exhausted health systems.

The eighth round of funding by the Global Fund has already made it clear that strengthening and improving national M&E capacities and systems is becoming a high priority for many of the applicants—20 per cent or 120 million USD of the funds that countries applied for within the health systems strengthening component of the Global Fund were requested for improving M&E (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009: p. 2157). A reason for countries to prioritise investments for improving HIS may well be the realisation of serious problems in the validity and reliability of the routine data collected and reported by health facilities, which in turn contributed to donors by-passing country HIS. Therefore, such funding priorities by recipient countries should be reflected in donor organisations’ fund allocations.

However, all efforts invested in strengthening country-ownership in M&E through technical assistance, capacity-building and alignment with national priorities will only have limited success as long as some powerful donor agencies decide to remain outside any structures for harmonisation and alignment. A study on national AIDS commissions in seven African countries concluded that when ‘substantial players [remain] outside the harmonisation and alignment agenda [they] challenge NACs’ coordination mandate’ (Dickinson et al., 2007: p. 12; Spicer et al., 2010). PEPFAR and USAID have, in the past, frequently been criticised in this regard. In South Africa, for example, it has been reported that PEPFAR has very recently insisted on introducing a new M&E evaluation scheme in the Western Cape, despite the fact that the South African government has a functioning and established system.14 The 5-year evaluation of the Global Fund published in 2008 also came to the conclusion that, even though ‘the core architectural principles and the business model of the Global Fund show the organisation is solidly committed to components of the Paris Declaration, […] the Global Fund model has functioned largely in isolation and has linked at best in only minor ways to the health strategies of country partners or to mechanisms established at country level’ (Mookherji et al., 2008: pp. 19/20). It was, however, acknowledged, that in some countries the Global Fund had succeeded in making the CCM entirely country owned (Tanzania) or had even successfully integrated the CCM into pre-existing national structures (Kenya) (Mookherji et al., 2008: p. 27).

6 CONCLUSION

Despite sustained efforts of global collaboration in order to improve data and information critical to health policy-making, M&E is still a neglected dimension of harmonisation and alignment efforts. This is reflected, firstly, in the fact that very little funding of global agencies goes into M&E of their activities in HIV/AIDS. Secondly, coordination efforts in M&E present themselves as a highly confused area of international policy-making with little agreement on what M&E implies. Thirdly, and most importantly, it is evident from the discussion of the various disincentives which reduce global and national actors’ motivation towards enhanced harmonisation and alignment that more thought needs to go into how to create structures of incentives through increased funds and improved institutional frameworks for collaboration in this field.

Acknowledging the primacy of national and district levels in further efforts to improve coordination could ease ongoing global struggles over leadership, knowledge and consensus. However, particularly in a field like HIV/AIDS control, with its strong competition of discourses and policy frameworks, it is to be expected that knowledge, best practices, indicators and outcomes will always be contested; and competition can be healthy. Emphasising the importance of the national context as the primary location for enhanced coordination could increase the possibilities of agreement among a limited number of global and local agencies on a viable framework for measuring health outcomes. Existing national frameworks for enhanced coordination through division-of-labour agreements in Mozambique, Nigeria or Zambia already suggest that individual collaborative frameworks at country-level are a much more feasible undertaking than finding solutions at the global level (UNAIDS, 2007: pp. 17–18).

Emphasis on coordination at country-level—both national and district—would also ensure that reporting and monitoring systems are designed to sustain the priorities of national AIDS frameworks rather than just the information needs of external actors (OECD, 2003: p. 55; Spicer et al., 2010). In such country-led processes, the numerous multilateral, global and bilateral instruments that have been created in order to coordinate M&E should play a critical role. Learning from and adapting existing standards and tools makes much more sense than the establishment of yet another global facilitating mechanism or institution, which may become yet another empire that will only further complicate the relationships between donors and the various multilateral and normative agencies, the consequences of which are ultimately borne by aid-recipient countries. As the Swahili proverb says: ‘When elephants jostle, what gets hurt is the grass’.

REFERENCES


