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NEGOTIATING HEALTH
IN A FRAGILE STATE:
A CIVIL SOCIETY PERSPECTIVE
A CASE STUDY OF THE GLOBAL FUND TB PROJECT IN SOMALIA

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The implementation of the Global Fund tuberculosis project in Somalia provides a compelling example of national participation and international donor coordination to provide lifesaving health services in a country riddled with conflict and a debilitated infrastructure. The success of the negotiations was largely attributable to a flexible and participatory based framework, cooperation between the national governments, civil society and international actors, all of whom were unified by a commitment to public health. The negotiation process reveals that only through an adaptable and inclusive course of action, guided by the principles of accountability and transparency, was any progress made in providing health services in a fragile state.

Key Words

Civil society, fragile state, health diplomacy, negotiations, Somalia, The Global Fund to Fight AIDS, Tuberculosis and Malaria, tuberculosis, World Vision International.

LIST OF ABBREVIATIONS

CISS	Coordination of International Support to Somalis
CCM	Country Coordinating Mechanism
HSC	Health Sector Committee
IGAD	Intergovernmental Authority on Development
MOU	Memorandum of Understanding
MDR-TB	Multidrug-resistant tuberculosis
OIC	Organisation of the Islamic Conference
PBF	Performance-based funding
PR	Principal Recipient
SACB	Somalia Aid Coordination Body
SATA	Somaliland Anti-Tuberculosis Association
TBCT	The Tuberculosis Coordination Team
TFG	Transitional Federal Government
UNICEF	United Nations Children's Fund
UNCITRAL	United Nations Commission on International Trade Law
WHO	World Health Organization
WVI	World Vision International

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NEGOTIATING HEALTH IN A FRAGILE STATE: A CIVIL SOCIETY PERSPECTIVE¹

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Despite two decades of devastating conflict, a shattered political system and a fragmented, bankrupt public health structure, thousands of Somalis are receiving free life-saving tuberculosis, malaria and HIV treatment and prevention services through a national programme financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). The Global Fund tuberculosis programme for Somalia is presented as a case study for negotiating health assistance in a fragile state. Despite the many challenges, it illustrates the potential of negotiation at multiple levels to contribute to increased health financing and, ultimately, to health outcomes comparable to or exceeding those of stable and unified countries in northern Africa and the Middle East. An umbrella grouping of partners – consisting of local and international non-governmental organizations, UN technical agencies and bilateral donors – came together to negotiate the details of the tuberculosis programme with three separate, quasi-governmental, political entities.

This case study considers the feasibility of negotiations for international health assistance in the midst of a political and security crisis; it addresses both the ‘who’ and the ‘how’ of negotiating health aid in a failed state with no internationally recognized national government, and the role of civil society in such negotiations.

The Somalia case study illustrates a shift in international health assistance policy from negotiations with state actors, to a more inclusive framework of national ownership, which includes a broad

¹ This paper was prepared for the fourth high level symposium on Global Health Diplomacy entitled “Negotiating Health in the 21st Century: Fragile States – Analyzing the Interface of Health and Diplomacy” held in Geneva on 29 November 2010.

spectrum of public, private and civil society parties. In such circumstances, non-state actors – including civil society as well as technical agencies – play a significant role in negotiating foreign assistance and can be effective in building a collective consensus around the right to public health that rises above political interests.

BACKGROUND: A HISTORY OF INSTABILITY

Conflict and collapse

Two decades of war have left Somalia's infrastructure devastated and its material and human resources depleted and fragmented. There has been a massive displacement of the country's estimated 8 million inhabitants, with approximately 1.25 million living abroad, and a further 300,000 displaced within the country. The destruction of agriculture, livestock herds and industry has resulted in food shortages, loss of livelihoods and widespread malnutrition. Health, educational and administrative infrastructure has received little investment and has largely collapsed; 75 per cent of Somalis live below the poverty line in what is currently ranked the third-poorest country in the world. Just over half the population is nomadic or semi-nomadic, while 17 per cent practise sedentary agriculture and 24 per cent are urban dwellers². Available data show that life expectancy in Somalia is 48 years, while the maternal mortality rate is 1,400 per 100,000 live births, and the under-five mortality rate is 200 per 1,000³. The people of Somalia struggle to survive without basic health services in this fragile or failed state.

The former government of Somalia collapsed in 1991 and, since then, no recognized central government has emerged. The country has split into three political entities: the Republic of Somaliland in the north-west, Puntland in the north-east, and the Transitional Federal Government (TFG) based in south and central Somalia. Only the TFG, formed in 2004, is internationally recognized. However, it maintains power in just a small area of southern Somalia, centred on the former capital, Mogadishu. The TFG has been unsuccessful in attempts to unify the country despite assistance from Ethiopian

² World Health Organization, *World Health Statistics 2010*.
Available at www.who.int/whosis/whostat/EN_WHS10_Part2.pdf

³ *ibid*

troops and the African Union. Most of southern and central Somalia is still experiencing violent civil conflict, with frequent violent clashes between various militias and troops of the TFG and the African Union. Somaliland and Puntland have experienced comparative calm, with some sporadic violence.

Throughout the 1990s, international, regional and bilateral bodies supported a complex and drawn-out political reconciliation process in Somalia, in an attempt to reconstruct the country. During this process, the health sector received very little funding, as donors focused on protracted governance and reconciliation efforts. The lack of funding reflected not only the pressures on donors' foreign aid budgets, as funds were shifted to peacemaking and peacekeeping efforts, but also a prevailing conviction that peace and the existence of a legitimate and stable sovereign government were basic prerequisites to negotiating a health assistance package. The reconstruction of the health system and the provision of health services to the public became increasingly difficult in this context.

- Since the governmental collapse in 1991, Somalia has experienced considerable political upheaval and conflict. Three separate governments and ministries of health were formed and began pursuing separate priorities.
- The country's educational, health and administrative infrastructure disintegrated during the conflict and lacked adequate international funding. The quality and accessibility of health services suffered considerably.

A fragmented and weak health system

Since the collapse of the central government, public investment in health services has been insignificant. Medical and nursing schools have been shut down and no new institutions established to develop human resources. This situation created a huge gap in the financing, supplying and staffing of hospitals and health facilities, which still rely entirely on external support. During the 1990s, the funding, drug supply and management of health facilities was provided by the World Health Organization (WHO), the European Commission, the Norwegian

government, the Global Drug Facility and implementing non-governmental organizations (NGOs).

The national health system is split according to the three political zones, each having established its own Ministry of Health. In both Puntland and Somaliland, with relatively greater peace and stability, sufficient progress was eventually made in order to put into place the basic elements of a healthcare system, which were delivered by the quasi-governmental health authorities and NGOs with technical support from UN agencies. In the south-central TFG region, public health services are managed almost entirely by NGOs due to the general level of insecurity and the government's poor grip on power. Overall, the national public health network is fragmented and weak as there is little coordination between the various ministries and programmes.

Tuberculosis: a complex public health emergency

Somalia has one of the highest rates of tuberculosis in the world (460 per 100,000⁴), which is strongly correlated with the poor economic conditions, instability, and lack of public health infrastructure. Malnutrition is common among tuberculosis patients, while HIV co-infection is a rapidly growing risk. Multidrug-resistant tuberculosis (MDR-TB) has also emerged as a result of the unregulated provision of drugs by the private sector, which soars during brief periods of relative stability, particularly in the north-west and in Puntland. Somalia's tuberculosis control programme was originally run by the Ministry of Health of Somalia's post-independence government and was based in government hospitals. However, this deteriorated following the collapse of central government. The programme was re-established in 1997 with the assistance of WHO, which set up a system of procurement and a supply chain for drugs and lab reagents, as well as community outreach programmes and education. Many NGOs were involved in efforts to rehabilitate basic health infrastructure, including tuberculosis services. Some national strategies and policies, such as the Health Sector Strategy, the Somalia Country Cooperation Mechanism, and tuberculosis treatment guidelines were developed through the efforts of UN agencies, partner NGOs and

donors during this period; these documents formed the basis of the health policy in Somalia.

International partners developed and negotiated health policy and programming together with the health authorities in Somalia under the auspices of the Somalia Aid Coordination Body (SACB). This was established in 1993 at the Fourth Coordination Meeting on Humanitarian Assistance for Somalia in Addis Ababa, Ethiopia. SACB (reorganized and renamed in 2006 as the Coordination of International Support to Somalis [CISS]) was a voluntary body based in Nairobi, Kenya, designed to provide a forum for a common approach for the allocation of international aid to Somalia. SACB consisted of over 100 partner agencies, including the main bilateral and multilateral donors, UN agencies and international NGOs. International agencies and bodies, such as the Intergovernmental Authority on Development (IGAD), the World Bank, the Organization of African Unity (OAU), the Organisation of the Islamic Conference (OIC) and the Arab League maintained ad hoc membership, mainly as observers. A network of Somali NGOs regularly participated in SACB meetings. The SACB mandate was to provide policy guidance to implementing agencies, to coordinate rehabilitation and development activities, and to make recommendations for the allocation of resources in the absence of a central government. Operating through a series of committees, SACB reached decisions by consensus; all decisions were issued in the form of recommendations, emphasizing the non-authoritarian nature of SACB. The Health Sector Committee (HSC) was one of five sectoral committees that were set up – in addition to a Steering Committee and Consultative Committee – and played a key role in the successful negotiation of a health programme in Somalia.

In 2002, with a very basic tuberculosis programme operating throughout Somalia's three zones, and in an effort to further expand and strengthen tuberculosis services, the SACB Health Sector Committee (SACB-HSC) made its first application to the Global Fund. The Global Fund's innovative fiduciary policies require that proposals are

developed by countries themselves in line with national strategies, and that all health stakeholders are involved in the process. The maturity of the SACB-HSC, its inclusiveness and democratic processes gave it an advantage in preparing the national proposal, and provided an umbrella framework for the negotiation of the many details of the Global Fund grant among a variety of political, civil society and multilateral actors representing different interests.

→ Three different political zones in Somalia, a multitude of actors and various interests created a complex and volatile environment for negotiating health policy. International actors coordinated their efforts through the Somalia AID Coordinating Body (SACB) which was designed to provide a platform for the coordination of international aid to Somalia.

→ The success of the TB program can be attributed to a number of factors including the TB Coordination Team (TBCT) administered by World Vision International (WVI), the emphasis on national leadership, multi-stakeholder participation within the structure of the Global Fund TB grant and the participatory design of the SACB-HSC.

Tuberculosis control has progressed in Somalia despite insecurity, financial constraints and the failure of political institutions, as well as the population's limited access to health services. The Somalia tuberculosis programme supported by the Global Fund is now considered to be a useful and successful case study for negotiating health in a fragile state. Negotiations for the Global Fund project were complex, protracted and involved numerous players. Key elements that contributed to the successful negotiations were the transparent, democratic and inclusive coordinating structures of the SACB-HSC and the participatory management structure of the Global Fund tuberculosis grant – the Tuberculosis Coordination Team (TBCT) led by World Vision International (WVI). Together, these structures provided a negotiating framework that enabled significant participation and ownership of the tuberculosis programme by the three quasi-governmental authorities, as well as providing legitimacy for the involvement and leadership of civil society and technical agencies, resulting in a unified national health programme. The

Global Fund policy framework and funding design made this successful negotiation possible thanks to its commitment to a new and broader definition of national leadership of health assistance programming that encouraged multi-stakeholder participation, particularly that of civil society.

ACTORS AND PROCESSES

The successful proposal, negotiation and implementation of the Global Fund tuberculosis grant in Somalia, starting in 2002, was led by a group of committed NGOs and UN agencies, which cooperated effectively and engaged in transparent negotiations with the national health authorities to present a unified funding application and implement a unified national tuberculosis programme. Owing to continuing insecurity in Somalia, most of the actors work from across the border at headquarters in Nairobi, while some also have offices in the relatively secure zones of Somaliland and Puntland. At the start of the proposal and negotiating process, the SACB-HSC already existed and therefore took the initial lead. The three national health authorities represented the interests of the government for public health, but were not in fact a unified government and had competing interests. The Global Fund, a very new institutional donor at the time, provided the funding and negotiated the terms chiefly with WVI, the Principal Recipient (PR) of the tuberculosis grant.

Health Sector Committee

The SACB-HSC (which, since 2006, has been known as the CISS-HSC) had been meeting monthly in Nairobi since 1995. It provided a forum for coordination, as well as information, policy and technical guidance on priority areas within the health sector. At the time of the Global Fund proposal, it had been recognized by international actors and local health authorities as the key decision-making body for health in Somalia. On average, 25 organizations and the three Somali health authorities participated in monthly meetings. There was a full-time health sector coordinator and acting secretariat, funded

by the European Commission. The SACB-HSC established transparent procedures for voting and managing conflicts of interest. The chair rotated between a UN agency and a civil society organization for fixed terms. All organizations had an equal voice and any issue raised by a member was discussed fully. The HSC also met quarterly in Somalia's three zones to facilitate communication during the Ministry of Health coordination meetings. The three zonal governments endorsed the HSC to act on their behalf in coordinating health policy and applying for financing because they did not have international recognition or the capacity to work together as a national entity. In addition, the three health authorities had confidence in the HSC since they had been completely involved in its processes and decision-making from its inception and because the HSC had the necessary technical competency in the form of WHO representation.

The HSC therefore assumed the role of Country Coordinating Mechanism (CCM) in making the first application to the Global Fund in 2002 for malaria and tuberculosis, as well as in all future applications. The CCM is a unique element of the Global Fund grant-making structural design and represents an important shift in international health assistance towards more inclusive and democratic processes for planning and managing national health programmes. According to the guiding principles of the Global Fund to ensure national ownership of national proposals, the central government, especially the health authorities, are to mobilize and form a CCM, representing all health stakeholders (UN, donors, civil society, faith-based organizations) and sectors (public, private, academic) of society in the country. The CCM then takes responsibility to develop and present the national proposals, select the Principal Recipients and monitor and supervise grant implementation. The purpose of the CCM is to broaden participation in national health programming, which had previously been dominated by government agencies.

The SACB-HSC presented its case to act in place of a CCM for Somalia within the Round 2 national malaria and tuberculosis proposal. The Global Fund accepted the HSC as the legitimate

non-CCM applicant for Round 2, and has accepted its subsequent grant applications due to the fact that the HSC had similar inclusive membership along with the transparent and democratic processes required of a CCM, and could perform the basic functions required of a CCM. The SACB-HSC also presented the additional advantage of providing the framework to bring the fragmented health authorities together in one national proposal. If the SACB-HSC did not exist, or did not have the representative membership and democratic transparent processes that had been strengthened over the last seven years, the Somalia Global Fund grants would not have been possible or would have been much delayed pending the formation of a working CCM.

In order to better comply with the CCM role, the HSC added some relevant Global Fund grant management tasks to its terms of reference, while some procedures were changed so as to permit greater speed and flexibility in making decisions according to tight proposal and grant deadlines. For instance, the previous requirement for decision-making by consensus was changed to a 70 per cent majority of participants. The HSC, led by the health sector coordinator, the chair and vice-chair and leaders of the malaria, tuberculosis and HIV/AIDS working groups, guided the Global Fund grant negotiations through the proposal stage.

**Ministries of health of Somaliland (north-west),
Puntland (north-east) and TFG (south-central)**

The north-west and north-east authorities were not recognized internationally, while the south-central ministry of the TFG, covering only part of the region, was incapable of providing coordination, unity or cohesion among the three and was not recognized by the other authorities. The three zones were not recognized by the Global Fund as individual governments or a national government for the purposes of the presentation of a national proposal for Somalia. For reasons of sustainability, ownership and institutionalization, the three separate entities had been the focus of inclusion, strengthening and capacity-building by the UN and civil society partners

since the SACB's inception. Their representatives were involved in the preparation of the Global Fund proposals; their views were sought, respected and recorded at the meetings of the HSC. At the same time, the three health ministries became principal quasi-governmental actors in the ongoing negotiations related to the Global Fund grants and were political actors inside their respective regions with their own political and economic interests. These entities were more competitive than cooperative, and were usually the focus of individual rather than collective negotiations with WVI.

The Global Fund

The Global Fund was established in 2002 as a financial institution, not an implementer, and therefore implements projects through signed grant agreements with selected Principal Recipients and using the contract services of a local fund agent to monitor implementation according to established policies and procedures. The Global Fund secretariat accepts, for review only, national proposals that meet eligibility standards such as being presented by a CCM or eligible non-CCM, while its board approves grants based on recommendations from an independent technical review panel. Following board approval, grant details are negotiated by the secretariat with the Principal Recipient and CCM before the grant agreement is signed. In this case, the Global Fund was not an active negotiator with the Somali health authorities, since the latter were not full parties to the grant. Instead, the Global Fund negotiated the detailed terms of grant agreement with the SACB-HSC acting as CCM and WVI as PR. The Global Fund policy for inclusive, national ownership of the grant proposal and the sole financial accountability of the PR, were key underlying factors that enabled the successful negotiating environment.

Principal Recipient

The Principal Recipient is the legal signatory to the Global Fund grant agreement and is directly accountable to the Global Fund for effective grant performance and financial management; the PR enters into sub-grant agreements with Sub-Recipients (SRs), who

implement grant project activities. The PR submits financial and progress reports to the CCM (HSC) and the Global Fund. The HSC nominated UNICEF as the PR for the malaria and HIV/AIDS grants and, at first, proposed WHO as PR for the tuberculosis grant in view of its technical capacity. However, both WHO and the Global Fund highlighted a conflict of interest, given that, at the time, WHO was seconding a significant number of staff to the new Geneva-based financial institution. Therefore, through a transparent and competitive application process, the HSC selected WVI as the PR – a decision subsequently affirmed by the Global Fund. WVI had been involved in humanitarian response and the rehabilitation of the health sector in Somalia for over 12 years and was an active member of the SACB and HSC, and co-chair of the tuberculosis working group. Once the grant was issued to World Vision, the NGO became responsible for leading negotiations of the tuberculosis grant with the Global Fund and with the Somali authorities, representing all the other 14 NGO and agency SRs in relation to their participation in the grants.

Tuberculosis Coordination Team

The Tuberculosis Coordination Team was mandated by the HSC to coordinate and manage all aspects of tuberculosis programme implementation. The team includes WVI operating as the Global Fund tuberculosis grant PR with overall responsibility for the programme; WHO as the Sub-Recipient responsible for tuberculosis technical advice and training; the health sector coordinator who coordinates with the HSC and assists in conflict-solving and ensuring linkages and synergies with other health programmes; CCM-Italy, the SR assigned with responsibility for supervision and monitoring; six local counterparts (two from each of the three zones) to provide joint supervision and liaise with the Somali health authorities. The aim of the TBCT was to provide a forum to address and manage technical issues, and to ensure the full participation of the three national health authorities in the tuberculosis programme. The TBCT meets quarterly to assist WVI in managing the grant. WVI, as PR and chair of the TBCT, represented this group in negotiations with the Somali ministries of health and with the Global Fund.

ISSUES OF NEGOTIATION DURING START-UP OF THE GLOBAL FUND GRANT

The key issues during the negotiation centred on the appropriate roles and funding of the various actors in the implementation of the national tuberculosis programme. Specifically, the ministries of health in Puntland and Somaliland aimed to play a more significant role in managing the tuberculosis programme, including decision-making over budget allocations and programme supervision. On the other hand, given that 95 per cent of health services in Somalia were being managed by NGOs, they played the dominant role in grant implementation strategies. Civil society–government relations can often be strained in the context of external development funding; in this case, matters were complicated due to the disputed legal status and weak management capability of the three separate quasi-governmental entities. In the original grant proposal, the national health authorities were actually included as Sub-Recipients with specific supervision roles. However, since they were not representatives of recognized governments, and also lacked sufficient implementing and management capacity, they did not meet the criteria of the Global Fund to directly receive or control funds as PRs or SRs.

Subsequent negotiations on grant details dealt with appropriate means to ensure full and significant participation of the government entities within the Global Fund fiduciary policy guidelines. If not satisfied, the government entities could delay programme implementation by virtue of their political control in their respective regions and their authority to deny or revoke permission to the implementing agencies. In the two years immediately following the submission of the grant proposal, the health authorities made a number of proposals and attempts to gain more control over grant funds and NGO implementing agencies, arguing that control was essential to their role as a government to provide public health services. The Principal Recipient and the SACB-HSC worked together to find a solution that would satisfy the legitimate goal of government, while maintaining compliance with Global Fund rules and also facilitating the smooth functioning of all

parties to the tuberculosis programme implementation so that rapid progress towards project goals would be achieved. Negotiations took place over an 18-month period and were resolved in December 2005 with the signing by all parties of an umbrella memorandum of understanding (MOU).

There were at least three specific conflicts that became the focus of the negotiations:

- The Somaliland Ministry of Health created a new NGO, the Somaliland Anti-Tuberculosis Association (SATA), and proposed it to represent the ministry as overall Sub-Recipient for all the tuberculosis centres in the north-west. The HSC could not accept this as SATA had not been previously selected through the HSC-approved process for inclusion in the national proposal, SATA did not meet the criteria as it was not a health partner, and other NGOs had already been selected and approved as SRs to manage the tuberculosis centres in the north-west.
- Both the ministries of health in Somaliland and Puntland, in their efforts to achieve greater control of the tuberculosis programme, requested that the 14 NGO SRs enter into individual agreements with their respective ministries. The position of the SRs was that such individual agreements presented the potential for unreasonable non-standard requirements and, as NGOs and civil society organizations, they should operate independently of governmental control (while cooperating fully through the endorsed structures and processes of the SACB-HSC) and that their activities and budgets should be governed by the terms of their binding grant agreements with the PR and the terms of the Global Fund grant agreement.
- The ministries of health in Somaliland and Puntland demanded funding to provide supervision of the tuberculosis centres and greater control over monitoring and evaluation and quality assurance activities, arguing that these were normal roles for government health authorities. However, these roles were

allocated to one of the NGO Sub-Recipients: CCM-Italy. The position of the HSC was that CCM-Italy had been approved by the HSC and the Global Fund for the role based on its expertise and objectivity, whereas the zonal health authorities lacked both expertise and neutrality. The HSC and PR did agree that the health authorities needed more substantial involvement in the programme supervision and monitoring to strengthen their capacity for this role and ensure sustainability.

PROCESS OF NEGOTIATION

The negotiation process was divided into three phases; each occurring in response to the dynamic situation, as opposed to being structured or pre-planned. The ultimate achievement was the full agreement of all parties to a framework for cooperation in compliance with Global Fund policies. The process ultimately clarified the roles of all parties, specifically providing scope to health authorities and their legitimate goal of building capacity in the supervision and coordination of the tuberculosis programme, and also reducing undue government interference in NGO implementation activities.

Phase I (April–December 2004)

Following board approval of the Somalia tuberculosis grant in March 2004, conflicts arose over how to engage the legitimate participation of government authorities without making them full SRs to the grant. The HSC authorized a delegation made up of the PR, WVI, the WHO representative and the Somalia health sector coordinator to visit the respective ministries of health and explain why they could not be SRs or nominate new SRs. The aim of this initial mission was to provide a full explanation to the ministries on the roles and responsibilities of all stakeholders in line with the Global Fund's policies and guidelines and the terms of the approved national proposal. The mission also expressed recognition of the importance of the participation of the zonal health authorities in tuberculosis programme coordination and supervision, as well as the continued

strengthening of their capabilities for this role. Throughout the negotiations, the mission emphasized the collective and universal desire to secure donor funding and increase the provision of quality tuberculosis services that would secure the right of all Somalis to healthcare. The mission thereby reduced political tension by identifying shared aspirations and defining the issues as technical rather than matters of sovereignty or control. The mission described how the ministries of health could be fully involved in supervision and monitoring through the secondment of six government staff to the programme: a lab supervisor and a tuberculosis supervisor for each zone, to be fully involved in the Tuberculosis Coordination Team and responsible for communicating with the Ministry of Health. The mission eventually convinced the ministries of health to respect the Global Fund proposal and policies, and Somaliland withdrew its proposal of SATA as SR. Programme activities began in earnest with the first disbursement of funds in December 2004 and WVI finalized sub-agreements with the implementing NGOs.

Phase II (January–August 2005)

Implementing NGOs were increasingly frustrated during this period as the government entities continued to interfere in their activities in the context of supervision, demanding they enter into individual agreements. CCM-Italy was forced to stop work altogether in Somaliland and Puntland over disputes with authorities concerning their registration. The PR, representing the TBCT, held a series of five bilateral meetings in Puntland, Somaliland and Nairobi during this period to discuss the issues. In April 2005, the PR, in a meeting with the Somaliland Ministry of Health, firmly rejected the option of individual NGO agreements and instead offered to draw up an umbrella memorandum of understanding between WVI and the ministry that covered the activities of all NGO implementing partners. This MOU explained the guiding principles of the Global Fund and established the roles and responsibilities of the partners, including the Ministry of Health tuberculosis supervisors, and specifically assigned the role of monitoring and

supervision to CCM-Italy. The MOU also incorporated assurances that CCM-Italy would work to strengthen the ministry's monitoring and supervision capacity. The MOU went through three drafts during the course of the meeting and was signed by WVI and the Somaliland Ministry of Health before being circulated to the HSC.

Meanwhile, issues in Puntland remained unresolved and also arose in the other Global Fund grants (malaria (Round 2) and the recently approved HIV/AIDS (Round 4)), for which UNICEF was the PR. During the August HSC meeting, a number of these conflicts were aired. The HSC then recommended that WVI and UNICEF use the Somaliland memorandum of understanding as a model and negotiate a similar MOU with all the health zones.

Phase III (August–December 2005)

In September, UNICEF and WVI drafted an umbrella MOU modelled closely on the Somaliland MOU. The WVI memorandum of understanding covered the activities of all the tuberculosis implementing partners, while the UNICEF MOU covered the malaria and HIV/AIDS implementing partners. The drafts were circulated to the HSC for comments and a revised draft was circulated to the HSC in November, after which no further revisions were made. During a December HSC meeting in Nairobi, a few changes were made on the spot and the final draft was endorsed by the HSC.

Two meetings were then immediately held in Nairobi with WVI, UNICEF, the health sector coordinator and the ministries of health of the three zones in order to review and finalize the draft MOU. Three final tuberculosis MOUs were signed between WVI and the three separate ministries of health on 13 December 2005.

→ The negotiations took place in three stages from April 2004 to December 2005. The common goal of the actors, to ensure the availability of funding and improve TB care, unified the efforts of the various actors.

- Two overarching MOUs were agreed upon, one by WVI and the Somaliland Ministry of Health which set out the responsibilities of various partners according to the principles of the Global Fund and the other, drawn up by UNICEF and WVI regarding the responsibilities of the tuberculosis implementing partners. The MOUs were essential to the successful implementation of the TB program and constructive collaboration of the actors involved.
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OUTCOME OF NEGOTIATIONS

The MOU established the comprehensive operating guidelines and overall formal framework of cooperation for the Global Fund grant activities; the Global Fund grant agreement and the SACB-HSC code of conduct were adopted as the regulatory framework. The MOU provided a mutually satisfactory settlement of all conflicts and issues that had arisen during the preceding 18 months. Specifically, the MOU:

- recognized the TBCT as the principal coordinating mechanism for the tuberculosis programme and affirmed its membership
- affirmed agreement to collaborate in accordance with Global Fund grant policies and procedures
- established the responsibilities and obligations of the PR as overall grant manager
- recognized the zonal health authority as the counterpart and representative of the zonal government
- called for the registration of SRs with their respective local authority and the commitment of all implementing agencies to abide by all local laws not contraindicated by international law
- affirmed the obligations, rights and responsibilities of SRs as implementers with a contractual accountability relationship to the PR
- described the secondment of two staff from the health authorities of each zone to the project as national

- tuberculosis programme supervisors with full terms of reference to strengthen the zonal coordination role
- affirmed the zonal authority obligation to allow access and provide security to all project areas and to facilitate the smooth operation of activities
 - defined coordination mechanisms to include grant reporting by the PR to be shared with health authorities during quarterly joint review meetings
 - assured the technical capacity-building of health authorities and other local counterparts by the grant implementers
 - reconfirmed the role of the SACB-HSC in project oversight, advice, mediation, linkages and synergies
 - identified the responsibilities of the local fund agent
 - described and allocated responsibilities for procurement, training, and supervision and monitoring
 - set out terms for mediation and dispute resolution, providing for assistance from the HSC and referral, after 60 days, to the UNCITRAL Arbitration Rules for a binding resolution

This memorandum of understanding became the model for all Global Fund malaria, and HIV and AIDS grants in Somalia, and is still in force today.

RESULTS

Since 2004, the tuberculosis programme has been supported by the Global Fund through two grants to WVI as the PR with consistent and excellent results. With the Global Fund grants from Round 3 (2004–2009) and Round 7, Phase I, (2009–2011), the national tuberculosis programmes for Somaliland, Puntland and the south-central region were established, along with some national structures. The Global Fund now provides full support to 51 tuberculosis management units and partial support to five others. The treatment success rate has been maintained above 85 per cent with a default rate below 4 per cent. Most tuberculosis centres use physical infrastructure that has been

rehabilitated by the 14 implementing NGOs and agencies working as Sub-Recipients to WVI; both clinical and community health services are provided almost entirely by the SRs. Given the lack of a government health information system, the tuberculosis programme uses the standard WHO recording and reporting system. The local health authorities are now closely involved in supervision and monitoring through the secondment of staff to the Global Fund project, and within the framework of the MOU with WVI.

The Global Fund performance-based funding (PBF) system requires regular evaluation of progress using a 'grant scorecard'. The Year 2 grant scorecard in 2006 awarded a 'Go' recommendation for Phase II, noting:

With no functioning Ministry of Health in place, the PR has had to negotiate with the three zonal national counterparts. This has led to prolonged lead times for decision-making and delays in drawing consensus. Nevertheless, the TB program enjoyed political support from the three health authorities. All the process/operational targets were met or exceeded and there was good grant management and use of funds by the PR.

By the end of the first five-year grant, there was at least one tuberculosis centre per region, and the programme received an 'A' rating.

LESSONS LEARNED

There are a number of lessons learned that are relevant to future programming and negotiations for health financing in fragile states. Approximately one-quarter of the world's population lives in low-income countries characterized by weak state capacity, and which often lack a legitimate government. This presents a major hurdle to health, well-being and security. The improvement and success of tuberculosis programming in Somalia is a testament not only to the unique framework, processes and parties involved

in health negotiations in a fragile state context, but also to the unique grant-making mechanism that allowed the Global Fund to finance health programming in the absence of legitimate government structures. Below, are several key lessons learned from these negotiations:

- **Strong bilateral negotiations led by a respected civil society organization can achieve consensus among parties where a central government is weak or non-existent.** The success of this grant was heavily dependant upon WVI's ability to engage with three separate health authorities across the country. WVI endeavoured to air issues, strengthen relations, and build confidence, while simultaneously representing a multi-stakeholder group of civil society and technical agencies. Throughout the negotiations, WVI's strategy was to build a consensus around shared aspirations for increased health funding and improved access to public health for all Somalis, and reach agreements on the legitimate roles and responsibilities of all the actors and players in the operation of the tuberculosis programme.
- **An inclusive stakeholder coordinating body with transparent and democratic processes can build collective ownership for a health programme and add legitimacy to the negotiations.** The PR was endorsed and supported by the collaboration framework of the HSC, which in this case also acted as the CCM. This body provided a forum for the full and equitable participation of all stakeholders, both public and private, in the Somalia health programme. The HSC inclusion of the three governmental authorities, together with all the civil society and technical implementing partners, established an operational context that promoted national quality standards for health, collective ownership and responsibility, and respect for the rights, roles and obligations of all parties. The sanctioning of WVI as PR by the HSC gave the NGO the legitimacy and authority needed to successfully negotiate the terms of the Global Fund grant with the government.

→ The Global Fund's policy support for a strong civil society role in grant negotiations made it possible to negotiate the health financing in Somalia despite the absence of a central government. The Global Fund innovative fiduciary policies require funding proposals to be developed by the countries themselves, that they be consistent with national strategies, and that all health stakeholders are involved in the grant-making and implementing process. The Global Fund's unique approach to health financing represented a major shift towards a broader concept of national ownership that promoted the collaboration of multiple stakeholders. These principles of partnership aligned well with the Somali context and established the enabling environment in which the negotiations relating to the details of grant implementation could succeed.

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