

# Civil Society Strategy Session on CS Consultations for Global Action Plan for Healthier Living

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Organized and supported by: Civil Society Engagement Mechanism for UHC2030 (CSEM) and the Global Fund Advocates Network (GFAN)

## *Summary of proceedings*

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### **Acronyms and abbreviations**

CSEM =	Civil Society Engagement Mechanism for UHC2030
CSO =	Civil Society Organization
GAP =	Global Action Plan
Global Fund =	Global Fund to Fight HIV, Tuberculosis and Malaria
GFAN =	Global Fund Advocates Network
SDG =	Sustainable Development Goal
UHC =	Universal Health Coverage
UNAIDS =	Joint United Nations Programme on HIV/AIDS
WHO =	World Health Organization

## **1. Introduction and Overview**

In October 2018, a consortium of 11 global health institutions formally launched a new initiative with the release of *Towards a Global Action Plan for Healthy Lives and Well-being for All: Uniting to Accelerate Progress towards the Health-Related SDGs*. Led by the World Health

Organization (WHO), the institutions are responding to a request from the governments of Germany, Ghana and Norway.<sup>1</sup>

The Global Action Plan (GAP) framework discussed in the document was drafted solely by the institutions themselves, without the participation of civil society or other sectors. Civil Society Engagement Mechanism for UHC2030 (CSEM) and the Global Fund Advocates Network (GFAN) organized the December 2018 two-day strategy session to consider how, where, when and with whom civil society engagement in the GAP – also referred to by some as the SDG3 Action Plan – can and should be undertaken.

A total of 21 individuals attended all or part of the session in person, with three others participating virtually by speakerphone. About two thirds of attendees were representatives from global or local civil society organizations (CSOs) that focus on advocacy for a specific health condition and/or for overall health. The other participants were representatives from some of the 11 partner institutions involved in developing the GAP. (Annex 1 contains a list of all participants.)

### **1.1 Rationale for and objectives of the strategy session**

The overarching rationale for the December meeting was a strong desire for meaningful civil society participation in the drafting and implementation of the GAP. Robust and meaningful civil society participation throughout the GAP process, in terms of both content and governance, is of essential importance for its validity, reach and success. Because of time constraints – largely due to the partners' commitment to present a final work plan by September 2019 (as noted in Box 1 below) – there is an urgent need to identify effective and relevant civil society entry points to maximize the sector's voice and influence.

The strategy session's main objectives included the following:

- to raise awareness about the GAP, including where it sits within the broader landscape of global health-related initiatives, processes and priorities such as universal health coverage (UHC);
- to provide a forum for partner institutions to provide up-to-date input about content, expected outputs and outcomes, timelines, structures and other key elements of the GAP;
- to identify opportunities for civil society consultation before operationalization of the GAP begins;
- to discuss how strong and meaningful civil society engagement might be structured and sustained; and
- to begin development of a road map for collaborative, coordinated engagement.

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<sup>1</sup> The 11 institutions include the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), UN Women, the World Bank, the World Health Organization (WHO), the Global Financing Facility (GFF), Unitaid, Gavi and the Global Fund to Fight HIV, Tuberculosis and Malaria (Global Fund). The World Food Programme (WFP) reportedly has signalled interest in joining the collaboration, which would raise the number to 12.

The session was presented as being an initial, preliminary step that can help jumpstart civil society involvement among a much broader group of individuals and organizations from the sector worldwide. Consultations and discussions will be needed with a far larger and more diverse set of stakeholders to ensure that the ideas, expectations, priorities and expertise of all those interested are heard and reflected.

## **1.2 About this summary report**

This document provides an overview of some of the main topics discussed, including those specific to the GAP and others more generally related to UHC and the broader global health architecture. It is not intended to be an in-depth, highly detailed report of all that transpired. The primary focus is on the GAP.

Concerns, challenges and opportunities from the civil society perspective are grouped by themes wherever possible. The report highlights several proposals and recommendations regarding process and content, some of which were reached and agreed by consensus. ***The information aims to lay the groundwork for further work by session participants and other civil society stakeholders that choose to be involved in guiding, influencing, implementing and monitoring the GAP.***

(Note: This report is timebound, as it is based on and represents information, progress and assumptions as of mid-December 2018. It cannot and does not take into account subsequent relevant developments.)

## Box 1. GAP progress and process: updates, information and observations from partners

Listed below are selected pieces of information and observations about the GAP process, as provided at the meeting by participants representing WHO and other partners:

- **Rationale for the initiative:** The world is not on track to achieve the Sustainable Development Goals (SDGs) by 2030. We are certain to fail collectively on most targets unless we take more concentrated and effective action. The GAP is focusing on changing the course for the health-centred SDG 3 ('Ensure healthy lives and promote well-being for all at all ages'), with the understanding that efforts to achieve targets and components of other SDGs would also likely benefit. (For this reason, 'SDG 3+' might be a more accurate description of the GAP's approach and impact.)
- **Roll out of the initiative:** Phase 1 of the GAP was the development of the framework disseminated in October 2018 ([www.who.int/sdg/global-action-plan/Global Action Plan Phase 1.pdf](http://www.who.int/sdg/global-action-plan/Global_Action_Plan_Phase_1.pdf)). Phase 2 involves turning the framework into a full-fledged plan that is underpinned with concrete actions for countries and other stakeholders that have committed to achieving the SDGs. The current goal is for this plan to be finalized and approved by September 2019. Phase 3 will begin when the plan is operationalized, if approved. Because the GAP is aligned with the SDGs, implementation is expected to continue to 2030.
- **Phase 2 schedule:** Different partners have responsibility for different parts of the GAP, including the seven accelerators through which key priority action areas are presented. No specific dates have been determined in the lead up to the finalization of the work plan in 2019, but it is assumed that the partners will start consolidating and reviewing for agreement at some point in April or May. *Working backward, it seems likely that input that can greatly influence and guide the content would be needed by mid-January or perhaps early February at the latest.*
- **Input process:** The accelerators are still a work in progress (as of mid-December 2018). The language currently available about each accelerator reflects the insights and thinking of the responsible partner (or 'lead') only, as nothing has yet been shared more broadly. GAP partner representatives at the strategy session indicated the following:
  - *Feedback and input from civil society and other sectors into each of the accelerators' content would be welcome and reviewed closely as designated partners work to finalize over the next few weeks (i.e., through mid-January 2019 or perhaps a little later).*
  - *There is no need for civil society to wait for a formal authorization or invitation to provide suggestions and input, including (for example) a list of specific issues and points relevant to each accelerator.*Additional opportunities for engagement by civil society and other sectors in the first part of 2019 are being considered. They may include Web-based mechanisms and multistakeholder consultations at global, regional and/or country levels.
- **Dates and events for engagement.** GAP partners see several potential dates and events in 2019 where the initiative can be described and discussed, and at which feedback can be sought (including from civil society). They include, among others, the African Union summit (January), the Africa Health Forum (March), the World Bank spring meetings (April), the World Health Assembly (May), the High-level Political Forum on Sustainable Development (July), and UN Economic and Social Council (ECOSOC) reviews, in particular those of the 2030 Agenda for Sustainable Development.

## 2. Putting the GAP in Context: Key Themes, Challenges and Opportunities in the Current Global Health Landscape

### Summary of top-level challenges for civil society

- There are many processes with different yet often overlapping objectives (e.g., UHC, the GAP, reemphasis on primary health care) and many global health institutions involved. How do we **coordinate** among all of them?
- There are many, and highly diverse, civil society perspectives and voices in the overall health arena. How do we ensure all are **included** in an efficient, effective way?
- Global health needs continue to increase as more people demand – often with the support of civil society – their rights to the health care they deserve. How can this be **paid for**?

The GAP is just one of many notable elements and structures in the global health landscape. Numerous health architectures are being reformed, devised and reshaped concurrently at the operational and programmatic levels. Although different, processes such as UHC and the GAP could converge to some extent in ways that make it difficult for civil society to understand, influence and engage with each or several of them.

In recognition of that reality, meeting participants discussed priorities, challenges and opportunities for civil society and communities across the overall health spectrum, most of which are relevant for the GAP in whatever form it takes. **Listed below are summaries of some observations – many of which are closely linked or associated – that could influence the decisions and priorities of collaborative civil society engagement with the GAP.**

- **Using existing engagement structures.** Avoiding duplication and redundancy should be a guiding principle. Several civil society engagement structures and mechanisms already exist in various health areas, including CSEM, which is part of UHC2030; the Civil Society Task Team, which advised WHO on how to strengthen its engagement with civil society to advance the 13th General Programme of Work (GPW); the H6 partnership;<sup>2</sup> and country coordinating mechanisms (CCMs), which oversee Global Fund grant implementation. It is useful to consider how or whether to use some of these or other mechanisms to advance civil society engagement in the GAP.
- **Strengthening and sustaining accountability.** Accountability is an important concept and aspect across all health initiatives and actors in the field, including governments, donors and civil society groups that have made commitments and pledges or have positioned themselves as advocates. Viable, transparent accountability frameworks and entry points are needed throughout the GAP process. Civil society and community stakeholders should advocate for and use such frameworks even as they hold themselves accountable for their own work on behalf of constituencies.
- **Making demands and the case for civil society involvement from the beginning.** To ensure that its needs are recognized and responded to, civil society should make its demands and ‘asks’ known as early as possible during the development of health

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<sup>2</sup> The H6 Partnership includes UNFPA, UNICEF, UN Women, UNAIDS, WHO and the World Bank Group. The partnership has focused primarily on delivering technical support to advance the Every Woman Every Child global strategy, which aims to improve women’s, adolescents’ and children’s health. Platforms created by and through the H6 Partnership have been established in several countries, with agencies in addition to the original six reportedly being involved in some of them.

processes, structures and strategies such as UHC and the GAP. The point should be made as well that the sector can offer types of services, support and leadership that advance the overall goals more effectively and successfully than other actors.

- **Prioritizing country-level focus.** Direct health services and support are provided at community and country level, regardless of the structures or parameters of any global health initiative. Raising awareness and buy-in within countries therefore is vital, including by translating to what is understood and makes sense at the community level. Civil society can and should be involved in such translation efforts, which require deep knowledge about documents, policies and approaches associated with all health initiatives such as UHC and the GAP.
- **Living up to the vow of ensuring no one is left behind.** Civil society has a responsibility to always recognize and safeguard the health and human rights of the most marginalized and vulnerable members of society, including by taking the 'leave no one behind' principle at face value. There are concerns, for example, that some UHC approaches being developed fail to meet that standard – such as in Kenya, where the government's current UHC package does not cover key services for people living with HIV. Local community and civil society groups need information and support to better understand and influence UHC-related actions in their countries. Similar efforts are likely to be needed vis-à-vis the GAP and other initiatives that governments are implementing already or will soon be.
- **Thinking and acting outside disease or initiative siloes.** Community and civil society groups are often supported through or focused on a small number (often only one) of global health initiatives, such as the Global Fund. Aligning and integrating health approaches requires new and different ways of thinking that remove the instinct to advocate or fight for just one initiative or disease response. If presented and rolled out well, UHC could be a way to make this shift at country level.
- **Bringing more nuance to resource mobilization.** The growing number of replenishments across the global development world has raised concerns about the negative effects of competition and difficulties in 'standing out' in a crowded field. Yet even if they currently focus on one or a small number of specific health or development issues, advocates and civil society groups should seek to identify opportunities in this emerging trend for initiating dialogue and building collaboration and coordination that could make all development-related resource mobilization more successful. Looking at the issue more holistically is also important because UHC efforts must be financed somehow, and there are no specific replenishments or other resource-mobilization approaches that focus on UHC.
- **Responding to changes and trends in donor financing.** Official development assistance (ODA) for health has been flat for years, with some disease-specific financing – e.g., for HIV – declining slowly but steadily. Ongoing shifts toward more integrated development support (driven in part by the 2030 Agenda) suggest that such trends will continue for the foreseeable future. Civil society has an important role to play in helping shape the evolving changes in the ODA approach and landscape.
- **Intensifying advocacy for domestic resources for health while maintaining realistic expectations.** Advocacy for increased and sustained domestic resourcing for health has been and should continue to be a priority for civil society everywhere. WHO estimates that domestic resources can supply 85% of the aggregate investments

needed to achieve UHC in low- and middle-income countries.<sup>3</sup> But domestic financing is not sufficient on its own, and it should not be considered a panacea in any context. At global and other levels, civil society must continue to be clear on what cannot or will not be possible – including where governments do not have the fiscal space or resources to cover needs and where they may be unwilling to fund vital services and programmes for marginalized groups such as key populations.

- **Slowing the momentum toward ‘medicalizing’ health.** The increasing emphasis on biomedical components of health care risk further crowding out resources for other important services that civil society often provides, including prevention and social support. In many places, prevention is also being rapidly medicalized – a development that reinforces the importance of civil society making strong efforts to justify investments in a much wider range of prevention interventions.

### 3. GAP Accelerators: Overview and Preliminary Feedback

The framework outlined in the GAP document is organized under three strategic approaches: align, accelerate and account. Strategy session participants agreed that although civil society engagement is relevant for all three approaches moving forward, it is especially important for the accelerate component – because that is where specific actions and interventions will be described.

As noted in Box 1 above, the development of work plans for each accelerator is being led by one or more GAP partner through designated Sherpas. As of mid-December 2018, each ‘lead’ was in the process of drafting papers that will propose what will be done through each accelerator. Once finalized, those papers will be shared with other partners and work will begin to consolidate them into one overall GAP operationalization plan based on collective action for global health.

Civil society participants at the meeting expressed by consensus an interest in engaging on all seven accelerators, including during the current ‘open’ period in which comments and input could directly influence the papers being drafted. They also agreed that three of the seven should be considered priority accelerators for the sector.

#### 3.1 Information and initial input specific to the accelerators

Listed below are lists of some key points and observations from brief presentations about each accelerator and selected impressions from resulting plenary discussions. (*Note:* The presentations did not reflect any decisions because all accelerators are still under development; instead, the presentations only signalled what had been considered to date as per different Sherpa-led processes. Also, the presentations and follow-up discussions varied greatly by length and detail, a situation that is reflected in the widely varying length and detail of the summaries below. More information about all of the accelerators can be found in the document released in October 2018, which reflects partners’ work in the GAP’s initial phase only: [www.who.int/sdg/global-action-plan/Global Action Plan Phase I.pdf](http://www.who.int/sdg/global-action-plan/Global_Action_Plan_Phase_I.pdf))

##### 3.1.1 Accelerators identified as ‘priority’ for civil society (three total)

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<sup>3</sup> *Together on the road to universal health coverage*, WHO 2017; <https://bit.ly/2CFfQdU>

## **Community and civil society engagement**

[Lead partner: UNAIDS]

*Selected points and observations from presentation by GAP partner representative:*

- The main aim is to harmonize partners' efforts to enable more meaningful engagement with civil society in global health. Reversing the 'shrinking space' for the sector is an important objective.
- Key roles assumed for civil society might include as demand creators, campaigners, innovators, experts, agents for change, implementers, and monitors and demanders of accountability.
- Some areas of focus through the accelerator might include increasing resources, including for civil society and communities; mobilizing political will and investment in SDG 3 and relevant health targets in other SDGs; setting guidance as to how and what engagement would consist of; and strengthening governance and accountability of global health institutions through enhanced civil society engagement.
- The current thinking is that it will be important for solidarity to be a central component of global health efforts through the SDGs and more broadly. This could be one way for all stakeholders to accept responsibility for acting on behalf and for everyone, and leaving no one behind.

*Initial impressions:*

- Ensure that grassroots/communities are identified as vital and positioned at the centre of responses.
- Ensure that the point is made that civil society and communities not only advocate for and represent those who access health care, but as importantly are often clients themselves.
- It is essential to highlight and prioritize the needs and rights of the most vulnerable and marginalized in all aspects of comprehensive, quality health care, as well as make clear commitments to removing barriers and challenges they face in every context.
- The right to health and gender equality should be spelled out and emphasized.

## **Sustainable financing**

[Lead partners: World Bank and Global Fund, with strong involvement of Gavi and WHO]

*Initial impressions:*

- There is no indication yet of anything truly ground-breaking or transformative in the accelerator, or anything that appears to recognize and respond to changing ODA approaches.
- Civil society should not support or be involved with any initiative that is not demanding and making the clear case for more money for health. It is not sufficient and acceptable to focus on doing more or better with the same amount now available.

## **Determinants of health**

[Lead partner: UNDP]

*Selected points and observations from presentation by GAP partner representative:*

- The current thinking is to focus this accelerator on three key determinants (environmental, commercial and social determinants), with a clear understanding and recognition of the right to health within all of them.

*Initial impressions:*

- Civil society could make a big difference here, largely because actors in the health field often have not been effective or successful in identifying ways to address determinants in other areas. Economic arguments might be helpful, including evidence showing the impact of not acting responsibly and aggressively to address challenges outside health.

### **3.1.2 Other accelerators (four total)**

#### ***Frontline health systems***

[Lead partner: UNICEF]

*Selected points and observations from presentation by GAP partner representative:*

- This accelerator refers primarily to expanding and improving primary health care. There is a growing acceptance, as noted at the Global Conference on Primary Health Care in Astana, Kazakhstan in late October 2018, that multisectoral and community engagement are among the main 'legs' of a strong primary health care structure in any context.

*Initial impressions:*

- Working within and through existing structures could be an important principle to highlight. At country level in many places, there are numerous groups and organizations, including coalitions of non-governmental organizations (NGOs) and health advocates, which are already making a difference and can be tapped into. They often can be found at district and at community levels. Some provide services, and many of the NGOs working at grassroots level have community volunteers with deep knowledge and commitment.
- This accelerator should directly address the challenge of civil society groups being under-resourced and unable to find consistent funding support.

#### ***Data and digital health***

[Lead partner: UNFPA]

*Initial impressions:*

- Disaggregation of data (e.g., by sex, age and key population) is critically important for improved health responses.
- Data should be conceptualized and approached more widely than it is now, including (for example) to encompass research and prevention as well as treatment and care. Similarly, a wider range of actors beyond just technology companies should be involved.
- While improved data collection is important, it can be much more useful and relevant if collection is undertaken beyond the health system. Currently, we miss many people who

are sick and suffering but who do not go to health facilities – with some, for example, going to traditional healers or seeking support in other informal places.

### **R&D, innovation and access**

[Lead partner: WHO (with support from the Wellcome Trust)]

*Selected points and observations from presentation by GAP partner representative:*

- One main area of thinking is to focus on innovations becoming available at a larger scale. The idea is that there are already many good and interesting technologies and other innovative solutions coming out and proven to work, but many of the most promising are not reaching those who most need them.
- Another idea raised early on is to identify new approaches for health research to be discussed, undertaken and analysed more closely to where people who might benefit actually live. This would be a component of top-level efforts to increase efficiency and transfer knowledge.

*Initial impressions:*

- Intellectual property (IP) issues and obstacles related to them seem to be missing. This is an area in which civil society has significant interest and expertise, and is keen to continue advocating around.
- It seems natural and useful for Unitaid to be leading on this accelerator, given its longstanding role in innovation for health. Civil society groups should consider advocating for Unitaid to resume its role as a lead, which it relinquished earlier in the GAP process.

### **Innovative programming in fragile and vulnerable states and for disease outbreak responses**

[Lead partner: WHO. WFP reportedly has expressed interest in helping shape this accelerator if and when it formally joins the GAP.]

*Selected points and observations from presentation by GAP partner representative:*

- Integration is a central objective, including in and around the humanitarian/development nexus.
- Many of the places where progress on the SDGs is stalling are fragile states and conflict-affected environments. We must do a better job in building up more sustainable structures in such countries, and service delivery by civil society is likely to be an important element.
- Disease outbreaks and epidemics can throw the world off track and contribute to stalled progress toward and diversion of attention from the SDGs. Health security therefore should be central to all discussions.

## **3.2 General observations about gaps in the GAP**

The following is a preliminary list of **what is missing** more generally in the current GAP documentation and process, according to strategy session participants. Additional and more detailed suggestions and recommendations of this sort are expected to be a major part of upcoming direct civil society engagement.

- **Human rights** is ‘weak’. It should be a central component and consideration throughout all accelerators – not just the one on determinants of health – and the overall GAP in general.
- Financing must be more ambitious. The GAP should specifically focus on securing a **‘bigger pie’ for health**, not just on identifying different ways to divide the currently inadequate financial pie.
- **Community systems strengthening (CSS)** should be a priority in several of the accelerators, including frontline health systems and sustainable financing.
- More attention should be given to the importance of **quality monitoring**, including the need for civil society to have the resources and capacity to do it. Vital areas for monitoring include the GAP process and progress toward the SDGs and other health-related country targets. Relevant civil society and community activities and interventions also should be monitored, both by the sector itself and others.

Some meeting participants also recommended that the GAP partners be more candid and transparent about the ultimate goals and objectives of the initiative. For example, in reality, is it more about harmonizing and aligning partners’ work than about transforming care and access on the ground? Civil society engagement is likely to be of little use – and could be a waste of time – if the former is the case.

### 3.3 Potential engagement mechanisms and processes

Strategy session attendees agreed on the need for a systematic way for civil society to engage with the GAP. Preliminary suggestions included the following:

- **Web-based input**, e.g. via SurveyMonkey or other services or methods.
- **Google docs**. One option might be to make the current text of the seven accelerators (and/or papers being drafted to devise work plans) available to be commented on by interested civil society representatives and members of grassroots groups. For transparency purposes, each commenter would be required to self-identify. Designated civil society representatives would then have responsibility for reviewing all comments and ‘coalescing’ them before submitting to the relevant GAP ‘lead’ or other representative. Clear deadlines for commenting and submission would be necessary.
- Civil society **consultations** that are co-organized by the partners and civil society representatives. They should be inclusive and diverse and could be in-person as well as virtually (e.g., via listservs).
- **Partnership forum(s)**, perhaps similar to ones organized in the past by the Global Fund to obtain multistakeholder feedback.

## 4. A Global Health Campaign

### New, civil society–led global health campaign: assessing preliminary interest

Any new civil society partnership and initiative created to engage in the GAP process also could have additional and different areas of work in the future. Some civil society advocates at the December 2018 strategy session gave a brief, informal presentation about a new, ‘big picture’ global health campaign developed and led by civil society. The discussion was part of their

efforts to gauge whether there is interest in such a campaign as they explore how or if to proceed.

Nothing concrete had yet been decided about the potential new global health campaign's priorities, approach, composition, messages or objectives. One likely main goal would be to greatly increase financing for health at global, regional and national levels. Another might be to raise awareness about the consequences of inaction and the benefits of radical improvement, including among the most vulnerable, poorest and most marginalized.

### **Rationale for a campaign**

The 'golden era' for global health, coinciding roughly with the Millennium Development Goals (MDGs), was a time when it was at the top of development and political agendas and money for it increased substantially. The passion has since cooled, however. The Nordic countries and other longstanding champions for health can no longer be counted on as reliable donors, as can be seen by shifting trends in official development assistance (ODA) away from health.

Most of UHC and the SDGs (including everything related to health) has been and will be financed domestically. Civil society and other advocates therefore must push for more domestic resourcing. But that source cannot cover all the critical gaps from flat or declining development assistance for health. More money is required and will continue to be required to further improve and sustain HIV and TB responses so that all critical prevention, advocacy and treatment needs are met. Much of the world has barely scratched the surface on funding for many non-communicable diseases (NCDs) that are a higher priority for emerging advocacy groups. These are only two of numerous similar examples of unmet need. They threaten the success of efforts to achieve UHC and the SDGs (and thus that of the GAP initiative).

### **Considerations, priorities and proposed potential next steps**

The following are summaries of some comments and observations at the strategy session about this nascent proposal for a new global health campaign:

- Important ***lessons and guidance can be found in the global HIV/AIDS movement***. It became one of the most successful campaigns because it was passionate; highlighted people who "spoke from the heart"; and emphasized international solidarity, including equity and equal rights for everyone no matter where they were living.
- A top priority is getting donors to substantially invest in such a campaign. One, the Bill & Melinda Gates Foundation, reportedly might be interested in helping ***fund a civil society-led campaign of this sort***. Substantial support is likely to be needed for the media component, which is crucial but also relatively expensive.
- One useful first step would be to see ***what is already being done in the same or a similar area***. For example, anything developed and promoted through a new global health campaign might have similar objectives and strategies as the WHO-led 'Triple Billion' initiative (for and through which the Civil Society Task Team has worked). Other civil society groups and advocates (e.g., the Global Health Council) reportedly have had ongoing discussions of a similar sort as well.
- To serve civil society constituencies better, the approach and messaging should have an ***integrated health perspective and be 'people-centred'***, not disease-specific. "I have only one health" was a comment from one strategy session participant that was seen by others as a potential guiding principle and message.

- A realistic global health campaign of this sort should be **country-specific**, including in terms of tailored messages and media approaches.
- A new campaign offers an opportunity to directly **challenge the current global health architecture**. An ambitious agenda could have the far-reaching transformative impacts we all want.
- Intensive **consultations** are a first step in developing and building such a campaign. This is essential to explain and learn, and to gain trust. Consultation should be broad-based and extend outside health, including (for example) with the women's movement and the education movement.

Meeting participants expressed interest in learning more about the proposed overall process and initiative, including being involved in any consultation efforts early on.

## 5. Next Steps: Proposals and Agreements

The following proposals were presented at the meeting. With some, civil society participants agreed by consensus on specific next steps.

### ***CSEM as 'host' of civil society engagement with the GAP***

Next step: CSEM representatives will discuss the proposal with its Secretariat and Advisory Group.

#### Considerations:

- CSEM currently focuses solely on UHC. It would need additional resources to adequately guide the GAP engagement process, which would in effect create a 'CSEM+'. One option might be to draft a basic funding proposal quickly and submit to donors, with the intention of them earmarking money early in the 2019 calendar year.
- CSEM would seek out and benefit from guidance from other civil society groups and representatives, including those at the strategy session.
- As it helped oversee the creation of a new civil society partnership to influence the GAP, CSEM would aim to create space for internal and external discussions of priority issues discussed at the meeting – such as community and civil society groups' experiences and challenges at country level, concerns about important services and individuals being excluded from UHC programmes, and the possibility of working with and/or through existing structures that have enhanced civil society engagement in various health processes.
- CSEM would seek out opportunities for shared hosting, which could help reduce concern among its Secretariat that it was acting beyond its mandate.

### ***CSEM creating a new, separate advisory group for the GAP process and other potential civil society coordination efforts***

Assuming CSEM moves forward as the 'host' of this new civil society partnership, it will form a special advisory group of civil society and community representatives for its GAP-focused work. There was an implicit understanding at the strategy session that this new group – separate from CSEM's main Advisory Group – could potentially help guide similar work by CSEM in addition to and beyond the GAP initiative, if such opportunities arise.

#### Next steps:

- CSEM to prepare terms of reference (ToR), create a selection committee/process, and hold an open call for members.

- Strategy session participants are encouraged to propose potential names to CSEM (by email).

Considerations:

- Initially, the group’s responsibilities would include oversight of and facilitating the engagement of civil society in all GAP processes. It would serve as a liaison to WHO and other partners as part of its oversight role.
- Membership would be small (e.g., perhaps six or eight individuals)
- Priority representation criteria include affected communities, people with experience at country level, gender, geography, generations (e.g., including young people), and cultural diversity.
- CSEM and the new advisory group might consider establishing small working groups for each accelerator and/or different types of engagement. In some instances, members of these groups might be involved in all meetings and discussions among partners throughout the GAP process over the next several months.

***Identify and invite experienced individuals to provide guidance***

Several individuals across the broad civil society sector have expertise and experience in organizing and implementing similar engagement processes. Efforts should be made to identify them and ask for advice and guidance – or even to participate directly.

Next steps:

A GFAN representative has agreed to reach out to Joanne Carter at Results, who was one of the co-facilitators of the Civil Society Task Team. A CSEM representative will do the same for the other co-facilitator, Kate Dodson at the UN Foundation.

***Comprehensive mapping to improve scope and efficiency***

The engagement process and work could benefit from mapping to identify networks, platforms and organizations that are doing the same type of analysis and work as indicated in the seven accelerators. This could help avoid ‘reinventing the wheel’ and might improve the quality and acceptability of input by civil society to the GAP process. For example, the Civil Society Task Team might have structures and systems (e.g., an online platform to solicit grassroots input) that could be used or adapted for GAP engagement.

***Recommend to WHO and the other GAP partners that they create a special grant mechanism for community-based organizations and other civil society groups***

As suggested in their GAP framework report, the partners recognize and value civil society involvement in health care and believe it should be increased to improve progress toward the SDGs. They could be encouraged to support that principle more directly as part of the GAP process by making funds available for community systems strengthening and other activity areas where financing is especially difficult to obtain. As part of this or similar efforts, GAP partners could also encourage bilateral donors to provide more funding in such areas as well.

***Time-sensitive stopgap measure already being undertaken: interim focal points for each accelerator***

Meeting participants agreed by consensus that representatives from the two organizing groups (CSEM and GFAN) should choose one or two civil society members to serve as focal points for each of the seven GAP accelerators. Those appointments, which ideally will be made within a week or two of the meeting, would be on an interim basis only – until the new CSEM GAP-focused advisory group is in place

This stopgap measure responds to a need to not miss any opportunities to engage during the brief ‘open’ window during which proposals are being accepted by Sherpas for the content and priorities of each accelerator. Initiating a more formal process to select the focal points would be time consuming and could prevent taking full advantage of existing opportunities.

### ***Specifically referencing 'UHC' in relation to the GAP***

There was a discussion around whether any emerging partnership to influence the GAP and – potentially – other global health initiatives and issues should have the term 'UHC' in its title. The rationale behind a proposal *not* to include the term is to avoid the confusion and political baggage associated with UHC in some quarters, including among some civil society and community groups at country level.

### ***Setting principles of engagement***

The following are initial proposals for principles of engagement for a new GAP-focused advisory group and more generally for civil society involvement in the GAP process: long-term commitment; frank feedback based on clear evidence and need; avoiding a tendency to 'over-engineer' by building something big, complex and unwieldy; and extending scope and attention across all countries that have committed to the SDGs, which includes middle-income and wealthy ones.

Meeting participants and other civil society stakeholders are encouraged to propose additional principles to CSEM representatives. The new advisory group, if constituted, will finalize and disseminate them in addition to incorporating into its work.

### ***Consult more broadly across the civil society spectrum***

As noted during the strategy session, "Not everyone is in the room who perhaps should be in the room." The engagement process initiated at the December 2018 meeting should be regarded only as a preliminary step aimed at galvanizing broader civil society interest and involvement. Many more organizations, networks and individuals should be involved. The discussions and proposals should be disseminated widely for input and to set priorities and parameters for further discussions and actions.

Next step: CSEM and GFAN will coordinate the dissemination of information about the new engagement partnership and opportunity.

## Annex 1. List of participants

The following individuals attended all or part of the strategy session. They are listed in alphabetical order. Participants from or representing civil society groups, including civil society delegations to global health institutions, are in **bolded orange** text. All others are non-civil society representatives from one of the 11 GAP partner institutions.

Name	Organization/affiliation
<b>Timur Abdullaev</b>	<b>Stop TB Partnership</b>
Soyoltuya Bayaraa	UNFPA
<b>Christoph Benn</b>	<b>Joep Lange Institute</b>
Katri Bertram	World Bank; representing the Global Financing Facility (GFF)
Susan Brown	Gavi
Jan Hendrik Schmitz Guinote	WHO
<b>Priya Kanayson</b>	<b>NCD Alliance</b>
<b>Justin Koonin</b>	<b>UHC2030 CSEM</b>
<b>Jack MacAllister</b>	<b>Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); representing a civil society delegation to the Board</b>
<b>Marwin Meier</b>	<b>UHC2030 CSEM</b>
Jean Pierre Monet	UNFPA
<b>Eliana Monteforte</b>	<b>UHC2030 CSEM</b>
<b>Maurine Murenga</b>	<b>Global Fund; representing a civil society delegation to the Board</b>
<b>Thokozile Nkhoma</b>	<b>Stop TB Partnership</b>
<b>Austin Obiefuna</b>	<b>Stop TB Partnership</b>
<b>Loyce Pace</b>	<b>Global Health Council</b>
Stefan Swartling Peterson	UNICEF
Gang Sun	UNAIDS
<b>Peter van Rooijen</b>	<b>Global Fund Advocates Network (GFAN)</b>
Josephine Wiklund	UNAIDS
<b>Simon Wright</b>	<b>UHC2030 CSEM; representing the Partnership for Maternal, Newborn and Child Health (PMNCH)</b>

The following participated virtually during all or part of the first day (12 December). They are listed in alphabetical order.

Name	Organization/affiliation
<b>Danielle Heiberg</b>	<b>Global Health Council</b>
Courtney Howe	Unitaid
<b>Mike Podmore</b>	<b>Global Fund; representing a civil society delegation to the Board</b>