Meeting Report of a Second Strategic Retreat for Civil Society Representatives to Global Health Programmes and Initiatives - September 2009 -

Attended by civil society representatives to:
UNAIDS Programme Coordinating Board
Global Fund to Fight AIDS, Tuberculosis and Malaria
UNITAID
GAVI Alliance
International Health Partnership and Related Initiatives (IHP+)
Roll Back Malaria
Stop TB Partnership
Partnership for Maternal, Newborn and Child Health

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Contents

Acronyms and abbreviations

CCM =	Country Coordinating Mechanism (of the Global Fund)
CFP =	Communications Focal Point
CSO =	civil society organization
CSS =	community systems strengthening
CTL =	currency transaction levy
FSP =	Free Space Process
GAVI =	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation)
Global Fund =	Global Fund to Fight AIDS, Tuberculosis and Malaria
HSS =	health systems strengthening
ICSS =	International Civil Society Support
IFFIm =	International Finance Facility for Immunisation
IHP+ =	International Health Partnership and Related Initiatives
IMF =	International Monetary Fund
JANS =	Joint Assessment of National Strategies
NSA =	National Strategy Application
PCB =	Programme Coordinating Board (of UNAIDS)
PMNCH =	Partnership for Maternal, Newborn and Child Health
RBM =	Roll Back Malaria
TB =	tuberculosis
ToR =	terms of reference
UNAIDS =	Joint United Nations Programme on HIV/AIDS

Note on text: All figures marked in $ are US dollar amounts.

1. Background and overview

1.1 About this report

This report provides an overview of a meeting on civil society strengthening and integration in the global health response that was held in Amsterdam from 31 August through 2 September 2009. Organized by Amsterdam-based International Civil Society Support (ICSS), the meeting was conceptualized as a joint retreat for members of civil society delegations to international organizations working on health care policy and access, including the following: the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the GAVI Alliance, UNITAID, the International Health Partnership and Related Initiatives (IHP+), Roll Back Malaria (RBM), the Stop TB Partnership and the Partnership for Maternal, Newborn and Child Health (PMNCH).

More than 30 individuals with current or recent responsibilities as civil society representatives—nearly all as Board members, Alternate Board members, Communications Focal Points (CFPs) or delegates—attended the meeting. Also in attendance were support staff and, for part of the meeting, guest experts from some of the organizations who delivered presentations about relevant initiatives and/or discussed key objectives at global and national levels. (Appendix 1 contains a list of all meeting participants.)

This report provides an overview of issues discussed, key priority areas identified and action steps proposed during the meeting. It is intended to serve more as a summary than a comprehensive, in-depth account of all proceedings. On the ICSS website are several documents providing background and supporting information regarding the issues discussed at the meeting.

1.2 Key rationale for and objectives of the meeting

The 2009 meeting was a follow-up to a similar joint retreat held the previous year, in September 2008. Both meetings focused on identifying ways to develop a more strategic, integrated approach to working together as civil society. The overall aim is to better influence and shape health policies and initiatives so that they are relevant and responsive to the needs of affected communities. Improved and enhanced efforts in these areas are considered increasingly vital in light of the massive, persistent resource gap in funding for global health. Estimates vary widely as to existing and projected financing gaps, but few doubt that the amount could soon reach into the hundreds of billions of dollars if current trends continue.

Numerous factors are behind the shortfall—including donors' inability or unwillingness to meet commitments or allocate greater resources, low levels of domestic financing and the impact of the global economic downturn. Civil society can and must play a more effective role in making the case that such factors are nothing more than excuses. The global health resource gaps should be bridged: the health, well-being and very lives of millions of people around the world, many of them poor and marginalized, are at stake. The necessary resources are available, but political will is lacking.

Building on the 2008 gathering and subsequent developments, organizers of the 2009 meeting structured it based on the belief that civil society's ability to better influence policy toward the achievement of health for all will come from:

- a common understanding of recent developments and issues in global health among civil society delegations;
- improved coordination and communication mechanisms among and within organized civil society delegations;
- improved mechanisms for consultation with the constituencies that will support transparent and accountable representation; and
- identification of common objectives, policy outcomes, and key opportunities for joint or coordinated action by civil society.

The 2009 meeting was larger and more inclusive than its predecessor, however, in that representatives from a wider range of initiatives were involved. The decision to broaden the scope of the process reflected the increasing priority among disease-specific health initiatives toward building a more integrated global health movement that strengthens and expands overall health systems across the developing world. This trend stems from the recognition that i) a united civil society front is stronger than one in which disease-specific initiatives appear to "compete" with each other for attention and resources; and ii) sustained improvements in overall health are best achieved through a more holistic approach, including the critical need to increase the quantity and quality of human resources for health.

Participants at the 2008 meeting, which initiated what organizers believe will be a vital ongoing process, identified a series of recommendations and action steps. Summaries of developments undertaken through two working groups established after that gathering are included in this report (Appendix 2). The meeting report produced after the initial joint retreat is available on www.icssupport.org.

1.3 Structure of the meeting

The meeting included plenary-style presentations, full group discussions and two sessions in which participants divided into small groups to discuss specific issues.

Summaries of the following are included in this report:

- presentations by participating delegations as to their respective actions and highlights over the past year, main priorities over the upcoming year, and current and future challenges (Section 3);
- presentations by civil society officers from participating organizations and initiatives as to their respective entities' institutional priorities (Section 3);
- presentations by participants who were asked to provide an overview and update on recent developments in global health that are relevant to the group's work (Section 4);
- presentations by participants on various strategies and initiatives aimed at generating additional resources for health (Section 4);
- presentations by guest experts on various health systems strengthening platforms, including their current and expected impact at the global and local levels (Section 4); and
- discussions and proposed action steps identified by a total of eight break-out groups convened during two separate sessions (Section 5).

1.4 About the Free Space Process

Both the 2008 and 2009 joint retreats are part of a new initiative, the Free Space Process (FSP), which is supported by ICSS. The FSP was formally unveiled in October 2007 during a

meeting in Amsterdam of some 20 civil society advocates, including some who also attended the 2008 and 2009 civil society joint retreats.

The FSP aims to provide a dedicated space for in-depth and creative thinking and sharing for the civil society architecture, both in terms of how it operates at the global level and how national-level work and priorities are connected to regional and global ones. It does so primarily by facilitating improved coordination among existing HIV/AIDS networks, and more broadly among civil society representation in the boards of the various international health initiatives. The overall goal is to strengthen civil society's response to HIV/AIDS and health in general through enhanced collaboration at the global, regional and national/local level.

2. Setting the context: Key challenges in global health funding and access

Current and projected challenges in global health were highlighted in presentations and discussions throughout the meeting. The goal was to summarize key issues and developments that have hindered efforts to expand equitable and affordable health services in the developing world.

More concretely, participants wanted to better understand the new processes that are developed (IHP+, National Strategy Applications (NSAs), joint assessment) and how it impacts the way countries develop health strategies and donors make funding decisions, and what civil society delegations need to be aware of; identify what support is needed by civil society delegations to increase civil society participation, particularly at country level; develop shared positions on new health systems strengthening platform by the World Bank, GAVI and GFATM; and develop common positions on the way forward in terms of innovative financing proposals and resource mobilization for health.

The following were among the most notable challenges identified and stressed:

- progress toward meeting the health Millennium Development Goals (MDGs)—numbers 4, 5 and 6—remains inadequate.[1] At most, only a handful of developing countries are likely to meet even one of those three MDGs by 2015;
- many health system constraints are unaddressed;
- global and domestic investment in health is insufficient;
- international funding is unpredictable; and
- support to countries is inefficient in terms of system, impact and sustainability.

Many stakeholders, especially those in the donor community and elsewhere in developed country governments, blame the global economic downturn for lack of progress in addressing these challenges. Civil society advocates generally reject that excuse, arguing instead that persistent gaps in global health funding and access stem primarily from insufficient political will. They note, for example, that developed country governments around the world have been willing and able to allocate hundreds of billions of dollars to banks and other financial institutions that have been weakened by the global credit crunch. At the same time, those governments have ignored existing commitments to increase

[1] Goal 4 focuses on reducing child mortality (specifically among those under five years old); goal 5 sets targets for improving maternal health (including sharp reductions in maternal mortality rates); and goal 6 seeks to halt and begin to reverse, by 2015, the spread of HIV and incidence of malaria and other major diseases. (See http://www.undp.org/mdg/.)

funding for global health in poorer parts of the world even though the value of such commitments is just a fraction of the funds made available for domestic economic priorities. Poor, vulnerable and sick people in developing countries bear the brunt of such decisions, and in many regions their future looks even bleaker as their own governments scale back spending on health.

The situation has been exacerbated by longstanding shortages in human resources for health in many developing nations, especially those in sub-Saharan Africa. The ratio of health care personnel to the general population remains far below WHO recommendations. This gap is particularly destructive in areas with high prevalence of HIV, malaria, TB and other diseases that require extensive care and attention as well as effective medicines to keep millions of people healthy and alive. Recent arguments that some of those diseases, notably HIV, receive "too much" funding are further harming advocates' efforts to increase health spending overall.

A number of civil society advocates have sought to respond to these challenges by forming alliances and initiating common agendas aimed at increasing resources and improving outcomes across the global health spectrum. For example, participants at a May 2009 meeting sponsored by Partners in Health (PIH) in Stony Point, New York (USA) developed a declaration of solidarity with the goal of uniting individuals and organizations that generally focus on just one or a limited number of health concerns. Their goal is to initiate and sustain advocacy efforts centring on the need to increase "health for all".

3. Perspectives of civil society delegations and officers

3.1 Civil society delegations: Overview of activities, priorities and challenges

A preliminary exercise at the meeting consisted of brief presentations by a member of each of the 10 distinct civil society delegations represented: the GAVI Alliance, UNITAID, IHP+, the UNAIDS PCB, the Stop TB Partnership, PMNCH, Roll Back Malaria, the Global Fund. Each delegation had been asked to i) discuss the main actions and highlights of its work over the past year; ii) outline main priorities for the coming year; and iii) list current and future challenges to its work.

It was clear from the delegations' presentations that the entities differ in many areas, including in terms of structure, focus, partnership choices, and resource delivery methods and priorities. GAVI, for example, focuses solely on disease prevention, while the Global Fund and UNITAID (among others) provide hundreds of millions of dollars annually for treatment. Unlike most of the other entities, PMNCH is not a funding initiative—with relatively few resources, it focuses instead on coordinating and facilitating activities of partnership members. Funding sources also differ: for example, UNITAID is financed by a mandatory tax on airline tickets in a handful of countries; the Global Fund and UNAIDS are largely financed by governments in wealthier nations, and GAVI makes use of innovative funding mechanisms such as the International Finance Facility for Immunisation (IFFIm) and Advanced Market Commitments (AMC).

Broadly speaking, though, the delegations have similar objectives. For example, most believe that more extensive and effective national-level advocacy is, or at least should be, an important priority for their initiatives. That is one reason that all seek to expand civil society participation and meaningful engagement in their organizations' work, including programmatically and in terms of policy-setting and -making. In response to pressure from

the IHP+ civil society delegation, for example, the initiative issued a Ministerial Review Communiqué in February 2009 stating the following [emphasis added]:

> *We commit to meaningful civil society engagement at all levels by **proactively supporting and adequately resourcing** activities to improve coordination and strengthen capacity, especially of national civil society organizations. We acknowledge that civil society participation is critical in country compact development, implementation and monitoring, as well as in assessing needs, setting priorities, developing, implementing and monitoring of national health and HIV/AIDS plans and strategies to ensure accountability.*

All delegations also said they desired and needed greater engagement with counterparts at other initiatives. Most observed that improved cooperation would help them address key challenges of importance to all civil society advocates working in health, including i) building local civil society advocacy, monitoring and service-provision capacity; ii) ensuring direct and meaningful engagement of members of vulnerable groups, especially those engaged in behaviours (drug use, gay sex, sex work, etc.) that are criminalized in their countries; and iii) changing the behaviour and attitude of donors and governments toward civil society in general.

3.2 Overview of institutional priorities and challenges faced by participating initiatives in regards to civil society engagement

Separate presentations were given by civil society officers at three of the participating initiatives: UNAIDS, GAVI, and RBM. The focus was on institutional priorities, including policy issues that were likely to be stressed and/or addressed over and the upcoming year. Presenters also discussed lessons learned and ongoing challenges related to working with and supporting civil society delegations.

Some presenters highlighted existing initiatives aimed at expanded civil society engagement at various levels. GAVI, for example, has two programmes—one still in pilot stage—that provide small seed grants to civil society organizations at national and local levels. The presentation from UNAIDS, meanwhile, centred on identifying how and why the agency's nine main priority areas clearly establish close links between responding to HIV/AIDS specifically and improvements in broader health areas. For example, efforts to prevent HIV infection among infants, which include the provision of antiretroviral treatment (ART) to both mothers and newborns, can significantly lower rates of maternal and child mortality in many countries.

The UNAIDS presentation notwithstanding, some participants said they were concerned that the institutions had not sufficiently prioritized greater coordination and integration with organizations focusing primarily on other diseases and health issues. In their view, synergies still need to be identified and implemented, especially if civil society's role is to be expanded effectively. As one participant observed, an ultimate goal would be for civil society advocates currently focusing on one health MDG to be able to speak on behalf of those who would more directly benefit from improvements toward meeting a different MDG. On a practical level, this would mean that an HIV activist would be a fully informed and effective maternal and child health activist as well. Most participants agreed that integrated advocacy of that sort could be accomplished without diminishing the effectiveness of awareness-raising messages that focus primarily on one specific health concern.

4. Overview of existing and proposed mechanisms aimed at improving global health access and outcomes

Improved financial resource mechanisms and outcomes—including not just higher levels of funding but support that is predictable and sustainable—is an overarching priority for all entities represented. This holds true regardless of how extensively each institution has sought enhanced civil society engagement or greater integration with initiatives focusing on other health issues.

Several initiatives and structures have been created recently in response to such concerns. A handful of other initiatives have been proposed, with some generating substantial support among various stakeholders, including government policymakers and civil society.

Presentations on some of the most high-profile and notable of these platforms and mechanisms were delivered at the meeting. Although the presentations varied in terms of depth and detail, all at least provided basic information on how the mechanism is structured; what it does and/or is intended to do; and how much (if any) financial resources it does or potentially will raise.

Listed below in Sections 4.1 through 4.3 are brief summaries of the structures, initiatives and issues discussed in the presentations.

Section 4.1 focuses on resource-delivery structures, not financing per se. It discusses three notable concepts developed recently with the goal of streamlining and coordinating external resources for development. Section 4.2 focuses directly on existing and potential funding sources for health: specifically, initiatives categorized as innovative financing mechanisms. Section 4.3 covers a vital source of health resources in the developing world: domestic budget support.

4.1 Structures, mechanisms and concepts aimed at streamlining resource provision

4.1.1 International Health Partnerships and Related Initiatives (IHP+)

IHP+ is a coalition of international health agencies, governments and donors that seeks to achieve better health results by mobilizing donor countries and other development partners around a single country-led national health strategy. A key goal of the unified structure is to make it easier for countries to solicit, accept and implement priority programmes by reducing duplication and streamlining diverse donor priorities. Launched in 2007, the initiative aims to increase “commitments, confidence and accountability” through i) more explicit country compacts between donors and recipient countries; ii) joint assessment of national strategies and plans; and iii) mutual accountability for results. Civil society is expected to play a role in all three objectives.

Joint Assessments of National Strategies, or JANS, are a relatively new initiative driven by IHP+. Currently in the process of being rolled out in a few countries, JANS will scrutinize the content and process of developing health plans and create, as an output, an assessment document of strengths and weaknesses
of national strategies as well as suggestions of how to address weaknesses identified. JANS could be applied to national health strategies in general or to disease-specific strategies. The idea is for JANS, which will be conducted according to previously agreed criteria, to be

accepted by multiple development partners as a basis for technical and financial support.[2]

4.1.2 National Strategy Applications (NSAs)

In 2008, the Global Fund Board agreed to establish a modified application process for supporting national strategies – either disease-specific or broader health strategies – called National Strategy Applications (NSAs). This approach aims to ensure that the Global Fund's systems are better aligned with recipient countries' budgetary or other internal systems. Improved harmonization with a country's own agenda is the ultimate goal.

This approach is designed to enable requests for Global Fund financing to be based primarily on an existing national strategy, which has been validated against agreed attributes (or criteria) using a non-Global Fund-specific validation approach. Effective NSAs are expected to be contingent upon having all development partners agree in advance to coordinate assistance to a broadly accepted national strategy. Therefore, the overall concept can be viewed as donors pooling their money into an overall national health programme. Global Fund assistance will flow into broad-based national health plans as well, with the only requirement being that the country continue showing that it is meeting the disease-specific focuses identified in the original Global Fund grant(s).

Assumed benefits of the NSA approach include i) increased country ownership; ii) improved alignment with country priorities and with national programmatic and budgetary timeframes; iii) greater harmonization of funder approaches to financing; iv) reduced transaction costs; and v) a greater common focus on managing for results and mutual accountability in a way that is aligned with national priorities.

The Global Fund has not yet officially rolled out the NSA approach. Instead, the Board decided to initiate a pilot project, known as the First Learning Wave (FLW). As part of that pilot project, a limited number of countries have submitted applications for Round 9 funding based on the NSA concept. The Global Fund's Technical Review Panel (TRP) will review those applications in November 2009 and, consequently, help determine how the NSA approach will be expanded in the future.

When developing its FLW pilot, the Global Fund decided to coordinate closely with similar streamlining efforts being developed by IHP+ (see Section 4.1.1). Most notably, FLW reviewers agreed to draw on the IHP+ draft assessment tool to support their review of national strategy documentation. In return, the lessons learned during FLW—on attributes, documents, tools, process, etc.—are fed directly into discussions of the IHP+ Working Group.

4.1.3 Joint Health Systems Strengthening platform

Three leading players in global health financing—the Global Fund, GAVI and the World Bank—are developing a platform for joint funding and programming of health systems strengthening (HSS). The main components of a joint approach to HSS are likely to include a joint proposal, common assessment mechanism and strategy, common funding and disbursement systems, and joint performance monitoring. The collaborative effort aims to reduce time-consuming and resource-wasting fragmentation and duplication at local levels that stem from complex and disparate donor reporting and implementation requirements.

[2] Also see: http://www.internationalhealthpartnership.net/en/about/j_1253621551

Moreover, it seeks to focus greater attention and resources on financing for HSS, including human resources for health, in capacity-constrained developing countries.

The initiative, which was officially launched by the three entities in March 2009 with technical support from WHO, reinforces the fact that HSS is one of the highest priorities on the international health agenda. It is based on the belief that strong and effective health systems are increasingly considered a prerequisite to reducing the disease burden and ultimately achieving the health MDGs.

More specific rationales for a joint HSS platform include the likelihood that it will i) reduce transaction costs for countries and accelerate progress towards achieving the health MDGs; ii) represent a practical step to make global health aid architecture more effective; iii) engender better long-term predictability of donor funding for HSS; iv) better harmonize external funding with national budgets and planning cycles; and v) more effectively counter the negative effects of the global financial crisis by leveraging existing funds more efficiently and promoting innovation.

According to the current process plan, preliminary options will be presented to the three entities' governing bodies in November 2009. A pilot project subsequently will be rolled out in two or three countries in 2010, with policies for a wider roll-out initiated later that year after initial pilot results are evaluated. Platform developers reportedly are seeking input from a wide range of global health stakeholders, including civil society, throughout the process.

4.2 Innovative financing mechanisms

Existing and proposed initiatives classified as "innovative financing mechanisms" can be grouped in two main categories: i) initiatives that raise and/or distribute funding directly, and ii) those that focus solely, or primarily, on streamlining structures and removing obstacles to more effective resource provision. Health advocates from across the spectrum strongly support continued development of new and improved innovative financing mechanisms. However, most also stress that such mechanisms should be considered complementary to—and by no means a replacement for—official development assistance (ODA) and domestic budget support.

Listed below in Sections 4.2.1 through 4.2.5 are brief summaries of the key innovative financing mechanisms discussed during the meeting.

4.2.1 High Level Taskforce on Innovative International Financing for Health Systems[3]

A political process started in July 2008, the Taskforce seeks to identify new, viable and mutually acceptable sources and structures of financing for global health. Two working groups conducted research in early 2009 and recently issued reports. Working Group 1 focused on existing constraints to scaling up and global health funding; Working Group 2, meanwhile, focused on raising and channelling funds. Its main objective in this regard was to i) look at existing global health initiatives and consider what could be done to improve their ability to raise substantial funds, and ii) recommend new structures and initiatives.

[3] Also see: http://www.internationalhealthpartnership.net/en/taskforce for the final Report of the Taskforce and both reports from the Working Groups 1 and 2

The following were among the mechanisms examined by members of Working Group 2 toward establishing a more robust health systems funding platform: raising new taxes (e.g., on tobacco use); encouraging private investment; encouraging voluntary contributions; and results-based "buy downs" (see Section 4.1.5). One proposed financing mechanism, a currency transaction levy (CTL), was specifically recommended by the Taskforce. In June 2009, it created a new working group to advocate for such a mechanism (see Section 4.2.2).[4]

4.2.2 Currency transaction levy (CTL)

A CTL is a charge levied on global currency transactions—i.e., dollars for pounds, or euros for yen. Such a mechanism is supported by a growing number of advocates and policymakers because even a tiny levy on individual transactions could raise large amounts of money due to the massive value of trades ($3.2 trillion a day in 2007). In theory, a CTL could be levied at any percentage, but most advocates currently propose a rate of half a basis point (0.005%) of the value of each trade. That rate has been carefully selected because it is small enough to have no practical "distorting" impact on the currency trading market.

A CTL could be applied by any sovereign nation to its currency. However, most advocates currently focus on the four currencies in which the vast majority of foreign exchange transactions are undertaken: the US dollar, the euro, the British pound and the Japanese yen. Conservative estimates indicate that a CTL of 0.005% on those four major currencies would raise at least $33-$60 billion every year. Armed with the recently announced support of the High Level Taskforce (see Section 4.2.1), global health advocates are making the case that such a mechanism would not only be simple to implement and administer, but that its revenues should be allocated primarily for health.

In 2009 a group of health advocates have started a Global Campaign for a Currency Transaction Levy for Health, its Declaration being signed by over 140 NGOs worldwide.

4.2.3 Levies on sales of airplane tickets: UNITAID and voluntary solidarity tax

UNITAID is an innovative financing mechanism that offers a useful model for those advocating for a CTL (see Section 4.2.2). It was established in 2006 when a small group of countries agreed to levy a special tax on sales of airplane tickets. The funds raised are used to support existing efforts to achieve the MDGs, in particular the health-related goals (numbers 4, 5 and 6). UNITAID does not spend the money itself; instead, it disburses funds to international partners working in global health and health commodities procurement. Some 30 nations currently support the initiative.

A new initiative modelled on UNITAID has recently been proposed as part of an effort to further maximize potential resources for health. Like the UNITAID levy, it would be presented as a solidarity tax. However, unlike the UNITAID tax, which is compulsory in the countries that participate, the new initiative would solicit voluntary contributions from buyers of airplane tickets worldwide. The current goal is to implement the mechanism in partnership with the main global airline ticket booking systems (such as Sabre, Galileo and Amadeus).

[4] Factsheets on each of the innovative initiatives can be found at http://www.internationalhealthpartnership.net/en/taskforce/taskforce_reports

The proceeds of the proposed voluntary levy would be collected by a new NGO, the Millennium Foundation for Innovative Financing for Health. The foundation would then allocate funds to programmes, projects and initiatives, such as the Global Fund, that focus on the health MDGs. The plus side of such a levy would be that it could conceivably raise hundreds of millions of dollars a year. On the other hand, it is impossible to accurately predict the amount of funds raised in advance, thereby making this source of funding highly volatile and not necessarily sustainable. Current plans are to launch at least a pilot initiative in early 2010.

4.2.4 World Bank IDA 'buy-downs'

So-called buy-downs are considered a highly promising source of additional revenue for initiatives and national governments seeking to meet health MDG targets. The mechanism has been used in the past for other objectives by major development nonprofits such as the Gates Foundation and Rotary International.

A buy-down is essentially a form of debt cancelation. An example of how a health-specific buy-down might work is as follows (albeit highly simplified). The Global Fund or GAVI would agree to pay all or part of the net present value (NPV) of a World Bank IDA[5] credit on behalf of a borrowing country. The credit total would then be extended to the country to apply to specific domestic health priorities. A key element of the mechanism is that it is performance-based. This means that IDA would release funds to the Global Fund or GAVI to purchase and cancel the credit only if the project's pre-determined goals are met.[6]

The main reason such a scheme has proved lucrative is that a credit's NPV can be as much as 50 percent less than the loan's face value. The gap stems from the fact that the NPV is calculated based on a long timeframe for repayment, while the face value tends to increase because of inflation. Another benefit is that substantial funds could be raised without the creation of an entirely new parallel financing and distribution system. The one major drawback from a civil society perspective is that IDA loans occur between the World Bank and sovereign governments. Civil society involvement and influence therefore could be limited even though the Global Fund or GAVI, for example, might serve as a facilitating partner.

It is worth noting that Working Group 2 of the High Level Taskforce (see Section 4.2.1) strongly supports close consideration of the buy-down concept. In its recent report, it "recommends that development partners consider establishing or expanding existing funds for results-based *'buy-down' funding and/or 'Debt2Health'* to fill financing gaps for health systems development" [emphasis added].

4.2.5 International Finance Facility for Immunisation (IFFIm)

IFFIm raises money for GAVI by issuing bonds in capital markets. In doing so, it converts long-term government pledges into immediately available cash resources. Strong commitment by participating governments—including France, Italy, Norway, South Africa, Spain, Sweden and the United Kingdom—enables IFFIm to have a triple-A credit rating and thus raise significant funds so quickly. Since the initiative was launched in 2006, it has

[5] IDA = International Development Association. It is one of the World Bank's two main lending agencies. As noted on the World Bank's website, "IDA lends money (known as credits) on concessional terms. This means that IDA credits have no interest charge and repayments are stretched over 35 to 40 years, including a 10-year grace period. IDA also provides grants to countries at risk of debt distress." (See www.worldbank.org.)

[6] Under the buy-down scheme, countries also have a "negative" incentive to meet pre-determined project goals. If a project's intended benefits do not materialize, the amount allocated remains a regular IDA credit. That means that a government does not reap the expected financial benefits.

contributed some $2 billion to GAVI for vaccines, programmes and targeted immunization initiatives.

IFFIm is a potentially useful initiative for those seeking to finance broader health issues, including health systems strengthening (HSS), for two reasons: i) the initiative itself could conceivably be expanded to provide resources in such broader areas, and/or ii) it could serve as a model for a separate, similar initiative. Steps toward the first option have in fact already been taken by IFFIm, based on an internal taskforce proposal that the initiative expand its remit. Some governments reportedly are interested, although as yet no formal decisions have been made as to how, or even if, expansion will occur.

4.3 Domestic financing for health

Domestic financing is not, and should not be considered, an example of an innovative financing mechanism. However, it was discussed in detail at the Amsterdam meeting because it is an area that most participants, including many from the developing world, believe should be a priority health-financing advocacy focus for civil society at all levels. In their view, most developing country governments have consistently shirked responsibility and ignored commitments to allocate increased funds for health. Their poor performance is a major reason that most countries are not on track to meet MDG targets, including those related to health.

Local civil society groups in Africa are particularly incensed that nearly all signatories to the 2001 Abuja Declaration have not honoured this high-profile commitment: “We pledge to set a target of allocating at least 15% of our annual budget to the improvement of the health sector.” Just 2 of 53 countries reportedly are currently meeting that target. Most African governments have also failed to increase per capita health spending for health to at least $34, a vow they made at the Abuja +5 gathering in 2006. Excluding South Africa, sub-Saharan African countries currently spend a per capita average of just $27 on health, by far the lowest level in the world.

Partly as a result, out-of-pocket spending on health accounts for about two-thirds of total health spending in low-income countries in Africa. Many individuals, families and communities continue to face catastrophic impoverishment when seeking access to vital health services.

A coalition of African civil society groups, the Africa Public Health Alliance, is spearheading a campaign to address such concerns. Now known as the 15%+ Campaign, it seeks to push African governments to increase i) the share of budget allocations targeted for health, and ii) per capita expenditure on health. It also urges governments to explore other innovative domestic financing methods. The campaign’s advocacy strategy focuses first on educating government officials, including those in finance and health ministries, about the Abuja pledges and offering solutions on how the targets might be met. It also works at the regional level by consulting with members of African Parliamentary Committees to build their understanding and capacity of key issues associated with health development and financing.

5. Break-out group summaries

The presentations discussed in Sections 2, 3 and 4 laid the groundwork for what was arguably the most important part of the Amsterdam meeting: break-out groups aimed at

digesting and discussing the information and beginning the process of identifying common civil society priorities and action steps. Although individual groups focused on different topics, the following overarching issues strongly influenced all talks:

- How, and to what extent, should civil society advocates integrate objectives and strategies in order to present a common agenda for increased resources for global health in general?
- Which innovative financing mechanisms and joint structural platforms should civil society support? How can civil society ensure that it is able to influence such mechanisms and platforms to the fullest extent possible? And finally, will—and should—civil society support for such mechanisms and platforms be united and integrated in principle, or vary by country and region based on locally determined needs and priorities?
- What mechanisms and strategies are likely to be most effective and successful in increasing funding and human resources for HSS and community systems strengthening (CSS)?
- How can civil society capacity and influence be increased in countries where the sector is weak or otherwise ineffective in regards to health? Similarly, how might civil society capacity be improved so that national and local NGOs are better able to handle key civil society responsibilities of monitoring as well as effective advocacy and, where appropriate, direct service delivery?
- How should civil society at all levels—global, regional, national and local—interact with national health plans and national strategy frameworks?

Two separate sessions of break-out groups were organized during the meeting. In the first session (see Section 5.1), three separate groups were organized by representation (i.e., by civil society delegation and/or initiative). The five groups in the second session (see Section 5.2) were organized by topic. All were asked to provide summaries of their discussions to the full group; those summaries form the basis of the brief overviews in Sections 5.1 and 5.2.

5.1 Break-out groups by representation

Participants divided into three separate groups based on representation: i) Global Fund and UNITAID; ii) UNAIDS PCB; and iii) all other participants. They were asked to consider the following:

- the implications of the information and developments presented on their delegations' work;
- whether—and if so, which—cross-cutting issues had emerged that should be prioritized; and
- what they wanted from the overall group in terms of moving forward.

5.1.1 Global Fund and UNITAID representatives

The group agreed that its aim regarding national plans is to have ambitious but feasible plans that can achieve priority health goals, particularly for poor people. Health systems should focus not only on the essentials, but also on how to finance each essential (and with indicators included). For example, specific yet viable targets should be created for increased numbers of health workers.

Group members also stressed the importance of civil society having a place at the table in all discussions regarding, and implementation of, national plans and country compacts. The sector's ability to participate meaningfully is dependent on adequate information flow at all

stages. Participants concluded that the most practical strategy for all stakeholders would be to initiate pilots in two or three countries and then evaluate how the compact structure could best be rolled out more widely. Evaluations should also consider issues regarding civil society engagement and influence.

5.1.2 UNAIDS PCB representatives

The group focused particularly on the implications of HSS and NSAs. In participants' view, a key entry point for civil society is the memorandum of understanding (MoU) between the Global Fund and UNAIDS. Members of the group observed that although UNAIDS personnel are expected to spend time and resources supporting Global Fund processes, it remains difficult for civil society to engage directly and meaningfully in Global Fund Country Coordinating Mechanisms (CCMs) in most contexts. Civil society PCB members could in response hold UNAIDS more accountable to what the agency's representatives—from country coordinators to portfolio managers to members of the Secretariat—are doing in terms of enhancing the participation of civil society, including members of vulnerable and affected groups, in CCMs and other Global Fund processes. This step is likely to be vital in terms of NSAs as well because once such frameworks have been established, there is a fear that civil society will be pushed out of the process.

Other key areas of focus identified for the UNAIDS NGO delegation:

- Universal access targets: are they being forgotten and/or ignored at global and national levels? What happens after 2010?
- UNAIDS should ensure that diseases and health conditions other than HIV/AIDS—including TB, malaria and maternal and child health—are not "lost".
- Country-level collaboration across the MDGs should be facilitated.
- Joint messaging is important, especially regarding stigma and discrimination of vulnerable populations and the rights and health of individuals engaged in criminalized behaviour. NSAs must not ignore such individuals and their communities.
- The implications NSAs have on dual-track financing, a relatively new Global Fund recommendation, should be monitored closely. This concept is crucial toward the greater involvement of civil society in Global Fund processes.

Group members recommended that letters and appeals outlining such concerns be written to members of the UNAIDS Secretariat and other key agency personnel.

5.1.3 Representatives from other initiatives

The third group comprised representatives from all other initiatives, including IHP+, GAVI, PMNCH, RBM, and the Stop TB Partnership. They agreed that in general, the concepts and ideas behind the joint HSS platform and NSAs, for example, are sound. They cautioned, however, that additional details are needed before civil society should support one or more of the initiatives.

Group members concluded, for example, that it was not clear how NSAs are different from existing Global Fund processes. They wanted more clarification on how NSAs would address health system bottlenecks and support longer-term HSS needs, such as training of doctors and nurses. A third main concern centred on ensuring opportunities for civil society participation in national planning.

The group recommended two main action steps:

1. Civil society stakeholders should jointly define and agree on criteria as to what

meaningful civil society engagement means in i) the development of the HSS platform and JANS, ii) the final product of the platform and JANS; and iii) national health sector planning and strategy development.

2. Civil society stakeholders should review Global Fund guidelines on multi-stakeholder participation and evaluate whether they remain adequate and relevant. If not, civil society should propose revisions.

5.2 Break-out groups by topic

During the second session of break-out groups, participants had the option to select from one of the following five topics, each of which had been discussed to some extent earlier in the meeting: NSAs, joint HSS platform, JANS, resource mobilization, and community systems strengthening (CSS). The main goal was to recommend strategies and action steps for a common civil society agenda for health.

Summaries based on report-backs are provided in Sections 5.2.1 through 5.2.5.

5.2.1 National Strategy Applications (NSAs)

The working group said it wanted the following in regards to NSAs:

- a fully consultative process, including involvement of civil society from a wide range of groups (including vulnerable communities throughout society);
- improved clarity as to the role of CSS within individual NSAs, with the main objective being that CSS should be a top priority; and
- a shift from a generic template towards a more operational-type strategic document based on specific contexts and needs. In particular, individual NSAs should include clearly delineated roles and responsibilities regarding implementation, and all plans should be fully costed.

Working group members stressed, too, that civil society could and should play a useful role in achieving all of this goals. Some of the responsibilities could also conceivably be delegated to the sector.

The group also came up with a list of action steps, some of which were also accompanied by proposed timelines. Among the action steps were the following:

- Clear guidelines are needed to define the role of civil society organizations (CSOs) in developing strategic plans and implementing them. They should be developed as a Global Fund Board decision point, preferably for the November 2009 Board meeting. The guidelines should include minimum standards for civil society participation and implementation. Independent (thus objective) observers, preferably civil society representatives not associated with the Global Fund, should be appointed to monitor progress toward these requirements with each NSA and report back.

- CSOs must have increased knowledge of Global Fund principles. This would help ensure enhanced inclusion of vulnerable groups, improve the quality of NSAs, and increase the capacity of CSOs to monitor strategic plans.

- Civil society networks should seek to increase awareness of the potential availability of funds through CCMs to build the capacity of local CSOs. This objective is likely to be enhanced following the revision of CCM guidelines, a process that some Global Fund NGO delegates are involved in.

- A process and mechanism should be initiated to independently monitor and evaluate the proposed NSA pilot initiative, with the focus on exploring the risks and benefits to civil society. In particular, such monitoring should consider the extent to which, if any, vulnerable populations are able to participate and exercise influence. This civil society-led monitoring initiative could eventually serve as the basis of a larger tracking and evaluation mechanism after the NSA approach is rolled out more extensively.

5.2.2 Joint HSS platform

Working group members agreed that they needed i) more clarity on the joint HSS platform process, and ii) a set of values and principles for how the platform operates that builds on the GAVI/Global Fund model.

The group identified the following strategic questions as among those that need clarification:

- How does (or will) the HSS platform specifically define health systems? For example, will home-based care and voluntary care be included?
- How will the platform be operationalized?
- How do we (civil society) identify, monitor and avoid gaps—for example, in immunization coverage related to GAVI funding?
- What is the division of labour among the three major partners (GAVI, the Global Fund and the World Bank)? For example, will one partner focus on "upstream" care?
- What is the balance of influence of the three major partners? This is important because the World Bank prefers to work primarily if not exclusively with governments, while GAVI has a model that could conceivably include a more substantial role for civil society.
- What links, if any, will be created between the platform and IHP+?
- Is the community sector included in the definition of HSS?
- How will fragmentation and duplication be avoided?
- How can civil society participate meaningfully in address larger fiscal policy issues, such IMF loan restrictions and developed country practices and policies that undermine HSS (e.g., the ongoing brain drain in many nations)?

The group proposed the following values and principles to help guide the HSS platform model:

- harmonization of values among the three major partners;
- the HSS platform cannot undermine the core values and principles of GAVI and the Global Fund, particularly in regards to civil society involvement, gender, and results-based financing;
- HSS requires CSS; health systems include more than just bricks and mortar—e.g., community systems and informal workforces are core elements; and
- support should be given to developing countries' efforts to achieve universal access and meet the health MDGs.

And finally, the working group proposed the following action steps:

- Civil society should develop common advocacy talking points. They can subsequently be used in boards and other forums to promote the ideas and principles civil society believes should guide the HSS platform.
- The boards of GAVI and the Global Fund should ensure that their values and

principles are operationalized in the HSS platform.
- GAVI and the Global Fund should explicitly demonstrate how their sector-specific work strengthens health systems, thereby helping ensure that the HSS platform includes successful initiatives in this regard.
- Civil society should build alliances with key member states (both donor and recipient countries), on and off boards. This would help ensure effective monitoring of the HSS platform approach.
- Civil society networks should collectively help GAVI civil society representatives develop an effective civil society constituency within the initiative.
- Civil society should partner with G20 activists to help change IMF policies regarding health spending. In particular, efforts should be made to promote support for social safety nets and participatory models of HSS.
- Efforts should be made to continue building an evidence base on the efficacy of the participatory model prioritized by GAVI and the Global Fund.

5.2.3 Joint Assessments of National Strategies (JANS)

Working group members were most interested in ensuring that JANS prioritize "good content and good process".

The following key objectives were listed under content:
- JANs should insist on ambitious but feasible plans that can achieve health goals.
- JANS should ensure that support is provided for countries to improve their national health plans and address their weaknesses. Civil society should develop a common position on the best way for technical assistance to be provided to countries that need it—and then advocate for that approach with JANS implementers.
- JANS must specifically address the needs of the poor and vulnerable and marginalised groups.
- JANS should include strong and detailed actions (with targets and indicators) to link health sector plans with other key sectors that are involved in the determinants of health—e.g., education authorities and officials from ministries of finance. The JANS approach should encourage representatives from these sectors to be involved in developing plans.
- JANS should prioritize protecting a budget line for civil society funding outside the national health sector basket.
- JANS should focus on infrastructure, workforce, health products and health information systems. For example, human resource problems should be addressed via costed and funded short-, medium- and long-term plans with clear indicators. Clear targets should be included in regards to budget ceilings (e.g., those mandated by the IMF).

The following key objectives were listed under process:
- Countries should be free to seek technical assistance (TA) from any institution according to their own specific standards. In particular in this regard, JANS implementers must recognize that many countries oppose wholly external TA for various reasons, including the fact that nations often want to develop their own capacity and empowerment and external consultants often lack sufficient knowledge of countries.
- JANS should ensure that countries are able to demand and/or encourage non-IHP+ donors to join the country processes.
- JANS should ensure a place for civil society in all aspects of the pilot phase—from assessment teams to country consultations. Similarly, the JANS approach should

ensure that civil society questions and priorities are included in the evaluation teams' activities.
- Global civil society networks (i.e., representatives of groups at the Amsterdam meeting) should organise consultations with CSOs in the pilot countries. Such consultations can be virtual, if necessary.
- JANS should fit seamlessly into country processes, including budget planning and annual reviews.

And finally, the group identified the following action steps as needed to help ensure that the above-mentioned priorities are presented to JANS implementers:

- Form a core group from civil society that has expertise on health and health system plans. This group should be committed to closely following the JANS process and provide support and advice to representatives of global civil society networks as well as CSOs at national and local levels.
- Civil society stakeholders should create a simple fact sheet on JANS that considers the initiative from the civil society perspective. The inter-delegation communications group subsequently should distribute the fact sheet to their constituencies.
- Virtual and/or real consultations should be organized among civil society representatives of global networks, the core group, and CSOs from pilot countries before the JANS pilot begins.
- Request funding from the JANS core team to ensure civil society participation in the process.

5.2.4 Resource mobilization

The resource mobilization working group listed a number of objectives, all of which also included proposed action steps toward achieving them.

1. Leverage Global Fund TRP recommendations for resource-mobilizaton campaigning purposes. The Global Fund should be asked to release the ranking of countries being recommended for Round 9 funding some time between 4 September 2009 (end of the TRP meeting) and 24 September (start of the G20 heads of state meeting). Then, a list of countries/programmes that will not be funded should be circulated—this list will indicate, among other things, the number of lives that will not be saved—if less than $1 billion is available for a $3.5 billion need. Such resource gaps should be communicated to G20 leaders, with attention paid to contrasting with hundreds of billions of dollars allocated to the IMF at the April 2009 G20 summit.

2. Advocate to maximize European Commission (EC) funding to the three Global Fund diseases and health in general. This effort would entail, among other things, stopping African-Caribbean-Pacific governments (ACPs) from repossessing, in 2010, the 50 million euros ($74 million) that is currently provided annually by the European Development Fund (EDF) to the Global Fund. (If the ACPs are successful, the annual EC contribution to Global Fund would be cut in half, from 100 million euros.) Southern civil society health advocates—those who feel that aid arriving as Global Fund grants is more likely to be well spent than aid arriving as health sector support—should attend the October 2009 European Union (EU)/ACP meeting in order to campaign and lobby there to prevent ACPs from cutting the EDF contribution to the Global Fund.

3. Leverage the EC's in-country budget support monies. EC embassies ("delegations") in-country have substantial funds to use at their discretion. They should be encouraged to give money to country governments for health investments. For example, the EC delegation and

the government could agree to co-finance or to top-up programmes funded primarily by the Global Fund or GAVI.

4. The proposed currency transaction levy (CTL) should be a major priority of civil society advocates and governments around the world.

5. Create a topic/go-to person list. This would help ensure that all involved know who to talk to when in need of detailed info about a particular topic

6. Investigate the World Bank "buy-downs" option for global health more thoroughly and seek to explain its potential benefits more clearly. This model has been used successfully for other purposes, but global health advocates have largely ignored it because it is complicated and difficult to conceptualize. Civil society stakeholders should be assisted in making fully informed decisions about whether this funding option should be a priority.

7. Create more frequent opportunities like this Amsterdam meeting for advocates to check-in on campaigning around issues such as resource mobilization. One option might be to arrange similar civil society meetings after Board meetings of the Global Fund and other groups.

8. Efforts should be sped up to properly resource advocacy on global health initiatives both at the global level (Board member work) and national level (IHP+ country teams, CCMs, etc.). Both levels of advocacy require advocates who have the time, funding, equipment and travel capacity to undertake such responsibilities. Several key initiatives—including IHP+, RBM, GAVI and the Stop TB Alliance—do not have CFPs, a situation that limits their advocacy capacity. The Boards of those initiatives should be encouraged to create positions similar to CFPs in order to facilitate more extensive and effective advocacy, particularly by civil society.

9. Health-focused civil society advocates around the world should strongly support the African Public Health Alliance's 15% + Campaign for domestic health development and financing in Africa. Such support could include providing financial and technical assistance to African CSOs and activists seeking to hold their governments accountable to meeting their Abuja commitments.

5.2.5 Community systems strengthening (CSS)

The working group that considered CSS focused primarily on the need to provide communities with the capacity—technical and institutional, primarily—to better initiate and provide advocacy, service-delivery, and monitoring services. Such improvements would allow them to participate more extensively in all health-improvement initiatives and ensure expanded ownership at the grassroots level. The most important shift in resources and influence should be from international NGOs to local ones, which nearly always are better placed to respond to community needs.

Enhanced CSS is dependent on increased core funding. Community groups are also likely to be able to increase their engagement when the following steps are taken:

- information and resources are shared more extensively and systematically with community groups;
- donors support CSS activities within all aspects of Global Fund processes; and
- donors and multilateral institutions place greater priority on establishing and maintaining partnerships at ground level. This would include, for example, a greater

commitment on the part of UNAIDS country offices to build capacity among civil society at the community level.

Working group members added that effective CSS was contingent upon civil society representatives at global health initiatives to recognize the importance of CSS and continually advocate on behalf of resources to improve community-based responses. They also stressed that CSS should be included in guidelines for NSAs and JANS.

Appendix 1. List of participants

The following individuals attended all or part of the meeting held in Amsterdam from 31 August to 2 September 2009. The country listed refers not to nationality or citizenship, but to where the individual is based.

Name	***Country***	***Position***
UNAIDS PCB delegation		
Lydia Mungherera	Uganda	Alternate Delegate Africa
Vince Crisostomo	Thailand	Delegate Asia and the Pacific
Gulnara Kurmanova	Kyrgyz Republic	Alternate Delegate Asia and the Pacific
Robert Carr	Jamaica	Alternate Delegate Latin America and the Caribbean
Pavel Aksenov	Russia	Delegate Europe
Evan Collins	Canada	Alternate Delegate North America
Alexandra Garita	USA	Delegate North America
Sara Simon	Belgium	Communications Facility
Natalie Siniora	Netherlands	Communications Facility
Global Fund Communities delegation		
Carol Nyirenda	Zambia	Board member
Rolake Odetoyinbo	Nigeria	Alternate Board member
Rachel Ong	Singapore	Communications Focal Point
Global Fund Developing Country NGO delegation		
Karlo Boras	Serbia	Board member
Cheick Tidiane Tall	Senegal	Communications Focal Point
Global Fund Developed Country NGO delegation		
Asia Russell	USA	Outgoing Board member
(Mohga Kamal-Yanni)	UK	Alternate Board member
Jacqueline Wittebrood	Netherlands	Communications Focal Point
UNITAID Communities delegation		
(Carol Nyirenda)	Zambia	Board member
Esther Tallah	Cameroon	Alternate Board member
UNITAID NGO delegation		
Khalil Elouardighi	France	Outgoing Board member
Mohga Kamal-Yanni	UK	Incoming Board member
Kim Nichols	USA	Alternate Board member
Jessica Hamer	UK	Liaison Officer UNITAID Delegations
GAVI delegation		
Alan Hinman	USA	Alternate Board member

IHP+ delegation		
Mayowa Joel	Nigeria	Alternate Southern Representative
Sue Perez	USA	Northern Representative
Elaine Ireland	UK	Alternate Northern Representative
Roll Back Malaria delegation		
Aude Galli	Brussels	Replacing Northern Representative
Uzo Gilpin	Sierra Leone	Southern Representative
Stop TB delegation		
(Carol Nyirenda)	Zambia	Communities representative
Perfaiz Tuvail	Pakistan	Communities representative
Partnership for Maternal, Newborn and Child Health		
Ann Starrs	USA	NGO representative and Co-Chair
Civil Society Officers		
Kate Thomson	Geneva	UNAIDS
Nilgun Aydogan	Geneva	GAVI
Thomas Teuscher	Geneva	Roll Back Malaria
Presenters		
Daniel Davies	Geneva	Global Fund
Phyllida Travis	Geneva	WHO
Geoff Adlide	Geneva	GAVI
Mauricio Cysne	Mozambique	UNAIDS
Bob Fryatt	Geneva	WHO
Support team		
Jeff Hoover	USA	Rapporteur
Peter van Rooijen	Netherlands	ICSS
Elsbeth Timmer	Netherlands	ICSS

Note: Carol Nyirenda and Mohga Kamal-Yanni are involved in both the Global Fund and UNITAID delegations. Each is therefore listed twice.

Invited but unable to attend were: Bobby John, Alternate Board member for the Developing Country NGO delegation to the Global Fund Board; Lola Dare, Southern Representative IHP+; Mick Matthews, Senior Civil Society Officer Global Fund.

Appendix 2. Report back on activities undertaken by 2008 working groups

The 2009 meeting in Amsterdam occurred almost exactly a year after a preliminary joint civil society retreat involving some of the same participants. Among the action steps agreed to at the initial meeting was the creation of two interdelegation working groups, one focusing on joint communication among the delegations, and the other on accountability.

Summaries of the activities undertaken by the two working groups were presented at the 2009 meeting. Highlights are listed below.

Communications working group

The ToR for this working group, which comprised CFPs at Global Fund and UNAIDS delegations, were based on two main recommendations from 2008:

- Create a joint communications structure for information sharing among delegations
- Carry out a pilot joint consultation on an issue of joint concern (i.e., the implications of NSAs)

Working group members decided to hire a consultant to develop and propose a joint communications structure for civil society delegations at global health initiatives. A total of 20 applicants responded to an open call for consultants, and the consultant selected recently completed a draft report that will be available for comment in early October. All participants at the 2009 meeting were urged to review the draft and submit comments to the Chair of the working group, Sara Simon from the UNAIDS PCB delegation, by the end of October The group hopes to finalize the process within two to three months and then develop the actual structures and mechanisms proposed to improve communications.

Less traction has been achieved toward meeting the second part of the mandate—the joint consultation. The original idea was to initiate an in-country pilot to evaluate the level and type of civil society participation in a particular structure or mechanism at national and local levels. Ideas and reactions were solicited for the pilot consultation: among those proposed are Global Fund national strategy applications, CCMs, and participation of vulnerable populations in all Global Fund processes. Next steps on a joint consultation will be taken in early 2010.

The Communications working group encouraged new participant constituencies, such as Roll Back Malaria, PMNCH, and Stop TB to appoint a communications representative to join this group.

Accountability working group

The ToR for this working group called on it to focus on the following:

- craft an accountability framework for civil society; including:
    - an agreed set of “non-negotiables” in terms of accountability;
    - creation of and regularly monitored compliance with a set of key performance indicators (KPIs); and
- establish mechanisms to improve documentation of informal and formal consultations with constituents.

As of September 2009, a bit less work had been done on this working group simply because members were not able to meet as often as those on the communications working group. An open call for consultants to draft proposals for an accountability framework resulted in six applications; they were reviewed at the end of August 2009. Members of the group

expect to select a consultant within a few weeks and have a draft report by the end of the year.

Current members of the working group are encouraging new membership, particularly from civil society delegations that were not present at the 2008 meeting (such as RBM, the Stop TB Alliance and PMNCH).

Distribution of ToR to 2009 meeting attendees

It was agreed at the 2009 meeting that ToR for both working groups would be distributed by email to all attendees at the 2009 follow-up meeting. Participants who were not present at the initial meeting were urged to review and, if possible, get involved in one of the ongoing activities.