Observations and recommendations from a strategic retreat for civil society representatives to international programs and initiatives;

Laying the groundwork for more effective and coordinated civil society participation in health and HIV/AIDS responses

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+)

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Contents

Acronyms and abbreviations

CFP	Communications Focal Point
FSP	Free Space Process
DAH	development/donor assistance for health
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HRH	Human resources for health
HSS	Health systems strengthening
ICSS	International Civil Society Support
IHP+	International Health Partnership and Related Initiatives
NSA	National Strategy Application
PCB	Programme Coordinating Board (of UNAIDS)
PRSP	Poverty Reduction Strategy Paper
SWAp	sector-wide approach
TB	tuberculosis
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 in the global health and HIV/AIDS response that was held in Amsterdam in September 2008. Conceptualized and organized by the Communications Facility for the UNAIDS PCB NGO Delegation and International Civil Society Support (ICSS), the meeting was structured in part 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 (GFATM), the GAVI Alliance, UNITAID and the International Health Partnership and Related Initiatives (IHP+).

These institutions differ in structure, focus and size, but all are notable in the field for including civil society representation in some institutional governance structures. All also have significant influence on efforts to expand access to health and HIV-related services around the world.

More than 20 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. It was the first time this diverse group of representatives came together to discuss common objectives and joint strategies. Also in attendance were support staff and two health care analysts who delivered special presentations. (Appendix 1 contains a list of all meeting participants.)

This report provides an overview of issues discussed, key priority areas identified and recommendations made during the meeting. It is intended to serve more as a summary than a comprehensive, in-depth account of all proceedings.
A full suite of supporting materials may be found on the ICSS website (**www.icssupport.org**), including:

- PowerPoint presentations from participating delegations as to their respective institutions' structures, policies, short- and long-term strategies, advocacy priorities, and engagement with civil society;
- PowerPoint presentations from experts invited to discuss trends and developments in the global health architecture and the global aid architecture;
- full text of background papers on a range of issues from defining accountability in the civil society context to detailed Terms of Reference for an ongoing search for the next UNAIDS executive director; and
- other supporting advocacy and background materials provided by participants.

1.2 Key objectives of the meeting

The primary purpose of the gathering was to discuss ways to develop a more strategic approach to working together as civil society. The perceived need was based on the following core assumptions:

- improved coordination and communication mechanisms among and within organized civil society delegations could boost civil society's ability to influence policy at international, regional and national levels;
- identification of common objectives could help leverage greater and more sustainable resources for civil society organisations providing direct service delivery at the national/local level; and

- representatives' accountability to their respective communities, most notably individuals living with and affected by HIV/AIDS, TB and malaria, could be enhanced through the development of a consistent, sector-wide understanding of what it means to properly and effectively serve their constituents. Mechanisms to ensure greater accountability and transparency are therefore necessary.

A planning team consisting of one representative from each participating body prepared the meeting agenda. This method was used to ensure that the issues and priorities identified by the participants, not the organizers or facilitators, would and should take precedence.

ICSS is willing and able to support (at least for two years) a collaborative process to increase and improve civil society coordination. However, as emphasized at the beginning of the meeting, the participants are responsible for determining the usefulness of a process and shaping it—with the expectations and needs of their constituents the underlying major factors.

1.3 Structure of the meeting

The meeting was a hybrid of sorts in that it contained plenary-style presentations, full group discussions and intimate roundtable talks on specific issues. Moreover, one full day was allocated to the individual delegations themselves to set their own agendas and meet separately. This so-called Delegations Day is not addressed in this report.

The sessions included the following:

- Brief initial presentations by each individual delegation summarizing key policy and advocacy issues and objectives (see Section 2 of this report).

- Presentations by two experts—Prof. Brook Baker, Northeastern University School of Law's Program on Human Rights and the Global Economy (Boston, USA) and Dr. Gorik Ooms, Institute of Tropical Medicine (Antwerp, Belgium)—who were invited to discuss notable global health issues and concepts, including highly technical ones such as the impact of IMF policies and the true costs and shortfalls of development aid. The goal of these presentations was to promote awareness among representatives, with the expectation that attendees would consider ways to disseminate that information to their constituents. Section 2.3 contains summaries of these presentations; full texts are available on the ICSS website (www.icssupport.org).

- Short presentations by participants regarding specific concepts, programs, policies and initiatives with current or potential direct impact on civil society's work. Among the topics discussed were sector-wide approaches (SWAps), National Strategy Applications (NSAs) and costed national AIDS plans. Summaries of these topics may be found in Appendix 2.

- Roundtable discussions on cross-cutting issues identified by participants. These discussions were enhanced by separate full-group discussions regarding the concepts of accountability and communication, both in general and in regards to participants' specific work and responsibilities. Summaries of the roundtable discussions, including recommendations stemming from them, may be found in Section 3.

This report concludes with a brief summary of priority next steps in the civil society coordination process (see Section 4).

1.4 About the Free Space Process

The meeting was an important development toward the realization of a proposed new initiative, the Free Space Process (FSP). 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 September 2008 gathering. (Meeting reports can be found at www.icssupport.org.)

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 plans to do 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.

Activities within the FSP will develop around the following activity areas:

1. Establishment of an HIV/AIDS strategy caucus. This will be a space for strategic thinking and systematic linking and learning among leaders of the networks[1] and other sectors of civil society (HIV/AIDS, key populations, health) from the international, regional and national level, in order to develop a proactive response based on a common vision on HIV/AIDS and health in general.

2. Supporting civil society delegations. This will consist of increased capacity support for civil society representatives in the international institutions[2] as well as facilitating a process for strategic collaboration among these representatives and with a wider group of civil society stakeholders.

3. Strengthening the civil society architecture at the country level. This will include enhancing collaboration at the country level to improve civil society's ability and inclination to i) strategize and work together on the national agenda vis-à-vis HIV/AIDS and health, and ii) develop a shared advocacy agenda and appropriate actions.

   Creating a better communications environment. Efforts will be made to collectively i) address the urgent need for alignment and support of an efficient civil society communications environment, processes and tools, and ii) develop accountability mechanisms at the international, regional and national level.

   Leadership development. A main priority will be on creating an environment and appropriate curricula for development and support of new (and young) leadership.

[1] Including the Global Network of People living with HIV/AIDS (GNP+), the International Community of Women living with HIV/AIDS (ICW), the International Treatment Preparedness Coalition (ITPC), the International Council of AIDS Service Organisations (ICASO), the International HIV/AIDS Alliance, the World AIDS Campaign, and the Ecumenical Advocacy Alliance.
[2] Including representatives to the UNAIDS Programme Coordinating Board, Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID, GAVI Alliance and IHP+.

Funding needs and resource mobilization. Funding needs will be considered in regards to essential capacity gaps—in communication, policy advocacy, and management—that hamper scale up and quality improvement of the response.

The overall goal is to support those networks and civil society representatives to identify and review current gaps in civil society infrastructures and capacities and propose various strategies to overcome them. Equally important, the FSP will create a space for the networks and delegations to discuss and build on current strengths and share resources more consistently. Taken together, these steps will increase the ability of civil society actors at all levels—national/local, regional and global—to provide extensive, appropriate, and sustainable services to their core constituents.

2. Knowledge sharing toward increased awareness

2.1 Delegation priorities and objectives

A preliminary exercise at the meeting consisted of brief presentations by a member of each of the eight distinct civil society delegations: the UNAIDS PCB NGO delegation; the GFATM Communities delegation; the GFATM Developing Country NGO delegation; the GFATM Developed Country NGO delegation; the UNITAID Communities delegation; the UNITAID NGO delegation; the GAVI Alliance delegation; and the IHP+ delegation. The objective was to clarify and raise awareness among all participants as to the most important strategic, policy and advocacy issues and objectives of the delegations themselves as well as, where possible and relevant, those of their affiliated institutions.

Delegations' presentations highlighted a wide range of advocacy and policy priorities for the institutions and their civil society representatives. For example, the relatively narrow and specific focus of UNITAID—on issues such as patent pools and improved supply-chain management systems for pharmaceuticals and other HIV/AIDS, TB and malaria commodities—contrasted with the following strategic issue (just one of six total) listed in the presentation by the GFATM Developed Country NGO delegation: "equity, access, evidence: gender, medicines issues, vulnerable groups, etc." (The presentations themselves can be found as part of the background information on the ICSS website, at www.icssupport.org)

2.2 Identifying cross-cutting issues

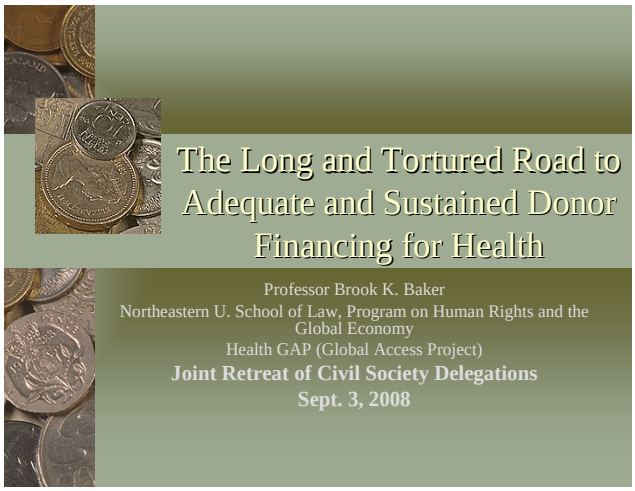
Ultimately, however, the presentations disclosed more commonalities and similarities—what could be termed 'cross-cutting issues'—than differences. Most delegations noted that they were concerned about, among other things, the following in regards to program implementation from the civil society perspective:

- human resource limitations at country-level health systems, which serve as persistent implementation bottlenecks;
- ensuring diversity (particularly regarding gender) in civil society leadership, representation and influence;
- the quality and extent of (appropriate) technical support at the local level;
- insufficient or ineffective civil society representation—shortcomings that are even starker in regards to vulnerable populations—on key policy-making entities such as GFATM Country Coordinating Mechanisms (CCMs);
- barriers to effective communications both in-country and globally, including those related to language, culture and technical constraints (e.g., poor telephone and Internet links);
- lack of expertise and capacity regarding (among other things)
    - basic management issues, such as how to set up and run an organization,
    - complex technical issues, such as intellectual property and trade rules that greatly influence access to affordable medicines and other commodities,
    - global health policy issues, such as financing mechanisms, political dynamics, macro-economic framework, resource allocation and spending, and
    - how to evaluate and contribute to a national plan;
- lack of capacity among civil society organizations to adequately fulfil essential monitoring roles (e.g., "watchdogging");
- inadequate efforts to identify, train and support new civil society leaders, especially young ones; and
- lack of clarity as to what it means to be accountable—and how to actually ensure that accountability is achieved.

The consensus among participants was that there are two overarching priority problems that could conceivably be addressed by an ICSS-supported coordination initiative. For one, they noted that nearly all of the cross-cutting issues point to severe capacity constraints and limitations at the national/local level, a situation that is particularly problematic from a civil society perspective because of the sector's important and extensive role in direct service delivery and grassroots advocacy. The second gap stemmed from participants' general agreement that more mechanisms are needed for sharing information and issues with counterparts in other institutions. One reason is that there currently is no systematic effort or strategy to allow civil society representatives to share experiences, observations and suggestions in a timely, comprehensive way.

2.3 Key global health issues, priorities and challenges: Presentations by experts

A handful of presentations by experts were intended to familiarize participants with some notable, timely and thought-provoking global health issues and challenges. The goal of these presentations was to promote awareness among representatives, with the expectation that attendees would consider ways to disseminate that information to their constituents and, where possible, utilize the knowledge and observations in their own work. This section contains summaries of the presentations' highlights only; full texts (and sources used by presenters) are available, including in PowerPoint format, on the ICSS website at www.icssupport.org.



Presentation 1: 'The long and tortured road to adequate and sustained donor financing for health' (*Prof. Brook Baker, Northeastern University School of Law's Program on Human Rights and the Global Economy and Health GAP*)

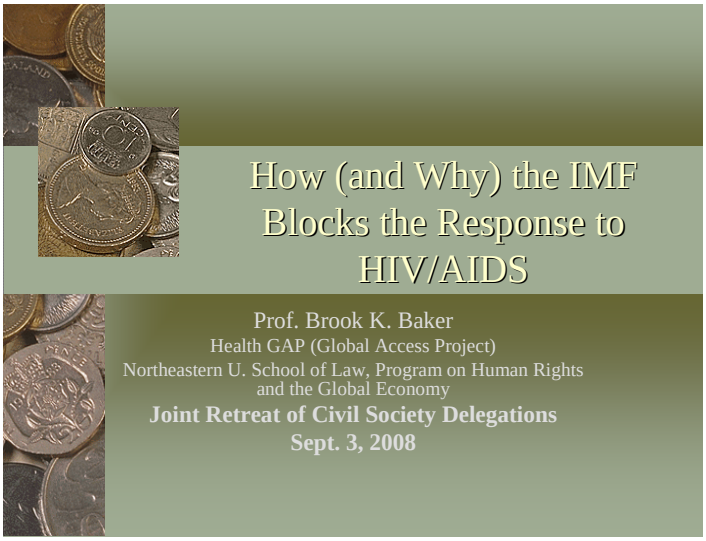
Baker's presentation focused on data, information and observations regarding current global health spending—domestic health spending and development/donor assistance for health (DAH)—and global health resource needs and financing gaps. He stressed the wide gap between developing countries' share of the global disease burden (92 percent) and their share of total health spending (12 percent of the global total). At the end of 2007, only three African countries—Botswana, Mauritius and the Seychelles—were meeting their 2001 Abuja Declaration commitment to spend 15 percent of the government's self-funded budget on health. Moreover, in most developing countries health spending is out of pocket (70 percent in low-income countries and 50 percent in

African countries).

The needs therefore remain great in much of the world. DAH has risen sharply in recent years, from $6.8 billion in 2000 to some $16.7 billion in 2006, but it still accounts for less than 5 percent of total developing country health spending. Most observers agree that greatly increased donor assistance for health is essential to ensure that countries have any realistic chance of meeting health-related components of the UN's Millennium Development Goals (MDGs). The World Bank, for example, estimates that between $25 billion and $70 billion in additional aid is needed per year for the MDG health goals to be met by 2015.

Baker noted, however, that such estimates may be far too low, especially when critical HRH (human resources for health) and HSS (health systems strengthening) priorities are included. He listed the following estimated global health funding gaps through 2015: $100s of billions for HRH, including education, costs and higher salaries for personnel; $121 billion for HIV/AIDS phased scale-up; $18.5 billion for tuberculosis; $33.87 billion for maternal and newborn health; and $30.5 billion for malaria. Baker said that the overall global health funding gap through 2015 could total $740 billion.

Inadequate as it may already be, DAH also faces competition from other priority needs. Poor countries have compelling and legitimate needs in education, infrastructure and economic development, for example. Perhaps the most pressing recent concern is that food and fuel shocks have increased in scope and severity throughout much of the world. Such shocks not only limit consumers' purchasing power, but have adverse effects on inflation, government spending and currency reserves in net importing countries—all factors that often lead to even tighter macroeconomic constraints from the IMF.



Presentation 2: 'How (and why) the IMF blocks the response to HIV/AIDS' (*Prof. Brook Baker, Northeastern University School of Law's Program on Human Rights and the Global Economy and Health GAP*)

In his second presentation, Baker provided background information and observations on the IMF's institutional role and practices. The organization's extensive and (some would say) out-sized influence in the developing world stems from the conditions it places on loans to resource-constrained nations. The

overall themes of Baker's presentation were that

- IMF macroeconomic stability and fiscal restraint policies prevent needed expenditures on HIV and other health programming, whether funded from domestic or donor resources;
- new evidence documents that IMF policies restrict spending of new aid funds in sub-Saharan Africa and that IMF policies are correlated with worse disease outcomes; and
- independent, academic and NGO critiques reject IMF conditionalities and strategies and urge more expansive, pro-growth and pro-health policies.

The main part of this presentation centred on explaining **key IMF assumptions** on issues such as

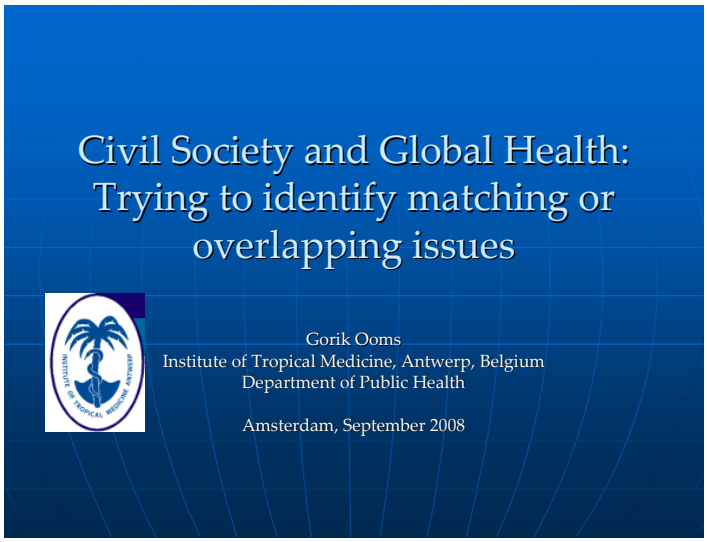
- macroeconomic stability (e.g., the IMF's strong belief in the necessity of single-digit inflation and very low fiscal deficits);
- foreign currency reserves (IMF: they should be kept high as a safeguard against, most notably, commodity price shocks);
- debt repayment (IMF: this should always be recipient governments' first priority when deciding where to allocate revenues);
- public spending (IMF: much government spending is "largely unproductive");
- health spending (IMF: such spending is not "productive");
- wage caps and budget ceilings (both are common conditionalities in IMF loans);
- free trade (IMF: tariff barriers should be eliminated because building an export-centred economy is the best way to ensure growth);
- foreign aid is unreliable (IMF: therefore it is best spent on achieving macroeconomic stability, not on social programs such as health); and
- foreign aid is unsustainable (IMF: therefore, expanding domestic revenue should take priority over increasing public expenditures).

Critiques of such assumptions and resulting conditionalities were provided from both economic and health-related standpoints. For example, one analysis noted that there is little evidence to support the IMF's focus on keeping inflation below the 5 percent level in low-income countries. Some economists believe the IMF should consider the supply-side benefits of additional spending on spare capacity utilization, investment, and future output growth.

From a health standpoint, reports were cited indicating that higher TB rates and deaths correlate with IMF programs; that there is a 30.7 percent decrease in mortality associated with exiting IMF programs; and that IMF programs correlated to large decreases in government expenditure, TB program coverage, and the number of physicians per capita.

Baker concluded by recommending that NGO campaigns focus on the following:

- the IMF should support broader and deeper debt cancellation;
- governments must be forced to instruct the IMF to drop conditionalities and to allow needed investment in health and education; and
- the IMF should allow outside experts and public stakeholders to participate in developing alternative policy scenarios and in impacting policy decisions.



Presentation 3: 'Civil society and global health: Trying to identify matching or overlapping issues' (*Dr. Gorik Ooms, Institute of Tropical Medicine, Antwerp, Belgium*)

Ooms' presentation had two distinct parts: i) a historical overview of attitudes regarding global health among what he termed the "international community", and ii) a global health financing proposal he developed to serve as an example of the kind of visionary mechanism needed to fully address gaps and constraints in health care access.

In the first part, Ooms defined two competing strategies for development, "structural adjustment" and "liberation/emancipation". Structural adjustment is a concept and strategy touted by the IMF, World Bank and many other donors: it is based on the belief that reducing the role of the state, reducing public expenditures, and privatizing social services will foster economic growth—and that this resulting economic growth will in turn provide social services. Some economists, policymakers and academics on the left, meanwhile, strongly support what Ooms calls the liberation/emancipation philosophy: this holds that priority should be given to empowering communities at the local and grassroots level to make them less dependent on their own governments (which the philosophy's backers believe are inherently evil) and the international organizations backing those governments.

Ooms said that many people in need have been denied higher levels of assistance and resources by what he called a "devil's pact" between structural adjustment and liberation/emancipation. This pact results in "the stupid idea that the provision of essential social rights should be financed through domestic resources."

He gave an example of one major consequence, lack of sufficient or adequate international health aid, in Malawi, one of the world's poorest and high-disease burden nations. According to Ooms, recent data indicate that the country has a per capita gross domestic product (GDP) of $163. In an optimistic scenario, the country could generate the equivalent of 20 percent of GDP as government revenue per year (about $32 per capita) and allocate 15 percent of that to government health expenditures (about $5 per capita per year). That amount is just 12.5 percent of the minimum level of $40 per capita needed to provide even basic, comprehensive health care.

The second part of Ooms' presentation was a thought experiment aimed at breaking the devil's pact and developing a "common vision". He based his "2 cents campaign" proposal on International Labour Organization (ILO) calculations that "less than 2 percent of the global GDP would be necessary to provide a basic set of social security benefits to all of the world's poor." If, he said, all humans agreed to put 2 percent of all they earn into a global social protection fund, an estimated $1.2 trillion could conceivably be raised each year (based on global GDP of $60 trillion a year). Assuming a global population of about 7 billion people, that would create an "entitlement" of $171 for each individual.

That amount could correspond to, for example, $43 per capita per year for health (25 percent of total entitlement); $43 for education (25 percent); $34 for food security (20 percent); $17 for safe water (10 percent); and $17 for housing ($10). Such a strategy would, Ooms said, create an "essential social rights floor" on which countries can and should build their own social protection. Specialized mechanisms could be developed to allocate funds collected for such priorities. A "2 cents campaign" could consist of a $300 billion Global Health Fund, a $300 billion Global Education Fund, a $240 billion Global Food Security Fund, etc.

Ooms acknowledged that such a plan seems completely unrealistic in the current world. He noted, however, that civil society had led the way in defeating a type of devil's pact that assumed HIV/AIDS treatment could not be provided cheaply and efficiently around the world. "We did it for the fight against AIDS," he said, which means "we can do it for comprehensive primary health care, for education, for food security, for water, for housing", etc. The first step, he concluded, is to develop a common objective and common framework.

3. Roundtable summaries and recommendations

The cross-cutting issues listed in Section 2.2 formed the basis for a series of roundtables structured as break-out discussions for small groups. Participants were asked to identify key issues related to the roundtable topic and recommend policies or action steps for a joint civil society initiative to consider.

A total of five roundtables were held; the topics included:

- accountability
- national level capacity
- global level capacity and leadership
- communications
- UNAIDS and GFATM thematic issues

Summaries of the roundtable discussions are listed in Sections 3.1 through 3.5. Where relevant, recommendations arising from the discussions are presented. In keeping with the meeting's goals, participants were asked to develop recommendations aimed at strengthening civil society collaboration, coordination and capacity so as to better serve constituents. As noted in Section 4, the recommendations grouped by roundtable discussion will serve as the basis for the identification of priority areas and subsequent development of action plans.

3.1 Accountability

The concept of accountability received special attention during the meeting. Not only was it identified as a cross-cutting issue of interest to all delegations, but more broadly it has been the subject of several papers and seminars involving civil society advocates, including at the August 2008 International AIDS Conference in Mexico City.

There are two distinct forms of accountability relevant for civil society delegations such as those attending the Amsterdam meeting: i) governmental or institutional accountability (e.g., seeking to ensure that government agencies meet their international commitments), and ii) civil society delegation members' own accountability as representatives of their communities and constituents. Discussions at this meeting focused on the second form, with particular attention paid to issues such as legitimacy, transparency and effective representation.

Participants defined accountability in this sense as fulfilling expectations (as spelled out in terms of reference); communicating regularly, clearly and credibly with constituents; and basing advocacy strategies on priorities and needs identified by those they represent. They agreed, however, that it was not always easy or possible to meet these objectives.

Recommendations

The importance of accountability to participants was reflected in the fact that the topic was the subject of a full group discussion as well as an individual roundtable. Based on those two separate discussions, the following were among the suggested steps and activities that civil society delegations could take collaboratively to improve accountability:

1. Craft an ethical and accountability framework that specifically outlines expectations, rules and objectives regarding conflict of interest, transparency and quality of representation. Such a framework could be developed from existing NGO codes of good practice.

   This process could include agreement on a set of "non-negotiables" as a

base from which to build true accountability. Such an effort would benefit from having a common civil society voice and agreement. A preliminary list of non-negotiables could include the following: health as a human right, gender equity and equality, zero tolerance for corruption, evidence-based decision-making and advocacy development, and opposition to tokenism.

The framework document would be agreed to and signed by all civil society delegations. It would include the list of non-negotiables and the processes for enforcement. (One such process would be that any breach of a non-negotiable should at first be addressed internally [by members of the specific delegation] and, if that proves unsuccessful, by an external panel or individual identified in advance).

2. Create and regularly monitor compliance with a set of key performance indicators (KPIs). Specific KPIs could include i) stating how representatives' decisions were based on constituents' active input, ii) mandating specific follow-up procedures showing impact and outcomes, and iii) mechanisms to evaluate, monitor and (if necessary) replace representatives. The KPIs could be developed for and by the individual delegations and/or integrated in the ethical framework as well.

3. Establish review mechanisms to set and regularly review guidelines regarding accountability. A sector-wide peer review panel could be charged with addressing complaints.

4. Establish mechanisms to improve documentation of informal and formal consultations with constituents. Also potentially useful in this area would be for delegations to draft and distribute annual reports and to require representatives to submit end-of-term/end-of-office reports. Such steps would not only more clearly indicate what was achieved (and how), but would greatly improve the transfer of institutional and experience-based knowledge to successors.

5. Establish mechanisms to increase communication, particularly at the grassroots level, in order to improve consultation processes.

3.2 National level capacity

As noted in Section 2.2, increasing and improving the capacity of civil society at the national/local level was identified as a particularly vital overarching priority by all meeting participants. Improved capacity at this level would enable civil society to better influence national health plans and institutions to ensure that health systems work for all, especially poor and marginalized people. To that end, greater civil society impact is needed during drafting, implementation and monitoring of national health and disease-specific strategies and budgets, national health policies in general, Poverty Reduction Strategy Papers (PRSPs) and sector-wide approaches (SWAps), among other priorities.[3] Increased capacity would also help improve downstream service delivery, support health workers and safeguard human rights, particularly in regards to access to health care.

Capacity in this context includes both financial and human resources. Currently, the extra demand placed on a few well-capacitated Southern CSOs by international organizations, researchers etc, puts strain and pressure on these organizations, whose staff already have full-time jobs to carry out. Most civil society organizations from the South also lack adequate human resource capital

[3] Information about PRSPs and SWAps may be found in Appendix 2.

due to financial constraints. Resource mobilization efforts are needed to address both kinds of limitations, and to be effective they should also consist of more adequate and appropriate training of local advocates—which points directly toward the need for better coordination among civil society representatives at all levels.

Both internal and external support, from other civil society entities as well as donors, were identified as being indispensable to future efforts to boost civil society capacity at the national/local level. The following were among the recommended activities:

1. Recognize and use existing opportunities, which in practice means not recreating the wheel in terms of building new structures when existing ones could be shored up.
2. Build expertise among local advocates in areas such as identifying national priorities, policy analysis, lobbying and negotiations with government.
3. Increase access to information about best practices and best tools.
4. Improve local organisations' capacity to initiate and follow processes and manage human and financial resources more effectively.
5. Identify, groom and support new advocates and policy-makers from the civil society sector. This is an important step toward building new leadership.
6. Foster the use of Southern academia and think tanks. This would require greater efforts to identify and build the capacity of existing ones as well as support the creation of new institutions in the South.

3.3 Global level capacity and leadership

Strengthened civil society capacity at the national/local level also requires improved capacity and leadership at the global level, including among delegation members to institutions such as UNAIDS and GFATM. Roundtable participants concluded that enhanced civil society impact at the global level requires being recognized as a credible, legitimate and respected source of information and policy recommendations.

One potentially useful step toward this goal would be the development and support of a pool of civil society experts. Such individuals would help develop the core competence and expertise of civil society in global discussions on, for example, national health plans and intellectual property/patent issues. Creating such a pool would require significant financial and human resource support, training and an ongoing commitment characterized by appropriate long-term planning. However, the ultimate benefits are likely to be substantial in terms of enhanced civil society engagement in policy and planning on a meaningful level. Such developments should in turn create greater opportunities for civil society capacity-building and resource mobilization at the national/local level.

The following were among the other recommended activities designed to improve global civil society capacity and leadership:

1. Place greater priority and effort on establishing contacts and relationships outside the civil society sector, including with international and government stakeholders. Appropriate preparation and support may be needed to ensure that interaction with such individuals and institutions is fruitful and positive.

2. Work toward the creation of and commitment to a broad code of conduct among civil society, particularly advocates and organisations focusing on HIV/AIDS and other health issues. The goal would be to reduce infighting

and increase solidarity and collaboration.

3. Develop and implement mechanisms to improve knowledge transfer. Such steps might focus on
    - mentoring, shadowing, and fellowship/internship programs, especially for younger advocates,
    - increased coordination and support across the sector for policy and advocacy papers,
    - placing greater priority on emotional support, which would include non-technical support to stakeholders and advocates engaged in difficult, stressful and complicated endeavours, and
    - recognizing and accepting diversity, in particular regarding how people from different cultures and backgrounds learn, interact and develop strategies. This point is important to consider when efforts are made to develop and obtain buy-ins for single global approaches to issues.

3.4 Communications

The overriding premise of the communications roundtable—and discussions regarding the topic throughout the meeting—was that effective accountability and coordination rely on adequate and well-designed communications channels and processes. Moreover, it was agreed that ensuring consistent and effective communications across civil society networks and structures should be a shared responsibility for all delegation members and representatives, not just CFPs.

Participants discussed the various systems and consultation processes that delegations currently have in place. The benefits and liabilities of those processes were subsequently examined in light of persistent challenges that hinder communication from a vertical perspective—between representatives and their constituents—and horizontally (among different delegations at the global level, and among national level stakeholders in different regions and contexts). Some of the challenges stem from inadequate structures and mechanisms to facilitate communications. Others, meanwhile, are related to capacity limitations.

For example, delegations and institutions may have listservs and email groups in place to solicit input from members and to share experiences and information. However, many members may be unfamiliar with or uncomfortable communicating (especially in writing) in English, which is nearly always the default language. They may therefore feel intimidated and refrain from participating as regularly or extensively as others. They may also be particularly affected by another common complaint from all participants: the amount of email received is often so massive as to be impossible to manage. The sheer volume has the added effect of making it difficult to gauge the importance or value of individual messages and to know which ones require responses.

In addition to such challenges, participants came up with a series of recommendations aimed at establishing more effective communications systems and procedures. As with the challenges, several of the recommendations focus on capacity limitations, while others are aimed at technical/technological constraints. The following are among the recommendations discussed:

1. Create a joint website to be shared by all civil society delegations working on global health issues. Such a website could be structured as an Intranet, which would mean it is password-protected and inaccessible to outsiders. This site would be a relatively inexpensive and simple way to improve coordination and communications because participants could easily post a

range of documentation from meeting agendas to lengthy policy papers. This central repository could also play an important role as a guarantor of institutional memory across the sector and among individual institutions.

2. In terms of improving consultation structures, carry out a pilot trying out a few models of broader consultation on more general issues (i.e., the implications of National Strategy Applications [NSAs] by the GFATM). Such a consultation could be initiated by the delegations and led at the country level by using existing structures and mechanisms such as regional focal points, National Partnership Platforms, the Civil Society Action Team (CSAT), and the technical support hubs of the International HIV/AIDS Alliance.

3. Empower advocates and representatives at all levels to communicate more confidently and effectively in English. This could consist of helping people get access to more language training services and to provide financial support for their efforts.

4. Better take into account cultural diversity and sensitiveness and how communication may be impacted by culture, language, etc.

5. Promote an increase in the number and type of documents that are translated from English into other languages, particularly those that are spoken relatively widely across regions. Additional effort should be made to distribute them effectively to where they are most likely needed (and/or are requested) at the national/local level.

6. Consider ways other than printed material to get information and resources to people, especially constituents at the grassroots level.

7. Identify measures to widen regular participation on listservs and promote a climate supporting equal and active engagement of all members.

3.5 UNAIDS and GFATM thematic issues

This roundtable focused on a range of issues considered important from a civil society perspective in regards to future developments at UNAIDS and GFATM. For example, UNAIDS is currently preparing for its December 2008 meetings, which will include a one-day thematic session on the relationship of the Global Fund and UNAIDS.

The goal of the roundtable was to identify key priority areas of common interest across delegations and (by extension) their constituents. These areas could then be raised by civil society representatives at UNAIDS and GFATM when and where appropriate.

One priority area centred on eligibility criteria for continued and increased support, particularly in regards to GFATM grants. This issue is especially important for (upper) middle-income countries that may no longer be eligible to apply for GFATM assistance even though they have significant and expanding HIV epidemics. Participants suggested that civil society representatives at GFATM seek to reframe eligibility criteria to ensure that resources are not denied those in need in such countries. Potential issues to emphasize are i) the importance of ensuring the continuation of treatment and services; ii) the need to determine more realistic epidemiological data and trends so as to have a more accurate portrait of national level epidemics, a step that is especially vital given that countries are eligible to apply if they can prove 5 percent prevalence among

certain key groups; iii) the extent, severity and impact of HIV-related stigma and discrimination, particularly regarding vulnerable groups such as injecting drug users, sex workers and men who have sex with men; and iv) the development of strategies to encourage cost-sharing schemes.

Other issues discussed during the roundtable included the following:

- Ensuring that civil society is involved, engaged and as influential as possible in all initiatives discussed, especially GFATM/NSA development and IHP+/Compact development (see Appendix 2).

- How to improve the functioning of and civil society representation on CCMs. For example, it would be useful to carefully consider what questions to ask and how to ensure that UNAIDS facilitates technical support to increase civil society access to and participation in these crucial GFATM bodies.

- Ensuring that the needs and rights of sex workers are adequately considered by GFATM and UNAIDS policymakers at all levels. Potentially useful steps in this regard could include greater recognition and support for evidence-based programming and increased consideration of how to use technical assistance to support sex worker communities and networks.

One recommendation aimed at addressing these issues was for UNAIDS to organize one or a series of meetings on a regular basis to inform civil society actors at country and regional level about recent developments and changes at GFATM. Such meetings could also serve to remind attendees of the civil society sector's rights and responsibilities under GFATM procedures, including in regards to CCM membership. UNAIDS might also consider providing more direct technical support at the local level to civil society groups already receiving or considering applying for GFATM assistance.

4. Next steps and follow-up

The introductory nature of the meeting largely precluded the determination of specific action steps and activities to achieve defined goals. The discussions did, however, result in a large number of recommendations aimed at improving civil society coordination and communication in the global response to HIV/AIDS and broader health issues. Those recommendations are grouped by roundtable topic throughout Section 3. In a broad sense, the recommendations clustered around two main issues: improving communication among delegations at the global level, and leveraging civil society capacity and resources at the national/local level.

Participants agreed that the next step would include reviewing all recommendations to select priority areas and activities. That step would be led by delegation CFPs, with support from ICSS and consultation with other meeting attendees. Upon selection of priority activities, concrete action plans would be drafted to implement them. Those plans would also include mechanisms to monitor and evaluate the activities and to ensure that appropriate resources (financial and otherwise) are available where needed.

Significant positive support was expressed for a suggestion to consider small pilot initiatives for some of the activity areas. Such an approach was considered particularly useful for potential consultations involving civil society at the national level on issues such as National Strategy Applications and how to better understand, respond to and influence national HIV and other health programmes. The lessons learned from a few pilot initiatives in this area could be useful in determining how and to what extent the effort is rolled out elsewhere.

It was agreed that ICSS and the delegation CFPs would develop a timeline for the process of identifying priority areas and developing and implementing action plans. Adequate time would be allocated during each step of the process for comments and feedback from all involved. The overall goal is for concrete activities to begin early in 2009.

The process will also be supported, reviewed and altered (if deemed appropriate) during additional meetings over the next two years. At the very least, it is expected that ICSS will organize and support one annual meeting for the same delegations who attended the September 2008 gathering. One or more smaller meetings were also being considered, most likely to comprise CFPs and/or individuals working directly on civil society communications issues at the country level—an important priority to help determine challenges and successes.

Participants also agreed that it would be useful and appropriate to have the next group meeting in the global South, preferably in the first half of 2009. That step would not only signal a clear recognition of the importance of country level work, but could also provide an opportunity to connect with local civil society and invite local government officials and help raise their awareness about civil society's vital role in the health and HIV/AIDS response.

Appendix 1. List of participants

The following individuals attended all or part of the meeting held in Amsterdam from 2–5 September 2008. Also included is a list of delegates invited but not able to attend.

Name	***Country***	***Position***
UNAIDS PCB delegation		
James Kayo	Cameroon	Delegate Africa
Vitaly Djuma	Russia	Delegate Europe
Michael O'Connor	Canada	Delegate North America
Mercy Machiya	Namibia	Delegate Africa
Gulnara Kurmanova	Kyrgyzstan	Delegate Asia and the Pacific
Violeta Ross	Bolivia	Delegate Latin America and the Caribbean
Sara Simon	Belgium	Communications Facility
Greg Gray	Thailand	Communications Facility
Global Fund Communities delegation		
Javier Hourcade Bellocq	Argentina	Board member
Carol Nyirenda*	Zambia	Alternate Board member
Shaun Mellors	UK	Communications Focal Point
Global Fund Developing Country NGO delegation		
Karlo Boras	Serbia	Alternate Board member
Cheick Tidiane Tall	Senegal	Communications Focal Point
Bobby John	India	Delegation member
Global Fund Developed Country NGO delegation		
Asia Russell	USA	Board member
Mohga Kamal-Yanni*	UK	interim Alternate Board member
Jacqueline Wittebrood	Netherlands	Communications Focal Point
UNITAID Communities delegation		
Carol Nyirenda	Zambia	Board member
UNITAID NGO delegation		
Khalil Elouardighi	France	Board member
Mohga Kamal-Yanni	UK	Alternate Board member
Robert Doble	UK	Liaison Officer UNITAID delegations
GAVI delegation		
Faruque Ahmed	Bangladesh	Board member
Jane Schaller	USA	former Board member
IHP+ delegation		
Sue Perez	USA	Representative

Presenters		
Prof. Brook Baker	USA	Health GAP / Northeastern University
Dr. Gorik Ooms	Belgium	Institute of Tropical Medicine Antwerp
Support team		
Peter van Rooijen	Netherlands	lead facilitator
Jeff Hoover	USA/SA	rapporteur
Raoul Fransen	Netherlands	ICSS

Invited but unable to attend		
Elizabeth Mataka	Zambia	Global Fund Board member Developing Country NGO delegation, and Vice-Chair of the Board
Esther Tallah	Cameroon	UNITAID Communities delegation
Sandra Batista	Brazil	UNAIDS PCB NGO Delegate for Latin America and the Caribbean
Vince Crisostomo	Thailand	UNAIDS PCB NGO Delegate for Asia and the Pacific
Sonja Weinreich	Germany	UNAIDS PCB NGO Delegate for Europe
Zonibel Woods	USA	UNAIDS PCB NGO Delegate for North America
Alan Hinman	USA	GAVI Alternate Board member
Elaine Ireland	UK	IHP+ representative

** Carol Nyirenda and Mohga Kamal-Yanni are involved in both the Global Fund and UNITAID delegations as (Alternate) Board members*

Appendix 2. Glossary of key terms, concepts and initiatives

This section includes a brief overview of terms, concepts and initiatives that were explained to meeting participants in presentations at various times during the gathering. All are currently or likely to be important for civil society stakeholders at all levels to recognize and understand. One of the key communications challenges will be building awareness and capacity about them at the national level.

The following are discussed in this glossary: National Strategy Applications (NSAs); sector-wide approaches (SWAps); Poverty Reduction Strategy Papers (PRSPs); costed national AIDS plans; WHO's Positive Synergies initiative; and the International Health Partnership and Related Initiatives (IHP+).

National Strategy Applications (NSAs)

The GFATM Board recently agreed to establish a modified application process for supporting national health strategies, called National Strategy Applications. This new approach aims to ensure that GFATM'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 will enable requests for Global Fund financing based primarily on an existing national strategy, which has been validated against agreed attributes (or criteria) using a non-Global-Fund-specific validation approach.
In one sense, it can be viewed as donors pooling their money into an overall national health programme. GFATM funds would flow into broad-based national health plans as well, with the only requirement that the country continue showing that it is meeting the disease-specific focuses identified in the original GFATM grant(s).

Civil society's role in NSA processes is not yet clear, given that the approach is so new. As such, there are few real or proposed mechanisms to measure civil society interaction, engagement and monitoring of NSAs. One hypothetical situation raised during the Amsterdam meeting was the development in a country of a national strategy that, despite the high number of injecting drug users, does not fund or prioritize harm reduction services. Civil society's ability to actively oppose this approach would depend at least in part on monitoring capacity and support. Therefore, one major priority for civil society would be to ensure that national plans are developed openly and transparently.

Sector-wide approaches (SWAps)

As defined by the UK Department of International Development (DFID), "SWAps are a form of programme aid directed to particular sectors. Within a SWAp, government and donor funding for a sector is directed towards the achievement of a holistic sectoral strategy which has been matched to available resources and implementation capacity. A single SWAp can incorporate a variety of different funding mechanisms, whether sector budget support, off-budget pooled funds, or projects."

SWAps are basically a consolidation mechanism. The concept stemmed from dissatisfaction with a more traditional development aid scenario in which many different donors fund many different sectors and projects in one country. That seems inefficient to many: why not, for example, consolidate all aid through one government agency (e.g., the Ministry of Health)? Thus the idea behind SWAps is that project funding is out, and sector-wide funding, based more directly on

government priorities, is in.

Most civil society observers agree that SWAps have both pros and cons. On the positive side, they allow governments to play a much more proactive role in identifying priority areas and, for example, spreading resources more widely. They also reduce the number and range of complicated reporting and monitoring mechanisms that officials must comply with when dealing with many different donors with a range of often dissimilar requirements.

On the negative side, however, SWAps could actually increase the influence of donors who otherwise would have had little say in national policy-making. For example, a donor government that funds a tiny fraction, say 0.05 percent, of a country's health budget is included in the SWAps mechanism and may feel emboldened to ask about all elements of the country's health sector and related policies. Such a possibility could negate the beneficial impacts of consolidation.

Other concerns regarding SWAps are i) disbursement tends to be slow, ii) it can be difficult to link funds allocated with real health outcomes, and iii) governments have greater leeway to pick and choose the civil society organisations receiving funds. This third potential outcome can limit innovation and independence within the civil society sector because organisations are fearful of displeasing government officials or criticizing policies.

Poverty Reduction Strategy Papers (PRSPs)

Poverty Reduction Strategy Papers (PRSPs)[4] are prepared by governments in low-income countries through a participatory process involving domestic stakeholders and external development partners, including the International Monetary Fund (IMF) and the World Bank. A PRSP describes the macroeconomic, structural and social policies and programs that a country will pursue over several years to promote broad-based growth and reduce poverty, as well as external financing needs and the associated sources of financing

The PRSP approach, initiated by the IMF and the World Bank in 1999, results in a comprehensive country-based strategy for poverty reduction. The introduction of PRSPs was a recognition by the IMF and the World Bank of the importance of ownership as well as the need for a greater focus on poverty reduction. PRSPs aim to provide the crucial link between national public actions, donor support, and the development outcomes needed to meet the United Nations' Millennium Development Goals (MDGs), which are centred on halving poverty between 1990 and 2015. PRSPs provide the operational basis for IMF and World Bank concessional lending and for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative. They are made available on the IMF and World Bank websites by agreement with the member country.

PRSPs are utilized in the developing world to help guide countries' economic planning. Although they sound beneficial in theory, many civil society advocates claim that they are merely a way for IMF and World Bank officials—who usually draft them without meaningful input by civil society—to apply longstanding restrictive policies in the guise of fighting poverty. In reality, these advocates say, PRSPs still require governments to hold down or even reduce public spending, even for crucial health needs, in order to meet unnecessarily rigid inflation and spending targets.

[4] The text in the first two paragraphs of this brief description was obtained from the IMF's website: www.imf.org/external/np/exr/facts/prsp.htm

Costed national AIDS plans

Central to the principles of the Three Ones and the Global Task Team recommendations is the development of a costed, prioritised, multi-sectoral national AIDS framework.

These frameworks will: *"drive implementation, emphasise results and provide a solid basis for the alignment of multisectoral and international partners' support; within related efforts to progressively strengthen national AIDS frameworks and root them in broader development plans and planning processes"* (Global Task Team 2005).

A comprehensive multi-sectoral response is most likely to yield results where there is strong alignment between national development instruments, particularly PRSPs (or national development plans), Medium Term Expenditure Frameworks, the national AIDS framework and sector and local government plans. Therefore the national AIDS framework is essentially the central planning tool that both provides and reflects guidance to the contributions from different levels and sectors and is the key plan behind which international donors will align their support. Alignment is dependent on the existence of formal linkages and networks between actors involved in developing PRSPs and other national development processes and instruments. A well costed national AIDS framework is essential if AIDS is to be implemented by multiple sectors and if AIDS is to be mainstreamed into broader budgeting processes.[5]

Put simply, the term "costed national AIDS plan" refers to a plan for which funding has been or will be available to achieve all objectives. Most advocates strongly push for such plans because they are more likely to be achievable, effective and sustainable over the medium- to long-term. (A plan that is not "costed" is one for which policy-makers make projections and objectives based either on weak or insufficient analysis, or on the unfounded expectation that necessary resources will be available down the line.)

As of March 2007, 92 out of 123 countries that held country consultations on scaling up towards universal access had set outcome targets in the key intervention areas, while 36 countries had incorporated these targets into their national strategic plan and costed these accordingly.[6]

UNAIDS has been at the forefront of efforts to support civil society in reviewing national AIDS plans to determine whether they can properly be defined as costed. To be successful, these efforts require significant capacity-building among civil society organisations at the national level.

Positive Synergies initiative

Positive Synergies refers to a World Health Organization (WHO) initiative officially launched at the International AIDS Conference in Mexico City in August 2008. The objective is to move beyond the debate (at least in some quarters) over whether global health initiatives (GHIs) such as GFATM and the GAVI Alliance distort or otherwise damage overall health systems in recipient countries by providing large amounts of money for relatively specific diseases or priorities. Positive Synergies is based instead on the belief that GHIs and national health systems can optimize their interactions and minimize negative impacts, thereby achieving their common goal of improving health outcomes.

[5] DFID Health Resource Center, National AIDS Coordinating Authorities: A synthesis of lessons learned and taking learning forward, Clare Dickinson, December 2005 - http://www.dfidhealthrc.org/publications/hivaids/NACAs.pdf
[6] http://www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/default.asp

The WHO initiative consists of a broad-based, international consultative process to create a base of evidence highlighting both the benefits and drawbacks of reliance on GHIs to achieve concrete health outcomes for specific diseases. What, for example, is the real impact of GHIs on funding for and attention to overall shared health goals, notably those not directly related to specific diseases? Is there evidence to support claims that, for example, GFATM-funded health systems strengthening programmes do not actually lead to an increase in the number of health workers, but merely increase competition by raising salaries?

As part of the initiative, WHO policymakers want to create a document that contains norms, standards and technical guidelines on how to leverage positive synergies. Based on data and evidence collected over the next several months, this document is intended to provide a road map for overcoming the debate between the merits of disease-specific funding on one side and broader health systems strengthening on the other.

Civil society's role in this process is likely to be extensive because NGOs are heavily represented at the grassroots and local level, where it is clear how and to what extent synergies have been achieved. Moreover, in many countries civil society implementers have been supported and enlisted to focus not only on disease-specific projects, but on complementary, broader public health goals.

International Health Partnership and Related Initiative (IHP+)

Launched in September 2007, IHP+ is an agreement among donors, multilateral agencies and developing countries that aims to accelerate progress towards the UN's health Millennium Development Goals (MDGs): eradicating hunger, reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

The primary output of the IHP+ is country level "compacts" between donors and developing country governments based on one single country plan; one single results framework; one single policy matrix; one single budget; and one single country-based appraisal and validation process for the country health plan. The aim is to simplify and coordinate the health-related aid processes and increase resources for health system strengthening—yet at the same time, ensure adequate and increased funding for the HIV/AIDS, TB and malaria responses.

Compacts are based on development plans and national health sector plan and budgets. As of September 2008, two compacts had been signed (Ethiopia on 26 August and Mozambique on 16 September), and at least three others are planned to be signed by end year.

The compacts' impact on civil society has yet to be known, and in any case will vary by country. However, experiences to date in Ethiopia and Mozambique indicate that civil society involvement in the compact development process has not been satisfactory. In both countries, civil society was not included from the start of the process and became involved only at the very end stages of compact finalization. Some observers believe that the very nature of the compact process—focusing on negotiations between the government and donors—limit civil society's influence on strategy development as well as its ability to monitor health spending. Concerns have also been raised about the fact that the compacts are not binding, which means (in the words of some meeting participants) that they "have no teeth".

Appendix 3. Overview of formal civil society participation in the governance of key international organizations

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (www.theglobalfund.org) was created to dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. It is a
partnership between governments, civil society, the private sector and affected communities.

Governance

The Board:

- Meets at least twice annually
- Responsible for overall governance, including approval of grants
- 20 voting members, divided into two blocks:
    - The donor block: 8 representatives from donor governments, 1 seat for Private Sector; 1 for Private Foundations.
    - The implementers block: 7 representatives from developing country governments and 3 representatives from civil society: 1 from the communities living with HIV, TB and affected by Malaria, 1 from the developing country NGOs and 1 from the developed country NGOs
    - 4 non-voting members [WHO, UNAIDS, World Bank (Trustee of GF funds) and host country Switzerland]
- 4 Board Committees, temporary in nature:
    - Policy and Strategy Committee
    - Portfolio Committee
    - Finance and Audit Committee
    - Ethics Committee

A Partnership Forum is convened every two years to provide persons and entities concerned about the prevention, care, treatment and eventual eradication of HIV/AIDS, tuberculosis and malaria, to express their views on the Foundation's policies and strategies.

Civil society participation

- Civil society delegations have equal rights to all other (voting) delegations.
- A delegation may bring ten people to each Board meeting. How the delegation processes are organized is decided upon by each delegation itself.
- There is a Civil Society Team at the Global Fund Secretariat in Geneva, currently a sub-unit within Global Partnership.

Current representatives[7]

Communities living with HIV, TB and affected by Malaria Delegation:
- Board Member: Javier Hourcade Bellocq
- Alternate Board Member: Carol Nyirenda
- Communications Focal Point: Shaun Mellors

Developing Country NGO Delegation:
- Board Member: Elizabeth Mataka (also Vice-Chair of the Board)
- Alternate Board Member: Karlo Boras
- Communications Focal Point: Cheick Tidiane Tall

Developed Country NGOs Delegation:
- Board Member: Asia Russell

[7] Current representatives are at the date of the meeting in September 2008 and may have changed since then

- Alternate Board Member: Mohga Kamal-Yanni
- Communications Focal Point: Jacqueline Wittebrood

Joint United Nations Programme on HIV/AIDS (UNAIDS)

UNAIDS (www.unaids.org) is a joint programme of the United Nations family and brings together 10 UN system organizations to help the world prevent new HIV infections, care for those already infected, and mitigate the impact of the epidemic.

- Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank.
- Based in Geneva, the UNAIDS Secretariat works on the ground in more than 75 countries world wide.

Governance

UNAIDS is guided by a Programme Coordinating Board (PCB):

- Established in 1994 by a resolution of the UN Economic and Social Council and launched in January 1996
- 22 government representatives from all geographic regions
- 10 UNAIDS Cosponsors
- NGO Delegation made up of 5 representatives and 5 alternates from civil society, which includes associations of people living with HIV/AIDS. Terms are two years with one renewable year if agreed by Delegation
- Meets twice annually
- Generally takes its decision by consensus

The Cosponsors and the UNAIDS Secretariat comprise the Committee of cosponsoring Organizations (CCO), which meets annually.

Civil society participation

- While the NGO delegation does not have voting rights, this delegation has significantly influenced PCB decisions
- As a result of a review of civil society participation in the PCB at the June 2007 PCB meeting, a Communication and Consultation Facility (CF) was established in April 2008. The objective of the CF is to strengthen NGO participation – and support enhanced incorporation of country- level civil society voices in PCB-related dialogue. The CF is an independent mechanism to provide support for internal delegation communications, and wider consultation with civil society.
- There is a Civil Society Partnership (CSP) team in the UNAIDS Secretariat whose role includes strategic support to the PCB NGO delegation.
- Currently recruiting for two North American, one Latin American, and one African representative.

Current representatives

Africa

- James Clovis Kayo [Cameroonian Network of Associations of PLWHA (RECAP+)],
- Ms Mercy Machiya [Southern African Network of AIDS Service Organizations (SANASO)], Alternate

Asia

- Vincent Crisostomo (The 7 Sisters, Thailand)
- Gulnara Kurmanova (AntiAIDS Association, Kyrgyz Republic), Alternate

Europe

- Vitaly Zhumagaliev (Russian Harm Reduction Network)
- Sonja Weinreich (Action Against AIDS, Germany), Alternate

North America
- Michael O'Connor [Interagency Coalition on AIDS and Development (ICAD)]
- Zonibel Woods (International Women's Health Coalition), Alternate

Latin America and the Carribean
- Sandra F. Batista [Rede Latinoamericana de Reduçâo de Danos (RELARD)]
- Gracia Violeta Ross [Bolivian Network of people living with HIV/AIDS (REBOL)] Alternate

Focal Point: Sara Simon

UNITAID

UNITAID is an international drug purchase facility to accelerate access to high-quality drugs and diagnostics for HIV/AIDS, malaria and tuberculosis in developing countries. Launched in September 2006, most countries contribute to UNITAID on the basis of the tax surcharge on air tickets. The Gates Foundation also takes part to UNITAID funding.

- Host: WHO
- Operating partners: WHO, UNICEF, Global Fund, Clinton Foundation, Global Drug Facility/Green Light Committee, Stop TB Partnership, Roll Back Malaria Partnership.

Governance

The Executive Board:

- Makes all decisions relating to UNITAID (except for those delegated to the Secretariat), including the approval of all partnership arrangements with other organizations and institutions.
- Generally takes its decisions by consensus
- 11 members:
    - 1 nominated by each of the five founding countries (Brazil, Chile, France, Norway and the United Kingdom);
    - 1 nominated by the African Union;
    - 1 from Asian countries (currently Korea);
    - 2 from civil society networks (NGOs and Communities of people living with the diseases);
    - 1 from foundations (currently Gates); and
    - 1 from WHO.

A Consultative Forum has been established as a platform for debate, advocacy, fund raising and inclusion of new partners, and to provide feedback.

Civil society participation

- Civil society delegations have equal rights to all other delegations.
- The Communities and NGO delegations hired a Communications Focal Point in September 2008.

Current representatives

Communities:
- Board Member: Carol Nawina Nyirenda (Treatment Advocacy and Literacy Campaign – TALC Zambia);
- Alternate Board Member: TBD;
- Observers: Louis Da Gama (Global Health Advocates/malaria) and Case Gordon (World Care Council/TB)

NGOs:
- Board Member: Khalil Elouardighi (ACT-UP Paris)
- Alternate Board Member: Mohga Kamal-Yanni (Oxfam UK)

- Observer: Anton Kerr (International HIV/AIDS Alliance UK)

GAVI Alliance

The GAVI Alliance (www.gavialliance.org) is a partnership of public and private sector to improve child health in the poorest countries by extending the reach and quality of immunisation coverage within strengthened health services.

- Unincorporated public-private partnership launched in 2000.
- Partners include UNICEF, WHO, the Gates Foundation, the World Bank, developing country governments, donor country governments, the vaccine industry, civil society groups, and research and technical health institutes.
- The GAVI Alliance is supported by the GAVI Secretariat in Geneva (hosted by UNICEF) and four affiliated charitable entities (The GAVI Fund, IFFIm Company, The GAVI Fund Affiliate and The GAVI Foundation). The GAVI Secretariat and GAVI Fund operate under the single leadership of the Executive Secretary and CEO.

Governance

GAVI has a board for each of its five entities. As a public-private partnership, the core of GAVI's strategic guidance and direction is vested with two independent Boards, with unique but complementary roles. The Alliance also relies upon two independent boards to oversee the financial affairs of the International Finance Facility for Immunisation (IFFIm) and the pledging of IFFIm proceeds for GAVI programmes (The GAVI Fund Affiliate).

The GAVI Alliance Board:

- Sets the programmatic policies for the Alliance, as well as monitors and oversees all programme areas.
- Does not have bylaws as it is not a legal entity. Its procedures are captured in its Guiding Principles.
- Meets in principle twice a year, with teleconferences held as needed. The meeting agendas are prepared by the Executive Secretary in consultation with the Working Group and the Chairperson. The Executive Secretary is the Secretary of the Board.
- Normally takes its decisions by consensus. Nevertheless should a vote be required each member will have one vote only. The decisions taken by the Board will not be considered as binding upon the organisations and will not override their respective governing bodies.
- 4 renewable members (WHO, UNICEF, The World Bank, and the Bill & Melinda Gates Foundation)
- 13 rotating members, with 3 year terms, including:
    - 4 from developing countries
    - 5 From industrialized countries
    - 1 from a research and technical health institute
    - 2 from the vaccine industry (1 industrialized country and 1 developing)
    - 1 from civil society

Civil society participation

- Civil society is represented on the Alliance board.
- It is the responsibility of the nonrenewable Board member whose term is coming to an end to undertake a timely and transparent exercise within the constituency to produce nomination(s) for a successor to the Board. The GAVI Executive Secretary provides support, including details of general and any specific selection criteria. The Executive Secretary may, on request of the Board member, jointly issue the invitation. All nominations will be subject to a Board consultation process, led by the Chair.

Current representatives
- Faruque Ahmed, Director BRAC Health Programme, Bangladesh,
- Alternate Alan R. Hinman, MD, MPH – The Task Force for Child Survival and Development.

International Health Partnership and Related Initiatives (IHP+)
IHP+ (www.internationalhealthpartnership .net) is a coalition of international health agencies, governments and donors to scale up coverage and use of health services to deliver improved outcomes in developing countries against the health-related Millennium Development Goals, while honouring universal access commitments.

- Global and country level 'compacts' will set out a process for the development and implementation of national health plans.
- Country level compacts are expected to include: 1 country health plan; 1 results framework; 1 policy matrix; 1 single budget; 1 country-based appraisal and validation process for the country health plan; and one mutual monitoring and reporting process.
- A work-plan for this and related initiatives, entitled 'Scaling Up for Better Health', has been prepared by WHO and the World Bank, in consultation with the partner health agencies (UN Population Fund, UNAIDS, GFATM, GAVI Alliance, and Gates Foundation).

Governance
A Scaling-up Reference Group (SuRG) comprised of WHO, World Bank, UNAIDS, UNFPA, UNICEF, GFATM, GAVI Alliance, Gates Foundation:

- Global level
- Business SuRG meets monthly to review progress and provide guidance on the IHP+ work-plan
- Steering SuRG includes, the H8 agencies, a wide range of development partners (i.e. donors), and selected IHP country partners. It meets bi-monthly to report on progress, in particular at country level

Core Team:

- Inter-agency
- based in World Bank (Washington), WHO (Geneva) and Brazzaville (WHO AFRO)
- facilitates the work overall

Civil society participation

- Civil society is currently represented on the business and steering SuRG.
- CS is undergoing a process to select Northern and Southern representation to the SuRG as well as a Communications Focal Point.
- CS representation at the country level varies by country and ideally comprises participation in the IHP+ country health sector teams.

Current representatives
Northern representation on the SuRG

- Sue Perez, Treatment Action Group (TAG) USA
- Elaine Ireland, Action for Global Health Europe

Southern representation on the SuRG

- To date, participation by a southern representative is based on which country is highlighted in each SuRG meeting in terms of progress towards developing a compact