Note for the Civil society engagement mechanism in UHC 2030: building an alliance to strengthen health systems

1. **Background:**

The SDGs framework result in a new approach for development. The inclusive consultation to build the global goals including all actors from global to local, demands an integrated approach to ensure its implementation. It requires a strong accountability system in place with the commitment of all actors behind it. In this new SDGs environment, under health objectives, UHC is one of the health target (target 3.8) able to support this integrated approach. UHC is the target that underpins the health goal by building strong and resilient health systems that give every person and community access to quality primary health care and other needed services of good quality that protect them from health threats without exposure to financial hardship. In this context, a UHC Alliance, building on the IHP+ initiative, is under discussion, with a clear mandate that includes building political momentum for UHC and strengthening accountability for UHC, which could be informed by the UHC accountability framework proposed by MSH and the Rockefeller Foundation with partners.[1]

One of the aspirations behind UHC -2030 is to reduce global and country disparity in access to health. The chances are in the absence of CSO participation both as implementers and advocates, CSOs voice would not be heard. CSOs would help to make voices from communities heard and advocate to influence policy design and implementation. The participation of civil society in the UHC Alliance and related accountability processes will be critical to bring attention to the needs of the most vulnerable communities and expose where duty bearers are failing to deliver on these needs. CSO's participation would thus assist in health policy and planning for their contribution to more equitable, rights-based and inclusive health systems – a role that has been long recognised and is well documented.[2]

In addition, CSOs role in accessing hard to reach and marginalized population group is also fully acknowledged and will act as a pivotal element for demand creation, helping to create the conditions for stronger community ownership of national and subnational health systems.

Both the UHC Alliance, and the proposed UHC accountability framework, are based on a multi-stakeholder approach. The composition of the Alliance should include the wide range of actors engaged in definition, implementation the monitoring and accountability with review and remedial action of health policies at the country, regional and international levels. Civil society in its diverse form[i] should participate as members of the Alliance, as representatives with

[1] Available at: http://www.msh.org/uhcaccountability

[2] Contribution of Civil Society to health in Africa , HPAF review, CSO contributions to GVAP implémentation

decision-making power on the Alliance Steering Committee, and as a coalition within the Alliance to raise political momentum and popular demand, to influence policy design and implementation and to drive efforts to strengthen citizen-led and social accountability mechanisms at sub national, national, regional and global level. This will be imperative to ensure the Alliance is inclusive and can deliver on both its mandate to drive accountability, and on the objective of the SDGs to leave no one behind.

As the IHP+ initiative, since its creation in 2007, counted in its structure a CSO contact group with representatives from northern and southern CSO, it seems logical (and the MSH/Rockerfeller Foundation options paper suggested it as well) to start thinking about the engagement of CSO in the UHC alliance based on what already exist while expanding the members, mandate, functions and expertise to be aligned with the new UHC Alliance. In the last couple of years, the IHP+ CSO Contact group and its activities to strengthen capacity building of CSO, was regularly assessed. Reports highlighted its added value, good practises as well as challenges that helped to improve the current proposal. [3]

This paper provides options for a structured mechanism for CSOs in order to ensure that CSOs effectively contribute to the objectives of the Alliance and influence its implementation, while strengthening the capacities for civil society to advocate and strengthen accountability for health systems and UHC at country, regional and global levels.

2. What a civil society engagement mechanism on UHC should look like:

a) Core functions of the civil society engagement mechanism in UHC Alliance 2030:

- Representing the CSO voice in UHC Alliance including participation in the UHC Alliance Steering Committee
- Facilitating information sharing across CSO network on advocacy and accountability efforts for health systems and UHC from global to local and vis and versa
- Monitoring of UHC implementation at country level with the production of an annual report
- Coordinating advocacy, consultations, communication and engagement of CSOs in global and regional UHC processes[4]
- Coordinating and collaborating with other related initiatives[5]
- Facilitate CSO Capacity building through TA on policy dialogue, planning and budgeting exercises, monitoring of sector performance as well as CSO-led social accountability mechanisms, citizen hearings, budget advocacy etc. This could

[3] http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/About_IHP_/mgt_arrangemts___docs/Steering_Committee_as_of_2014/SC_III/Session_4_Case_for_CSO_Fund_vF_Dalberg_report_EN.pdf

[4] HLPF, WHA, WHO regional assemblies, HHA etc

[5] Non exhaustive list: Health data collaborative: CSO group, CSO constituencies of GAVI, GFATM, PMNCH, WB

include facilitating capacity strengthening trainings on health system strengthening/UHC (budget analysis/ Health system financing/ advocacy messages/others issues to be identified) at national and/or regional levels upon request from CSOs[ii]
- Support /facilitate small grants to CSOs for catalytic implementation
- Acting as a learning and knowledge platform, developing tools, documenting best practices, and facilitating peer exchange

b) Guiding principles:

- Balance between income classification countries and regions and representation from different income categories HIC, MIC and LDC:
- Focused on health systems and UHC with integrated approach and not specific sub-sectoral interventions
- CS working on cross cutting system aspects (health financing, service delivery, human resources, pharmaceuticals information systems and governance), generally as well as in relation to improving health outcomes from major diseases. (NCD, SRMCH, TB, Malaria HIV)
- Gender equality
- Focus on the needs of marginalised and vulnerable populations to accelerate equitable progress towards UHC

c) Civil society engagement mechanism proposed governance and organisation
further detail on options for how these bodies would operate etc. is provided below

- **CSO country groups members**: CSOs platforms working on UHC/HSS at country level members of the UHC alliance
- **CSO advisory group** with CSOs representatives from diverse regions and health constituencies varying from 14 to 20 member organisations to set the priorities for the CSO coalition and agree on the workplan
- **CSO participation in the UHC Alliance Steering Committee**: 3 CS representatives and 3 alternates (one by LIC MIC HIC) to represent CSOs in UHC Alliance Steering Committee, nominated by the CSO advisory group
- **CSO secretariat**: A co-hosted secretariat to deliver the workplan, with a coordinator in the Alliance Secretariat and another in a CSO organisation based in the south. Different option for hosting the secretariat is proposed in the framework below

d) Options for the Civil Society engagement mechanism:

<table>
<tr><td rowspan="3">CSO country groups</td><td colspan="3">Core Function:
Participate in UHC alliance country mechanism and health sector review committees
Participate in policy dialogue, planning and budgeting exercises and monitoring of sector performance
Monitoring of UHC implementation at country level to feed UHC monitoring rounds as well as feeding the production of an annual report
Advocacy, including linking with the political system, e.g. parliamentarians and local government, and media
Feed the advisory group with country information’s (Challenges, good practices, processes and policy updates)</td></tr>
<tr><td colspan="3">Options for membership:</td></tr>
<tr><td>CSO national platforms participating in UHC and health sector review mechanism in countries as members of the UHC Alliance.</td><td>Voluntary /open organisation depending on country context and situation with at least CSO IHP+ country focal point participation</td><td>Voluntary /open organisation organisation depending on country context and situation.
With a minimum requirement would include CSO focal points representatives in sector wide and sub sectorial committees (ICC, CCM, GFF country mechanism etc, UHC alliance)</td></tr>
<tr><td>CSO advisory group</td><td colspan="3">Core functions:
Set up the priorities of the CSO UHC alliance mechanism based on the UHC alliance work programme and manage CSO UHC secretariat
Guidance to the CSO secretariat on the advocacy products (shadow reports and scorecards etc) on UHC implementation based on CSO country groups feedback
Feed country groups with UHC alliance global and regional processes
Guidance to the CSO secretariat on the development of a CSO funding mechanism to strengthen capacity building of CSO at national level to better engage in national health policy processes [iii]
Nominate the CSO representative in UHC alliance governing bodies</td></tr>
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- Define the agenda and strategic objectives for the CSO consortium annual assembly in collaboration with the coordinators
- Designate CSOs to participate in UHC alliance adhoc committees

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<tr><td></td><td colspan="2">Options for membership</td></tr>
<tr><td></td><td>

14 members through an open call for proposal for 3-year term with a representation between geographic and sectorial expertise

- 2 CSO representatives per region as following:
  - Africa Anglophone,
  - Africa Francophone,
  - Latin America
  - Asia Pacific
  - Central Asia
  - Northern America
  - Europe
- Should reflect a broad spectrum of organizations with geographical and gender diversity and a range of thematic expertise (e.g. sexual and reproductive health; maternal, newborn and child health; HIV and AIDS; tuberculosis; malaria; nutrition; neglected tropical diseases; vaccine-preventable diseases; health system strengthening and community system strengthening)

</td><td>

Membership: 20 members for3 year term with a representation between geographic and sectorial expertise

- Regional representation (2 per region) through an open call for proposal as following:
  - Africa Anglophone,
  - Africa Francophone,
  - Latin America
  - Asia Pacific
  - Central Asia
  - Northern America
  - Europe
- Health constituency representation with participation from each major CSO constituency (GFF CSOs, PMNCH, GFAN, Gavi CSO constituency, NCD alliance, Health Data collaborative) would nominate a representative to participate in the advisory group

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	Options for selection[6]	

[6]In any scenario the current IHP CSO representatives will not be able to apply and take part in the UHC Alliance civil society engagement advisory group for a minimum of 2year but would stay in place until the CSO Advisory group is set and could stay in place with additional but limited time to ensure a smooth transition

	Selection will be made by the UHC alliance secretariat and a panel composed with current IHP+ CSO representative and additional CSO representative selected by the Alliance secretariat (criteria TBD) Any conflict of interest such as projects funded by WHO and WB for the organization or for the individual member as consultant should be declare.		Selection process: involved secretariat / rep of each initiatives and request them to nominate a CSO representative for the advisory group – Selection process will depend on them. Those initiative would be involved in the wider consultation process of this paper.
CSO participation in the UHC Alliance Steering Committee: 1 CSO LDCs representative 1 CSO MICs representative and 1 CSO HICs representative + Alternates	**Core functions:** • Represent CSOs in the UHC alliance main governing body • Participate in the definition and monitoring of the UHC alliance priorities and work plan • Reflect on country situation in the UHC alliance governing body, based on input from the Advisory group and the country groups • Share regular information's on country situations to UHC alliance members and secretariat		
	Membership: Elected by the Advisory group		
CSO secretariat	**Host organisation**: 2 coordinators based in a LDC/MIC CSO Pros: • Stronger ownership • Capacity development for CSOs in the South Cons:	**Host organisation**: One coordinator based in a LDC/MIC CSO and One coordinator in a HIC CSOs (i.e. Administration and Finance function) Pros: • Stronger ownership	**Host organisation**: one coordinator based in the UHC alliance secretariat and one coordinator based in LDC/MIC CSOs Pros: • Strong coordination with UHC alliance development

	• Limited number of organisation the financial and management capacity • Potential disconnect with Alliance	• Maintain specificity of North and south agendas Cons: • Complexity the organisation and coordination and centralisation of information	while maintaining minimum level of independency and autonomy Cons: • More costly • Inequity in staff compensation and salary • Complexity the organisation coordination and centralisation of information
	Core functions: • In charge of the coordination and liaison between country groups, advisory group and the CSO representative and the secretariat • Ensure the flow of information and communication between UHC alliance 2030 and CSO advisory group as well as collaboration and coordination between different CSO groups linked to other health related processes (Health Data collaborative, Gavi, GFF, PMNCH, GFATM, PHCPI etc) • Assist in documenting lessons learned and best practices of CS participation in global regional and country-level UHC alliance processes • Develop advocacy product • Manage all stages of CSO engagement mechanism including budget management, work plan implementation and reporting to the UHC alliance secretariat		

	Membership: • An open call for proposal will be issued for applications. Criteria will include a proven track record in managing I.O, grants, expertise in CSO coordination from various regions/ countries, facilitation of international processes CSO host of the secretariat should not exceed a 3-year mandate • The CSO host(s) will sign a long term financial support guided by a MOU with annual funding agreement with the UHC alliance secretariat. • Access to funding on the next year will rely on compliance with financial rules and deliverables agreed in the annual funding agreement. • Any conflict of interest such as projects funded by WHO and WB for the organization or for the staff member as consultant should be declared • Selection will be done by the Advisory Group

[i] CSOs, INGOs, affected population representatives, etc …

[ii] Training sessions and small grant not budgeted – Would actually delete that or put into brackets depending on budget availability

[iii] A Funding mechanisms paper will be done to go in details about this specific aspect of the CSO engagement mechanism explaining how this will be organised – proposing option for funding and clarify the organisation and responsibility of this activities