SUPPORTING SOUTHERN CIVIL SOCIETY ENGAGEMENT IN POLICY DIALOGUE AND PERFORMANCE MONITORING: WHAT SHOULD BE THE FUTURE ROLE OF IHP+?

Background note for IHP+ Steering Committee Meeting Session 6, 20 June 2014

BACKGROUND: WHY IHP+ HAS SUPPORTED SOUTHERN CSO ENGAGEMENT IN POLICY DIALOGUE

Civil society involvement in national health policy dialogue and accountability processes at country level is critical to efforts to improve health service delivery and outcomes. The role of civil society in health development is emphasized in the IHP+ Global Compact, and by the Global Partnership for Effective Development Cooperation.

In late 2009, IHP+ created a small grants programme, known as the Health Policy Action Fund (HPAF)1, to support greater engagement of southern CSOs in national health policy processes. To date this has been managed by Oxfam. There have been two rounds of grants: thirteen grantees from 10 IHP+ countries in 2010, and 10 grantees from 8 IHP+ countries in 2012 (see Annex 3). Individual grants are in the region of US$ 30,000. In total since 2010, IHP+ has allocated just over US$ 1 million to support the HPAF small grants programme, approximately 5% of the IHP+ biennium budget. Funding ends in June 2014.

HPAF REVIEW

Dalberg Global Development Advisors reviewed the HPAF programme in late 20132. The Executive Summary of their report is in Annex 2. The objectives of the review were to determine:

- Whether the HPAF small grants programme helped increase CS engagement in national health policy, partnership and accountability processes?
- What are the achievements, benefits and limitations of the programme?
- To what extent are grantee activities and deliverables in line with overall IHP+ objectives?
- Should IHP+ continue supporting national CSO engagement through HPAF, or are there other ways limited IHP+ resources could be more effectively used, to support the same overall objective?

Findings: achievements and added value

I. HPAF has played a unique and positive role in stimulating CSOs to engage in national health policy, monitoring and accountability processes. There are very few alternate sources of funding for the types of activities supported through HPAF.

II. HPAF has enabled grantees to engage in national health policy dialogue in ways that have leveraged their ability to bring different constituencies’ voices to the table. Grantee CSOs have increased their networking and coalition building activities, though more could be done.

Findings: areas for improvement

I. The impact could be greater if IHP+ support was more than just financial: capacity building is important for grantees and the coalitions in which they work. While some capacity building took place, in the form of sharing and learning events, this was not the main focus of support.

II. Longer timeframe for grants

III. Few grantees had a good grasp of the aid effectiveness agenda more generally

Dalberg concluded that IHP+ should continue financing a grants-based programme for southern CSOs, but with some strategic changes to the approach. It proposed that there should be more focus on supporting coalitions and networks. Given the diversity of IHP+ countries and levels of CS cohesion and capacity, other types of support such as capacity building should also be considered. Four alternative models for CS support were proposed (see table A, page 8, in Annex 2). The first three models (called A, B and C) are variations of the HPAF

1 http://www.healthpolicyactionfund.org/
2 read the full report here
approach. Model D is a more ambitious scale-up, together with a possible delinking from IHP+ altogether.

**IHP+ CORE TEAM FOLLOW UP ON OPTIONS FOR FUTURE FUNDING SUPPORT, WITH PARTNERS**

In December, the Dalberg report was discussed with the IHP+ Civil Society Consultative Group. Since then, the Core Team has talked informally with a number of global health initiatives and organizations supporting southern CSOs – see box.

The Global Fund; GAVI; Partnership for Maternal, Newborn and Child Health (PMNCH); Rockefeller Foundation; Gates Foundation; USAID; UNICEF; UNFPA; World Bank; Children’s Investment Fund Foundation (CIFF); Catholic Medical Mission Board; Oxfam.

They were asked:

- Their views on the different models, given their experience.
- What interest / appetite there might be to form a broader funding consortium to create a Model D (the scale-up model), and the pros and cons of doing so.
- About opportunities to link with relevant CSO capacity building activities organised by other global partnerships - e.g. GAVI, PMNCH – where these add value to local or regionally funded CS support.

Reactions can be summarised as follows:

- There is no single way in which CS engagement in national health policy processes is strengthened. Coalitions are important, but other approaches adapted to national circumstances are also needed.
- On Model D, there is interest in the basic idea and a number view this option favourably, including from CSOs themselves, but so far, and in the absence of a specific proposal, few potential funders are signalling definite interest. It is the most complex and time-consuming model to establish.
- Capacity building: there needs to be a balance between direct CSO funding and capacity building. Capacity building should focus on supporting skills for policy dialogue, not CSO administration. There may be opportunities for IHP+ to more systematically link with other relevant capacity building efforts.

These discussions led the Core team to conclude that, should a small grants programme continue, it should be along the lines of either Model C or D (Annex 1 outlines key features of these 2 models).

**The IHP+ Core Team requests the Steering Committee to consider the following**

The success of the HPAF model and the unmet need for support for broad CS engagement to address cross-cutting systemic issues (including UHC), as well as the agreement among IHP+ signatories of the importance of CSO participation, argue for continued financial support to a CS small grants programme. However, as with any funding decision, it is also important for the Steering Committee to consider the question of whether funding by IHP+ to this activity should continue, before considering the future model to be used.

**Questions for Steering Committee**

1. **Should IHP+ continue to provide funds to support a southern civil society small grants programme?**

2. **If so, which of the following options is preferred?** (see Annex 1 for more detailed analysis)
   
   - **Model C - continue but adapt the current approach.**
   
   - **Model D - take the more ambitious Model D forward now, on the grounds that there is an unmet need and sufficient experience to justify going to scale.**

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3 **CSCG Members**
ANNALYSIS OF MODELS C and D

Model C: ‘Blended approach’.
This is essentially a variation of the HPAF model. It would:

- target both i) national coalitions in IHP+ countries with mature CSO involvement; and (ii) individual CSOs in IHP+ countries with less mature CSO involvement.
- support CSO capacity building – focusing on skills needed for health policy dialogue, rather than administrative skills - which has been a critical unmet need to date.
- be managed by an external grant manager.
- provide funding until end 2015.
- estimated budget: $500,000.

Model D: ‘Scaling the approach’
This model is about launching a bigger programme, covering more countries and grantees, with a longer grant period. It would:

- require more financial resources, and entail setting up a funding consortium.
- be managed by an external grant manager, who would monitor progress, and ensure that donors can report back on results.
- possibly be institutionally de-linked from IHP+, be open to non-IHP+ countries, and be able to continue operations beyond the lifespan of IHP+.
- provide funding to more CSOs.
- support CSO capacity building – focusing on skills needed for health policy dialogue, rather than administrative skills.
- require an IHP+ Working Group to develop the model, in consultation with potential funders and possibly in conjunction with an agency such as Dalberg.

The launch could be done in two phases, with Phase 1 having a management arrangement similar to HPAF and launched fairly quickly. Phase 2 - move to an independent pooled funding arrangement with its own governance structure independent of IHP+ - could happen within 1-2 years.

What are the main pros and cons for the two models?

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<th>Pros</th>
<th>Model C</th>
<th>Model D</th>
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|      | *Can be established fairly quickly (3-4 months), once criteria set and grant manager selected.*  
*Time limited.*  
*Estimated budget to end 2015: $500,000* |  
*Addresses an unmet need.*  
*Provides a more coordinated and effective way for DPs to provide funding for southern CS engagement in health policy processes.*  
*A potentially much larger volume of funding, for more CSOs.*  
*Sustainable beyond the lifespan of IHP+.*  
*Could be launched in two phases.* |
| Cons | *Limited reach, only 8 grantees.*  
*Limited duration - max 2 years.* |  
*Complex structure to establish, could take 1-2 years.*  
*Core Team capacity limited for project of this size.*  
*Funding sources unclear.* |