REPORT

IHP+ Civil Society Meetings

Kampala, Uganda

November 11-16, 2011

Review and strengthening of civil society engagement in IHP+
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1. Introduction
The IHP+ Civil society Consultative Group Meeting (CSCG) in Sub Saharan Africa was held in Kampala, Uganda on 12 – 13th November 2011. The meeting focused on reviewing and strengthening the civil society engagement with the IHP+. It provided an opportunity for participants to identify areas and issues to include in the future plans, particularly how to increase civil society engagement in IHP+ activities. The meeting was held at the Lake Victoria Serena Resort in Kampala to coincide with the 7th Annual Meeting of the African Science Academies. The list of main speakers and Agenda is given in the Annex.

1.1 Aims and Objectives of Meeting
Aim: - To review and strengthen CS engagement with the IHP+

Three key objectives include:-
- Update all CSCG members on the recent IHP+ related activities and how CS has engaged with these.
- Provide an overview of the status of IHP+ now and future plans
- Review effectiveness of IHP+ Northern and Southern CSCGs and agree on future make-up, activities and expectations for the groups

1.2 Background
The IHP+ Civil Society Consultative Group (CSCG) was established by the Civil Society Representatives as an advisory group of individuals from developed and developing countries. Each member of the CSCG brings unique knowledge and expertise from various health systems and disease-specific areas that enhance the contribution of civil society engagement in the IHP+. As part of efforts towards enhancing civil society engagement in IHP+ processes, the Civil Society Representatives on the IHP+ proposed combined meetings of both Northern and Southern Civil Society Representatives and members of Civil Society Consultative Group to be held on 12-13 November 2011. The meeting intended to:
- Review civil society engagement with the various IHP+ processes
- Review and update the CSCG action plan and budget for CS engagement in line with the IHP+ work plan
- Propose concrete recommendations on how CS engagement could be strengthened in the next phase of IHP+
- Participate in the International Conference on Aid Effectiveness in Africa’s Health Sector and contribute to Africa position paper and recommendation to HLM-4 on Aid Effectiveness in Busan

1.3 Expected meeting outcomes
Participants came up with the following expectations.
- Better understanding of what has been happening in the IHP+
- In what direction the IHP+ is going and how to link the CS plans into the IHP+
- Find out how effectively CS can be engaged on accountability and transparency issues
- To learn about IHP+, its tools, and principles
- To share on IHP+ results and the monitoring processes
- To hear about the experiences and engagement with IHP+ and learn from colleagues
- Measuring CS engagement and building stronger links between the CS and IHP+
- Networking with participants/CSO representatives
- To improve CS coordination and engagement
- Learn and share as well as contribute in developing concrete action plans
- To find out how the science academies can bolster CS and IHP+ strategies
• Ensuring that CSOs are properly engaged in the health sector
• To learn about the level of harmonization and alignment in the IHP+ process
• To ensure that the IHP+ is delivering against its mandate and how it can be more effective
• Learn more of what is happening in other countries
• What it means for the structure of IHP+ if more countries join and how we can get all the voices from all the member countries
• How CSOs have been engaged, challenges and how the IHP+ can go forward
• Latest development on IHP+

1.4 Methodology
The meeting was conducted over two days. Topics were introduced by PowerPoint presentations. For each subject area examined a series of plenary presentations and discussion sessions were followed by group work on draft recommendations. Group work was used to develop prioritization and recommendations for a final list of priority products proposed. Parallel break-out sessions were followed by group work presentations and discussion forums. Consensus was achieved in plenary sessions on the wording and strength of the recommendations.

Meeting presentations were shared via email to all participants and shall be made available on civil society webpage of IHP+.

2. Updates on IHP+ and its Future
2.1 IHP+ basics, Roles and Key aims
The IHP+ was launched in 2007. It is a multi-sectoral partnership of development partners, recipient countries and civil society that was set to support countries accelerate progress towards the health MDGs. The IHP+ governance structure is composed of the IHP+ core team (World Bank & WHO), the Executive team and the Scaling Up Reference Group which is composed of all signatories. It is an open partnership to which anyone ready to commit to the basic principles can belong, and from which lessons and experiences can benefit all low-income countries. It isn’t a permanent fixture.

IHP+’s role is to act as a catalyst for change and work through existing institutions to generate greater attention and support for national planning processes, reinforced by activities such as joint assessment, compact development, one M&E platform, its work is based on the principles from the Paris Declaration on Aid effectiveness and the Accra Agenda for action. Its key aims are to keep a focus on health results; improve the use of resources in the Health sector; build on what already exists, enhance country led health development; reduce transaction costs; encourage longer term more predictable funding and promote mutual accountability.

2.2 IHP+ Recent updates
2.2.1 IHP+ Partners and Activities
The number of partners involved in the IHP+ has doubled between 2007 and 2010. It now currently has 55 partners, 30 from developing countries, 25 development agencies and includes signatories from Africa, Asia and Latin America with the majority of signatories now coming from developing countries. Over half of the 30 IHP+ countries have renewed their National Health Strategies and plans.

A series of activities are being carried out by IHP+ towards achieving the health MDGs to ensure more international agencies allow genuine country leadership in defining health strategies and to find ways to give investors the confidence to invest in those strategies thus reduce dependence on multiple projects that have high transaction costs.
i. JANS (Joint Assessment of National Strategies): - This is the most visible part of the IHP+ and is a process of joint assessments supported by all stakeholders and involves reviewing the strategies against a set of agreed desirable attributes. Health sector JANS have been conducted in 5 countries, disease specific JANS in 10 countries.

ii. Partnership Agreements and Compacts: - IHP+ is encouraging signing of compacts. A compact is a set of negotiated commitments by the signatories to change their ways of working so as to better support strategy implementation which is then monitored. Since this is based on strengthening existing agreements, most countries review their existing agreements against the compact benchmarks and identify areas for negotiation.

iii. Monitoring and Review of National Health Strategies: - IHP+ has supported efforts to strengthen country monitoring and review processes. A common M & E framework and monitoring toolkit was developed and reviews have been done in 5 countries.

iv. Mutual accountability: – 2 rounds of monitoring have been carried out in some countries by an independent consortium, the IHP+ Results. A third round is taking place in 2012.

2.2.2 Future activities of IHP+ in 2-3 years:
1) Continue 5 strategic directions
2) Keep country focus: consolidate
3) Strengthen global role
4) Improve CS engagement in IHP+
5) Enhance accountability for results

2.2.3 IHP+ Looking ahead

- There is need for further strengthening of the CS role in IHP+ and national processes.

- After 4 years of the IHP+ establishment the Executive team agreed that IHP+ should not exit at the end of 2011 because that would compromise efforts to consolidate new ways of working. It was agreed that IHP+ should continue, but adapt with a defined time frame.

- The JANS tools have been improved and simplified and are now in 4 languages, being used by countries that are / are not signatories to the compacts.

- Every developing country needs to define locally what it wants achieved by end 2013.

- Need to come up with a simplified reporting mechanism.

- More engagement with CS is required.
2.3 Questions, Discussions and Recommendations

Following the IHP+ recent updates presentations, participants had a Q & A session, Buzz Group and discussions as below:-

2.3.1 Q & A session

- Will power point presentations will be circulated via email to members present? Yes, by email and hard copies will be distributed too.
- How many signatories to the IHP+ are there? In April 2011, they were 27. Now they are 30 as Cape Verde, Ivory Coast and Mali recently joined.
- Is IHP+ in danger of not continuing? IHP+ is supposed to catalyse the process that will be country owned and country sustained so they will not be in existence forever. Future direction of IHP+ is under discussion.
- What was the reason of putting the exit option at the top of the list of options for the future of IHP+? At that time, the political support for the IHP+ was waning particularly on the side of bilateral donors and that is why exiting was the first option discussed/considered. The executive unanimously agreed that it continues.
- At Country level how are the IHP+ processes functioning and are CSOs involved in this? Involvement at policy and planning level by CSOs is lacking and it is hoped that IHP+ can help in CSOs being more involved at that level.
- Umbrella organizations of health-focused NGOs is lacking in many countries. This limits CSOs participation. Kenya, Rwanda and Ethiopia provided very good examples.
- There is need for more support for CSOs in order for them to effectively engage in the IHP+ processes.
- Can CSOs be signatories to the Compacts? Civil Society being part of signing of the Country Compact is more effective.
- Do we have an alternate representative for the North and South? Yes we do.
- There is value for IHP+ to continue because it is like a common tool for CSOs to use to move forward in pushing for health issues at country level.
- How well have we progressed in engaging CSOs and their representation at country level in the south? Civil Society engagement with the IHP has improved. It is still far from perfect. CSO Capacity building and engagement is being supported by the IHP Core team and executive members.
- As member countries increase, how shall we ensure that we are getting information out to the grassroots CSOs and also receiving feedback from them? We need to come up with a concrete solution on how this challenge can be resolved.
- Shall we have focal points when countries are many? There is a big challenge here on who will it be and how the focal will be chosen.
- CS has no capacity to fully and effectively work well with the IHP+. CSOs are not entirely engaged in practice. IHP+ is not moving well in line with its objective of the participation of CSOs. Accountability and commitment by the government to the CSOs is not easy. There is need for a joint effort for the IHP+ and CSOs to engage more.
- There is general consensus from all participants that there is need to make a joint effort to strengthen engagement of CSOs in a genuine way and build their capacities so that they can engage in the processes and various levels of decision making.

2.3.2 Buzz groups and discussion

1) What are the CSO engagement priority areas for the next year?
Developing National Health Strategies with mechanisms at country level through the CS – CG, the CSHPAF and the ET and sharing the Country planning cycle / sector plan which is on the website.

2) How many country health sector teams are there? Many countries have already got a coordination network on health policy but the number of CSs varies. It also varies whether they are active or simply exist on paper. What IHP+ can do on a global level through country representatives is to influence engagement of CS. Making use of the IHP+ website and encouraging slightly greater transparency of what is being done.

3) What is IHP+ doing to improve the country health sector team? If CS is part of the country health sector team then they are in from the start and can be assisted to develop national health plans and strategies.

4) Who needs to know about IHP+ on country level and how shall the outreach occur? If it’s a new country – how does info filter down to CS groups? There is need to form special CSO forums and also make it a principal but not an absolute requirement.

5) CSOs are mostly involved when the issue of HIV/AIDS is to be discussed – our aim as IHP+ is to make CSOs meaningfully involved in all IHP+ processes. Meaningful involvement of CSOs can only happen when their capacity is strengthened.

6) Was there anytime a mentioning of CS engagement during the WHO country rep meeting? WHO doesn’t talk about IHP+ issues only.

7) On the structure, does the global team have a mechanism to scale up the reference group because it needs to be strengthened as there are more countries now? Engagement strengthening is a difficult one. CSOs are many with very different agendas. Government can’t deal with them individually. In other countries CSOs have representatives or umbrella organizations that can deal with government. Peer learning is also useful. There should be a mechanism to get feedback to IHP+ from CSOs in the future.

8) What is the process that is used to select the members of the WGs in particular the CS? Members are usually defined by the one leading the group. Sometimes the Core team talks to the CS representatives. The working group should be seen as a process. There aren’t as many CSs in WGs. In the start, there were 8 WGs and now they are 3 WGs. Main route is through IHP+ representatives.

Each CS has a right (and should take the initiative) to go to the WHO resident rep and ask for information on IHP+. It is a form of helping them to engage CSOs.

3. CS Engagement with the IHP+

3.1 Timeline:
In 2007 – 2008 there was limited CS involvement and engagement into the IHP+ global compact but with a series of advocacy activities the space was opened, CS Representatives and alternates were selected; a model for CS engagement was established and guidelines set and agreed in 2008. In 2009 the North and Southern CS Representatives became members of the ET and during the same period the CSCG was formed. CS was now involved in various activities and process of the IHP+ such as the development of the JANS guidelines.
3.2 CS Engagement with IHP+ at country level:
The meeting highlighted a dwindling in the engagement of CSOs with IHP+ since 2009 to date. Participants broke away into groups to discuss and brainstorm on the general engagement of CS within their countries and IHP+, the challenges being faced, success stories and recommendations. Countries represented included S. Africa, Uganda, Nepal, Benin, Mali, Nigeria, Ethiopia, Kenya and Rwanda. Participants pointed out that their countries had CSs organized in networks but with no clear lead and coordination, most of the country CSs hadn’t signed the Compacts apart from Kenya. The following challenges and recommendations were highlighted; -

<table>
<thead>
<tr>
<th>Experiences / Challenges</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Low awareness, communication and limited access to information on IHP+ amongst CSOs</td>
<td>Working with networks and credible focal organizations on IHP+</td>
</tr>
<tr>
<td>No mechanism in place for engagement of CSOs with MOH</td>
<td>A credible organization which is tasked with information dissemination</td>
</tr>
<tr>
<td>Capacity gap; Lack of support and resources available for meaningful engagement</td>
<td>Support should come from government and development partners</td>
</tr>
<tr>
<td>There is no clearly defined role/guideline for CSOs engagement at the country level</td>
<td>Role of CSOs to work together to develop the role and get buy-in at the country level. Guidelines developed by IHP+ core team</td>
</tr>
<tr>
<td>Limited number of CSOs which focus on policy advocacy – compared to service delivery</td>
<td>Increased awareness and capacity of CSOs on policy advocacy versus accountability and transparency, etc</td>
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3.3 CS Engagement with IHP+ at Global level:
The 3rd group comprising the Global team brainstormed on the global involvement of the CS and IHP+. The Global team was comprised of Tim, Sarah, Elaine, Louise and Lara. They came up with the following recommendations;- a. To bring the North and South consultative groups closer b. To establish a better process for CSO representation on working groups c. To encourage the Core team to use consultative group to identify WG participants d. To explore how to disseminate executive team documents to consultative group and arrange feedback i.e. Clear expectations in ToR, Routine dates e. To manage workload for monthly executive team calls – rotation f. To have regular communication between country and global CSHPAF issues g. For Clarity/transparency i.e. consultative group – how members are selected, representativeness h. Effectively use the Website and listserv – disseminate upcoming missions/information, etc (include listserv and its use)

3.4 IHP+ Civil Society Consultative Group.
3.4.1 What is the CSCG?

The IHP+ Civil Society Consultative Group (CSCG) was established to serve as a platform for the engagement of the broad range of CS constituencies in Health Systems Strengthening (HSS), Community Systems Strengthening (CSS) and the related priority burdens to which they must respond. It supports the North and Southern CS representatives and alternates to the Scaling up Reference Group (SuRG) which represents the management structure of the IHP+ to ensure country level engagement and participation of community organizations, in the monitoring of country level progress of the IHP+ in compact signatory countries to hold all IHP+ signatories accountable for delivering results.
3.4.2 Composition and Membership

Membership of the Consultative Group is by constituency. The current TOR for the group says that the CSCG shall be comprised of up to 25 civil society members representing diverse health constituencies and be led by the IHP+ CS representatives and assisted by 2 Co-Chairs to be elected by members of the CSCG. Consultative group members shall also include those from various community organizations other neglected / vulnerable groups.; representation from Northern and Southern CS, especially from IHP+ developing country signatories, including CS from IHP countries that have signed a compact as well as those that have signed the global compact but are not developing a country compact.

3.4.3 The added value of the IHP+ CSCG

The TOR was reviewed by the participants and comments and recommendations were shared. Participants discussed on the added values of having a CSCG and ways on how to maximize its added value at both country and global levels.

The added value of having a CSCG:
- Distribution of the burden of work
- A collective North / South voice
- Strengthening the capacity of the global team and making them more responsive
- Broader representation
- Better consultation mechanism – more information from the ground
- Systematic means of sharing updates and experiences on global/country Developments/practices
- Legitimacy/accountability of the representatives
- More ‘buy-in’
- Opportunity for tracking resources together as a team
- Strengthening of the global partnerships towards the health MDGs

What needs to be done to maximize the added value at the global and country levels?
Participants brainstormed and pointed out three areas:

a). Structure;
- It was agreed that there is need to change the structure of the CSCG to better reflect the perspectives of different geographic regions. In addition to having members representing different health areas, there should be at least one representative from IHP+ regions e.g. East Africa; West Africa; North Africa; South Africa; Latin-America; Carribean
- Encourage health networks and umbrella organizations to participate in the CSCG.

b). Capacity;
- Need to find ways of coming up with concrete ideas on how we go about capacity building.
- Get more involved and build members’ capacity in policy and advocacy engagement.
- Have a plan to enhance CS engagement in the IHP+ global agenda e.g CS can advocate to policy makers when they meet in different global or regional fora especially with the Ministers of health from the south.
- There is need for IHP+ to develop a mechanism for proper orientation and strengthening the capacity new country signatories.

c). Communication; -
There is need for a communication focal point to improve information flows between the IHP+ CS Reps and the CSCG as well as with broader civil society.

3.4.4 Way Forward:
It was proposed that the existing CSCG be disbanded and the TOR be updated. Participants who attended the meeting agreed to become interim CSCG members in addition to the few active members of the existing CSCG. The CSCG will be reconstituted in early 2012. Membership should not exceed 15 people who represent different thematic areas and geographical regions.

4. Civil Society Health Poverty Action Fund
4.1 Overview of the CSHPAF
The Fund was created in March 2010. A Project technical committee (PTC) managed and implemented by Oxfam was formed to support in setting up of the basic structures of this fund. The fund works in a 10 step process from call for proposals to grant closure.

In the 1st phase, there were 13 grantees from 9 countries. All of them except Nepal were from Africa.

In the second phase, there are 5 grantees that were all part of the original 13. Of the 5, only one is from a francophone country. The Core team decided to continue funding the 5 for another 6 months till end of 2011:
1) Benin: Social Watch Benin
2) Nepal: BP Memorial Health Foundation
3) Nigeria: Positive Action for Treatment Access
4) Sierra Leone: The Shepherd’s Hospice Sierra Leone
5) Uganda: Action Group for Health, Human Rights and HIV and AIDS

4.2 Strengths and weaknesses of the CSHPAF
Participants had group discussions on the strengths and weaknesses of the CSHPAF and what needs to happen next.

Participants Questions and Discussions

- Why reduce grantees? The fund would like to increase the number of grantees, but they don’t have the money and there is also need to be more focused. The fund intends to reach out to other donors and encourage them to support more grantees by sharing with them their success stories. This plan is for the next 12 months as CSHPAF is in a much better position now than they were 6 months ago.
- Why use only internet for the call for proposals yet upcountry they don’t have access to it? Not only internet was used, but also the Listserv and other means.
- Before the call for proposal goes out, is there anything we should do in terms of raising awareness about aid effectiveness and IHP+, what it’s about and how the fund can support engagement with the IHP+? It is a challenge, but we shall find ways to work around it. One option could be to work with organisations that are active at national level and also involve the CSCG.
- Is there a way that we can ensure alignment of grantees with some of the IHP+ processes? This can be achieved by building the capacity of the CSOs.
- Comments on future – Participants highlighted that they will appreciate if more focus on the network, aid effectiveness and accountability and engagement of CS is done not only at national level, but also at decentralised level in planning and monitoring what is going on.
• What was the basis/reason of the extension of the funding to the 5 grantees for another 6 months? Did the proposition come from Oxfam or the grantees themselves? It was not an extension, because the grantees submitted new proposals. The new funding was given based on the performance of the grantees in the previous phase. In the future, there might not be much increment from the 30,000 dollars that are currently being received.

• Why does the fund want to focus more on coalitions and networks other than individual CSOs? Does this mean the fund wants to focus more on improving the work that the coalitions and networks do or improving coalition between CSOs? There is need for clear coordination of CSOs. The fund prefers to support networks rather than individual CSOs doing their individual advocacy work.

Participants’ views and recommendations

• Don’t get too fixated on the acronym IHP+. Added value of IHP+ is to get more engagement of coalitions and networks.

• There is a lot that can be done on capacity building on CSOs so we should not leave all the work to Oxfam.

• There is need to have a wider in-country involvement to put proposals together to get the resources.

• The grant should develop a 2 page fact sheet on best lessons learnt and what has been done. The fund will develop a template on what should go there. It will be one way of making information on the fund easily available/accessible

• In the future IHP+ meetings, there should be presentations on lessons learned and best practices.

• There is need for the CS consultative group to work closer with the fund

• Need to identify focal points in the consultative group that can take on that work and be accountable for it

• There is need to give support to the CSOs in proposal writing and target organisations that are active at the National level.

• Integrating members of the CSCG into the PTC would be a way to involve them and will enable accountability and transparency.

• There is need to link the JANS and other IHP+ tools closely to the fund

• It is not advisable to involve the country in looking at proposals – do not demand that it should go through country health sector coordination committee because it can be a nightmare to get it through government processes. If it is an issue of measuring policy then it will be harder to get it through.

4.3 Way forward

Adaptations for the Interim Phase:

• CSO broadening their work from HIV/AIDS is not easy.

• Activism is good, but there is need for constructive engagement in policy processes

• Due to more reports required from grantees now, the fund can, at an early stage, track progress, identify problems and opportunities

• The 5 grantees also submitted proposals for capacity building

• Giving grantees more exposure on health aid effectiveness

Preparing for phase II:

• Plan to fund fewer grantees for a longer period like 18 months

• Stronger focus on funding networks/coalitions rather than individual CSOs

• Issue call for proposals without being too prescriptive

• Budget for capacity building

• Closer follow up of grantees

• More systematic support from members of the CSCG
5. IHP+ Results
5.1 Overview of IHP+ Results and outcomes

IHP Results: Outcomes to date and future plans
Overview of IHP+ results outcomes and future plans and update on IHP+ civil society indicator – presentation by Tim Shorten

Main areas focused upon:

5.1.1 2010 monitoring – what the process included and how did it translate at country level?
During the 2010 monitoring, there were 10 countries involved, 15 development partners and 4900 data points. The IHP+ Results has implemented a reporting framework that has yielded 5000+ data points through a systematic process of data collection which can enable stronger accountability if used in the right way.

Monitoring packs were sent to each participating country and they scored themselves. There was self reporting thus no triangulation of the information given, there were limited country-level discussions as well as methodological limitations.

On the positive side, the monitoring was well received and provided useful data on the progress in the participating countries. It also showed how score cards can be useful in mutual accountability.

5.1.2 2012 monitoring – how can CSOs get involved and when?
• Germany, Belgium and the Global Fund have confirmed participation
• Countries to confirm participation by 18 Nov 2011

5.2 Civil society priorities in relation to IHP+ Results

Discussion:

What are civil society’s priorities in relation to IHP+ results and how can they be taken forward?

Three areas of discussion:
A) 2010 monitoring – what the process included and how did it translate at country level?
B) 2012 monitoring – how can CSOs get involved and when?
• Germany, Belgium and the Global Fund have confirmed participation
• Countries to confirm participation by 18 Nov
C) Feedback on proposed measures of the CSOs engagement in health policy processes

5.2.1 CS Indicators
• Under the possible categories of CSOs that could/should be involved in Health sector policy processes
• Categories need to be related to the MDGs and they should be the thematic categories that we should use
• Nutrition could also be included as a category
• We could also add networks at the top of the list of the categories
• Professional associations e.g. labour unions that are health related could also be added
• Is there a possibility of finding out the percentage of funding to each of the possible categories of the DP support? Total amount provided to the health sector was provided, but it is not easy to get the information on budget spent on each of these issues. We cannot measure the effectiveness of input by the amount spent.

• Under possible categories of DP support – on the part of facilitations, it was suggested that logistical support could be a better word to use.

5.2.2 Qualitative survey (Scope) – Hoping to do it by end July. Need to find out what questions will be asked in the survey, who should participate, how will they be selected, when should it be done and by whom.

• Inclusiveness – are the right people involved?
• Governance – Does the process allow/enable CSO participation?
• Effectiveness – does the process have any impact?

Questions raised:
• Is there a mechanism to measure the level of honesty by government and CSOs when answering questions in the survey? It is a matter of trust as honesty cannot be measured.
• Are any of the technical working groups in MOH chaired by CSOs? This can be added to the questionnaire.
• Capacity building of CSO staff by MOH can also be done.
• Are CSOs involved in the road-map? How can we ensure there is a voice of CSOs in the 2012 monitoring? CSOs have been encouraged to participate in the 2012 monitoring.

5.2.3 CSO Engagement in monitoring and use of results e.g. using scorecards

• There is need to verify the results at a global level.
• Data on scorecards is not complete/all inclusive and thus makes it harder to use.
• It is good to have the scorecards, but how can we ensure that the CSOs are involved.
• IHP+ can add to their TOR the involvement of CSOs – what is the process for the countries to do this and is there a process/guidelines to be followed e.g. there are guidelines on how to use the JANS. Improve organization of CSOs so there the government has a contact from CSOs whom they can call upon when the CSO involvement is needed.
• It is important for the CSOs to sign the compact. This will give the CSOs power to be involved in the process from the start.
• Engage DPs that are CSO minded to push for the involvement of CSOs in the survey.
• Right CSO focal person at country level needs to be identified. North an southern representatives are in a position to assist on identifying the right CSO focal person.
• There is a challenge to identify which CSOs will participate in the survey for proper representation as some countries have so many CSOs e.g. Nigeria has 100,000+ and Ethiopia 5,000+.
• North and South representatives can also inform the CSOs in the 30 countries about updates at the IHP+ global level.

6. Action Plan and next steps

The last session of the meeting focused on developing an action plan and next steps in order to take forward the recommendations generated over the past two days. A draft action plan can be found in Annex 4.

Planning:

Step 1: Indentifying civil society priorities for 2012
Step 2: Identify key actions for priorities
Step 3: Strengthening the CSCG
Step 4: Confirming next steps (roles and timelines)

Way forward: Participants were divided into 2 groups for discussions

Step 1: Identifying civil society priorities for 2012

The following areas were identified as priorities for 2012:
1. Deepening CS engagement in JANS process
2. Deepening CS engagement with Country compacts
3. Capacity building of CS
4. Ensuring CS is fully engaged in 3rd round of IHP+ results
5. Strengthening the CSCG:
   a. Review membership
   b. Improve communications – Internal and external
   c. Develop tools to M & E effectiveness of the CS reps
6. Executive team and WGs

Group 1 possible actions:

JANS
- Information on upcoming JANS
- Information on upcoming JANS disseminated at country level using existing communications platforms
- Contact Ministry of Health for CSO engagement in the JANS process

CSCG
- Review its ToR and membership
- Call for applications in early 2012 so as to select new members
- Define clear roles, responsibilities, guidelines and action plan for CSCG members
- Recruit communications focal person to support CS reps and develop communications strategy to increase interest and engagement in IHP+
- Develop process for performance evaluation of CS reps
- Resource mobilisation for CS engagement activities
- Organise another annual meeting for CSCG members in 2012
- Review listserv and clarify mandate
- Learn from other delegations on resource mobilization (GF, WB, GAVI, WSA, UNAIDS, UNITAID, etc)
- Review IHP+ website page and update
- Develop a clear action plan for next 2-3 years
- Identify country/sub regional correspondents

Executive team and WGs
- Strategy for managing participation in ET meetings
- List of WG members (especially CS members) shared with CSCG and on IHP+ website
- Advocate for formal transparent process for selection of CSO representatives to WGs

Group 2 possible actions:

IHP+ Results
• Contribute to finalizing CSO indicators
• Advocacy for continuation of IHP+ results beyond 2012
• Guidelines to be reviewed and include CS engagement
• CSCG to develop plan for using disseminating, discussing scorecards in second half of 2012
• Communication from CS reps to encourage countries and development partners to sign up to IHP+ results
• Help shape qualitative survey for CS engagement and encourage engagement from countries

ET and WGs
• Ongoing participation in ET calls by CS reps – share burden by alternating participation between northern and southern reps
• Develop clear process for selection of CS reps to WGs
• Create a list of CS members of WGs and strategy for engaging with them – increase transparency by putting names up on the internet

Priority areas for 2012: 
• Ensure greater CSO engagement within the IHP+ and all its processes and procedures. That could be facilitated through CSOs signing the Compact.
• Ensure that the CSO representatives to the IHP+ get a communications focal point.
• Continue to improve engagement between and within Southern and Northern CSOs.
• The TOR for the CSCG be revised and the CSCG be reconstituted in early 2012.
• Engage and learn from other CSO delegations and constituencies in other international health mechanisms and organizations.
• IHP+ results should continue to provide evidence-based information to feed into the work of the CSCG, including areas for improvement based on continued tracking
Annex 1: Participants List

<table>
<thead>
<tr>
<th>S/N.</th>
<th>NAME</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Prince Bosco KANANI</td>
<td>Rwanda NGOs Forum on AIDS and Health Promotion</td>
</tr>
<tr>
<td>2.</td>
<td>Tim SHORTEN</td>
<td>Re-Action, UK</td>
</tr>
<tr>
<td>3.</td>
<td>Jean–Pierre DEGUE</td>
<td>Social Watch, Benin</td>
</tr>
<tr>
<td>4.</td>
<td>Cheryl JACOB</td>
<td>Civil Society Health Policy Action Fund</td>
</tr>
<tr>
<td>5.</td>
<td>Francis UMOH</td>
<td>Positive Action for Treatment Access, Nigeria</td>
</tr>
<tr>
<td>6.</td>
<td>Femi FASINU</td>
<td>Centre for Health and Development Impact, Nigeria</td>
</tr>
<tr>
<td>7.</td>
<td>Semu Ketema TEFFERA</td>
<td>Consortium of Christian Relief and Development Association, Ethiopia</td>
</tr>
<tr>
<td>8.</td>
<td>Lara BREARLY</td>
<td>Action for Global Health</td>
</tr>
<tr>
<td>9.</td>
<td>Louise HOLLY</td>
<td>Save the Children, UK</td>
</tr>
<tr>
<td>10.</td>
<td>Robert NAKIBUMBA</td>
<td>Africa for Health Research Initiative, Uganda</td>
</tr>
<tr>
<td>12.</td>
<td>Mayowa JOEL</td>
<td>Communication for Development Centre, Nigeria</td>
</tr>
<tr>
<td>13.</td>
<td>Noumousa SAGANOGO</td>
<td>Groupe Pivot Santé, Mali</td>
</tr>
<tr>
<td>14.</td>
<td>Dinesh POHKREL</td>
<td>BP Memorial Health Foundation, Nepal</td>
</tr>
<tr>
<td>15.</td>
<td>Mette KJAER</td>
<td>African Medical and Research Foundation, Kenya</td>
</tr>
<tr>
<td>16.</td>
<td>Elaine IRELAND</td>
<td>Sight Savers, UK</td>
</tr>
<tr>
<td>17.</td>
<td>Gabriel MADIYE</td>
<td>The Shepherds Hospice, Sierra Leone</td>
</tr>
<tr>
<td>18.</td>
<td>Christian ACEMAH</td>
<td>Africa Academy of Science</td>
</tr>
<tr>
<td>19.</td>
<td>Harriet NANFUMA</td>
<td>Uganda National Academy of Science</td>
</tr>
<tr>
<td>20.</td>
<td>Tobias LUPPE</td>
<td>Oxfam International, Germany</td>
</tr>
<tr>
<td>21.</td>
<td>Phyllida TRAVIS</td>
<td>WHO/IHP+</td>
</tr>
<tr>
<td>22.</td>
<td>Sarah MIDDLETON-LEE</td>
<td>Facilitator</td>
</tr>
<tr>
<td>23.</td>
<td>Anne NUWUMBA</td>
<td>Rapporteur</td>
</tr>
<tr>
<td>24.</td>
<td>Charlotte TSHIBANGU</td>
<td>Translator/ Rapporteur</td>
</tr>
</tbody>
</table>
Annex 2: Programme Agenda
IHP+ Civil Society Consultative Group (CSCG) Meeting, 12-13th November 2011

**Aim of meeting:** To review and strengthen civil society engagement with the IHP+

**Objectives of meeting:**
- To update all CSCG members on recent IHP+ related activities and how civil society has engaged with these
- To provide an overview of the status of IHP+ now and future plans
- To review effectiveness of IHP+ northern and southern CSCGs and agree on future make-up, activities and expectations for the groups

**Day 1: Saturday 12th November:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Purpose</th>
<th>Activities</th>
<th>Resource people</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30–10.00</td>
<td>To welcome the participants to the meeting</td>
<td>Welcome and introductions:</td>
<td>Mayowa Joel/Elaine Ireland/Christian Acemah</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Welcome to the meeting</td>
<td>Facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Introduction of participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Overview of meeting objectives and programme</td>
<td></td>
</tr>
<tr>
<td>10:00–11:00</td>
<td>To provide an overview of IHP+ and recent updates</td>
<td>IHP+: The basics and the latest</td>
<td>Louise Holly/Elaine Ireland/Mayowa Joel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation:</strong> IHP+ the basics</td>
<td>Facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation:</strong> IHP+ recent updates (e.g. IHP+ Results, review of future of IHP+, Bussan High Level Forum)</td>
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<tr>
<td></td>
<td></td>
<td>□ Q&amp;A and discussion</td>
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<tr>
<td>11:00–11:15</td>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:15–12:30</td>
<td>To review effectiveness of civil society engagement in IHP+</td>
<td>Civil society engagement in IHP+: What has and hasn't worked?</td>
<td>Elaine Ireland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation:</strong> ‘The story so far’ of civil society engagement in IHP+</td>
<td>Facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Group work:</strong> What has civil society engaged in IHP+ to date (both globally and in-country, e.g. JANS, country compact, IHP+ Results)? Where has that engagement been effective, where not and why?</td>
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<td></td>
<td></td>
<td>• <strong>Brainstorm:</strong> What are the key barriers to engagement and what can be done about them?</td>
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<tr>
<td>12:30–13:30</td>
<td>Lunch</td>
<td></td>
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</tr>
<tr>
<td>13:30–15:30</td>
<td>To review effectiveness of IHP+ CSCG: What is its added value and how can we maximise it?</td>
<td></td>
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</tr>
<tr>
<td>Time</td>
<td>Purpose</td>
<td>Activities</td>
<td>Resource people</td>
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</tr>
<tr>
<td>15:30-15:45</td>
<td>Break</td>
<td></td>
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</tr>
<tr>
<td>15:45-17:30</td>
<td>To provide an update on IHP+ Results</td>
<td>IHP+ Results: Outcomes to date and future plans</td>
<td>Tim Shorten (IHP+ Results)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation</strong>: Overview of IHP+ Results outcomes and future plans</td>
<td>Facilitator</td>
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<tr>
<td></td>
<td></td>
<td>• <strong>Discussion</strong>: What are civil society’s priorities in relation to IHP+</td>
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<td>Results and how can they be taken forward? (e.g. civil society</td>
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<td></td>
<td></td>
<td>indicator, qualitative survey of civil society engagement; use of</td>
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<td></td>
<td></td>
<td>scorecards by civil society, involvement in data collection)</td>
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</tr>
</tbody>
</table>

Day 2: Sunday 13th November:

<table>
<thead>
<tr>
<th>Time</th>
<th>Purpose</th>
<th>Activities</th>
<th>Resource people</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30-09:45</td>
<td>To recap on day 1</td>
<td>Welcome and re-cap on day 1</td>
<td>Mayowa Joel/Elaine Ireland</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Welcome to participants</td>
<td>Participant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Re-cap on key issues raised on day 1</td>
<td></td>
</tr>
<tr>
<td>09:45-11:00</td>
<td>To provide an update on IHP+ activities and future</td>
<td>IHP+: Key activities and the future</td>
<td>Phyllida Travis (WHO)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation</strong>: IHP+ recent activities, upcoming activities and future</td>
<td>Facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>directions and challenges</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• <strong>Buzz groups and discussion</strong>: Key questions and comments from participants</td>
<td></td>
</tr>
<tr>
<td>11:00-11:15</td>
<td>Break</td>
<td></td>
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<tr>
<td>11:15-12:30</td>
<td>To provide an update on CSHPAF</td>
<td>Civil Society Health Poverty Action Fund: Outcomes to date and</td>
<td>Tobias Luppe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>directions for the future</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Presentation</strong>: Overview of the CSHPAF (outcomes, achievements,</td>
<td></td>
</tr>
</tbody>
</table>
12:30-13:30  Discussion: What were the strengths and weaknesses of the CSHPAF? What needs to happen next?

13:30-15:30  To identify/agree on key ways to enhance future CSCG engagement in IHP+

13:30-15:30  Lunch

15:00-15:15  Break

15:45-18:00  (Continued from previous session)

17:45-18:00  Wrap-up and farewell

<table>
<thead>
<tr>
<th>Time</th>
<th>Facilitator</th>
<th>Key actions to enhance CSCG engagement in IHP+</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:30-15:30</td>
<td>Facilitator</td>
<td>Group work and discussions: What changes/actions are needed to increase and improve the CSCG’s engagement in the future of IHP+? Focus on: Communication within the CSCG and with external stakeholders Coordination among the northern and southern CSCG groups Specific opportunities in the future (e.g. JANS, compacts, IHP+ Results) Concrete action steps for 2012</td>
</tr>
</tbody>
</table>

Facilitator

Mayowa Joel/Elaine Ireland
Annex 3: CSCG ToR

Terms of Reference
IHP+ Civil Society Consultative Group

Purpose
The IHP+ Civil Society Consultative Group (CS-CG) was established to serve as a platform for the engagement of the broad range of CS constituencies in Health Systems Strengthening (HSS), Community Systems Strengthening (CSS) and the related priority burdens to which they must respond. Issues of importance include but are not limited to HIV/AIDS, malaria, tuberculosis, nutritional disorders, vaccine preventable diseases, priority health burdens that affect marginalized and/or high risk population such as women and children.

The CS-CG will support the northern and southern civil society (CS) representatives and alternates to the Scaling up Reference Group (SuRG)[1] of IHP+ to ensure country-level engagement and participation of community organizations, in the monitoring of country-level progress of the IHP+ in compact signatory countries and to hold all IHP+ signatories accountable for delivering results.

Key Responsibilities of CS-CG Members
- Provide input via the northern and southern civil society representatives and their alternates into IHP+ policy, guidance and other relevant documents and activities
- Participate in CS consultations of the IHP+, including those related to IHP+ working groups and other taskforces (e.g., the Taskforce on Innovative Financing for Health Systems)
- Support the CS representatives in promoting country-level engagement of CS organizations in feedback on country progress and gaps in country-level IHP+ processes
- Participate in the annual IHP+ CS Consultative Forum as a part of the review process of the IHP+ and in preparation for the annual IHP+ Ministerial Review meeting
- Work with national CS-led health coalitions to support country-level advocacy and contribution of civil society organizations and community-based organizations to the development of country compact and national health plans, including HIV/AIDS, TB, malaria, immunizations, and HCW plans/strategies
- Identify ways of improving communication and coordination among various health constituencies at global and country-levels (e.g., bilateral and multilateral donors, Global Fund)
- Assist in documenting lessons learned and best practices of CS participation in global and country-level IHP+ processes including health sector needs assessment, national health plan and strategy development and compact development, implementation and monitoring
- It is also desired that CS-CG members have solid experience in advocacy; representing CS at national, regional and international fora; and demonstrated commitment to ensuring voices of marginalized, vulnerable and less vocal groups are heard.

Composition & Membership
Membership of the Consultative Group is by constituency, represented by individuals or institutional focal points. However, key organizations active in areas related to the IHP+ at country, regional and global levels may also be invited to membership of the CS-CG by merit and track record of relevance and achievements.
The CS-CG will be led by the IHP+ CS representatives and assisted by 2 Co-Chairs to be elected by members of the Consultative Group.

The Consultative Group will be comprised of up to 25 civil society members representing diverse health constituencies including:
- Sexual and reproductive health
- Gender
- Immunizations
- Maternal, Newborn and Child Health
- Health Systems Strengthening
- Community Systems Strengthening
- HIV/AIDS
- Tuberculosis
- Malaria
- Nutrition

[Note: This list is not exclusive. Civil society working on neglected tropical diseases, non-communicable diseases, primary health care and other health constituencies are also encouraged to apply.]

Consultative Group members should include those from community organizations, including patient groups, health workers, unions, professional associations, faith-based organizations, refugees, and other neglected/vulnerable groups. It is expected that the Consultative Group will include representation from northern and southern civil society, especially from IHP+ developing country signatories[2] - including civil society from IHP+ countries that have signed a compact, as well as those that have signed the global compact, but are not developing a country compact.

**Communication & Meetings**
The majority of interaction with members of the Consultative Group will be via email and telephone. Therefore it is required that members have regular access to these forms of communication. Frequency of teleconferences will be determined collaboratively and as needed. It is expected to have at least one teleconference quarterly.

The IHP+ CS listserv will be strengthened and utilized by the Consultative Group as one of the platforms for communication to the broader CS community. This will be supplemented by other forms of communication, such as mobile phone texting and other country- and regional-specific modes, in order to support effective consultation across various constituencies and regions. Other CS consultations of the SuRG, IHP+ working groups (WGs) and taskforces will be facilitated and coordinated in collaboration with SuRG, WG and taskforce designates.

The Consultative Group will meet annually, ideally prior to the annual IHP+ Ministerial Review meeting or another appropriate time. This meeting will be supported by the IHP+ core team (TBC).

**Time Commitment**
Consultative Group members are asked to commit approximately 10% of volunteer working time per month. Where membership has been identified by institution, the institution will be required to designate a focal point for the Consultative Group who will also be required to commit approximately 10% of volunteer working time. The institution should also be willing and able to provide support for the work of the institutional focal point. It is expected that participation will be for two years and can be renewable for a maximum of one additional
year; however only 50% of those on CS-CG can been renewed for an additional year thereby ensuring sufficient turn over.

In order to assess the contribution of the Consultative Group members, and for a matter of accountability, it is required from each individual member to draft and share a brief note on his/her key actions related to his/her commitment with the other Consultative Group member.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Action</th>
<th>Person(s) responsible</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building</td>
<td>Use CSHPAG call for proposals on opportunity to support new/existing umbrellas</td>
<td>Oxfam</td>
<td>January-12</td>
</tr>
<tr>
<td>Country CS organisation</td>
<td>Information on whether health CS umbrella networks exist in IHP+ countries</td>
<td>CSCG</td>
<td>February-12</td>
</tr>
<tr>
<td>Country CS organisation</td>
<td>Identify training opportunities &amp; share on listserve</td>
<td>CSCG</td>
<td>February-12</td>
</tr>
<tr>
<td>Country CS organisation</td>
<td>Where absent, initiate umbrella health CS networks in IHP+ countries through letters to health CSOs</td>
<td>CSCG</td>
<td>April-12</td>
</tr>
<tr>
<td>Country CS organisation</td>
<td>IHP+ lessons learning series documenting health CS network best practices</td>
<td>CT &amp; CSCG</td>
<td>June-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Review ToR and membership of CSCG</td>
<td>IHP+ CS Representatives - Elaine &amp; Louise, &amp; CSCG -</td>
<td>December-11</td>
</tr>
<tr>
<td>CSCG</td>
<td>Develop ToR and recruit communications focal point</td>
<td>IHP+ CS Representatives - Elaine &amp; Louise, &amp; CSCG -</td>
<td>January-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Call for applications/selection of new members</td>
<td>IHP+ CS Representatives &amp; ICSS</td>
<td>February-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Define clear roles, responsibilities, guidelines, action plan for CSCG members</td>
<td>IHP+ CS Representatives &amp; CSCG</td>
<td>March-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Identify and develop list of country/sub-regional focal points</td>
<td>IHP+ CS Representatives - Mayowa &amp; Innocent, &amp; CSCG -</td>
<td>March-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Develop process for performance evaluation</td>
<td>IHP+ CS Representative - Elaine, &amp; ICSS</td>
<td>April-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Develop communications strategy (incl. listserve, website, PR)</td>
<td>CFP &amp; CSCG</td>
<td>May-12</td>
</tr>
<tr>
<td>CSCG</td>
<td>Develop process for resource mobilisation for CS engagement activities (incl. learning from other delegations) - global, country, CFP</td>
<td>Mayowa, Tobias</td>
<td>July-12</td>
</tr>
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</tr>
<tr>
<td>CSCG</td>
<td>Annual meeting with CSCG</td>
<td>IHP+ CS Representatives &amp; CSCG</td>
<td>#######</td>
</tr>
<tr>
<td>ET &amp; WG</td>
<td>List of WG members (especially CS members) shared with CSCG and on IHP+ website</td>
<td>CT</td>
<td>November-11</td>
</tr>
<tr>
<td>ET &amp; WG</td>
<td>Strategy for managing participation in ET meetings</td>
<td>IHP+ CS Representatives</td>
<td>December-11</td>
</tr>
<tr>
<td>ET &amp; WG</td>
<td>Advocate for formal transparent process for selection of CSO representatives to WGs</td>
<td>IHP+ CS Representatives</td>
<td>December-11</td>
</tr>
<tr>
<td>IHP+ Results</td>
<td>Communication to countries and development partners for IHP+ Results involvement - raise participation on ET call</td>
<td>IHP+ CS Representatives</td>
<td>November-11</td>
</tr>
<tr>
<td>IHP+ Results</td>
<td>Communication to countries and development partners for IHP+ Results involvement - template letter sent to DPs and country governments</td>
<td>Louise &amp; CSCG</td>
<td>November-11</td>
</tr>
<tr>
<td>IHP+ Results</td>
<td>Ensure inclusion of CS engagement in IHP+ Results guidance</td>
<td>IHP+ CS Representatives &amp; Tobias</td>
<td>December-11</td>
</tr>
<tr>
<td>IHP+ Results</td>
<td>Contribution to CS indicators and qualitative survey paper</td>
<td>IHP+ Results &amp; IHP+ CS Representatives &amp; CSCG</td>
<td>December-11</td>
</tr>
<tr>
<td>IHP+ Results</td>
<td>Develop strategy for CS use of scorecards and IHP+ Results report, incl. dissemination</td>
<td>IHP+ Results &amp; CSCG - Tobias</td>
<td>May-12</td>
</tr>
<tr>
<td>JANS/CC</td>
<td>Share information on CS signatories to existing CC</td>
<td>CT</td>
<td>November-11</td>
</tr>
<tr>
<td>JANS/CC</td>
<td>Information on upcoming JANS/CC on IHP+ listserv</td>
<td>CT to ET to IHP+ CS Representatives, or Country CS representatives</td>
<td>Ongoing</td>
</tr>
<tr>
<td>JANS/CC</td>
<td>Information on upcoming JANS/CC disseminated at country level using existing communications platforms</td>
<td>Country CS representatives</td>
<td>Ongoing</td>
</tr>
<tr>
<td>JANS/CC</td>
<td>Contact Ministry of Health for CSO engagement in JANS/CC process</td>
<td>CSO umbrella network</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>