

GAVI Alliance Civil Society meeting
Geneva 8-9 October 2008

The GAVI Alliance held a meeting of civil society representatives in Geneva 8-9 October 2008. The approximately 25 participants were drawn from civil society in the countries eligible for GAVI support to CSO activities, the GAVI CSO task team, and the newly elected CSO representative and alternate to the GAVI Board. The main objectives of the meeting were to learn from civil society organisations (CSOs) from the ten pilot countries for GAVI CSO support, and to increase the awareness of CSOs as a key partner in the GAVI Alliance, including the development of a civil society constituency.

Contents

1.	Key messages and follow-up points	3
2.	Opening	3
3.	Overview of GAVI CSO engagement, GAVI's CSO funding opportunity, and the task team.....	4
4.	GAVI Secretariat teams and CSO engagement.....	5
5.	The role of civil society in the broader health and development architecture	9
6.	Summary of proposed GAVI CSO constituency.....	10
7.	Group work: Strengthening CSO constituencies at national level	10
8.	The Independent Review Committee – feedback from CSO proposal review..	13
9.	GAVI gender policy	14
10.	Group work: implementing GAVI CSO support	15
11.	Country experiences implementing GAVI CSO support.....	18
12.	Monitoring and evaluating the GAVI CSO investment.....	22
13.	Overview of CSO mechanisms and materials for communicating GAVI CSO support	24
14.	Closing	25
	ANNEX 1: PARTICIPANTS	26

1. Key messages and follow-up points

On GAVI CSO support:

- GAVI CSO funds take too long to reach country and this is seriously delaying and causing problems for implementation.
- Working with ministries of health is challenging for CSOs, and GAVI is encouraged to look into other fund flow arrangements.
- Lack of communication and organisation among CSOs is major barrier to CSO representation in national and international bodies. GAVI's Type A support aims to help CSOs get organised and strengthen their voice in relevant forums, the Secretariat, Task Team members and other partners will step up efforts to encourage countries to apply.

On GAVI CSO involvement:

- Task Team and Secretariat to finalise and obtain necessary approvals to enable implementation of the CSO constituency paper, simplifying it to focus (at least initially) on the Forum and the Steering Committee, ensuring an active group to support the CSO Board member and alternate

On advocacy:

- There is still little recognition of the important role CSOs play in immunisation, and all meeting participants will step up efforts to use existing evidence to increase recognition of CSOs.
- In the broader health and development community, GAVI can galvanise CSOs involved in immunisation and health, participating in the broader health debate at national and international levels.

2. Opening

The GAVI Executive Secretary, Julian Lob-Levyt, opened the meeting, emphasising the key role that civil society plays at all levels of immunisation and health, from service delivery to advocacy and policy development. He also emphasised GAVI's commitment to ensuring that the civil society constituency is highlighted and promoted and receives the necessary support. The ultimate aim is to ensure that CSOs help raise issues that other constituencies don't, that women and children receive the support of CSOs and CSOs remain engaged with advocating for resource mobilisation. Dr. Lob-Levyt thanked the GAVI civil society task team for providing critical guidance on the development of the GAVI funding for civil society. While GAVI is changing, there is still a civil society

seat on the new, merged GAVI Board, and a nominee for the new Policy and Programme Committee which will advise the Board.

Also, evolving GAVI policies provide opportunities for engagement with new segments of civil society. GAVI is discussing investing in new vaccines, such as HPV, which attracts the interest of reproductive health groups, women's groups, and other organisations, and GAVI is committed to ensuring that these groups are heard. In the broader development environment, GAVI has signed on to the International Health Partnership which emphasises alignment and harmonisation at country level. By participating in the recent meeting in Accra, we remain committed to implementing the Paris declaration on aid effectiveness. This very much promotes strengthened links with civil society groups, and the civil society task team as well as the secretariat are exploring how to become more involved.

3. Overview of GAVI CSO engagement, GAVI's CSO funding opportunity, and the task team

By Jane Schaller (International Pediatric Association)

From the very beginning the challenge has been to give a voice to civil society, including through recognition by national governments. In GAVI, there has been an NGO seat (as it was then called) on the GAVI Alliance board since 2000. Mark Kane was the first representative, and he pioneered the idea of regional meetings of CSO's. The next representative was the International Federation of the Red Cross from Sierra Leone, however during this time regional coordination became more of a challenge. The International Pediatrics Association (IPA) took over the NGO seat in 2004. Shortly after, a Partners Meeting took place in 2005 and it was around this time that the Task Team started coming together. In order to request funding from the GAVI Alliance Board, the Task Team, together with support from the secretariat, hired a consultant to show evidence on the importance of civil society in immunisation. On the basis of this study, two types of funds were requested from the Board, one for mapping civil societies in country and the other for direct support, now known as Type A and Type B respectively. In addition to CSO Funding, the Task Team also set up a process to democratically elect the next CSO representative. In fact, the Task team originally asked for two seats on the next Board and as a result succeeded in securing one Seat and one Alternate, allowing for representation of both North and South civil society.

Looking forward it will be necessary to discuss the future of the CSO constituency in GAVI. The Civil Society Task Team is time-limited and can only achieve so much in this time. Jane also reminded the meeting that since the start of GAVI there has also been a

significant shift in the way the alliance operates, and a broadening support to countries to also address bottlenecks to immunisation in the broader health system.

Discussion

With regard to CSO support window however there are challenges to attracting applications for Type A support. Craig Burgess from GAVI Secretariat agreed that the challenge has also been in communicating and raising awareness for this type of support among CSOs in all the GAVI countries. Jane noted that another challenge has been to justify disbursement to CSOs rather than directly to the Ministries. Mercy Ahun, the Head of GAVI's Country Support Team suggested that the question is simply to assure that the organisation to which funds are disbursed is auditable. One of the options that have been suggested is the use of umbrella CSOs. Majeed Saddiqui from Afghanistan suggested that the challenge when funds are channeled through government is that the money often takes a very long time to arrive to civil society. This is especially challenging as the CSO window of GAVI support is time limited.

Mette Kjaer of AMREF suggested that the Global Fund to Fight AIDS, TB and Malaria has also realised the limitations of disbursing to governments only and increasingly civil society organisations are the prime recipients of these funds. The health sector in developing countries is far from being fully participatory yet, and the Civil Society Task Team should advocate for direct support to CSOs. Huma Khawar from Pakistan suggested it is important to keep in mind the traditional rift that exists some countries between the government and CSOs. Maziko Hisbon Matemba from Malawi suggested that, for ease and speed of disbursement and implementation, UNICEF and WHO could also facilitate the fund disbursement in collaboration with the Ministry of Health. Joan Awunyo Akaba from Ghana reminded that the involvement of the Ministry of Health in the disbursement of CSO funds can also help to strengthen the relationship between CSOs and the government, as has been the case in Ghana. The participants agreed that UNICEF and WHO should be involved if they have strong links with the national government.

4. GAVI Secretariat teams and CSO engagement

Implementing GAVI CSO support

By Craig Burgess (Country Support Team)

The Board in late 2005 approved \$30 Million for two types of support: Type A for helping CSOs in each country organise and strengthen the CSO voice in national and international forums, and Type B for implementation of programmes. Some of the key challenges that we face with this window of support are:

- Ensuring that CSOs at country level have information, in particular regarding Type A support
- Balancing scrutiny while ensuring the government knows what CSOs can contribute. CSOs are making links into other sectors where the government in some cases does not. This is why CSO representation on the Health sector coordination committee (HSCC) or equivalent is vital.
- Making the application mechanism workable. Often there is the need for technical assistance for preparation of proposals
- Time pressure: the CSO support window is limited and there is a need to demonstrate results by 2010 to request and ensure more funding in the future
- Ensuring the voices of our key consumers, women and children in developing countries, are heard. GAVI has a CSO Board representative but how can we ensure that these voices arrive to him?
- There is a need to strengthen CSO coordination at regional levels. At present few regional networks exist in this sector. WHO coordinated Regional working groups could serve as an entry point for CSO engagement

Discussion

- In Ethiopia the pediatric society has been working closely with the government, especially on training health professionals in integrated management of childhood illnesses (IMCI). A number of activities are carried out with UNICEF and WHO in the areas of immunisation such as mid-level management (MLM) training and module development. The collaboration with the government, WHO and UNICEF helped the Pediatric Society establish itself as a reputable association as well as to strengthen its financial capacity
- In Malawi similarly it was recognised that the participation of CSOs in the preparation of HSS proposals has resulted in increased recognition from the government of the value of CSOs, however the limited capacities of CSOs remain a challenge.

Advocacy

By Geoff Adlide and Bjorg Sandkjaer (Advocacy and Public Policy Team)

The GAVI mission is best achieved by achieving influence at the global, regional and country levels in order to facilitate reaching our end goal: to save children's lives and improve people's health through improved access to immunisation. As part of our advocacy strategy GAVI assesses which global forums to participate in order to elevate the importance of immunisation and the role of public-private partnerships therein.

A great example of how far we have got in this respect is the advance that has been made at the global level since the Paris Declaration which referred to Public-private partnerships (PPPs) as a problem, to the Accra Agenda for Action a few years later in which PPs were acknowledged as having an important contribution to make to development. The H8 is another good example – this is the informal gathering of heads of agencies working on Health, including WHO, BMGF and WB. The inclusion of GAVI in this forum shows to what extent immunisation has been elevated since our inception.

Bjorg Sandkjaer talked about the interest that evolving GAVI policies are evoking among civil society groups that have not traditionally engaged with GAVI. This includes CSOs working on financing for development and access to medicine/intellectual property around IFFIm and AMC, and women's groups and CSOs working on reproductive health around possible GAVI investment in the HPV vaccine. This is very welcome engagement, and the Secretariat is looking for ways to engage flexibly and constructively with these (and other) CSOs around issues of interest.

Discussion and issues raised

- GAVI should advocate for the impact immunisation has and can have on reducing mortality rates (there is a wrong impression created by currently circulating statistics that vaccine preventable diseases do not contribute significantly to child mortality).
- GAVI should develop/produce evidence for more evidence based advocacy, including addressing the challenge of discrepancy between official data and NGO reported data on immunisation.
- Civil society in PAHO countries do not receive information about the GAVI CSO support, and the Secretariat should work with PAHO to get information out.

Advanced Market Commitment

By Tania Cernuschi (Technical & Policy Team)

Initially, GAVI's involvement of CSOs around the Advanced Market Commitment (AMC) Pneumococcal vaccine pilot¹, was reactive, in particular to the requests of a few NGOs who expressed a particular interest. From the onset CSO involvement and views have been strongly welcomed and this consultation has led to a significant change to one aspect of the AMC pilot model. A missed opportunity in the past has been coming to CSOs for consultation at a late stage rather than from the beginning. Learning from this example the Technical and Policy team has been trying to get CSOs involved from an

¹ For more information see: <http://www.vaccineamc.org/>

earlier stage in the process of monitoring and evaluation of the AMC pilot. One briefing has already been set up and more consultation is planned as the process continues. Looking forward there is a need to expand the consultation list. One of the key challenges remains to involve more CSOs at country level, however discussions are often quite technical and effective communication is an issue.

Programme funding and donor relations

By Ana Stefanovic (Programme Funding Team):

The Programme Funding Team is responsible for relations with donor governments, management communications around innovative financing and building constituencies in donor countries, with the ultimate goal to increase the predictability and sustainability of long-term financing for national immunisation programmes. Constituencies in donor capitals include CSOs as well as academia but also private individuals or organisations interested in our work. A Campaign to raise sources from private individuals called the Every Child Campaign also exists. It is based and managed out of GAVI's Washington office.

The program funding team engages with CSOs in donor capitals for a number of reasons: often we have common causes (such as health, children's rights, innovative financing) and we can also advocate together for increased government funding for these issues. In addition CSOs also have a keen interest in how their government's funds are being spent and we try to keep them informed on the use of funds by GAVI. We collaborate through exchange of information, joint events, as well as joint advocacy and publications. Experts from countries can also participate in GAVI through structures such as working groups and task teams, either standing or time-limited. The kind of engagement generally varies across the donor capitals, and some examples were given of some of the NGOs GAVI engages with more systematically.

Some of the challenges in our collaboration with CSOs relate to the schism between CSOs from the North and from the South (it was noted that this was also a challenge in the South!), as well as coordination of outreach from different departments. Recently some of the questions that donor governments have asked about CSO support have included to what extent GAVI CSO support is coordinated with Global Funds work with CSOs in countries, as well as how we can ensure that the CSO window does not end up producing parallel systems.

GAVI Governance transition

By Lisa Jacobs (Governance Team)

In 2005 the GAVI Alliance and the GAVI Fund management merged. A year later in 2006 the decision was made to also consider merging the GAVI Alliance and GAVI Fund Boards. The Board meeting taking place on 29 – 30 October will see the new Board structure launch. The idea is to maintain the public private partnership balance by including in the Board also private individuals – this is the first Board of its kind in the international development arena that we are aware of. The Board will be made up of 27 voting members, divided among 18 representational members and 9 independent. The current structure with a standing Working Group and a number of different task teams with undefined mandates and timelines will be considered by the new Programme and Policy Committee. The CSO board member alternate will be a member of this committee. The work on bringing the two Boards together is being led by a Governance Implementation Committee.

As of January 2009 the GAVI Secretariat will move out of UNICEF, which has provided our administrative platform here in Geneva until now.

5. The role of civil society in the broader health and development architecture

By Eileen Ireland (Action for Global Health)

The International Health Partnership (IHP) was created in an attempt to combine the various global initiatives on health under the IHP+, as part of an attempt to better coordinate aid and reinvigorate the Health SWAPs. There are still some discussions on the value added of such a mechanism especially in countries which already have a strong SWAP. So far Ethiopia and Mozambique have signed 'country compacts'.

Country compacts each have a monitoring and evaluation framework. A consortium is also going to be selected for ongoing M+E work. The current focus of this however is donor alignment and not outcomes for the health system. An first phase evaluation is scheduled for mid-2009.

The role of Action for Global Health in the IHP+ has been to ensure CSO engagement in this process both at the global and the country level. In order to achieve this, a Technical Advisory Group of CSO experts is in the process of being established as well as a CSO Electronic Forum which any CSOs can contribute to. It was suggested that immunisation should be reflected in this group of expertise. Funding has also been secured for a Communication Focal point that will support and give impetus to this

process by improving communication with CSOs globally and in countries which participate in the IHP+.

Discussion

- Very few meeting participants had heard of the IHP+, demonstrating that communication is a clear challenge.
- Participants cautioned that initiatives as the IHP+ may bring an additional administrative burden.
- CSOs in IHP+ countries should also feed into global IHP+ structures.

6. Summary of proposed GAVI CSO constituency

By Thomas O'Connell (WHO)

The CSO constituency paper lays out a structure for a GAVI CSO constituency which provides three levels of engagement:

- a CSO constituency, which is largely virtual (website, listservs), drawing in a wide range of CSOs interested in immunisation and health;
- a CSO forum, consisting of about 40 members, meeting once a year and providing feedback and input to the CSO representative on the GAVI Board and on other relevant issues;
- a steering committee, elected by the Forum, which consists of about five people and which provides more day to day input and participates actively in GAVI structures.

7. Group work: Strengthening CSO constituencies at national level

The groups' discussions focused on three main themes: (i) barriers and ways to overcome barriers to stronger CSO involvement in GAVI and in general, and (ii) based on previous experiences, advice for organising the civil society constituency, and (iii) geographical levels of organisation and structure to facilitate CSO influence in GAVI and health system policies.

- (i) Barriers to stronger CSO involvement, and ways to overcome them

The biggest challenges are:

- **Lack of financial, organisational, human capacity** to organise as civil society (within and among CSOs) to fulfill role as a bridge and clearly communicate issues and build trust between grass roots and policy makers.

- **Diverse and fragmented civil society** precludes strong voice (result of lack of capacity to meet + different points of view). CSOs don't share experiences between themselves.
- **Lack of government frameworks** ('political space') for CSO to be heard through formal channels (media, engagement with government). Some countries selectively recognise CSOs, and not being recognised is a challenge to involvement.
- **Lack of support from those you claim to represent**, disruption between grassroots and 'representatives'. Government, international agencies select unrepresentative CSO representatives.
- **CSOs that are 'GONGOs' ('Government Owned NGOs')**: CSOs only in name, but are really extended arms of government, claim space and raise issues that are not real concerns from the communities.
- **Historical context**: In countries coming out of conflict or where there has been a regime change, collaboration may be difficult between CSOs or between CSOs and governments for historical reasons.
- **Competition**: International and local CSOs can compete for the same space in-country.
- **Obscurity**: Lack of experience sharing from national to international levels.

These can be overcome by:

- International organisations (such as GAVI) involving CSOs (creates political space).
- Those who have leverage with governments (donors and UN agencies) at country level should dialogue with policy makers to create political space, more legitimacy for national civil society.
- Mapping; SWOT analysis; assessment as basis for (human, organisational, financial) capacity building and improved organisation.
- Bring civil society together, support to get organised at country level (GAVI Type A).
- Share lessons learned at international/global level (GAVI could facilitate).
- Social mobilisation to link communities with representatives/organisations.
- Address perception of civil society as problem – civil society as constructive partners! Bring out evidence to support advocacy.

(ii) Drawing on experience to organise the GAVI civil society constituency

General discussion outcomes:

- Civil society movements around HIV and AIDS are strong and successful advocates. It would be useful if civil society working on health more broadly could come together under a similar cause. The GAVI civil society constituency presents an opportunity to do that.

- Start with the CSO forum (a tighter group) and work towards building a larger, more broad-based constituency in an organic and logical fashion.
- The visibility provided by a visit from GAVI/partners has been useful to 'kick-start' GAVI support application development.
- Bilaterals are important supporters of civil society at country level.
- Think of GAVI CSO organisation as concentric circles: Steering Committee on the innermost layer; CSO forum in the middle layer; CSO constituency in the outermost layer

Experiences shared:

- TECHNET

- Developed as an in-person meeting every 1-2 years of field-experienced immunisation experts to discuss technological and operational issues of immunisation programs.
- Members were for the most part from funded organisations, although some key consultants were unfunded and had to locate funding each time to attend the meetings.
- This constituency was expanded into a TECHNET listserve, developed in about 1999 (now called Technet21) for moderated on-line discussion of operational issues, and includes some 900 or so people.
- TLAC (Technologies and Logistics Advisory Group) is a small, 12-member committee that has recently been formed to advise the WHO immunisation director.

- AGA KHAN

- Get CSOs involved first before asking them to work.
- Give-and-take relationship.
- Formalised partnerships with CSOs through MoUs.

(iii) Will organising at national, regional and global level facilitate CSO influence in GAVI and health systems policies?

General discussion outcomes:

- The national level form the basis for engagement at other levels. A well organised CSO 'constituency' at country level (eg. GAVI Type A-supported) would facilitate CSO engagement with national (Ministry or other) and international level bodies.

- Organising regional level is difficult but can be important for coordination, advocacy and information sharing across national boundaries in a particular region (e.g. polio outbreaks in Nigeria). General consensus to engage with the regional level when the national and global level constituencies are better established.
- Having too many layers is a challenge.
- Merge M&E for CSO involvement in the HSS framework and highlight role of CSOs in HSS.
- The global forum level is useful, but composition is important. Balanced representation of GAVI eligible countries is important. The forum is an important link between the CSOs and policy makers, and must take care to report back to their region (not just country) and share with all CSOs working in health sector.
- The forum should be lead by a steering committee, selected/ elected by the Forum and should have at least seven CSO members on board. Task and composition of the steering committee should be well defined. The Steering Committee should make sure that all regions are represented.

8. The Independent Review Committee – feedback from CSO proposal review

By Maureen Law (chair of HSS Independent Review Committee)

The Independent Review Committee (IRC) is the body which reviews all proposals to GAVI and makes approval recommendations to the Board. The IRC is comprised of about 10 independent experts, put together to ensure geographical and gender balance, as well as representing different expertise to enable a thorough review of proposals. Following the review, the IRC makes a recommendation to the Board of either

- (i) outright approval (has so far only happened once or twice),
- (ii) approval with clarifications (the country is asked to provide clarifications to issues that are not considered to fundamentally change the proposal, and there is no need for a re-review by the IRC),
- (iii) approval with conditions (the country has 12 months to respond to more serious concerns raised, and the response is reviewed by the IRC), or
- (iv) resubmission (the proposal is so poor that it has to be redone).

The Board makes the legally binding and final decisions about the approval status of the proposal. The same IRC reviews HSS and CSO Type B proposals. The first CSO Type B proposal was reviewed at the IRC held in November 2007. The subsequent IRC in April 2008 reviewed 5 CSO proposals, and the current IRC reviewed two proposals that received conditional approval in the previous round as well as two new proposals. In total, so far three proposals have been approved by the Board.

When reviewing CSO proposals, the IRC is particularly concerned about how certain issues are handled, such as:

- alignment with the national health plan and the country's HSS proposal: What is the added value of the CSO proposal? (must be more than replacement of funding)
- what was the process to select the organisations and areas of work? What were the criteria employed, and how was the inclusiveness of the process?
- There must be clear links between the objectives, activities and indicators in the proposal.
- Budgets must be detailed and show costed activities, not just overall lump sums.
- The proposal should show evidence of coordination of efforts in the implementation phase. One of the objectives is to bring government and CSO together to increase immunisation.

9. GAVI gender policy

By Eva Wallstam and Ana Stefanovic (GAVI Secretariat)

The GAVI Alliance and Fund Boards approved "The GAVI Alliance Gender Policy – Towards Gender Equality in Immunisation and related health services" in June 2008.

The goal of the policy is to promote increased coverage and effectiveness of immunisation and related health services by ensuring that all girls and boys, women and men receive equal access, to these services.

GAVI has committed to integrate a gender perspective in all its work plans, programs, policies, mechanisms, guidelines and through new responsibilities of its managers, based on four strategic directions of the Gender policy:

- Generate, report and analyse new evidence.
- Ensure gender-sensitive funding and policies.
- Advocacy for gender equality as a means to improve immunisation coverage and access to health services.
- Gender sensitive approaches within the GAVI Alliance structures.

To facilitate this work, an **implementation plan** is currently being developed for the Secretariat and across the Alliance partners, to be ready by the end of 2008.

Discussion

Suggestions:

- Look beyond immunisation to the broader health systems.

- Need to be clear about what data we are trying to gather.
- Look at immunisation in the context of fragile states.
- Disaggregated data in immunisation are largely missing with the exception of tetanus. CSOs can be seen as one source of information.
- Ensure countries are not overwhelmed with demand for data.

Examples:

- Malawi men are not engaged in immunisation of their children as this is seen as the mother's role. It is important to look not only at who is being immunised but also at who is bringing the child for immunisation.
- Sri Lanka has been found to be one of the few countries where both fathers and mothers come together to immunise their child. The country is also very systematic about social mobilisation for immunisation.
- In Bangladesh the report "Immunisation divide" may be of interest. It was originally censored by the Ministry of Health.
- In Kenya due to political crisis and the subsequent weakening of health systems, the immunisation coverage has dropped to around 40%. Gender impact of such change should be assessed. Many states in Africa are in crisis.

10. Group work: implementing GAVI CSO support

The groups discussed four questions, and the discussion outcomes are summarised below.

1. **Monitoring and Evaluation:** what support (training, resources) is needed to help CSOs assess their annual progress against agreed upon plans? What mechanisms could best document the qualitative as well as quantitative aspects of CSO work?

Discussion outcomes:

Support for M&E activities is required. This could include:

- **Capacity building:** In documentation the organisation's activities qualitatively (stories and written reports that can form the basis for advocacy, lessons sharing, organisational memory) and quantitatively (tools such as software; and training). GAVI Secretariat and partners can provide this support.
- **Documentation to underpin decision about GAVI CSO support for the future:** need to assess performance quantitatively and qualitatively (there is a decision to make in 2011: how will GAVI know?) through systematic fact finding (visits to countries, case studies for deeper qualitative information); committing adequate resources to enable GAVI to do this.

- **Ten pilot countries:** regional M&E meetings.
 - **CSO:** GAVI should provide to countries a core set of illustrated indicators and guidance note on how to measure the activities of CS in countries and they should remain flexible on country context. Timeframe for monitoring should be clearly stated.
2. **Increased uptake:** What would you recommend to GAVI to help CSOs become better informed about GAVI funding opportunities (Type A & Type B)? What would help to encourage CSOs and MoHs to apply?

Discussion outcomes:

- Involve other agencies to mobilise CSOs at country level (e.g. WHO, UNICEF, bilaterals).
- Have CSOs participate in the mapping process so that the CSOs are more involved in the GAVI initiatives rather than just receiving information.
- Build on existing structures (CSO coordinating mechanisms) and international NGOs.
- Spread information directly to CSOs and not only to the MoH.
- Better communicate the funding opportunities to the MoH and emphasise the CSO engagement as a requirement.
- Address language issue (translate documents into Spanish).
- Increase the country visits and hold workshops. GAVI raised the issue of joint country visits with other partners as this is part of a common effort to not overburden countries, however in some countries (e.g. Afghanistan) joint missions have become “giant” Missions and become much more complicated to prepare and manage. Joint missions seen as more favourable solution only in case of executive visits.
- Establish GAVI focal points (maybe they could be from UNICEF or WHO?) at various levels in-country.
- Disseminate materials customised for the country and include a contact person (leaflets, flyers, newspaper adverts, radio, etc).
- CSO recipient contact information and website or forum for CSOs to share experiences.
- Compose a GAVI “official” email promoting this support that we (this meeting participants) can disseminate to our networks.
- Provide technical assistance for proposal development – either externally or internally.
- GAVI should revise (i) the requirements for CSOs that can receive support (the registration for three years excludes relevant organisations) and (ii) type A support to make it more attractive (revising amount, scope, type of activities)
- Sustainability of cross-cutting consortiums created for this support limited to duration of funding.

3. How can you **increase CSO participation** in the HSCC and other decision making bodies?

Discussion outcomes:

Steps required to get organised – based on country experiences:

(i) IDENTIFY THE CSOs IN YOUR COUNTRY

- Faith based organisations
- International NGOs
- Local and national NGOs
- Academia
- Professional societies – all levels of the health system
- Labour unions
- Women's / Men's Groups and other CBOs
- Business Groups
- Youth Groups
- Media – Newspapers, TV, Radio

(ii) IDENTIFY PROCESS FOR CSO ORGANISATION

- Identify/one CSO takes on role as convener
- Bringing together relevant organisations: clarification of mandate
- Decision making: what does the group want to do/achieve?
- Create consortium
- Emphasise standards: transparency, credibility
- Identify support/funding needs and look for funds/support

(iii) EXTERNAL VISIT (GAVI Task Team/Secretariat)

- Useful to convince minister of the value of civil society
- Can help/give weight to request to inclusion of CSOs on HSCC

4. **Fund flow:** What are the problems with the flow of GAVI funds to CSOs, which you would be able to solve at your level?

Discussion outcomes:

- Problems at country level include (i) procurement legislation which specifies that funds cannot go out from MoH without a transparent bidding process, and also that bidders need bank guarantees which CSOs generally are unable to obtain (Afghanistan), (ii) funds may arrive, but the right part of the MoH not be notified.
- Delay in funds transfer from GAVI is the main obstacle to implementation.

Solutions:

- Include funding options in the proposal so the CSOs can specify which options would work best in their situation and provide the justification and explanation of how it is accountable and auditable
- Talk with grant-making foundations to see how they deal with all of these issues. Learn from their discussions, decisions, and experiences. In particular Global Fund on their experience in pioneering use of CSOs as primary recipients of funds.
- Solutions which are found are sometimes only temporary – need to find sustainable solutions
- Two year pilots should only be started once all the frameworks for its implementation are explored and in place. GAVI must find alternate mechanism for fund disbursement.
- Multilateral organisations in country can sometimes be very bureaucratic and slow process down also. WHO prefers not to hold funds as this is not seen as part of its mandate.
- Ideally it should be the government or national CSOs who take the responsibility for funds (rather than multilaterals) in line with the principle of country ownership
- There have been challenges in how to transfer funds, e.g. of DRC where \$35 000 was lost in bank transfer charges from the MoH to the CSO consortium.

11. Country experiences implementing GAVI CSO support

Democratic Republic of the Congo

DRC is experiencing one of the highest maternal and infant mortality rates globally, as well as high mortality from vaccine preventable diseases among women and children. There are a number of factors that come together to create this situation, including lack of community involvement, low health worker motivation, and low coverage because of lack of financial, technical, logistical capacity. Following the prolonged conflict, security is still an issue.

Overall, GAVI is one of the main contributors to support for immunisation.

In the context of a run-down health infrastructure and a country struggling to rebuild following amidst the remains of a violent conflict, NGOs, and particularly faith-based organisations play a key role in health service delivery. About half of the country's health zones are administered by catholic and protestant FBOs, which have a long history of service delivery in DRC.

When the opportunity to apply for GAVI CSO support presented itself, a consortium of 5 NGOs (Association of Rotary Clubs in DRC (ARCC), Catholic Relief Services (CRS), the rural health programme of the Protestant Church (ECC/SANRU), the DRC Red

Cross (CRRDC), and the National Council of Health NGOs (CNOs)) was formed to apply. Together, these NGOs cover 65 (roughly 10%) of all health zones in the country. The consortium is organised to carry out different, complementary roles: CNOS is responsible for overall advocacy, CRRDC provides technical support and social mobilisation, and ECC/SANRU (25 health zones), CRS (26 health zones), ARCC (14 health zones) each provide services in health zones they are present in.

The objectives of the GAVI-supported CSO activities in DRC are to (i) increase immunisation coverage, (ii) improve participation of other local CSOs, (iii) increase resources for vaccines (government contribution and other partners).

The project started in May. Some activities are on track, but there are some delays in training. The consortium is implementing advocacy to local and national government, and experience-sharing with others (GFATM) to show what GAVI can do is ongoing.

Challenges: (i) This is a pilot for DRC as well, it is the first time to have a consortium. Organisations are learning as the project unfolds, but there are delays in some activities. (ii) The project budgeted with the cost of bank transfers from the consortium to each of the consortium members, but did not budget for the bank charges associated with transfer from the Ministry of Health to the consortium. The project has lost USD 35,000 as a result. (iii) DRC is still waiting to receive the Type A funds. This is unfortunate as the country would have preferred to implement the Type A-funded activities first (as is also advised by GAVI), but to avoid further delay the country decided to go ahead and implement the Type B-funded activities. (iv) The CSO proposal is integrated with the GAVI HSS proposal, and there are significant delays in HSS implementation, which has knock-on effects on implementation of CSO Type B funds, however, implementation has been able to start in about 20 health zones.

Pakistan

The GAVI CSO Secretariat visit in September 2007 was a catalyst for Type B proposal development. For this meeting, relevant CSOs, (NGOs and INGOs, academic institutes) working on maternal and child health at provincial and national level, were identified. Most of the CSOs had a history of working with either Ministry of Health or partner organisations (UNICEF and WHO) on immunisation, social mobilisation or health system strengthening. An invitation was sent out by the MoH to more than 30 CSOs, who attended the meeting in Lahore.

Following the September 2007 Meeting, a proposal for GAVI Type A support was developed and on receiving the approval (in December 2007), a scrutiny/evaluation of the CSOs who had expressed interest to the Ministry of Health in the new initiative was

carried out by a consultant hired as a CSO Coordinator by the Ministry of Health. This was done to ensure that the CSOs fulfilled the strict criteria given in GAVI Guidelines to ensure eligibility as a recipient of Type B funding. The CSO Coordinator of the MoH, personally visited the office of each CSO to meet their *staff*, gather information on their *registration, years of working and completed similar projects* (criteria in GAVI Guidelines). As a result of the process one CSO was found to be a 'ghost' NGO.

To inform the CSOs of the details pertaining to Type B support, a follow up meeting of the CSOs was organised in January 2008. The organisers asked the CSOs to choose the objectives and activities (from the HSS objectives) depending on their comparative advantage and geographical presence and submit a proposal (Type C) keeping in view the limited time available to complete the pilot project. Out of the 19 proposals (Type C) received by the MoH, 15 were accepted by the technical working group set up to handle the GAVI CSO support. These 15 CSOs formed a consortium.

Within the consortium, the 15 CSOs were subdivided into three clusters based on geographical presence. Each cluster nominated one CSO as their coordinator.

The 15 CSO proposals were merged into one Type B proposal and submitted to the GAVI Secretariat on March 7th, 2008. In April 2008, Pakistan received 'Conditional Approval' for the proposal, meaning that some issues had to be addressed and approved by the Independent Review Committee (IRC) before final approval would be given by the GAVI Board. The Cluster Coordinators and the CSO Coordinator worked together to address the conditions and submitted them in September 2008, to be reviewed at the IRC meeting to be held in October 2008. On November 4th, 2008, Pakistan was informed about the approval of the Type B proposal (with clarification).

While forming the GAVI CSO consortium, CSOs raised concern about the sustainability and need of a consortium (as the funds are limited and available for a limited time), as well as about duplication (another health network exists, but could not be included because of GAVI's criterium that eligible organisations have to be registered for at least three years).

Under Type A support a work plan was developed for 2008, by the Cluster Coordinators to strengthen the capacity of partner CSOs and learn from each other's experiences. Exchange field visits at project sites were held in second and third quarter of 2008 by all the three clusters and a training workshop for all the clusters was planned for the last quarter of 2008.

There is no head of the CSO consortium, and all the three cluster coordinators are nominated to sit on NHSCC (the national health sector coordination committee), to ensure participation at the meeting by at least one member. This was approved by the

Health Secretary (MoH) who chairs the NHSCC. CSOs still have apprehensions whether they will be heard, but would like to try this representative role to have a voice at the policy level. The organisation around the GAVI support has therefore strengthened the CSO representation in the Ministry of Health.

Unfortunately, due to delay in transfer of Type A funds (from GAVI to UNICEF Pakistan), the activities (under Type A), while started with UNICEF support, could not continue as planned in the last quarter 2008. Eleven months after the approval (in December 2007) Pakistan is still waiting for the funds from GAVI.

Afghanistan

In tandem with the GAVI HSS implementation, Afghanistan sought to develop a CSO proposal that would complement the activities included in the country's HSS proposal. Some donors (GFATM) have rigid criteria on announcement of funding opportunity, such as a requirement to advertise in the media, and so this will be done – however, the Ministry of Public Health already works very closely with civil society to bring health services to the war-torn country, and therefore already has a good overview of relevant organisations. Starting the process toward GAVI CSO proposal development, the Ministry of Health invited more than 200 CSOs to a meeting. A CSO coordinator was elected during the first day of the meeting, and he chaired the meeting's second day. The meeting participants decided on the priority areas for the CSO proposal in order for it to link with the HSS proposal. These criteria were approved by the steering committee for HSS (a body in the MoH), and publicly announced together with some additional criteria, such as a requirement for larger CSOs to form consortiums with smaller CSOs to ensure that funding did not just go to large CSOs with proposal writing capacity. CSOs then applied with full proposals, and these were reviewed using a scoring system. Nine organisations or consortiums were selected, and their proposals were integrated and sent to GAVI. There have also been other positive spin-off requests: Previously, the MoPH selected the CSO representative to the CGHN. In January, there was a meeting to discuss representation, and as a result there are now two CSO representatives in this important coordinating body. WHO provides technical assistance.

Ghana

Following last year's GAVI civil society meeting, the Ghana representative brought back information about the support opportunity. The deadline for proposal submission was very tight, and the guideline said the support shouldn't be spread too thinly. Ghana therefore started working with nine CSOs to develop the proposal. A GAVI visit (on other issues) raised why the country had not applied yet, which brought the Ghana Health Service to call a meeting with CSOs. Using the guidelines, the GHS found it

difficult to limit the CSOs who could apply, and decided to draw up and circulate criteria for CSOs to access GAVI funding.

A team comprised of GAVI CSO Task Team and Secretariat then visited the country, and held a meeting with the CSOs and the GHS. This meeting decided that there is a need for a CSO consortium, because not all CSOs present were members of the CSO coalition of NGOs in health, which had initially been involved in proposal development. The GAVI visit and the ensuing renewed thinking about proposal development enabled a broader range of CSOs to become involved.

The broader CSO consortium was formed, identified gaps in the health system plan, and invited CSOs to apply for activities to fill these gaps. The directorate of planning lead the process. There were five major CSOs in the consortium, and the country was aware of the total funding amount available: 380,000 USD. The consortium divided the funding into 25 'slots', selected CSOs that work in disadvantaged areas (geographically), and allocated slots to regions. When the funding is awarded, consortium members will receive funds according to this system.

Lessons learnt from country level proposal development processes

- Visits by GAVI CSO Task Team/Secretariat have been useful in sparking country engagement with the GAVI CSO support and more inclusive proposal development processes.
- Several countries saw a need to adapt the guidelines to their particular context, and chose different solutions (Afghanistan chose two of the HSS proposal principles to ensure close linkages with the HSS proposal, for example).
- The broad definition of 'civil society' posed a challenge to many countries, where such a broad range of organisations were not used to working together. The Ministry, in convening these groups, also needed time and in some cases clarification from the GAVI Secretariat and/or Task Team through a visit before getting the broad range of CSOs involved in developing proposals.
- CSOs organising to access GAVI support has had positive spin-off effects such as strengthened CSO representation in Health Sector Coordination Committees or equivalent.

12. Monitoring and evaluating the GAVI CSO investment

Monitoring by Craig Burgess (GAVI Secretariat) and evaluation by Abdallah Bchir (GAVI Secretariat) and Robert Steinglass (JSI/ImmunizationBASICS)

Monitoring: Overall, GAVI is moving towards a more results-oriented, accountable, auditable approach. Aiming not to create additional reporting requirements, the country

should report on GAVI Type B CSO support, including audited reports, through the annual progress report (APR) the country submits to GAVI by 15 May every year. The APR is reviewed by the Monitoring IRC. Importantly, the CSO is accountable to the monitoring body in the country, not to GAVI, and may be requested to report more frequently to this body.

Discussion

- For monitoring, process indicators are required, and this should be built in to the proposal and agreed between relevant parties.
- To determine global monitoring indicators, we could start with those included in the submitted proposals – each country looking again at their proposals, and the Secretariat drawing together these indicators (GAVI Secretariat to do).
- Monitoring of different types of CSOs raises different challenges. GAVI could develop typologies of organisations (eg. service delivery CSOs, advocacy CSOs, etc) and apply monitoring indicators by type of CSOs (top-down approach) to ensure some consistency across CSOs and countries. In addition, each country could apply more tailored indicators to capture specifics (bottom-up) (Secretariat to do).
- Managing expectations: in the short time frame for implementation, process (and possibly output) is really only what can be monitored, should have low expectations of output and outcome. Qualitative rather than quantitative aspects in focus.
- Documenting lessons learned is key to subsequent decision-making on continuation of support/learning (Secretariat/Bjorg to gather from countries).
- CSOs have limited capacity to delineate indicators, and capacity building may be needed to strengthen monitoring during implementation.
- Type B support implementation is reported through the country's annual progress report (APR) to GAVI. It is therefore important that CSOs are involved in APR writing. To make this happen, GAVI secretariat should encourage countries implementing Type B support to include CSOs in APR writing, and the CSOs in Type B countries on their part will contact their respective Ministries of Health to ensure they are included in the reporting exercise.

13. Overview of CSO mechanisms and materials for communicating GAVI CSO support

By Bjorg Sandkjaer (GAVI Secretariat)

As discussed in previous meetings, the objective of CSO related communication activities is twofold: (i) increase uptake of GAVI CSO support; (ii) increase awareness of the role of CSOs in immunisation and health at country and international/GAVI levels.

To increase uptake of GAVI CSO support, a number of activities have been undertaken. For the Type B support, the Task Team has visited 8 countries together with GAVI Secretariat staff, and these have all submitted proposals. Three countries (DRC, Indonesia and Afghanistan) have been approved. Two countries (Bolivia and Georgia) have not yet applied.

To advocate for increased uptake of both types of GAVI CSO support, information about this funding opportunity has been included in standard presentations given by GAVI Secretariat staff in country visits. During some country visits, GAVI staff also meet with CSOs. Fact sheets and other materials have been developed and disseminated through meetings and the website. However, these efforts have not been stepped up to the extent discussed at the May meeting, due to internal problems with fund disbursement. These are now largely solved, and we can therefore confidently campaign for uptake of GAVI CSO support.

As the applications for both type A and B need to come through the Ministry of Health, that is our main target audience. As target audiences in their own right, but also as channels to reach the various Ministries of health, are civil society organisations and multilateral and bilateral GAVI partners. The group agreed that civil society organisations, such as those represented at the meeting will work through their networks, relevant partners and country offices to create demand for this support in the countries that the organisation is present. To not spread ourselves too thinly, the group agreed to focus on the countries with the larger lump sums (more attractive) and those where Task Team members have contacts (feasibility).

To increase awareness of the role of CSOs in immunisation and health at country and international/GAVI levels, the group agreed that a more tailored approach is required, making use of existing networks and meetings. The Task Team members, when going to a meeting where these issues could be raised, will do so – requesting the support of the Secretariat as required (providing background information, fact sheets, slides etc).

In addition to this targeted effort, the group agreed that to spread information widely, the group will make use of e-mail lists, listservs and web forums, posting information on lists

and forums (with cc to Bjorg, just to keep track), and/or to send Bjorg/the Secretariat contact details for lists and forums that participants find useful and think should be used to spread information.

Follow-up:

- Participants send information about listservs and web forums to Bjorg
- The Secretariat to circulate materials (Q&A in English and French, fact sheet, link to GAVI website) to participants
- Participants to seek out opportunities to advocate for Type A uptake, and to request Secretariat support to do so.

14. Closing

Faruque Ahmed thanked all the attendants for their participation and highlighted what an important learning experience this had been. The group comes with an incredibly rich experience that will benefit the CSO work. Jane Schaller also recognised the diversity of the group and the fruitful discussion that was had. In the future it will be important to engage translators, even if voluntary in order to allow full participation of all colleagues.

When reflecting on expectations outlined at the beginning of the meeting it was felt that most had been fulfilled. Key areas to follow up on are:

- Architecture of GAVI CSO engagement.
- Funding modalities for HSS and the CSO window.
- Monitoring and Evaluation.
- Communication.
- Commitment of all the meeting participants to diffuse information regarding GAVI CSO support and engage with other CSOs working in health in their countries.

The group then held a one minute silence for Task Team member Simon Mphuka, who tragically passed away earlier this year. The group also sent all their best wishes to CSO focal point in the GAVI Secretariat, Nilgun Adaygan, for a speedy recovery.

The meeting closed with a quote from Simon: “A closed door gives you an opportunity to open it in the future”.

ANNEX 1: PARTICIPANTS

Name	Affiliation
Faruque AHMED	BRAC, CSO representative to the GAVI Board, GAVI CSO Task Team
Leah BARRETT	VillageReach, Mozambique
Kathy BARTLESS	Aga Khan Development Network
Edwin Vicente BOLASTIG	Health Systems Action Network
Pascal DAHA BOUYOM	Health Social Scientist, Cameroon
Craig BURGESS	GAVI Secretariat
Liliane DIATEZULWA	Project Manager GAVI CSO consortium, DRC
Kate ELDER	International Federation of Red Cross and Red Crescent Societies, GAVI CSO Task Team
Amparo ERGUETA	New Initiatives Manager, PROCOSI Bolivia
Alan HINMAN	Task Force for Child Survival and Development and alternate CSO representative to the GAVI Board, GAVI CSO Task Team
Jean KASEYA	SANRU, DRC
Huma KHAWAR	Coordinator GAVI CSO Alliance, Pakistan
Mette KJAER	African Medical and Research Foundation (AMREF), GAVI CSO Task Team

Maziko Hisbon MATEMBA	Health 'n Rights, Blantyre, Malawi
Amha MEKASHA	University of Addis Ababa, Ethiopia
Tom O'CONNELL	World Health Organization, GAVI CSO Task Team
Majeed SADDIQI	HealthNet/GAVI CSO focal point, Afghanistan, GAVI CSO Task Team
Bjorg SANDKJAER	GAVI Secretariat
Jaya SHAH	Rotary, Nepal
Jane SCHALLER	International Pediatric Association, GAVI CSO Task Team
Ana STEFANOVIC	GAVI Secretariat
Robert STEINGLASS	JSI/IMMUNIZATIONbasics, member of GAVI CSO Task Team