Zimbabwe

CSO GFF Platform-building and Action-planning Meeting Report

PVO 01/2014

Hosted by the **CWGH** in co-operation with the GFF Zimbabwe CSO Interim Steering Committee

With support from **CSO GFF HUB**

19-21 February, 2020
Harare, Zimbabwe

Contents

I. Background

Zimbabwe joined the GFF in July 2019 to improve the health and nutrition of Zimbabwean people. The Government of Zimbabwe through the Ministry of Health and Child Care (MOHCC) is currently leading the GFF process.

The experience of GFF countries has shown that civil society is most effective when it is structured and coordinated in a coalition. Through forming a new GFF CSO Platform, or designating an existing platform for engagement on GFF, Zimbabwean civil society can be stronger together. Civil society can collectively define priorities to share information, ensure that policy and program "asks" by different members of the platform are mutually reinforcing and emphasize shared concerns, and streamline engagement with government and donors.

A small team of Zimbabwean civil society organizations working in the health sector formed an interim coalition steering committee: CWGH, supported by Zimbabwe AIDS Network (ZAN), Women's Action Group (WAG), and The Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR Zimbabwe). This group worked with the CSO GFF Resource and Engagement Hub to design a workshop to orient Zimbabwean health civil society organizations to the GFF, and develop plans to engage in the process. Two weeks before the meeting, the draft Health Sector Investment Case was shared with the interim steering committee, and so this was integrated into the meeting agenda.

Specific meeting objectives were:

1. To bring together CSOs that are working on GFF focus areas for dialogue, and even those working to strengthen those focus areas;

2. To ensure all participants have a common understanding of the GFF mechanism;

3. To identify opportunities and develop plans to engage in the GFF processes; and

4. To define a structure or platform for civil society to engage in the GFF processes.

Anticipated outputs of the workshop were: (1) Civil society health sector investment case priorities identified; and (2) A coalition/group governance structure & responsibilities.

The interim steering committee identified participants based on being membership based organizations working in the health sector, or whose work is related to health. On the first day, the meeting was open to wider stakeholders including a delegation from the World Bank, USAID, and other development and technical partners. At the outset of the meeting, participants expressed their expectations around 5 broad categories: understanding the GFF, coalition building, health sector challenges, engagement & action planning, and accountability.

II. Health Sector Investment Case & GFF Process in Zimbabwe

Ministry of Health and Child Care

Mr. Gwati Gwati who is responsible for donor coordination from the Dept of Policy and Planning of the Ministry of Health and Child Care (MOHCC) presided over the official opening of the workshop. Mr. Gwati Gwati presented some of the health sector challenges that had been identified, and how the MOHCC plans to overcome them.

He started by reviewing the status of the health sector in Zimbabwe. Zimbabwe is a leading country in family planning and contraceptive use, although the maternal mortality ratio remains unacceptably high. Gaps in health service delivery include a mismatch in the number of workers compared to population, skills-mix, and geographical distribution of human resources for health, as well as poor remuneration for health workers. Health infrastructure and equipment is old and is not well maintained, and there are too few health facilities. Existing facilities have low availability of medicines and supplies. There is also a lack of a well-defined, comprehensive health benefit package. Financial protection is weak, there is no implementation of the free user fee policy particularly in urban areas (these are also the areas which are not implementing the results-based financing project). In fact, declines in out-of-pocket spending which will be shown in the forthcoming 2017-18 National Health Accounts should be interpreted to say that the health system in Zimbabwe is so unable to meet people's needs that health seeking behavior has suffered to the point that people would prefer to stay home and die than go to a health facility.

Mr. Gwati Gwati explained that the MOHCC is taking important steps to address the causes of these challenges. Zimbabwe has just concluded its Mid-term Review (MTR) for the National health Strategy 2016-2020. The MOHCC also completed the development of a National Health Sector Coordination Framework, to overcome challenges posed by verticalized funding for disease specific programmes. Weak corporate governance, as expressed for example through greed and mismanagement, will be addressed through full implementation of corporate governance act within MOHCC.

The MOHCC has developed a zero draft of the Health Sector Investment Case (HSIC) which will complement this framework. The main goal of the HSIC is to present a set of high priority reforms/interventions to advance the country's UHC agenda. Specific objectives are to:

- Outline the bottlenecks in the health system
- Articulate a Theory of Change
- Guide investment with clear strategies and costing interventions
- Utilize the one plan, one implementation, and one monitoring framework
- Increase funding for health sector by jointly advocating for new financing, especially domestic resource mobilization
- Link health sector reforms to national budget and planning process
- Improve accountability in line with planned results and the country's regulatory frameworks

By making the HSIC broad, the MOHCC is ensuring that the HSIC is inclusive of all the priority areas and emphasizing the country-led aspect of the GFF process. At this point, the Ministry is slowing down on the HSIC development to ensure broader stakeholder involvement, further prioritization, and costing. The MOHCC is also pausing on the HSIC to develop its National Health Sector Strategic Plan by June 2020, following the MTR. A NHSSP Taskforce has been established with technical working groups in the same six priority areas as the HSIC task teams. The MOHCC is planning a formal consultation on the NHSSP around March 15-16. Once the NHSSP is completed, MOHCC will align and re-prioritize the HSIC based on the outcomes.

In terms of the GFF process, the Government of Zimbabwe recognizes the strength in using existing structures and strengthening them for the HSIC, rather than creating a new one. It is planning to merge the Health Development Fund (HDF) steering committee and the Country Coordinating Mechanism (CCM) for use as the GFF multi-stakeholder country platform, but is still figuring out exactly how that will work.

Mr. Gwati Gwati explained that Zimbabwe is a special case GFF country. Since the government is not servicing its current debts to the World Bank, it is not currently eligible for the larger project typically funded by the World Bank. Zimbabwe will receive a US$25 million GFF Trust Fund grant to expand the RBF project in Harare and Bulawayo and is anticipating further funding from the Government of Zimbabwe, and financing from other partners unnamed at this point (later in the meeting, participants learned that the government of Zimbabwe is providing another US$34 million to maintain the RBF project).

In February 2012, Stakeholders convened to review the Zimbabwe Equity Watch and in the discussions for improving equity proposed options for funding Universal Health Care (UHC). Stakeholders concluded that domestic tax based health financing should be strengthened, to grow as the economy recovers in Zimbabwe, and that tax financing for health needs to be progressive, linked to sectors that are expected to grow substantially in the economy and linked to population health and health behavior. Mining, tourism, agriculture, transport/infrastructure and consumption taxes (such as on alcohol and cigarettes) were identified as options, and earmarking mining, tourism and airline taxes, alcohol and cigarette duties, road taxes, VAT and financial transaction taxes were identified as areas that should be further explored.

Community Voices

After the presentation by Mr. Gwati Gwati, participants from communities around Zimbabwe shared their perspectives, which were welcomed by Mr. Gwati Gwati.

Thabiso Sibanda, of DOT Youth Zimbabwe, questioned whether people are getting services for health? Is their right to health dignified? There are no medicines in the clinic, or people are asked to pay in US dollars for prescriptions, but who gets paid in US dollars? The bottom line is that people aren't going to health centres because they can't afford it. Some of the gravest challenges are with young access to quality emergency services and cited an example of a young woman going to emergency services in an ox-drawn cart.

Martha Tholana explained the particular challenges that she faces living positively and with painful, chronic non-communicable disease Ankylosing Spondylitis (a form of arthritis). There is no "one-stop-shop" for medicines, so public health in Zimbabwe means you go from queue to queue. There is no ability to manage pain in the public health system, and challenges remain with HIV/AIDS.

Mr. Gwati Gwati (MoHCC), *extreme right* with Martha Tholanah (*left*) and Thabiso Sibanda (*in the middle*)

Ezabel Mombe, Village Health Worker, speaking in Shona. Despite their vital functions, the numbers of VHWs and the role played by VHWs has diminished over the past two decades in Zimbabwe. Whilst communities cite low morale due to lack of incentives as the major setback, the VHWs point to lack of incentives and supporting resources and protective equipment as a major barrier to their performance. In their early years, Village Health Workers benefited from incentives such as uniforms, bicycles and allowances, which were meant to enhance their work and motivate them. Bicycles were both a token of appreciation, and a tool to enable these volunteers to take their services to a wider population. The allowances they received helped them to buy basic necessities such as soap, so that they could look presentable whilst they carried out their duties. These incentives are now a thing of the past; and the remaining cadres are at times compelled to use their own resources to ensure that they can continue to serve their communities.

GFF Secretariat and World Bank

Dr. Patron Mafaune, the GFF Liaison Officer in Zimbabwe, provided an overview of the Tanzania GFF Orientation workshop and the process to date in the country, as well as the Roadmap moving forward. The Zero draft of the HSIC was developed by a small writing team and was shared with the newly formed CSO HSIC Coalition for comments and input. The HSIC Technical Working Group responsible for developing the document established six task teams to advance certain health sector priority areas. They are:

1. Health Systems Strengthening
2. Service Delivery Platforms
3. Non-Communicable Diseases
4. Communicable diseases
5. RMNCAH+N
6. Health emergencies & emergencies in health

On the third and final day of the workshop, Dr. Ayodeji Oluwole Odutolu "Wole," the GFF Secretariat Focal Point for Zimbabwe encouraged civil society in Zimbabwe to keep engaging government and development partners all the way through to implementation. He recognized that civil society plays a key role in advocacy, representation, and sensitization of communities and demanding accountability. He also noted that civil society is more effective when it comes together to engage government.

Dr. Wole was also joined by Luis Pinto, who joined the GFF team in November and leads Knowledge & Learning (K&L). The K&L agenda at the GFF is disrupting "business as usual" by challenging assumptions of how we know what we know, and building a strategy around competence, skills, and attitudes to help people learn. Mr. Pinto also emphasized "mutual learning" as a key aspect for GFF, which is based on the idea that "I believe I can learn from my neighbor" and "I trust I have something I can share with my neighbor."

The GFF Liaison Officer for Zimbabwe, Dr Patron Mafaune

III. The HSIC We Want

During the workshop, civil society participants broke into groups by the six priority areas of the HSIC zero draft to: (1) Share experiences to identify the most important problems/or issues based on their knowledge and expertise; (2) Compare these problems/or issues with those identified in the HSIC situational analysis; and (3) Evaluate the HSIC prioritized interventions to identify gaps and include those problems that have not be addressed. This process resulted in dozens of gaps or potential priority actions which were discussed plenary and captured on flip charts (for full details, please see the meeting notes here). Following this plenary report-back, one participant per organization identified the most urgent six priorities using a simple voting system. The facilitators then reviewed the prioritized priorities, and came back to the group with the results. In plenary, the group discussed and identified the cross-cutting issues and distilled the many suggestions into five most urgent actions to be included in the HSIC. These are outlined below (in no particular order).

On the final day of the workshop, the HSIC coalition had an opportunity to share their priorities for the HSIC with the GFF Secretariat members present and will continue engaging MOHCC around these priority areas, and further prioritizing the priorities.

Priority 1: Improving resources for the health sector: Better spent, coordinated, and effective

Participants observed that inadequate levels of government financing and wastage underlies many of the challenges in the health sector (Health system inefficiencies). The Government of Zimbabwe provides around 9% of its budget for health, well below the 15% Abuja Declaration target. This funding is also well below the target of US$86 per capita. Additionally, countries must invest 5% of their GDP if they have to progress towards UHC.

Participants noted the challenges mobilizing government funding in the current environment. The Health Levy and AIDS levy are two positive examples, although the Health Levy funds are sometimes directed elsewhere to other sectors that are not necessarily health related. When properly designed and implemented, results-based financing can pay for and motivate health workers, as well as promote efficiency gains and enhance equity.

Priority 2: National health insurance then abolishing user fees

The practice of user fees also emerged as a key barrier to health services across RMNCAH, communicable diseases, and noncommunicable diseases. Catastrophic costs are common particularly for chronic conditions, and still the health system is ill-equipped to treat them or provide palliative care. A sustainable, domestic source of funding is needed to bolster the public health system and accelerate progress towards achievement of Universal Health Coverage. The establishment of a universal national health insurance scheme would provide that resource base. With the sustainable financing of health facilities through insurance, user fees could be truly abolished. However, the Free User Fee Policy must be backed by adequate resources

Priority 3: Safe water, good sanitation and food in health facilities

Health facilities lack of supply of safe water, toilets, bathing facilities, inconsistent supply of electricity emerged as a key concern in all health priority areas and a main reason that people do not go to facilities in pursuit of health care. It is noted in the HSIC, but the potential response should be strengthened. Participants noted the challenge that these types of environmental improvements in health facilities often fall outside the responsibility of the MOHCC, for example running water is the responsibility of the municipal government. A special response must take a multi-sectoral approach or revise the arrangements for health facility infrastructure responsibilities to ensure that health facilities meet basic standards.

Priority 4: Emergency services: Functioning ambulances, availability of medicines, sundries, medical technology

The weaknesses in the health sector's ability to respond and refer to higher levels of care are most acute when it comes to emergency services. The acute challenges with ambulances for transport repeatedly came up-broken down vehicles, ambulances sitting idle in secondary or tertiary hospitals due to inadequate resources to support maintenance, while people in districts need transport. The lack of basic medical supplies and medicines, adequate bedding, inadequate food rations as well as medical technology was also a priority area that cut across the health care system.

Priority 5: Better community engagement and response in health emergencies

In the aftermath of cyclone Idai, civil society has a lot of reflections regarding what should be done differently next time. Health emergencies and Health in emergencies are included in the HSIC, but should be bolstered to ensure adequate community engagement in disaster preparedness, warning systems, and response (an evacuation plan, etc.). The time is right for a post-emergency audit that includes all stakeholders, including communities and civil society organizations, and a plan to better engage communities and use community data systems to prepare and respond to emergencies.

Ranking and scoring session

IV. Coalition structure & leadership

Civil society's recommendations to strengthen the HSIC outline what needs to be achieved to contribute to Zimbabwe's GFF process. Facilitators presented experience from civil society engagement in country-led GFF processes in Kenya, Uganda and Senegal, which suggests that a coalition who can coordinate civil society engagement around shared objectives is more effective than a fragmented approach. The emphasis on coalition engagement was reaffirmed by the MOHCC and GFF Secretariat representatives.

The coalition developed a structure (See figure 1). Any organization is welcome to join the coalition, although there was some sentiment that members should be drawn from a network of specific constituency. The coalition consists of a steering committee responsible for developing operational guidelines (eg a terms of reference); overseeing inputs into the HSIC and developing advocacy materials, pursuing funding opportunities, and developing a communication mechanism for members, eg a Google Group. Organizations on the Steering Committee must be membership-based. The steering committee will rely on the six thematic groups to help advance certain areas of work as necessary.

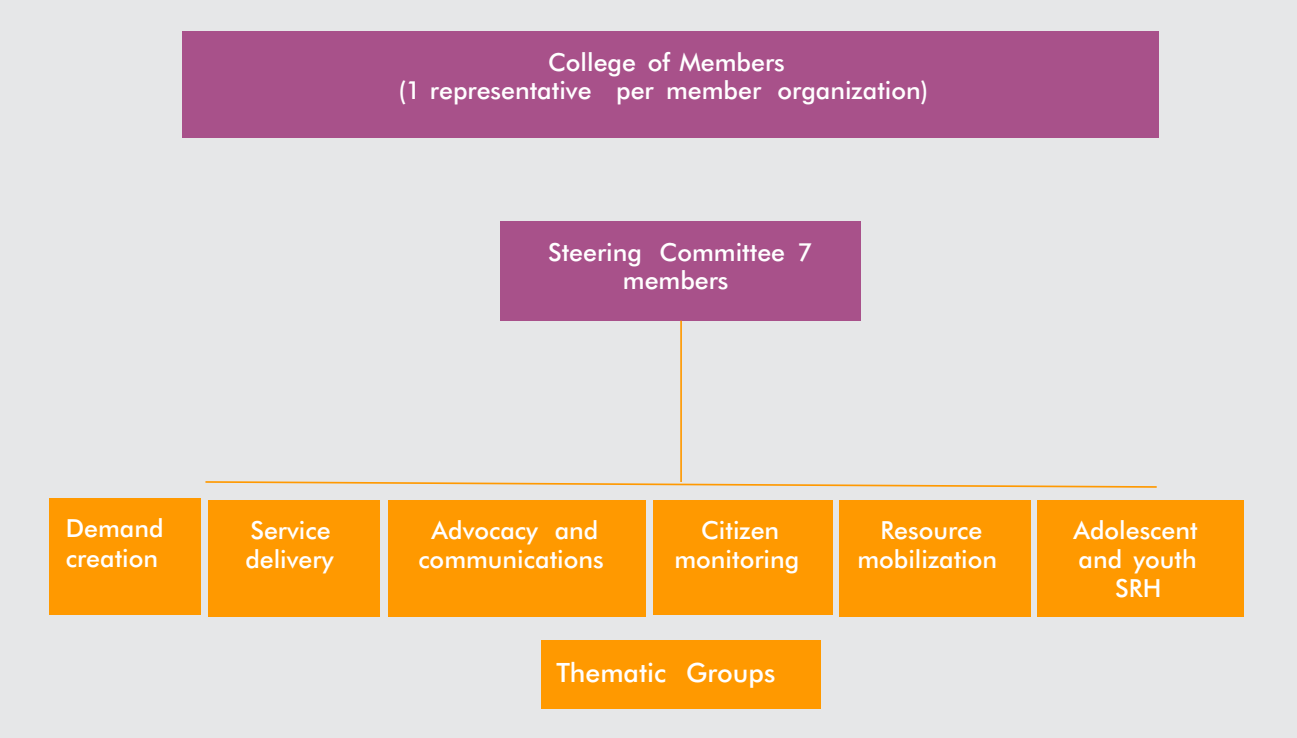


Figure 1. Zimbabwe Health Sector Civil Society Coalition

Participants noted the important progress that had been made by the interim Steering Committee members--CWGH, ZAN, WAG, and CeSHHAR Zimbabwe--in making the initial meeting a reality. There was unanimous support that those four members should remain on the steering committee. Some steering committee members and participants expressed a desire to add more members to the Steering Committee to help share the responsibilities. Since a Steering Committee typically has 7-9 members, there was support to add another three seats to the Steering Committee.

Facilitators explained that for purposes of representation to the global CIvil Society Coordinating Group on the GFF, the coalition will be asked to nominate a representative from a youth-led organization. Participants expressed that this youth representative should be on the Steering Committee. Participants started nominating youth-led organizations, and using a blind vote elected Youth Ignite.

In order to fully populate the Steering Committee, participants also suggested seats on the Steering Committee for; labor/health care worker organizations and elected Jointed Hands; and people with disabilities which unanimously nominated Disability HIV & AIDS Trust (DHAT).

Coalition Steering Committee:

1. CWGH
2. ZAN
3. WAG
4. CeSHHAR Zimbabwe
5. DHAT
6. Jointed Hands
7. Ignite Youth Organisation

The Steering Committee is empowered to make decisions on matters of external representation, for example designating a focal point and alternate for any meetings convened by the global Civil Society Coordinating Group for the GFF (CSCG). To adhere to good transparency practices, the facilitation team and CSCG will communicate via email any opportunities with all members of the Steering Committee, who will deliberate and respond copying all members of the steering committee.

Participants volunteered to be part of six working groups based on their organizational areas of expertise. These working groups will support the work of the Steering Committee.

CSO Zimbabwe GFF Executive Committee members and GFF Liaison Officer for Zimbabwe, the GFF delegation from Washington and PAI facilitators.

Table 1. Coalition Working Groups

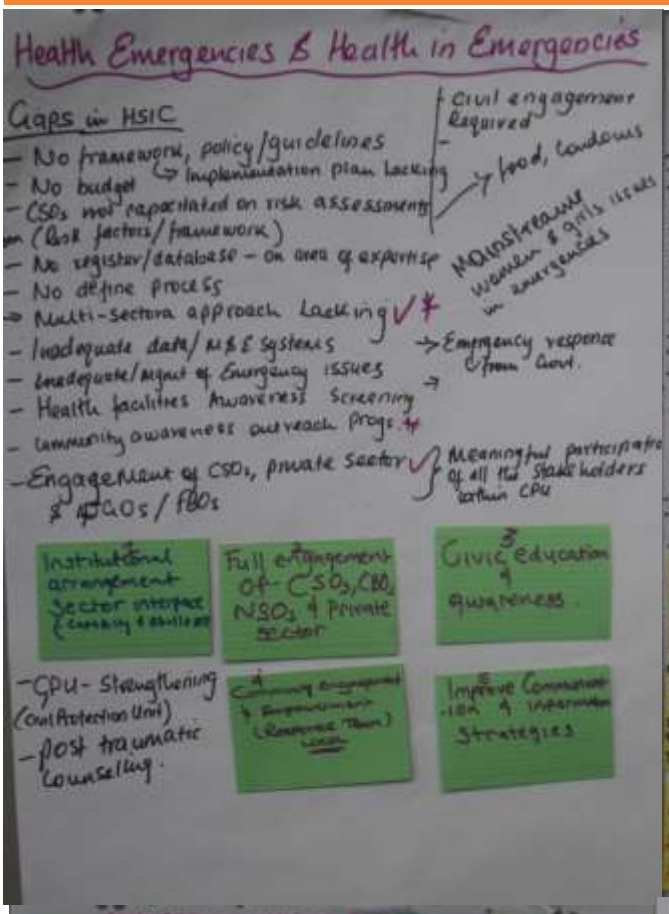
Adolescent/Youth SRHR	Youth Engage; Sexual Rights Centre; ICW-Zim; NZPWH; Jointed Hands; Youth Boundless; Ignite Youth; CWGH; ZAN; DOT Youth; Crown Agents; WASN; ZCC; MRRA; WAG; ZYT; ZNNP+; DHAT/ZimNEDHAD; Fact-Chiredzi
Resource Mobilization	Zimbabwe Environmental Health Association; PATAM; ZNNP+; Jointed Hands; NZPW+; CWGH; ICWZim; DHAT/ZimNEDHAD; ZAN; WAG; Carelite
Service	Kariba Urban Residents Association; Consumer Council of Zim; Carelite; MRRA; ZHPF; AMWUZ; Zimbabwe Hospital Doctors Association (ZHDA); ICW ZIM; NZPW+; ZNNP+; CWGH; Zimrights; Jointed Hands; ZCC; Youth Engage; Crown Agents; ZEHPA; DHAT/ZimNEDHAD
Advocacy & Comms	Kariba Urban Residents Association; ZCTU; ZHPF; Carelite; WAG; Youth Engage; ZAN; Consumer Council of Zimbabwe; ZEHPA; ICW-Zim; NZPW+; GAPWUZ; Jointed Hands; Zim Rights; GALZ; ZHDA; CWGH; Ignite Youth; DOT Youth; DHAT/ZimNEDHAD; ZNNP+; PATAM; MRRA; ZCC; WASN
Social Accountability & Monitoring	ZCTU; PATAM; CSU; CWGH; DHAT/ZimNEDHAD; ZNNP+; Youth WAG; ZAN; GALZ; Crown Agents; Jointed Hands; NZPW+; ZimRights; ZCC; Kariba Residents Urban Residents Association
Demand Creation	WAG; ZHPF; NZPW+; ICW-Zim; ZEHPA; ZNNP+; Sexual Rights Centre; Fact-Chirgozi; DHAT/ZimNEDHAD; ZimRights; Jointed Hands; Youth Engage; Zan

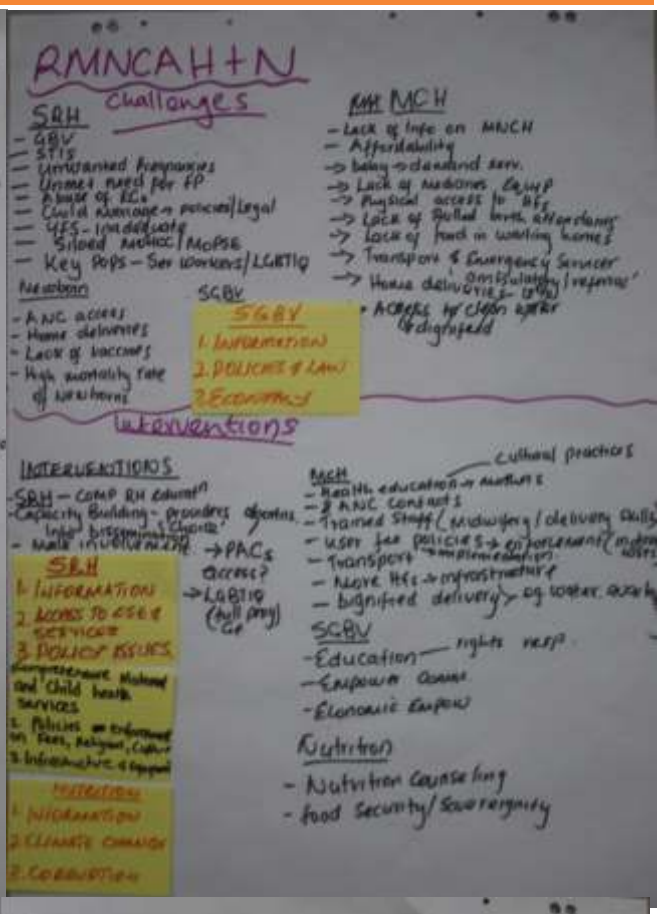
In addition to these thematic groups, the group had a very productive dialogue on data ownership & integrity. Communities are requested to produce information that is collected by various governmental bodies, but there is little feedback on how that information is used or what difference it makes. Data from CSO constituencies should underpin evidence-based advocacy, and there needs to be more deliberate engagement between civil society and government about how community-generated data is collected, used, then conveyed back to the communities. As one participant stated, "Our data should be making a difference."

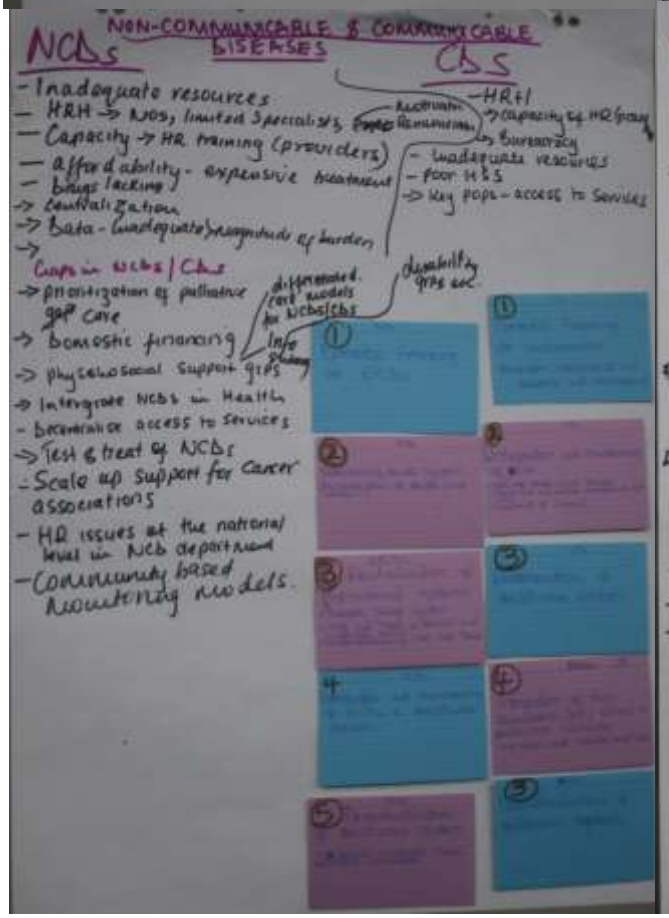
Active youth participation in the meeting

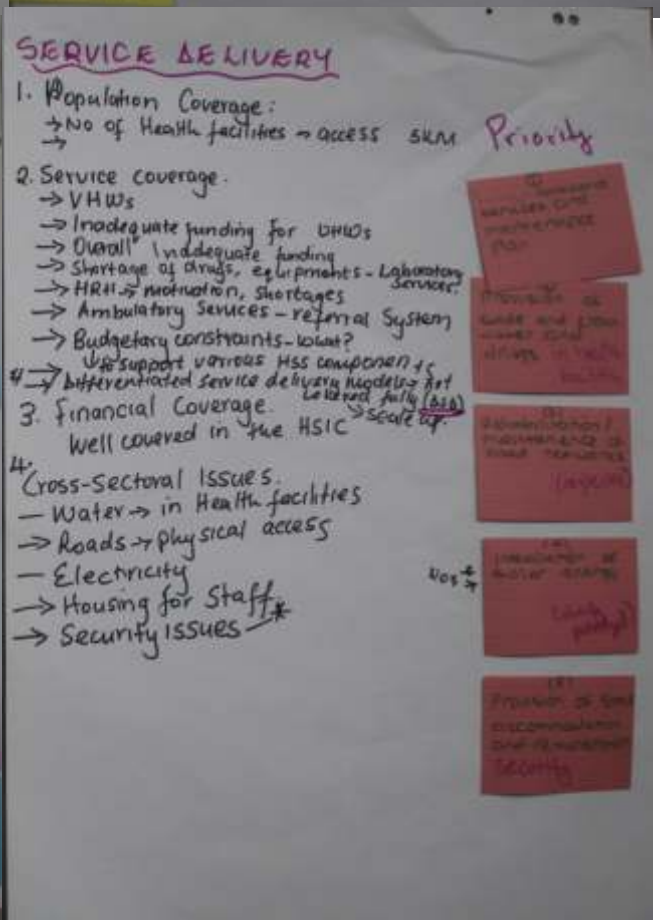
Leadership and Commitment from Honourable Members of Parliament of Zimbabwe

Identifying civil society inputs into the HSIC









The HSIC We Want

V. Next Steps

Participants identified a number of next steps and agreed on the most urgent actions. Next steps are:

1. **HSIC Advocacy:** The Steering Committee will consolidate CSO inputs into HSIC, re-prioritize to further refine the suggestions, and communicate these to the technical working group. The advocacy and communications working group is standing by and ready to assist as called upon.

2. **Report-back:** Participants will go back to their networks and share the outcomes of the meeting and next steps, ways to engage with any civil society organization whose work is implicated by the HSIC and related processes but could attend the meeting. There was also a suggestion to conduct a mapping exercise of civil society working in the health sector.

3. **Coalition Terms of Reference & Workplan:** The Steering Committee will develop the governance document for the coalition (a terms of references, charter or constitution with roles, methods of communications, expectations of steering committee, etc.). This was requested by the end of March, with a follow-up meeting to review the governance document and orient new members of the coalition by the beginning of May. The external facilitation team will share a few examples from other countries that may be adapted for the Zimbabwean context. CWGH volunteered to create a google group with all participants, immediately after the workshop. Working groups/subcommittees in each area should start meeting and communicating, and a workplan for the first year should be developed.

   For ongoing advocacy and collaboration, it will be important for the coalition to be introduced, then engage and work with MoHCC/GoZ. There was a suggestion to have an interface with the Permanent Secretary & Minister of Health on a quarterly basis, and also a need to link with other structures including the CCM (and HDF+CCM when that arrangement is decided).

4. **Fundraising:** The steering committee, with support from the resource mobilization working group, will develop a proposal for funding the most urgent next steps coming out of this meeting. This proposal should be part of an overall fundraising strategy for the coalition.

5. **Budget tracking and accountability:** The $25 million GFF Trust Fund grant is anticipated to be operational in June 2020. It will be important to conduct budget tracking of these funds,including the $34 million DRM, to monitor the utilization and impact on access to affordable, equitable quality health services to the citizens of Zimbabwe.

Appendix 1: Programme

CSO GFF Platform-building and Action-planning Meeting

February 18-20, 2020 Holiday Inn Hotel Harare, Zimbabwe
Twitter: #GFFInCountry

AGENDA

Meeting objectives:

1. To bring together CSOs that are working on GFF focus areas for dialogue, and even those working to strengthen those focus areas;
2. To ensure all participants have a common understanding of the GFF;
3. To identify opportunities and develop plans to engage in the GFF processes; and
4. To define a structures/platform for civil society to engage in the GFF processes.

DAY 1 – Tuesday, February 18	
8 :30 – 9:00	**Participants registration**
09:00 – 09:15	**Welcome Remarks** *Itai Rusike – Community Working Group on Health (CWGH)*
9:15 – 9:45	**Participants Introductions** Meeting objectives, expectations & overview of the workshop agenda *Facilitators: Suzanna Dennis, Senior Health Financing Advisor, PAI &* *Dr Fortunate Machingura - Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR)*
9:45-10 :30	**Session 1. Overview of the GFF: Model & Governance** *Presenters: Suzanna Dennis & Joyce Kyalo, Health Systems Strengthening Consultant* • Presentation (20 mins): Overview of the GFF; • Questions and discussion (25 mins) *Expected outcome: participants have a common understanding of the GFF's purpose, financing, governance and important stakeholders.*
10:30 – 10:45	**Coffee/Tea break**
10:45-12:00	**Session 2. Overview of the GFF: Country Process** *Joyce Kyalo & Suzanna Dennis* • Presentation (20 mins): Overview of the GFF process; • Questions and discussion (55 mins) *Expected outcome: participants are aware of the anticipated stages of the country-level GFF process and opportunities for engagement.*

12:00 – 13:00	**Session 3.** Civil society engagement on the GFF to date: country-level experience and lessons learned (Kenya, Zambia) *Co-presenters: Joyce Kyalo Churches Health Associate Zambia Moderator: Suzanna Dennis* • 2 Presentations, 10 minutes each: opportunities and challenges of engaging in the process, and lessons learned. • Questions and discussion (40 minutes) *Expected outcome: participants are familiar with civil society's experience engaging in country-level GFF process in two countries.*
13:00 – 14:00	**Lunch break**
14:00 – 15:30	**Session 4.** Official Opening of the Workshop & The Health Sector Investment Case and GFF process in Zimbabwe *Permanent Secretary of the Ministry of Health and Child Care, Dr Agnes Mahomva GFF Focal Person Dr. Robert Mudyiradima* *GFF Liaison officer Dr. Patron Mafaune* *Community Voices: testimonies from people's experience with health services Moderators: Fortunate Machingura & Itai Rusike* Presentation (20 mins) • Questions and discussion (60 mins) *Expected outcomes: participants understand how the GFF process is working in Zimbabwe, and opportunities for CS engagement.*
15:30 – 16:00	**Coffee/Tea break**
16:00 – 17:15	**Session 5.** Investigation of the HSIC *Facilitator: Suzanna Dennis and Itai Rusike* In depth plenary discussion on the HSIC content and process with small groups as needed *Expected outcomes: participants understand how the GFF process is working in Zimbabwe, and opportunities for CS engagement. Group also identifies the overarching groupings of civil society's inputs into the investment case.*
17:15 – 17:30	**Wrap up and closing**
DAY 2 – Wednesday, February 19	
9:00 – 9:15	**Recap of day one – Overview of daily agenda**
09:15 – 10:30	**Session 6.** Identifying civil society inputs into the HSIC *Facilitators: Suzanna Dennis* Group work: Participants break into groups based on the type of input to the HSIC they will help shape: • Health financing and governance reforms • 2-3 Thematic priorities identified in Session 4. *Expected outcome: Civil society's priorities for the IC and health financing reforms identified.*

10:30 – 10:45	**Coffee/Tea break**
10:45 – 13:00	**Session 7.** The HSIC We Want *Facilitators: Joyce Kyalo* Small groups pair up to present their recommendation to a peer group and refine based on their colleagues' inputs (1 hour) Plenary presentation of 3-4 refined recommendations (1 hour 15 minutes) *Expected outcome: Consensus on civil society priorities for the HSIC.*
13:00 – 1400	**Lunch break**
14:00 – 15:30	**Session 8.** Civil Society Engagement: Mapping & Setting Objectives *Facilitators: Suzanna Dennis* Participants map out the next steps in the HSIC process (30 mins): • HSIC Document • GFF Trust Fund Investment • Decision-makers • Important allies • Mechanisms for CS engagement
	What are the most important next steps for civil society to engage? (1 hour) Develop 2 SMART objectives: • [Decision-maker] [takes specific action regarding civil society's recommendations for the HSIC] [by what date] • Process for overall CS engagement (CS engagement framework) *Expected outcome: Identified upcoming opportunities to advance CS priorities into HSIC; objectives to take advantage of these opportunities.*
15:30 – 15 :45	**Coffee/Tea break**
15:45 – 16:30	**Session 9.** Civil Society Engagement: Activity Planning *Facilitators: Joyce Kyalo* • What is the most effective and timely ways to achieve each objective set in session 7? • By when do these activities need to happen? • What kind of collateral materials will help make the case? • Roughly how much money will this cost? • Where will the resources come from? • Who is responsible? *Expected outcome: A rough workplan with activities and responsibilities.*
16:30 – 17:00	Next steps and closing remarks *Suzanna Dennis*

DAY 3 – Thursday, February 20	
9:00 – 9:15	**Recap of day one– Overview of daily agenda**
09:15 – 10:30	**Session 10.** Working more effectively through a coalition *Facilitators: Suzanna Dennis* • Presentation (15 min): Benefits and challenges of working in a coalition, principles of effective collaboration, examples of coalitions • Questions Small group or plenary discussion (15 minutes) • What structure or mechanism is needed for RMNCAH+N coalition to engage in HSIC? *Expected outcomes: General consensus on the attributes of the coalition/working group/mechanism.*
10:30 – 10:45	**Coffee/Tea break**
10:45 – 12:00	**Session 11.** Mapping Zimbabwe CSO Coalitions *Facilitators: Dr. Fortunate Machingura & Suzanna Dennis* • Group work Exercise (25 mins): ○ What are the existing national CS coordination mechanisms? ○ What are the strengths and weaknesses of the CS coordinating mechanisms, when compared to the criterion? (highlight 3-4 each) ○ How can they be harmonized for better alignment of resources? ○ How can a working group on the GFF be integrated into any of these harmonized structures? Report back from group work and discussion (35 min.) • Group work (30 min) ○ Looking at the CSOs who are currently engaging in or interested in engaging in the GFF, who is doing what where? What are the areas of strong knowledge and skills? Where are the gaps? • Group report back and discussion (45 min) *Expected outcomes: Mapping of civil society coalitions and coordinating structures; understanding of comparative advantage of different actors.*
12:00 – 13:00	**Session 12.** Vision & governance framework *Facilitators: TBD* • Presentation (10 min): ○ Benefits of a good governance framework ○ Examples of governance structures of other national coalitions: Kenya, Zambia, Senegal, others • Group work (50 min): ○ Based on the self-assessment exercise done by the group, and the examples of governance structures presented, what might work well for GFF engagement? ○ List potential roles and activities of a national CS coalition engaging in the GFF (Networking, Communication and coordination, advocacy, resource mobilization, accountability, monitoring and evaluation and learning, etc.) ○ Propose an institutional diagram to illustrate the results

13:00 – 14 :00	**Lunch break**
14:30 – 15:30	**Session 13.** (continued) Consolidating group work and agreeing on a governance structure *Facilitators: TBD* Plenary • Choosing the right governance structure for Zimbabwe CSOs • Establishing thematic groups • Assigning roles and responsibilities *Expected outcome: Agreed mechanism for coordinated CS engagement with designated roles and responsibilities; and persons or institutions responsible.*
15:30 – 15:45	**Coffee/Tea break**
15:45 – 16:45	**Session 14.** Interactive discussion on coordination and communication, how the mechanism will function, next steps *Facilitators: TBD* *Expected outcome: Agreed communication and coordination functions for inclusion into the coalition's terms of reference.*
16:45 – 17:00	**Wrap up and closing**

Appendix 2: List of participants

Name	Sex	Organisation & Contact Details
V. T. S. Chitimbire	F	Zimbabwe Association of Church related Hospitals
Thomas Chikumbirike	M	Counseling Services Unit
Tawanda Zvakada	M	Zimbabwe Hospital Doctors Association
R Kuyawa	M	Gays and Lesbians Association of Zimbabwe
Edinah Masiyiwa	F	Women's Action Group
Caiphas Chimhete	M	CWGH
C Terera	F	National Association of NGOs
Tanyaradzwa Munouya	F	CWGH
N Banda	M	Zimbabwe Congress of Trade Unions
L. Mafare	M	Zimbabwe Congress of Trade Unions
Anna C Penduka	F	Women and AIDS Support Network
Emmanuel Gasa	M	The Arts and AIDS Foundation
N Mushonga	F	Institute of Food, Nutrition and Family Sciences
Mtandazo Maphosa	F	Sexual Rights Centre
Tariro Kutadza	F	Zimbabwe National Network of Positive Women
Chamu Ndlovhu	M	Zimbabwe Young People's Development Coalition-Bulawayo
A. T. Sibanda	M	Carelite - Hwange
James Goneso	M	General Agriculture Plantation Workers Union of Zimbabwe
Ndumiso Magutshini	M	Consumer Council of Zimbabwe
Isao Zvarevashe	M	Family AIDS Caring Trust- Chiredzi
Samson Coffee	M	Kariba Urban Residents Association
Entrance Takaidza	F	ZIMRIGHTS
Gellie Bepete	F	Village Health Worker - Chiwundura
Ezabela Mombe	F	Village Health Worker - Chikwaka
Otilia Tasikani	F	Network of Zimbabwe Positive Women+
Alexious Zindoga	M	National Council of Disabled People in Zimbabwe
Delphine Chirimuuta	F	Association of Mine Workers Union of Zimbabawe
Tjedu Moyo	F	Ignite Youth Organisation

Thabiso Sibanda	F	Dot youth
Mongi Khumalo	M	Youth Boundless Zimbabwe
Desmond Ntini	M	Zimbabwe Council Of Churches
Stephen Musarapasi		Zimbabwe Environmental Health Practitioners Association
Juliet Vambe	F	Mutare Residence Ratepayers Association
Kudakwashe Matayi	M	Zimbabwe Young People's Development Coalition - Mutare
Donald Dennis Tobaiwa	M	Jointed Hands
Itai Rusike	M	Community Working Group on Health
Suzanna Dennis	F	PAI
Chelsea Mertz	F	PAI
Joyce Kyalo	F	Consultant
Charles Siwela	M	Youth Engage
Chenjerai Sisimayi	M	World Bank
Abebe Shibru	M	Population Services Zimbabwe
Fortunate Machingura	F	Center for Sexual Health and HIV/AIDS Research in Zimbabwe
Talent Maposa	F	Zimbabwe AIDS Network
Patron Mafaune	F	GFF Liaison Officer
Ayodeji Oluwole Odutolu	M	World Bank
Luis Pinto	M	World Bank
Caroline Mubaira	F	Crown Agents
Norest Hama	M	World Vision
Gwati Gwati	M	MOHCC
Philimon Simwaba	M	Disability HIV and AIDS Trust
Hon. D. Molokele	M	Parliamentary Portfolio Committee on Health
Tonderai Chiduku	M	Zimbabwe National Network of People Living with HIV
Calvin Fambirai	M	Zimbabwe Association of Doctors for Human Rights
Nyasha Masunda	M	World Health Organization
Tafadzwanashe Nkrumah	M	CWGH
Edgar Mutasa	M	CWGH
T. Moyo	M	Parliamentary Portfolio Committee on Finance and Economic Development
Vanessa Gonye	F	Newsday
Nokuthaba Nkomo	F	Daily News
Anesu Tonde	F	The Herald

Community Working Group on Health

HEAD OFFICE

CWGH HARARE

No. 4 O'Connor Crescent, Cranborne, Harare • PO Box BE 1376, Belvedere • Harare, Zimbabwe

Tel: +263-242-573285/6, +263 772 363 991, +263 719363991

Email: cwgh@mweb.co.zw • Website: www.cwgh.co.zw

Twitter Account: @CWGH-ZIMBABWE Facebook: CWGH