To: Lead agencies of the ACT-A Health Systems and Response Connector
Dr Zsuzsanna Jakab, World Health Organization
Dr Peter Sands, The Global Fund to Fight AIDS, Tuberculosis and Malaria
Dr Juan Pablo Uribe, World Bank

RE: HSRC Strategy Update and Civil Society Participation

The draft ACT-A strategy shared on 19 Oct, which reframes the Health Systems Connector (HSC) as the Health Systems and Response Connector (HSRC), was the first presentation of the refreshed pillar strategy to its civil society representatives, who were introduced to the lead agencies in April 2021. In the absence of a formal consultation call, we as representatives of civil society and communities would like to highlight critical additions to the HSRC strategy conversation through the attached statement (see, *Annex: Critical Additions to the HSRC Strategy Conversation*).

On behalf of the Platform of Civil Society and Community Representatives to the ACT-A, we emphasize the importance of engaging civil society and community representatives, particularly those at the country-level, during the development of the pillar strategy and workplan. While we have heard commitments to meaningful civil society engagement, it is unclear where civil society fits in the new HSRC structure consisting of the Secretariat, the Partners Group, Project Management Team and workstreams. Of particular concern is the omission of the Community-led Responses Workstream.

We agree that the HSRC reframing may be a good opportunity to ensure integration of health systems capacities for emergency preparedness and essential health services, and welcome the strengthened language and targets on health workforce. However, the revised strategy continues to be heavily focused on commodities, and there is little mention about the role of the HSRC to meaningfully address in-country inequities that are hampering response efforts. The strategy currently lacks a clear, coherent definition of health systems.

We cannot wait until this crisis is over to begin addressing longer-term health systems constraints, and delaying this articulation further hampers response efforts as critical capacities to deliver care and maintain essential health services are overlooked. ACT-A solutions and interventions — particularly through the HSRC — must support the building blocks for strong health systems to address long-standing gaps and the systemic health disparities within and across regions. With our active partnership and that of in-country civil society, the HSRC lead agencies must strengthen coordination and promote harmonized solutions at the implementation level.

We also urge the HSRC lead agencies to critically consider the review of the ACT-A strategic plan by the Platform for Civil Society and Community Representatives to the ACT-A, which highlights specific priorities from civil society for all pillars. We echo the recommendation of the recent ACT-A Strategic Review for transparent and accountable decision-making across all pillars and especially in the context of the HSRC. Rather than consulting civil society and communities after major decisions are made, a truly participatory governance approach must engage us as co-creators and partners. Civil society stakeholders must be urgently included in finalizing the HSRC strategy and action items for 2021-2022.

We specifically ask for:

- A call with civil society representatives to the HSRC to develop an articulation of the role and scope of civil society participation in the revised HSRC structure, to discuss how HSRC will work with and across the ACT-A pillars on integrated areas of work, and address the other key issues raised in the statement attached
- The revival of the community-led responses workstream and other workstreams with specific openings for civil society and community representatives in the governance structure
- Updates to the strategy based on the concerns highlighted in the statement attached

We look forward to your response to these requests at the earliest.

Sincerely,

Community and Civil Society Representatives to the ACT-A Health Systems Connector Pillar

ANNEX

Critical Additions to the HSRC Strategy Conversation

REF: ACT-A STRATEGIC PLAN SHARED 19 OCTOBER 2021

- **Strengthening health systems must tangibly include investing in the organizations, people and actions who promote, restore or maintain health — including, without reservation, community health systems.** The pillar does not prioritise, articulate or even acknowledge community systems strengthening and community-led responses to COVID-19 as an integral element of the health systems. Community-led responses that include community health workers help to reach the poorest and hard-to-reach communities. Importantly, they also provide a platform for delivering and maintaining other essential primary healthcare services as well as the pandemic preparedness responses.

- **Health workers must be centered in the Connector's strategy and workplan.** Despite stronger language than in previous iterations, the biggest health system gap and challenge — that of severe shortage of healthcare workers, including community health care workers, to deliver the COVID-19 response — is not adequately prioritized. CSOs recognise that the lead agencies of this pillar have varied positions and may lack a cohesive policy direction around investments in the health workforce. We reiterate that this intervention is urgent, a critical part of emergency response that cannot be sidelined. Lead agencies must acknowledge the fact that there is, pre-COVID-19, a shortage of about 18 million health care workers to deliver essential care, and that between 80,000 to 180,000 of the limited health care workers have lost their lives during the pandemic (see, working paper); many more are suffering from burn out and leaving clinical care altogether. The pillar does not acknowledge or address the regressive impact of diverting health workers from the delivery of other programs such as TB, malaria, HIV, child immunisation, and maternal and child health programs that the lead agencies also support.

  As CSOs we also continue to lobby governments to increase their investments in the health workforce, some are trying but this is not enough and needs global solidarity; in fact, the World Bank projects a fall in government per capita spending for health. Lastly, investment in the health workforce, of which over 70% are women, could be a strategic investment not only for health outcomes but also for gender equality, economic growth and equitable development, and future pandemic preparedness.

  Donors, especially the HSRC pillar leads and additional actors beyond ACT-A, with national governments must conduct an analysis of the existing global human resources for health financing that should feed into an investment case and costing of real gaps and needs inclusive of the additional recruitment, protection and care of the health workforce. Similarly, integrated data management needs to be developed or updated, that could be used for aggressive resource mobilisation as other pillars. The pillar agencies, especially World Bank, need to promote investment in and additional recruitment of the health workforce as a core in economic recovery packages as well as in any pandemic response and preparedness investments. A clear investment case and analysis needs to be done and shared widely as has been done by the other pillars.

- **As part of its goal of strengthening national responses and reinforcing health systems, the Connector must ensure investments by lead agencies and partners are harmonized across all health programs.** The HSRC strategy must include a vision of how the pillar plans to harmonise, align and coordinate real investments in health systems, including the health workforce, to deliver COVID-19 services and sustain other programs that the lead agencies fund without worsening the gaps. The strategy must also explicitly articulate the need to address fragmentation between health systems interventions for health security and universal health coverage, including integrating emergency risk management, essential public health functions, and primary health care.

- The Connector must outline **specific goals on how the HSRC will be "working with Vaccines Pillar to address surge staffing and other infrastructure needs to support vaccine deployment."** While we welcome the recognition of this shared deliverable, there is an urgency in moving this work forward with clear, actionable goals as the vaccines pillar stands poised for an increased number of vaccine doses in Q4. The HSRC mandate in

this section must address: providing adequate training and remuneration to frontline health workers, including community health workers who are delivering vaccines, generating demand and improving uptake, supporting investments in digital health systems to track and manage vaccine delivery, and building on existing community health systems to make healthcare and supplies accessible to all people.

- Similarly, the **work with the Therapeutics and Diagnostics Pillars "to support countries in delivering more effective test & treat strategies" must include a specific commitment to community-led responses**, especially those that support health literacy and service delivery. As the ACT-A strategic plan notes, the COVID-19 pandemic is here to stay, and health systems need to be prepared to continue to address the virus in the foreseeable future. Rather than waiting for commodities to be developed before considering the health system costs and implications of their implementation, it is imperative that the long-term solutions for health systems are developed simultaneously so that all COVID-19 countermeasures can be implemented effectively and equitably when available.

- **The HSRC strategy must greatly strengthen its approach to addressing equity at the domestic level.** The entire ACT-A strategy suffers from over-emphasizing "equity" at a global level while almost entirely neglecting to acknowledge in-country disparities, preventing meaningful improvement in access to response tools in the long-term. While gaps on in-country delivery are occasionally noted, the strategy doesn't leverage the role of the HSRC which was designed to address this or how disparities like gender barriers will be mitigated.

    - When discussing delivery and fair allocation, language should be included on mandating supplies for vulnerable groups in-country (not just between HIC and LIC), including health workers (majority female) and women who may struggle to access care (in addition to other groups like LGBT+, refugees, and ethnic minorities who may be marginalized in health systems).

    - When discussing trainings and guidelines, explicit reference should be made to mainstreaming language on gender-responsive and community-led strategies.

    - When discussing data collection and gaps, language should be included on sex and gender-disaggregated data as well as other intersectional indicators.

    - When discussing collaboration, clear mechanisms and guidance on including women and other minorities in leadership and decision-making roles, as well as robust CSO participation.

    - There must be more clear guidance and planning on how response efforts will not disrupt essential health services, particularly those that are relied on by key populations like women and girls such as maternal health clinics, cancer screenings, surgeries, etc.

    - Guidance should be issued to governments to ensure that all healthcare workers (majority women) are fairly remunerated for their work in delivering COVID-19 vaccines and other commodities.

    - When discussing reaching the most vulnerable, the HSRC should promote clear guidance to address misinformation and instill confidence in all communities.