

RESEARCH BRIEF

Effective Civil Society-led Strategies for Increasing Domestic Resource Mobilization for AIDS, TB and Malaria in Low- and Middle-Income Countries

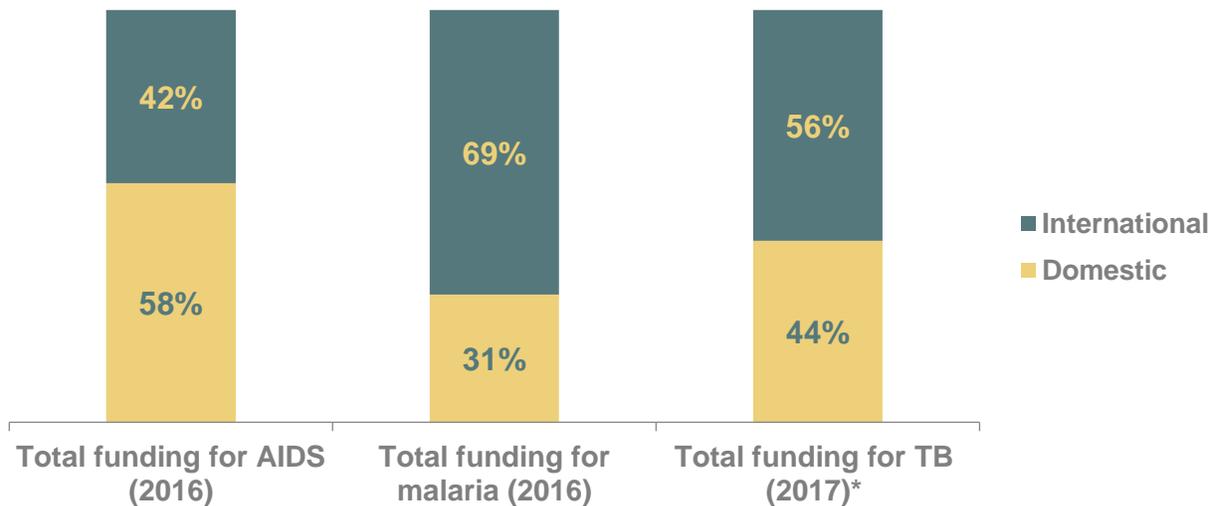
Background and Context

Generally speaking, funding for health can be collected through five basic mechanisms (Wysong et al., 2017):

- ▶ User fees or out-of-pocket payments
- ▶ Prepaid funding or financing of insurance (voluntary insurance, compulsory insurance, general taxes, and earmarked taxes)
- ▶ Community loan funds
- ▶ Health savings accounts
- ▶ External funding from public or private external sources such as nongovernmental organisations (NGOs) and donor agencies

For AIDS, TB and malaria, the fifth mechanism is a very significant one (Figure 1). In 2016, external funding made up 42% of total resources for AIDS and 69% of total resources for malaria (UNAIDS, 2017b; WHO, 2017b). In 2017, 56% of total funding for TB in low-income countries was from international donor funding (WHO, 2017a).

Figure 1: Share of total funding for AIDS, TB and malaria (2016/2017) (UNAIDS, 2017b; WHO, 2017a; WHO, 2017b)



**low-income countries only*

Affected countries are disproportionately reliant on donors to fund AIDS, TB and malaria programs, compared to other health challenges. In low-income countries development assistance for health (DAH) made up 34.6% of total health spending in 2016 (IHME, 2017).

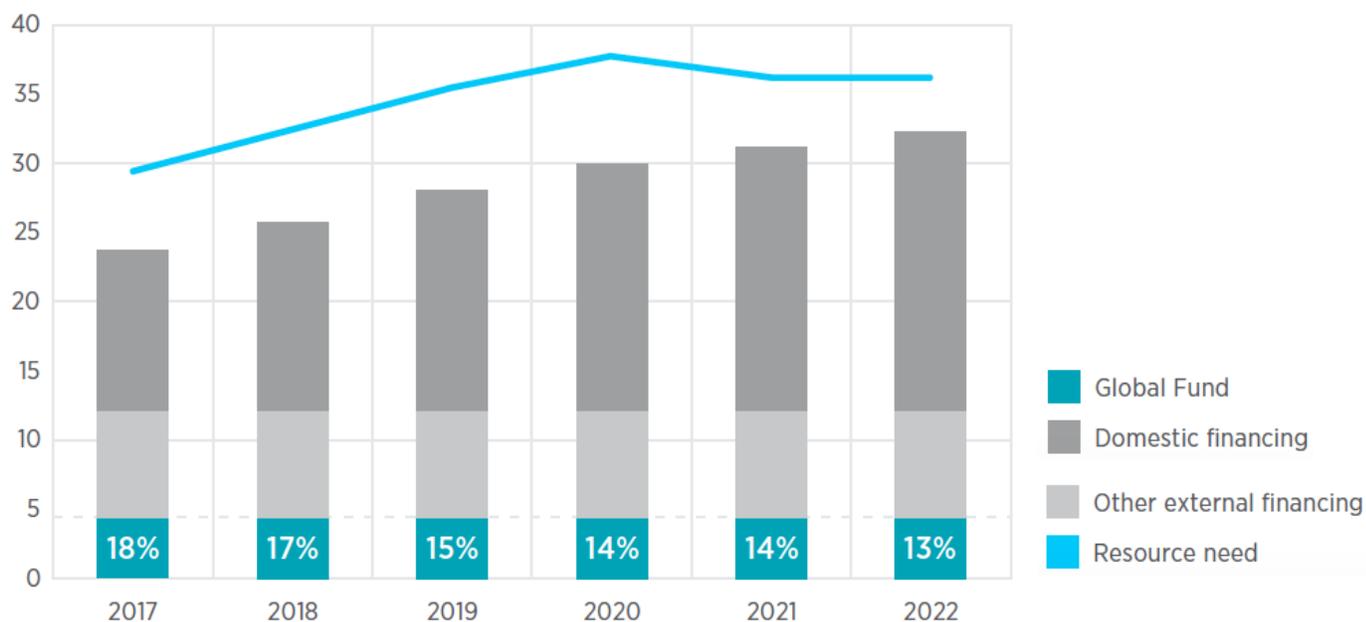
Trends indicate that donor funding for the three diseases is either flat- lining or in decline. Donor funding for HIV fell from \$8.6 billion in 2014, to \$7.5 billion in 2015, to \$7.0 billion in 2016 (Kates & Wexler, 2017). For malaria, donor contributions have fallen by about \$300 million since 2013 (WHO, 2017b). International donor funding for TB has remained relatively flat, at US\$ 1.1 billion, despite a growing need (WHO, 2017a).

Declining donor investment is happening at the same time as the world has set ambitious global targets to scale up responses end the three diseases as public health threats by 2030. The price tag for achieving the Sustainable Development Goals (SDGs) for health is estimated to be \$371 billion/year in low- and middle-income countries – a near threefold rise from the \$134 billion/year currently being invested (Stenberg et al., 2017). Within SDG 3, several global plans and strategies estimate the resources needed for the three diseases:

- ▶ UNAIDS’ Fast Track strategy is estimated to cost about \$26.2 billion by 2020, after which total resource needs will steadily decrease to \$22.3 billion in 2030 (UNAIDS, 2016).
- ▶ Stop TB Partnership estimates that the Global Plan to End TB will require \$11.2-11.6 billion a year (between now and 2020) (Stop TB Partnership, 2015).
- ▶ Rollback Maria’s plan for Action and Investments to Defeat Malaria (2016-2030) requires \$6.8 billion/year.

Strong economic growth in affected countries could potentially offset dwindling donor funds, closing the gap between resources needs and available funds. According to the Global Fund’s Investment Case for 2017 2019, domestic financing is estimated to contribute a total of \$41 billion during 2017-2019, and is projected to continue growing through 2022 (Figure 2).

Figure 2: Projected Investments (billions USD) in HIV, TB and Malaria (Global Fund, 2015)



Increasing domestic funding for health to achieve global targets will be difficult, but not impossible. For instance:

- ▶ A World Health Organization (WHO) analysis found that **85% of SDG 3 costs** could be afforded by national governments (Stenberg et al., 2017).
- ▶ One study estimates that if all fiscal sources were simultaneously leveraged in the next five years, public HIV spending in the **14 most HIV-affected countries** could increase from US\$3.04 to US\$10.84 billion per year (Remme et al., 2016).
- ▶ Another study found that in a maximum effort scenario, **Botswana, Namibia and South Africa** should be able to fully fund their own AIDS programs with domestic resources by 2018 (Resch, Ryckman & Hecht, 2015).
- ▶ It has also been estimated that domestic contributions could cover over 65% of financing required for TB care and control in **118 Global Fund-supported countries** if there is increased political commitment from countries that currently underperform in comparison to their ability to pay (WHO, 2013).

However, with 16 other SDGs to compete with, health advocates in each country will need to make a compelling case for why governments should prioritize spending on health.

There are success stories which give reason for optimism. Governments in affected countries can be successfully lobbied to step up to the plate.

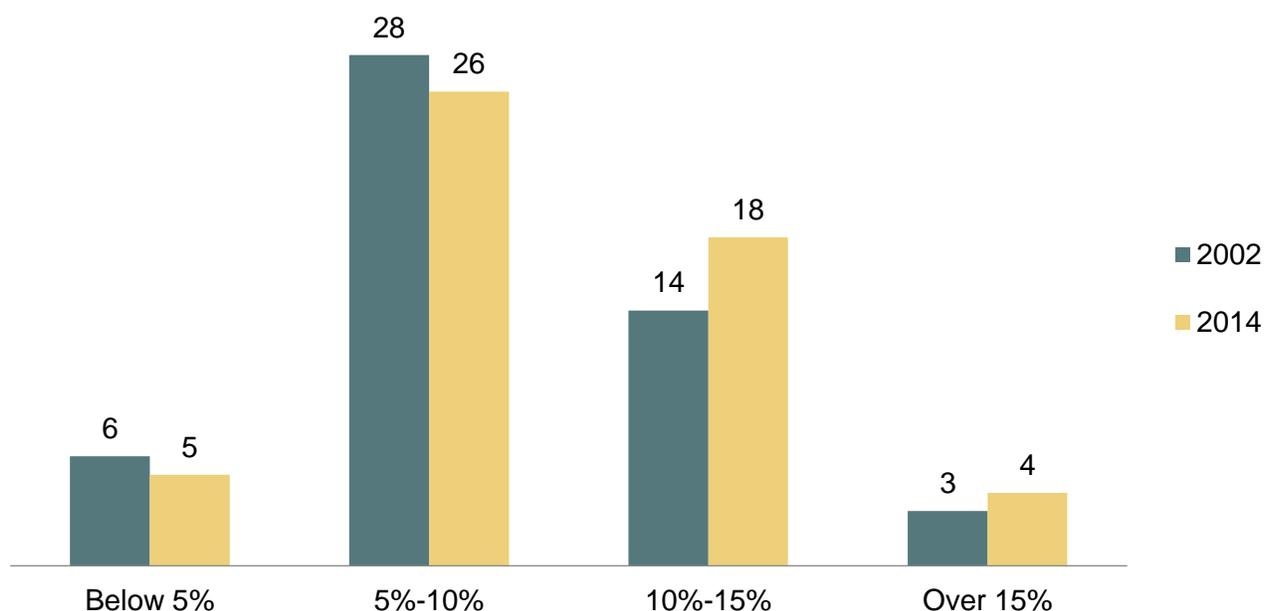
- ▶ Over 2014-2016, domestic financing **commitments for AIDS, TB and malaria went up by US\$5.9 billion**, spurred in part by co-financing requirements by the Global Fund (Global Fund, 2015).
- ▶ In **India**, the country with the largest burden of TB, high-level (Prime Ministerial) political commitment led to a doubling of the country's annual TB budget and a tripling of domestic contributions from 2016 to 2017 (WHO, 2017a).
- ▶ In **Zambia**, domestic funding for malaria has nearly doubled in the past three years, increasing from \$15.5 million in 2014, to \$22.6 million in 2015, to \$28 million in 2016 (SADC, 2017).
- ▶ In **South Africa**, the country's National Strategic Plan projects that the total government's budget for HIV, TB and STIs will grow by 8.1 billion Rand (approximately US \$680 million) over the next five years, making up 78% of total funding by 2021/2022 (SANAC, 2017).

Analyses credit various efforts with such gains in domestic spending on health, including improved tax collection, development impact bonds, advocacy from civil society groups, among other strategies (RESYST, 2013; SADC, 2017; Zardiashvili, 2016). Scholars recommended that civil society differentiate advocacy strategies based on country context, and craft advocacy messages that are tailored to specific country needs (Stenberg et al., 2017; Whiteside & Bradshaw, 2014).

Increased domestic financing for the three diseases is inextricably linked to increased domestic financing for health in general, and to achieving Universal Health Coverages (UHC). UHC is the new political framework for global health, based on principle that everyone receives needed health services without financial hardship.

Yet, in 2017, many countries are not spending enough on health to meet their commitments. Governments attending the Universal Health Coverage Forum 2017 acknowledge that 800 million people are spending at least 10 percent of their household budget on out of-pocket health care expenses, and nearly 100 million people are being pushed into extreme poverty each year due to health care costs (Tokyo Declaration, 2017). Spending on health in many African countries remains below the target of 15%, a commitment that all African Union countries made in the Abuja Declaration back in April 2001. Only four African countries currently spend more than 15% of their total budgets on health, and 31 spend less than 10% (Figure 3).

Figure 3: African Governments’ Spending on Health, as a Proportion of Total Government Spending (Number of Countries) (2002 and 2014) (World Bank, 2016)



The Global Fund acknowledges this link and is in the process of developing a strategy for increased domestic financing for health. The draft strategy notes that countries need support in mobilizing domestic resources to respond to overall health needs, including to HIV/AIDS, tuberculosis and malaria, and to move beyond programming silos with a view towards UHC (Global Fund, 2017).

The draft strategy identifies civil society (explicitly mentioning the Global Fund Advocates Network) as a key sector to be involved. The strategy suggests that civil society should raise public awareness at national and international levels regarding the need for, and benefits of, increased domestic financing for health. It further underscores the importance of civil society’s role in organizing youth groups and movements in support of increased domestic financing for health. The strategy identifies the following key activities for civil society to perform to increase domestic financing for health:

- ▶ Hold “Days of Action” in target countries
- ▶ Organize side events on increased domestic financing for health at key regional/international fora
- ▶ Collaborate with the Global Fund and the African Union on country studies to generate evidence-based arguments for IDF for health
- ▶ Monitor and evaluate own activities to generate practice based evidence

Towards achieving UHC, the sources of funding countries use to finance health follow a general trend (IHME, 2017):

- ▶ **Low-income countries** tend to finance most health spending from out-of-pocket and development assistance funds.
- ▶ **High-income countries** tend to finance health with government spending, which includes social health insurance.
- ▶ **Middle-income countries** transition away from dependence on development assistance as they develop economically, although a country’s ability to replace financing with sustainable, prepaid sources for all populations generally relies on their government’s capacity to generate and allocate resources for health.

Particular concerns exist that middle-income countries may not have sufficient resources for affordable health care, resulting in increased out-of-pocket financing during the transition, which can deter access to care and lead to medical impoverishment (IHME, 2017). A recent publication from Médecins Sans Frontières (MSF) concluded that overall, commitments to support progress towards UHC are not backed up by the necessary resources, driving an increase in out-of-pocket payments, which exclude and deter people from seeking care, negatively affect quality of services, and exacerbate poverty and the disease burden (MSF, 2017).

Effective advocacy for domestic resource mobilization for health is an important prerequisite for functional UHC.

Overview

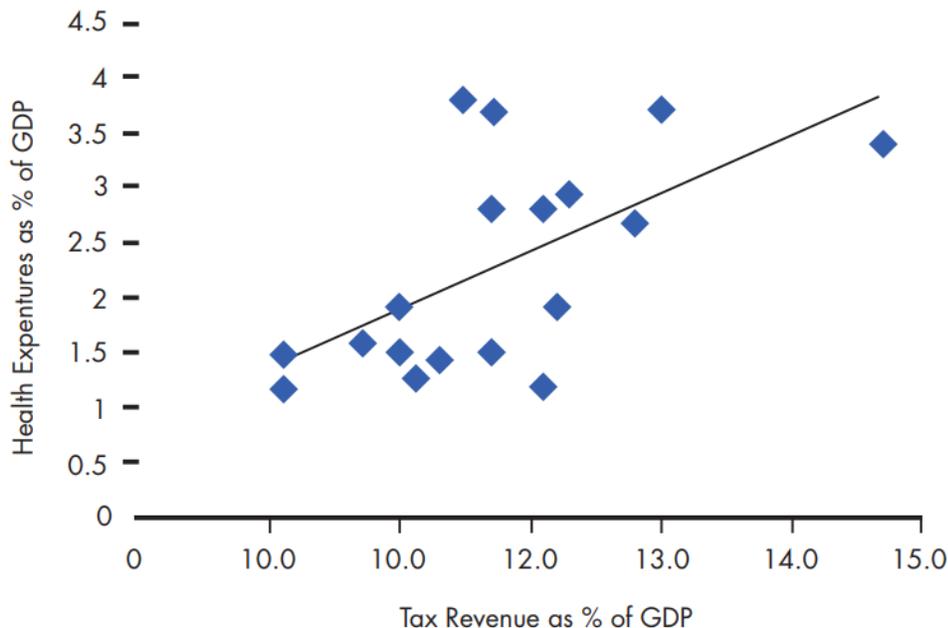
This research brief examines the recently available evidence on effective civil society-led strategies to increase domestic resource mobilization health, focusing on AIDS, TB and malaria in low- and middle-income countries. The brief is organized by four key DRM advocacy entry points for civil society organizations, focusing on:

- ▶ Advocacy for improved tax revenue collection
- ▶ Advocacy for government budget allocation to health
- ▶ Advocacy for co-financing of donor-funded programs
- ▶ Advocacy for improved absorption and budget execution

Advocacy for Improved Tax Revenue Collection

Growth in tax revenue has been linked with countries' progress on universal health coverage (UHC), especially in countries with low tax bases (Reeves et al., 2015). Increased tax revenue collection in Tanzania is directly associated with increased health expenditure (Figure 4).

Figure 4: Relationship between Tax Revenue and Health Expenditure in Tanzania (1996-2013) (HPP, 2016a)



Some analyses show that domestic civil society actors influence tax policy decisions to a limited extent. One study in Uganda found that influence was minimal, even though there are signs that tax associations are being formed and are increasingly vocal (Kjær et al., 2017). Box 1 provides some innovative ideas for how fledgling tax associations can seek to strengthen their advocacy.

Other analysts agree that tax issues often neglect the importance of investing in independent policy research, public outreach, and engagement with the media and civil society, instead tending to be taken up purely from a technical capacity building perspective (Bhushan & Samy, 2014). Bhushan & Samy (2014) suggest that broadening the stakeholder base involved in tax issues can have significant benefits and remains an area donors could not only invest more in but also share their own domestic experience.

An analysis of taxation to enhance fiscal space for health and HIV in Tanzania found that advocacy efforts done through partnerships with civil society organizations and other actors are more effective (HPP, 2016a). The same analysis found that using the media to sensitize parliamentarians and the general population on the merits of the proposal and how it will benefit citizens, may generate national political attention to the issue and increase the likelihood that the proposal will be approved (HPP, 2016a).

BOX 1: INNOVATIVE IDEA

National Tax Payers Association in **Kenya** Fosters Constructive Civil Society Engagement and Partnership on Tax Issues

Civil society engagement is a crucial piece of the relationship between the tax administration and civil society. In principal, business association should be one of the most important voices arguing for a better tax system and for citizen engagement. Unfortunately, business associations tend to be relatively weak and highly fragmented in LMICs. An interesting possibility is to support the creation of associations of small and medium enterprises as a means of bringing the informal sector into the tax fold. While many countries have smaller business associations these associations are generally quite weak and poorly resourced. Taxpayer associations developed on the pattern of business associations have the potential to engage constructively with the government. They can create pressure for greater equity in tax reform and be valuable partners in expanding public education and awareness and building trust in the tax administration.

One example from Sub-Saharan Africa is the national taxpayers association in **Kenya**. This kind of partnership between the tax administration and civil society can support a more equitable and effective tax agenda. Trusted nongovernmental bodies may also reinforce the importance of paying taxes and explain controversial tax issues, increasing confidence in the system through greater understanding.

A possible strategy is to work closely with local private sector associations, which, although weak, can serve as a conduit for information and discussion. Outside of government, tax professionals, both accountants and tax lawyers, can work with private firms for tax-filing purposes and serve as a general resource for taxpayers. Tax professionals already play an important role in improving compliance in high-income countries (Junquera-Varela et al., 2017).

Recipient governments may perceive political costs and benefits of donor funding for health versus any increased efforts on taxation as alternative sources of revenue (Morrissey and Torrance, 2015). But, the administrative costs of tax should be offset against bureaucratic costs of aid, including proposal development, numerous officials traveling and meeting with donors, and many complex monitoring and reporting requirements (Morrissey, 2015).

Effective advocacy strategies could therefore emphasize that more effort has to be made to account to donors for how aid is used than to account to taxpayers for how taxes are raised or spent (Morrissey, 2015). In other words, the bureaucratic cost of aid is likely higher than the perceived political cost of increased tax collection.

Similarly, advocacy on the 'win-win' nature of sin taxes and creating evidence on the implications on revenue and health outcomes are identified as key strategies for achieving increased taxation of harmful habits and products and directing this increased revenue to health (AU, 2016b). Partnerships between civil society organizations and government are credited a key success factor in the establishment of the Philippines sin tax on tobacco (Box 2). Modelled after the Philippines success story – civil society and government partnership is identified as critical to the establishment of the Vietnam Tobacco Control Fund (Cashin et al., 2017). Civil society partnerships with other actors – including funding partners – has also been identified as a good advocacy strategy for establishing earmarked taxes (or levies) for HIV in Africa (Box 3).

BOX 2: SUCCESS STORY

Civil Society's Integral Role in Driving Sin Tax Reform in the **Philippines**

In the **Philippines**, 85% of “sin tax” revenue is earmarked for health (Friends of the Global Fight, 2015). Linked to improved tax collection, the government committed to fund 85% of the country's HIV response over 2015-2017, up from just 18% in 2009 (Friends of the Global Fight, 2015). Civil society played a pivotal role in tax reform efforts to accomplish this success story in domestic resource mobilization for health (Madore et al., 2015).

In 1997, civil society coalition members requested meetings with legislators allied with the Aquino administration to ask if they would champion a sin tax reform measure that would increase taxes on cigarettes and direct the profit towards government investments in health. They focused initially on members of the Ways and Means Committee in the House of Representatives, where fiscal bills were filed first. This was strategic, since legislators with known connections to the tobacco industry typically dominated the Committee (Madore et al., 2015).

Civil society groups reached out to local chronic disease experts to gather data on the impact of smoking. After years of lobbying and coalition building, in 2012, civil society mobilized and conducted a massive communications campaign that helped influence the tax reform legislation and the public. As a result, the law passed (WHO, 2015).

These actions - both spontaneously and proactively coordinated - were so sustained that even parties who felt that sin tax reform was not in their short-term interest were brought into the dialogue and became convinced that the reform will serve the greater good (Kaiser et al., 2016).

As soon as the new tax law passed, tobacco industry stakeholders asked the Bureau of Internal Revenue and the Department of Health for evidence that the tax increase was meeting revenue generation and smoking reduction objectives. In November 2013, the Department of Health worked with civil society groups to conduct and publicize local impact studies. Survey and focus group results showed the tax reform was having the desired effect; that fewer Filipinos were smoking

Kaiser et al. (2016) identify **five main civil society advocacy success factors** for tax reform in the Philippines:

- ▶ Building momentum and maintained persistence. Efforts began in 1997 but the Sin Tax Reform bill only came into effect in December 2012.
- ▶ Strategic communications. Framing the reform as a health measure rather than tax measure helped its success.
- ▶ Taking the initiative to create a close coalition across the government, private sector, and civil society was also crucial. Listening and reaching out to all stakeholders made for a broadly agreed on and, ultimately, better reform.
- ▶ Rigorous technical analysis.
- ▶ Careful consideration of political economy issues from all angles—health, tax, and governance.

BOX 3: INNOVATIVE IDEA

AIDS Levies in **Zimbabwe** and **Uganda**

Established in 1999, the AIDS Levy in **Zimbabwe** is made up of a 3% income tax for individuals and 3% tax on profits of employers and trusts. The Levy funds the National AIDS Trust Fund (NATF), mobilizing about \$35 million each year towards treatment and prevention activities (Bhat et al., 2016).

The NATF was founded partly due to the advocacy efforts of people living with HIV who lobbied for the establishment of a dedicated AIDS-fund to meet their treatment and care needs (AU, 2016a). As a result of the involvement of community groups' advocacy for the Levy, the funds from the Levy now go (in part) towards advocacy for people living with HIV and programs that support gender mainstreaming. The AIDS Levy has directly supported advocacy groups including Zimbabwe National Network of People living with HIV and Southern Africa HIV and AIDS Information Dissemination Service (Bhat et al., 2016).

Modelled after the Zimbabwe success story, in 2014 in **Uganda**, the HIV Prevention and Control Act established the National AIDS Trust Fund, a mechanism to increase domestic financing for HIV/AIDS. Uganda's trust fund is structured to collect a revenue contribution of 2% from taxes levied on items like water, soda, beer, spirits, and tobacco. However, the fund is not yet functioning.

One advocacy strategy being employed by civil society there is to appeal to major donors to help put pressure on the Ministry of Finance, Planning and Economic Development (MoFPED) to move the Fund forward. In a joint statement, Ugandan civil society urged PEPFAR to secure assurance from MoFPED, Ministry of Health and other stakeholders that the 10th Parliament will work with partners to prioritize and expedite operationalization of the National AIDS Trust Fund, before finalization of their Country Operational Plan for 2016 (UNASO et al., 2016).

More recently, civil society organizations under the Uganda Network of AIDS Service Organisation (UNASO) demanded to be involved in the drafting of the regulations for the proposed AIDS Trust Fund. UNASO convened a breakfast meeting in April 2017, bringing together partners from local civil society as well as officials from Irish Aid Uganda, the United States mission, Uganda Aids Commission, United Nations Children Emergency Fund, and World Health Organization (Mawanda, 2017).

In these two countries, key success factors in establishing AIDS Trust Funds include:

- ▶ The leadership of communities affected by the three diseases, including networks of people living with HIV, to impress upon the importance of increased domestic financing for health in order to save lives.
- ▶ Leverage civil society and communities' role in establishing earmarked tax systems to ensure that the revenues from those taxes go towards continued and sustained advocacy activities led by civil society and communities.
- ▶ Appealing to funding and development partners, including the Global Fund, PEPFAR and others, to support advocacy efforts for earmarked taxes.

Advocacy for Government Budget Allocations for Health

Advocacy is recognized as a key strategy in efforts to redistribute existing African government revenues to health (AU, 2016b). Strong budget analysis, coupled with sustained and strategic advocacy to create stronger links between policy priorities and budget allocations can play an important role in improving the level, prioritization and stability of general revenue flows to health (Cashin et al., 2017).

In **Zambia**, Planned Parenthood Association of Zambia and the Centre for Reproductive Health and Education (CRHE) worked with the government to reinstate the budget line for reproductive health supplies funded at US\$9.3 million, of which US\$1.9 million came from locally generated revenue (Dennis, 2016).

In **Sierra Leone**, in 2012, the government of Sierra Leone cut the national budget allocation to the health sector. Civil society organizations planned a nationwide health budget advocacy campaign, coinciding with the 2012 general elections, to hold future leaders to account on financing for women's and children's health. As part of the campaign, Evidence for Action produced district health budget tracking scorecards. The scorecards presented Ministry of Finance data on the allocation and disbursement of health funds in each district. The data were communicated using simple, non-technical language so that citizens could understand the key messages and take action. A total of 5600 scorecards were shared at district electoral forums attended by political candidates, community members, and health activists. Since the election, the proportion of the total government budget allocated to health increased from 7.4% in 2012 to 11.2% in 2014. However, transforming politicians' commitments and pledges into implementation has been challenging, confirming that accountability is a long-term process (Lebbie et al., 2016).

In **Haiti**, the establishment of a specific HIV budget line two years ago is a step forward. The development of the health financing strategy is an important entry point to ensure domestic resources for HIV (UNAIDS, 2017a).

The Forum for Women in Democracy (FOWODE) in **Uganda** has been successful at significantly increasing civil society organizations' participation in the budget approval stage. FOWODE developed a "Gender Budget Checklist for Parliament on National Budget Framework Paper" In June 2010 an assessment of 12 sector ministerial policy statements and budgets for the 20 FY 2010/2011 was undertaken to ensure the compliance with the Budget Call Circular stipulations on gender and equity budgeting, informed by FOWODE's checklist.

Also in **Uganda**, a training manual in health budget tracking at local levels has been developed for Uganda's youth leaders and advocates (Rehema, 2017). To be implemented by Re!gnite Africa, the manual contains background information about the decentralization policy, power and budget tracking structures from the central to local government, and a step by step guide to tracking. One of the key success factors identified in the manual for budget tracking advocacy is to build an ally base among three kinds of stakeholders: (1) duty bearers (decision-makers and those who have a duty to protect and uphold every citizen's human right), (2) rights holders (those who are affected by the decisions of the duty bearers) and (3) influencers (those who seek to influence decisions, including civil society organizations) (Rehema, 2017).

Box 4 showcases a success story in advocacy for budget allocation to health, from Malawi.

BOX 4: SUCCESS STORY

Civil Society's Role in Advocating for a Family Planning Budget Line Item in Malawi

Malawi is one of the fastest-growing countries in sub-Saharan Africa. High rates of unplanned and mistimed pregnancies, caused in part by a lack of access to family planning services, create serious health and development challenges for the country. Yet, until 2013, the government budget did not include any allocation for family planning. Instead, Malawi relied exclusively on donors to provide FP commodities and services.

Advocacy efforts began in February 2012, when the Family Planning Association of Malawi (FPAM) with assistance from HPP, presented on the social and economic effects of high fertility to Malawi's Parliamentary Committee on Health.

In August 2012, HPP partnered with PPD-ARO to conduct a regional advocacy training in Uganda. During the workshop, women from Malawi reiterated their commitment to establishing a budget line item for family planning. Following the meeting, HPP organised country monitoring meetings, and coalitions with chairpersons of various national committees were set up, thereby establishing a strong voice for family planning in Parliament.

In April 2013, a new family planning line item was created in the 2013/14 national budget; however, no funding was allocated. Led by the delegates who had participated in the advocacy trainings, a large group of MPs declared they would not pass the budget unless the FP line item was funded. Media coverage of this event helped build momentum in support of funding the line item.

In 2014, the parliamentarians successfully lobbied for an increase in funding for the FP line item, and 60 million MKW was allocated in the FY2014/15 budget. Advocates continue to engage and push for additional increases in the FY2015–2016 budget; which is projected to be 70 million MKW.³¹

Mbuya-Brown & Sapuwa (2015) identify **three main civil society advocacy success factors** for budget earmarking for family planning in Malawi:

- ▶ Evidence was vital to advocacy success; data enabled MPs to confidently articulate issues, ask relevant questions, and make a strong case for investing in family planning.
- ▶ Timing is also critical. Advocates engaged fellow parliamentarians, the MOH, and the Ministry of Finance, Economic Planning and Development (MoFEPD), long before parliamentary budget debates. When parliamentarians “made noise” during parliamentary debates, the key players at the MOH and MoFEPD were already aware of the family planning budget line item issue, and ready to take action. Had parliamentarians not been engaged, this could have created confusion or delays.
- ▶ Budget advocacy does not stop at securing allocations; advocates must also monitor disbursements. There is a need to closely monitor commitments made by the MOH and MoFEPD.

Advocacy for Co-Financing of Donor-Funded Programs

Many funding partners, including the Global Fund, require countries to contribute a certain proportion of domestic co-financing in order to receive grants. The Global Fund recognizes its privileged position to support countries to establish and increase their domestic health financing strategies and goals through its co-financing policy as well as advocacy efforts, and should therefore actively continue to try obtaining funding commitments to the health sector from government leaders with highest-level budgetary authority (Global Fund, 2017).

The Global Fund funding request process can be used as leverage to get countries to commit more domestic funds. **Guyana** has increased its domestic spending on HIV following the signing of a grant agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2014 that included willingness-to-pay requirements (UNAIDS, 2017b).

However, advocacy from civil society and community groups is needed to ensure that these co-financing commitments are maximized, and that they are directed towards critical program areas that government have historically been reluctant to invest in, such a community systems and responses and key population programming.

In **Costa Rica**, government funding for the response to HIV was \$18.4 million in 2012, and this is expected to grow to \$25.6 million by 2018. Based on the country's recent national AIDS spending assessment (NASA), it was clear that there were particularly large gaps for prevention among MSM and transwomen. The evidence from the NASA helped to motivate co-financing in these areas, as part of the country's Global Fund concept note for the 2014-2016 funding cycle. One of the main modalities for the co-financing was funding the Social Projection Board (JPS), a government funding mechanism which ensures local HIV NGOs are able to access public money. Key informants from Aidsplan's (w015) research suggests that civil society played a big role, with the vice-chair of the CCM (from civil society) pushing much of the negotiations. As a result, Costa Rica's concept note states that \$516,492 per year will go into the JPS, totalling \$1,549,476 over the grant cycle (Aidsplan, 2015).

In **Ukraine**, advocacy led by civil society organizations and Principal Recipients of Global Fund investment – and strongly underpinned by the Global Fund's co-financing conditions put to the government of Ukraine – resulted in a September 2016 commitment from the parliament of Ukraine aimed to increase financing treatment of Tuberculosis (TB) by 141% and HIV by 132% (Zardiashvili, 2016). The state budget also contains increased funding for Hepatitis by \$540,000.

Once commitments are secured, sustained monitoring is required to ensure that co-financing commitments are executed. A 13-country Aidsplan (2015) analysis – including **Belize, Botswana, Bulgaria, Costa Rica, Fiji, Iran, Jamaica, Mauritius, Romania, South Africa, Suriname, Thailand, and Ukraine** – suggests that civil society must be able to hold governments accountable for their Global Fund co-financing commitments.

Key informants from the Aidsplan (2015) analysis suggested that TB programs in particular were not very open to civil society to expenditure tracking and co-financing monitoring is difficult. This was noted by key informants from both **South Africa** and **Romania**. Therefore, it may be

critical to provide intensified support civil society working on TB to monitor government co-financing commitments.

At this point it could also be highlighted that DRM advocacy focusing on donor co-financing also have donor advocacy as a flip side? Here the work from advocates in implementing countries, targeting donors to deliver on their promises (0.7% of GNI, et.) could be mentioned.

Advocacy for Improved Absorption and Budget Execution

Over the past decade, civil society organizations have more actively intervened in the budget process, including tracking public expenditure (Mbuya-Brown & Sapuwa, 2015). One study of civil society budget advocacy in Uganda, Bangladesh, and the Philippines concluded that the involvement of civil society in budget advocacy positively influenced budget allocations for sexual and reproductive health (Dickinson, et al, 2012).

Increasing DRM for health is a two-part process. One part is to secure a commitment to spend. The second part is to make sure that commitment is fulfilled and that the money is actually spent. A 2015 Aidsplan report calls for appropriate investment in watchdog activities, especially as key informants from several counties in the sample expressed uncertainty about their country's ability to deliver the promised funding in practice (Aidsplan, 2015). As one Global Fund staffer said:

“The overall financing for health picture is unclear – budget amounts go up and down with no meaningful trend. However, a larger problem is that budgets are very rarely matched by disbursements – what is budgeted for at the beginning of the year seems to have very little bearing on the amount of funding actually received by a ministry or disease program” (Whiteside et al., 2013)

The importance of community monitoring on budget execution cannot be overstated. Following on from the case study in Box 4, what happened next in **Malawi** illustrates the importance of sustained engagement, monitoring and follow-up. In the third quarter of the 2013–2014 budget year the Family Planning Association of Malawi held a roundtable meeting with Ministry of Finance, Economic Planning and Development (MoFEPD) and the Ministry of Health (MoH) representatives and discovered that nine months after the allocation for family planning commodities, the MoH had not spent any of the funds. Once discovered, pressure and scrutiny from parliamentarians – who had been partners with civil society in the advocacy effort - brought the problem to the attention of the Minister of Health. As a result of this monitoring and follow-up advocacy, the MoH spent all the funds in the earmarked budget line within the final quarter of the fiscal year. Without follow-up monitoring and advocacy, the resources would likely have remained unspent. This would have jeopardized future DRM advocacy efforts, made the case for future family planning budget line allocations more difficult (Mbuya-Brown & Sapuwa, 2015).

Similarly, a participatory budgeting approach led by communities in **Brazil** has been linked to improved municipal expenditure, with impact seen on living conditions and better allocation of resources on health-promoting priorities such as basic sanitation and waste removal (Gonçalves, 2014). Further, there was a significant reduction in the infant mortality rates among municipalities that adopted participatory budgeting. Gonçalves (2014) concludes that the significant declines in infant mortality in Brazil as a result of the participatory budgeting, was likely as a result of external

changes to sanitation. This means that community monitoring and budget expenditure tracking in other sectors can have a positive spillover effect in health.

The rationale for watch dogging activities and community monitoring activities is strong. One analysis of development funding estimates that for every \$1 invested in independent watchdogging activities, the rate of return is \$201 (Collins et al., 2009). This is mostly driven by reduced diversion and misuse of funds, but also from increased efficiencies in day-to-day procedures.

BOX 5: GOOD PRACTICE

Civil Society’s Role in Assessing the Absorptive Capacity of Spending Agencies in Uganda

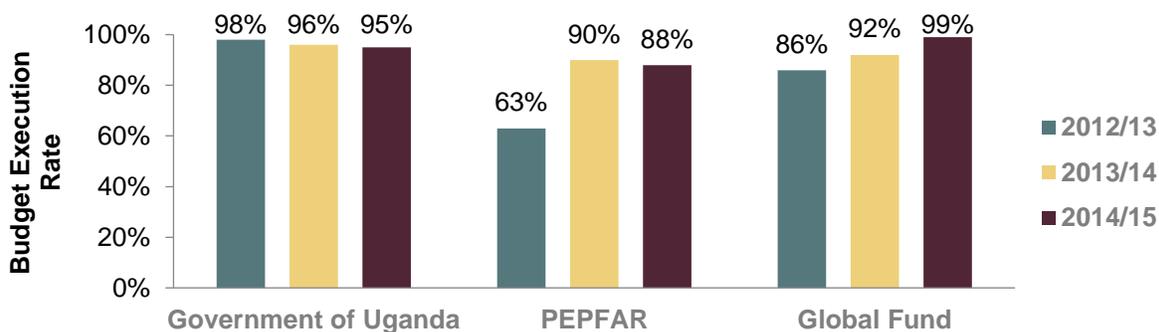
In August 2014, Civil Society Budget Advocacy Group (CSBAG) conducted a study to identify the precise constraints that undermine the utilization of public funds. The study included the following focus objectives:

- ▶ To document funds/ unspent balances that have been returned to the Consolidated Fund for FY 2013/14 by local and national spending agencies
- ▶ To identify and analyze key constraints to effective utilization of public funds
- ▶ To analyze the uncompleted sector work plans due to unspent balances
- ▶ To propose concrete evidence-based recommendations

The analysis found that only 76.4% of the health budget was released (CSBAG, 2014). The report makes broad multi-sectoral recommendations around the main bottlenecks identified, including financial management, planning processes, procurement practices and private-sector capacity, and human-resource management. CSBAG used this analysis and others like it to develop alternative budget proposals, submitted to Parliament and used for advocacy purposes. One analysis of CSBAH’s work found that “These CSO’s contributions could be picked up in official budgets” (Dietl et al., 2014, p. 20).

As a result of strong civil society advocacy on budget execution and absorption in Uganda, HIV budget executive in the country is fairly high over the past three years, particularly for government which has been 95% or higher (Figure 5). Global Fund absorption has also steadily improved. By comparison, budget execution by the Ministry of Health in Zambia, in 2015, was 69% (HPP, 2015b).

Figure 5: HIV Budget Execution in Uganda – Partner Comparison (HPP, 2016b)



Conclusion and Identified Success Factors

Despite projected increases in health spending, a financing gap of \$20–54 billion per year is projected (Stenberg et al., 2017). Policymakers have an obligation to decide what combination of user fees, insurance schemes, taxes, community loan funds, health savings accounts and donor funds they will use to collect funds for health (Wiysonge et al., 2017).

Each country should use available evidence and tools to prioritize equitably, plan strategically, and cost realistically its own path towards SDG 3 and UHC (Stenberg et al., 2017). Civil society organizations have a key role to play in advocating for increased domestic resource mobilization for health, especially in the context of declining donor investment, increasing need and ambitious global targets.

The investment case for health is strong and can be easily made. If advocates are successful, the optimal SDG 3 funding scenario would save 97 million lives and increase life expectancy by up to 8.4 years (Stenberg et al., 2017).

Overall success factors

- ▶ Differentiate advocacy strategies and tailor messages based on country context
- ▶ Consider the issues from a range of angles—health, tax, governance, etc.

Success factors in advocacy for improved tax revenue collection

- ▶ Emphasize that the bureaucratic costs of donor funding is likely higher than the political cost of increased tax collection
- ▶ Form coalitions with government, private sector, disease experts and the media
- ▶ Plan and prepare to build momentum and sustain advocacy efforts for a long time
- ▶ Perform or make use of rigorous technical analyses to support advocacy messages
- ▶ Communicate strategically, framing issues as health measures (not tax measures)

Success factors in advocacy for government budget allocation to health

- ▶ Push for the development of a health financing strategy as an important entry
- ▶ Make use of evidence to make a strong case for investing health
- ▶ Have strategic timing. Engage parliamentarians long before parliamentary budget debate. Plan health budget advocacy campaigns during elections to lobby future leaders

Success factors in advocacy for co-financing of donor-funded programs

- ▶ Make use of national spending assessments to advocate for co-financing of critical program areas, especially key populations programming
- ▶ Make use of civil society CCM members to carry your advocacy messages forward
- ▶ Ensure that advocacy efforts link responsibilities and commitments of donors and implementing countries alike.

Success factors in advocacy for improved absorption & budget execution

- ▶ Do not stop advocacy efforts at securing allocations. Continue to monitor disbursements.
- ▶ Conduct budget execution and absorption analyses and use the results to create alternative budget proposals and submit them to Parliament

References

- African Union (AU) (2016a). Innovative and Domestic Financing for Health in Africa - Documenting good practices and lessons learnt. African Union and the Global Fund. Online at https://au.int/sites/default/files/pages/32894-file-idf_lessons_learnt_en_hires.pdf
- African Union (AU) (2016b). Innovative and Domestic Financing for Health in Africa - Expanding the Fiscal Space for Health in Africa. African Union and the Global Fund. Online at https://au.int/sites/default/files/pages/32895-file-expanding_the_fiscal_space_for_health_in_africa.pdf
- Aidspan (2015). The “Fair Share” of Shared Responsibility: An Aidspan Report on Willingness to Pay. Aidspan. Online at <http://www.aidspan.org/publication/%E2%80%9Cfair-share%E2%80%9D-shared-responsibility-aidspan-report-willingness-pay>
- Bhat, N., Kilmarx, P. H., Dube, F., Manenji, A., Dube, M., & Magure, T. (2016). Zimbabwe's national AIDS levy: A case study. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 13(1), 1-7.
- Bhushan & Samy (2014). Bhushan (2014) Fiscal Capacity and Aid Allocation: Domestic Resource Mobilization and Foreign Aid in Developing Countries. Working Paper 2014-7, prepared for the UNRISD project on Politics of Domestic Resource Mobilization for Social Development. Online at <http://www.unrisd.org/80256B3C005BCCF9/search/6FD41B9BB6628328C1257CD300556010?OpenDocument>
- Cashin, C., Sparkes, S. & Bloom, D. (2017). Earmarking for Health: From theory to practice. Health Financing Working Paper No. 5. World Health Organization and Results4Development. Online at <http://apps.who.int/iris/bitstream/10665/255004/1/9789241512206-eng.pdf?ua=1>
- Collin, M., Zubairi, A., Nielson, D., Barder, O. (2009). The Costs and Benefits of Aid Transparency: A Draft Analytical Framework. Page 20. Online at <http://www.aidtransparency.net/wp-content/uploads/2010/06/1140-100407- Framework-for-Costs-and-Benefits-of-transparency-with-Annexes.pdf>
- Civil Society Budget Advocacy Group (CSBAG) (2014). Constraints Undermining Budget Absorption in Uganda.
- Dennis, S. (2016). Civil Society Guide to the GFF. <https://pai.org/wp-content/uploads/2016/10/CS-GFF-Guide-2.pdf>
- Dickinson, C., T. Collins, R. Loewenson, and S. Ghosh. (2012). Civil Society's Contribution to Budget Advocacy for Sexual and Reproductive Health: Findings and Lessons Learned from Three Country Studies in Bangladesh, the Philippines, and Uganda. *Global Health Governance* VI(1). <https://blogs.shu.edu/ghg/2012/12/31/civil-societys-contribution-to-budget-advocacy-for-sexual-and-reproductive-health-findings-and-lessons-learned-from-three-country-studies-in-bangladesh-the-philippines-and-uganda/>

Dietl, s., Gubitzer, L., Kabonesa, C. & Klatzer, E. (2014). The Budget Process in Uganda Entry Points for Gender and Gender Responsive Budgeting in the Budget Process in Uganda. Working Paper Promoting Gender Responsive Budgeting and Gender Mainstreaming in Uganda. Online at <https://www.wu.ac.at/fileadmin/wu/d/i/vw3/workingpaper.pdf>

Friends of the Global Fight (2015). Increasing Domestic Investment in AIDS, TB & Malaria

Global Fund (2014). Global Fund strategy for increased domestic financing for health.

Global Fund (2015). Investment Case for the Global Fund's 2017-2019 Replenishment. The Right Side of the Tipping Point For AIDS, Tuberculosis and Malaria. Presented on 17 December 2015 at the Global Fund's Fifth Replenishment Preparatory Meeting in Tokyo, Japan.

Gonçalves, S. (2014). The effects of participatory budgeting on municipal expenditures and infant mortality in Brazil. *World Development*, 53, 94-110.

Health Policy Project (HPP) (2015a) Health Budget Advocacy - A Guide for Civil Society in Malawi. Online at https://www.healthpolicyproject.com/pubs/747_MalawiBudgetAdvocacybooklet.pdf

Health Policy Project (HPP) (2015b) Sustainable HIV Financing in Zambia - Baseline Analysis and Prospects for New Domestic Resource Mobilization. Online at https://www.healthpolicyproject.com/pubs/2876_ZambiaHIVFinancingFeb.pdf

Health Policy Project (HPP) (2016a) Analysis of Taxation to Enhance Fiscal Space for Health and HIV and AIDS in Tanzania. Online at https://www.healthpolicyproject.com/pubs/872_HPPTaxationFiscalSpaceHIVAIDSTanzaniaReportC.pdf

Health Policy Project (HPP) (2016b) Sustainable HIV Financing in Uganda - Baseline Analysis and Prospects for New Domestic Resource Mobilization. Online at https://www.healthpolicyproject.com/pubs/2877_UgandaHIVFinancing.pdf

Institute for Health Metrics and Evaluation (IHME) (2017). Financing Global Health 2016: Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage. Seattle, WA: IHME. Online at http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2017/IHME_FGH2016_Technical-Report.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2014). Fast-Track: Ending the AIDS Epidemic by 2030. Online at http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2016). Fast-Track Update Update on Investments Needed in the AIDS Response. Online at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Reference_FastTrack_Update_on_investments_en.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2017a) Country Snapshots - Quickening the pace of action to end AIDS. Online at

http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2017/september/20170919_UNGA_sideevent_concept

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2017b). Ending AIDS: Progress Towards the 90-90-90 Targets. Global AIDS Update. Online at http://www.unaids.org/en/resources/documents/2017/20170720_Global_AIDS_update_2017

Junquera-Varela, R. F., Verhoeven, M., Shukla, G. P., Haven, B., & Moreno-Dodson, B. (2017). *Strengthening Domestic Resource Mobilization: Moving from Theory to Practice in Low-and Middle-Income Countries*. World Bank Publications.

Kaiser, K., Bredenkamp, C., & Iglesias, R. (2016). *Sin tax reform in the Philippines: transforming public finance, health, and governance for more inclusive development*. World Bank Publications. Online at <https://openknowledge.worldbank.org/bitstream/handle/10986/24617/9781464808067.pdf?sequence=2>

<http://files.kff.org/attachment/Report-Donor-Government-Funding-for-HIV-in-Low-and-Middle-Income-Countries-in-2016>

Kjær, A. M., Ulriksen, M. S., Kangave, J., & Katusiimeh, M. W. (2017). A Political Economy Analysis of Domestic Resource Mobilization in Uganda. Working Paper 2017-8, prepared for the UNRISD project on Politics of Domestic Resource Mobilization for Social Development. Online at <http://www.unrisd.org/80256B3C005BCCF9/search/98FD9753BE1DA42BC1258144003622DE?OpenDocument>

Lebbie, S. A., Le Voir, R., Tom-Kargbo, J., Yilla, M. D., Kamara, A. B., & Nam, S. L. (2016). Using evidence to strengthen accountability for health financing in Sierra Leone. *International Journal of Gynecology & Obstetrics*, 135(3), 380-384.

Madore, A., Rosenberg, J., & Weintraub, R. (2015). Sin Taxes and Health Financing in the Philippines. *Cases in Global Health Delivery Module Note, April*, 1-33.

Mawanda, P. (2017, April 27). CSOs Demand Involvement in the Drafting AIDS Trust Fund Regulations. Uganda Radio Network. Online at <https://ugandaradionetwork.com/story/civil-organisations-call-upon-m-o-h-to-involve-stake-holders-in-the-drafting-of-the-aids-trust-fund-regulations>

Médecins Sans Frontières (MSF) (2017). Taxing the ill - How user fees are blocking universal health coverage. Online at <http://www.msf.org/en/article/report-taxing-ill-how-user-fees-are-blocking-universal-health-coverage>

Mbuya-Brown, R. and Sapuwa, H. (2015). *Health Budget Advocacy: A Guide for Civil Society in Malawi*. Washington, DC: Futures Group, Health Policy Project.

Morrissey, O., and Torrance, S. (2015), 'Aid and Taxation', ch. 31 in B. M. Avin and B. Lew (eds), *Handbook on the Economics of Foreign Aid*, Cheltenham, Edward Elgar, forthcoming.

- Reeves, A., Gourtsoyannis, Y., Basu, S., McCoy, D., McKee, M., & Stuckler, D. (2015). Financing universal health coverage—effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries. *The Lancet*, 386(9990), 274-280.
- Remme, M., Siapka, M., Sterck, O., Ncube, M., Watts, C., & Vassall, A. (2016). Financing the HIV response in sub-Saharan Africa from domestic sources: moving beyond a normative approach. *Social Science & Medicine*, 169, 66-76.
- Resch, S., Ryckman, T., & Hecht, R. (2015). Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries. *The Lancet Global Health*, 3(1), e52-e61.
- Rollback Malaria (2015). Action and Investment TO Defeat Malaria 2016-2030: For a Malaria-Free World. Online at http://rollbackmalaria.org/wp-content/uploads/2017/09/RBM_AIM_Report_A4_EN-Sept2015-ORG.pdf
- South African National AIDS Council (SANAC) (2017). Let our Actions Count: South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022. Online at <http://sanac.org.za/2017/10/24/download-the-full-version-of-the-national-strategic-plan-for-hiv-tb-and-stis-2017-2022/>
- Southern African Development Community (SADC) (2017). SADC Malaria Report 2017. Online at <http://www.health.gov.za/index.php/component/phocadownload/category/422-malaria-2017?download=2529:sadc-malaria-report-2017>
- Stenberg, K., O. Hanssen, T. Tan-Torres Edejer, M. Bertram, et al. (2017). "Financing Transformative Health Systems Towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries. *The Lancet Global Health*, 5, e875-e887.
- Stop TB Partnership (2015). The Parading Shift: Global Plan to End TB. Online at http://www.stoptb.org/assets/documents/global/plan/GlobalPlanToEndTB_TheParadigmShift_2016-2020_StopTbPartnership.pdf
- Tokyo Declaration (2017). Tokyo Declaration on Universal Health Coverage: All Together to Accelerate Progress towards UHC. Universal Health Coverage Forum 2017
- Uganda Network of AIDS Service Organisations (UNASO). (2016). Civil society recommendations: Uganda COP 2016. Online at [https://d3n8a8pro7vnmx.cloudfront.net/healthgap/pages/249/attachments/original/1463580533/Civil_society_recommendations_Uganda_final_\(1\).pdf?1463580533](https://d3n8a8pro7vnmx.cloudfront.net/healthgap/pages/249/attachments/original/1463580533/Civil_society_recommendations_Uganda_final_(1).pdf?1463580533)
- Whiteside, A., Surgey, G., Greener, R., Bradshaw, S. & Mucheuki, C. (2013). Responding to Health Challenges: the role of domestic resource mobilisation. Online at <https://alanwhiteside.files.wordpress.com/2016/01/03122013-responding-to-health-challenges-final-1330.pdf>
- Wiysonge, C.S., Paulsen, E., Lewin, S., Ciapponi, A., Herrera, C.A., Opiyo, N., Pantoja, T., Rada, G. and Oxman, A.D. (2017). Financial arrangements for health systems in low-

income countries - an overview of systematic reviews (Review). Online at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011084.pub2/epdf>

World Health Organization (WHO) (2013). Tuberculosis Financing and Funding Gaps in 118 Countries Eligible for Global Fund Support. Online at http://www.who.int/tb/WHO_GF_TB_financing_factsheet.pdf

World Health Organization (WHO) (2015). "Sin Tax" expands health coverage in the Philippines. Online at <http://www.who.int/features/2015/ncd-philippines/en/>

World Health Organization (WHO) (2017a). Global Tuberculosis Report. Online at <http://apps.who.int/iris/bitstream/10665/259366/1/9789241565516-eng.pdf?ua=1>

World Health Organization (WHO) (2017b). World Malaria Report. Online at <http://apps.who.int/iris/bitstream/10665/259492/1/9789241565523-eng.pdf?ua=1>

Zardiashvili , T. (2016) Advocacy for increased domestic funding a success in Ukraine. Global Fund Observer, Issue 297. Aidspan. Online at http://www.aidspan.org/gfo_article/advocacy-increased-domestic-funding-success-ukraine