Sustainable Health Financing Advocacy:

Civil Society Advocacy for Sustainable Financing for Health

Concept Note

gfan global fund advocates network

Sustainable Health Financing Advocacy

Civil Society Advocacy for Sustainable Financing for Health

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Cover Photo: GFAN Speaker and LGBT advocate in Cameroon, Serge Douomong Yotta hosting a capacity building meeting of key population representatives on community engagement and Global Fund Civil Society Support Mechanisms
For more on Serge's story visit: http://www.globalfundadvocatesnetwork.org/campaigns/serge-douomong-yotta/

Executive Summary

"*Sustainable health financing advocacy*" (SHFa) is a unified framework for advocacy originally proposed by advocates from GFAN regional partners and other advocacy partners in Africa, Asia-Pacific, Eastern Europe and Latin America at a global meeting in February 2018.

As a broad framework, SHFa encompasses advocacy across multiple health priorities and in multiple health financing contexts. This unified framework for action can help advocates align efforts, understand the interlinkages and potential synergies for collaboration, and avoid silos in our work.

The rationales and urgency for the use of such a unified framework are clear:

- For GFAN advocates, this framework aligns and embeds work on the HIV, TB and malaria response within broader advocacy for the Sustainable Development Goals (SDGs).
- This framework establishes intended aims and outcomes that can be shared and supported by a broad range of allies.
- This framework therefore encourages a unified and aligned global advocacy effort for sustained financing of all of the SDG3 targets for health and progress toward broader SDG aims related to human rights, gender equality global security and economic development.

Through this proposed framework, GFAN calls for advocates to avoid being caught in fragmented silos of work. As advocates rooted in the HIV, TB and malaria response, we can and must remain committed to working across issues such as harm reduction, sexual and reproductive health services, access to essential medicines, universal health coverage, domestic resource mobilization, and broader issues of poverty, justice, gender equality and human rights. Additionally, if we truly want to build inclusive, resilient, and sustainable systems for health, we must invite advocates in those related efforts to join us in coalition.

GFAN is now circulating this concept note to encourage further advocate dialogue about, and resource mobilization for, the work described in this document. Specifically, GFAN will seek to develop further resources and plans for:

- Developing convergent work across multiple areas of health advocacy, including priorities related to HIV, TB, malaria, harm reduction, sexual and reproductive health, universal health coverage (UHC), accessibility and affordability of essential medicines, and broader issues of poverty, social justice, gender equality and human rights.
- Developing convergent work across multiple areas of financing advocacy, including (progressive) tax policy, innovative financing, insurance schemes, funding for community-based and community-led health programming, and inclusive expenditure planning, expenditure oversight and monitoring for expenditure accountability.
- Building new partnerships, training, technical support, and funding initiatives to link HIV, TB and malaria advocates with coalitions for shared sustainable health financing goals.

Table 1: A unified framework for sustainable health financing (SHF) advocacy

Contexts that shape SHF advocacy	Components, costs, and process objectives of SHF advocacy	Intended short-term outcomes of SHF advocacy	Intended long term outcomes and impact of SHF advocacy
Health: Leading causes of DALY, and progress indicators of SDGs and SDG3 targets **Health spending:** Financing sources, and progress indicators (e.g. DRM, UHC, OOP, DAH) **Political environments**: Key channels of influence and decision-makers **Platforms for advocacy:** Networks, organizations, people, tools, resources	**Components and costs:** • People: People, bringing experience, skills, and abilities related to SHF policy work, organizing, communications, management, and advocacy • Community Systems: Structures, tools and resources: Providing capacity for people to work together and communicate • Architecture: Support from global and regional levels to contribute funding, information, access, skills, and credibility **Process objectives:** • Capacity building: Build informed vocal constituencies for health financing • Conceptual influencing: Shift the framing of policy issues and debates related to health financing • Political influencing: Create political willingness and ability to fund health by building support among stakeholders and embedding commitments in strategies, plans, and programs • Measure and learn: Monitor implementation and build accountability to commitments and results	**Increased and improved revenue generation,** such as through DAH, taxes, innovative financing, and insurance schemes. **Increased and improved funding allocations,** such as for programs aimed at specific SDG and SDG3 targets, including for community-based,and community-led programming. **Improved efficiency, effectiveness and quality of investments**, including through inclusive planning, expenditure oversight and monitoring, accountability to results, and accountability to quality, rights, equity and justice (i.e. to the sickest, poorest, marginalized and unequal)	**Progress toward SDG3 targets**, including: • Reducing incidence and ending epidemics of HIV, TB, malaria • Improving access to harm reduction services • Improving access to SRHR and RMNCAH-N services • Achievement of UHC • Supporting accessible and affordable medicines **Progress toward other SDGs**, such as priorities related to poverty, hunger, economic growth, education, and gender equality

Context

The Goals of Health & Development

The concept of advocacy for sustainable health financing can be defined first by its goals of improved health and development. The current globally agreed on standard set of health and development goals are the Sustainable Development Goals (SDGs).

Agreed through a 2015 United Nations General Assembly resolution, the Sustainable Development Goals cover 17 broad interlinked priorities including poverty, hunger, health, education, gender equality and economic opportunity and growth. The third Sustainable Development Goal (SDG3) focuses on health and wellbeing and defines thirteen internationally agreed upon targets.

At least five of the SDG3 targets, and the related work to define the financing levels necessary to achieve those targets, are highly relevant for GFAN in its conceptualization of sustainable health financing advocacy. Those five targets are:

- **Reducing incidence of HIV, TB, malaria, and viral hepatitis:** The SDG3 target 3.3 specifically lists reduced incidence of HIV, TB, malaria and viral hepatitis as priorities for global and national investments. In alignment with this target, global institutions including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization (WHO), UNAIDS, the Stop TB Partnership, and the RBM Partnership to End Malaria are working to help countries to define country-level targets, calculate resource needs, and mobilize sufficient international and national funding to end these epidemics by 2030.[1]

- **Improving treatment and prevention of harms related to substance use:** Building from SDG3 target 3.5, global institutions including the Global Fund, WHO, UNODC, UNAIDS, Harm Reduction International (HRI), and the International Drug Policy Consortium (IDPC) are working to help countries to define needs and targets related to harm reduction services for people who use drugs and to reduce the harms of prohibitionist drug policies and criminalization and punitive policing of people who use drugs.[2]

- **Improving access to sexual and reproductive health care services and reducing maternal, neonatal, and child mortality:** In alignment with global SDG3 targets 3.1, 3.2 and 3.7, global institutions including the WHO, UNFPA, the World Bank, Guttmacher, and IPPF are working to define financing needs and targets for both sexual and reproductive health and rights (SRHR) services and reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services.[3] [4]

- **Achievement of universal health coverage (UHC):** Building from SDG3 target 3.8, global organizations and coalitions including the WHO, World Bank, and the International Health Partnership for UHC2030 (UHC2030) and its working groups, including the Civil Society Engagement Mechanism (CSEM) and Sustainability and Transition Working Group (STWG) are working to define financing needs and targets for UHC.[5]

- **Supporting access and affordability of essential medicines:** Toward advancement of the SDG3 target 3B, the WHO, UNITAID and other organizations are continuing to define and promote policy solutions and financing to ensure production, procurement, supply, accessibility and affordability of essential medicines.

These five areas of work are interlinked and interdependent. More than half of the world's people live in countries with a high burden of preventable communicable diseases and premature mortality and disability due to lack of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) health services (see Table 2).

In recognition of the interdependent nature of the SDG3 goals, many governments, international agencies, and advocacy organizations are working to advance toward multiple targets together, with combined or complementary strategies, policy work and advocacy for multiple overlapping priorities for health and development.

Therefore, GFAN's conceptualization of advocacy for sustainable health financing is necessarily:

- Targeted to specific SDG3 aims such as ending epidemics of HIV, TB, malaria.
- Encompassing of and coordinating across multiple SDG3 aims such as those related to harm reduction, sexual and reproductive health, universal health coverage, and accessibility and affordability of essential medicines.

Table 2: Example of countries with high burden of preventable disease and needs for improved health services [6]

Countries	Total DALY burden 2016 – all causes, all ages (IHME GDB 2017)	DALYs 2016 due to communicable, maternal, neonatal, and nutritional diseases (Group 1)	UHC Index (projected 2019 - scaled coverage of 16 essential services) 2016)	High burden of HIV (> 500k people or >1% prev)	High burden of TB (among the high burden 22 counties)	High burden of malaria (rate per population)
India	466.3	152.6	43	Y	Y	Y
China	347.7	21.6	78		Y	
Nigeria	103.9	75.0	38	Y	Y	Y
Indonesia	72.7	18.1	43	Y	Y	Y
Pakistan	70.6	28.6	30		Y	Y
Russia	62.9	4.3	64	Y	Y	
Brazil	57.1	7.8	62	Y	Y	Y
Bangladesh	44.6	11.9	52		Y	Y
Ethiopia	38.2	20.6	26	Y	Y	Y
Philippines*	30.1	7.7	41		Y	Y
South Africa	27.5	14.3	47	Y	Y	
Vietnam*	24.1	3.2	63	Y	Y	Y
Tanzania*	23.7	14.6	39	Y	Y	Y
Uganda	19.8	13.4	30	Y	Y	Y
Thailand	18.3	2.2	74	Y	Y	Y
Kenya*	16.6	10.5	50	Y	Y	Y

The Contexts of Health Financing

The concept of sustainable health financing advocacy can also be understood in the context of current trends in economic development and funding for health.

The cost 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.[7]

Domestic spending by low- and middle-income countries (LMIC) already accounts for most of the current investments in health. The share of domestic spending by LMIC as a part of overall health investment is widely expected to increase during the coming years in many countries. For example, a 2017 WHO analysis[8] suggests that 85% of the SDG3 costs could be afforded by national governments, and a 2018 Lancet article projects that large countries such as China, India, Indonesia, Bangladesh, and Ethiopia will all double their overall health spending by 2030, and that most of these countries will significantly increase spending by government health programs.[9]

Building from this expectation, and as part of their anti-poverty focus, wealthy countries have been reducing their international development assistance for health to middle-income countries and have increasingly been making an increase in domestic health spending, and progress in 'transitioning' away from international aid, conditions for continued support through mechanisms such as the Global Fund.

The context of health financing varies by country. Even in many countries where there are strong and increasing government-run health investments and development of (private) pre-paid health coverage schemes, people are still vulnerable to out-of-pocket household spending for health care and international assistance remains essential for developing, promoting, and protecting specific health programs and services for key populations (See Table 3, following page).

This varied context country-by-country necessarily shapes the priorities and forms of advocacy for sustainable health financing. Depending on the context, advocacy for sustainable health financing must cover multiple targets, including domestic resource mobilization for health, government budget allocations for health, investment in systems for health, and international development assistance for health.

Mobilizing increased and improved domestic funding for health: Many upper middle-income countries have the theoretical ability to ensure health services and health programming to benefit all of their populations, but advocacy is needed to ensure that this happens. In countries with relatively strong tax revenues and government-run health programs, including countries such as South Africa, Thailand, Russia, and Argentina, advocates need to work with national and local governments to increase health budgets and to create and promote inclusive health programs and health budget allocations that fund appropriate programming for appropriate, effective and high-quality services.

Advocating for universal health coverage: Governments attending the 2017 Universal Health Coverage Forum acknowledged that 800 million people are spending at least ten 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.[10] In alignment with SDG3 target 3.8, there is now a major global push for universal health coverage in every country. But health insurance mechanisms face resource constraints and policy or structural issues that create biases against the poorest and sickest populations, and potentially overlook or exclude costlier or less routine health services and relatively marginalized populations. In countries with existing and growing national health insurance and health coverage schemes, including Kenya, Senegal, Philippines, and Brazil, an important focus for advocacy is to make those systems fair and equitable through adequate standards and resourcing, monitoring of quality and accessibility of health coverage programs, financing of subsidies and stop-loss provisions to cover populations that are comparatively sicker, poorer, or more marginalized, and coverage services that are more intensive, expensive or specialized.

Table 3: Economic and health financing indicators that are shaping the targets of advocacy [11]

Example Countries	Total health spending per person (PPP 2016)	Government health spending per total health spending (2016)	>5% increase in govt share projected by 2030	Prepaid private spending (2015)	>10% increase in pre-paid private spending projected by 2030	Out-of-pocket spending (2016)	International development assistance for health (2015)
Brazil	1,864	33%		28%	Y	44%	0%
Argentina	1,616	76%		10%		15%	1%
Russia	1,470	58%		3%		39%	0%
South Africa	1,162	54%		36%	Y	8%	2%
Mexico	1,001	53%		7%		40%	0%
Thailand	654	77%		9%		12%	0%
Ukraine	567	43%		4%		52%	1%
Vietnam*	347	50%	Y	3%		48%	3%
Philippines*	333	30%	Y	15%	Y	54%	1%
Senegal*	172	30%	Y	11%	Y	49%	13%
Kenya*	187	34%	Y	13%	Y	27%	24%
Uganda	168	16%		12%	Y	38%	43%
Malawi	141	23%		5%		10%	61%
Tanzania*	129	34%	Y	2%		23%	42%
Haiti	113	13%		4%		36%	47%

Sustaining international development assistance for health: Despite predicted increases in health spending by lower and middle-income countries, the 2017 WHO analysis of financing needs for the Sustainable Development Goals projected a gap of $20–54 billion per year to achieve the SDGs for health in LMICs. National health programs in many middle-income countries, including in Asia, Eastern Europe and Latin America, are facing serious resource constraints and other limitations in sustaining and extending services and programming for health. In many cases where international development assistance for health (DAH) has been reduced, governments have resorted to scaling back effective programs, including programs for HIV, TB, malaria, viral hepatitis, harm reduction, sexual and reproductive health, and subsidy of essential medicines. In countries with significant amounts of international development assistance for health, including funding from agencies such as the Global Fund, a priority for advocates is to ensure the success of and continued quality investments from those funding mechanisms.

Political & Human Rights Contexts of Advocacy

Advocacy is the active promotion and defense of an opinion, a cause, a policy and/or a group of people. It is, at its essence, an effort to communicate with and influence those who hold power, and not only creating and defining obligations but also holding those in power to be accountable to those obligations. In any country, the stakeholders who may have influence or power over health programs and other interests and priorities of the country and public well-being generally include:

- Leaders, managers and representatives of organized government (including legislative, executive, judicial or military leaders).
- Leaders of for-profit corporations and other private market interests (including organized crime).
- Leaders of major civil society sectors and institutions, including faith-based organizations, media, universities, labour unions, charities, and local communities.
- Representatives of international agencies, including regional, multilateral or bilateral funders.
- Other economic, political or social elites.

Advocates have a crucial role in society by creating and leveraging accountability between these stakeholders, such as accountability between branches of government, accountability of government to civil society, or accountability of for-profit companies or of civil society sectors to government.

Across all of the many contexts and dynamics, sustainable health financing advocacy:

- Builds constituencies and support for health, over (or alongside) other overlapping and competing interests, including other economic, social, military, or ideological priorities.
- Creates willingness and political ability to fund health, through expression of values, positions, decisions, policies, laws, legislation, regulations, and standards.
- Realizes the manifestation of a positive willingness and ability to fund health through programs to generate revenue, allocate funding, and spend and manage funds for health.

Advocates' work is shaped by the context of civil and political freedoms. In politically open democratic contexts, advocacy can communicate through media and public pressure, directly confronting and challenging decision-makers with information, ideas, and priorities. In many of these contexts, advocates work as both "outsider" protesters, mobilizing constituencies to be visible and vocal, and "insider" advocates helping in collaborative program design and planning, decision making, service implementation, and monitoring & evaluation.

In contexts with greater limits on political expression and political dissent, effective advocacy uses subtler strategies that can communicate ideas, win allies, and promote priorities while cognizant of the risks of directly or openly challenging authority and political hierarchies.

The impact of advocacy is also influenced by the degree of rule of law, corruption, and enforceability of contracts, all measures related to the ways that people and organizations are formally accountable.

Table 4: Broad types of political environments that shape advocacy[12]	Examples of Countries
Shaped by free press, relative openness of political expression, existence of democratic processes for influence, relatively low perceptions of corruption	South Africa, Senegal*, Ghana, Philippines*, Jamaica
Shaped by limits to political expression or dissent	China, Thailand, Morocco
Shaped by high perceptions of corruption	Bangladesh, Nigeria, Kenya*, Tanzania*, Haiti
Shaped by both limits to political expression or dissent and high perceptions of corruption	Russia, Egypt, Vietnam*

Platforms to Sustain Advocacy

Advocacy must be supported to make the case for increased and improved health financing, from both domestic and international sources, in all of the varied contexts of health, economic development, and political contexts described above.

- Effective advocacy needs to be supported with information and policy work to define potential actions and outcomes, and involvement of local expertise to tailor the advocacy to diverse political, social and cultural contexts, unique dynamics and channels for influence, and the needs of key decision-makers.

- Effective advocacy also needs support for organizational and network structures through which people can work together, communications tools and resources, and support to reinforce advocate skills, access, and credibility.

- Effective advocacy also needs to be sustained. Advocates need to be ready and in place for specific negotiations, votes or decisions when they are about to happen, and the advocacy work needs to be sustained through cycles of successive achievements or set-backs and through the process of gaining audiences, credibility and influence.

The potential cost of these advocacy resources and support are far outweighed by the potential impact. Researchers have calculated that if an optimal SDG3 funding scenario was achieved, 97 million premature deaths would be averted, and average global life expectancy would increase by up to 8.4 years.[13] Ample evidence also shows that, in the absence of advocacy, many countries risk continuing on their current trajectories of enduring endemic unmet health needs with insufficient health financing and relative political unaccountability and impunity, resulting in a global failure to meet its SDG goals. One cost-benefit analysis of advocacy related to development funding calculated that for every $1 invested in independent advocacy, the rate of return is $201, driven by reduced diversion and misuse of funds and also increased efficiency in health program spending and implementation.[14]

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GFAN as an example of a platform to sustain advocacy: The Global Fund Advocates Network (GFAN), established to support, foster and coordinate advocacy for a fully funded and effective Global Fund, has the experience and structures to support effective sustained advocacy. Beginning in 2011, GFAN began supporting advocacy in high-income counties to promote international development assistance for health, including and especially donor country funding for and through the Global Fund to Fight AIDS, TB and Malaria.

GFAN has since grown to serve as a platform for over 330 organizations working throughout the world to advocate for full funding of HIV, tuberculosis and malaria programming, building from a network of long-time advocates who are passionate, committed, connected globally, and deeply experienced in battles to win resources for health. GFAN's work is centred on full funding of HIV, TB and malaria efforts but necessarily encompasses broader health financing issues, including achievement of the SDGs and UHC, advocacy for domestic resource mobilization and sustainability, transition and co-financing, and policies that protect and promote human rights and gender equality, social and economic justice, quality of health services, and the goal of "leaving no one behind". As an example, the lead of the GFAN Africa hub is a member of the UHC 2030 Steering Committee and the chair of the GFAN Asia Pacific hub is the alternate. In addition, GFAN Asia Pacific is helping to lead and facilitate discussions around "The UHC We Want"[15], and the GFAN Secretariat is actively supporting and promoting these efforts at a global level.

Through the GFAN Regional Partners in Africa and Asia-Pacific and through partners and emerging GFAN partners in Latin America and the Caribbean, GFAN is engaged with many advocates in low- and middle-income countries. Through the New Venture Fund (NVF) for Global Fund Advocacy, GFAN has provided support for advocate organizations in Kenya, Senegal, Tanzania, Philippines and Vietnam and has supported advocacy networks and actions at a regional and global level. In addition to supporting advocacy for funding to and through the Global Fund, GFAN and/or GFAN regional partners also organizes calls and meetings for advocates that address a variety of related health financing advocacy priorities, including the Sustainable Development Goals (SDGs) and goals of Universal Health Coverage (UHC), the shift faced by many countries of reduced international development assistance for health (DAH) and needs for domestic resource mobilization (DRM) and plans for sustainability, transition and co-financing (STC), and issues of service access, quality and human rights environments.

Through the NVF program, GFAN has demonstrated an effective approach and structure to:

- Build informed vocal constituencies about health financing issues, as a basis for political action and influence and for holding decision-makers accountable to their commitments;
- Elevate the voice of people affected by Global Fund investments to policy and decision makers in donor countries;
- Raise attention and awareness about the Global Fund and other health financing issues such as UHC and STC among community advocates and policy makers;
- Shift the framing of policy issues and debates related to health financing;
- Persuade policymakers through high-quality analysis and the credibility of advocates, and build support among politicians, political parties, and influential media and community stakeholders, and;
- Embed health funding commitments into political documents, national health and development frameworks, and new STC strategies, policies, and health financing mechanisms.

Concept

A Unified Framework for Sustainable Health Financing Advocacy

Given the interdependent SDG targets for health and development, and priorities for financing across all of SDG health issues, a broadly framed approach to advocacy is now needed.

The Global Fund Advocates Network (GFAN), as a collective of advocates rooted in the HIV, TB and malaria response, works on a full range of related health priorities including access to harm reduction, sexual and reproductive health services, access to essential medicines, universal health coverage, domestic resource mobilization, and broader issues of poverty, justice, gender equality and human rights.

As such, GFAN has recommended[16], and now proposes, a unified framework for action to support a coalition to align efforts with others, understand the interlinkages and potential synergies for collaboration, and avoid silos in its work (see Tables 5-7).

The rationales and urgency for the use of such a framework are clear:

- For GFAN advocates, this framework aligns and embeds its work on the HIV, TB and malaria response within broader advocacy work for the Sustainable Development Goals.

- This framework establishes intended aims and outcomes that can be shared and supported by a broad range of allies.

- This framework therefore encourages a unified and aligned global advocacy effort for sustained financing of all of the SDG3 targets for health and progress toward broader SDG aims related to human rights, gender equality global security and economic development.

Through this proposed framework, GFAN calls for advocates to avoid being caught in fragmented silos of work. As advocates rooted in the HIV, TB and malaria response, we can and must remain committed to working across issues such as harm reduction, sexual and reproductive health services, access to essential medicines, universal health coverage, domestic resource mobilization, and broader issues of poverty, justice, gender equality and human rights. Additionally, if we truly want to build inclusive, resilient, and sustainable systems for health, we must invite advocates in those related efforts to join us in coalition.

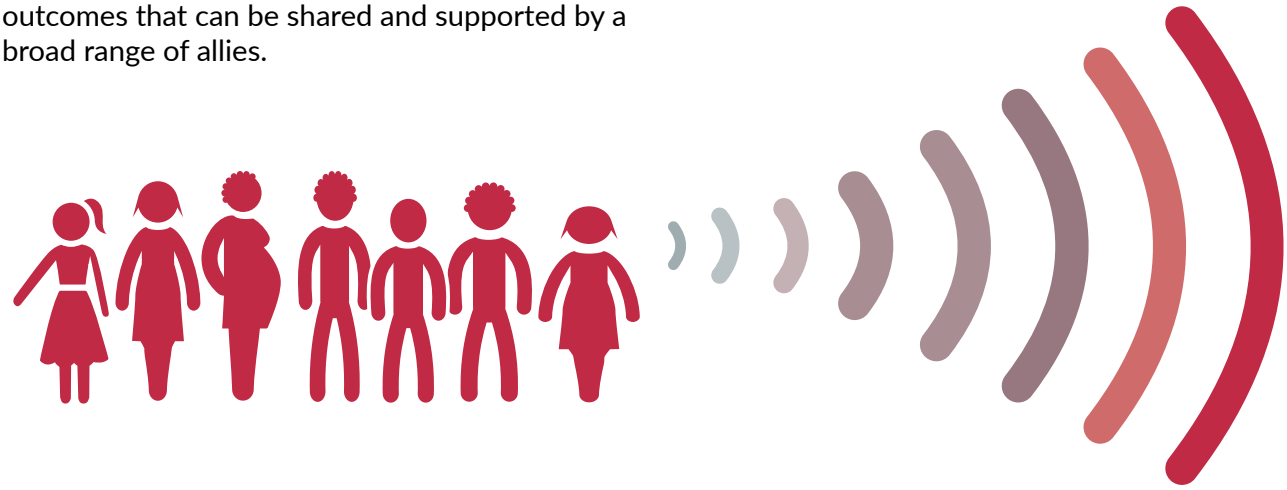

Table 5: A unified framework for sustainable health financing (SHF) advocacy (note Table 5 is a duplicate of Table 1 in the Executive Summary)

Contexts that shape SHF advocacy	Components, costs, and process objectives of SHF advocacy	Intended short-term outcomes of SHF advocacy	Intended long term outcomes and impact of SHF advocacy
Health: Leading causes of DALY, and progress indicators of SDGs and SDG3 targets **Health spending:** Financing sources, and progress indicators (e.g. DRM, UHC, OOP, DAH) **Political environments**: Key channels of influence and decision-makers **Platforms for advocacy:** Networks, organizations, people, tools, resources.	**Components and costs:** • People: People, bringing experience, skills, and abilities related to SHF policy work, organizing, communications, management, and advocacy • Community Systems: Structures, tools and resources: Providing capacity for people to work together and communicate • Architecture: Support from global and regional levels to contribute funding, information, access, skills, and credibility **Process objectives:** • Capacity building: Build informed vocal constituencies for health financing • Conceptual influencing: Shift the framing of policy issues and debates related to health financing • Political influencing: Create political willingness and ability to fund health by building support among stakeholders and embedding commitments in strategies, plans, and programs • Measure and learn: Monitor implementation and build accountability to commitments and results.	**Increased and improved revenue generation**, such as through DAH, taxes, innovative financing, and insurance schemes. **Increased and improved funding allocations**, such as for programs aimed at specific SDG and SDG3 targets, including for community-based,and community-led programming. **Improved efficiency, effectiveness and quality of investments**, including through inclusive planning, expenditure oversight and monitoring, accountability to results, and accountability to quality, rights, equity and justice (i.e. to the sickest, poorest, marginalized and unequal)	**Progress toward SDG3 targets**, including: • Reducing incidence and ending epidemics of HIV, TB, malaria • Improving access to harm reduction services • Improving access to SRHR and RMNCAH-N services • Achievement of UHC • Supporting accessible and affordable medicines **Progress toward other SDGs**, such as priorities related to poverty, hunger, economic growth, education, and gender equality

Table 6. Framework of civil society advocacy for sustainable health financing (by short-term outcome)

Advocacy for **revenue generation** for health
• Taxation (advocacy for progressive, earmarked, taxation of specific sectors, and innovative financing involving the public sector, private charitable sector, and private for-profit sector)
• Insurance schemes (advocacy to include HIV, TB and malaria (HTM) and all SDG3 goals, develop risk pools, ensure external subsidy and stop-loss for high-cost areas, and set policies to minimize out-of-pocket / household spending)
• International development assistance for health / donor resource mobilization
  ◆ Global Fund (GF), UNITAID, World Bank, Global Financing Facility, and other multilateral assistance for health, including advocacy within GF country processes and advocacy for GF Replenishment
  ◆ USAID / PEPFAR, DFID, AusAid, and other bilateral IDAH

Advocacy for **funding allocations** for health • Overall health investments (e.g. for SDG and SDG3 goals and advocacy for 5%/15% to health) • Creation, protection and promotion of allocations to specific health programs, including contracting mechanisms and programs focused on HTM and other SDG3 targets, issues of poverty, justice, gender equality and other SDG priorities, and community-based and community-led health programming • Universal health coverage (e.g. CSEM advocacy, UHC Forums, and advocacy for UHC and inclusion of HTM and other SDG3 targets in UHC) • Participation in GF concept note development, government budgeting and allocations of GF grants for HTM and KP programming, and advocacy for government co-financing and transitional financing of HTM and KP programming)

Advocacy for **health program expenditure efficiency, effectiveness and quality**
• Expenditure monitoring, and advocacy for efficiency and effectiveness of spending (e.g. improving spending in health care settings, improving scale up and preventing loss due to corruption or inefficiencies)
• Advocacy for quality implementation through inclusive planning, decision making, implementation and monitoring processes.
• Advocating for quality of spending
  ◆ Holding expenditures accountable to results (e.g. health outcomes)
  ◆ Holding expenditures accountable to patient experience and human rights
  ◆ Holding expenditures accountable to gender equality and other social and economic equity and disparities in health
  ◆ Ensuring investment in community-based and community-led health programming

Table 7. Examples of civil society advocacy for sustainable health financing (by outcome)		
Outcomes	**Areas of work**	**Examples**[17]
Improved revenue for health	• Tax advocacy • Insurance advocacy • IDAH advocacy	Kenya: National taxpayer association supporting equity in taxation Tanzania: Policy analysis and advocacy for increased tax revenue for health (HPP, 2016) Uganda: Proposed National AIDS Trust Fund from dedicated tax on alcohol/tobacco Zimbabwe: Advocacy for AIDS Levy / National AIDS Trust Fund Philippines: Sin tax for health in 2012 (Kaiser, 2016) Global: GFAN advocacy for GF IDAH
Improved funding allocations for health	• Health budget advocacy • UHC advocacy • Advocacy for allocations related to specific SDG3 targets (e.g. HTM, harm reduction, SRHR, essential medicines)	Global: People's Health Movement re health budgets Global: GFAN / CSEM advocacy re: UHC Africa-wide: African Health Budget Network push for 15% for health Malawi: FPAM advocacy for budget line for family planning (Mbuya-Brown, 2015) Sierra Leone: Advocacy for budget for health (Lebbie, 2016) Uganda: Forum for Women in Democracy (FOWODE) assessments and advocacy about proposed budgets in related to gender and equity. Zambia: CRHE / PPAZ advocacy for repro health budget (Dennis, 2016) Brazil: Municipal participatory budgeting and related expenditure tracking (Gonçalves, 2014)
Improved health program implementation and quality	• Expenditure monitoring (efficiency and effectiveness) • Quality monitoring (accountability to results, rights and equity)	Malawi: FPAM advocacy for spending of budget line for family planning (Mbuya-Brown, 2015) Uganda: Civil Society Budget Advocacy Group (CSBAG) documents unspent funds and constraints to effective utilization, including financial management, planning processes, procurement practices, private-sector capacity, and human-resource management. Uganda: Reignite Africa health budget tracking Costa Rica: Use of NASA to motivate increased domestic financing of community-based prevention efforts for key populations

Priorities for Investing in Sustainable Health Financing Advocacy

GFAN's experience from supporting advocates in low- and middle-income countries to advocate for funding to and through the Global Fund as well as achievement of SDGs and UHC, domestic resource mobilization (DRM) and plans for sustainability, transition and co-financing (STC), advancement of harm reduction, sexual and reproductive health services, and access to essential medicines and broader issues of poverty, justice, gender equality and human rights, is that ***advocacy for sustainable health financing is not, and has never been, adequately funded.***

Despite the clear impact and cost-effectiveness of advocacy, advocates in LMIC have survived (or not) by piecing together funding through a range of short-term initiatives under a series of labels and acronyms.[18] In many cases, those initiatives have not provided deep core multi-year funding for advocacy work, but instead have emphasized funds for one-off meetings and trainings. This leaves the ongoing, intensive, necessary, strategic policy work needed to influence (policy) change severely under-funded or completely without funding.

A unified advocacy agenda will need sustained funding if it is to attract and retain the right people and build the strategies, tools and resources to achieve its intended outcomes. GFAN sees three investment priorities: people, advocacy structures and resources, and international advocacy support.

Investing in People

The effectiveness of advocacy depends entirely on the people who are leading and powering it. This means that investment in advocacy requires investment in people who can contribute experience, skills and abilities related to the following functions:

Health financing policy analysts and strategists: Effective SHF advocacy requires people with technical knowledge of taxation, other revenue generation, budgeting, and expenditure tracking. Those technical experts are needed for their abilities and efforts to analyse and synthesise data, determine facts (versus public assumptions or official claims), understand alternative options for action and potential for change, and develop targeted aims, tactics and strategies to achieve change, and develop regularly updated summary information and messages for communications and legal or political action. Multi-year funding allows these individuals to develop analyses and recommendations that are sustained over time, and to offer evidence-based arguments for innovations in health financing. The economic and political independence offered by guaranteed multi-year funding gives these individuals the independence to generate analysis and strategies that expose and challenge mis-spending, corruption, or faults in official government data and policies.

Health financing advocates: Effective SHF advocacy also needs people with knowledge of and relationships and credibility with key decision-makers and stakeholders in health financing, including government leaders, agency managers, political leaders, and influential people in the judiciary, military, private for-profit sector, faith-based organizations, media, universities, labour unions, charities, and local communities. Advocates work to access information related to health financing, shift the framing of policy discussions and debates, create political willingness and ability to fund health by building support among stakeholders, and embed commitments in strategies, plans, and programs.

Health financing activists and organizers: Effective SHF advocacy also needs people who can organize coalitions and constituencies to become informed about health financing issues, conduct front-line monitoring to collect evidence about health expenditures (including the availability, accessibility and affordability of health services), and to be vocal when and where increased communications and public opinion can build accountability to health financing commitments and results.

People with direct experience as health providers and consumers: In all of the functions above, it is essential to have people with direct experience and knowledge of health financing issues from the perspectives of provider and consumer, including people

with experience of HIV, TB, malaria, and hepatitis services, experience of drug use and harm reduction services, and experience of sexual and reproductive health services, across a diversity of geographic locations, populations, gender, ages, and socioeconomic status.

Investing in Advocacy Structures & Resources

Advocacy doesn't necessarily need formal organizations but does need some established structures and coordination to support people in working together and communicating with each other. This includes capacity to access, store, and analyse data, share information and strategize with allies; and communicate recommendations and data to core constituencies, decision-makers, stakeholders and to the media and public.

Supporting Advocacy from Global & Regional Levels

By definition, health financing advocacy is focused on analysing existing patterns of government revenue and funding and potentially challenging these structures. This can also be seen as challenging those who might be threatened by changes in revenue and funding flows, including government leaders, political leaders, and influential people in the judiciary, military, private for-profit sector and health labour unions. In representing the needs and priorities of people impacted by health financing decisions, including health providers and health consumers in communities that are poor, marginalized and experiencing health disparities, health financing advocacy inherently challenges existing dynamics of social, economic and political power.

Because of these political dynamics, country governments and many international development donors do not provide extensive funding for advocacy. Yet independent policy analysis, budget monitoring, service monitoring, policy debates, and public awareness are fundamental to building quality and transparent health systems.

Regional and global funding and advocacy networks can also be important as mechanisms through which advocates independently can access funding, information, endorsements, access to political elites and government decision-makers, access to international media, and access to exchange and cross-training with peers in other countries and regions.

Next Steps to Further Develop & Invest in Sustainable Health Financing Advocacy

This concept note was developed from recommendations made by GFAN advocates in February 2018 and builds on a series of GFAN documents and conversations.

GFAN is now circulating this concept note to encourage further advocate dialogue about, and resource mobilization for, the work described in this document. Specifically, GFAN will seek to develop further resources and plans for to support global and regional work in strengthening SHFa through:

- Developing convergent work across multiple areas of health advocacy, including priorities related to HIV, TB, malaria, harm reduction, sexual and reproductive health, universal health coverage (UHC), accessibility and affordability of essential medicines, and broader issues of poverty, justice, gender equality and human rights.

- Developing convergent work across multiple areas of financing advocacy, including tax policy, innovative financing, insurance schemes, funding for community-based and community-led health programming, and inclusive expenditure planning, expenditure oversight and monitoring for expenditure accountability.

- Building new partnerships, training, technical support, and funding initiatives to link HIV, TB and malaria advocates with coalitions for shared sustainable health financing goals.

Endnotes

1 The Global Fund to Fight HIV, TB, and Malaria. Step Up The Fight. February 2019: https://www.theglobalfund.org/en/stepupthefight/
2 Global Commission on Drug Policy. Drug Policy and the Sustainable Development Agenda. September 2018: http://fileserver.idpc.net/library/ENG-2018_SDGPaper_WEB.pdf
3 International Planned Parenthood Federation (IPPF). Financing Demystified. October 2015: https://www.ippf.org/sites/default/files/ippf_financingdemystified_1.pdf
4 Investment case for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N): https://www.globalfinancingfacility.org/guidance-note-investment-cases
5 www.uhc2030.org
6 All data from IHME, accessed August 2018. Asterisks denote the primary countries where advocates are supported by GFAN Africa and GFAN Asia Regional Partners through the NVF for Global Fund advocacy.
7 Stenberg M., Hanssen O, Tan-Torres Edejer T et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals. The Lancet Global Health. September 2017: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext
8 ibid
9 Global Burden of Disease Health Financing Collaborator Network. Trends in future health financing and coverage. Lancet, April 2019.
10 Tokyo Declaration on Universal Health Coverage, 2017: https://www.who.int/universal_health_coverage/tokyo-decleration-uhc.pdf
11 Asterisks denote the primary countries where advocates are supported by GFAN Africa and GFAN Asia Regional Partners through the NVF for Global Fund advocacy. All data from: Institute for Health Metrics and Evaluation (IHME). Financing Global Health Visualization. Seattle, WA: IHME, University of Washington, 2019. Available from: http://vizhub.healthdata.org/fgh/. Accessed May 2019.
12 High or low perceptions of corruption derived from 2017 scores from Transparency International; “low” corruption defined as a score above 40, and ‘high corruption defined as a score below 30. Similar categorizations derived from the 2017 World Press Freedom index, Freedom House 2017 scores of political freedoms, and the 2018 Economist index of democracy. Asterisks denote the primary countries where advocates are supported by GFAN Africa and GFAN Asia hubs through the NVF for Global Fund advocacy.
13 Stenberg et al., 2017.
14 Collin M, Zubairi A, Nielson D, and 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-Frameworkfor-Costs-and-Benefits-of-transparency-with-Annexes.pdf
15 GFAN Asia Pacific and APCASO developed an position paper on UHC that was widely supported by GFAN members and beyond: http://apcaso.org/wp-content/uploads/2017/12/v1-Final-UHC-AP-Statement-for-UHC-Forum-2017.pdf
16 GFAN meeting, February 2018, Amsterdam: http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2019/03/2019-GFAN-Global-Strategy-Meeting-Report.pdf
17 “Effective Civil Society-led Strategies for Increasing Domestic Resource Mobilization for AIDS, TB and Malaria in Low- and Middle-Income Countries”, Gemma Oberth, February 2018: http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2018/10/Domestic-Res-Mobilization-Advocacy-GFAN-Research-Brief-February-2018.pdf
18 A partial list related to HIV, TB and malaria during the past five years includes meetings, trainings, and partial support under the labels of (in alphabetical order): Amplify Change, the Bridging the Gap initiative, Community Systems Strengthening, GF Country Dialogue Processes, GF Community Rights and Gender platforms, the Investment Framework “critical enabler” of community mobilization, the HIV PITCH program, and international consultations, trainings and processes related to Global Fund governance, GF transition and co-financing, human rights, national strategy development, social contracting, and more.

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