# Health budget literacy, advocacy and accountability for universal health coverage

## Toolkit for capacity-building

May 2021

# Contents

# Abbreviations and acronyms

| | |
|---|---|
| **CSO** | civil society organization |
| **GDP** | gross domestic product |
| **IBP** | International Budget Partnership |
| **IPU** | Inter-Parliamentary Union |
| **MP** | member of parliament |
| **NGO** | nongovernmental organization |
| **PFM** | public finance management |
| **SDG** | Sustainable Development Goal |
| **UHC** | universal health coverage |
| **UNDP** | United Nations Development Programme |
| **UNICEF** | United Nations Children's Fund |
| **WHO** | World Health Organization |

# Acknowledgements

The toolkit on health budget literacy, advocacy and accountability for UHC, is the product of a collective effort coordinated by UHC2030 and PMNCH and should be used as a compendium of information on health financing and budget analysis that is relevant for health budget literacy, advocacy and accountability for UHC. The toolkit can be used to design trainings and capacity-building workshops for the specific learning needs and interests. The content is based mainly on existing resources produced by WHO and other partners with the objective of making it a repository of such knowledge that can be used for capacity-building for various stakeholders.

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# Glossary of terms

This glossary is intended to help users of the toolkit to understand and use the terms referred to below. The terms used in this toolkit are derived from three main sources:

- Health systems strengthening glossary. Geneva: WHO **(**https://www.who.int/healthsystems/Glossary_January2011.pdf?ua=1)
- A glossary of terms for community health care and services for older persons. Kobe: WHO Centre for Health Development; 2004 (https://apps.who.int/iris/handle/10665/68896).
- Glossary of terms. Health & Budgets (workshop). Washington DC: International Budget Partnership; undated (https://www.internationalbudget.org/wp-content/uploads/Glossary-of-Terms.pdf).

**Advocacy for health.** A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.

**Advocate.** A person who acts on behalf of another, usually for a cause or plea, to support or suggest an idea, development or way of doing something.

**Access (to health care).** The ability of an individual or a defined population to obtain or receive appropriate health care. This includes the availability of programmes, services, facilities and records. Access can be influenced by such factors as finances (insufficient monetary resources), geography (distance to providers), education (lack of knowledge of services available), the appropriateness and acceptability of a service to individuals and population and sociological factors (discrimination, language or cultural barriers).

**Accountability:** the result of the process which ensures that health actors take responsibility of what they are obliged to do and are made answerable for their actions.

**Administrative classification.** A way of categorizing expenditure in a budget according to the administrative unit responsible for spending funds, such as a department or programme.

**Auditor-general (supreme audit institution)**. Person who reports on the accounts, financial statements and financial management of ministries, departments and agencies.

**Budget.** Government's planned expenditures and anticipated revenues, reflecting its priorities for the financial year.

**Budget cycle.** Comprises four stages: formulation, when the executive branch puts together the budget plan; enactment, when the legislature debates, alters and approves the budget plan; execution, when the government implements the policies in the budget; and auditing and legislative assessment, when the national audit institution and the legislature account for and assess expenditure under the budget.

**Budget deficit.** The difference between budget expenditure and budgeted revenues.

**Capital.** Fixed or durable non-labour inputs or factors used in the production of goods and services, the value of such factors or the money specifically allocated for their acquisition or development. Capital costs include, for example, the buildings, beds and equipment used in the provision of hospital services. Capital assets are usually permanent and durable, as distinguished from consumables, such as supplies.

**Capital expenditure.** Expenditure on an asset that lasts for more than 1 year; includes equipment, land, buildings and legal expenses and other transfer costs associated with property.

**Catastrophic health expenditure.** Out-of-pocket payment for health can cause households to incur catastrophic expenditures, which can push them into poverty. Out-of-pocket payment can also dissuade households from seeking care when they need it. SDG indicator 3.8. 2 defines the incidence of catastrophic health spending as "the proportion of the population with large household expenditure on health as a share of total household expenditure or income." (greater than 10% or 25% of total household consumption or income)

**Co-payment.** The specified portion (cost or percentage) that a health insurance company or a service programme requires people to pay towards their medical bills or services.

**Costing.** Methods and processes for calculating the costs (actual and estimated) of certain goals or those necessary to obtain certain products, carry out certain processes or maintain the health service.

**Country health programming.** A managerial process for selecting priority health problems, specification of operational objectives and translation of the objectives into activities, resource needs and organization.

**Direct tax.** Tax charged on the taxable income of individuals and legal entities.

**Economic classification.** Classification of expenditures (or expenses) and the acquisition and disposal of assets into economic categories, which underlines the economic nature of the transaction (salaries, interest, transfers, etc.).

**Effective, effectiveness.** The degree to which a treatment plan, programme or project has achieved its purpose within the limits set for reaching it. For example, an expression of the desired effect of a programme, service or institution in reducing a health problem or improving an unsatisfactory health situation.

**Evidence-based care.** The conscientious, explicit, judicious use of current best evidence in making decisions about the care of individuals. In this approach, the best external evidence must be balanced with the desires of the individual and the clinical expertise of health-care providers.

**Evidence-based decision-making.** In a policy context, application of the best available scientific evidence to policy decisions on specific treatments or care, as well as changes to the delivery system.

**Financing.** Function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people in the care system, individually and collectively.

**Global budgeting.** A limit on total health care spending from all sources of funds for a given unit of population.

**Governance.** The exercise of political, economic and administrative authority in the management of an organization's affairs at all levels.

**Health insurance.** Financial protection against the health care costs arising from disease or accidental bodily injury. Usually covers all or part of the costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

**National health accounts.** Information, usually in the form of indicators, that a country may collect on its health expenditures. Indicators may include total health expenditure, public expenditure, private expenditure, out-of-pocket expenditure, tax-funded and other public expenditure, and social security expenditure.

**Functional classification.** Classification of expenditure (and expense) transactions, acquisitions and disposals of financial assets according to the purpose for which the transactions are undertaken. A functional classification is independent of the administrative organizations or units that carry out the activities or transactions concerned.

**Health.** The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined.

**Health care.** Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health.

**Health information system.** Generation and use of appropriate health information to support decision-making, health-care delivery and management of health services at national and subnational levels.

**Health literacy**. Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to empowerment

**Health outcome.** Changes in health status that result from the provision of health (or other) services.

**Health policy.** A formal statement or procedure in an institution (notably government) that defines goals, priorities and the parameters for action in response to health needs, within the available resources.

**Health programme.** Organized activities for the attainment of defined health objectives and targets.

**Health promotion.** Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health.

**Health resources.** All the means available for operation of the health system, including human resources, buildings, equipment, supplies, funds, knowledge and technology.

**Health sector.** Consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related nongovernmental organizations (NGOs) and community groups, and professional associations.

**Health service.** Service provided by health care professionals or by others under their direction for the purpose of promoting, maintaining or restoring health.

**Integrated care.** The methods and strategies for linking and coordinating the various aspects of care delivered by different systems, such as general practice, primary and specialty care, preventive and curative services and acute and long-term care, as well as physical and mental health services and social care, to meet the multiple needs and problems of an individual or a category of people with similar needs or problems.

**National strategy.** Based on national health policy, a set of decisions that includes the broad lines of action required in all sectors involved to realize the national health policy and indicates the problems and ways of dealing with them.

**Out-of-pocket payment.** Represents the share of the expenses that a patient or a family pays directly to a health-care provider, without a third party (insurer or state). Usually, the family bears the cost, with no risk-sharing or solidarity mechanism involved and no possibility of spreading the cost over time.

**Policy.** A policy is typically described as a deliberate plan of action to guide decisions and achieve rational outcome(s). The term may also be used to denote what is actually done, even though it is unplanned. For example, the health policy of a government reflects its

understanding of the health situation and recommends actions to be taken to improve the situation for the larger benefit of society.

**Programme budgeting.** Making resources available to attain the objectives of programmes. Programme budgeting differs from other budgeting in that the emphasis is on the results to be achieved rather than on unconnected budgetary items. The objectives and targets of the programme are defined clearly, and, in order to attain them, the resources required are grouped, those who will receive them specified and their sources determined.

**Public budget.** Government's planned expenditures and anticipated revenues, reflecting its policy priorities for the financial year.

**Resource management.** Actions to attain the most rational use of human resources, knowledge, facilities and funds to achieve the intended purposes with the least outlay.

**Revenue.** Gross earnings received by an entity for operation of a specific activity. It does not include deductions for such items as expenses, bad debts or contractual allowances.

**Resource allocation.** Deciding what is needed to carry out an activity and providing for those needs. Can include making provision for financial resources (money), capital resources (such as buildings and computer hardware) and staff resources (including the number of staff and the skill mix required).

**Sustainable development.** Development that meets the needs of the present generation without compromising the ability of future generations to meet their needs.

### Glossary of terms for the media

**Advocate:** Someone who speaks up (or writes) publicly about how things are and how they should be. Promotes change towards a particular goal.

**Audience:** May be as small as one person or as large as billions of people around the world consuming any type of media content.

**Blog**: Online journal, diary or a mini-website that allows expression of opinions; to cover news, share photos, videos and even audio recordings; and to provide links to other websites considered relevant for the specific audience and message.

**Citizen journalist:** Anyone who plays an active role in collecting, reporting, analysing and disseminating news and information.

**Civil society organization:** Non-State, not-for-profit, voluntary entities formed by people in the social sphere who are separate from the State and the market. Represent a wide range of interests and ties.

**Closing civic space:** Erection by governments of legal and logistical barriers to democracy and rights programmes, public vilification and harassment of their domestic and international civil society organizations (CSOs), media, human rights and aid groups. As a result, the space for manoeuvre of media and civil society has been seriously reduced.

**Health budget advocacy:** Lobbying and campaigning to influence the size and distribution of government health budgets.

**Mass media:** Technologies used to communicate across distances and time to a large audience. Include broadcast, digital, outdoor and print media.

**Media:** Means or channels of communication outlets or tools used to store and deliver information, data or entertainment in society.

**Media content:** Films, dramas, documentaries, talk shows, advertisements, social media posts, blogs, web pages, radio programmes, newspaper articles and so fo that can reach millions of people and create a positive change.

**Parliamentarian:** Member of a parliament

**Twitter:** Service that allows the user to send very short messages to people who “follow” them.

**YouTube:** Virtual platform that allows the creation, sharing and viewing of videos online.

# Chapter 1. General guidelines and resources for users and facilitators

## Introduction

All countries have now committed themselves to the Sustainable Development Goal (SDG) of ensuring healthy lives and promoting well-being for all at all ages, and universal health coverage (UHC) is increasingly accepted as an "umbrella" agenda. Achievement of UHC will ensure that all individuals and communities receive the health services they need without undergoing financial hardship. To achieve this goal, both increased investment in health and health-enhancing sectors and better use of existing resources are necessary.

Investment in health is a political choice, underpinned by the social contract between citizens and the state.[1] Governments are responsible for progressive realization of the right to health by allocating the maximum available resources, establishing priorities and ensuring that planned and actual expenditures are transparent, equitable and efficiently used *(1)*. Citizens, civil society,[2] the media, parliamentarians and other stakeholders[3] can be instrumental in holding governments accountable for policy and investment choices made along the pathway towards UHC.

The COVID-19 pandemic has dramatically changed the landscape of health globally and nationally and reinforced the importance of budget advocacy and accountability. COVID-19 is threatening a decade of human capital gains, including progress towards primary health care and UHC *(2)*. The crisis disproportionately affects vulnerable populations, including poor, marginalized women, children and adolescents, the disabled, those living in humanitarian and fragile settings and ethnic minorities. Its effects are felt in particular by women, who shoulder a disproportionate burden as well as social and economic impacts. COVID-19 is further increasing the burden on women and is disrupting essential health services for everyone. Countries are grappling with falling public revenues, increasing expenditure and rising debt obligations resulting from the pandemic. The resulting shrinking fiscal space for the public sector is affecting health. Evidence also shows that a successful response to the crisis must ensure that everyone, everywhere is covered by proven public health measures and appropriate health care.

1 While states hold the primary responsibility for ensuring the human right to health, health is also a shared global responsibility. Development assistance still represents a significant proportion of health financing in certain countries. As countries require less development assistance for health, more public spending on health and ensuring efficient and equitable use are increasingly important.

2 We acknowledge the heterogeneity of civil society and that a deliberate, specific approach is necessary in identifying civil society organizations (CSOs) with which to work. It is important that the CSOs with which we engage represent the voices of underserved communities.

3 These include academia, think tanks and others, such as human rights organizations and the Open Government Partnership, all of which can play an important role in strengthening social accountability for health. These bodies act beyond the focus of this work, but they will be important partners for advocacy at country level.

The interdependence of health and economic security makes a strong case for advocating for adequate allocation of public domestic resources for health and efficient use of those resources towards UHC that builds on common goods for health and includes primary health care. The pandemic shows the imperative of investing in the common goods for health, which include public health activities such as emergency preparedness, integrated surveillance and strengthening primary health care as a cornerstone of people-centred, integrated service delivery. Hard-won gains in essential service coverage must be sustained and scaled up.

Health budget literacy is critical for civil society and other stakeholders to influence decision-making on allocation and use of public resources for health. Health literacy includes accessing budget information, analysing it to expose the decisions made and their implications, and influencing budget choices through advocacy and accountability *(3)*. Approaches to health budget advocacy should be strengthened to promote better multi-stakeholder collaboration and coherence across the sector.

## The roles of civil society, the media and parliamentarians in health governance

UHC2030's joint vision for healthy lives *(4)* establishes that good governance is important in moving towards UHC. In good governance, "all sectors are part of the UHC road to success and all stakeholders, beneficiaries, providers and the state must be involved in its design, implementation and follow-up".

To guide collective action, UHC2030 has established a set of principles to which all parties must commit on the road towards UHC. Two of these principles are particularly important for the purposes of this toolkit:

> *Transparency and accountability for results:* Transparency and accountability are key attributes of governance and determine the performance of a health system if they lead to adjustments in policies, strategies, and resource allocation. Transparency in decision-making, monitoring and review, as well as participation by populations, is pivotal for accountability. Transparency requires access and availability of citizens to budget information. Open and participative decision-making on health policies and priorities can promote accountability. Therefore, strong parliaments and institutions with adequate capacities are needed to hold governments to account.
>
> *Making health systems everybody's business- with engagement of citizens, communities, civil society and private sector:* Civil society participation has to be anchored systematically in Health Systems Strengthening action and enable people-centred health services. Mechanisms for civil society engagements, such as accessible platforms for citizens' voice, as well as responsiveness and accountability to citizens' needs are relevant in this regard.

The agenda for sustainable development established the attainment of UHC as part and parcel of the overarching goal of equity, ensuring that no one is left behind.

In order for these principles to be put into practice and be applicable to action points, civil society, the media and parliamentarians must strengthen their knowledge and capacity to monitor the commitments made by states for the achievement of UHC. As it has been demonstrated that UHC is best attained through increased, improved government spending and strong, transparent, accountable public financial management (PFM), these stakeholders must be involved in budget analysis and advocacy.

## What is a toolkit?

The best way to think of a toolkit is as a real box of tools. When you first open it, you may look through the whole box to find out what is inside. After that, you seldom need all the tools at once: you use them as you need them. You might use the saw and the hammer very often when you are building a house; for another task, you might need the screwdriver and pliers; you may never use some tools in your box. Similarly, this toolkit is intended to give you options. It invites you to select and combine elements that suit your work in your context, as you need them. The toolkit is not designed to be used from the first page to the last page; rather, the user should pull out tools to suit the audience, purpose and relevance.

## Why this toolkit?

The objective of the toolkit is to strengthen the capacities of CSOs, the media and parliaments for health budget advocacy by **promoting coherence** and **constructive multi-stakeholder collaboration** to hold governments to account for the level and use of funding allocated to health. It provides tools and materials to strengthen country-level analysis, advocacy and accountability for UHC from a budget perspective. The aims of these resources are to:

- show a clear link between public budget analysis in UHC evidence-based advocacy and accountability;
- provide key terms, approaches and strategies that are used in budget analysis for UHC, in order to plan advocacy and accountability;
- emphasize the importance of multisectoral collaboration by bringing advocacy and accountability perspectives to the media, parliamentarians and civil society; and
- provide the tools for all users, including workshop facilitators, for health budget analysis, to learn and develop the skills to advance UHC goals and principles through advocacy and accountability.

The proposed approach is built on other efforts to strengthen capacity for health budget analysis, advocacy and accountability. The intention is not to “reinvent the wheel” but on the contrary to convene partners with expertise and experience in this area to draw on

good practice, learn from challenges and develop a collective approach to strengthening health budget advocacy and accountability in the context of the SDGs.[4]

## Who will find this toolkit useful?

The toolkit is directed at facilitators or trainers or health activists who have experience in budget analysis for advocacy and accountability in health and who will use this toolkit to the build capacity of CSOs, the media, parliamentarians and staff in their own organizations.

## How can this toolkit be used?

The toolkit can be used in various ways. For a workshop or training session, the parts of the toolkit to be used will depend on the purpose of the training session. We provide a guideline for Planning a workshop using the toolkit, Sample agendas for a workshop using a mix of the toolkit content, with the purpose and the timing suggested for each session. Suggestions for Workshop evaluation
This toolkit complements other resources and materials on UHC, health budgets and health financing produced by WHO and partners. The content of this toolkit is based mainly on existing resources with the objective of making it a repository of such knowledge so that it can be used for capacity-building for various stakeholders. The toolkit should be understood and used as a compendium of information for health finance literacy, budget analysis, advocacy and accountability for UHC that can be used to design ad-hoc training and capacity-building workshops for the specific learning needs and interests of prospective participants.
There is already a wide array of capacity-building materials on the subject, and prospective users are invited to fill in any gaps of the toolkit with their own knowledge, experience and materials. The toolkit is meant to be a living document that can be improved upon, updated and used as a basis for other, similar resources.

## Toolkit structure

- The toolkit has three chapters. Each chapter has a number of modules, each of which has a few sections, tools and activities.
- The chapters have objectives, which are attained by meeting the objectives of the modules.
- Each module consists of small, manageable sections that provide information and skills for achieving the module objectives.

[4] This includes the "Accountability loop for health budget advocacy" *(5)*, conducted by a number of partners to strengthen accountability for following-up the recommendations of the Commission on Information and Accountability for the Secretary General's Global Strategy for Women and Children's Health. See references *5–7*.

- Tools are provided in some sections when they are useful for measuring the knowledge and skills covered.
- Activities also include descriptions of application of the tool to ascertain users' knowledge and skills or to the users' context.

## Planning a workshop with the toolkit

The toolkit is designed to provide users and workshop participants with the knowledge and skills to find credible evidence for budget advocacy to advance UHC. Budget advocacy plans must reflect the realities of the lives of people affected by the changes advocated, the health policies and systems in place, public finance management and health financing regulations. The toolkit supports facilitators and users to adapt the content to each audience and country.

The toolkit is for adult education, which is learner-centred, draws on the skills, knowledge and experience of participants and ensures that the workshop is focused on impact.

> Learning to learners' wants and needs helps shape a program that has immediate usefulness to adults. The dialogue begins long before the course starts *(8)*.

The lead facilitator, who plans the workshop, should be familiar with either budget advocacy, UHC and SDG3. Facilitators rarely have experience and knowledge in all three subjects; therefore, a team of facilitators should be constituted who will complement each other in the various sessions of the workshop. In addition to facilitators, the workshop could benefit from presentations by invited experts, credible researchers or activists and advocates working on UHC, public finance management in general and health financing specifically. Participants in the workshop with experience, skills and knowledge in specific topics could also be invited to make presentations. In addition to the audiences identified by Avrett *(9)*,[5] researchers or partners in the International Budget Partnership (IBP), an international civil society organization specialized in budget transparency and participation, could be invited, for example to present on budget transparency and participation), or from the ministry of finance (on health financing), the World Bank or the ministry of health (on UHC reform, national health planning). The guest speakers or additional facilitators should be selected once the agenda of the workshop has been set.

Once the facilitators have been chosen, they could use the toolkit to set the agenda. The eight steps listed below will ensure that the workshop responds to the organizers' objectives, supports the participants' interest in furthering the goals of UHC and contributes to advocacy by the organizations and networks they represent. The design should reflect synergy between the objectives of the workshop organizers and the interests and UHC advocacy objectives of the participants.

[5] Audiences include health financing analysts and strategists, health financing advocates, health financing activists and organizers and people with direct experience as health providers and consumers.

### *Eight steps in designing a workshop*

| | | |
|---|---|---|
| **Who?** | The people | Deep understanding of who will participate in the learning programme and who will lead it |
| **Why?** | The current situation, rationale or need | Description of the situation that calls for the learning event or meeting; the complex |
| **So that?** | The anticipated change | Realistic vision of what will change as a result of the joint learning experience |
| **When?** | The time and timing | Detailed description of the time available for learning, as this will determine the amount and depth of content that can be taught |
| **Where?** | The place and space (in-person or virtual) | Best location for learning, and limitations of the place |
| **What?** | The content | Carefully constructed set of skills, information and perspectives to be addressed |
| **What for?** | The achievement-based objectives | Specific description of what learners will do during the programme, with each piece of priority content, in order to learn it |
| **How?** | The learning tasks | A flexible yet structured, process through which all learners build their skills and share their learning |

Source: Adapted from Global Learning Partners *(10)*

The eight steps should be completed well in advance of the workshop. Once a draft is available, the next step is an assessment of learning needs and resources, to be completed by potential workshop participants. The purpose of the assessment is to:

- identify suitable participants for the workshop. For example, such an assessment can indicate their commitment to engage in and advocate on health budget issues in the context of UHC. The assessment can also indicate ways of combining staff from CSOs, media institutions and parliamentarians.

- ensure a balanced mix of participants to enhance learning, experiences, knowledge and skills; and
- refine the agenda and content.

The assessment could include the following questions:

- Describe your involvement in UHC advocacy or health advocacy in general at national level.
- Describe a recent situation in which you had to consider the public budget for health.
- What, in your opinion, are the greatest challenges in your country to budget advocacy to advance UHC2030? List three challenges.
- State how this workshop on budget advocacy will improve your involvement in advancing UHC in your country.

The results of an assessment of learning needs and resources could also suggest content for the modules and sections of the toolkit. Participants could rank their priorities for content, for example from 1 to 10, 1 being the highest priority:

| Name: | Organization: | Job title: |
|---|---|---|

On the list of possible workshop agenda items, rank the items from 1 to 5, 1 being the most important to you and 5 the least important.

| Topic | Content | Ranking |
|---|---|---|
| Introduction to concepts of public financing for health relevant for UHC budget advocacy | Key concepts of public policy and public policy relevant for UHC | |
| | Key concepts and information on public budgets, their content, classification and what is relevant for UHC | |
| | The content of budget documents and that relevant for UHC | |
| | Information on the overall budget cycle, its stages, actors and the role of the ministry of health | |
| | Where to find budget information and resources for finding budget information for health and UHC | |
| | Information on transparency, access to information and citizen participation and its association with UHC goals and principles | |

This example could include the questions above. In planning, it is useful to know participants' areas of interest, experience and knowledge in relation to the subject of the workshop and their intentions for applying their learning after the workshop.

The selection of participants is important for sustaining advocacy and networking for UHC2030. A well-considered selection of participants should include the networks to which the participants belong, the role of participants in their organizations and their ability to apply the knowledge and skills they gain from the workshop. As some participants may play many roles in their organizations and networks, two participants from each network or organization should attend the workshop. For optimal learning, it is recommended that the number of participants be limited to 24.

Avrett *(9)* states

> (t)he 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 analysts and strategists … health financing advocates … health financing activists and organizers … people with direct experience as health providers and consumers.

This group of people should be considered in selecting participants for a workshop.

As the users of this toolkit will include the media and parliamentarians and their staff, the facilitator(s) should work with representatives of those groups in designing a workshop for them. Socio-political power dynamics in each country will determine whether it would be beneficial and strategic to include participants from civil society, the media, parliamentarians and their staff in one workshop, to conduct separate workshops for each group or to combine two of the three.

## Achievement-based objectives

Achievement-based objectives are expressed as a verb, e.g. "select", "define", "identify", "describe", "solve" or "design". The objectives of workshop give the participants an idea of what is to be accomplished by the end of a module or session. Objectives indicate the tasks and activities to be designed by the workshop facilitator. An example of an objective is: "By the end of this module, participants should be able to: *describe* UHC; *calculate* year-to-year budget growth rates; and *design* a budget advocacy plan for the next 3 years in order to achieve UHC. The workshop facilitators therefore design tasks and activities to allow participants to perform these tasks. The activity may involve multiple steps to reinforce the objectives. Bloom's taxonomy *(11)* is a useful reference for workshop designers, as it provides a set of verbs for objectives.

## Workshop evaluation

Apostolopoulos *(12)* provides 99 questions for compiling an evaluation of a workshop, listed below.

### How would you rate the preparation of the workshop?

Were the training goals and objectives clearly stated before you started the course?

Were the course's title and description easy to understand?

How would you improve the preparatory phase?

### Course structure

How would you rate the course's sequence and flow?

Did you feel equally engaged in each course section?

Were there clear separations between the course chapters and modules?

### Content

Was the quality of the content consistent throughout the course?

Was there enough variety in terms of course module types?

Was the language easy to understand?

How engaging would you say the overall content was?

Was the reading material presented in an interesting way?

Was the course content too challenging for the average learner?

Was the content detailed enough?

How would you rate the overall course content?

Did you notice any unnecessary repetition in the content?

Did you, at any point, have to re-read the content to understand it?

Which sections do you consider were lacking? In what way were they lacking?

Was the course easy to follow?

## Delivery

How would you rate the overall course delivery?

How would you rate the participatory methods used during the course?

## Duration

How would you rate the total course duration?

## Trainer

How would you rate your trainer's expertise?

How would you rate your trainer's communication skills?

How would you rate your trainer's delivery skills?

Did you feel comfortable in expressing your problems to the trainer?

How would you rate the trainer?

How would you rate the course's overall design?

**Statements that can be included in an evaluation form are listed below. These responses are given on a scale of, e.g. 1–5, where 1 = 20%, 2 = 40%, 3 = 60%, 4 = 80% and 5 = 100%.**

The training met the stated objectives.

The training will help me in my role.

The training covered what I expected it to.

The training was enjoyable.

The training was well organized.

The trainers' knowledge was good.

Questions were fully answered.

Discussion played an important part in the workshop.

The techniques and approaches used were effective.

The course materials were effective.

*Comment on:*

What do you intend to do as a result of this workshop?

What's your overall impression of the training?

If you had to pass on three key learning points to your colleagues at home, what would they be?

Would you recommend this training? Why or why not?

# Chapter 2. Core content for understanding universal health coverage and public budgets for health

## Overview

Module 1 addresses key aspects of health and UHC relevant for budget advocacy. It provides information on:

- key aspects of UHC as defined by WHO in the context of the SDGs and particularly SDG3;
- the principles of the right to health (on which UHC is based;
- how to identify international, regional and national commitments to the right to health and UHC; and
- the relevance of health system strengthening, primary health care, common goods for health and public finance for UHC.

Module 2 introduces public financing for health relevant to UHC budget advocacy. It provides information on:

- the concepts of public policy relevant for UHC;
- the concepts of and information on public budgets, their content, classification and what is relevant for UHC;
- the content of budget documents and that relevant for UHC;
- the overall budget cycle, its stages, actors and the role of ministries of health;
- where to find information and resources on budgets for health and UHC;
- transparency, access to information and citizen participation and their relation to UHC goals and principles; and
- ideas on budget analysis relevant for UHC and the tools to engage.

## Introduction

This section contains content, tools and activities that are relevant for building basic knowledge and skills with respect to UHC and budget analysis and to advocacy for UHC. It comprises two modules:

- Module 1. Key aspects of health and UHC
- Module 2. Introduction to public financing for health relevant for UHC budget advocacy

The content of this section is applicable and can be useful for building the skills of the many stakeholders interested in participating in UHC budget advocacy. The core content is useful for stakeholders with basic-to-medium understanding of UHC and/or budgets. It is not meant for highly specialized readers, for whom the content may be too basic.

Nor is the content meant for particular stakeholders, for whom the content of this section should be combined with that of section 3.

This is considered the core content of the toolkit, as it is necessary for budget advocacy in general. Thus, all prospective stakeholders in budget advocacy should understand the content of this section to conduct budget analysis and advocacy. That said, it is not necessarily meant to be used all together. The use will depend on the learning needs of prospective participants, the time allocated to the workshop and the objectives of the capacity-building activities.

# Module 1. Key aspects of health and universal health coverage

## Section A. Universal health coverage

### A1. Defining UHC in the context of SDG3

#### What is UHC?

UHC will ensure that **all individuals and communities receive the health services they need without suffering financial hardship**. It comprises the full spectrum of essential, good-quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care *(13)*. It is firmly rooted in the notion that health is a human right, an entitlement of all people without discrimination to receive the highest attainable standard of health.

The principle of universality is crucial, as it ensures that **no one is left behind**. Hence, health systems must include a robust primary health-care approach that emphasizes equity in access to health services. Different schemes for selected populations undermine equity, universality and the principle of non-discrimination. They lead to fragmentation of health care and inequity in both allocation of resources and access to health-care services.

Thus, at policy level, health and health care must to be recognized as public goods and, ideally, mandated by legislation and/or become a constitutional right. Therefore, health must become a right for people if UHC is to be realized and no one is left behind for their health care needs. Further, achieving UHC is one of the targets set by the nations of the world when they adopted the SDGs in 2015. Countries that make progress towards UHC will also advance towards other health-related targets and the other goals. Good health allows children and adolescents to learn and adults to earn, helps people escape poverty and provides the basis for long-term economic development *(13)*.

Making progress towards UHC will involve building and extending equitable, resilient, sustainable health systems, funded primarily by public finance and based on primary health care, that deliver integrated, comprehensive, people-centred, high-quality health services for all, with the necessary measures to protect households from the financial hazard of health expenditure. The effort should be led by national governments, according to national health policies and plans, building on and strengthening sector-wide processes to avoid fragmentation.

A short video on UHC is available here

### UHC in the SDGs

UHC is a critical component of the SDGs, which include a specific health goal:

> "Ensure healthy lives and promote well-being for all at all ages" (SDG 3). Within this health goal, target 3.8 is specifically to "Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" *(1)*.

While UHC is the focus of target 3.8, it brings together all the health issue-, disease- and population-specific health targets in an integrated approach to strengthen health systems and provide comprehensive health care without financial hardship. It is therefore often presented as an "umbrella" for SDG3. The global movement for UHC is supported by a wide range of international and domestic actors, including multilateral organizations, bilateral organizations, national governments and non-state networks and actors.

Making progress towards UHC will help countries to advance towards other health-related targets and the other goals, such as eliminating extreme poverty (SDG 1), educational outcomes (SDG 4), gender equality (SDG 5), economic growth (SDG 8) and effective institutions (SDG 16) *(14)*. Further, SDG 17 and its targets 17.1–17.5 emphasize strengthening of finances in all their dimensions, including international aid commitments, as, without such resource commitments, both the SDGs and UHC will remain mere statements.

SDG target 16.6 goes further by emphasizing the importance of both transparency and accountability. Transparency is important for accountability beyond parliaments, including to citizens. The target is to "develop effective, accountable and transparent institutions at all levels", while the related indicator 16.6.1 is defined as primary government expenditure as a proportion of original approved budget, by sector (or budget code or similar), and indicator 16.6.2 addresses the percentage of the population satisfied with their latest experience of public services *(15)*.

## A2. Relevance of UHC for disease- or population-specific interests

Disease-, intervention- and population-specific interests are part of UHC, according to the definition, which specifies necessary services, quality of services and access according to need for all people, with financial protection. Extending coverage of treatment for a specific disease such as AIDS, for noncommunicable diseases and reproductive health services or for populations, such as adolescents, who require specific services is a contribution to UHC.

WHO has developed a compendium of interventions for UHC *(16)* for policy-makers, national health authorities and decision-makers to support them in building packages of essential services. The compendium offers a database of over 3500 health actions in all

health areas, from which they can choose in planning and budgeting health programmes. The compendium brings together evidence, guidance, resources and cost analysis on one platform. In addition, it gives tips and options for choosing the most cost–effective actions for a comprehensive package suited to the national context.

The database provides a global reference point for organizing and presenting information on health interventions for UHC throughout the life course and for all diseases. It describes a diverse set of actions for prevention, rehabilitation and treatment, as well as inter-sectoral interventions. To sustain the gains made in coverage of specific diseases or populations, effective coverage of priority interventions and services must be increased. Programmes may be efficient on their own but may have inefficient aspects within the health system. To maximize coverage of priority interventions for all, therefore, the overall health system must be strengthened, including cross-cutting sectors such as information and supply systems. This perspective will also improve efficiency, reduce duplication and result in a better-integrated system to respond to the comprehensive health needs of the population *(17)*. As UHC is universal, the whole population and the whole system must be the unit of analysis. Similarly, budget analysis and dialogue make sense at the level of a sector and not just at the level of a disease or intervention *(18)*.

WHO has also developed a cross-programme efficiency *(19)* approach to provide a framework for countries to identify and correct inefficiencies that compromise their governments' capacity to improve, or at least sustain, the delivery of priority health services . The specific aim is to review all the health programmes in each country's health system to detect "cross-programme" duplications, overlaps and misalignments.

WHO has also developed an online module on cross programmatic efficiency analysis, based on the approach where participants learn how to unpack health programmes based on their common health system functions – financing, governance, service delivery, and creating resources (e.g. supply chain, information systems, health workers) – to understand how they interact with one another and the overall system, and where inefficiencies can be identified.

## A3. Importance of social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age *(20)*. Their circumstances are shaped by the distribution of money, power and resources globally, nationally and locally. The social determinants of health are responsible for most health inequity – the unfair, avoidable differences in health status within and between countries. Inequity is seen, for example, in determinants such as safe, affordable housing, safe water, hygiene and sanitation, access to education, public safety, food security and nutrition, public health services, pollution free environment.

The health system itself is an important determinant of health. If it is designed appropriately and adequately resourced, it can help to remove wider inequities that affect

health service coverage, financial protection and outcomes. Nevertheless, even a robust, equitable health system cannot correct all the social determinants of health, which will require systematic examination of health in all public policies, for which the WHO action framework (health in all policies) *(21)* seeks synergies and avoidance of harmful health impacts in order to improve population health and health equity. Thus, social determinants of health and "health in all policies" are integral to realizing the UHC goals, and budgetary resources for social determinants of health may be as crucial as those committed to overcome health inequities.

## A4. Common goods for health: A foundation for UHC

Public or common goods in health *(24)* are population-based functions or interventions that are obtained by collective financing. Examples of common goods in health are public health operations such as emergency preparation and response, integrated surveillance systems and immunization coverage. Unlike for individual services, the mode of delivery of these goods is population-based, and the benefits accrue to entire populations. It is therefore generally not possible to exclude an individual from the benefits (e.g. by allowing only fee-paying consumers to benefit), and the "consumption" of a common good in health by one individual does not usually reduce the opportunity of others to benefit equally from it. Common goods for health are an important foundation and first step in moving towards UHC. Despite repeated warnings and their relative affordability, however, common goods in health suffer from severe underinvestment *(23, 24)*.

## A5. Need for strong health systems with emphasis on primary health care

A comprehensive strategy to transform health systems with the primary health-care approach *(25)* and commitment to the principles of equity, non-discrimination and universality are crucial to achieving UHC. Primary health care is an approach to health and well-being based on the needs and circumstances of individuals, families and communities. It addresses comprehensive, interrelated physical, mental and social health and well-being. It provides whole-person care for health needs throughout life, not just treatment of specific diseases, as close as feasible to people's everyday environment *(13)*.

The WHO definition of primary health care *(13)* has three components:

1. ensuring that people's health problems are addressed with comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, strategically prioritizing key system functions for individuals and families and the population as central elements of integrated service delivery at all levels of care;

2. systematically addressing the broader determinants of health (including social, economic, environmental factors, as well as people's characteristics and behaviour) through evidence-informed public policies and actions in all sectors; and
3. empowering individuals, families and communities to optimize their health as advocates for policies to promote and protect health and well-being, as co-developers of health and social services through their participation and as self-carers and caregivers to others.

A strong primary health care system is essential for UHC and the most cost–effective way to address the population's health needs comprehensively. It provides a platform for integrating services for communicable and noncommunicable diseases and also those for specific populations such as women and children, which are often provided in silos.

Table 1 lists the key attributes and corresponding domains for strengthening health systems towards UHC *(26)*.

**Table 1. Health system attributes and actions for achieving UHC**

| Health system attribute | Action domain for achieving UHC |
|---|---|
| Quality | Regulations and regulatory environment |
| | Effective, responsive individual and population-based services |
| | Individual, family and community engagement |
| Efficiency | System design to meet population needs |
| | Incentive for appropriate provision and use of services |
| | Managerial efficiency and effectiveness |
| Equity | Financial protection |
| | Service coverage and access |
| | Non-discrimination |
| Accountability | Government leadership and rule of law for health |
| | Partnerships for public policy |
| | Transparency, monitoring and evaluation |
| Sustainability and resilience | Public health preparedness |
| | Community capacity |
| | Health system adaptability and sustainability |

Source: Adapted from reference *26*

Globally, there has been clear commitment to the priority of primary health care (as reflected in the Astana Declaration *(25)*) and a clear shift to increased budgetary support for primary health care in the context of UHC as noted in the 2018 WHO report on health financing *(27)*.

## A6. Role of public finance

To build strong health systems based on primary health care for UHC and to secure financial protection for all people, robust, equitable financing systems are required. The modules that follow provide more detailed information and analysis; however, some concepts are introduced here.

**Essential criteria** for health financing for UHC are *(28)*:

- **automatic or mandatory entitlement**: Population coverage should be automatic or mandatory, as a human right, with no obstacle or condition that determines entitlement, such as employment.
- **compulsory and public financing:** Compulsory contributions should be based on the ability to pay and unrelated to health care needs. Greater reliance on public funding will mean greater reliance on general government budget revenues *(28)*. No country has attained universal population coverage by relying on voluntary contributions to insurance schemes.
- **subsidization** to minimize fragmentation: Resources for health must be pooled at scale under public oversight to reduce fragmentation.
- **universal approach:** The unit of analysis is the whole population, requiring a shift to an inclusive, universal system.

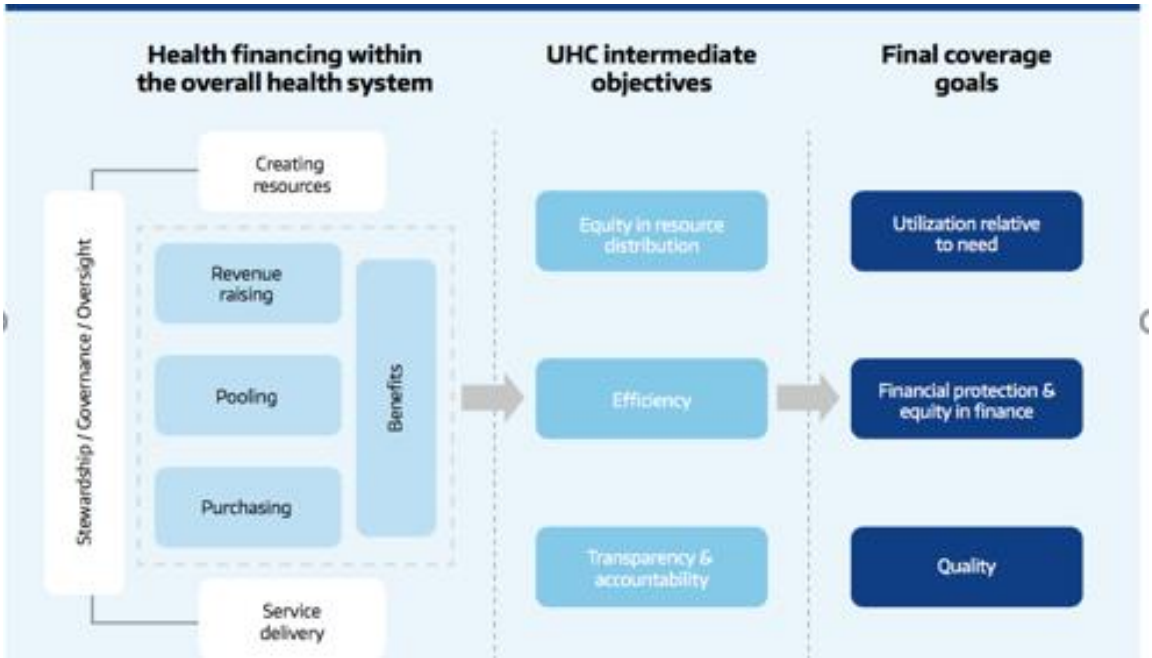
**Key functions of health financing** are revenue raising, pooling and purchasing *(29)*. All countries have policies in which benefits are funded by government; in other countries, those that are not covered and paid for by patients through user fees (sometimes called “co-payments”). WHO has identified principles or signposts for each of the health financing sub-functions and policy areas *(30)*:

- **Revenue generation**:
  - Move towards predominant reliance on public or compulsory funding sources (i.e. some form of taxation), reducing the share of total health spending from private or voluntary sources, and particularly out-of-pocket.
  - Increase the predictability of the level of public (and external) funding over several years.
  - Improve stability (i.e. regular budget execution) in the flow of public (and external) funds.
- **Pooling:**
  - Enhance the redistributive capacity of available prepaid funds.

  - Ensure explicit complementarity of different funding sources.
  - Reduce fragmentation, duplication and overlap.
  - Simplify financial flows.
- **Strategic purchasing:**
  - Increase the degree to which allocation of resources to providers is linked to population health needs, information on provider performance or a combination of the two.
  - Move away from the extremes of rigid, input-based line item budgets and completely unmanaged fee-for-service reimbursement.
  - Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements.
  - Move towards a unified data platform for patient activity, even if there are several health financing or health coverage schemes.
- **Benefit design:**
  - Clarify the population's legal entitlements and obligations (who is entitled to what services and what, if anything, they are meant to pay at the point of use).
  - Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries.
  - Align promised benefits, or entitlements, with provider payment mechanisms.

Fig. 1 shows the UHC goals and intermediate objectives that are influenced by the health financing policy.

**Fig. 1. UHC goals and intermediate objectives influenced by health financing policy**




Source: reference 30.

# Section B. Right to health and international, regional and national commitments to universal health coverage

This section describes the principles of the right to health, the various international agreements and declarations that mandate the right to health and the actions that governments should take to establish the right to health and UHC.

## B1. What is the right to health and how is it linked to UHC?

UHC and the right to health have a synergistic relation. The right to health is a human right, enshrined in articles of the WHO Constitution in 1946 and committed to by Member States in Article 25 of the United Nations 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Economic, Social and Cultural Rights. UHC reflects the right to health and is an important vehicle for its progressive realization.

What does the right to health mean in practice? As stated by the United Nations Special Rapporteur on the right to health

> The right to health can be understood as the right to effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system *(31)*.[6]

To operationalize the right to health, the United Nations Committee on Economic Social and Cultural Rights adopted General Comment 14, which elaborates on what the right to health means in practice. It states that a State Party has three obligations:

- *respect*: simply not to interfere with the enjoyment of the right to health;
- *protect*: to ensure that third parties (non-State actors) do not infringe upon the enjoyment of the right to health; and
- *fulfil*: to take positive steps to realize the right to health.

In order to implement the above effectively, General Comment 14 specifies four principles or elements that form the core of the right to health *(31)*[7]:

- *Availability*: Functioning public health and health-care facilities, goods and services, as well as programmes in sufficient quantity
- *Accessibility*: Facilities that are accessible physically (in safe reach for all sections of the population, including children, adolescents, older people, people with disabilities and other vulnerable groups) as well as financially and on a basis of non-

[6] The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2006), quoted in reference *20*.
[7] Note: 3AQ is now expanded to 4AQ or even 5AQ wherein adaptability and accountability have been added.

discrimination. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including people with disabilities) but does not impair the right to confidential treatment of personal health data.

- *Acceptability*: Facilities, goods and services that respect medical ethics and are gender-sensitive and culturally appropriate; i.e. are both medically and culturally acceptable.
- *Quality*: The facilities, goods and services must be scientifically and medically appropriate and of good quality. These include, in particular, trained health professionals, scientifically approved, unexpired drugs and hospital equipment, adequate sanitation and safe drinking-water.

General Comment 14 also states the core content that States Parties are obligated to ensure immediately. These minimum essential services include essential primary health care; minimum essential, nutritious food; sanitation; safe, potable water; and essential drugs. Another core obligation is adoption and implementation of a national public health strategy and plan of action, which must address the health concerns of the whole population; be devised and periodically reviewed in a participatory, transparent process; include indicators and benchmarks by which progress can be closely monitored; and pay particular attention to all vulnerable or marginalized groups. States Parties must also take steps to conform with the principle of progressive realization, which imposes an obligation to move forward as expeditiously and effectively as possible, individually and with international assistance and cooperation, to the maximum of available resources.

So, how is the right to health linked to UHC? The core principles of the right to health should be the basis of UHC. UHC enshrines the principle of universalism, which places equity as a central political consideration when choices are made on who benefits and who's left behind on the pathway towards UHC *(32)*. UHC also reinforces the place of the comprehensive primary health-care approach as the foundation on which health systems and their financing must be built.

## B2. Which international agreements and declarations mandate the right to health and international mechanisms to hold government to account?

Beyond the WHO Constitution and the Universal Declaration of Human Rights referred to above, the first major covenant agreed upon by countries is the **International Covenant on Economic, Social and Cultural Rights** *(33)*, which was ratified in 1966, of which Article 12 states:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

**Other international treaties** that mandate some aspect of the right to health are *(31)*:

- the 1965 International Convention on the Elimination of All Forms of Racial Discrimination: article 5 (e) (iv);
- the 1979 Convention on the Elimination of All Forms of Discrimination against Women: articles 11 (1) (f), 12 and 14 (2) (b);
- the 1989 Convention on the Rights of the Child: article 24;
- the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: articles 28, 43 (e) and 45 (c); and
- the 2006 Convention on the Rights of Persons with Disabilities: article 25.

An important declaration at the International Conference on Primary Health Care in Alma Ata in 1978 provided a huge impetus to rapid advancement towards the right to health and UHC. **The declaration of Alma-Ata** affirms the crucial role of primary health care, which addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly (article VII). It stresses that access to primary health care is the key to attaining a level of health that will permit all individuals to lead a socially and economically productive life (article V) and to contribute to the realization of the highest attainable standard of health.

This was reiterated 40 years later as the **Astana Declaration 2018** *(25)*. The Global Conference on Primary Health Care in Astana, Kazakhstan, in October 2018 endorsed a new declaration emphasizing the critical role of primary health care around the world. The aim is to refocus on primary health care to ensure that everyone everywhere enjoys the highest possible attainable standard of health. This Declaration further emphasizes that primary health care is the cornerstone of a sustainable health system for UHC and health-related SDGs to achieving UHC, so that all people have equitable access to the quality and effectiveness of the health care they need, ensuring that use of these services does not expose them to financial hardship.

The **Political Declaration** of the **United Nations High-level Meeting on UHC** in September 2019 is another reflection of Member States' commitment to the right to health and UHC and to accelerate efforts to achieve UHC, progressively extending both coverage and financial protection, with particular attention to poor and vulnerable populations. Specific commitments have been made to prioritize health in government spending, increasing sustainable public investment and optimizing budgetary allocations to health. The commitment to leave no one behind reiterates the SDG statement of reaching the furthest behind first. As a follow-up, the Declaration calls for a high-level meeting in 2023 to review implementation. The Declaration was highly significant for consistently marginalized groups, such as women, children and adolescents (adolescent girls in particular), emphasizing the unique needs, concerns and considerations of each population, while situating their needs in the broader UHC agenda.

The right to health is also recognized in several **regional instruments**, such as the African Charter on Human and Peoples' Rights (1981), the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador (1988), and the European Social Charter (1961, revised in 1996).

Various mechanisms are available to review States' obligation to realize the right to health such as the **Universal Periodic Review** and the **Committee on Economic, Social and Cultural Rights**. The Universal Periodic Review reviews the human rights records of all Member States, providing an opportunity to focus on pressing concerns and identify priority actions.

## B3. Domestic commitments to the right to health and UHC, including constitutional rights and laws, policies, plans and election pledges

National governments are increasingly committing themselves to UHC and the right to health response to both international covenants and agreements and in their countries, through civil society action, media campaigns, political campaigns and commitments in election pledges, policy development and commitments and sometimes even through legislative action and constitutional amendments. The types of actions and the extent to which they reflect the right to health and UHC differ from country to country.

Global experience shows that domestic legal commitments can be crucial to accelerating realization of the right to health and UHC. For instance, health has been made a constitutional right in Brazil, the Islamic Republic of Iran, Mongolia and South Africa; constitutional mandates have been included in directive principles in India, Malawi, the Philippines and Uganda; and laws mandating the right to health or UHC have been passed in Canada, Japan, the Republic of Korea, Thailand and the United Kingdom. In some countries, the legal actions are comprehensive and thereby better

reflect UHC, whereas in others they are targeted and partial, which may undermine a universal and inclusive approach to realizing UHC.

National health policies, strategies and plans and the accompanying policy and planning cycle are opportunities for budget-related advocacy. The policy and planning cycle includes a diagnostic phase, in which the health sector is analysed; a strategy formulation phase; a phase for a broad costing exercise to understand the monetary implications of the strategy; a stage in which the costs are translated into health budgets and formatted into the overall national budget; and, finally, an operational planning phase when broad strategic directions are translated into activities *(34)*. The phases are ideally participatory, involving all health stakeholders, giving the opportunity for civil society and others to exchange and provide input. If this is not the case, advocacy for a more transparent, participatory process should apply pressure to ensure that policy-making involves more stakeholders.

Research on the public budget shows how the country has budgeted and spent in the past and how well the spending has corresponded to the objectives stated in policies, strategies and plans. As a single group or organization may not be able to harness the expertise necessary to understand and take part in every step of the policy and planning cycle, partnerships among civil society groups, community and grassroots organizations, the media and the parliament are essential for sharing information and expertise and demonstrating a common focus on ensuring that the right to health and UHC are anchored in the national health strategy as the orienting vision of the country.

In this sub-section, the facilitator and participants will share experiences in each activity.

## Activity: Agreements, declarations and domestic commitments

1. The facilitator introduces the concept and features of the right to health, including international agreements and declarations (B1 and B2) and domestic commitments (B3) and engages the participants in an interactive discussion about the extent to which the right to health obligations are reflected in their context (60 min).

2. The participants separate into groups of three or four for 10 min to note down the various obligations of their governments related to the right to health and UHC. They analyse how UHC is interpreted in their context, particularly in the national health plan and health financing strategy (which may specify mechanisms for financial protection), to identify strengths, weaknesses, opportunities, threats and what must change in order that the right to health and UHC are better reflected in domestic commitments, policies and plans. The charts are displayed for everyone to review.

Some documents to which they might refer for this activity include the constitution and any law that refers the right to health or UHC or access, the national health plan and recent applicable election pledges

# Module 2. Introduction to public financing for health relevant for budget advocacy for universal health coverage

## Section A. Introduction to public policy and its association with budgets in relation to universal health coverage

Although the toolkit and this module focus on the public budget and UHC, this module begins with a section on public policy, as the public budget reflects a government's priorities. The first step in budget analysis and advocacy is understanding the policy priorities.

### A1. What is public policy in general terms?

Broadly speaking, public policy is a set of decisions to solve a problem that the government considers a priority *(35)*. Public policy is designed by a public entity (sometimes with the participation and input of other stakeholders) and may be implemented by a combination of public and private actors. The instruments used to implement public policy depend on the objectives. Public policy is not static, and it is also the means for a government to state its vision of, for example, equality, human rights and social development.

The literature suggests a model such as that shown in Fig. 2 for understanding how public policy flows.

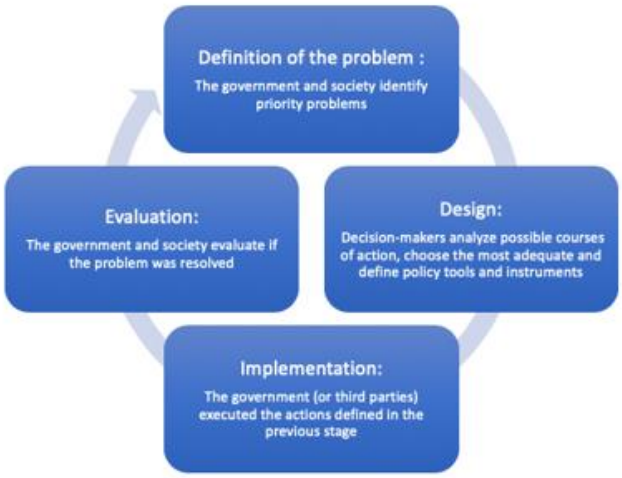



**Fig. 2. Public policy cycle**

Source: Reference *36*, based on a review of literature on public policy *(37–42)*.

According to this cycle, the first step in designing public policy is to define what are called in public policy literature and by experts "the public problem(s)". On the basis of this definition and the prioritization of public problems, actions to address the problems are defined and prioritized in a complex process. The way in which a government defines the public problem determines the design of the public policy and the instruments for implementing it, including the public budget as a key element. In a best-practice scenario, public policy is evaluated to identify its impacts and contributions.

The main concept in this approach is the "public problem", as policy design and implementation stem from it. Broadly speaking, the public problem can be understood as the gap between the current situation and a desirable situation that will affect a group of people in a given context. For policy-makers, defining the public problem entails at least the following:

- identifying what the problem consists of;
- identifying its underlying causes and those that are the most important;
- identifying who it affects and to what extent; and
- determining how it will evolve if it is not addressed.

The definition of what constitutes a public problem is neither neutral nor objective but depends on who is defining it and their ideology, prejudices, political agendas, etc. The same type of public problem can be defined (and therefore addressed) in different ways, depending on who defines it. A public problem has at least three dimensions:

- **a technical dimension:** data that sustain the argument of why it is a public problem, the main causes and the priority solutions;
- **a political dimension:** solid justification for prioritization of a public problem in lieu of others; and
- **a social dimension:** the implications of the choice for society as a whole.

Table 2 summarizes the considerations of government actors in defining a public problem according to public policy theory and the policy to address it.

**Table 2. What to consider in the design and implementation of a public policy**

| | |
|---|---|
| Justification | Why should we intervene? |
| Diagnosis | What are the causes and consequences of the problem? |
| Objective | Why and how should we solve the problem? |
| Process | What are the steps in solving the problem? |
| Actors | Who will participate? |
| Resources | What tools are available? |
| Temporality | When do we expect the problem to be solved? |
| Expected results | What changes do we expect to see after the intervention? |

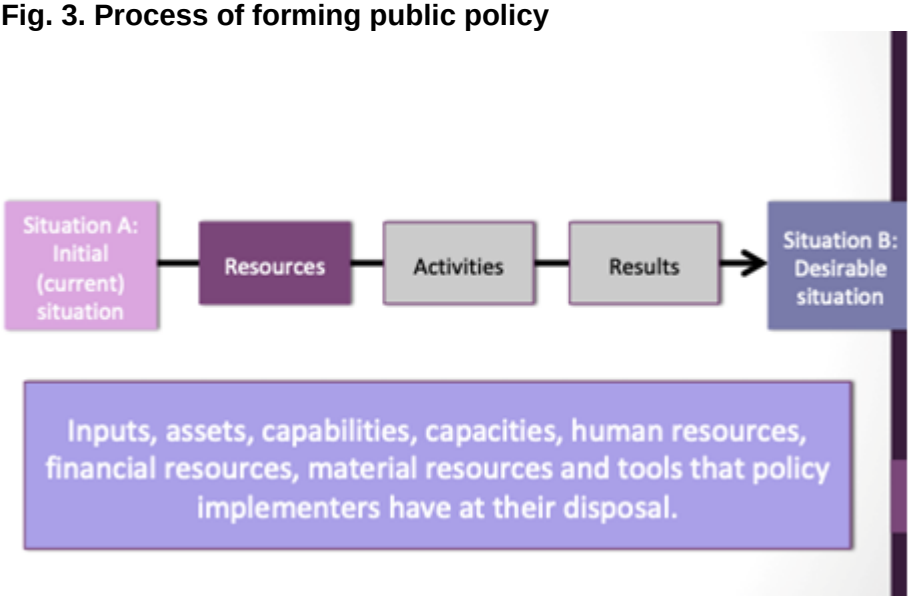
Source**:** Adapted from reference *36,* based on a review of literature on public policy *(43, 44)*.

National development plans are a common instrument for providing a government's perspective on what it has identified as priority "public problems" and how it plans to address them. Such plans follow the life cycle of a particular government and offer a view of what it will prioritize as public problems and how it will address them during its administration. It is therefore a multi-year blueprint of a government's priorities and its views on the best ways to address them.

## A2. What is the role of public resources in relation to public policy?

Fig. 3 summarizes the process for forming public policy. The government begins by defining the public problem (situation A) and the steps or actions to transform it (situation B). In this approach, resources are a key element for implementing activities, arriving at results and transforming the public problem. Resources are varied but they include financial resources; when it comes to public policy, the provision of human resources, material resources and other tools will also probably depend on financial resources.

**Fig. 3. Process of forming public policy**




Source: reference *36*.

In this process, the most obvious link between public policy and the public budget is that public policy cannot (or with great difficulty) be implemented without concrete financial resources, expressed in the budget as public expenditure. If order to analyse or measure the extent to which a particular policy is a priority for a given government, one can determine how much resources are allocated to it and how efficiently and effectively they are spent. For budget analysis, it is important that prospective budget advocates understand that public policy analysis accompanies (or should accompany) budget analysis, particularly for sector-specific research and advocacy.

## A3. On what should health policies focus in order for countries to achieve UHC?

In advocacy for UHC, it is important to understand what UHC means and the types of public policy choices it should entail. Module 1 in this section provides an overview of the content of UHC and is a good source for identifying the types of policies it should include. This module provides some ideas for advocates on aspects of UHC policies they should monitor to link public policy in general with public policy for UHC.

> UHC means that all individuals and communities receive the health services that they need without suffering financial hardship. It includes the full

> spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care *(13)*.

A strong health system is necessary to achieve effective, high-quality coverage:

> Health systems and their strengthening are seen as the foundational set of policies, institutions, actions, approaches and tools, required to achieve the goals of UHC and the SDGs *(34)*.

According to the WHO factsheet *(13)*, UHC-related policies refer to actions linked to health systems strengthening that include:

- coverage;
- elimination of out-of-pocket expenses such as user fees;
- health promotion;
- disease prevention, treatment and rehabilitation;
- palliative care; and
- improvements in the quality of care.

By understanding what UHC is **not**, the types of policies necessary to achieve it can be identified in more detail.

Box 1 summarizes in the words of WHO *(13)* what does not constitute UHC.

### What UHC is not

There are many things that are not included in the scope of UHC:

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.
- UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, and so on.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

A few elements that might useful to consider with regard to UHC policy budgets are:

- Progressive extension of coverage and financial protection according to the availability of resources: thus, as more sources of public financing become available, coverage should be extended.
- Policies should include individual treatment; however, broader policies such as health campaigns and malaria prevention help prevent disease.
- Policies should go beyond health and health care per se.

WHO provides guidelines for monitoring and measuring UHC and, in collaboration with the World Bank, has published a framework for tracking progress towards UHC with global UHC monitoring reports released biannually The two main indicators in the framework are:

- the proportion of the population that can access essential, high-quality health services; and
- the proportion of the population that spends a large amount of household income on health.

The framework cites WHO's 16 essential health services as indicators of equity and coverage, which are a good start for tracking advances towards UHC. They are also a good start for analysing public policies and budgets related to UHC:

Reproductive, maternal, newborn and child health:
- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

Infectious diseases:
- tuberculosis treatment
- HIV antiretroviral treatment
- hepatitis treatment
- use of insecticide-treated bed nets for malaria prevention
- adequate sanitation.

Noncommunicable diseases:
- prevention and treatment of raised blood pressure
- prevention and treatment of raised blood glucose
- cervical cancer screening
- tobacco (non-) smoking.

Service capacity and access:
- basic hospital access
- health worker density
- access to essential medicines

- health security: compliance with the International Health Regulations (2005).

For more information on the types of policies related to UHC, refer to module 1 in this section.

## Tool. The WHO global health expenditure report

WHO has issued a global expenditure report annually since 2017 *(46).* The 2020 report provided global health spending in 190 countries between 2000 and 2018 and health spending between the Millennium Development Goals era and the SDG era, before the COVID-19 pandemic of 2020. The data show that out-of-pocket spending has remained high in low- and lower–middle-income countries, representing more than 40% of total health spending in 2018. The report summarizes data on expenditure for primary health care and by disease and intervention, including for immunization. The report also presents analyses of the data on budget allocation in response to the pandemic. In addition, the report combines projections from the World Bank and the International Monetary Fund of the macroeconomic and fiscal impacts of the pandemic, with an analysis of the historical determinants of health-spending patterns and UHC indicators. On this basis, they report the probable implications for future health spending, highlighting key policy and monitoring concerns.

The recommendations are as follows:

1. Secure domestic public spending on health as both a societal and an economic priority.
2. Fund common goods for health as step zero of UHC at country level.
3. Invest in global common goods for health to ensure global health security.
4. Prioritize public funding to ensure equitable access and financial protection through a primary health care approach.
5. Increase the level of aid to lower-income countries, but adjust aid modalities.
6. Fund national institutions for transparent, inclusive tracking of health spending at both national and global levels.

## Tool: The WHO health financing progress matrix

The health financing progress matrix *(47)*, developed by the WHO Department of Health Systems Governance and Financing, allows assessment of national health financing systems against evidence-based benchmarks, framed as 19 desirable attributes. Each attribute represents one critical element of a health financing system and signals the direction that institutions, policy and implementation should follow to make progress towards UHC. The matrix complements both quantitative measures of UHC performance, such as financial protection, and estimates of health expenditure (available

in the Global health expenditure database *(48)*) to assess shifts in policy development and implementation. By close-to real-time monitoring of health financing policy, the matrix provides regular, action-oriented feedback to policy-makers.

Use of the progress matrix can bring stakeholders together on a common point of reference, to focus scarce resources on priorities and interventions and to track progress transparently over time. Version 2.0 of the matrix, released in late 2020, is the culmination of almost 3 years of conceptual development and testing in countries.

## Activity: Exploring UHC budget information with the Global health expenditure database

Suggest how participants could use these two tools and particularly the Global health expenditure database, as it is complex to navigate. Your advice on key search terms for UHC would be useful. You could go through the following steps with participants:

1. Go to http://apps.who.int/nha/database/Select/Indicators/en.
2. Click on “Indicators” and then on “Aggregates”. Select an indicator: “Current health expenditure as % of gross domestic product”.
3. Go to “Countries” (grey box on the left), and click on it. You should see countries listed in alphabetical order. Find your country and click on it.
4. Now go to “Years” (same grey box on the left). and click on it. Find 2014, 2015 and 2016, and click on the boxes.
5. Click on “View data”, and build a report. You should be able to download the data in Excel or PDF.
6. Now try examining prioritization. For this, you should go to “Indicators”, then “Financing sources” (not “Aggregates”). Then, go through the same steps as before.
7. Now, complete these steps for the following indicators, and create a table. List a few bullet-points on what the table tells you about (a) revenue-raising capacity, (b) prioritization of health spending in your country, (c) dependence on external assistance in health and (d) level of out-of-pocket spending.
    - domestic general government health expenditure as a percentage of general government expenditure;
    - external health expenditure as a percentage of current health expenditure;
    - out-of-pocket spending as a percentage of current health expenditure; and
    - general government expenditure as a percentage of GDP.

## Tool: WHO handbook for strategizing health in the 21st century for designing public policies for universal health coverage

**Purpose of the tool:** WHO provides several tools to support countries in developing UHC policies, including Strategizing health in the 21st century *(34)* and an online repository of national planning tools *(49)*. This tool provides governments (and other stakeholders involved in health public policy planning and implementation) with information and guidelines for strategic design, implementation and evaluation of national health policies. It is useful for understanding the policies that advance UHC and how they should be formulated, implemented, budgeted for, monitored and evaluated.

## Activity: Understanding key elements of health policy design for UHC

Read the introductory chapter of Strategizing health in the 21st century *(34)*, and respond to the following questions, which may help understand the importance of national health plans for UHC and the types of policies you might use in your context:

- What are the key elements of good practice in a robust national health plan? (Mention only key points.)
- Why should UHC be the overarching vision for a national health plan?
- Who should be involved and how in developing a national health plan, and why?
- What is the role of the public budget, and how do you think it is linked to national health policy on UHC?
- According to this handbook, what do you consider is the role of your constituency in development of a national health plans?
- What questions or ideas come to your mind with respect to your government's national health policy after reading this introduction?
- What do you think you should investigate and learn more about?

# Section B. Introduction to the public budget and its relevance for universal health coverage

## B1. Political economy approach: a conceptual framework for the politics of public budgeting

What do we mean by the "political economy of public finance", and why does it matter?

In simple terms, the political economy of public finance is the way in which governments raise revenue and distribute and use it for diverse social and economic priorities, which entails decisions and political decision-making. To grasp the concept of "political economy", we shall explore some examples.

For example, a government may choose to stop its reliance on foreign aid. One way of doing this is to strengthen its fiscal policy through taxes. Which taxes and who pays those taxes has winners and losers and affects different people (rich, poor, interest groups, etc.) in different ways. When a government chooses to prioritize or strengthen a given source of revenue over another, it is making a political choice that has political implications and will entail different levels of negotiation. The same is true for expenditures and how the different sources of revenue are distributed among a wide array and competing set of priorities. For example, is a government spending more on the military or on health? Is the government prioritizing the communities most in need or not? Are some provinces receiving a larger share of the budget than others? Are expenditures promoting equality? Where money is spent and how it is spent are also political choices that will have different impacts on different groups of people and stakeholders.

For this reason, within the public finance community, public budgets are considered the true expression of a government's priorities. A recent publication by the IBP offers a definition of public budgets that helps us to understand priorities from the point of view of political economy *(50)*:

> As a decision on how public resources are to be raised and spent, they (budgets) are the yearly embodiment and expression of the social contract that binds state and its citizens together. And as a means for (re) distributing these resources, they are a key arena of political negotiation and for ensuring accountability.

*The political economy of health finance*

For WHO, a political economy approach is essential to explain and understand health financing and the health financing reforms that are necessary to achieve UHC. The approach includes, of course, the **public resources** that are raised and used for

achieving UHC. Module 1 of this section provides the definition of UHC promoted by WHO *(13)*, which is repeated here in order to frame the learning objectives.

> UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

For WHO, a core means for achieving UHC is health system strengthening, which, in turn, should drive reforms in health financing *(51)*. WHO recognizes that, in order to advance towards UHC, countries will have to make important reforms to both their health financing policy and their PFM structures and processes. It also recognizes that the starting-points of different countries are different, and some may be more advanced in their reforms than others.[8] These include an interesting way in which WHO explains why health financing and the increasing role of public budgets should be understood through a political economy approach *(52)*:

> Health financing reform often involves complex interactions among many stakeholders of varied positions, power, and influence within the health sector and beyond. In many cases reform is politically contentious because it seeks to change sensitive distributions, as with entitlements and responsibilities of beneficiaries, or remuneration and working conditions of providers.

An approach to political economy analysis is suggested *(53)* to help policy-makers develop more effective strategies for managing political challenges that arise in reform. Here, political economy analysis is used to assess the power and position of political actors in order to develop strategies to change the political feasibility of desired reforms. An example is given by Sparkes et al. *(53)*.

In sum, anyone seeking to conduct budget advocacy in relation to UHC should bear in mind that public budgets are more than technical tools for implementing public policy. Public budgets are embedded in a context in which different groups of people have interests and can be affected in different ways by how budgets are designed and the priorities they reflect. Budget advocates in general and health budget advocates in particular are part of this complex political ecosystem, as are their budget advocacy demands and objectives.

## B2. What is the public budget, and why is it relevant?

A budget is generally considered to be an action plan for spending in the future according to the income expected. Governments must therefore calculate the total amount of

[8] WHO has therefore published several guides, working papers and other materials to strengthen the capacity of countries to develop a strong health financing strategy.

money they wish to spend on schools, hospitals, roads and salaries throughout the year. A national budget is arguably one of the most important public documents, as it is a translation of a country's national development goals into annual spending plans. Budgets are the medium through which policies are funded and executed and, in turn, activities to support selected priorities are delivered. The development, implementation and reporting of the budget all require technical understanding of the PFM process. In addition, as budget outcomes also may depend on political as economic factors, it is also important to understand the politics of the budget cycle *(54)*.

WHO has collated key PFM resources to raise understanding and awareness on the role of PFM rules and processes for health spending. The resource portal on PFM for health contains various types of materials (working papers, policy briefs, audio files, video podcasts) produced by a range of partners and experts (IMF, World Bank, WHO, OECD, IBP, CABRI). The materials are all available online and easy-to-use for self-learning

Knowledge of the workings of the budget and the broader PFM system in a country help to understand why resources are spent on certain things and in certain ways and then to find mechanisms to influence the process and decisions that lead to spending on these "things" and "ways" *(54)*.

It is important to consider the budget within the broader context of UHC. What are the links and gaps between UHC, the formulation of policy, the allocation of resources, budget execution and service delivery on the ground? How do those links and gaps affect the welfare of the population? If the links and gaps are understood, opportunities can be found to improve the design of policies, their inclusion in the budget cycle and their implementation to achieve a greater impact on children's welfare *(54)*.

The budget is the most relevant policy document of any government, as it explains the amount of resources it expects to receive (**revenue**) and how it plans to spend them (**expenditure**).

**Revenue** represents the income that a government receives from various sources to spend on public service delivery. In many countries, most funds come from revenue raised from taxes and varying proportions of funds from external aid and public borrowing. Understanding the sources of revenue for the budget is important because they have implications for public policy decisions *(54)*. It is money that comes from the public – a simple condition that gives people the right to know the final use of public monies.

When the total revenue is insufficient to meet spending commitments, governments have to borrow money. Such borrowing is known as **"public debt"**, which may be external (when the government borrows from other governments, international institutions or foreign commercial banks) or internal (when loans come from the issuance of bonds or certificates payable by the government, with attractive rates, to the public). Loans must be paid back in the future.

**Expenditure** represents authorized spending on various aspects of public service delivery by government agencies and line ministries. The two basic types of expenditure are recurrent and capital; however, as shown in the sections below, three classifications better explain spending decisions. For now, let us say that **recurrent expenditures** are made by the government to maintain operations during the budget period and do not result in the creation or acquisition of fixed assets. Recurrent expenditures include wages, rent, office requirements, interest payments on borrowed funds and maintenance of fixed assets. The recurrent expenditure budget does, however, sometimes include some capital expenditures (for example, equipment such as computers and chalkboards), depending on how the economic transaction is defined. **Capital expenditures** are those on assets that last for more than 1 year. They include equipment, land, buildings, legal expenses and other transfer costs associated with a property. For capital projects (e.g. building schools), all associated expenses are also considered as capital expenditure *(55)*.

## B3. The revenue side of public expenditure on health and what is relevant for UHC budget advocacy

The sources of the public budget are either tax or non-tax revenues. The revenue sources of public expenditure for health are defined as follow in the System of health accounts 2011 *(56)*:

- compulsory or voluntary
- prepaid or payment at the time of service use (out-of-pocket)
- domestic or foreign.

From the perspective of health financing policy, public sources are those which are compulsory and pre-paid, while voluntary sources are considered private. Categorization of a source as compulsory implies that the government requires some or all people to make the payment, irrespective of whether they use health services. Thus, compulsory sources are also prepaid and are essentially the same as taxes. In this category, some of the most important distinctions are:

- direct taxes paid by households and companies on income, earnings or profits directly to the government or another public agency; examples include income tax, payroll tax (including mandatory social health insurance contributions) and corporate income or profits taxes;
- indirect taxes paid on what a household or company spends, not on what they earn, and paid indirectly to the government via a third party, e.g. a retailer or supplier. Common examples are value-added tax, sales taxes, excise tax on the consumption of products such as alcohol and tobacco and import duties;
- non-tax revenues, e.g. from state-owned companies, including the “natural resource revenues” common in many mineral-rich countries, e.g. on oil and gas; and

- financing from external (foreign) sources, typically categorized as “public” when these funds flow through recipient governments (see Box 2).

Taxes may also be regressive or progressive, but what does this mean? Depending on how they are applied and on how they account for the income of taxpayers, taxes can be regressive, progressive or proportional.

- A tax is **regressive** when it is in inverse relation to the income level of taxpayers. Regressive taxation imposes a greater tax burden on lower-income taxpayers.
- **Progressive** taxation increases the tax burden for taxpayers as their income increases; it allows for greater social progressivity and justice, as better-off citizens, i.e. those with a higher income, bear a higher tax burden.
- In **proportional** taxation, the amount of taxes levied on an individual is proportional to his or her income.

### Understanding revenues in relation to UHC

Having committed themselves to achieving SDG 3, to “ensure health lives and promote well-being for all at all ages” *(59)*, which includes SDG 3.8, to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”, many countries will have to review and modify the way in which they finance health *(51)*.

The previous section provided information for understanding how public budgets are financed in general terms. The sources of revenue for health vary and include public resources. The proportion of health that is financed by the public budget differs from country to country; however, in order for countries to achieve UHC progressively, they should try to derive most of their resources from public finance, as “no country has made significant progress towards UHC without relying on a dominant share of public funds to finance health” *(51)*.

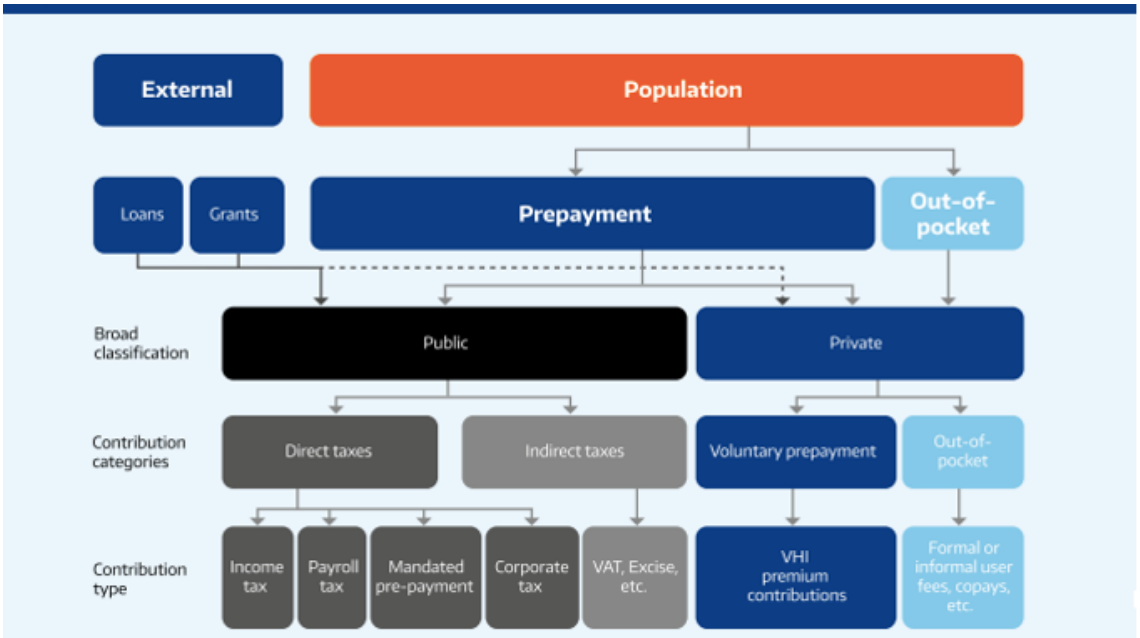
According to WHO *(51)*, health financing

> consists of the policies and arrangements that a country has for revenue sources and contribution mechanisms, pooling of funds, purchasing services, policies on benefit design, rationing, and the basis for entitlement and the governance of all of the above functions and policies.

## How is health financed, and how does the public budget fit within this broad configuration?

Fig. 4, published by WHO in a guide for developing a national health financing strategy *(50)*, is useful for understanding the different sources of revenue that finance health.

**Fig. 4. Major sources of revenue and mechanisms for contribution**




Source: reference *51*

Broadly speaking and as seen in Fig. 4, health is financed from two sources: public and private. Public resources, which are the focus of this toolkit, are derived mainly from the following sources of revenue:

1. **External revenue from loans and grants:** The vast majority of low-income countries rely on external sources of revenue to finance health, making them what is commonly known as "debt-dependent" or "aid-dependent". An important aspect to consider and explore with respect to this source of revenue is whether the resources are incorporated into the public budget or are "off-budget". If the resources flow

outside the realm of the public budget, the general budget documents will not show how much and for what the resources are used. It is important to understand at this point that loans and grants obtained by a government are a key source of income for public health.

2. **Prepayment sources of revenue:** These types of resources can finance both public health (health provided by and managed by the government) and private health (provided and managed by private entities). For the purposes of this toolkit and as per B3 above, the prepaid revenues that finance public health are of interest, as they should be reflected in the public budget. “prepaid contributions can take the form of taxes and either compulsory or voluntary health contributions.” For example, in some countries, like Mexico, a proportion of the income of formal workers included in the social security schemes is deducted, which is complemented by a contribution by the State that entitles them to health services provided by the Mexican Institute of Social Security.

3. **Different types of taxes**: Fig. 4 shows a wide array of taxes that can levied on a population, which, once they flow through the public budget, can contribute to financing health. This illustrates why, for a strong health financing system, it is recommended that countries strengthen their internal revenue sources and why this may require a more robust fiscal policy. Many countries, however, find it difficult for various reasons (including political ones) to raise taxes. As mentioned before, who pays what taxes matters a lot and is a political decision.

Box 3 describes means for reducing out-of-pocket spending on health care.

**Box 3. Out-of-pocket spending on health**

One of the main objectives of moving towards UHC is to ensure that access to health does not impose financial hardship on the population, particularly the more disadvantaged.

WHO defines out-of-pocket spending as "direct payments made by individuals to health care providers at the time of service use." Out-of-pocket spending is particularly prevalent in countries in which the health financing system relies heavily on user fees and co-payments, and it has a particularly devastating impact on the poor. This type of payment is common in countries in which health workers are not well paid, as it is a way for them to complement their wages.

In a UHC approach to health financing, countries move away from heavy reliance on out-of-pocket spending to ensure equitable access to health and to reduce financial hardship on the population. Out-of-pocket spending can be reduced by:

- abolishing formal and informal user fees and other charges in health facilities;
- applying policies that exempt vulnerable populations (for example, pregnant women, adolescents or the poor) from any payment for health services; and
- delivering key health services, such as maternal and child health, free of charge.

Source: reference *60*

## Impact of health financing from pooled funds on public finance

An important health financing function is referred to by health finance experts as "pooling" funds. Pooling "refers to the accumulation of prepaid revenues on behalf of a population and they are pooled by both public and private entities" *(51)*. The WHO definition in the context of guiding governments in developing health financing strategies is *(51)*:

> Funds for health are pooled by a wide array of public and private agencies, including national ministries of health, decentralized arms of ministries of health, local governments, social health insurance funds, private for-profit and not-for-profit insurance funds, nongovernmental organizations (NGOs) and community organizations.

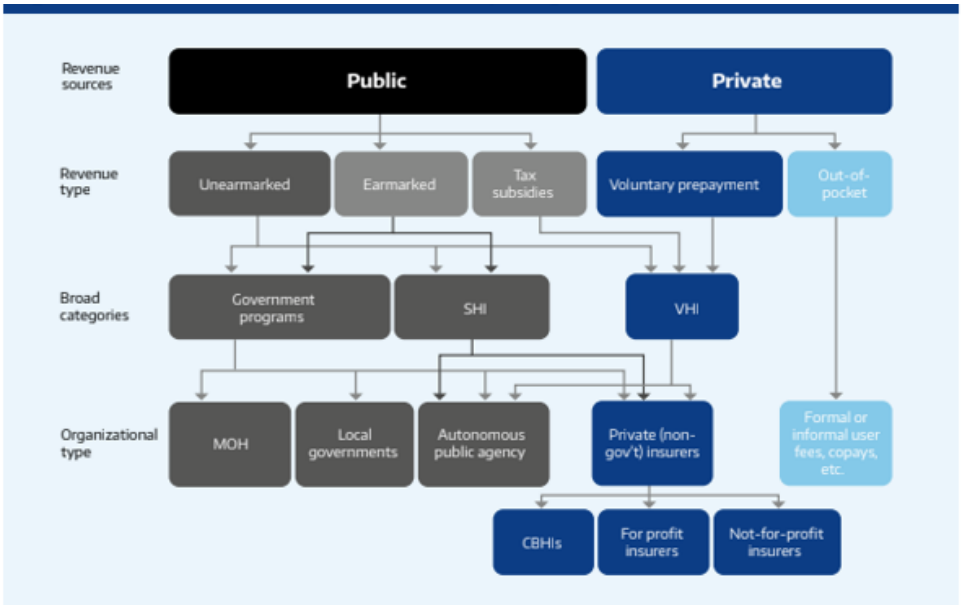
Pooling is an important concept for health budget advocacy for UHC, given the important role of the public budget in UHC. As suggested by the definition above, both national and subnational governments participate in or finance health through pooling mechanisms. For example, in decentralized health systems *(61)*, as is the case in many countries, pooled funds are an important source of health financing, enhancing the role of both national and subnational budgets and the way in which they interact.

According to WHO *(61)*, pooling revenues should result in the health financing strategy:

- enhancing the redistributive capacity of available prepaid funds;
- enabling explicit complementarity of different funding sources;
- reducing fragmentation, duplication and overlap; and
- simplifying financial flows.

Fig. 5, from the WHO national health financing strategy guide *(51)*, shows common ways in which pooled funds flow from different sources, including private, into health. Box 4 shows the relation between budgets and UHC.

**Fig. 5. Common revenue flows from sources to pooling entities**




Source: reference *51*

**Box 4. The relevant relation between budget and UHC**

There is a strong relation between the quality of budget systems and UHC.

- Robust public budgeting in health could improve predictability in the sector's resources, which would increase the possibility of planning health policy actions.
- Proactive engagement of health ministries in the budget cycle facilitates alignment of budget allocations with sector priorities.
- When budgets are better designed, execution improves.
- If the health budget is formulated according to goals and the rules for execution are aligned with those goals, it will allow a certain degree of spending flexibility and make budgets more responsive to sector needs.

Source: reference *62*

The resources included in revenue might be treated differently:

- **On-budget.** Allocations that are included in the budget;
- **Off-budget.** Allocations that are excluded from the budget by law and are financed by taxes or levies that are not in the budget *(63)*.

"On-budget expenditure" follows the process and rules of the general budget; however, "off-budget expenditure" could present some obstacles for analysis, because it is usually more difficult to monitor and, in many countries, is used to finance health services and goods. See Box 5.

**Box. 5. Off-budget health expenditure**

The main form of off-budget health expenditure is off-budget funds, which are special funds owned by the government that are not part of the budget and that consist of earmarked levies and possibly other sources, such as fees and contributions from the general tax fund.

Earmarked levies are different from fees, as they do not reflect the market value of the services that are financed from the revenues.

Off-budget funds are found mainly for the areas of social security, health care, transport and pensions.

Government economic ownership of off-budget funds means that the government can dispose of the assets of the fund, if necessary by changing the law by which it was established, without compensation. The reasoning with respect to social security and public health care funds is that the premiums are paid by the social partners (employers and employed; patients) and that the funds thus "belong to them", at least to the same degree as to the government. For the same reason, the social partners are often represented on the boards of the funds.

Thus, in analysing a health budget, it is important to know the origin of the resources for the health budget, the rules that apply to the expenditure and where sufficient information can be found. In the next sections, we provide some examples and exercises to better understand health expenditure and how to identify it.

## B4. Expenditures in the public budget and those relevant for UHC budget advocacy

As stated above, a public budget is composed of two elements: revenue and expenditure. In section B.3 we discussed a few elements of the revenue side of the public budget in general and for UHC. This section focuses on expenditure of the public budget and its relevance for progressive achievement of UHC.

**Public expenditure** refers to the money the government spends in complying with its duties: to provide public services such as education and health; to build roads, schools and hospitals; and to provide services such as water and electricity. Public resources are also allocated to programmes for poverty alleviation or to support economic activities. Public spending also covers the operating expenses that the government incurs in carrying out its activities, paying interest or repaying government debt.

The health budget is "the allocations to ministries of health, their attached agencies and to other ministries involved in the delivery of health-related expenditures" *(63)*. These simple WHO definitions show that the expenditure side of the public budget indicates on what the estimated revenues will be spent. The expenditures should, ideally, reflect the public policy priorities of the government.

In a public budget, public expenditures are classified in different ways, which represent how the public budget is organized or structured and how it is presented, recorded and reported in different budget documents.

## B5. Key budget classifications

**The classification and organization of a budget are central to preparation of sector budget proposals** *(64)*. Budget classifications serve to categorize public expenditure in the annual budget law and thereby structure the budget presentation. They provide a normative framework for policy development and accountability *(62)*. The main classifications and their applicability to health are summarized in Table 3.

**Table 3. Main types of budget classification and their application to health**

| Budget classification | |
|---|---|
| Economic | Classifies expenditure by economic categories (e.g. salaries, goods, services) To be consistent with the Government Finance Statistics Manual (GFSM)2001 economic classification *(53)*. Economic classifications are often associated with input based or line item budgets. |
| Administrative | Classifies expenditures by administrative entities (e.g. agencies, health facilities) responsible for budget management |
| Functional | Categorizes expenditures by sector (e.g. health, education) Within each sector, subfunctions of expenditures (e.g. outpatient services, public health services) are further divided into classes (e.g. outpatient services include general medical services, specialized medical services, dental services and paramedical services). Categories have been pre-defined internationally for the purposes of comparison *(53)*. |
| Programme | Classifies and groups expenditure by policy objective or outputs for the sector (e.g. maternal health, primary health care, quality of care) irrespective of their economic nature. Unlike other classifications this is meant to be country specific. Activity based classification e.g. provision of supplementary food has also been introduced in some countries prior or supplementary to larger budgetary programmes, as an effort to group expenditures into coherent policy actions *(54)*. |

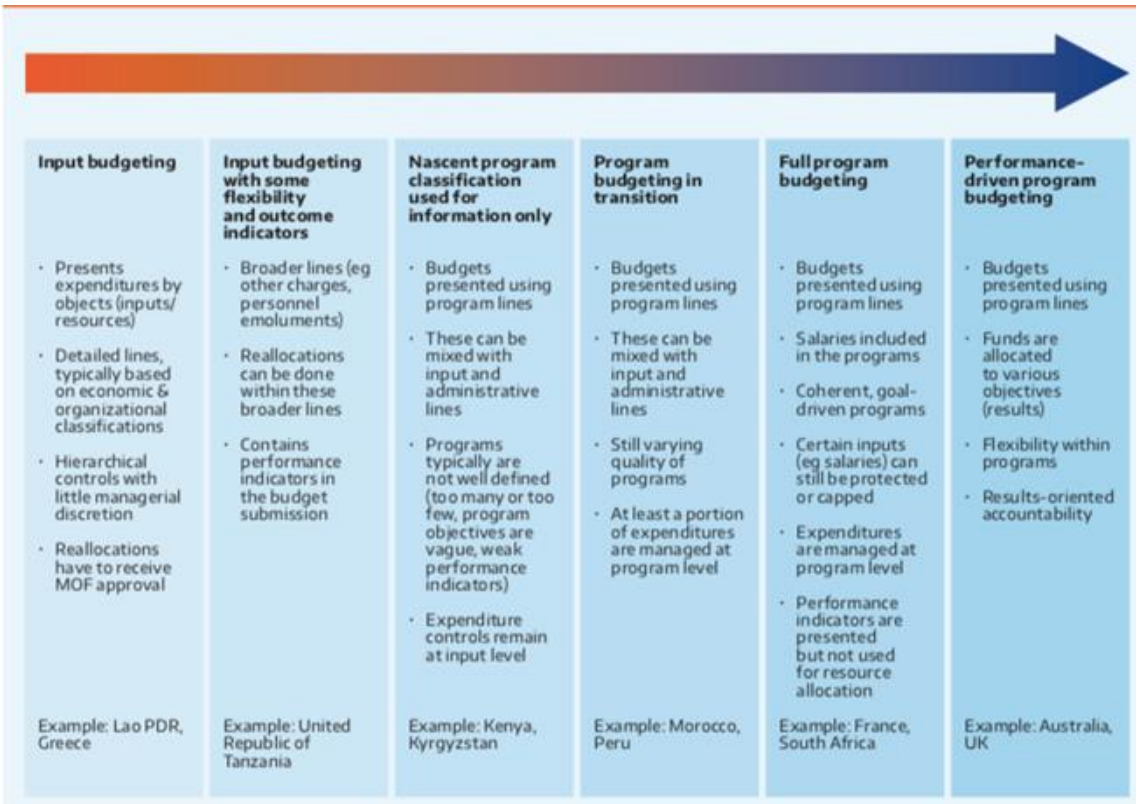
Source: adapted from reference *62*

The choice of budget classification is crucial for sectors because it pre-empts the underlying rules for budget implementation and plays a pivotal role in actual spending *(62)*.

The choice is an important connection between PFM and health financing. Often, improvements in health financing and health budget information must be coupled with reforms in the public finance system so that budget information is better organied, classified, structured and presented. This ensures that health spending is not only more efficient and responsive to health needs and diagnostics but also more accountable.

The trend is to a more detailed, tailored approach for the UHC budget that relies more heavily on programmatic classification. Nonetheless, this transition is not easy, and it is better to move gradually to a complete programme-based budgeting reform. Fig. 6 shows some examples from countries that are moving in this direction.

**Fig. 6. Input- and programme-based budgets: stylized examples for health**




Source: reference 62
Note: The examples are for national budgeting. Countries do not fall neatly into these categories, as one may be transitioning from one to another.

Most countries use an additional budget classification: “programmatic classification”. A programme has been defined *(65)* as “a set of activities that meets specific policy objectives of the government (e.g. pre-primary education or the development of crop production)”.

Classification by programme is different from functional classification, as it accounts for the government’s policy objectives and how the policies will be implemented *(65)*. Classification of expenditures by programme can serve two purposes:

- to identify and clarify the goals and objectives of government spending and

- to monitor operational performance with performance indicators, which may be related to the inputs, outputs or outcomes of a particular programme.

## Tool: WHO country mapping of health budget classifications

WHO mapping of countries' health budget classifications *(66)* provides an overview of those used to present recurrent health expenditure in more than 100 countries. Health budget information is organized so that users can identify those countries that are using administrative, economic, functional, programmatic and hybrid classifications. It is a useful reference for national stakeholders interested in understanding how health spending is presented to the legislature. Further updates are also available here.

## Activity: What budget classifications is my country using to organize health- and UHC-related expenditures?

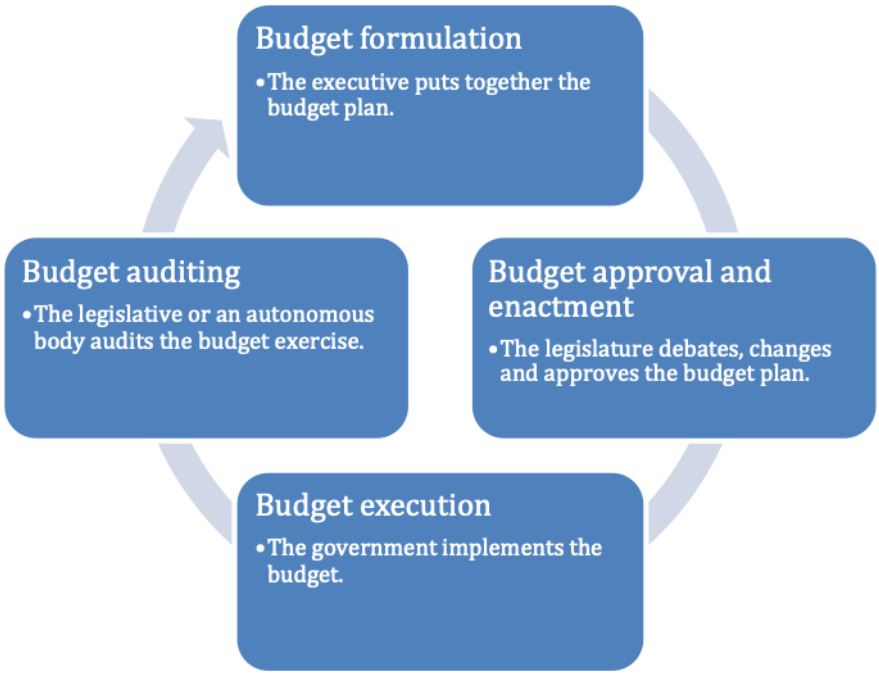
- Log on to WHO's country map of health budget classifications: https://www.who.int/health_financing/topics/budgeting-in-health/country-mapping/en/: What classifications do you find in this resource?
- Identify your country in the resource: What budget classifications is your country using for health?
- Is your country using multiple classifications? Which ones?
- Which classifications do you consider would be most useful for identifying the government's UHC-related interventions? Why?
- Place your cursor on one of the classifications in your country (without clicking). In some cases, the map will provide a short summary of the types of health-related programmes in this classification.
- What are some of the key interventions and programmes that your government is implementing according to this information?
- How are they connected to UHC?
- With just this simple tool, what can you conclude about your country's prioritization with regards to UHC? What can you conclude about the completeness of the budget information available?

# Section C. Introduction to the budget cycle and links with planning universal health coverage

## C1. What is the budget cycle, and what are its key stages and actors?

The budget is designed, implemented and audited in stages, commonly known as "the budget cycle", as shown in Fig. 7. The stages may be subdivided into steps according to the legal and institutional framework of each country; however, the cycle is used by most governments.

**Fig. 7. The budget cycle**




Source: reference *67*

In order to influence the budget, it is important to understand the budget cycle of a country, the responsible authorities and their functions to engage in policy dialogue and monitoring of the budget at various stages *(55, 64)*. In this toolkit, we use the "four-stake" budget cycle proposed by the IBP, as it is that which is more commonly used and referred to by the budget advocacy community of practice. This is not because it is the only budget cycle formulation, as there are other approaches.

During the **formulation** stage, the executive, through the ministry of finance, coordinates elaboration of the budget plan by requesting information from other line ministries. The ministry elaborates a draft budget after an analysis of the macroeconomic context, which includes government revenue, proposed budget ceilings and the priorities of all line ministries. This process may take several months, depending on the involvement of each ministry *(55, 64)*.

Once the budget is formulated, the executive presents the budget to parliament for approval. Depending on the powers conferred on the legislature in the constitution of the country, this branch can approve, modify or make substantial changes to the budget. During this stage, the legislature reviews, debates and amends the draft budget plan and enacts the final budget into law. This stage is known as **approval or enactment** *(55, 64)*.

Budget **execution** starts when the government spends financial resources according to the approved budget. During the fiscal year, the executive may modify the budget to meet unexpected situations. The extent to which the executive can change the budget should also be described in the legal framework *(55, 64)*.

In the last stage, **auditing**, an independent agency or body reviews execution of the budget to determine whether the resources were used effectively and efficiently. Auditing also addresses the performance of line ministries in executing the budget. Generally, an autonomous audit institution (supreme audit institution) is charged with this duty, or the legislature may undertake auditing process *(55, 64)*. The results of auditing represent a valuable input for designing the budget for the next year.

## C2. Main stakeholders in the budget cycle

Various stakeholders participate in the budget cycle, depending on their duties and interests. The same stakeholders may participate in different stages. Table 4 lists the main stakeholders and their roles in the four stages of the budget cycle.

**Table 4. Main stakeholders that intervene in the budget cycle**

| Stage | Stakeholder | Roles |
|---|---|---|
| Formulation | Ministry of finance | Determines the overall government budget and proposes resource allocations |
| | Line ministries, departments and agencies | Define sector or policy priorities and evaluate the cost of activities, goods and services |

| Stage | Stakeholder | Roles |
|---|---|---|
| | Other branches of government and autonomous institutions | Define sector or policy priorities and evaluate the cost of activities, goods and services |
| Enactment or approval | Legislature | Approves and amends the budget<br>Has the power to call line ministries to account or to explain policy decisions, allocations and expenses |
| | Line ministries, departments, agencies<br>Other branches of government and autonomous institutions | Account for or explain policy decisions, allocations and expenses if requested by the legislature |
| Execution | Line ministries, departments, agencies<br>Other branches of government and autonomous institutions | Execute and implement the approved budget<br>During execution and depending on the legal framework, line ministries could propose changes to the approved budget regarding its sector, which should be approved by the ministry of finance, the executive or the parliament. |
| | Ministry of finance | Monitors and reports budget execution<br>Approves changes to the approved budget according to its legal powers |
| Auditing | Supreme audit institutions | Review, monitor and evaluate budget execution.<br>Review, monitor and evaluate ministries' performance in budget execution<br>Report on the results of the evaluation |
| All stages | Citizens<br>Civil society organizations<br>Media | Monitor and conduct independent evaluations and assessments of budget formulation, approval, execution and auditing<br>Influence relevant stakeholders during the budget cycle to change policy priorities, allocations and expenses |

Sources: references *36*, *55* and *67*

## Activity: Building the budget cycle for your country

Log on to your country's Ministry of Finance website.

- Search for a link or document that provides information on the budget cycle.
- With the content presented on the general budget cycle, identify the stages of the budget cycle in your country.
  - How many stages does it have?
  - When does it start and when does it end?
  - What are the names of the key actors?

### C3. The budget cycle and its stages and stakeholders for UHC

Key stakeholders in several stages of the budget cycle are line ministries such as the ministry of health. To effectively influence UHC-oriented budget decisions at different times in the budget process, it is important to understand when and how the ministry of health intervenes. Chapter 8 in the WHO handbook Strategizing national health in the 21st century *(34)* provides an overview of the budget process and the key roles of the ministry of health. The handbook identifies two stages of the budget cycle at which the ministry of health intervenes – formulation and execution – and the purposes. During formulation, the ministry of health can advocate for UHC budget priorities by

> Analysis of expenditure forecasts against expected revenues … aiming to estimate the potential for increased health spending…. Drafting of credible, well-defined health budget proposals; systematizing costing and priority-setting exercises within the defined envelope…. Engaging in budget negotiations and advocating for sound health budget allocations.

The ministry of health must engage in many negotiations with the ministry of finance in order to arrive at a health budget proposal. The ministry of health must base its requests on the budget ceiling established by the ministry of finance, the health policies established by the government and a situational analysis of priorities.

During execution, the policies established in the national health plans and their budgets are implemented. The role of the ministry of health at this stage of the cycle is implementation of the health budget. Its roles include supervision, support and oversight. For WHO, this stage is pivotal and one in which strengthening of ministries of health is crucial, as those in charge of these tasks "require understanding of Public Finance Management systems and, in particular public expenditure rules and regulations" *(34)*.

## Tool: Handbook on strategizing health in the 21st century to identify the role of the ministry of health in the budget cycle

Chapter 8 of the handbook *(34)* addresses budgeting for health and provides ample information on the budgeting process for the sector, including the budget cycle and the role of the ministry of health. For this toolkit, chapter 8 of the handbook should be used to illustrate the link between the overall budget cycle and the health budget cycle.

## Activity: Identifying the role of the ministry of health in the budget cycle

Look at sections 8.4 and 8.5 in Chapter 8 of WHO's Strategizing health in the 21st century *(34)*.

- From this information, identify they key roles and functions of ministries of health in the budget cycle.
- At which stage do you think its role is more important? Why?
- At which stage of the cycle do you think it most strategic to seek to influence or collaborate with the ministry of health in order to advocate for UHC? Why?
- From this information, what type of input do you think you could have to the ministry of health in order to advocate for UHC?
- What does this information teach you in terms of the budget cycle in general and its connections with UHC?

# Section D. Budget information: budget documents relevant for budget advocacy and useful resources for locating budget information related to universal health coverage

## D1. Key budget documents and their content

A capacity to be developed for budget analysis or for influencing the budget is finding, reading and using budget documents. Governments publish some basic budget documents that are reviewed in this section. First, we should learn to identify the key budget documents produced during the budget cycle. Table 5 lists the most relevant documents, their main content and by which body they are produced.

**Table 5. Relevant budget documents by stage of the budget cycle, content and emitter**

| Stage of the budget cycle | Relevant document | Content | Emitter |
|---|---|---|---|
| Formulation | Pre-budget statement | Discloses the parameters of fiscal policies before the executive's budget proposal<br>Outlines the government's economic forecast and expected revenue, expenditure and debt | Ministry of finance |
| | Executive's budget proposal | Lists the sources of revenue, allocations to ministries, proposed policy changes and other information about the country's fiscal situation.<br>Submitted by the executive to the legislature for approval | Ministry of finance |
| Enactment | Enacted budget | Budget approved by the legislature | Legislature |
| Execution | In-year reports | Include information on actual revenues collected, actual expenditures made and debt incurred; may be quarterly or monthly | Ministry of finance |
| | Mid-year review | Contains a comprehensive update on implementation of the budget at the middle of the fiscal year, including a review of economic assumptions and an | Ministry of finance |

| Stage of the budget cycle | Relevant document | Content | Emitter |
|---|---|---|---|
| | | updated forecast of budget outcomes | |
| | Year-end report | The government's accounts at the end of the fiscal year and, ideally, an evaluation of progress made toward achieving the budget's policy goals<br>Submitted to the auditing institutions for review | Ministry of finance |
| Auditing | Audit report | Examines the soundness and completeness of the government's year-end accounts. | Supreme audit institutions |
| All stages | Citizen's budget | Simplified, less technical version of the government's executive budget proposal, the enacted budget and any other budget document, to convey key information to the public | Ministry of finance<br>Legislature<br>Supreme audit institutions |

Source: Adapted from reference *68*

## D2. Where to find budget documents

According to international best practice in terms of budget transparency and access to information, all countries should produce and publish the eight key budget documents listed in Table 5 *(69)*.

Governments can make budget documents available to the public in at least three ways:

- by publishing them on the portals of the ministries of finance and or those of line ministries;
- if this is not possible, by making them physically available on request to citizens and other stakeholders; and
- in response to requests for **ACCESS TO INFORMATION** from various **STAKEHOLDERS** through legislation on freedom of information.

Section E of this module provides information on budgetary transparency and access to information, including tools that may be useful for budget advocates in accessing budget information. International institutions interested in good governance and good PFM provide compilations of budget documents from around the world. Two tools that are

useful in countries in which budget information is not readily accessible are the World Bank's Open budget portal *(70)* and the WHO Repository of health budgets *(71)* (Box 6).

**Box 6. Tools for accessing national budget information**

**World Bank Open budget portal** *(70)*

**What is it?**

The BOOST portal is an open online compilation of budget documents from national and subnational entities in developing countries that have made important advances in budget transparency.

**What does it contain?**

- Exhaustive information on expenditure
- Links to countries' budget data portals for more information

**WHO's Repository of health budgets** *(71)*

**What is it?**

The repository consolidates open-source information on finance laws and related documents applicable to the health sector from more than 100 countries for researchers and policy-makers interested in analysing and monitoring health budgets.

**What does it contain?**

- Finance laws
- Other documents relevant to the health sector.

## Activity: Finding and exploring budget documents in your country

***Purpose:*** Learn where to find budget documents in your country. Explore the websites of the ministry of finance, ministry of the budget or any other ministry that is responsible for producing budget information in your country.

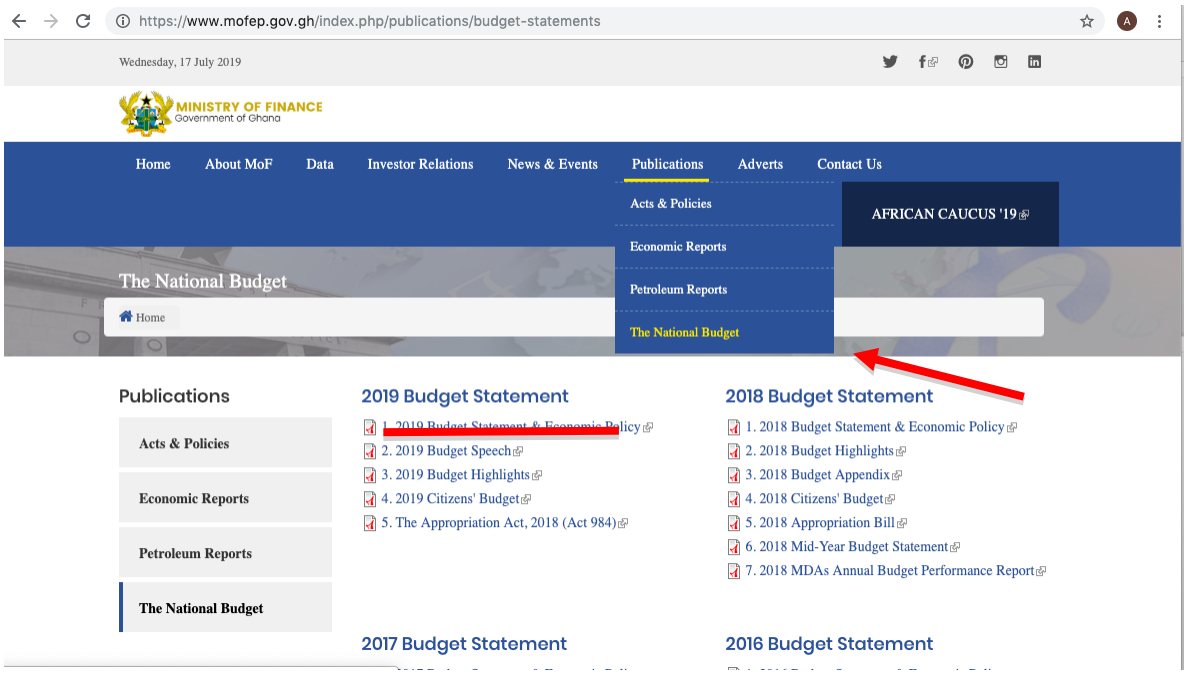
Step 1: Enter the website of the ministry.

Step 2: Search for the eight key budget documents.

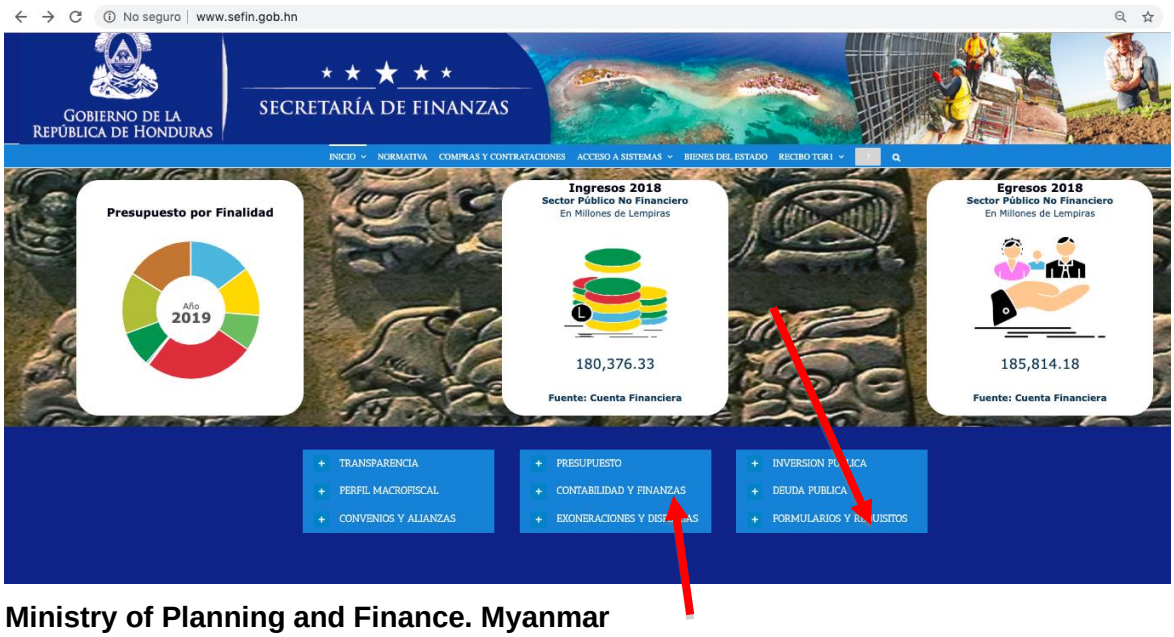
Fig. 8. Gives examples of ministry of finance websites in three countries.

**Fig. 8. Websites of the ministries of finance in Ghana, Honduras and Myanmar**

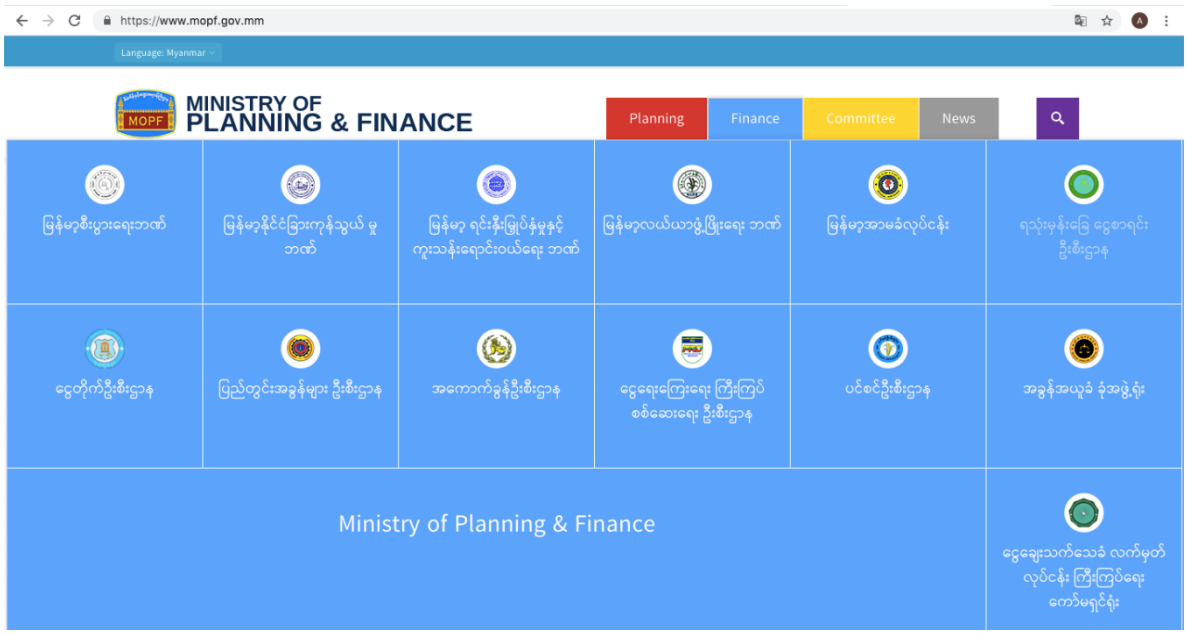
**Ministry of Finance. Ghana**



## Secretaría de Finanzas. Honduras




## Ministry of Planning and Finance. Myanmar



## Activity: Finding budget documents in your country

Individual task and plenary

*Instructions:*

- Enter the website of the Ministry of Finance
- Search for budget documents.
- Explore one or two budget documents.
- Once you are familiar with the documents, answer the following questions, and share your answers with the group.

*Questions:*

1. Does your country publish key budget documents? How many?
2. Are these documents easy to find?
3. Do these documents include information on the health budget? Note that the availability of national budget documents does not mean that you will find sufficient information to analyse the budget for UHC. Often, limited information is available on the breakdown of ministry budgets, especially if some activities are funded by off-budget mechanisms, such as a health insurance or social security fund. There is an important difference between a national budget and a detailed ministry or section budget, and the latter might not be publicly available at all times and in all countries.
4. What is your recommendation for improving budget transparency in your country?
5. Do these results surprise you?

### D3. Budget information relevant for UHC and where to find it

The health budget is part of the overall public budget. Information on the health budget, including that relevant for UHC, can be found in different places in the public budget depending on the country. For example, the budget of the ministry of health is usually provided separately, in the budgets of other line ministries that implement policies for advancing health outcomes or programmes related to health or in annexes to yearly budgets for specific programmes or policy priorities, organized according to, for example, thematic issues. The primary source for identifying UHC-related budget information should therefore be the eight budget documents produced by each country.

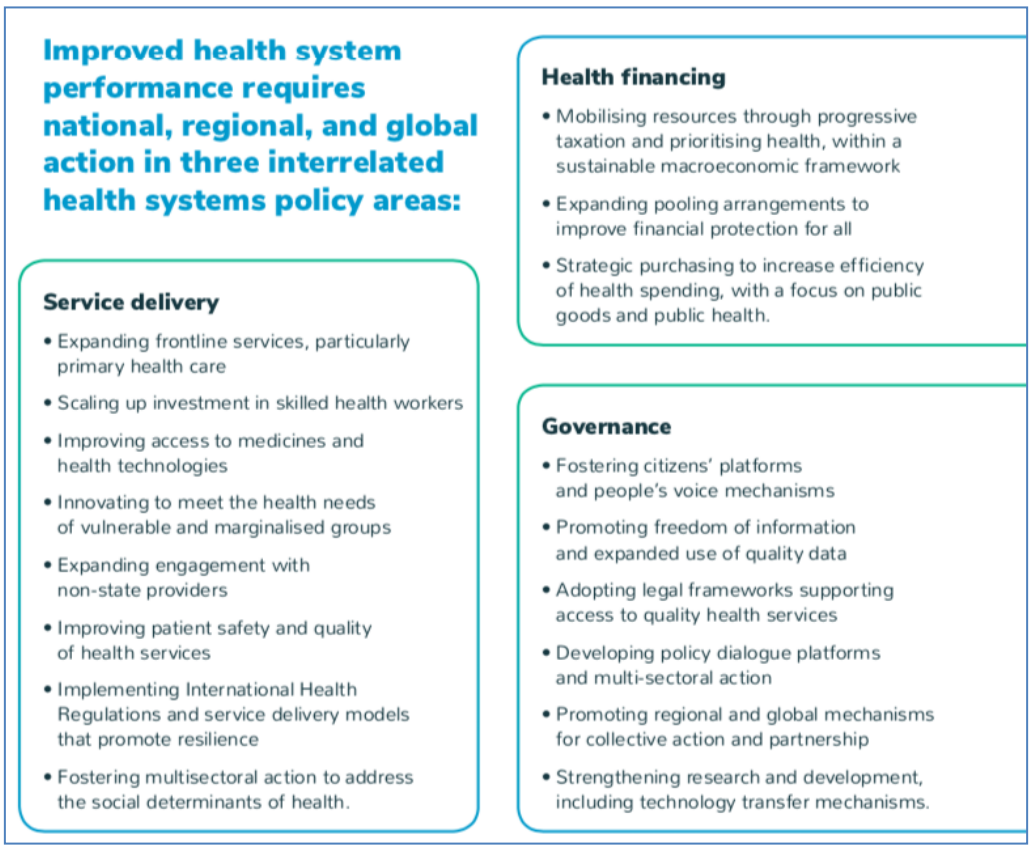
As it is difficult in some countries to access public budget information, budget advocates must find alternative sources. WHO produces useful resources for advocates to locate budget information pertaining to UHC, such as the repository of health budgets *(71)* (see Box 6, above).

# Section E. Transparency, access to information and citizen participation as key elements of budget advocacy and budget accountability

## E1. Why are transparency, access to information and citizen participation relevant in the context of UHC?

The UHC2030 joint vision *(4)* argues that transparency, access to information and participation are crucial for achieving UHC. For UHC2030, improved health systems are the basis for achieving UHC, and actions are necessary in three policy areas: service delivery, health financing and governance (Fig. 9).

**Fig. 9. Improved health system performance requires national, regional and global action in three interrelated health systems policy areas**



Source: reference *4*

In terms of governance, citizen participation and use of information, including budget information, should be promoted. In this joint vision *(4)*,

> Governance is concerned with the processes and institutions for collective decision-making. Governance arrangements determine key institutional attributes such as transparency, accountability, participation, integrity and capacity and therefore have far-reaching consequences for system performance.

Those interested in budget advocacy for UHC should therefore be familiarized with best practices in budget transparency, access to information and citizen participation. The subsections below provide input from the international promoters of these aspects of governance, which, although they refer to more general accountability, are equally important for UHC.

## E2. Tools for understanding and measuring budget transparency around the world

The most widely recognized international source of information on budget transparency is the Open Budget Index, issued every 2 years by the IBP since 2006. The survey provides a comparison of the three aspects of budget accountability: transparency, oversight and public participation. The Index is based on a survey, from which the IBP assigns a transparency score on a 100-point scale from answers to a subset of questions on the amount and timeliness of budget information made available by governments in eight budget documents, in accordance with international good practice standards. In the 2017 edition, 115 countries were assessed.

The Index is useful for:

- understanding key concepts and best practices for public budget transparency;
- identifying advances and challenges in budget transparency around the world;
- identifying the scores of individual countries for budget transparency and, therefore, the extent to which a government produces and publishes budget information and its completeness;
- identifying the extent to which parliaments and supreme audit institutions participate (and how effectively) in the budget process; and
- the extent to which citizens can engage with budget stakeholders

## Tool: The Open Budget Index

***Purpose of the tool:*** Learn about budget transparency, oversight institutions and opportunities for public participation from a comparative perspective.

***How to use the tool:*** A comprehensive website shows the general results of the Survey. The information includes general results, results by country and results in all the previous edition of the survey.

## Activity: Learning about budget transparency oversight institutions and public participation in your country

Individual task and plenary

*Instructions*

- Enter the Open Budget Survey website: https://www.internationalbudget.org/open-budget-survey/.
- Enter "Results by country".
- Scroll down and select your country (if your country is not included in the survey, choose any other country that interests you).
- Read the "Country summary" document.
- Once you have read the document, answer the following questions and share your answers with the group.

*Questions*

1. What was your country's score for transparency, and how does it compare with those of other countries in your region?
2. How many of the eight budget documents does your country produce?
3. Has budget transparency improved in your country over time?
4. Which document do you think is more likely to contain information about the health budget? Why?
5. What are the main recommendations for your country on budget oversight and public participation?
6. Do these results surprise you?

## E3. Freedom of information around the world

Budget information is thus an essential element for analysing funding for UHC. The information might include:

- government priorities in health;
- how the priorities are being addressed;
- sources of funding for health;
- allocations for health;
- populations targeted for health policies;
- execution of the health budget; and
- health outcomes and other inputs for monitoring health expenditure over time.

In the previous section, we reviewed some tools for consulting the most important budget documents. The information contained in those documents might not, however, be sufficient for analysing advances towards UHC, and some governments simply do not publish information on performance towards UHC. More detailed information is therefore necessary to make a good analysis.

Some countries have legislation on access to information that allows their citizens to request information. Some, like Mexico, have online platforms on which people can ask for and receive information directly on their computers.

Legislated access to information is an important tool for obtaining relevant information from governments, including UHC-related documents. Another important source is donors' websites and other international resources on health, which might be important in other countries. Adherence to the laws for access to information may, however, may be time-consuming, and such research may also be expensive, as some countries charge for copies of certain documents.

## Tool: Freedom of information legislation

***Purpose of the tool:*** To learn about legislation on freedom of information around the world

***How to use the tool:***

- http://freedominfo.org/describes best practices, consolidates lessons learnt, explains campaign strategies and tactics and links the work of advocates of freedom of information around the world. It contains crucial information on such laws, how they were drafted and implemented and how the provisions have worked in practice.
- **Right to information rating.** The rating is a measure of the strength of legal frameworks for the right to access information held by public authorities, in seven

categories: 1) right of access, 2) scope, 3) requesting procedure, 4) exceptions and refusals, 5) appeals, 6) sanctions and 7) protections and promotional measures.

Step 1: Enter the freedom info website at http://www.freedominfo.org/about-us/

Step 2: Explore “Country info”

## Activity: Learning about freedom of information advocates in your country

Individual task

*Instructions:*

- Enter the website http://www.freedominfo.org/
- Enter “Country info”
- Scroll down and select your country.
- Learn about freedom of information legislation in your country.
- Enter the right-to-information ranking website at https://www.rti-rating.org/
- Enter “Country data”
- Scroll down and select your country.
- Learn about freedom of information legislation in your country.

Once you are familiar with both websites, answer the following questions, and share your answers with the group.

*Questions:*

1. Does your country have legislation on access to information?
2. In comparison with other countries, how strong is the legal framework for accessing information?
3. Do these results surprise you?
4. How do you think you might use access to information to get information on UHC?

# Section F. Budget analysis as a tool for budget advocacy for universal health coverage

## F1. Why analyse the public budget?

No matter what type of stakeholder you are, if you are interested in advocating for improvements or advancements in any issue or sector that depends on public decision-making, it is important to undertake budget analysis, for several reasons, including the following.

- The budget contains the answers to the key questions we have about the overall economy, how our government manages our money and particularly in specific sectors, such as health, that we care about.
- It can provide us with important evidence to make our case to government and key stakeholders.
- It is useful for monitoring, in concrete terms, whether a government is or is not advancing towards a given end, such as UHC.

To implement public policies, the government must allocate financial resources to them, which must be sufficient to respond to needs and trends. Nonetheless, allocation of sufficient resources to key elements of UHC is a necessary but not a sufficient condition for the public budget to be a useful instrument for advancement in this direction. Public funds must be spent efficiently, effectively and in a timely fashion.

## F2. Basic budget analysis

Basic budget analysis, like that proposed in this toolkit, can include:

- **budget allocations:** analysis of trends in public spending to understand how much money the government allocates for different policy priorities and to different levels of government;
- **resource flow:** analysis of how public money flows from central to local level (depending on the country's system); and
- **budget execution:** analysis of how much of the allocated funds are spent and whether they are spent effectively and efficiently.

The budget can also be analysed to determine whether the government is advancing in:

- **human rights:** analysis of whether the public budget advances human rights through
  - use of maximum available resources,
  - progressive realization and
  - non-discrimination;

- **gender:** analysis of whether the public budget advances gender equality (gender-responsive budgeting or gender-sensitive budgets);
- **transparency and participation:** analysis of whether the system produces and provides budget information to the public and makes spaces for the public to participate in decision-making; and
- **age-disaggregated data** *(73, 74)*.

Although not all budget advocates engage deeply in budget analysis, successful budget advocacy should include some evidence derived from monitoring the budget, as this evidence will constitute a key element and argument for advancing budget advocacy agendas.

## F3. Common problems in the use of public resources that can be identified by budget analysis:[9]

When analysing budgets, budget advocates usually begin with a set of hypotheses or assumptions about the use of public funds, which can be proven or unproven by budget analysis.

- **Wastage:** a programme or department does not produce the best or the most outputs with the money it has at its disposal.
- **Under-spending:** a programme, department or state is not spending the funds allocated to it, which may be due to poor capacity to deliver or other reasons.
- **Under-funding:** a programme, department or state has been allocated too little money. This can be analysed in relation to:
  - other times;
  - other programmes, departments or states;
  - the need to be met;
  - the responsibilities imposed, e.g. by law;
  - some international benchmark or standard; or
  - what is possible with the available resources.

By analysing the common budget issues described above, stakeholders interested in using budget analysis and advocacy to measure whether a country is advancing towards UHC can formulate various hypotheses that can be proven by applied budget analysis.

[9] This information is derived from training materials developed by the IBP in 2013–2014 for a group of budget advocates in Ghana as part of its Partnership Initiative.

## F4. Budget analysis relevant for budget advocacy for UHC

Choosing what to monitor and analyse in a public health budget may become daunting and confusing, and those who begin may get lost. One recommendation from budget advocates around the world is to know what to look for before analysing a budget.

This toolkit suggests that stakeholders, particularly those for whom this type of work is new or relatively new, begin with simple questions that the budget may help resolve and then move to more elaborate or detailed budget analysis. Some ideas about where to begin a budget analysis relevant for measuring advancement towards UHC are given below.

### Agreed budget spending benchmarks for UHC

One place to start might be commitments to spending benchmarks set to achieve UHC and/or international health. Some international benchmarks for public health spending that might be useful for UHC are:

- government to spend 5% of GDP on health and US$ 86 per capita *(75)*;
- maximum threshold for out-of-pocket spending, 20% of total health expenditure *(76)*;
- governments to allocate 15% of their total budget to health *(77)*; and
- (the most recent WHO-recommended target) an additional 1% of GDP or more for primary health care *(78, 79).*

An example of this kind of work is that of Save the Children *(80)*.[10] In 2015, as the world began to transition from the Millennium Development Goals to the SDGs, which include a commitment to achieve UHC, Save the Children determined how much developing countries would have to spend by 2030 in order to advance towards UHC on the basis of an analysis on international estimates of public health spending for UHC. With basic calculations (Tool 6), UHC budget advocates could begin by asking the following questions about their country's public budget:

- What is the share of the health budget with respect to overall spending?
- What is per capita (per person) health spending? How close or far is it from the benchmark?
- What is the share of total revenues raised through taxes? (This can help understand whether the country is advancing towards the UHC-related goal of increasing public financing for health.)

Monitoring budget allocations and revenue sources in relation to agreed international benchmarks can provide useful information about whether a government is moving towards UHC.

[10] This reference is to be used only as an example of how to use benchmarks and not as actual current information. It is an example of the type of analysis, and the numbers may be outdated.

## Analysing the revenue side of the budget to identify sources of public health financing

One means to achieve UHC is to ensure that health spending is primarily from public resources. To measure the extent to which a country is moving in this direction, the following analysis could be conducted.

1. What is the total amount of estimated revenue for the fiscal year?
2. What are the key sources of revenue from which the government will draw resources?
3. How much of these resources are internal (see revenue section above)?
4. How much of the total internal resources come from direct and indirect taxes?
5. How much is the public debt?
6. How much resources are derived from public resources?
7. How much revenue is derived from development assistance for health?
8. Which main international partners provide resources for health?
9. What are the proportions of domestic public resources for health and international resources for health?

## Identifying allocations and spending relevant for the UHC objective

Another means of analysing the public budget in relation to UHC is to monitor revenue raising pooling, allocation and expenditure in the context of UHC..

Tool. The WHO Health financing progress matrix As already mentioned (see Module 2, section A, reference *47*), the WHO health financing progress matrix, launched in 2020, allows comparison of country health financing systems with a set of evidence-based benchmarks, framed as 19 desirable attributes. Each attribute represents a critical element of a health financing system and indicates the direction in which institutions, policy and implementation should develop to make progress towards UHC. Complementing quantitative measures of UHC performance such as financial protection and the health expenditure estimates in the Global Health Expenditure Database *(48)*, the health financing progress matrix allows assessment of shifts in policy development and implementation. Use of the matrix provides a common point of reference for multiple stakeholders, to focus scarce resources on priority actions and interventions and to track progress transparently over time.

## Tool: Basic budget calculations to identify common problems in the use of public resources[11]

**Purpose of the tool:** Basic budget calculations are an entry to applied budget analysis for budget advocates. The calculations can be used to test hypotheses of wastage, under-spending and under-funding and for identifying allocations and execution (at a basic level) of public budgets.

**How to use the tool**: This tool should first be used by facilitators as an introduction to budget analysis before asking participants to analyse data related to UHC. It is suggested that a full session be dedicated to this content with participants, as suggested below.

**Content of the tool:** Basic budget calculations that are not too technical and can be applied to basic budget data include: shares, averages, inflation, growth and per unit

*Share*

- A share is a part of one number represented by another; usually expressed as a percentage.
- Do not confuse with ratio, which is a way of comparing two numbers, such as the ratio of teachers to students of 1:25.
- Calculation of shares helps to analyse the overall composition of a government or subnational budget, such as the share of a total budget health budget that is allocated to reproductive rights or the share of a government budgeting in one sector as compared with another.

*Average*

- Important for understanding trends, i.e. over time or regions:
  - How much will the government spend this year in comparison with how much it spent in the past few years?
  - On average, how much did other governments spend on health in the past few years?
- Useful in exceptional years, e.g.
  - The government spent 10% of the budget on health in 2011, 11% in 2012, 10% in 2013, 5% in 2014 and 11% in 2015.

[11] The information in this section is from training materials developed by the IBP, including the health and budgets workshop and the training workshop for budget advocates in Ghana. It is also based on adaptations by COMETA of these materials for training.

- Although the trend changed abruptly in 2014 for an exceptional reason, you might want to know what the government spends on health on average.

*Inflation*

- In very simple terms, inflation is a general rise in the prices of goods and services in the economy over time.
- The value of money changes.
- Inflation erodes the earnings of families but also the buying power of governments.
- To determine the impact of inflation, which would show the "real" increase in government spending over specific periods, you must adjust for inflation.

The consumer price index is necessary to adjust for inflation. Budget documents show budget data that are not yet adjusted for inflation. Adjustment for inflation reveals the "real value for money" or what the resources can actually purchase. For example, sometimes when inflation is adjusted for, the budget is seen not have increased over time.

- Inflation changes the value of money over time.
- By adjusting for inflation, we equalize the budget values to one year, and we can compare changes in the budget over time.

For a simple introduction to inflation, see the following video produced by IBP: A citizen's guide to understanding and using inflation for budget analysis: https://youtu.be/r_ikGjR5pzE?list=PLQ1WGH8_cXF_qAuKAyD3FdXl1sRl0v7Bm.

*Growth*

The tool for comparing budget changes over time is **percentage growth**. The calculation is particularly relevant for measuring progressiveness in the budget. It tells us wither a budget has increased or decreased in percentage terms over time.

*Unit cost*

- Calculating unit costs indicates whether spending is efficient and fair.
- It may be difficult to determine unit costs, as, in some instances, it is difficult to define the "delivery unit" or a particular programme or sub-programme that is responsible for the provision of an output or service, as a service or delivery unit may be the result of work by many programmes.
- Depending on the service or output on which you are gathering evidence, you will arrive at the best possible indication of unit cost with the information available.
- The results may have several possible explanations. For example, if the government is spending twice as much on some students or patients than on others, this may be because, for example:

- It is wasteful.
- The two groups are different, and one needs more.
- The two groups are different, and one is more politically influential.

The same logic applies to calculation of per capita budget expenditure. The only difference will be that a population number is required, such as the per capita budget executed for the **public health care** programme in any given year.

## Tool: 20 key questions about your country budget, IBP Kenya

The Kenya office of the IBP has been building the skills of country budget advocates in understanding the country budget and conducting sound budget analysis at both national and subnational levels since 2014. In 2015, they developed a tool, "20 key questions about your country budget" for budget analysts and advocates to develop a roadmap for budget analysis *(81)*.

**Purpose of the tool:** The tool provides examples of the types of questions that budget advocates can ask about the budget and that can be answered by budget analysis.

## Activity: Adapting the 20 questions to UHC

- Participants will be handed a physical or virtual copy of the 20 questions produced by IBP Kenya.
- The participants will be divided into groups such as by country.
- They will review the tool and identify 5-10 questions that they consider particularly relevant for UHC-related budget analysis.
- In the group, they will propose how the 5-10 questions could be adapted to UHC-related questions
- The proposed questions will be shared in plenary, which will choose 5 to investigate during the workshop and/or as a homework after the workshop.

# Chapter 3. Content for civil society organizations, the media and parliaments

## Module 1. The role of civil society

Module content:

- basic concepts of civil society budget advocacy from international experience;
- relevance and contribution of civil society health budget advocacy to UHC;
- importance of strategic thinking and strategic objectives for effective budget advocacy for UHC;
- examples of successful health budget advocacy relevant for UHC;
- tools and practical exercises for prospective UHC budget advocates to conceptualize national UHC budget advocacy.

## Section A. General introduction and overview of civil society budget advocacy

### A1. What is advocacy?

Advocacy is a concept and practice that is familiar to all CSOs, as it is at the heart of what they do. But there are as many definitions of advocacy as there are CSOs, as it may mean something slightly different for each of them according to their context, the people who compose them and what they seek to achieve.

To ensure clarity, particularly for those for whom the concept and practice of advocacy are new, this toolkit adopts the systematized definitions of the International Planned Parenthood Federation (IPPF) Western Hemisphere Region in their Handbook for advocacy planning *(82)* (Box 7).

**Box 7. Definitions of advocacy from civil society actors from around the world**

"Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision makers toward a solution. Advocacy is working with other people and organizations to make a difference. "
CEDPA: Cairo, Beijing and Beyond: A Handbook on Advocacy for Women Leaders.

"Advocacy is a process that involves a series of political actions conducted by organized citizens in order to transform power relations. The purpose of advocacy is to achieve specific changes that benefit the population involved in this process. These changes can take place in the public or private sector. Effective advocacy is conducted according to a strategic plan and within a reasonable time frame."
*Fundación Arias (Arias Foundation)*

"Advocacy refers to the planned process of organized citizens to influence public policy and programs."
*Corporación PARTICIPA 2003*

"Advocacy is defined as the promotion of a cause or the influencing of policy, funding streams or other politically determined activity."
*Advocates for Youth: Advocacy 101*

"Advocacy is a set of targeted actions addressed to decision makers in support of a specific political cause."
*Policy Project, 1999*

"Advocacy is the deliberate process of influencing political decision makers."
*Cooperative for Assistance and Relief Everywhere (CARE), 1999*

"Advocacy is a set of political actions implemented according to a strategic plan and aiming to focus the attention of the community on a specific problem and guide decision makers toward a solution."
*International Planned Parenthood Federation – Western Hemisphere Region*

These definitions infer that advocacy entails, in simple terms, the actions of a group (almost always citizens or organizations) to influence a decision-maker, policy-maker or power broker to do something different for the benefit of a particular community or public issue. In the same handbook, the IPPF suggests that advocacy – as opposed to strategies such as public education, public relations, community mobilization, lobbying and fundraising – entails: targeting a decision-maker and having a political or policy change as a goal *(82)*.

Facilitators can also use the definitions that they or their civil society partners use to define or refer to advocacy. The aim is that participants understand that advocacy is asking someone in power to make or change a decision related to the issue or problem that their organization addresses.

## Activity: Initial advocacy definition map: Identifying participants' definitions and concepts of advocacy

1. Each participant receives a card of the same colour, which will have no particular meaning for this activity.
2. Referring to the IPPF definitions, each participant will consider how their organization defines advocacy. The facilitator will ask: what is your organization's (not your) definition of advocacy?
3. Once each participant has written his or her definition, the group will be divided into three or four people, who will share their definitions.
4. The facilitator will then ask them to identify what their definitions have in common (for example, they all mention policy change or citizens) and to write them on a card of another colour.
5. Each group will stick the card with "common definitions" on the wall.
6. In plenary, the facilitator will ask two participants to find the three to five common elements or concepts in all the definitions.
7. The group will have a shared vision of advocacy from which to begin understanding budget advocacy.

### A2. What is budget advocacy? Who does it and why?

For at least 20 years, a number of citizen groups and CSO have expressed concern about the way in which governments decide and use public resources. A global community of practice of civil society budget work has developed and evolved, and their research, analysis and advocacy strategies have become more and more sophisticated. Today, well over 200 CSOs direct the vast majority of their work to budget advocacy on a wide array of issues, using different methods, tactics and approaches. Civil society groups that focus more on sectors or issues (such as health, education, human rights, gender equality, poverty) have also adopted budget analysis and budget advocacy as components of their work.

The key reference for civil society budget advocacy around the world is the IBP, which advocates for budget transparency and accountability at global level and supports a variety of civil society groups engaged in budget-related research and advocacy, including work on budget transparency. As one of the key references for this work, their definitions of budget advocacy are useful.

> Applied analysis is undertaken with the explicit intention of advancing policy goals, such as assisting the most disadvantaged in society. It is not simply research for the sake of research. While applied budget work demands

quality analysis, it also requires that its findings be presented in a way that maximizes its impact on the policy debate *(83)*.

The logic of budget advocacy work is to use information and persuasion in order to ensure that needed services and interventions are delivered by those who are meant to deliver them. The impact that civil society groups are trying to achieve with budget advocacy therefore almost always involves a causal chain of events. By influencing the decision-making sequence and the process of public service delivery, budget advocacy groups generally aim to trigger impact via the existing infrastructure and/or delivery mechanisms of the public sector. They try to make the system operate more optimally for the people it is meant to serve *(84)* (2015).

When CSOs can combine an in-depth knowledge of a policy issue, such as health or education, with a solid knowledge of budgets and an effective advocacy strategy they can positively influence policy decisions. Strengthening civil society's ability to analyze budgets and participate effectively can play an integral role not only in policies and service delivery but also in constructing a more open and participatory democratic society *(85)* (2019).

These definitions indicate a key element of budget advocacy: it necessarily entails some budget analysis, as it is the results of analysis that provide the evidence on which to base solid arguments for change or impacts of the budget. Chapter 2 of this toolkit provides content and tools to understand and begin to undertake simple budget analysis relevant for UHC. For the purposes of CSO budget advocacy, it is important to understand what types of organizations engage in budget advocacy and their motivation. These include the following.

- **Civil society budget organizations**, concerned primarily with budgets, budget systems and budget accountability in general. They advocate for opening of budget information, increasing citizen participation in decisions about the budget and better accountability for overall use of public resources.
    - The International Budget Partnership (IBP)
    - Fundar, Centre for Analysis and Research, Mexico
    - Centre on Budget and Governance Accountability, India
- **Sector- or issue-specific CSOs**, concerned with social development, such as health, education, water and sanitation and gender equality. They are not commonly recognized as budget organizations, but they undertake budget analysis and advocacy to achieve policy changes in these sectors. Extensive budget advocacy has developed in the health sector, much of it linked to the Millennium Development Goals and the SDGs.
    - Population Action International
    - Save the Children
    - Haki Elimu, United Republic of Tanzania

- Groupe de Recherche en Economie Appliqué et Théorique, Mali

- **Human rights organizations** (and organizations with a human rights approach) promote, protect and advance human rights, such as economic, social and cultural rights and civil and political rights. They use budget analysis and budget advocacy to advance these rights or to measure the extent to which a government is advancing towards them. A body of work has emerged in civil society linking human rights and budgets; see for instance Article 2 of the International Covenant on Economic, Social and Cultural Rights and government budgets *(86)*.
  - Instituto de Estudos Socio-Economicos, Brazil
  - Muslims for Human Rights, Kenya
- **Community organizations** are usually subnational or local groups comprising members of the community. Their concerns commonly include the provision of basic goods and services such as housing, schools, clinics, medicines and basic water and sanitation. They engage in advocacy and citizen mobilization and have recently begun to use simple budget analysis to further their demands.
  - Omar Asghar Khan Development Foundation, Pakistan
  - Mazdoor Kisan Shakti Sangathan, Samaan Samarthan and Supporting Association for Thematic and Holistic Initiatives, India
  - Concerned Citizens of Abra for Good Government, Philippines
- **Social movements and coalitions** are CSOs that include broader movements on issues or more formal national or international coalitions campaigning for a cause. They also engage in budget advocacy, with both movements to foster greater budget transparency and accountability and those for specific issues or themes, the latter advocating for better use of resources for global concerns such as UHC and other health-related issues.
  - Global Fund Advocates Network (GFAN)
  - African Health Budget Network
  - People's Health Movement
  - Treatment Action Campaign, South Africa
  - Uganda Debt Network, Uganda
  - Red de Justicia Fiscal de América Latina y el Caribe

## Activity: Ecosystem of civil society budget advocacy in your country

1. After the overview of types of budget groups, ask participants to log on to IBP's website, www.internationalbudget.org, go to "Budget work by country" and then to "Country directory" to find their country
2. Ask them to identify the civil society groups listed by the IBP and to answer the following questions:

- Do you know any of these groups and/or have you collaborated with them?
- Do you know any other health groups in your country working in budget advocacy?
- What type of work are they doing?
- Do you collaborate with them?
- Does this indicate that the ecosystem of budget advocacy work in your country is vast, or is it limited?
- What would your organization's engagement in budget work contribute?

3. Ask them to give the answer to the last question in plenary, to show the group how much they know about budget work in their country and how strong or weak it is and to consider their potential contributions.

## A3. What is the potential impact of budget advocacy?

An important characteristic of budget advocacy is that it is evidence-based. The evidence from budget research and analysis and policy analysis can be used to understand the causes of a problem and propose evidence-based solutions to:

**social issues**, when the budget is part of the cause or the solution to e.g. service delivery, human rights or equality, because resources are:

- insufficient,
- not spent efficiently,
- not being spent on the main problem or cause,
- being mis-spent or diverted,
- not flowing efficiently from one level of government to another or
- not reaching the target populations or those most in need; and

**the budget process**, when, for example, the process by which budget distribution is decided:

- excludes citizens and does not consider their needs or proposals or
- is not transparent or accountable.

Successful budget advocacy can have important impacts, which may include the following *(87)*:

- influence decisions on the distribution and use of public resources;
- increase the efficiency and openness of budget processes, decision-making and systems;
- improve the quality of government services for the public;
- contribute to increasing access to (and the quality of) budget information in the public domain;

- improve the capacity of budget implementers to translate public funds into programmes and services;
- strengthen the capacity of budget oversight bodies to monitor and scrutinize disbursement of public funds; and
- increase the capacity of citizens to participate in budget processes, to demand and analyse budget information and to hold leaders to account.

## Tool: Case studies of civil society budget analysis and advocacy documented by the International Budget Partnership

**Purpose:** to familiarize participants with examples of budget analysis and advocacy (not necessarily for health) to recognize them and to ascertain the type of impact they have or have not achieved

**How to use the tool:** The case studies in reference *87* are used as examples of different types of budget work. Facilitators should select five case studies that they consider relevant for participants, such as studies from a particular region, conducted with a particular method or that document budget advocacy for a specific issue or sector. It is recommended that the tool be used for the activity described below to show participants that budget advocacy is conducted in many countries and contexts. This may help to dispel the notion that budget advocacy cannot be done or will have no impact in developing countries.

## Activity: Budget advocacy by CSOs and its impact

1. The facilitator should select five case studies before the workshop and summarize them in two pages, including:
    - the organization and where it is based,
    - the issue, problem or policy on which their work is focused,
    - why and how they used budget analysis and advocacy,
    - the method used and
    - the main impact of their work.
2. The group should be divided into groups of four to five people and given one case study; or each participant will have a manual containing all the case studies. Each group will be assigned to analyse one case study by answering the following questions:
    - What type of organization is depicted in the case study (budget, sector issue, community, coalition, social movement, human rights, other)?
    - What was the main concern of the organizations and what were they advocating for?

- What was the role of the public budget in the advocacy?
- Why do you think that they were successful or were not successful?
- What do you think you could apply from this case study or that provides an important lesson for your budget advocacy?
- If you could ask one question to this group that would help you better understand the purpose and potential impact of budget advocacy, what would it be?
- Does this work motivate you to continue to engage with budget advocacy?

# Section B. Budget advocacy related to health and universal health coverage

## B1. What does health budget advocacy seek to accomplish, and what has been its focus?

Budget advocacy more specific to the health field has increased at the same time as overall budget advocacy over the past 20 years. The work is done by both traditional budget advocacy organizations, which may conduct some research and advocacy on health issues, but also (and more importantly for the purpose of this toolkit) by health-oriented international and national civil society groups, which have turned to budget advocacy because, in the context of global and national commitments by governments to reduce maternal and child mortality, AIDS, tuberculosis and malaria and other health issues, more investment is necessary (and promised many times) to achieve specific goals.[12] Monitoring where funds come from, how they are allocated and spent and their impact is crucial.

According to WHO and other global health stakeholders, UHC depends on increased domestic public resources. Advocacy and monitoring for public domestic resources and how the public health budget is allocated are essential for ensuring accountability for commitments made by governments. In addition, the UHC2030 principles call for processes that are transparent, accountable and participatory and include the contributions of citizens and CSOs.[13]

The health financing progress matrix *(47)*, developed by the WHO department of Health Systems Governance and Financing, can be used to compare national health financing systems to 19 evidence-based benchmarks, framed as desirable attributes. Each attribute represents a critical element of a health financing system and signals the direction in which institutions, policy and implementation should develop to make progress towards UHC. The matrix complements quantitative measures of UHC performance, such as financial protection, and the health expenditure estimates available in the Global Health Expenditure Database *(48)* to assess shifts in policy development and implementation. By close to real-time monitoring of health financing policy, the matrix provides more regular action-oriented feedback to policy-makers. Use of the progress matrix can bring stakeholders together on a common point of reference, focus scarce resources on priorities and interventions and monitor progress transparently over time. Version 2.0, released in late 2020, is the culmination of almost 3 years of conceptual development and country testing.

[12] For maternal health, for example, most of the commitments made to the United Nations' Every Woman, Every Child Initiative and the Global Strategy by national governments were financial or required resource mobilization. The civil society initiative Women Deliver called on governments to "invest in women, it pays" by mobilizing resources from national budgets.

[13] See specific reference in the introduction to this chapter.

A number of international CSOs and coalitions are conducting UHC-related budget advocacy or are supporting other civil society groups to do so. These include the following members of the reference group set up to prepare this toolkit:

- Global Health Advocates
- the Global Fund's Advocates Network (GFAN)
- Population Action International
- Results for Development
- Save the Children
- the People's Health Movement
- the Africa Health Budget Network
- Centre for the Study of Equity and Governance in Health Systems
- Community of Practitioners on Accountability and Social Action in Health
- the Eurasian Harm Reduction Association
- the NCD Alliance

Although these organizations mobilize and advocate for different health issues, that which brings their advocacy together is a call for increased, improved financing for health. The budget advocacy of these groups is backed by solid budget analysis to ensure strong health systems that are accessible to all, and particularly vulnerable populations, at little or no cost. Their aims are therefore much in line and even explicitly oriented towards advancing UHC.

## Activity: Identifying civil society groups working to advance UHC

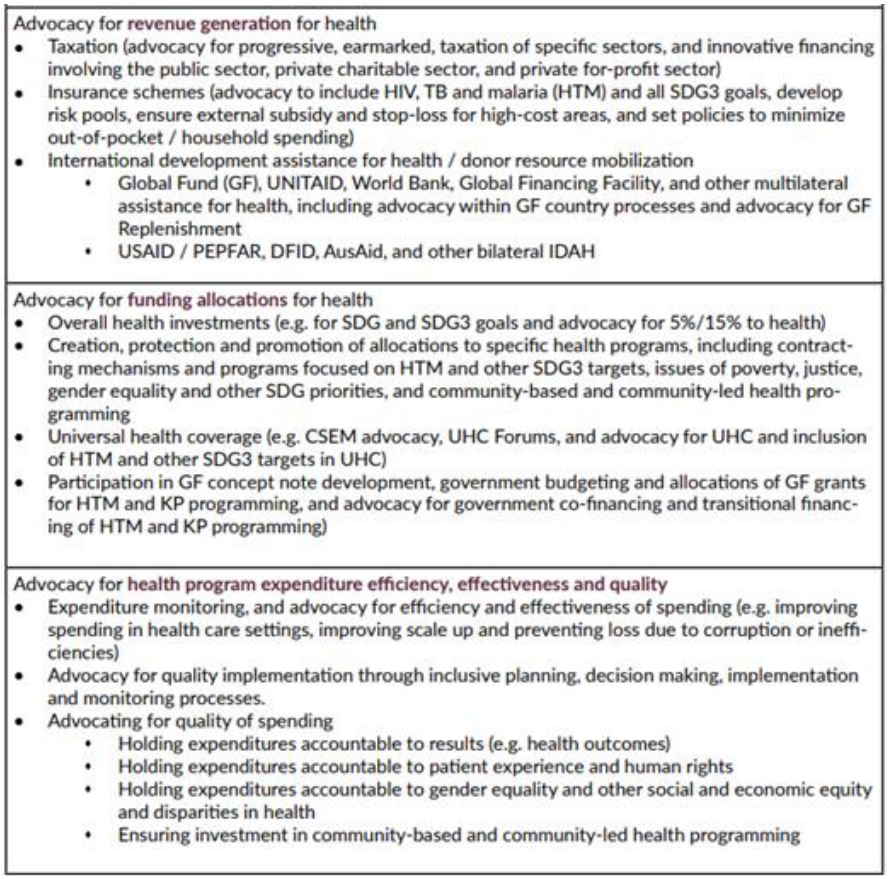
1. In plenary, ask the participants to log on to the websites of the international organizations and coalitions listed above.
2. Ask them whether they are they conducting or supporting national UHC-related work and whether any of the work is related to public financing for health or UHC in particular.
3. Do they support or collaborate with national civil society groups for UHC budget advocacy? If yes, what are they doing?
4. What other groups in your own country are involved in UHC-related advocacy? Do those groups conduct budget advocacy of any sort? If so, what are they achieving? What do they need to strengthen their work? How are they conducting budget advocacy?

## B2. Examples of CSO budget advocacy for health and UHC

The purpose of this section is to illustrate the types of budget analysis and advocacy for UHC. The examples include descriptions of the organizations, the type of work they do and how they use budget advocacy to advance UHC. The examples also include how and why the organization is involved with UHC and the type of analysis or tools they use to advocate for increased or better public resources for UHC. The examples show that this work is possible and is diverse in scope and action. They are meant to inspire CSOs and activists to consider the type of work that might be relevant for them. A range of other UHC budget advocacy is being conducted at various levels, and users and facilitators should complement this section with other work with which they are familiar.

**Global Fund Advocates Network (GFAN)**

GFAN, a global network formed in 2011 to advocate for a Global Fund to Fight AIDS, Tuberculosis and Malaria, engages and mobilizes other health advocates for "sustainable financing for health advocacy" *(88)*. According to GFAN, global or national health advocacy must be oriented to "mobilizing increased and improved domestic funding for health" and "advocating for universal health coverage". They propose the framework shown in Box 8 for CSO advocacy for sustainable health financing.



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

**Box 8. Framework for civil society advocacy for sustainable health financing, by short-term outcome**

Source: reference *88*, with permission

### Eurasian Harm Reduction Association

The Eurasian Harm Reduction Association is a not-for-profit organization of activists in central and eastern Europe and Central Asia. For their health-related advocacy, they have developed a Budget advocacy guide for community activists *(89)*, in which they define health budget advocacy as follows:

> Health budget advocacy is specific lobbying and campaigning activities to change the way in which public resources are used to deliver health services. By analyzing how healthcare is funded and how budgets are drawn up, civil society groups have a greater opportunity to influence the way in which the government defines priorities for health spending, plans and executes those expenditures, and, finally, monitors the outcomes. Working on policy, programme and regulatory documents, as well as acting as a “watchdog”,

engaging in campaigns and "cabinet" advocacy, influence budget allocations, as well as the process of execution and accountability.

The guide for local community activists includes useful tools for advocating for UHC budgets. It emphasizes that:

- the guide is for local organizations, demonstrating that the work is possible and useful at this level as much as at national or international level;
- CSOs should conduct budget advocacy, and health budget advocacy in particular;
- it is for both national and subnational levels; and
- it demonstrates that community mobilization and capacity-building are important elements of advocating for health.

In this sense, it is a similar and complementary to this toolkit. The guide includes a simple budget advocacy planning tool (Box 9) for identifying key budget elements for health advocacy and could be applies to UHC-related budget advocacy. It is added as an example rather than a tool, but facilitators could adapt it if they consider it useful.

### Box 9. Budget advocacy planning tool

| Budget Cycle | Your advocacy goal | Documents to influence | Target stake-holders | Allies and partnerships | Arguments | Information needed |
|---|---|---|---|---|---|---|
| 1. Budget Formulation | | | | | | |
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| 2. Budget Enactment | | | | | | |
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| 3. Budget Execution | | | | | | |
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| | | | | | | |
| 4. Budget Oversight & Evaluation | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Source: reference *89*, with permission

### Save the Children

Another example of UHC budget analysis and advocacy by CSOs is "Within our means" *(80)*. Save the Children is an international NGO working to protect and advance the rights of children, including for health and UHC. The authors of "Within our means" analysed trends in public spending on health in countries involved in the "Count down to 2015" *(90)* and compared it with internationally agreed minimum per capita health spending of US$ 86. They argued that all countries, including developing countries, can afford to increase domestic resources for health and UHC through better decision-making on collecting revenues for health and on spending them. Their conclusions included the following:

- In countries in which UHC has been nearly achieved, health is financed mainly from domestic resources (mandatory pre-payment).
- Most countries that are close to the recommended health spending target for better health outcomes (5% of GDP) finance it from public resources.
- If countries achieved the United Nations Development Programme (UNDP) taxation target of 20% GDP by 2030 and the allocation of revenues to health remained at current levels, the funding gap would fall from US$ 101 billion to US$ 76 billion.

Box 10 summarizes the aims of advocacy by Save the Children, many of which are related to UHC budget advocacy.

**Box 10. Conclusions and recommendations of "Within our means" from Save the Children**

This paper has sought to demonstrate that low- and middle-income countries have many opportunities to expand domestic resources for health, and should do so progressively, and that this can go a long way towards closing the funding gap. This is largely a matter of national policy choices and political commitment to UHC.

The post-2015 framework is an opportunity to make progressive taxation, public investment in health and aligned development assistance global priorities. As well as facilitating progress towards UHC, raising higher domestic revenues should make governments more accountable to their own people, rather than to donors, and strengthen the social contract between citizens and state.

Our analysis has looked at various ways in which countries can afford to spend $86 of public money on healthcare for every person in the population. Economic growth is a major determinant: as a country's GDP increases, so can its per capita health spending. But this will take time. More critical will be increasing the revenues available for health (in a way that is not to the detriment of other important sectors) and ensuring that the funds raised are well spent.

The targets we have used are minimums – and we recommend that in the few countries where 5% of GDP exceeds the $86 per capita minimum threshold, countries should expand the package of services provided and the extent of financial risk protection, and begin to graduate from a reliance on aid for health.[82]

With the final push to accelerate progress on the MDGs, and as the goals shift to end preventable maternal, newborn and child deaths and accelerate progress towards UHC by 2030, we call on:

**low- and middle-income governments to:**

- commit to end all preventable maternal, newborn and child deaths by 2030
- accelerate progress towards UHC and ensure its inclusion in the sustainable development goals
- develop a health financing strategy for achieving UHC, eliminating OOPS for essential health services and moving towards mandatory prepayment with a national risk pool and universal entitlements
- prioritise expanding fiscal space for health, reviewing opportunities to increase government tax revenues as a share of GDP to reach at least the 20% target and to do that progressively
- increase investment in health, allocating at least 15% of the total government budget to it
- tackle inefficiencies within health spending, ensuring that investments benefit the most vulnerable people first
- increase tax collection capacity and efficiency across different taxes to improve compliance and create a progressive tax system.

**development partners to:**

- ensure ending all preventable maternal, newborn and child deaths, and achieving UHC are included in the sustainable development goals
- provide technical and financial support to help Countdown countries promote sustainable and progressive domestic revenue sources for health
- help Countdown countries strengthen national health plans, which are fully costed and implemented, filling funding gaps
- deliver on aid commitments and adhere to aid effectiveness principles
- implement domestic and international reforms to curb illicit financial flows.

**civil society to:**

- engage in tax processes, advocating for progressive tax reforms and increased transparency
- advocate for strong agreements on public and donor country financing for health as part of the sustainable development goals
- monitor domestic budgets to track resource flows, and advocate for increased and more equitable revenue and expenditure.

Source: reference *80*, with permission.

### Global Health Advocacy Partnership (ACTION)

ACTION's advocacy for building equitable, sustainable systems includes cross-cutting outcomes such as UHC, based on strong primary health care systems, increasing the health workforce, strengthening supply chains for vaccines and essential medicines, increasing partnerships for research and development, promoting innovation in health tools, delivery mechanisms and community engagement and targeting services to people who are often underserved.

ACTION advocates for:

- increased domestic spending on health, innovative finance to extend the available resources and more responsible targeting of donor funding;
- governments and their development partners to enact policies that extend primary health care services to the poorest, most marginalized people and resolve health worker shortages in order to achieve UHC; and
- accountability, to evaluate how well the policies and practices of governments, donor agencies and multilateral organizations enhance or undermine the sustainability and equity of health systems.

In collaboration with RESULTS UK and the United Nations Foundation, ACTION has conducted research and advocacy on global health transitions,[14] the impact that they could have on health systems and the quality of care and how CSOs could ensure that this process does not have a negative impact *(91)*. The analysis focuses on the impact of official development assistance on health and health outcomes in developing countries and how they will replace it. This type of advocacy is particularly relevant for CSOs in countries currently in transition, as it invites analysis of:

- the country's current dependence on official development assistance to finance health, health systems and UHC;
- sources of revenue over time to determine how the governments will cover the financial gaps due to the transitions and whether it will come from domestic resources;
- whether and how these countries are strengthening their PFM and health financing systems; and
- whether the transition is having a positive or a negative impact on the achievement of UHC over the time during which it is implemented.

[14] The process whereby many countries will dramatically change the way in which they fund public health, by moving from development assistance to use of domestic resources

## Tool: GFAN research brief on effective civil society strategies for increasing domestic resources for AIDS, tuberculosis and malaria in low-income countries

The tool is available in reference *93*.

**Purpose of the tool:** The research brief includes case studies documenting the success of CSOs in Kenya, Malawi, Philippines, Uganda and Zimbabwe in monitoring and mobilizing resources for AIDS, tuberculosis and malaria. Although it does not focus on UHC, the case studies and their analyses are good examples of prospective health budget analysis and advocacy for participants to decide what to monitor and how to advocate successfully for UHC priorities. The case studies also touch on health systems strengthening relevant for UHC.

## Activity: Identifying a UHC budget advocacy problem or agenda in my country

1. Provide each participant with a link or a copy of the tool, refer them to the UHC-related examples, and allow them 20 min to read the document. Suggest that they focus on p. 6, the framework for budget advocacy.
2. Allow each participant another 30 min to identify:
    - three or four components that are related to or important for UHC;
    - one or two components that they or their organization could and would be interested in exploring in their country;
    - the type of information they would require to conduct research and advocacy on the two selected issues or aspects;
    - where they could find the information;
    - with which other groups or stakeholders they could liaise to collect the information, such as parliamentarians, the media, other CSOs or people in line ministries; and
    - the obstacles they foresee in doing this kind of work and why.

This activity can be conducted before providing content on strategic advocacy and specific, measurable, achievable, realistic, time-bound (SMART) objectives (see Table 6), although participants should have a basic understanding of UHC.

## Table 6. SMART objectives

| | | |
|---|---|---|
| S | Specific | The objective of budget advocacy is specific when it clearly states:<br>• Who is to be affected?<br>• Where is the impact to be?<br>• What will be the form or shape of the impact or the observable benefit?<br>Example: Rural men, women, adolescents and children in the poorest provinces of country X are enrolled in the national health insurance scheme by increased allocations to the scheme from all levels of government. |
| M | Measurable | When applicable, strategic budget advocacy objectives should be measurable. It can be useful to state in the objective how much it would cost the government to make the change being sought by your organization.<br>According to the IBP budget advocacy toolkit, a measurable objective can:<br>• determine the size and scale of the desired impact;<br>• provide a means for measuring impact;<br>• facilitate translation into budgetary terms; and<br>• concretize the goal of advocacy.<br>Example: National and state governments increase their resource allocations to the national health insurance scheme by 5% annually in order to enrol men, women and children in the poorest communities. |
| A | Achievable | The achievability of a strategic objective for budget advocacy depends on the social, political and economic circumstances. Therefore, a detailed context analysis is necessary when defining an objective, and it is essential to ensure that the change sought is related to the budget. This can be ascertained by ensuring that the change sought is linked to the public sector and falls under their responsibility and that it involves use of public funds.<br>Other contextual elements might affect the achievability of the objective.<br>• Will you have access to the necessary information to implement the activities for your objective?<br>• Is the civic space open enough to engage in meaningful dialogue with those responsible for change or at least with those who can influence “change-makers”?<br>• Is the stakeholder you wish to influence interested in and committed to the issue you want to change?<br>• Who will be negatively affected by what you ask for?<br>• Are there adequate resources and possibilities to make the change? |

| | | |
|---|---|---|
| | | • Are there potential allies or more voices that could push for similar change?<br>This list of questions is not exhaustive and only exemplifies the types of questions and strategic reflections necessary in developing a strategic budget advocacy objective. |
| R | Realistic | A strategic budget advocacy objective is realistic when your organization has the capacity and ability to achieve it. It is a strategic reflection with regard to your institution, movement or self. You could ask yourself:<br>• Does my organization or I have the knowledge to conduct the analysis necessary for achieving this objective? If not, do we have the resources to fill this gap?<br>• Does my organization have the necessary financial resources to pursue this objective? If not, will it be able to obtain them?<br>• Will pursuing this objective contribute to or divert my organization from its strategic vision?<br>• Will seeking this objective open or close doors for my organization that might positively or negatively impact other work?<br>This non-exhaustive list of questions is designed to stimulate a strategic discussion on the institutional capacities and resources necessary for establishing objectives. |
| T | Time-bound | The objective of strategic budget advocacy must have a time-frame; otherwise, it will remain an aspiration. The time-frame of a budget objective is also important because public budgets are decided by governments and economic contexts that may change, if there are free elections. For global issues such as health and UHC, the time-frame may be based on international commitments such as the SDGs. Time is also important in view of the complexity and challenge of implementing UHC policies.<br>The main questions that the objective should answer in terms of time are by when should this change materialize, and will this occur at a set time or gradually?<br>Example: National and state governments increase their resource allocations to the national health insurance scheme by 0.2% per year for 10 years in order to achieve SDG 3.8, ensuring that all rural men, women and children in the poorest provinces are enrolled by a specific time. |

# Section C. The importance of strategic advocacy for a universal health coverage budget

## C1. When is civil society budget advocacy successful?

Civil society budget advocacy is most successful when it has an impact on the issues it seeks to address and, ultimately, on the lives of people affected by those issues *(83)*. IBP has identified several conditions for the impact of budget advocacy *(83, 92)*:

- The potential for impact increases when organizations have clear objectives.
- Budget advocacy campaigns that bring about change are those that persist and adapt.
- The impact of budget advocacy depends in large part on nurturing and maintaining key relations.
- The desired impact is achieved by using the right methods of analysis and engagement.
- Impact is assured by "knowing the rules of the budget game" and how to navigate them.
- Impact is not achieved once and for all: advocacy gains must be consolidated.
- Budget advocacy works best in contexts where there is at least some possibility of democratic participation.

The GFAN provides some insights into what successful and sustained health-related budget advocacy entails (Box 11).

### Box 11. 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.

Source: reference *88*, with permission

## Activity: Identifying participants' understanding of the impact of UHC budget advocacy and what they think is necessary to achieve it

This activity can be used as an introduction to section C.

1. Separate participants into groups of three, and ask them to discuss the following for 20 min:
   - What is the first thing that comes to mind when you hear the word "impact"?
   - How does your organization define "impact"?
   - How does your organization define "impact" with respect to UHC and other health variables?
   - What is necessary to achieve impact?
2. In plenary, ask the groups to share their conclusions, and summarize what constitutes successful health budget advocacy that has an impact.

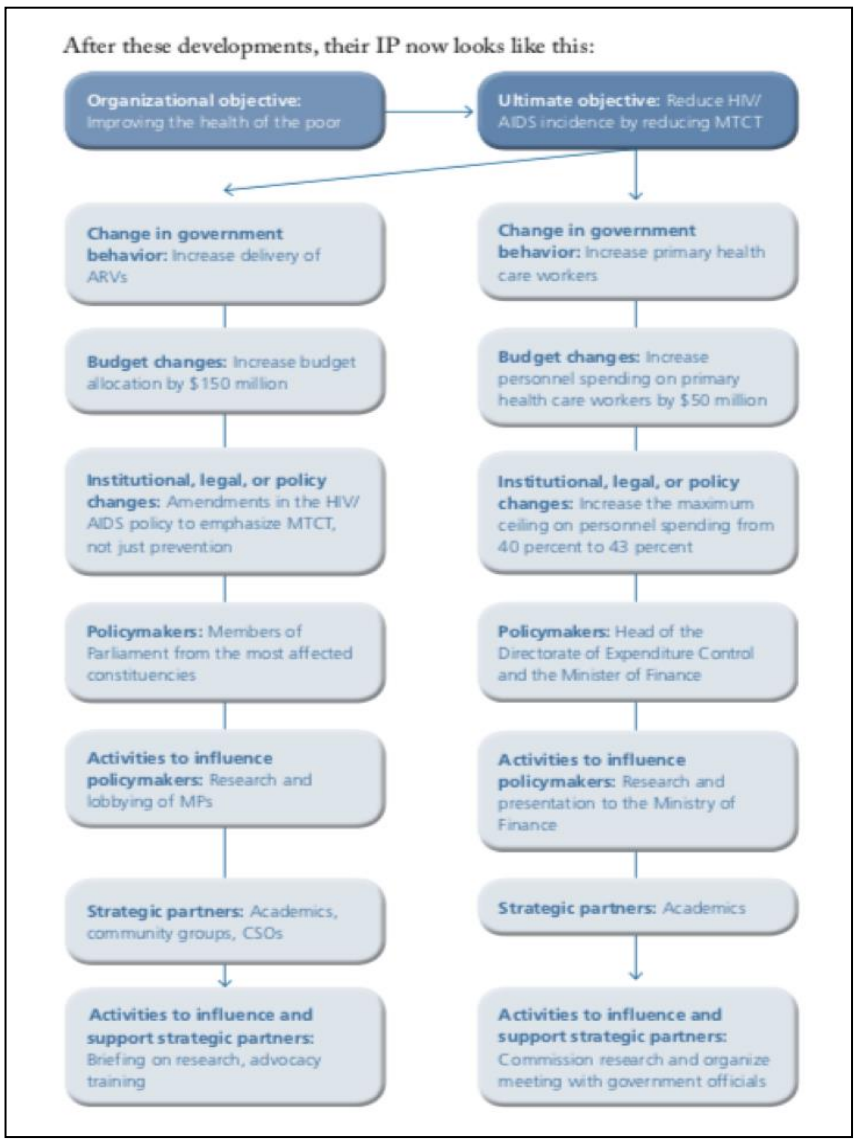
### C2. How to plan budget advocacy with an impact

IBP, one of the main international budget advocacy organizations, has prepared methods for CSOs to plan budget analysis and advocacy strategically. They call the method "impact planning", which is summarized in the "Super duper impact planning guide" *(94)*. The guide was designed for 45 CSOs in 18 countries to guide theories of change for budget advocacy, including health budgets. The tool has been used by a wide range of civil society activists and has proven effective in developing strategic thinking on budget advocacy problems and objectives. The IBP describes an impact plan as:

> … an explanation of how you expect your organization's strategies or campaigns to work. It shows the chain of cause and effect between the strategies that your organization uses and the ultimate results that you hope to achieve.
>
> Any advocacy strategy already assumes that such a chain of cause and effect exists. An IP is just an explicit statement or graphic representation of the sequence of changes that you hope to contribute to through your work. This guide will help you use IPs as a tool for formulating and implementing strategies for campaigns or projects. IPs can help you to unpack the assumptions implicit in these strategies. Understanding and improving these linkages can help you reach the objectives of your work.

The tool includes a strategy based on answers to guiding questions and analysis of contextual, institutional and issue-specific elements, allowing CSOs to construct a visual map of their budget advocacy work. An example of an impact plan flow chart is given in Box 12.

**Box 12. Impact plan flow chart**




Source: reference *94,* with permission

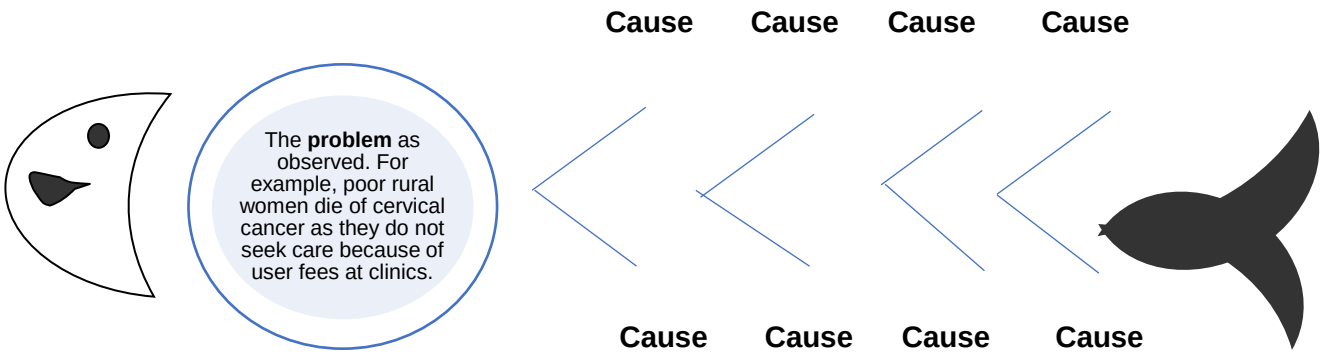
A key component of this approach is “the ultimate objective”. For the impact plan to be adequate and lead to an impact, the objectives must be strategic and well defined. Definition of the strategic objective is perhaps the most complex but most amusing and important part of any theory of change or impact planning, as the entire trajectory to be followed is based on its clarity. A commonly used method for developing strategic objectives that is readily applicable to planning UHC budget advocacy is the SMART approach (see Table 6). A budget advocacy objective that is SMART therefore sets a clear path towards change and provides a vision of what is to be changed, who will change it, how the change will materialize, by how much and by when. If the budget advocacy objective is SMART, so will be the research and actions.

## Tool: Is budget advocacy necessary for your organization or issue?

According to the IBP, budget advocacy is not necessarily the best tool for all organizations, types of campaigns or issues. They therefore developed a tool for organizations to determine whether budget analysis and advocacy are appropriate *(83)*. The tool is designed to be used in training sessions in which most CSO participants are new to budget advocacy to stimulate them to think strategically about this option and about the A in SMART. The tool can be used to gauge the interest of participants in UHC budget advocacy and SMART objectives and to stimulate discussion of whether the UHC issue they are addressing is linked to the budget. It can also be used at the end of training to identify which of the participating groups will actually further engage in UHC budget advocacy.

## Tool: Slippery problems

**Purpose of the tool:** Many tools are available to identify the causes of a problem and seek possible solutions. Some include a diagram of fishbones as a way of analysing and thinking strategically about how and to what extent a problem is linked to the public budget.




## Activity: Slippery problems *(83)*

- Write the problem you wish to solve in a circle at one end of the fishbone. The backbone, running to the problem, holds the skeleton of causes.
- Discuss possible causes of the problem, and write a word describing each cause above or beside the diagonal lines connecting to the backbone. In identifying causes, consider the **conditions**, **actions** and **traditions** that might play a role. List all the factors that might contribute to the cause and add them to the diagram as smaller bones.
- Now circle in colour the six causes that you think contribute most to the problem.
- Then circle in another colour the six causes over which you have or could have the most control or influence.
- Any causes that have been circled twice provide the greatest scope for impact. All those circled with the second colour should be reviewed.
- Discuss what you could do to affect make sure that these causes no longer contribute or contribute less to the problem.

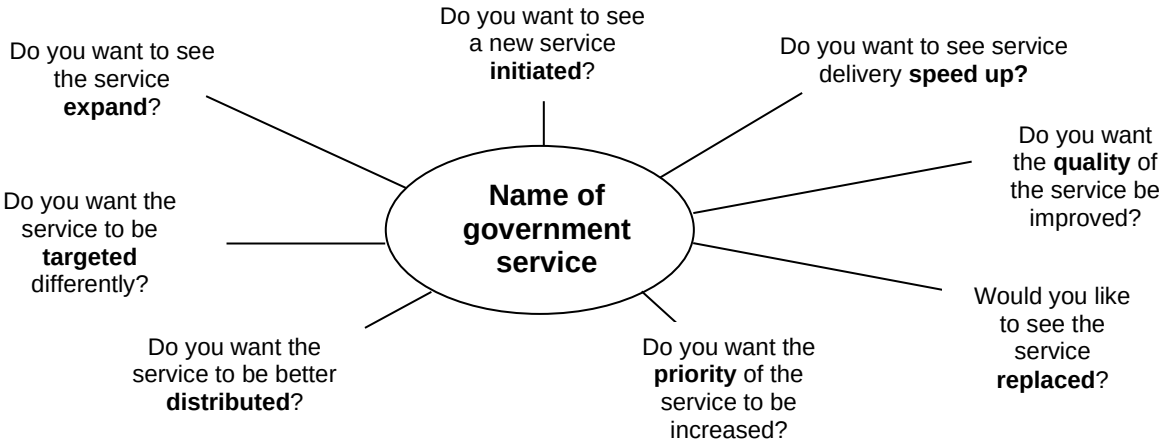
## Tool: Eight ways to change service delivery

It is not always clear how a government service should change in order to have the effect you seek, and it is often impossible to predict which solution will work best. Budget advocates are therefore obliged to make assumptions about multi-dimensional, often turbulent problems and circumstances. Usually, a complex web of factors influences the delivery and uptake of services and the results in terms of development outcomes and peoples' well-being. It may be useful to try different possible changes in service delivery before selecting one you consider could have the desired impact.

Box 13, adapted from reference *4*, presents eight options to be considered in relation to changes to typical public services. Create your own chart for the objective you are pursuing in your project or campaign:

- Write the name of the service or programme you want to change at the centre of the chart; e.g. "training midwives" or "school transport services".
- Use the eight questions in the box to try different solutions. Discuss whether or how well each possibility could further your objective.
- Select one change in the service or programme for which you will advocate.

**Box 13. Options to be considered for changes to public services**




- **Initiating**: You might decide to advocate for introduction of a new service to advance a human right or meet an unmet need, such as safety patrols on public trains used by schoolchildren.
- **Expanding**: You might be satisfied with the content or quality of a service, such as inoculation of babies against measles, but want to extend the service to more beneficiaries.
- **Speeding up**: You might be satisfied with the content and nature of a service, such as payment of disability grants, but want to extend the service faster to new beneficiaries.
- **Improving quality**: The scale and distribution of the service may be adequate, such as provision of basic education to primary school students, with a high enrolment rate; however, the quality of education being received is low.
- **Targeting**: A service about which you are concerned may be adequate in scale and quality but is not reaching the beneficiaries who need it most. For example, a school feeding scheme may provide nutritious food efficiently but not to the most undernourished children.
- **Distributing**: A service may reach its target beneficiaries but not be available everywhere it should be. For example, support services for households headed by women may reach such households only in urban areas or only in some districts.
- **Replacing**: The existing service may not be the best means to fulfil its development function. For example, a state school bus service should be replaced with a system of coupons for public transport.
- **Prioritizing:** A service may be defined adequately in policy documents, such as a new programme for early childhood development to be delivered at state-subsidized pre-schools. In reality, however, the service is of low priority for implementation and requires more dedicated commitment.

There are many other ways to change a government service. It could, for instance, be made more accessible, combined with another, replaced, revised, divided, out-sourced, centralized, decentralized or phased out.

# Module 2. The role of the media

Each section below contains explanations about different aspects of UHC budget advocacy, accountability and the role of the media. The text can be used to develop activities and presentations for a workshop. Each section also contains example activities to help participants explore issues, apply their knowledge and build understanding.

This section introduces media engagement with UHC budget advocacy, what the media can do in health budget accountability and with whom they should engage, at what point(s) in health budget accountability they can play a part, how to address UHC budget accountability in an engaging way and challenges, risks and considerations in addressing health budget accountability. The section ends with a “final pitch”.

## Section A. Introduction to media engagement with universal health care budget advocacy

Media content, including films, plays, documentaries, talk shows, advertisements, social media posts, blogs, web pages, radio programmes and newspaper articles, can reach millions of people and make a positive change. This might be through audiences who participate in programmes, discussing issues in a range of media, talking about or sharing original content and their ideas and opinions. Content can spark activism and mass movements leading to societal and behavioural shifts and changes.

### A1. What are health budget advocacy and accountability?

Health budget advocacy and accountability are the means of ensuring that appropriate resources are allocated to national health budgets, in this case to support UHC. While CSOs, citizens and parliamentarians may conduct health budget advocacy and use the media (particularly nowadays social media) for advocacy, the principles of journalism mean that the media may focus more on health budget accountability.

Health budget advocacy involves lobbying and campaigning to influence the size and distribution of government health budgets, to increase the amount of resources allocated to health to improve health service access and delivery.

An advocate is someone who speaks up (or writes) publicly about the current situation and what it should be. Advocates promote change towards a goal, on behalf of a group or with a group *(96)*. Advocacy is sometimes confused with other concepts, such as fund-raising, awareness-raising or community and social mobilization. Although an advocacy campaign may include specific tactics or steps, the targets of advocacy are decision-makers, and the goals are changes to laws, policies or budgets. In accountability for health budgets, those responsible for allocating and spending money on health services can provide evidence that they have spent the money allocated to health on health.

The media has a strong role to play in accountability: to analyse how health care is funded, how the government prioritizes health spending and how money intended for health care is spent; to explain these issues clearly on the basis of evidence for the wider public; and to provide opportunities for the public to engage with decision-makers about health spending to help improve access to good-quality health services for all *(97)*.

Good accountability is often the result of a system of checks and balances by internal and external stakeholders. Internal accountability includes policies and processes for spending money and deciding on resource and supervisory systems in in institutions to check that resources go where they are intended. External accountability includes public oversight (anti-corruption bodies, parliamentary standing committees, supreme audit institutions) and civil society watchdog groups, media and community groups that monitor how public resources are used.

By analysing how health care is funded and how budgets are drawn up, civil society groups and the media have more opportunity to influence how the government prioritizes health spending. The media may not only influence the size and distribution of health budgets but also play an increasingly important role in monitoring governmental commitments and holding public officials accountable for resource allocations and use, ensuring that funds are disbursed and used as planned.

This module will help members of old and new media to understand how they can support the achievement of UHC by monitoring accountability for health budgets. It should give rise to ideas on making accountability for health budgets interesting, relevant and understandable for all audiences.

## Activity: Advocacy and accountability

1. Setting objectives (10–15 min)
    - Participants set objectives, which helps the facilitator to understand their expectations of the workshop and whether any clarification of the training is required.
    - The objectives could be written on a post-it note or paper and stuck to a wall.
    - The facilitator should review them rapidly to determine if any cannot be met in this workshop.
2. Advocacy and accountability – discussion (15 min)
    - What is “advocacy”, and what is “accountability”? What are the differences or overlaps? Could be discussed in small groups or in plenary to determine their understanding and areas on which the facilitator might wish to spend more or less time.
    - Discussion on the media’s approach (accountability, not advocacy)

- Small groups could identify the questions related to each term, starting with Who, What, When, Where, Why and How.
- Examples:
  - Which internal and external bodies monitor health sector accountability? What are their findings? Reference may be made to e.g. the WHO health financing progress matrix, country assessments.
  - Ask participants to give examples of health budget advocacy and health budget accountability to verify that the difference between the two is understood.

3. Summarize the presentation, including definitions of health budget advocacy and accountability, focus of the media on accountability and its importance.

# Section B. What can the media do in health budget accountability?

Facilitators should consider the audience: traditional media (print, radio, television), new media (on-line platforms, such as social media, podcasts or vlogs), highly trained, experienced investigative journalists, citizen journalists, bloggers or social media influencers with little or no training but access to technology and who are digitally literate or local journalists in rural areas with minimal training, less literacy and no regular salary. Facilitators should understand access to and use of the media by the public (including those in positions of power), the expectations of the participants and any pressure they might be may be under, such as any restrictions on media freedom.

## B1. What the media can do

"Media" encompass all means of information and communication available to people, including mobile and Internet technologies *(98)*. The media can engage in health budget accountability by:

- empowering audiences,
- giving audiences a voice and
- creating space for decision-makers and citizens to discuss challenges and find solutions together *(99)*.

They may help audiences to understand their right to health, health budgets and the link to their health. It will enable them to understand how they can and wish to have opportunities to hold budget decision-makers to account.

The participation of media in communication on health and development activities can strengthen the voices of ordinary citizens and ensure their involvement in decisions that affect them, their families and their communities. People who are directly affected by an issue should be able to understand the ability and experience of the media and build on it. Participation increases the impact of health and development activities and leads to long-term sustainability as individuals and groups become actively committed and increasingly capable of improving their health and living conditions *(100)*.

Two-way and multi-way conversations are critical, and the media can ensure that both citizens and budget decision-makers can discuss health service provision. Journalists can also share evidence about whether governments are meeting their budget commitments for health and, if they are not, help citizens to question them about why they are not.

Interviews, podcasts, social media posts, radio, television, features, investigations, "vox pops" and other media formats most be guided by the principles of public interest, made interesting, engaging and relevant and respect the ethical values of journalism.

## B2. Ethical values

Free speech ensures the exchange of information and ideas without state interference. Freedom of expression is not, however, an absolute right but carries duties and responsibilities and is subject to legal restrictions and limits. Audiences have the right to receive creative material, information and ideas without interference but expect that we balance the right to freedom of expression with our responsibilities towards them *(101)*.

All media activities should be guided by the ethical values of journalism. Some organizations express these values as detailed, specific guidelines and guidance; others, which may be independent or are on-line, may be less regulated and appreciate the values for first time.

- *Truth and accuracy*. All relevant facts and information are weighted, well sourced, based on sound evidence, thoroughly tested and presented in clear, precise language, with honest, open expression of what is unknown and avoidance of unfounded speculation.
- *Impartiality and diversity of opinion*. The media strive to be fair and open minded and reflect all significant opinions through the range and conflict of views. They do not promote their own or others' views, opinions or judgements. Impartiality does not, however, mean ignoring truth and accuracy; the media make clear what is opinion, what is mis- or dis-information and what are facts, so that audiences can form their own opinions.
- *Fairness, safeguarding and doing no harm*. The media have a duty to care for their contributors and sources and to treat contributors honestly and with respect. Outputs are based on openness and straight-dealing. Safeguarding contributors, sources or subjects of a media piece is essential: all media should avoid doing harm, which may mean protecting anonymity. It is the media's responsibility to ensure that all contributors understand how they will contribute and how their contribution will be used so that they can provide voluntary informed consent.
- *Privacy*. The media respect privacy and will not infringe on it without good reason, anywhere in the world. Private behaviour, correspondence and conversation will not be brought into the public domain unless there is a clear public interest. Safeguarding is part of privacy.
- *Editorial independence*. Editorial independence is vital to ensure that these values are upheld, that stories are issued without third-party influence or pressure. This may be difficult in some contexts, particularly for journalists who are paid to cover a story, event or issue by a third party.

Resources such as the BBC editorial guidelines *(101)* are publicly available for further information.

Participatory budgeting is still being developed. Health budget accountability consists not only of criticism but can be addressed creatively in various formats. The media can

constructively shape new forms of participation and more transparent policy-making *(102)*.

## B3. Why should I work on health budget accountability for UHC?

The following broad criteria are proposed for choosing issues to be covered by the media and how.

- Does the issue uphold or go against the ethical values for journalism?
- Is it in the public interest? Whose interest? Who is most affected, and who can influence change?
- What are my responsibilities in covering this issue in the media? To my sources, audience and myself? (No story is worth a person's life.)
- Do I have enough good-quality, reliable evidence to tell the story?
- Is this story important, compelling, original enough to command the attention of the audience in the saturated media market?[15]

As part of health accountability, the media can stress evidence-based health priorities, analyse health budgets, identify gaps in national health statistics and health spending, explain new health policies, fact-check sensational stories and dispel rumours *(103)*. A close look at national budgets shows whether government policies favour the rich or the poor. Reporting sheds light on who wins, who loses and who is missed by the system. At its best, media scrutiny helps keep governments honest and stimulates public debate.

According to the IBP, transparency in budget processes requires that governments provide timely, accurate, comprehensive information in eight key budgets documents (see chapter 1, module 2, section D): pre-budget statement, executive budget proposal, enacted budget, citizens' budget, annual report, mid-year review, year-end report and audit report. The media can help their audiences understand these documents and provide opportunities for them to engage with government on the information in the documents.

Health budget accountability is promoted not only by journalism; personal stories, drama, games and story-telling can also build understanding, skills, motivation and confidence among audiences to engage in health budget accountability.

[15] From meetings and talks with various teams of BBC journalists

## Activity: Media and health budget accountability

1. Discuss seven ideas from each group on what the media can do to support accountability on health budgets for UHC.

2. Present a case study of why health budget accountability should be addressed by the media, with examples. Ask participants to decide why the story or issue was addressed and how it has supported accountability for health budgets for:

   - the audience
   - parliamentarians
   - CSOs
   - women
   - people living with disabilities
   - young people
   - the elderly and
   - any other group.

3. Ask participants how they think this was achieved.

   - What audience was engaged or targeted?
   - Why were the particular media platform, format and style chosen?
   - What research would be required to prepare this kind of piece?
   - What reviews or checks would be necessary to ensure accuracy?
   - What questions were asked for a discussion, an interview or a personal story?
   - What safeguards were there to protect sources, participants and the journalist?
   - What other formats or styles could have been used in your context?

     Presentation: feedback on the case studies, how they were received and their impact

4. Ethical values: scenarios

   - The facilitator should create three or more scenarios related to health budget accountability to test participants' understanding of ethical values.
   - The participants should form small groups to review the scenarios and answer the following questions:

- Which ethical values were upheld in the scenarios?
- Why do you say this?
- Which ethical values were not?
- Why do you say this?
- What would you do differently to make sure all ethical values were upheld?

- Summarize presentation on ethical values

5. Summarize presentation on what the media can do and ethical values.

## Section C. With whom should the media engage on health accountability?

The media have come to encompass a wide range of communication specialists and activities. Traditional journalism was public communication of information through print (e.g. newspapers), radio and television; however, the advent of the Internet has broadened means of communication, so that people with no training can write and share their opinions and those of others without verifying sources or providing evidence. A lot of information is being shared, and the media space is crowded. Sensationalism is not necessary to draw attention to issues, but people use many media platforms, formats and styles, and anyone with digital access can write whatever they want.

### C1. Mutual benefits of collaboration and targeting audiences

The media are powerful and can have a large positive impact when they complement and reinforce field activities by CSOs and national and international NGOs. Combining the diverse skills of different organizations working towards UHC can pay great dividends. For example, use of the mass media to improve health could worsen health inequality unless an effort is also made to reach those who do not have access to the media. Partnerships between mass media organizations and organizations working in communities without access to the media can effectively bridge this gap.

Both content and partnerships must be designed from the outset, including the extent of the collaboration and who will lead. As in any collaboration, communication and transparency are essential.

Audiences are the people who listen, watch and read media outputs and are widely diverse. Deciding who to engage with on health budget accountability for UHC depends on the audiences, how they use the media and how the media can help and empower them. Each media piece must be targeted to a specific audience in order to be accessible, relevant, useful, engaging and of interest.

Audience segmentation is useful for targeting media outputs. Segmentation of a large audience into smaller groups with similar needs, values or characteristics is based on differences in their responses to communication and interventions for social and behavioural change *(104)*. Knowing the audience allows the media to understand the views of different people about important issues according to their gender, age, ethnicity, (dis)ability, relationships, family context, education, work and life experience and other social groupings.

### C2. Networks: With whom can I collaborate and learn from?

Organizations in various sectors increasingly recognize the potential of greater cooperation to achieve positive change and improve the way they work. Partnerships

can include those for capacity-strengthening that are defined as enduring and meaningful and also less intensive partnerships for providing content, training and guidelines.

The media require networks of experts for advice, sources and contributors on health budget accountability and UHC. Collaborations should not compromise editorial independence, and the media should not promote the agenda of other organizations. Rather, such collaborations ensure that media outputs are factually accurate and relevant *(105)*. All partnerships should be based on a mutual desire to promote UHC systems and reliance on health communication to that end. Examples of organizations and people with whom the media could network are given below.

- ***CSOs***

CSOs may work on both health budget advocacy and health budget accountability. They can be a useful source of expertise on health budgets and on audience perspectives and interests in the issues. CSOs can also be helpful collaborators for community engagement and community media activities, such as discussions, debates, live dramas and features or personal stories. In return, media's attention to the issues that the CSOs address helps to raise awareness and thereby increase their impact.

- ***National and international NGOs***

National and international NGOs provide an additional level of expertise, especially with national parliamentarians and policy-makers, and can provide expertise from international debates and commitments to UHC. National and international NGOs may also support and help coordinate networks of CSOs, providing a useful basis for networking.

- ***Parliamentarians***

Engaging with parliamentarians can be complex. The media invite parliamentarians to represent different points of view on programmes and to explain government commitments and also to hold them to account on government health expenditure. The media should be aware of the agendas that parliamentarians may have in working with them and ensure editorial independence. (See module 3.)

- ***Engaged audiences***

Some audiences may already be interested in or engaged in health budget accountability. Media that are considering addressing health budget accountability should map how health budgeting is addressed in traditional and new media, particularly social media, in order to identify the areas are already covered, gaps and needs, with whom they wish to engage and any mis- and dis-information that is circulating and that media can help to challenge. Examples of the use of on-line platforms and digital technology by media for health budget accountability are described below. Any information to be shared and due diligence of contributors should be checked before working with them.

*Blogging*: A blog is an online journal or diary, or even a mini-website, that allows expression of opinions and news, sharing of photos, videos and audio recordings and links to other websites considered to be relevant for the audience and message. The most popular blogging sites are WordPress and Blogger, and see the IBP's "open budgets blog". A blog can be set up by anyone. Bloggers may be useful contacts if they provide factually accurate, useful information and have a large following in the target audience; however, they may spread mis- and dis-information.

*Citizen journalism*: Digital media make it possible for ordinary people to become journalists. Using computers, mobile phones and digital cameras (including on mobile phones), anyone can publish stories of importance to them. Some citizen journalism sites or organizations, such as Global Voices Online, have an editorial staff to ensure that the stories comply with certain minimum standards. Some citizen journalists have had basic training in journalism from media and media development organizations.

*Twitter*: This service allows emission of very short messages (maximum, 280 characters) to "followers" and also to follow others to read their "tweets." People use Twitter almost like newspaper headlines: to alert their followers to news or to an interesting website or blog. As in other forms of social media, the information shared is not necessarily checked for accuracy.

*YouTube*: This virtual platform allows the creation, sharing and viewing of videos online. It has a specific "channel" dedicated to non-profit groups. Many organizations use YouTube to share advocacy information. The information must be checked with reliable sources before sharing it.

## C3. Strategic collaboration: when, what for and how can they bring about change?

Strategic collaboration involves getting to know organizations and people before you need them, how others work and plan in collaborating and how the collaboration will work. The media can work with other stakeholders in health budget accountability for UHC in a number of ways.

- **When:** Map what CSOs, national and international NGOs and parliamentarians and other organizations and individuals are doing online and in the media, and identify the key players and with whom you should speak.
- **Why:** Collaborations can help the media to learn and check information and also to find relevant, reliable expert advisers, contributors and audiences for programme development and production. Collaboration can also help in planning combined activities, such as community recordings.
- **How:** Collaboration between media and non-media can ensure a more holistic approach to addressing health budget accountability, as each sector will learn to understand how each other's activities can bring about change. Working together

can also ensure consistency and trust in factually accurate information, avoid confusion and normalize new practices for the media, non-media and audiences.

### C4. How can I build collaborations?

The first step in forming a strategic alliance involves due diligence. You should decide what you want to achieve and then ask questions about your partner's character, objectives and resources. You may want partners who provide similar resources or, on the contrary, one that will complementary your resources *(106)*.

Secondly, the alliance should have the common objective of ensuring that all the organizations are committed to the main goal and can share advocacy. Collaborations can be treated as strategic alliances in which the partners share resources and risks in advancing towards an agreed goal. In strategic partnerships, the working methods, standards and desired outcomes are matters for negotiation.

Trust, transparency and credibility are critical for a successful relationship. With these elements, the answers to questions on whether and how to best serve the audience should be obvious.

Inherently, collaboration involves activities outside one's immediate control, which may appear threatening to some. Aspects to be considered before establishing a collaboration are whether the roles are unclear or uncomfortable and whether the collaboration will involve more work. Often, collaborations represent friction among ideas and new ways of working, which make new demands on all participants.

The relationships you build at different levels of the health system are vital not only to obtain the information you need but also to form strategic allies for influencing policy change. A number of strategies can be used to build momentum for change. One is to nominate "champions" in parliament and build relationships with them or with decision-makers who can raise issues in the appropriate forums *(97)*.

## Activity: Collaboration

1. Quick discussion on to whom health budgets and expenditure might be of interest to and why.
2. Three stories will be covered.
   - Small groups should discuss the following questions, perhaps with a similar or the same response for several questions.
     - What is the issue? Who or what is being held to account and about what?
     - Who is the audience for the story – influencer, beneficiary? (Add gender, age group, ethnicity, disability and anything else that defines them that could influence how you cover the story.)

- Who are your sources?
- Who are your partners or allies, such as CSOs, NGOs, networks, parliamentarians?
- Who are your contributors? Those being held to account or those with an interest in the story?
- What risks are associated with collaboration or working with any of the groups and sources?
- How can you mitigate those risks?

- Feedback – are all the responses appropriate? Is anyone missing?

3. Doing no harm to ourselves or others
   - In the same groups, write down the possible risks for each group in one of the stories.
   - Ensure safeguarding, privacy, fairness and doing no harm.
   - What are the potential risks for you and your organization?
   - How would you mitigate each of those risks?
   - Feedback to the group: Do we agree? What's missing? What other considerations are there in working with these groups?
4. Summarize the presentation.

## Section D. When and where in health budgets can I play a part?

The media are important in ensuring open, accountable public budgeting. Traditional print and broadcast outlets and new media can help the public understand health budget decision-making and implementation, what is in the budget and how funds are actually raised and spent. They also play an important role in oversight.

### D1. Where in the budget process can I have the most positive impact, and why?

The budget sets out how the government will raise funds and distribute them to ministries, states and local structures responsible for delivering basic services, such as health. In general, the budget cycle consists of four stages *(107)* (see Chapter 2, module 2, Section C). National media should understand their government's budget cycle so that they know when to cover issues, inform discussions and help audiences to contribute to and monitor the outcome of decisions. There are four stages.

1. Planning and preparation are the beginning of the budget cycle. The media's role is in making the cycle easy to understand and to indicate where the general public might be involved. The media must have access to budget documents during this stage so that they can help their audience to engage with decision-makers and to understand how the cycle starts. The media could help their audience to engage by holding debates and discussions with budget decision-makers and in drama, features and analysis. Covering the budget over time helps audiences to understand the stages of the process and the consequences of government decisions.
2. At the stage of analysis and approval, the media can help the public to attend parliamentary select committee hearings by announcing when and where the hearings will be held and how and who can access them. They can also build understanding of and provide updates on the approval process. The media can help civil society to look critically at the budget to ascertain its conformity with national priorities and seek further clarification where necessary.
3. During implementation, the media can help citizens to hold the government (at all levels) to account by measuring the impact of budget allocations, disseminating the findings and monitoring budget spending by engaging with authorities and service providers.
4. The media can monitor budget expenditure at each stage, while the government monitors and evaluates its expenditure on health for UHC and reviews its expenditure. As in the other stages, the media can track the reviews and compare them with CSO and NGO evaluations of expenditure.

The results of analysis and monitoring of the government's health budget should be shared strategically by knowing when and how to lobby decision-makers, with evidence to support the arguments about what should change, and why *(97)*. For example, when

the national budget is presented, a news story or drama could indicate the overall changes in the budget since the previous year or compare funding for the health sector with that for other sectors or with the health budgets of neighbouring countries. Consider appropriate contributors to whom the audience will listen, and invite them to be involved in covering an issue.

## Activity: Role of the media in the budget process

1. Hold a quick discussion on what could be covered, talked about or be the subject of a story on the health budget process.
2. Understanding where a positive impact can be made on the budget process.
    - Give small groups a health budget topic, such as the budget for emergency maternal and newborn health, childhood vaccination services, care for mental health issues, sexual health services, HIV services, accident and emergency health services.
    - Ask each group to draw the budget process and the stages and steps of each element.
    - Ask each group to propose seven ideas for stories that hold budget-makers to account at each stage. Help each group to think beyond news stories and to identify the audience for each story.
    - Provide feedback to the group, discuss, ask whether the whole group agrees on which are workable and why. Keep these ideas aside for a later activity.
3. Summarize the key points of the section.

# Section E. Addressing universal health coverage budget accountability in a way that engages the audience

## E1. How can the media support UHC budget accountability?

The main activities are to:

- **empower audiences** to hold health budget decision-makers to account;
- **give audiences a voice** to share their concerns, ask questions and give opinions;
- **create a space for decision-makers and citizens** to discuss challenges and find solutions *(99)*;
- **highlight initiatives and interventions** that could improve access to good-quality services and financial protection for people and communities; and
- **hold policy-makers and politicians accountable.**

For these activities, the knowledge and understanding of audiences should be built by providing clear, relevant, easy to understand, factually accurate information in various formats. Audiences should be given the opportunity to ask questions of health budget-makers and financial experts in call-ins, debates and small group discussions. The confidence and motivation of the audience should be built with support, skills, personal stories from people like them and experts to understand how to act, why it is worth engaging in health budget accountability and consider themselves able to do it. This should be done as creatively as possible. News journalism may be a part, but other formats can be used to engage audiences who prefer non-traditional media. The range of factual, drama, stories, voices, short formats, rhymes, music and influencers should be used to interest and engage your audience. Use of multiple channels, platforms and outputs can normalize the general public's engagement in health budget accountability.

Examples of media activities to support participatory budgeting include the following *(102)*:

1. Convey expert information on the topic, for instance by creating appealing visualizations, drama or personal stories from information provided by a municipality, which will strongly support participatory budgeting.
2. Help audiences to participate. Participatory budgeting that is mentioned on only a small notice on the last page of a newspaper will not become a topic of public discussion or engage the wider public.
3. During the accountability phase, share information and update the public on decisions. The media and the public could enquire when information on the outcome of the participation phase will be provided.
4. Act as the "fourth power", with the legislature, the executive and the judiciary. The media have an important role in scrutinizing policies and the administration, for example by denouncing lack of transparency.

5. Cover health budget processes in various ways. Critical journalism and also other styles and tones can be used to engage a range of audiences and help them to understand successes, failures and opportunities for improvement.

## E2. Setting objectives for stories

Once the media decide to address health budget accountability, they should consider why, what they hope to achieve and for whom in the long term, thus arriving at a goal for the work, such as, "In 4 years' time, my audience will be engaging in participatory health processes and considering that they have a say in health budget processes". If that is your goal, consider what your audience requires at different stages during the next 4 years from the point of view of information and skills. This will differ according to the media platform and format. Thus, at the start of an idea, a media outlet should consider who is the audience and what they will think, know, feel and be able to do once they have engaged with the strategy or output. This may not be what was wished but what can actually be achieved with the strategy or output. The activity below can be used to explore and practise such considerations.

## E3. What platform, format and style should be used?

The media platform (television, radio, digital, mobile phones), format (e.g. drama, factual, social media, podcast, interview, feature, magazine programme) and style (e.g. formal, informal, personal, humorous, serious) will depend on the topic and what and how the intended audience engages with the media.

The audiences must be identified and targeted through the appropriate media. They can be identified by research in media mapping and information on media usage in many countries[16] or through your own research. Many media organizations have websites, which usually contain useful facts and figures, such as target audience and audience size. Examples of audiences and media that might be targeted by an organization involved in applied budget work are *(93)*:

- *Finance officials and parliamentarians*: through weekly financial magazines, business newspapers, business inserts in major newspapers, opinion pages of major newspapers, current affairs programmes and talk shows on national radio. The Internet is an increasingly important medium for this group, as weekly financial magazines increasingly emphasize their online versions, and some influential business and financial media operate solely online (e.g. the South African Moneyweb). Influential bloggers or columnists in online publications could also be targeted.

[16] For more information, see Internews, BBC Media Action and BBC Monitoring initiatives.

- *NGOs and CSOs*: specialist development publications, development supplements in newspapers and magazines, websites or portals such as the Communication Initiative Network, Development Gateway and SANGONeT in South Africa.
- *The general public*: mass circulation newspapers; radio stations, particularly community radio stations and public radio stations; television; and, when easily accessible, on-line and social media with news and talk content, drama, personal stories, recorded community discussions, quiz shows, music, interviews and features.

How a topic is covered and how well accountability is addressed will be depend partly on the collaborators, such as experts in health budgets and expenditure and the right contributors. Will the piece be supported and shared by others? Was the best possible evidence used? All depends on the strength of the networks.

## Activity: Engaging your audience

1. Small groups should be asked to design seven formats and styles for supporting health budget advocacy.
2. For setting and using communication objectives, give the small groups the following scenario:
    - Your audience is not engaging in discussions being held by parliament about the health budget. You realize that your audience needs information about how to engage and also feels motivated and able to attend.
        - Know when parliamentary discussions are occurring and how to attend.
        - Know what happens during the discussions and how to participate.
        - Consider attending whether these discussions is important and possible.
    - You decide to organize a series of discussions in local communities with parliamentarians and CSOs to support participatory budget processes and to learn how to engage in discussions led by the government:
        - What do you want people to think, know, feel and be able to do after engaging in one of the discussions? Ask groups to state objectives that start with: “know that”, “feel” or “can”.
        - Your audience research indicates that men listen to the radio mainly on their phones at or on their way to and from work, while women tend to listen to the radio early in the morning and in the evening. People tend to watch television in the evenings and at weekends and often watch sports on a Saturdays and a popular drama in the evening on Sunday. Some men and women have access to the Internet at work, while others do not. WhatsApp is the most popular messenger app, and, while many young people do not have smartphones, those who do tend to use Instagram and YouTube and show the posts to friends who do not have access.

  - What platforms, formats and styles will you use to reach your different audiences? Ask the groups to propose seven ideas for each audience.
  - Feedback to group: Why do you think these ideas will work?
3. Traditional vs new media. How might an investigation into budgets be developed differently for e.g. radio and for Twitter?
   - Ask the small groups to develop one of their seven ideas into an idea for radio or television and another for social media or other on-line platform or format.
   - Who do you wish to engage on each platform?
   - How does the development differ, and how is it similar?
   - Would you listen to, watch or share the output? (Be honest!)
4. Ideas for covering health budgets
   - Assign each group one stage in the budget process.
5. Summarize the presentation.

# Section F. Limitations to media engagement

This section addresses the potential risks, limitations and challenges that the media might face in working on accountability of government finances. The lessons below can be applied to any issue and not just health budget accountability.

## F1. Consideration of challenges and risks for media

### Fragmentation of media

The media are becoming increasingly diverse and complex, and audiences are fragmenting. In most countries, one can no longer be assured that most people will see or hear a story on national radio or television or read it in a major newspaper. At the same time, new technologies make it easier to produce media and to access a wide range of media, through digital television with hundreds of channels, cell phones, new radio stations and the Internet. There is also a dramatic change in how news is made and disseminated: the model of the authoritative, trustworthy news institution is breaking down, as Internet and cell phone technologies make it possible for ordinary people to produce and share news.

We have seen the rise of citizen journalism, blogs and media-sharing portals. Another trend is technological convergence. You can now watch television and listen to the radio on your cell phone, read newspapers online, surf the Internet on your television with a set-top box, make phone calls from your computer, record audio on your phone or MP3 player and reach wide audiences by posting podcasts, photos or videos on the Internet. This has dramatic implications for the ways in which the media can influence public discussion and policy-makers. In a number of countries, bloggers exert a great deal of influence on the mainstream media and thus on political life.

It is important to keep up to date with these developments and to seek innovative and effective ways to respond to them, while not forgetting traditional media, as, in many countries, radio continues to be the most commonly used medium among those without media access. Despite the rapid proliferation of different media platforms in recent years, some populations still cannot listen to the radio, watch television or access the Internet, either because they lack money to pay for equipment, because of gender-based discrimination or because they live in remote or hostile terrain, with no signals and where transmitters cannot be erected.

### Language and jargon

In general, health and governance stories are riddled with complex language, technical economic terms and numbers, which are challenging for both the media and audiences *(103)*. The media must communicate scientific, medical and political information in a way

that the public can understand and provide clear information about the concepts and how to apply them.

## The legal context for the media

How freely and independently the media and citizens can hold those in power to account depends partly on the legal context within which they conduct their activities, which derives from international legislation. The Universal Declaration of Human Rights is the international law that determines how other laws are interpreted. In its Article 19, the Declaration establishes a fundamental guarantee of the right to freedom of expression, including the freedom of the media. This has repercussion on and influences Article 19 of the International Covenant on Civil and Political Rights: Any person must have the right to freedom of expression; this right must include the freedom to investigate, receive and share information and ideas of any nature, without considering borders, whether oral, written or printed, through art or any other means of their choice.

There are similar regional treaties in Africa, the Americas and Europe, each of which provides similar guarantees on freedom of expression and media freedom. At national level, however, regulations may stifle the independence and impartiality of the media. In this context, the media can use ethical values to determine whether they can run a story and from what angle.

## Engagement on budget in a closing civic space

Media is a critical component of the civic space, not least because of the importance of the fundamental freedom of expression but also because the media have the power to hold governments to account, reveal violations and provide a platform for the most marginalized voices *(108)*. Dozens of governments are erecting legal and logistical barriers to democracy and rights, publicly vilifying and harassing their domestic and international CSOs, the media, human rights and aid groups. This has seriously reduced the space for manoeuvre for the media and civil society.

This should be the golden age for free speech, as our smartphones can call up news and information from the other side of world in seconds, and we can connect with the rest of the world via social media at any time. New media or social media have become effective, accessible tools for active citizen participation and engagement. As they operate in real time, new media may be ahead of traditional media in drawing immediate attention to an issue. Anyone with access to the Internet can be a publisher. Nevertheless, the world today is a more dangerous place for journalists, defenders of civil society and human rights, and the general public often does not understand the risks of having a public profile on-line and how to mitigate those risks. The number of journalists and defenders of human rights who are imprisoned, attacked or killed is increasing *(109)*.

### Cyber security

Media companies are often manipulated because of their wide audiences.

## Activity: Limitations and challenges

1. Ask the group to discuss the key challenges, limitations and considerations for their contexts, to consider national laws, media freedom (in general and on different platforms), media accessibility, independence and control, health context and infrastructure and as many other aspects as possible that could limit or challenge media coverage of health budget accountability for UHC or put contributors and audiences at risk.
2. In the case study in section A:
   - What limits or challenges do you think the people who produced this study faced?
   - Was there any mitigation?
   - What unintentional or undesirable results or outcome might have this had? What changes would you suggest? Focus on the approach, not the activities.
   - Summarize the approach, discuss the general limits and challenges for accountability for UHC budgets and safeguarding and protection of sources, participants and journalists.
3. Step 2 of activity in section D:
   - In the same groups, work through at least three of the ideas they have proposed. Consider, for the context and media platform and format you work on, the potential impacts of doing this story. For sources? For contributors, including people who wrote comments on social media? The subject of the story? Your audience? You?
   - Feedback to the group: Was anything missed (e.g. context, ethical values)? Anything to add? Mitigation?
   - Would you run the story? If yes, with any caveats?
4. Summary of key points

## Activity: The final “pitch”

Considering everything you have learnt, use the scenario you have been given to identify an idea, concept or story, and “pitch” it to your editor or manager.

- Identify the issue you want to investigate or cover, and explain why it is of public interest.
- Identify your approach to covering the issue. What platforms, formats and styles will you use, and why?
- Identify how and why your approach to covering the issue will help your audience and in what way.
- What research should you do? What should you learn more about? Where and how can you do the research? Who should you speak to? What experts, networks and sources can you use?
- Outline the story or idea.
- "Pitch" it to a panel.

The facilitator will form a panel of three or four people, who will give feedback on each idea. The panel should include at least one new media person if possible, one senior traditional media person and one or two audience members.

Summarize the key points and next steps and commitments by participants on what they will do next.

# Module 3. The role of parliamentarians

The main audiences for this module are legislators and members of parliament (MPs) and their staff interested in UHC budget issues. For simplicity and because the objective of this module is not to discuss different legislative or parliamentary systems, the term "MP" refers to legislators and "parliament" to legislature. The objective of the module is to clarify the accountability of these groups for oversight of the public budget to achieve UHC in their country. It provides information on their roles, responsibilities and potential contribution to achieving UHC and collaboration with other stakeholders towards this goal. The information in this module may also be helpful for CSOs and the media to understand the role of MPs in advocating for UHC budget accountability.

This module covers:

- parliaments and their relevance for UHC budget accountability,
- parliamentary oversight functions and why they matter for UHC budget accountability,
- challenges to and limitations of parliaments for effective budget oversight and
- engaging citizens and other constituencies in effective participation in UHC budget accountability and oversight.

## Section A. Parliaments and their role in accountability for the Sustainable Development Goals

### A1. Why should parliaments engage with the SDGs, and what is their role?

In democratic systems, MPs are elected to represent their constituents and their needs. By accepting this power of representation, MPs also accept the obligation to ensure that governments comply with commitments made to advance the rights and well-being of the citizens they represent.

The Global parliamentary report 2017 of the Inter-Parliamentary Union (IPU) and the UNDP *(110)* addresses parliaments' oversight role in its introductory note:

> Parliamentary oversight improves the quality of government. It helps to keep in check the power of the executive and therefore contributes to strengthening democracy. Globally, parliamentary oversight is expected to underpin countries' progress toward the goals set out in the 2030 Agenda for Sustainable Development.

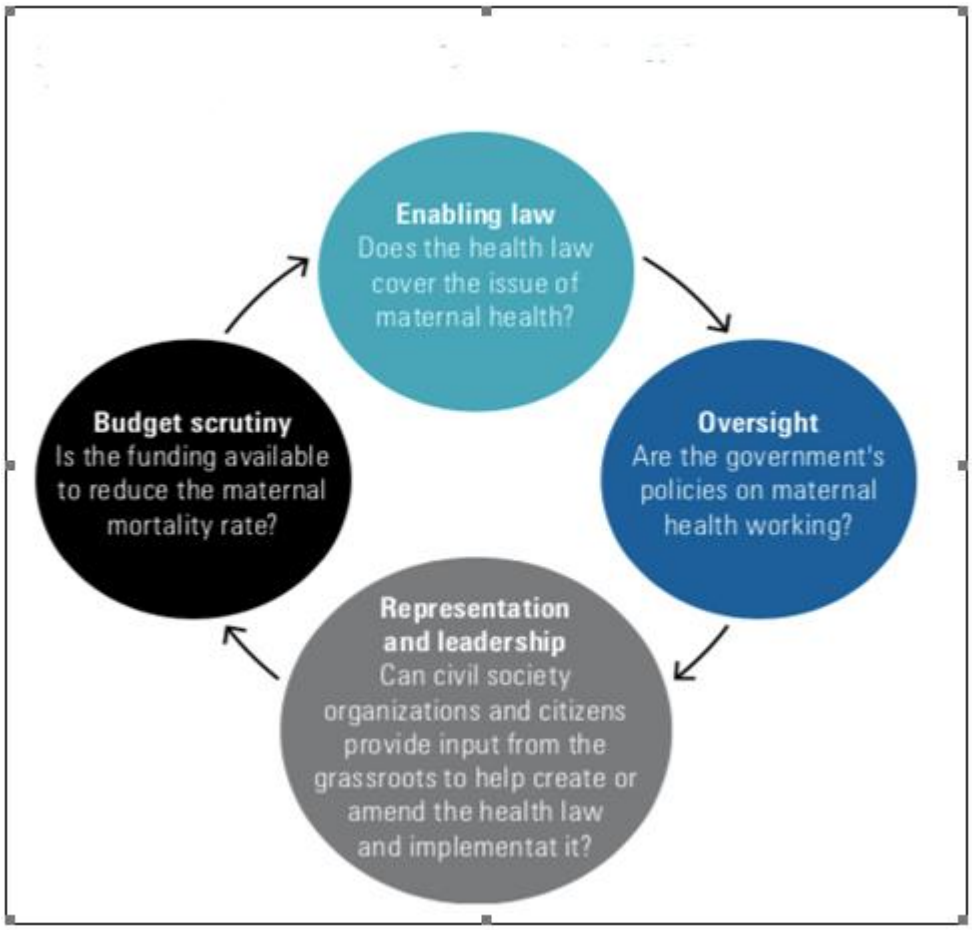
The SDG agenda mobilized strong commitments to advancing the right to health of all peoples. SDG 3.8 mobilized the global health community, including states actors, to commit to progressive achievement of UHC. Furthermore, on the basis of experience with the Millennium Development Goals, the SDG agenda recognizes the value and

potential impact of multi-stakeholder platforms and collaboration in achieving each of the Goals. Because of their unique oversight power, therefore, parliaments should be understood (and understand themselves) as key actors in monitoring and evaluating achievement of these goals at national level.

In the Global parliamentary report 2017 *(111)*, the IPU and the UNDP recognized in relation to the SDGs that

> Parliaments can drive significant change toward sustainable development by: translating the SDGs into enforceable national laws that respond to, and fit into existing, country-specific development priorities; monitoring implementation of these laws; and ensuring government is accountable to the people for progress on these goals. Fig. 10 illustrates the role of parliaments in achieving SDG 3.

**Fig. 10. Role of parliaments in achieving SDG 3, promoting healthy lives**



Source: reference *111*

As for all the SDGs, parliaments have a fundamental role to play in ensuring that countries, according to their financial capacity, advance towards achievement of UHC. Because public budgets are instrumental to achieving UHC, the budget oversight function of parliaments can contribute to ensuring that governments choose the right budget priorities, allocations, distribution and use of public resources related to UHC.

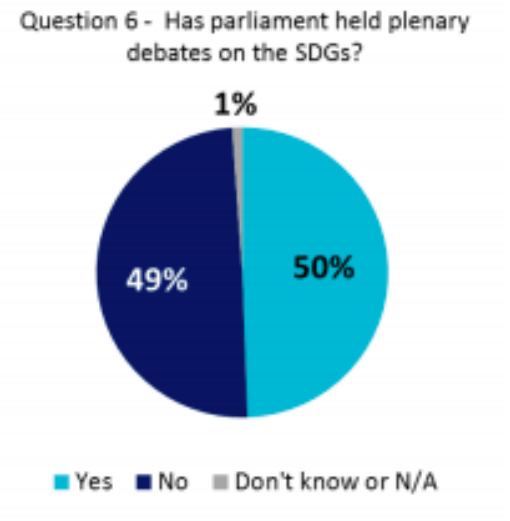
Parliaments are also key in achieving SDG 16 and its targets for transparency, participation and accountability at all levels.

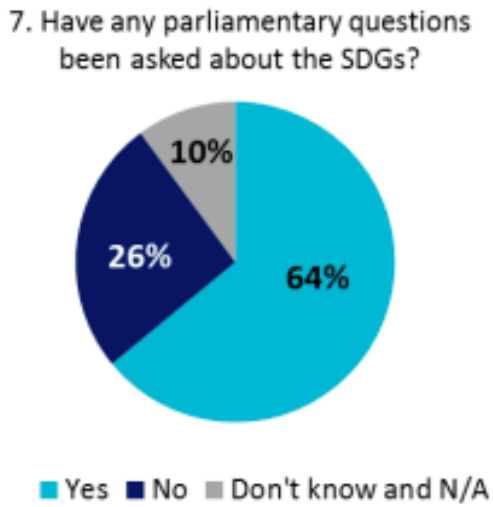
## A2. To what extent are parliaments engaging with the SDGs?

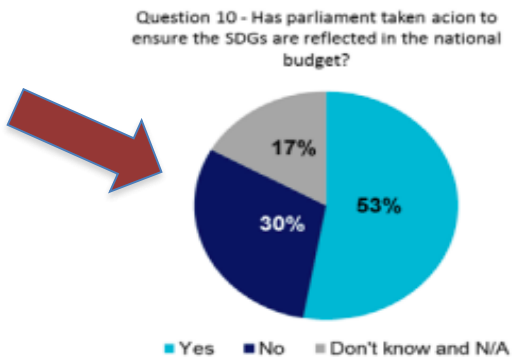
In 2018, the IPU conducted a global survey of the extent of engagement and institutionalization of the SDGs in the work of parliaments around the world *(112)*. The survey received responses from 89 MPs, all but one of which were members of the IPU.

Fig. 11 shows a few results that might be of interest for identifying the type of activities MPs are doing with regard to the SDGs, including their budget oversight role.

**Fig. 11. Responses to selected questions in the IPU survey of the role of parliamentarians in UHC budget oversight**






Source: reference *111*

The survey does not provide details of the respondents' answers, and the answers were self-assessed. It is nevertheless interesting that, overall, SDGs appear to permeate legislative debates. Although the majority responded that the SDGs (including SDG3) should be reflected in national budgets, a surprising 30% of respondents reported that this was not the case, and 17% reported that they didn't know. These negative responses indicate that MPs should be more aware or more engaged in mobilizing their peers in considering the SDGs key legislative actions. In the context of UHC, the engagement of MPs in ensuring that resources are allocated (and well spent) to achieving SDG3 is important.

## Tool: Questions for assessing parliamentary involvement in the SDGs

**Purpose of the tool:** The IPU, the UNDP, the Islamic Development Bank and the Global Organization of Parliaments against Corruption prepared a self-assessment toolkit and handbook to help parliamentarians to evaluate their engagement with the SDGs *(112)*. This resource includes some questions that MPs can ask themselves, both as individuals and as part of a larger institution, to assess the extent to which they are (or not) engaged with the SDGs and how effectively. For our toolkit, this tool can incite MPs to pose similar questions with regard to the UHC-related SDGs. Box 14 lists questions that might be particularly relevant for UHC budget accountability.

**Box 14. Self-assessment relevant for UHC budget accountability by parliamentarians**

- To what extent does parliament review, debate and act on progress reports and other relevant government documents on implementation of the SDGs and/or national sustainable development plans?
- How are parliamentary recommendations on sustainable development and/or SDG-related issues incorporated into government policy? To what extent can parliament ensure follow-up of recommendations about SDG implementation from global bodies, such as the high-level political forum?
- Are recommendations by international bodies to governments on SDG implementation tabled in parliament for review, debate or action? To what extent can parliament conduct its own inquiries into issues related to SDG implementation?
- Is the authority to initiate inquiries used to examine government implementation of SDG-related programmes or policies?
- How effective is parliamentary monitoring of the government's development policy, as a donor or a recipient of overseas development assistance?
- Are annual reports on disbursement or receipt of overseas development assistance submitted to parliament for consideration in plenary or in committee?
- How effective is parliamentary monitoring of the government's interactions with international development partners (e.g. bilateral donors, regional bodies and multilateral organizations)?
- Is the government required to table information in parliament on programmes, projects and activities supported by international development partners?

## Activity: Application of the self-assessment tool on engagement with SDG 3 and UHC.

Ask participants to work in pairs to translate the questions in the self-assessment tool or the full self-assessment questionnaire, available here, into questions more closely linked to health and UHC.

- Separate the participants into pairs or groups of three.
- Ask each group to choose three or four questions and translate them into questions pertaining to UHC and UHC budgets.
- Ask them to discuss both the general question on SDGs and that which they created on UHC budget advocacy and to identify commonalities and differences.
- In plenary, ask the groups to share their results.

- Ask the whole group to conclude whether their current level of engagement with the SDGs and UHC should be improved and whether some lessons and experiences should be shared with the others.

# Section B. Parliamentary oversight function and its relevance for universal health coverage budget accountability

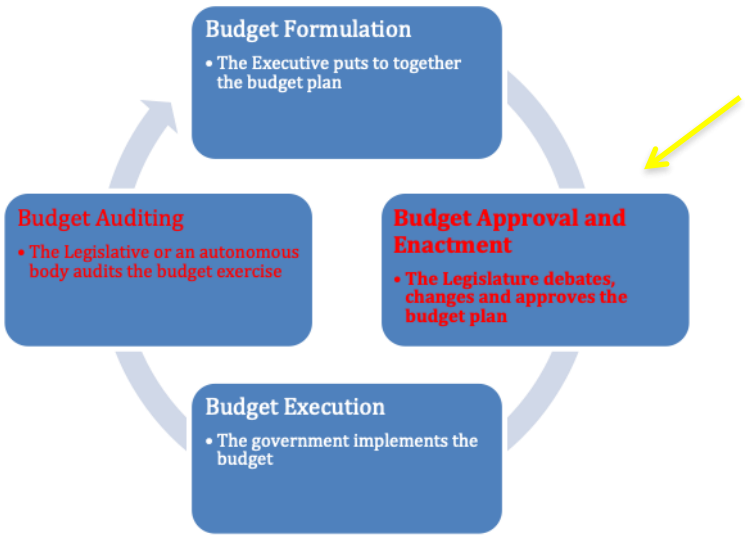
## B1. Parliaments and the public budget, a brief introduction

The relations between parliaments and the budget constitute what is commonly known as the "balance of power". The IPU and UNDP clearly explain this historical relation *(110)*:

> One of the historic reasons for the development of parliaments was to provide financial resources to the executive arm of the state. In exchange, the government was bound to report back to parliament on the use of these funds. This led to the development of the oversight function of parliament."

Parliament's instrumental role in relation to the budget is manifest during the approval or enactment and the auditing stages of the budget process (Fig. 12).

**Fig. 12. Role of parliaments in relation to the budget**




Parliaments have the most decision-making power with respect to the budget during the stages of approval, enactment and auditing. Traditionally, the executive formulates a budget and sends it to parliament for review, approval, amendment and enactment. The

IBP has published a budget advocacy toolkit that clearly describes the stage of approval of the public budget and the role of MPs,[17] as summarized in Box 15.

**Box 15. Process of approval of a public budget**

1. Parliament receives the executive budget proposal from the ministry of finance, considers the proposal and delegates revision and discussion to various parliamentary committees.
2. According to good practice, parliament must have at least 3 months to review the proposal exhaustively, to discuss it and, depending on the country, make recommendations for amendments. Some, if not most, countries allow less time, and many parliamentarians do not have the technical knowledge or capacity to do so.
3. Some countries may hold public hearings, at which MPs consult citizens, experts and other constituencies to inform their recommendations and decisions on the budget.
4. Once the budget has been reviewed and perhaps amended, it is subject to a vote and ultimately passed into law.

## Activity: Checklist for an executive budget proposal (from reference *3*)

This activity can be conducted individually or by partners. The objective is for participants to assess relevant information in the executive budget proposal that they, as MPs, should understand.

- The duration of this activity is 1 h or 1.5 h if you choose to have a plenary discussion afterwards.
- Provide each participant with a copy of Table 7.
- Ask each to log onto the website of the ministry of finance in their country and search for the most recent executive budget proposal.
- Individually or in pairs by country, they should answer as many of the questions in the table as possible.
- Prompt participants to identify questions to think about while reading the document and to include their answers in their comments.
- Give them 45 min for this activity.
- In plenary, ask participants to present what they found and what they consider interesting, confusing or relevant.

[17] This toolkit has not yet been published; however, COMETA received written permission from IBP's training and technical assistance staff to use this material in the toolkit.

**Table 7. Executive budget proposal checklist**

| Does the proposal include: | | Yes, No, Comments |
|---|---|---|
| 1 | A budget speech (usually made by the minister of finance) that introduces and contextualizes the budget proposal. | |
| 2 | A budget summary, outlining the main points in the proposal. | |
| 3 | A budget bill, setting out the specific expenditures for legislative authorization in the format required by the country's public finance law. | |
| 4 | An economic outlook, describing recent developments in the domestic and international economy and important macroeconomic variables. | |
| 5 | A medium-term fiscal framework, including forecasts and a discussion of fiscal policies. | |
| 6. | Revenue projections, with a detailed account of all expected revenues by type, including new revenue measures and their fiscal implications. | |
| 7. | All proposed expenditures, presented by administrative unit, economic classification and functional classification. | |
| 7.1 | Priority spending programmes, such as expenditure for UHC. | |
| 7.2 | Information on capital projects, with details, total approved cost, expenditure to date, sources and types of financing. | |
| 7.3 | Performance indicators, including both financial and non-financial measures for monitoring progress during budget execution. | |
| 8. | A financing strategy, explaining how the budget proposal will be funded, with details of domestic and external financing of the deficit. | |
| 9. | A debt overview, including a detailed account of the level and composition of all public debt, debt servicing and how the debt is being managed. | |
| 10. | A summary of assets, including all the financial assets held by the government, by entity and category. | |
| 11. | Supporting documents on all fiscal activities that do not require annual appropriations, such as social security funds and autonomous agencies. | |
| 12. | Information on state-owned corporations, with overviews of their assets, liabilities and financial performance (profits and losses). | |

## B2. Budget oversight role of parliaments and the association with UHC budget accountability

Parliamentary oversight of the budget is essential to ensure both checks and balances and accountability. The IPU and the UNDP have identified several opportunities for budget oversight by parliament, which are summarized in Table 8, to help MPs build knowledge and skills for engaging more meaningfully in budget oversight. A few additional ideas have been added that MPs might find useful at each stage, which are based on best practice,

**Table 8. Opportunities for budget oversight by parliament**

| | |
|---|---|
| Contribute to budget formulation. | • Become involved in the budget process before the budget is introduced to parliament for consideration and approval and before public hearings in which parliamentary committees collect information on needs and priorities of which they may not be aware.<br>• Hold debates on the pre-budget statement in which the government describes potential priorities and macroeconomic assumptions in order to identify key issues and questions that may be relevant during budget discussion and approval. |
| Examine the proposed budget. | • Substantively engage with the committees that will scrutinize the budget once it arrives in parliament for discussion and approval.<br>• Engage technical staff to analyse the budget for issues of interest to obtain solid evidence for discussion.<br>• Call for public hearings or invite stakeholders to present evidence and data that may be useful in reviewing and final approval of the budget. |
| Amend the budget. | • When MPs have the power of amendment, they should ensure that the budget reflects the priorities expressed by their constituencies and evidence from other stakeholders and technical staff.<br>• If the budget does not reflect these priorities, participate in requesting amendments to ensure that allocations meet those needs.<br>• When the power of amendment is restricted or inexistent, MPs can encourage amendments indirectly by initiating debates on, for example, lack of results or meeting the original objectives. |
| Oversee public accounts. | • Participate in reviews of budget execution by requesting and reviewing in-year and end-year reports.<br>• Identify gaps in spending or areas in which funds have been reallocated by the government during execution.<br>• Hold public hearings with constituents to determine whether allocated funds are being spent and spent on the original priorities.<br>• This information can be powerful for use in discussions and decisions for the subsequent fiscal year. |

## Tool: Tips for MPs on budget oversight

**Purpose of the tool**: These tips were developed by the IPU and the UNDP in their Global parliamentary report 2017 *(110)* to prompt MPs to reflect on their budget oversight role (Box 16). **Box 16. Tips for MPs on budget oversight**

**Tips for MPs: Oversight of the budget**

**Why should I get involved?**

Government sets out its policy intentions and how it intends to resource them through an annual budget. It is one of the most important documents government produces. Parliamentary oversight is equally important. Only a few parliaments have the power to set budgets, but many more are able to amend or reject the budget, while some parliaments have no powers at all over budgets.

Subject area committees can also oversee the budgets and spending of the relevant ministry, bringing significant knowledge and experience of the particular services.

**What do I need?**

- An understanding of the budget process, including timescales and key dates.
- An understanding of key concepts:
  - income (how government raises money);
  - expenditure – how government spends money;
  - the difference between revenue and capital expenditure;
  - variances between budgets and actual expenditure;
  - deficits – the difference between expenditure and income;
  - debt;
  - borrowing;
  - cash management.
- Expert advice and analysis where available, including gender analysis; some parliaments provide budget research offices.

**How can I contribute effectively?**

- Consider the issues facing government for the next and future financial years:
  - Are there specific critical issues which need to be funded, such as a military intervention, a national emergency, or a debt or deficit to pay off?
  - Is government committed to particular levels of spending as part of an international commitment, such as membership of a regional body?
  - What new policies are being introduced? Can they be funded? Is government intending to reduce other spending to fund the new policy? Is this justifiable?
  - How effective has spending been to date? What outcomes are expected from the proposed expenditure? Has value for money been achieved?
- Some other questions to consider:
  - Income (how is the government going to raise money); what taxes are in place?
  - Is income tax progressive? That is, do those who earn more have to pay more?
  - Consider the budget from a gender perspective – for example, how do taxes impact on men compared to women?

## Activity: Sharing experiences on budget oversight in relation to UHC

Group discussion and collective reflection on the oversight role of MPs in the public budget and the positive or negative influence on UHC

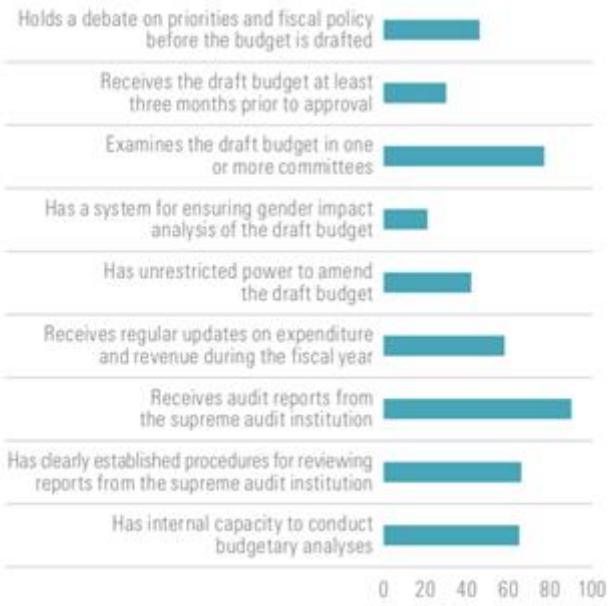
- Separate the group into groups of three to five people. Combine representatives of different countries for cross-learning.
- Ask them to reflect for 35 min on the information you have provided with regard to the following questions:
    - On a scale of 1–10 and on the basis of the information provided on the oversight role of parliament, to what extent are you effectively playing this role?
    - What is effective oversight of the budget in general and of the budget for UHC, and what role could you as an MP potentially contribute?
    - If you consider that you are playing an effective oversight role, how are you doing so?
    - What would allow you to play a more effective role?
- After 45 min, ask each group to present their conclusions in plenary in 5 min.
- The facilitator should identify examples of good practices in oversight for UHC in order to document examples.
- The examples should be written on one page each and be distributed to the participants after the workshop.
- The question for collective reflection will be on lessons and good practices that have been identified.

## B3. Challenges and limits of parliaments and their members for effective oversight

The section above outlines the roles of MPs and parliaments in budget oversight. In practice, however, they are not always fulfilled, and parliamentary oversight functions are often limited for many reasons, which include formal power arrangements (that is, what is mandated to them), lack of technical capacity, lack of access to information and non-compliance with their roles for other reasons.

Box 17 is from reference *110*. It shows the opportunities identified by a sample of 100 MPs from different countries for engagement in budget oversight.

**Box 17. Opportunities for parliamentarians to engage in budget oversight**



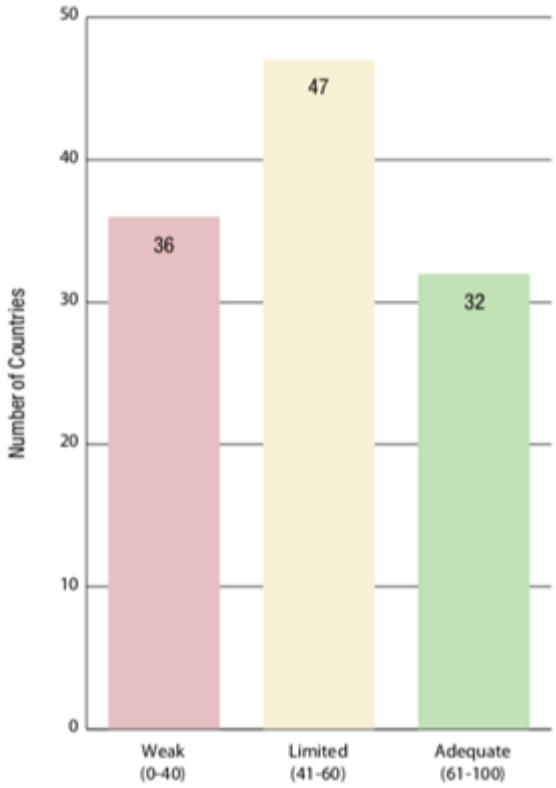

The results are consistent with traditional parliamentary engagement with the budget process, as most MPs identified more opportunities for oversight during the approval and auditing stages of the budget process. Some important limitations are highlighted, however, which should be considered by MPs who wish to play a substantive role in overseeing UHC- and SDG-related budgets:

- at least 40% do not have the internal capacity to conduct budget analysis;
- less than 50% have unrestricted power to amend the budget; and
- 60% do not have 3 months to review the budget before its approval.

In many countries, therefore, parliaments should be further strengthened to oversee public budgets effectively and to monitor and ensure advances towards UHC. This is an important challenge, which should be recognized if MPs are committed to and are expected to ensure accountability in the achievement of UHC.

The Open Budget Survey *(68)* provides additional evidence of the sometimes limited oversight power of parliaments in some countries. The survey assessed the extent of oversight power by national parliaments, and Fig. 13 summarizes the results in terms of the strength of oversight of the budget by parliaments.

**Fig. 13. Countries grouped by legislative oversight score**




Source: reference *68*

Most parliaments have weak or limited budget oversight power *(68)*:

> only 32 legislatures (28 percent) out of 115 surveyed have adequate oversight practices. A plurality of 47 countries (41 percent) have only limited legislative oversight, while 36 countries (31 percent) have weak legislative oversight.

## Section C. Engaging citizens in effective participation in budget oversight for universal health coverage

*Representation and oversight: the role of parliaments in fostering effective participation in the budget process*

One of the key functions of parliaments is representation, as MPs represent the views and needs of their constituents. In order for this role to be effective, MPs should continuously engage with their constituencies, through:

- public consultations and dialogue,
- research and analysis of their needs and perspectives,
- using information and evidence from their constituents in making decisions for which they are responsible; and
- opening parliament to constituents and sharing relevant information with them.

To the extent that MPs do this, "the work of the Parliament will reflect the context and reality of people's lives" *(68)*.

One area in which effective representation can be ensured is the public budget. If public budgets are the government's key tool for implementing policies and responding to people's needs, public participation in the budget and the budget process is paramount. Citizens are, like MPs, key actors in oversight and accountability, as discussed in depth in Chapter 2. In this section, we underscore the role of MPs and parliaments in ensuring effective public participation in the budget process as a means to improve oversight of the budget and the budget for the SDGs and UHC.

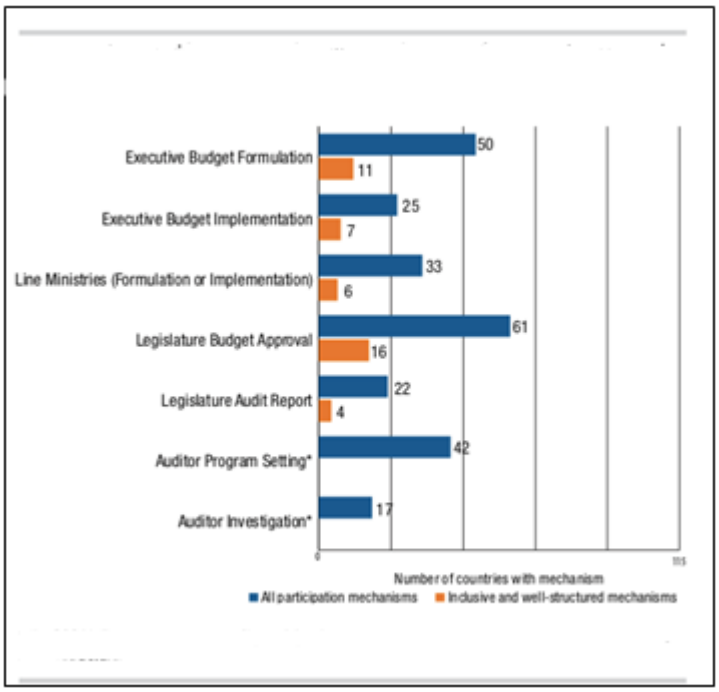
MPs consult and talk with their constituents to identify their needs and then ensure that they are reflected in the public budget. MPs also form alliances with their constituents and their organizations or use their information and evidence to make decisions in all phases of the budget process. MPs also provide citizens and their organizations with relevant information to which they might not otherwise have access.

The Open Budget Survey also assessed the extent to which citizens can effectively participate in the budget process. The 2017 survey concluded the following with regards to parliaments and citizen participation *(68)*:

> Legislative mechanisms. Another area of relatively strong performance in our participation assessment is for legislative hearings on the formulation of the budget prior to approval. Some kind of public hearing takes place in over half of the surveyed countries *(68)*, and the scope of these hearings is fairly extensive in nearly half of these countries (half or more of the major topics that should be discussed in such hearings are covered). Still, this means most countries fail to hold extensive legislative hearings. In only 16 countries are all members of the public (as opposed to invited groups or individuals) able to testify on budget formulation or to provide submissions through another mechanism.

The results (Fig. 14) show that there have been some important improvements in the openness of parliaments to involving citizens in budget formulation, but there is still room for improvement. Moreover, the scores for citizen engagement in legislative oversight show that it was possible in only 22 of the surveyed countries.

**Fig. 14. Results of the Open Budget Survey with respect to the seven mechanisms of participation assessed**




Source: reference *68*

The survey assessed whether a mechanism for participation in audits exist but not whether it is inclusive or well structured.

*What is the effect on UHC budgets and MP representation?*

The results of the IBP Open Budget Survey *(69)* and the IPU SDG survey *(67)* show that, although parliaments play an instrumental role in ensuring that the voices of the people and the SDG targets that affect them are reflected in the budget, their role should be strengthened.

The self-assessment tool provides a means for MPs to understand their role in the SDGs and UHC and to engage more effectively, for example by asking questions about UHC and fostering parliamentary discussion, commissioning reports and raising the issue in parliamentary debates. To ensure participation in UHC budgets and the link with their representation, MPs could explore the following.

- Engage continuously and consistently with constituencies and organizations that have knowledge and experience with regard to UHC, its relevance and how it can be advanced with the public budget.
- Foster dialogue among relevant parliamentary committees and these constituencies during legislative discussion and approval of the budget.
- Use evidence provided by these constituencies to ask the government questions about the executive budget proposal during its approval phase.
- Ensure that the public budget does in fact represent the needs of people in relation to access to health.

Concrete recommendations to parliaments for improving citizen participation in the budget process are provided in the Open Budget Index 2017 report *(67)*.

## Activity: Sharing experiences and thinking creatively about engaging citizens and other constituencies in the health budget for SDG 3

- Separate the group into four, and assign a constituency to each group on which they will share experiences and think creatively:
  - group 1: citizens and CSOs,
  - group 2: the media,
  - group 3: international institutions and donors,
  - group 4: academia.
- Each group will share their experiences of engagement or collaboration with the group, for what purpose (stress whether it was related to health) and the result (35–45 min).
- They will then consider how they could collaborate with the group for more effective oversight of UHC budgets and make a proposal (35–45 min) including:
  - why they would collaborate with the group for more effective oversight of UHC commitments and resources;
  - their potential contribution;
  - our potential contribution; reaching out
  - the expected outcome of the collaboration.
- Then, bring the participants back to plenary and ask each group to presents their proposals.
- By the end of the workshop, the group will have a compendium of ideas of how to collaborate with different stakeholders for UHC oversight.

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# Annex 1. Sample agendas for workshops conducted with this toolkit

| ***Core content for workshops*** |
|---|
| ***Chapter 2. Core content for understanding UHC and public budgets for health*** |
| *Module 1. Key aspects of health and UHC* |
| Section A. UHC |
| A1. Defining UHC in the context of SDG3 |
| A2. Relevance of UHC for specific diseases or populations |
| A3. Importance of social determinants of health |
| A4. Common goods for health: A foundation for UHC |
| A5. Importance of strong health systems with emphasis on primary health care |
| A6. Role of public finance |
| Section B. Right to health and international, regional and national commitments to UHC |
| B1. What is the right to health and how is it linked to UHC? |
| B2. Which are the key international agreements and declarations that mandate the right to health and the international mechanisms for holding governments to account? |
| B3. What are domestic commitments to the right to health and UHC, including constitutional rights and laws, policies, plans and election pledges |
| *Module 2. Introduction to public financing for health relevant for UHC budget advocacy* |
| Section A. Introduction to public policy and its association with budgets in relation to UHC |
| A1. What is public policy in general? |
| A2. What is the role of public resources in public policy? |
| A3. What should be the focus of health policies for achievement of UHC? |
| Section B. Introduction to the public budget and its relevance for UHC |
| B1. Political economy approach: a conceptual framework for the politics of public budgeting |
| B2. What is the public budget, and why is it relevant? |
| B3. The revenue side of the public budget in detail and what is relevant for UHC budget advocacy |
| B4. The expenditure side of the public budget in detail and what is relevant for UHC budget advocacy |
| Section C. Introduction to the budget cycle and links with planning budgets for UHC |

C1. What is the budget cycle, and what are its key stages and actors?

C2. Main stakeholders in the budget cycle

C3. The budget cycle, its stages and stakeholders for UHC

| Sample agenda: Introduction to budget advocacy for UHC. Civil society and the media (4 days) | | |
|---|---|---|
| *Duration* | *Sessions* | *Objectives* |
| 1 h 15 min | **Chapter 2, Module 1. Key aspects of health and UHC**<br>***Section A. UHC***<br>• A1. Define UHC in the context of SDG3<br>• A2. Relevance of UHC for specific diseases or populations<br>• A3. Importance of social determinants of health<br>• A4. Common goods for health: A foundation for UHC<br>• A5. Importance of strong health systems, with emphasis on primary health care<br>• A6. Role of public finance | By the end of this session participants should be able to:<br>• describe key aspects of UHC as defined by the WHO for the SDGs, particularly SDG3;<br>• recognize the principles of the right to health on which UHC is based;<br>• identify international, regional and national commitments to the right to health and UHC; and<br>• discuss the relevance of health system strengthening, common goods for health, primary health care and public finance for UHC. |
| 14 h | **Chapter 2, Module 2. Key concepts of public financing for health relevant to budget advocacy for UHC**<br>***Section A. Introduction to public policy and its association with the budget in relation to UHC***<br>• A1. What is public policy in general?<br>• A2. What is the role of public resources in relation to public policy?<br>• A3. On what should health policies focus for countries to achieve UHC?<br>***Section B. Introduction to the public budget and its relevance for UHC***<br>• B1. Political economy approach: a conceptual framework for the politics of public budgeting | By the end of these sessions, participants should be able to:<br>• discuss key concepts of public policy relevant to UHC;<br>• identify key concepts and information on public budgets, their content, classifications and what is relevant for UHC;<br>• understand the content of budget documents and that which is relevant for UHC;<br>• describe the overall budget cycle, its stages, actors and the role of the ministry of health; |

- B2. What is the public budget and why is it relevant?
- B3. The revenue side of the public budget in detail and what is relevant for UHC budget advocacy
- B4. The expenditures side of the public budget in detail and what is relevant for UHC budget advocacy

***Section C. Introduction to the budget cycle and links with UHC planning***

- C1. What is the budget cycle and its key stages and actors?
- C2. Main stakeholders in the budget cycle
- C3. The budget cycle, its stages and stakeholders for UHC

***Section D. Budget information: budget documents relevant for budget advocacy and resources for locating UHC-related budget information***

- D1. Key budget documents and their content
- D2. Where to find budget documents
- D3. Budget information relevant for UHC and where to find it

***Section E. Transparency, access to information and citizen participation as key elements of budget advocacy and budget accountability***

- E1. Why are transparency, access to information and citizen participation relevant to UHC?
- E2. Tools for understanding and measuring budget transparency around the world
- E3. Freedom of information around the world
- E4. Principles of public participation: intervening in the health budget cycle to achieve a UHC advocacy objective

***Section F. Budget analysis as a tool for budget advocacy for achieving UHC*** (optional for media)

- understand where to find budget information and the resources for finding budget information for health and UHC;
- explain transparency, access to information and citizen participation and their association with UHC goals and principles; and
- conduct budget analysis relevant for UHC and use tools for engaging audiences on the topic (optional for media).

| | | |
|---|---|---|
| | • F1. Why analyse the public budget?<br>• F2. Basic budget analysis: On what should budget activists focus in using the budget to monitor advances towards UHC?<br>• F3. Common problems in the use of public resources that can be identified by budget analysis[18]<br>• F4. Budget analysis relevant for budget advocacy to achieve UHC | |
| 4 h 30 min<br>(media representatives may leave the workshop at the end of these sessions) | **Chapter 3, Module 2. UHC budget advocacy: the role of the media**<br>***Section D. When and where in health budget processes can the media play a part?***<br>• D1. Where in the budget process would I have most positive impact, and why?<br>***Section E. How best can I engage my audience in UHC budget accountability?***<br>• E1. How can media support UHC budget accountability?<br>***Section F. Limitations to media engagement***<br>• F1. Consideration of challenges and risks media are facing.<br>  • Fragmentation of media<br>  • Language and jargon<br>  • The legal context for media<br>  • Engagement in budget advocacy in a closing civic space<br>  • Cyber security | By the end of these sessions, participants should be able to.<br>• describe media engagement in UHC budget advocacy;<br>• describe the role of the media in health budget accountability;<br>• identify stakeholders for engagement on health accountability;<br>• explain when and where in health budget processes the media can play a role;<br>• describe how the media can address UHC budget accountability in an engaging way; and<br>• list challenges, risks and considerations for addressing health budget accountability. |
| 4 h 30 min | **Chapter 3, Module 1. UHC budget advocacy the role of civil society.**<br>***Section A. General introduction and overview of civil society budget*** | By the end of these sessions, participants should be able to: |

[18] This information is based on training materials developed by the IBP in 2013–2014 to train a group of budget advocates in Ghana as part of its Partnership Initiative.

| | | |
|---|---|---|
| | ***advocacy***<br>• A2. What is budget advocacy? Who does it, and why?<br>• A3. What is the potential impact of budget advocacy?<br>***Section B. Health- and UHC-related budget advocacy***<br>• B1. What does health budget advocacy seek to accomplish, and what has been its focus?<br>• B2. What could be the key contributions of CSOs to UHC budget advocacy?<br>***Section C. The importance of strategic advocacy for a UHC***<br>• C1. When is civil society budget advocacy successful?<br>• C2. How can budget advocacy be planned to have an impact? | • understand the basic concepts of civil society budget advocacy work on the basis of international experience;<br>• appreciate the relevance and contribution of civil society health budget advocacy in the context of UHC;<br>• use strategic thinking and strategic budget advocacy objectives to ensure meaningful budget advocacy for UHC;<br>• find examples of successful health budget advocacy that may be relevant for CSO UHC budget advocacy; and<br>• use tools to conceptualize national UHC budget advocacy. |
| 30 min | **Next steps** | |

| **Sample agenda: Oversight to accountability for UHC and public budgets. Parliamentarians and staff (2 days)** | | |
|---|---|---|
| *Duration* | *Sessions* | *Objectives* |

| | | |
|---|---|---|
| 1 h 15 min | ***Chapter 2. Module 1. Key aspects of health and UHC***<br>***Section A. UHC***<br>• A1. Defining UHC in the context of SDG3<br>• A2. Relevance of UHC for specific diseases or populations<br>• A3. Common goods for health: A basis for UHC<br>• A4. Importance of social determinants of health<br>• A5. Importance of strong health systems, with emphasis on primary health care<br>• A6. Role of public finance<br>***Section B. Right to health and international, regional and national commitments to UHC***<br>• B1. What is the right to health, and how is it linked to UHC?<br>• B2. What are the key international agreements and declarations that mandate the right to health, and what international mechanisms hold governments to account?<br>• B3. Domestic commitments to the right to health and UHC, including constitutional rights and laws, policies, plans and election pledges | By the end of this session, participants should be able to:<br>• describe key aspects of UHC as defined by WHO in the context of the SDGs, particularly SDG3;<br>• recognize the principles of the right to health on which UHC is based;<br>• identify international, regional and national commitments to the right to health and UHC; and<br>• discuss the relevance of health system strengthening, common goods for health, primary health care and public finance for UHC. |

| | | |
|---|---|---|
| 1 h 45 min | ***Chapter 2. Module 2. Introduction to public financing for health relevant for UHC budget advocacy***<br>***Section A. Introduction to public policy and its association with budgets in relation to UHC***<br>• A1. What is public policy in general?<br>• A2. What is the role of public resources in public policy?<br>• A3. On what should health policies focus for countries to achieve UHC?<br>***Section B. Introduction to the public budget and its relevance for UHC***<br>• B1. Political economy approach: a conceptual framework for the politics of public budgeting<br>• B2. What is the public budget, and why is it relevant?<br>• B3. The revenue side of the public budget in detail and its relevance for UHC budget advocacy<br>• B4. The expenditure side of the public budget in detail and its relevance for UHC budget advocacy<br>***Section C. Introduction to the budget cycle and links with planning UHC budgets***<br>• C1. What is the budget cycle, and what are its key stages and actors?<br>• C2. Main stakeholders in the budget cycle<br>• C3. The budget cycle, its stages and stakeholders for UHC | By the end of this session, participants should be able to:<br>• discuss key concepts of public policy relevant for UHC;<br>• identify key concepts and information on public budgets, their content, classifications and relevance to UHC;<br>• recognize the content of budget documents and that relevant for UHC; and<br>• describe the overall budget cycle, its stages, actors and the role of the ministry of health. |

| | | |
|---|---|---|
| 8 h | **Chapter 3. Module 3. Role and relevance of parliamentarians as advocates for UHC budget accountability**<br>***Section A. Relevance of parliaments for accountability for the SDGs***<br>• A1. Why should parliaments engage in achieving the SDGs, and what is their role?<br>• A2. To what extent are parliaments around the world engaging with the SDGs?<br>***Section B. Parliamentary oversight function and its relevance for UHC budget accountability***<br>• B1. Parliaments and the public budget, a brief introduction<br>• B2. Budgetary oversight role of parliaments and its association with UHC budget accountability<br>***Section C. Challenges and limits that parliaments face for effective oversight***<br>***Section D. Engaging citizens in effective participation in budget oversight for UHC*** | By the end of these sessions, participants should be able to:<br>• explain their role in holding governments to account for health spending and progression towards UHC;<br>• discuss their capacity to influence public budgets; and<br>• identify key stakeholders and ways of working with them. |
| 30 min | **Next steps** | |