HEALTH & BUDGETS

TRAINING WORKSHOP

Facilitator’s Manual
May 2014
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ACKNOWLEDGEMENTS

The content of this workshop has taken shape through a team process of curriculum design, resource development, and testing with different audiences. The initial workshop was conceptualized in 2008 in Mexico by Shaamela Cassiem, Ravi Duggal, Manuela Garza, Teresa Guthrie, Helena Hofbauer, Aaron Katz, and Gabriel Lara. The first pilot workshop was hosted by the International Budget Partnership (IBP), Fundar: Center for Analysis and Research, and the Centre for Economic Governance and AIDS in Africa (CEGAA) in India in 2009. Ann Blyberg and Jennifer Sleboda provided substantial feedback to the pilot workshop. Drawing on numerous evaluations, the 2010 workshop in Cape Town was redesigned by Shaamela Cassiem, Erica Coetzee, Ravi Duggal, Manuela Garza, Helena Hofbauer, Thoko Madonko, and Albert van Zyl. The materials for this training were further revised by Shaamela Cassiem, Ravi Duggal, Helena Hofbauer, Gabriel Lara, and Jennifer Sleboda in preparation for the 2012 workshop. The IBP is also thankful for reviews of our training materials by Peter Noteboom of Global Learning Partners (www.globalearning.com).

The International Budget Partnership acknowledges with gratitude the generous financial support of the Bill and Melinda Gates Foundation, the Ford Foundation, Open Society Foundations, and the William and Flora Hewlett Foundation for the development and implementation of this workshop. Shaamela should write a new acknowledgement for the publication – A.B.
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PREFACE

The International Budget Partnership offers a training workshop on Health & Budgets in order to address the capacity needs of civil society organizations that are undertaking budget work in the health sector and want to deepen and sharpen their knowledge and skills. The workshop was conceptualized by the IBP in collaboration with Fundar: Center for Analysis and Research (Mexico) and the Centre for Economic Governance and AIDS in Africa (South Africa).

The workshop consists of an intensive eight-day learning experience and helps participants to develop substantial, practical competence in health and budget advocacy work.

The Goals of the IBP Health & Budgets Training Workshop

1. To demonstrate that adequate allocations and expenditures for health can strengthen provision of public health services and promote realization of the right to health;

2. To build the capacity of civil society organizations in budget research, analysis, and advocacy to improve allocations and expenditures so as to advance enjoyment of the right to health;

3. To enhance understanding of how these skills have an impact on issues like transparency, accountability, citizen participation, and people’s enjoyment of their right to health; and

4. To highlight the importance of strategic collaborations among different kinds of institutions and organizations promoting public health.
ABOUT THIS WORKSHOP

The workshop consists of eight modules, including those for the introduction and conclusion of the workshop. Each module is relatively self-contained and can be expanded or condensed to suit the needs of the trainees. Experienced facilitators may also choose to rearrange the sequence of the modules, though care should be taken to preserve the cumulative learning that takes place through the Polarus simulation activities as the workshop proceeds. In any event, facilitators should have some knowledge of health systems, health budgets and human rights.

The workshop features extended simulation activities in the hypothetical country of Polarus. This learning strategy provides participants with the foundational knowledge and skills required to conduct health budget analysis and advocacy in other contexts.

This Facilitator’s Manual is designed to be used in combination with the:

- The Participant’s Workbook for the Health & Budgets Training Workshop;
- The Republic of Polarus Sourcebook for the Health & Budgets Training Workshop;
- The Health & Budgets Training Workshop presentations;
- The Health & Budgets Training Workshop data file for Participants – Health & Budgets Master Data Sheet (Excel);
- The Health & Budgets Training Workshop data files for Facilitators – Health & Budgets – Calculations for Summary of Findings and Health & Budgets – Summary Data Tables for Hypotheses (Excel files).

The Facilitator’s Manual provides guidance and content information to support facilitators of the workshop. It presents an outline of each module, as well as detailed notes about each session, including time allocations, activities, information to support presentation slides, and guidelines for facilitating the learning process. For easy reference, the Facilitator’s Manual also contains copies of all of the reading material, task sheets, and activities contained in the Participant’s Workbook. Together with the Sourcebook on the Republic of Polarus (and data files), this should provide a training team with the core of what it needs in order to run the Health & Budgets Training Workshop.
PREPARING FOR THE WORKSHOP

It is recommended that facilitators read carefully through the sections entitled Workshop Preparation and General Facilitation Notes (after Health & Budgets Training Workshop Agenda) in order to plan for the workshop. Some factors, such as the selection and preparation of participants, the composition of the training team, and any invitations to and scheduling of guest speakers, should receive consideration well in advance of the workshop itself.
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<td>Participants’ presentations (30 min.)</td>
<td>Participants’ presentations (30 min.)</td>
<td>Participants’ presentations (30 min.)</td>
<td>Participants’ presentations (30 min.)</td>
<td>Module 7 (55 min.)</td>
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<td>Module 5 - Part I (1 hour, 15 min.)</td>
<td>Module 6 (1 hour, 15 min.)</td>
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<td>Module 5 - Part II (1 hour, 30 min.)</td>
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<td>Break 3:30 - 3:45</td>
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<td>Module 6 (15 min.)</td>
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*Please note:* Due to the length of this training, we strongly recommend that a one-day break be included in the workshop, after Day 4.

**Key to Health & Budgets Training Workshop Modules:**

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<td>Module 2: Civil Society Budget Work - Strategies &amp; Impacts</td>
<td>1 hour, 45 minutes</td>
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<td>(Four 30-minute segments - Participants' Presentations)</td>
<td>2 hours</td>
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<td>Module 3: The Rights Framework</td>
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<td>Module 4: Health Information, Systems, and Financing</td>
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<td>Module 5: Budget Advocacy (Part I)</td>
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<td>Module 5: Budget Advocacy (Part II)</td>
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<td>Module 8: Evaluation, Certification, and Closure</td>
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**TOTAL TIME =** 52 hours, 50 minutes
WORKSHOP PREPARATION

The preparations for a Health & Budgets Training Workshop generally begin months before the event itself. The following arrangements must be made in advance.

Selection/Composition of the Training Team

- The facilitation of the course requires input and commitment from a team of trainers. It is important that as many of the trainers as possible be present and engaged throughout the workshop, and not simply attend the sessions for which they are responsible. Being present allows the training team to be more attuned to the participants and to the learning process as it unfolds. Selection of the training team may thus be influenced by trainers’ availability for the duration or large parts of the workshop.
- It is an asset for members of the training team to have expertise and practical experience in one or more of these areas: the right to health, health information, systems and financing, the budget process and budget analysis, and advocacy. Consider the mix of skills and experience in drawing together the training team.
- All the members of the training team should be proficient in the primary language of instruction. Where necessary, consider pairing facilitators with different language skills so that they can provide back-up for one another in specific sessions.
- Ideally, the training team should reflect the diversity of the participants. If possible, ensure a mix of genders, backgrounds, and ages in the team. The General Facilitation Notes (next section) provide further pointers on the division of roles within the training team.

Invitation and Selection of Participants

- As this workshop is intensive and requires a high level of commitment from participants, it is essential that those attending have a genuine interest in undertaking health and budget advocacy work, and have the (at least potential) capacity to do so.
- The composition of the participants should allow for one primary language of instruction over which all have some command. The workshop is highly participatory, and language barriers can adversely affect how much a participant can gain from and contribute to the learning process.
- The workshop should ideally have at least 15 participants and no more than 25.
- The workshop is enriched by diversity, so if possible ensure that participants include a mix of genders, geographical location, ways of working, and issues of interest.
• At the same time, it is useful for participants to share more or less the same level of skills and knowledge about budget work. When they do, the learning can be pitched at a level that should allow everyone to participate equally and gain substantially from the workshop.

• The workshop assumes the follow pre-program work by participants: Participants will have identified any right to health provisions in their national constitutions.

CHOICE OF VENUE

• The workshop should ideally take place in a training room that is spacious enough to accommodate all participants and trainers with ease. There should be scope to move around and enough wall space to display flipchart sheets as the workshop progresses.

• It is important to have a training room where the chairs and tables can be arranged in group clusters, or in a horseshoe shape or other arrangements that supports inclusivity and enable active participation. Try to avoid lecture theaters where the seats are bolted to the floor.

• The training venue should be quiet, have natural lighting (windows), and at least 3 or 4 break-away spaces for participants to work in small groups.

• The facility should be equipped with basic training devices, such as an LCD projector, screen, at least 2 flipchart stands, flipchart paper, and markers.

• Tea, coffee, and meals should be served not too far from the training venue, so that it is possible to stick to the time schedule for breaks.
GENERAL FACILITATION NOTES

EDUCATIONAL APPROACH

The Health & Budgets Training Workshop uses participatory learning principles and techniques. The learning experience is treated as a process in which participants draw on their prior knowledge and experience, are introduced to new knowledge and skills, have ample opportunities to try out and apply their new knowledge and skills, and reflect on what they have learned, as well as to adjust and consolidate their learning.

In facilitating the workshop, the following practices should be observed:

- Encourage active and equal participation.
- Allow participants to share and draw from their prior knowledge and experiences, and link these to the learning taking place.
- Give practical examples of new concepts and information whenever possible.
- Provide ample time for participants to complete exercises and activities. This is where learning is being internalized and owned.
- Resist the temptation to skip tasks or applications, or to rush. You may be leaving out a vital link in the learning process. The timings provided in the facilitation notes are based on careful consideration and testing in the field. Participants need time to internalize and consolidate what they learn.
- Recognize that learning is consolidated through reflection, revision and recapping. Don’t leave out these parts of the sessions.
• Fun games and ice-breakers allow participants to stay energized and engaged. Even when the educational content is not “serious,” participants may be learning something indirectly or opening up for the learning which is to follow.

• Be aware of saturation points. Participants are exposed to a great deal of new information and skills during the course of the workshop. Use regular evaluations (see below) to gauge how the learning process is working and be willing to adjust and revise if necessary.

POLARUS SIMULATION ACTIVITIES

The workshop is designed around an extended simulation in which all participants adopt citizenship of a hypothetical country, Polarus, for the duration of the training. Tasks and activities using scenarios and data from Polarus are scattered throughout Modules 3 to 7.

THE FACILITATION TEAM AND HOST FACILITATOR

The Health & Budgets Training Workshop is best facilitated by a team of trainers. Due to the length and intensity of the workshop, it makes sense to divide up the modules among the members of the team, and provide back-up and support to one another as required.

It is recommended that one person in the team be identified as the Host Facilitator for the duration of the workshop. It is the role of the Host Facilitator to maintain the overall flow of the workshop. The Host Facilitator is typically responsible for:

• Facilitating Module 1, which includes introductions and the goals of the workshop.
• Making announcements and acting as the general on-site contact person for workshop participants.
• Coordinating and introducing participants when they present their organizations and the budget work they do.
• Chairing the health budget advocacy group work presentations I and II as well as the feedback discussions.
• Facilitating Module 8, which includes certification, evaluation and closure.

The Host Facilitator may or may not be responsible for leading any of the other modules.
**REGULAR EVALUATIONS**

The formal evaluation of the workshop is introduced to participants in Module 1, at which time they receive evaluation forms to complete as the workshop progresses. In addition to these forms, regular evaluation discussions should take place in the evenings. For example, the training team can plan evening evaluation sessions for the second, fifth, and seventh days. In preparation for each session, they can ask a few participants to volunteer to solicit feedback and suggestions from other participants, and to pass these on to the facilitators at the evening meeting. Such feedback may be about the content of the modules, the facilitation, level of participation, resource materials, logistics, and/or administration. Through such a process, problems can be quickly identified and possible solutions considered by the facilitators. The feedback team may want to wear badges on the days that they will be gathering participants’ comments.

On the days when no evening evaluations are scheduled, other tools can be used to keep an open flow of communication about the learning experience between participants and facilitators. For example, the training team can provide a Mood Meter by posting three sheets of flipchart paper in a public space, close to the exit of the workshop room. The charts should have drawings or symbols that represent different emotional states, for example 😊😊😊 (happy, neutral, unhappy), in three different colors: green, yellow, and pink. They then can provide participants with green, yellow, and pink Post-It notes and request that each participant paste a Post-It note of the matching color on the sheet of flipchart paper that best represents their mood.

**ENERGIZERS**

The Health & Budgets Training Workshop is an intensive learning process, during which participants are expected to take in a great deal of information and interact extensively with others. As a facilitator, you will be tuned to the energy levels of the group and be able to assess when participants are struggling to learn because they are too tired, distracted or saturated with information. Be aware of training overload, and use breaks and energizers wherever appropriate to create moments of rest or to stimulate energy in the group. Some suggestions are listed below (and at various points throughout the materials).

**Energizers for tired groups who need some rest:**

- After lunch, or if they are tired, let participants sleep on their arms for two minutes.
- Get participants to close their eyes and maintain a minute’s silence. This is very useful during the calculations sessions; some people can get very agitated while trying to perform the calculations.
• Ask them to close their eyes and to keep their bodies absolutely still for one minute.

Energizers for groups who have been sitting still for too long:
• Talk the group through a light stretch. Be careful of injuries! Ask the group to stretch up towards the ceiling as far as they can. Then ask them to bend forward as far as they can. If people find this hard, let them hold on to the chair/desk in front of them.
• Ask the group to go for a short, silent walk – no talking allowed.
• Let the group stand in a row and have each person put their hands on the shoulders of the person in front of them. Then ask them to massage the shoulders in front of them. Next ask them to turn around and massage the shoulders of the person who has just massaged theirs.

Energizers for groups who need a spark of mental energy:
• If you are near a library/bookstore/office, ask everyone to grab a book/magazine and read quietly for five minutes. Afterwards they should each share one interesting thing that they read.
• Find something short and inspirational to read. Read it to them and/or give them copies to read and reflect on silently. Some examples below:
  
  **Martin Luther King**: “The hope of a secure and livable world lies with disciplined nonconformists who are dedicated to justice, peace and brotherhood.”
  
  **Nelson Mandela**: “For to be free is not merely to cast off one's chains, but to live in a way that respects and enhances the freedom of others.”
  
  **Gandhi**: “Live as if you were to die tomorrow. Learn as if you were to live forever.”
  
  **Margaret Mead**: “Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has.”
  
  **Alice Walker**: “The most common way people give up their power is by thinking they don’t have any.”
MODULE 1
INTRODUCTIONS AND GOALS OF THE WORKSHOP
MODULE 1 ■ INTRODUCTIONS AND GOALS OF THE WORKSHOP

SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of this module</th>
<th>1 hour, 45 minutes</th>
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</thead>
<tbody>
<tr>
<td>Timing of this module</td>
<td>This module corresponds with the following session in the <em>Health &amp; Budgets Training Workshop Agenda</em>:</td>
</tr>
<tr>
<td></td>
<td>• <strong>SESSION 1 on Day 1</strong></td>
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<td>(Note that one session is 1 hour, 45 minutes.)</td>
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<td>Resources needed</td>
<td>• Flipchart paper and colored markers</td>
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<td>• Name tags</td>
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<td></td>
<td>• Participant’s Workbook for each participant</td>
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<td></td>
<td>• Budget BINGO!</td>
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<td></td>
<td>• Evaluation forms for all participants</td>
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<td>• Colored Post-It notes</td>
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<td></td>
<td>• In the Participant’s Workbooks:</td>
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<tr>
<td></td>
<td>➢ Budget BINGO!</td>
</tr>
</tbody>
</table>

LEARNING OUTCOMES TO BE ACHIEVED

By the end of this module, participants will have:

• Introduced themselves to the group, and begun to feel comfortable with one another and the facilitators;

• Recognized the goals and structure of the course, as well as the process for evaluating it;

• Identified the ground rules for the workshop (regarding laptops, mobile phones, punctuality, breaks, and so forth);

• Reached an understanding about the general ethos and participatory spirit of the course; and

• Prepared information about their organization on a sheet of flipchart paper.
STRUCTURE OF THE MODULE

1. Welcome 5 minutes
2. Economy of Words 45 minutes
3. Overview and Goals of the Training Workshop 10 minutes
4. Budget BINGO! 10 minutes
5. Ensuring Maximum Participation and Learning 10 minutes
6. Task 1.1 ■ Participants’ Poster Preparation 25 minutes
INTRODUCTIONS AND GOALS OF THE WORKSHOP

Duration of session: 1 hour, 45 minutes

1. WELCOME
   5 MINUTES
   - Welcome all the participants to the training course. Ask everyone to write their names on a name tag.
   - Explain that the aim of this first session is purely to get to know one another better and to introduce some important aspects of the course.
   - If necessary, clarify any practical arrangements that may be worrying or distracting participants, so that everyone is relaxed and at ease.

2. ECONOMY OF WORDS
   45 MINUTES
   - Each participant will introduce themselves and state in exactly 5 words what they want to change about the health system in their country.
   - Ask each participant to introduce themselves in the following way:
     “My name is ____, and if I could change one thing about the health system in ____
     (the name of their country) it would be _____ _____ _____ _____.”
   - If all the participants’ 5 words end up being very similar, draw out the point that the group already shares many commonalities despite working in different contexts and on different issues.
   - If the participants’ 5 words turn out to be very different, perhaps this shows how diverse civil society health work can be – and how powerfully issues can be expressed in just a few words.
   - Close the exercise by bringing it back to budget advocacy work: Why did we ask you to use only 5 words? It was an exercise in trying to achieve as much as you can with as little as possible. Like language, most resources have limits. We don’t often have unlimited resources at our disposal. Budget work involves making strategic choices and deciding what is most crucial to pursue with available resources. It also involves getting the right message across at the right time – choosing your words carefully for maximum impact.
3. **OVERVIEW AND GOALS OF THE WORKSHOP**

10 MINUTES

- Distribute a copy of the Participant’s Workbook to each person in the group. Explain that it contains almost all of the information participants will need during the course of the training.

- Ask participants to turn to the “Goals of the Health & Budgets Training Workshop” in the Preface of their Workbooks. The goals are:
  - To demonstrate that adequate allocations and expenditures for health can strengthen provision of public health services and promote realization of the right to health.
  - To build the capacity of civil society organizations in budget research, analysis, and advocacy to improve allocations and expenditures so as to advance enjoyment of the right to health;
  - To enhance understanding of how these skills have an impact on issues like transparency, accountability, citizen participation, and people’s enjoyment of their right to health; and
  - To highlight the importance of strategic collaborations among different kinds of institutions and organizations promoting public health.

Discuss why it is so important for participants to strengthen and develop their skills, capacities, and strategic vision when they want to build the impact of their health and budget work.

- Participants will be split into four working groups for most of the workshop. The working groups allow for greater participation by each person and provide a space where participants can practice using their new knowledge and skills. Participants in these working groups should have a mix of knowledge and skills, so that each group has within it the capacities necessary to do the tasks assigned to them. Those with greater knowledge and skills in necessary areas should be expected to help others in their group when they are struggling. Briefly explain to participants that they are going to be split into four working groups for most of the workshop and how these groups should function.

- Briefly present the “Health & Budgets Training Workshop Agenda,” which appears after the Preface in the Participant’s Workbook:
  - Field any questions for clarification. Explain that the course makes use of experiential learning activities, together with inputs to present new information.
  - The approach to training that will be used throughout the workshop emphasizes active and equal participation, open discussion and debate, mutual respect, and learning by asking and doing.

- Distribute copies of the evaluation form and briefly explain how the evaluation process will work. Participants are encouraged to use the evaluation form to assess the learning process throughout the workshop.
• Explain that the workshop has two methods of evaluation:
  
  - The first takes place during the workshop. Facilitators will ask for two volunteers to talk with the other participants each day to get their opinions on content, administration and logistics, participation, training, and facilitation. The volunteers will then provide this feedback to the facilitators at the end of each day. The facilitators will consider how to modify and improve the workshop as it is occurring in response to the feedback.
  
  - The second evaluation takes place via the form that participants receive to fill out throughout the workshop (and to complete at the end). These two types of evaluation will help to improve the overall workshop experience.

4. **BUDGET BINGO!**

   **10 MINUTES**

• The aim of this exercise is to enable participants to get to know each other better.

• Refer participants to the BUDGET BINGO! sheet in their workbook.

• Game rules:
  
  - You need to score 4 blocks across, 4 blocks down or 4 blocks diagonally.
  
  - As soon as you find a person who responds to the description in a block, write that person’s name in the block.
  
  - You need to have one person per block.
  
  - When you have a name in each of four adjacent blocks in a line – across, down or diagonally – call out BINGO!
  
  - You cannot write your name in any of the blocks.
  
  - You may use a person twice, but not in adjoining blocks.

5. **ENSURING MAXIMUM PARTICIPATION AND LEARNING**

   **10 MINUTES**

• Ask the participants to consider what they need in order for them to feel that they are in an environment that allows for open, respectful dialogue, and maximum learning and participation.

• Open with an example: “For me to feel comfortable, mobile phones should be switched off or turned on silent.”

• Hand out two pieces of Post-It notes to each participant.

• Ask each participant to write one contribution per note.

• Participants should stick these up on the flipchart paper provided.

• Facilitators should sort the notes according to themes/similarities.
• Read these out, *ask if there is agreement*, and then display what has been agreed upon throughout the workshop.

• Key principles are: coming on time to sessions; no talking while someone is else is talking; mobile phones should be switched off; no checking email, chatting online, or reading websites during the workshop; and maximum participation.

6. **Task 1.1 ■ Poster Preparation for “A Network of Budget Advocacy” 25 MINUTES**

• Ask participants to work with colleagues from their organization.

• Provide each participant (or team, in cases where there is more than one participant from the same organization) with one sheet of flipchart paper.

• Participants’ presentations should cover the following:
  - The name of their organization.
  - How long has their organization (and they) been doing budget work?
  - The number of people in the organization involved in budget advocacy work.
  - The level of government at which the organization works (e.g., national, sub-national, local).
  - The focus of their organization’s budget work (e.g., earthquake relief, children’s budgets, gender responsive budgeting, health, etc.).
  - How the organization works (e.g., public hearings, advocacy, research, capacity-building, networking with other organizations).
  - The impact that their budget work has had on policies, laws, civic participation, budget transparency, the lives of people in the communities in which they work, etc.

• Remind participants of their “Economy of Words” exercise – that is, they should be as concise as possible in describing their organization and its work.

• Ask them to write their points on the flipchart paper. Encourage participants to be creative in depicting the work they do.

• Explain to participants that these posters make up part of **Module 2: Civil Society Budget Work – Strategies and Impacts**, and that they are preparing them as part of the 10-minute presentations that they will give at the start of each day.

• Each day two organizations will give their presentations to the entire group. The two organizations will be selected and notified the day before they are to give their presentations.
BUDGET BINGO!

Find Someone Who:

<table>
<thead>
<tr>
<th>Has done budget work for more than 2 years</th>
<th>Comes from a country that has a Freedom of Information Act</th>
<th>Has worked with the media to influence health policy</th>
<th>Is part of a health coalition or network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has experience in research</td>
<td>Can use Excel</td>
<td>Speaks more than 3 languages</td>
<td>Has visited a public health care facility in the last 6 months</td>
</tr>
<tr>
<td>Loves cats</td>
<td>Has analyzed a health budget</td>
<td>Is a member of an organization currently receiving funding and technical assistance from the IBP</td>
<td>Enjoys working with numbers</td>
</tr>
<tr>
<td>Is working on a health budget project in his/her country</td>
<td>Has experience of lobbying the legislature in his/her country</td>
<td>Reads the news everyday</td>
<td>Is a trained medical professional</td>
</tr>
</tbody>
</table>

- You need to score 4 blocks across, 4 blocks down or 4 blocks diagonally.
- As soon as you find a person who responds to the description in a block, write that person’s name in the block.
- You need to have one person per block.
- When you have a name in each of four adjacent blocks in a line – across, down or diagonally – call out BINGO!
- You cannot write your name in any of the blocks.
- You may use a person twice, but not in adjoining blocks.
TASK 1.1 ■ POSTER PREPARATION FOR “A NETWORK OF BUDGET ADVOCACY”

Working with other participants from your organization, on a piece of flipchart paper, develop a presentation about your organization that includes the following information:

- The name of the organization.
- How long your organization (and you) have been doing budget work.
- How many people in the organization are involved in budget advocacy work.
- The level of government at which your organization works (national, sub-national, local).
- The focus of the budget work (e.g. earthquake relief, children’s budget, gender responsive budgeting, health).
- How the organization works (e.g. public hearings, advocacy, research, capacity-building, through a network of organizations).
- The impact the budget work has had on policies, laws, civic participation, budget transparency, lives of people in the communities in which you work, etc.

When you have finished, put the sheet up on the wall.
MODULE 2

CIVIL SOCIETY BUDGET WORK:
STRATEGIES AND IMPACTS
# MODULE 2 | CIVIL SOCIETY BUDGET WORK: STRATEGIES AND IMPACTS

## SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of this module</th>
<th>1 hour, 45 minutes plus four 30-minute segments</th>
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<tbody>
<tr>
<td>Timing of this module</td>
<td>This module corresponds with the following sessions in the Health &amp; Budgets Training Workshop Agenda:</td>
</tr>
<tr>
<td></td>
<td>- SESSION 2 on Day 1</td>
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<td>(Note that one session is 1 hour, 45 minutes.)</td>
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<td>This module also includes four 30-minute segments that are distributed throughout the workshop. They are designated for participants to introduce their own organizations and their health budget advocacy work. These segments fall at the beginning of SESSION 1 on the following days (see Workshop Agenda):</td>
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<tr>
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<td>- Day 2</td>
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<td>- Day 3</td>
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<td>- Day 4</td>
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<td>- Day 5</td>
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<td>- TASK 2.1</td>
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<td>- TASK 2.2</td>
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<td>- TASK 2.3</td>
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<td>- READING 2.1</td>
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<td>1. India: Samarthan’s Campaign to Make Real the Right to Work</td>
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<td>2. Argentina: Claiming the Right to Education with Budget Analysis and Litigation</td>
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<td>3. India: Budget Tracking to Give Dalits a Fair Share of Development</td>
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<td></td>
<td>6. South Africa: Civil Society Uses Budget Analysis and Advocacy to Improve the Lives of Poor Children</td>
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</tbody>
</table>
LEARNING OUTCOMES TO BE ACHIEVED

By the end of the module, participants will have:

- Compared case studies of budget analysis and advocacy work from around the world;
- Familiarized themselves with various budget analysis and advocacy tools and methodologies used by civil society groups around the world;
- Been convinced of and inspired by the value that evidence-based budget advocacy has for improving the transparency of budget decisions and the budget process, increasing budget awareness and literacy, and deepening engagement in the budget process;
- Outlined the challenges and opportunities involved in budget analysis and advocacy work in their countries;
- Reflected on the value of using evidence-based budget advocacy to enhance the impact of their organizations’ work; and
- Practiced presenting their organizations’ health and advocacy work.

STRUCTURE OF THE MODULE

Civil Society Budget Work: Strategies and Impacts (1 hour, 45 minutes)

1. **Facilitator Input**: Strategies and Impacts of Budget Work 15 minutes
2. **Task 2.1**: Strategies and Impacts of Budget Work 50 minutes
3. **Task 2.2**: Budget Tools and Strategies for Health Advocacy 25 minutes
4. **Plenary Discussion** 15 minutes

A Network of Budget Advocacy (total of 2 hours)

1. **Task 2.3**: A Network of Budget Advocacy (30 minutes at the beginning of Days 2, 3, 4, and 5 – see Health & Budgets Training Workshop Agenda)
CIVIL SOCIETY BUDGET WORK: STRATEGIES AND IMPACTS

Duration of session: 1 hour, 45 minutes

<table>
<thead>
<tr>
<th>STRUCTURE OF THE SESSION</th>
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<tr>
<td>1. FACILITATOR INPUT: Strategies and Impacts of Budget Work</td>
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<tr>
<td>2. TASK 2.1 ■ Strategies and Impacts of Budget Work</td>
</tr>
<tr>
<td>3. TASK 2.2 ■ Budget Tools and Strategies for Health Advocacy</td>
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<tr>
<td>4. PLENARY DISCUSSION</td>
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</tbody>
</table>

1. FACILITATOR INPUT: STRATEGIES AND IMPACTS OF BUDGET WORK

15 MINUTES

- Introduce the objectives and outline of the session.
- Explain the rationale for budget work.
  - Public budgets influence service delivery to poor and marginalized communities. Civil society budget work can help improve service delivery to these same communities.
  - It does this through bringing about changes in allocations and expenditures in governments’ budgets.
  - It also encourages transparency and accountability by government. By encouraging citizen interest in the budget, it can enhance civic participation.
  - Budget work can help empower communities by enabling them to understand governments’ budgets.
- Slide 2 of the PPT presentation, Module 2 – Strategies & Impacts of Budget Work, has a quote from a participant in a social audit in India that provides strong evidence of the value of civil society budget work.

2. TASK 2.1 ■ STRATEGIES AND IMPACTS OF BUDGET WORK

50 MINUTES

- Ask participants to count from 1 to 4 in order to organize themselves into 4 groups.
- Each group should work on a set of three case studies. The groupings of the case studies are reflected in the charts on the following pages (i.e., Samarthan/ACIJ/Coalition in South Africa for group 1; HakiElimu/NCDHR/OAK Development Foundation for group 2; Coalition in South Africa/NCDHR/Haki Elimu for group 3; ACIJ/ Samarthan/Oak Development Foundation for group 4). Suggest that participants spend about 10 minutes reading their group’s assigned case studies.
• After reading, in their groups participants should discuss and respond to the questions in **Task 2.1 ■ Strategies and Impacts of Budget Work** about the three case studies they were assigned.

• Suggest that the groups spend about 40 minutes discussing and responding to the following questions. They can use the matrices provided to record their answers.
  1. What issue was the organization responding to?
  2. How did the organization use budget work as a tool to advance their initiative?
  3. What advocacy strategies/tactics did they use?
  4. What impact did their efforts have?

• Ask the participants to note their individual observations on these questions (in addition to those discussed by the group).

#### 3. **Task 2.2 ■ Budget Tools and Strategies for Health Budget Advocacy**

**25 Minutes**

• Refer participants to **Task 2.2 ■ Budget Tools and Strategies for Health Budget Advocacy** in their workbooks for this activity.

• Using the questions in the task sheet as a guide, ask each participant to reflect on their own health advocacy work in relation to the what they have now read about civil society budget work, advocacy strategies used, and the impacts achieved in the three case studies.

• Some of the key tools and strategies used in the case studies are:
  - Coalitions
  - Citizen mobilization
  - Engaging with the Executive
  - Litigation
  - Working with oversight institutions
  - High-level working groups
  - Media

#### 4. **Plenary Discussion**

**15 Minutes**

• Facilitate a plenary discussion to gather feedback and insights from the participants about the two previous tasks. Invite both comments and questions.

• Summarize the session.
**TASK 2.1 ■ STRATEGIES AND IMPACTS OF BUDGET WORK**

**GROUP 1 CASE STUDIES: SAMARTHAN, ACIJ, AND COALITION IN SOUTH AFRICA**

<table>
<thead>
<tr>
<th>WHO</th>
<th>What issue was the organization responding to?</th>
<th>How did the organization use the budget to advance their advocacy campaign?</th>
<th>What advocacy strategies/tactics did they use?</th>
<th>What impact did their efforts have?</th>
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<tr>
<td>Samarthan</td>
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<tr>
<td>Coalition in South Africa</td>
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</table>
## Task 2.1 Strategies and Impacts of Budget Work

### Group 2 Case Studies: HakiElimu, NCDHR, and Omar Asghar Khan Development Foundation

<table>
<thead>
<tr>
<th>WHO</th>
<th>What issue was the organization responding to?</th>
<th>How did the organization use the budget to advance their advocacy campaign?</th>
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<td>NCDHR</td>
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<tr>
<td>Omar Asghar Khan Development Foundation</td>
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</table>
### TASK 2.1 ■ STRATEGIES AND IMPACTS OF BUDGET WORK

**GROUP 3 CASE STUDIES: COALITION IN SOUTH AFRICA, NCDHR, AND HAKI Elimu**

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<thead>
<tr>
<th>WHO</th>
<th>What issue was the organization responding to?</th>
<th>How did the organization use the budget to advance their advocacy campaign?</th>
<th>What advocacy strategies/tactics did they use?</th>
<th>What impact did their efforts have?</th>
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</table>
## Task 2.1 | Strategies and Impacts of Budget Work

### Group 4 Case Studies: ACIJ, Samarthan, and Omar Asghar Khan Development Foundation

<table>
<thead>
<tr>
<th>WHO</th>
<th>What issue was the organization responding to?</th>
<th>How did the organization use the budget to advance their advocacy campaign?</th>
<th>What advocacy strategies/tactics did they use?</th>
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<tr>
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<td>Samarthan</td>
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<tr>
<td>Omar Asghar Khan Development Foundation</td>
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</tbody>
</table>
READING 2.1 ■ SIX IMPACT CASE STUDIES

1. Argentina: Claiming the Right to Education with Budget Analysis and Litigation

The Constitution of the City of Buenos Aires states that the government must guarantee and fund a public and free education system that provides equal opportunities for every child older than 45 days. The Constitution also says that budget items allocated to education cannot be reallocated for other purposes.

Between 2002 and 2009 the shortage of early education facilities prevented thousands of children from beginning their education. During these years, demand for education for young children was increasing but no new early education facilities were added. By 2008 almost 8,000 children were excluded. More than half of the excluded children lived in the city's six poorest districts, and less than 15 percent lived in the six wealthiest districts.

The nongovernmental organization, Civil Association for Equality and Justice (ACIJ), became aware of the problem through its other education work in the very poor areas of the city. The organization gathered testimonies and evidence, issued a report that included information on budget expenditures, and produced a film to raise public awareness of the problem. It also prepared a draft bill aimed at resolving some of the problems.

Government did not respond to these actions. Therefore, in 2006 ACIJ filed a class action lawsuit. ACIJ had legal expertise and experience in litigation within their staff. For this case the organization used research it had previously done on budget allocations and expenditures to strengthen their legal arguments.

ACIJ had two main arguments.

- Children were being denied their right to early education because of a shortage of spaces at schools. This violated both the right to early education and the right to equal treatment, because the shortage was worse in the poorer parts of the city.

- The government had been under-spending the budget allocated to school infrastructure and maintenance. The money was thus available, but was not being used to meet the need and fulfill the right.

ACIJ regularly faced the problem that necessary budget information was not publicly available. The organization in this case used the city's Freedom of Information Act, requesting information on the total number of schools offering early education, the number of students who had applied for early schooling from 2001 to 2006, and the number of children placed on waiting lists in each school. It also requested information about all budget allocations to school infrastructure between 2001 and 2005, and detailed spending data on construction and maintenance for these years.

At first the government refused to provide the data, but in 2006 the court forced it to do so. The data provided allowed ACIJ to prove that for five years the city's government had failed to fully spend the budget allocated for infrastructure, building, and maintenance of early education facilities, and that between 2002 and 2005 an average of 32% of the allocated budget was spent. ACIJ asked the court to order the government to comply with its constitutional obligations, and to design and implement urgent measures to correct the situation.

In its counter-argument, the city government pointed to a number of infrastructure works being done in respect of school facilities. However, it did not try to refute the budget analysis.

In August 2007 the court found in favor of ACIJ. It said that the government had failed to guarantee early education. It said that the court could not tell government how to comply with
its obligations, but it could (and did) order government to prepare and submit a plan showing how it would do so.

The city government appealed against the court’s ruling. While the High Court was making its decision, ACIJ had discussions with government. These discussions were encouraged by a Ministry official who believed it would be good to reach agreement outside the courts. Also at this time a new Minister of Education took office and the new Minister was more willing to discuss a solution. The High Court encouraged the dialogue.

After seven months of negotiations, ACIJ and government presented a draft agreement to the High Court. The city government agreed to take action to meet all space needs at existing early educational facilities, and to prioritize districts with the highest demand. Government also agreed to a work plan to create new spaces. Deadlines were set. Government also agreed to ensure that an adequate budget was allocated to fulfill the promises. In response to ACIJ’s request, the High Court organized a public hearing to discuss the agreement. The hearing gathered all relevant actors in the education community, and support for the draft agreement was almost unanimous.

Between 1996 and 2004 the Government of Tanzania implemented various programs to increase primary and secondary school enrollment. As a result, primary education enrollment increased from 90.5 percent of the relevant age group in 2004 to 97.3 percent in 2007. The number of primary school leavers who went on to secondary school increased from 147,490 to 448,448 over the same period.

However, enrollment was not the only problem in the education sector. In 2004, HakiElimu, a non-governmental organization that focuses on education, partnered with the Tanzania Teachers’ Union to survey teachers on their living and working conditions. Half of the 1,383 teachers surveyed said that they would stop teaching if they found another job. More than three-quarters said the salary was too low. More than half said that they paid more than 15 percent of their salary for accommodation. About 41 percent of teachers in urban areas and nearly 80 percent in rural areas said that they received their salaries late.

HakiElimu used media to educate the public and foster debate on the problems in Tanzania’s school system. It used radio spots and also produced and distributed 44 popular publications.

In September 2005 the government issued an interdict against HakiElimu, and told all regional and local government authorities that the organization was banned from activities in schools. Ironically, this government action helped to raise further public awareness about the organization and campaign.

In December 2005 a new president came to power in Tanzania. After a meeting with teachers, the new president formed a task force to investigate teachers’ problems. HakiElimu tried to contribute to the investigation. For example, HakiElimu contacted the finance minister with a proposal on how to solve the delays in teachers’ salaries.

However, at about the same time, the Prime Minister’s Office issued a letter banning HakiElimu’s publications and advertisements on the grounds that they were contrary to public interest. This banning led to a debate in Parliament and further media coverage. In 2006 HakiElimu published a booklet that contained 32 articles, 10 editorials in national newspapers, 22 letters to the editor, 16 statements from civil society organizations, and 23 news stories about the interdict.

In February 2007 representatives of HakiElimu went to the capital city, Dodoma, to meet with several ministers, including the Prime Minister and Education Minister. After the discussions, the Education Minister agreed to lift the ban on HakiElimu.

Subsequently, the government introduced some reforms that addressed problems highlighted by HakiElimu’s campaign. In January 2007 the government increased the minimum wage for teachers. Since 2007 teachers’ salaries have been paid on time. And between 2005 and 2008 the number of teachers employed in primary schools increased from 135,013 to 154,895, the number of government primary schools increased from 1,202 to 3,039.
3. India: Budget Tracking to Give Dalits a Fair Share of Development

In India Dalits were historically seen to have low social status, because they fall outside the four recognized castes. Because of this, Dalits were treated as “untouchables,” forced to do low status work, and were not permitted to own land or attend school.

The Indian Constitution of 1950 prohibited discrimination against Dalits. However, Dalits continued to be disadvantaged in a number of respects, including in terms of poverty and illiteracy. To help address the situation, in 1980 the Government of India introduced the Scheduled Caste Sub-Plan (SCSP). The SCSP said that at least 16% of the government’s development spending must directly target Dalits, because Dalits make up 16% of the population.

In 1995 the government introduced a budget code 789 to categorize SCSP funds in budget documents. However, many national and state governments did not use this code.

In 1998 a group of Dalit activists, intellectuals and writers established the National Campaign for Dalit Human Rights (NCDHR). In 2006 the NCDHR started working with another civil society organization, the Centre for Budget and Governance Accountability, to develop a methodology to track and analyze code 789 expenditures.

NCDHR filed a court case against the government on the grounds that the government had not allocated the required 16% of the budget to programs for Dalits. However, NCDHR was forced to withdraw its case, because the government had not used budget code 789 consistently, with the result that there was insufficient information to back the court claim.

NCDHR then used the Right to Information Act to ask the Delhi state government why it was not using the 789 code. It also disseminated its research to Members of Parliament, the Auditor General, the Planning Commission, and other relevant institutions. It ran workshops around the country to train activists to do similar budget analysis in their own regions. It also organized a demonstration called "The Bounced [Check] Rally" to protest against the failure of the government to deliver the necessary funds for Dalit communities.

In 2008, before the Right to Information request had been finalized, the Delhi government instructed all its departments to use code 789. This was the first big budget victory.

In 2010 the Commonwealth Games were held in New Delhi. There were many allegations of high-level corruption in connection with the Games. The Housing and Land Rights Network, which had worked to expose the corruption, found a document that suggested that SCSP funds had been used to help pay for the event. The Network passed on this information to NCDHR.

NCDHR used its knowledge of budgets to confirm that the SCSP funds had been used to pay for the Games. After it publicized its findings, Parliament discussed the issue for two days. During the debate in Parliament, the Minister of Home Affairs admitted that government money was being unfairly diverted from one of the most deprived social groups.

Subsequently, the government made it compulsory for all departments to use code 789 in the 2011/12 budget, and the Planning Commission set up a taskforce in June 2010 to revise the guidelines for the SCSP. This was a further budget victory for Dalits.
4. Pakistan: Earthquake Reconstruction:
Case Study of the Omar Asghar Khan Development Foundation

On 8 October 2005 a large earthquake shook the Hazara region of Pakistan. The earthquake destroyed many homes and livelihoods as well as lives in a very poor part of this poor country.

Donors promised large amounts of aid to help the country recover from the earthquake. The Government of Pakistan established the Earthquake Reconstruction and Rehabilitation Authority (ERRA) to manage reconstruction and the funds.

The largest part of the money – R1.5 billion – was allocated for building houses for families whose homes had been destroyed. President Musharraf said that about 400,000 families would each receive a subsidy of US$3,300 to help them build “earthquake-proof” houses.

ERRA presented four detailed “earthquake-resistant” designs for the houses. People from the affected region expressed concerns about the designs. Their concerns were at first not acted upon, but after further pressure ERRA accepted some designs that used more appropriate materials.

Less than two years after the earthquake, ERRA claimed that housing grants had been given to 600,000 people, 99 percent of those eligible. However, the evidence gathered by the Omar Asghar Khan Development Foundation and its allies contradicted this claim.

The Foundation’s main ally was the People’s Coalition of Hazara, which brought together more than 300 people’s organizations, lawyers, workers and the media. The Foundation worked with these allies to conduct analysis, outreach, and advocacy. The Foundation also decided to become an executing agency for ERRA in one union council (the lowest level of local government). This work gave the Foundation a detailed understanding of ERRA’s approach.

The Foundation also asked experts to help it analyze data released by ERRA. The experts concluded that ERRA had achieved much less than claimed.

The Foundation trained 150 community members from the affected communities to help people in 57 villages identify their needs and priorities. It also conducted a small survey of recipients of the housing subsidy to compare the time and money costs of accessing the subsidy with the amount received. The survey showed that the amount paid was less than had originally been promised, and that, on average, subsidy recipients’ costs were US$299 more than the value of the subsidy. In addition, by 2008 inflation had halved the real value of the subsidy. The Foundation used the media – and especially television – to disseminate the findings of its research.

In October 2008, on the second anniversary of the earthquake, about 200 activists staged a sit-in in front of the Parliament and the President’s Office in Islamabad to publicize the problems in the reconstruction effort. TV coverage of the sit-in pressured ERRA officials to visit the protesters, who demanded to see ERRA’s top official.

ERRA’s top official agreed to meet with three Foundation officials. After the meeting, ERRA agreed to 1) pay all outstanding housing subsidy payments immediately; and 2) speed up reconstruction of roads, health, education, and water supply facilities. Analysis of subsequent data from ERRA showed that reconstruction started happening more quickly after the protest and meeting.
5. India: Samarthan’s Campaign to Make Real the Right to Work

India’s economy has grown at an average annual rate of more than 7% over the last decade, but the country still has more poor people than any other. Rural households are the worst off. In 2005 the government of India passed the National Rural Employment Guarantee Act (NREGA), which said that every rural household was entitled to 100 days per year of unskilled employment on public works projects. The Act was a bold step to address the widespread poverty.

The NREGA says that each of India’s local councils, the gram panchayats, must make a list of needed public works projects such as digging wells, contouring land, horticulture, toilet construction and road construction. Village officials must also work with officials at higher levels to prepare a labor budget for the year. Any rural resident adult who submits a simple application form to the local official must then be given work within 15 days. If no work is given, the person must instead be given an unemployment allowance.

One problem with the scheme is that many eligible people are not aware of it. Also, many poor families do not have the “job card” they need to participate. For those who do apply, there can be bureaucratic problems: The panchayat secretaries do not always give a written receipt for the job application. The panchayat officials also sometimes choose to use machinery rather than human labor. The village secretaries sometimes delay giving approval for labor and materials. Local officials sometimes work with bank and higher-level officials to allocate money to “ghost” workers, so that they get the money instead.

There are also delays in payment. Payments are made into bank accounts, and sometimes there are no branches of the bank nearby. Sometimes, when poor people travel to the bank to get their money, bank officials say that they are too busy to help them. All these problems encourage poor people to migrate in search of work rather than to participate in the program near their rural homes.

Samarthan is an NGO established in 1994 to support the development of civil society groups in the state of Madhya Pradesh. It focuses on the poor and disadvantaged sections of the society. The government of India chose Madhya Pradesh to launch NREGA in 2006. Samarthan has thus been involved in monitoring the program since its earliest days.

Samarthan began by organizing social audits of the NREGA program in several districts. The social audits involved village gatherings where government records from the program were read out for everyone to hear. The records included the names of those who were recorded as working on the program. Samarthan also developed a system for tracking the paperwork and payments made. For example, it looked at the certificates issued by officials who verified the completion of public works projects. It looked at village-level records of the number of persons given work, wages paid, delays in payment, and unemployment allowances. Together with the social audits, this analysis revealed the pattern of abuses.

To address the lack of awareness of the program, Samarthan organized village youth to distribute the application forms for NREGA. The application forms were also made available in the village grocery shops. Samarthan told people that they must ensure that they got a dated receipt for their application so that they could get the unemployment allowance if they were not given work. Unfortunately, some of the secretaries threatened the workers who asked for a dated receipt, saying that those who insisted on a receipt would only get work after 15 days, whilst those who did not would be called to work within two to three days. However, other officials appreciated Samarthan’s work. One district-level official had a copy of Samarthan’s pamphlet sent to all residents in the district living below the poverty line.

Samarthan discovered in its work that village-level leaders did not have the capacity to plan the necessary works projects or to budget for the work because they had not been properly trained by the government. Samarthan therefore assisted in building the skills of these officials. This assistance increased the effectiveness of the program and also helped to reduce the officials’ opposition to Samarthan’s activities.

In addition to the other activities, Samarthan provided the local press with evidence-based news stories. It organized a workshop of civil society organizations and the press to raise journalists’ awareness of development issues, including NREGA. This press coverage angered some government officials. When this anger was worst, Samarthan staff feared to work in some villages where the worst problems had been reported.
6. South Africa: Civil Society Uses Budget Analysis and Advocacy to Improve the Lives of Poor Children

In 1996, two years after the end of apartheid, the Government of South Africa established a committee to recommend a new approach to social security grants for children. This new approach was needed because the apartheid-era grant did not reach children from the majority black population despite the fact that black people were the most likely to be poor. Government told the committee that the new approach must not cost more than the old approach, although it would need to reach far more children.

The committee proposed that the old grant be replaced by a new Child Support Grant (CSG) that would cover more children but with a lower monthly grant payment. The CSG was introduced in 1998 for children up to their seventh birthday. The monthly amount was R100.

Over the following years civil society organizations advocated to improve the grant. Their advocacy included budget analysis, other research, informing and mobilizing the public, engaging with policymakers and government officials, and court cases.

Civil society groups did research, because they believed that advocacy based on evidence would be stronger than demands without evidence. Some of the organizations had developed evidence through the assistance they provided to CSG applicants in poor communities. Other organizations did research through surveys, interviews, examining documents, and budget analysis. Organizations with different skills worked together to make the advocacy stronger.

The budget-related research included calculations that showed that the value of the grant decreased in real terms (after adjusting for inflation) in the first years. Government responded quickly by increasing the size of the grant, and there have been regular increases at least once a year ever since. Other budget-related research estimated the budget that would be needed for the age of the qualifying group to be increased and the means test changed to make more children eligible.

Some of the research done by civil society organizations was commissioned by government. Some of this showed that even though there were no similar requirement to qualify for the CSG, the grant resulted in increased school enrolment and improved health and nutrition and other benefits that other countries (for example, in Latin America) reported as a result of conditional grants provided there.

In some cases when changes did not happen after the research and advocacy, civil society brought cases before the courts. For example, a court case was needed before the rules were changed to allow people without identity documents to use other documents when applying for the grant. This change was important, because government was not delivering identity documents efficiently.

Civil society’s advocacy helped achieve important improvements in the grant. For example, as of 2012 the amount of the grant was R280 per month, and children could receive the grant up to their 18th birthday. The means test was also increased. As a result of all these efforts, in 2012 nearly 11 million children received the grant, compared to fewer than 2 million in 2001.
Now that you have been introduced to applied budget work, reflect on and identify possible opportunities for incorporating applied budget work into your health advocacy work. Use the following questions to guide your reflection.

1. Which of the tools and strategies used in the case studies could your organization consider for its health advocacy work?

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2. How would they need to be adjusted for local conditions and for the health issue that your organization is working on?

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A NETWORK OF BUDGET ADVOCACY

1. PARTICIPANTS’ PRESENTATIONS

- At the end of Module 1: Introductions and goals of the workshop, participants prepared posters about their organizations to present to the entire group at the beginning of Days 2, 3, 4, and 5. A half-hour slot is allotted at the beginning of each day for two organizations to present (see Health & Budgets Training Workshop Agenda at the beginning of this Manual).
- The day before the presentations are to take place identify two CSOs and ask them to be ready to present their organizations the following morning.
- At the beginning of each presentation slot, introduce the organizations and invite the participants to display their posters and deliver a short presentation of no more than 10 minutes each.
- After the first 10 minute presentation, field questions from the other participants for 5 minutes. Then ask the second organization to make its presentation, using the same time allotments.

2. THE TASK OF PARTICIPANTS AS THEY LISTEN TO THEIR PEERS

- The aim of the peer presentations is to highlight the importance of and support a network approach to health budget advocacy work. By learning more about one another’s organizations and the way that they work, participants come to understand that they are part of a growing and learning CSO community.
- Building knowledge of other organizations within the civil society budget network is an important aspect of enriching participants’ own capacities. It is often this community on which they can best rely for assistance, expertise and advice on methodologies and other aspects of the work, rather than on external “experts” disconnected from the civil society movement.
- During or after the peer presentations, participants are encouraged to note down relevant insights and ideas for their own budget work, using Task 2.3 ■ A NETWORK OF BUDGET ADVOCACY in their workbooks.
The review of civil society budget work and its strategies and impacts also includes YOU and the other participants in this workshop. You have been asked to prepare a short presentation about your organization and the health budget work that you do (or will be doing). The facilitator will allocate a time for you to share this information with the rest of the participants. Likewise, at intervals throughout the workshop, you will have a chance to learn about the organizations of your peers and the work that they are engaged in. Use the space below to make notes during or directly after every participant’s presentation. Again, be sure to capture the ideas that interest and inspire you, including possible advocacy issues or research questions to explore further when you are back home.

PARTICIPANT _____________________________________________

NAME OF ORGANIZATION __________________________________

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MODULE 3
THE RIGHTS FRAMEWORK
# MODULE 3 ■ THE RIGHTS FRAMEWORK

## SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of this module</th>
<th>4 hours, 10 minutes</th>
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<tbody>
<tr>
<td><strong>Timing of this module</strong></td>
<td>This module corresponds with the following sessions in the <em>Health &amp; Budgets Training Workshop Agenda:</em>  &lt;br&gt;• SESSION 3 on Day 1;  &lt;br&gt;• SESSION 4 on Day 1; and  &lt;br&gt;• Part of SESSION 1 on Day 2.  &lt;br&gt;(Note that one session is 1 hour, 45 minutes.)</td>
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<tr>
<td><strong>Resources needed</strong></td>
<td>• Flipchart paper and colored markers  &lt;br&gt;• Post-Its  &lt;br&gt;• PowerPoint presentation: Module 3 – The Rights Framework  &lt;br&gt;• Polarus Sourcebooks for all participants  &lt;br&gt;• In the Participant’s Workbook:  &lt;br&gt;  ➢ TASK 3.1 ■ Value Added by a Rights Framework  &lt;br&gt;  ➢ TASK 3.2 ■ What is the Right to Health?  &lt;br&gt;  ➢ TASK 3.3 ■ The Right to Health Nationally and Internationally – How Do They Compare?  &lt;br&gt;  ➢ TASK 3.4 ■ General Comment 14 and the 3AQ  &lt;br&gt;  ➢ TASK 3.5 ■ Legal and Policy Provisions of the Right to Health in Polarus  &lt;br&gt;  ➢ TASK 3.6 ■ Availability, Accessibility, Acceptability and Quality in Polarus  &lt;br&gt;  ➢ TASK 3.7 ■ The Government’s Obligations related to the Right to Health  &lt;br&gt;  ➢ TASK 3.8 ■ The Government’s Obligations and its Health Budget  &lt;br&gt;  ➢ TASK 3.9 ■ Access to Information and Participation as Rights  &lt;br&gt;  ➢ READING 3.1 ■ General Comment 14 on the Right to the Highest Attainable Standard of Health  &lt;br&gt;  ➢ READING 3.2 ■ Summary of Guidance Provided by the Committee on Economic, Social and Cultural Rights (CESCR) on ICESCR Article 2 Obligations</td>
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LEARNING OUTCOMES TO BE ACHIEVED

By the end of this module, participants will have:

- Considered the value added of using a rights framework for budget work in the health sector;
- Reflected on what the right to health should mean;
- Compared national legal guarantees to the right to health with international guarantees;
- Tracked down and articulated the 3AQ in General Comment 14;
- Identified the legal and policy framework related to the right to health in Polarus;
- Practiced applying the 3AQ standards in General Comment 14 by assessing the right to health situation in Polarus, and how those standards relate to the budget;
- Identified the legal obligations of the State under international and national law, and their relationship to the government’s budget; and
- Reflected on the importance of the right to information and participation for their health budget work.

STRUCTURE OF THE MODULE

The Legal Framework of the Right to Health and Government Obligations (1 hour, 40 min.)

1. **TASK 3.1** ■ Value Added by a Rights Framework 10 minutes
2. **TASK 3.2** ■ What is the Right to Health? 30 minutes
3. **TASK 3.3** ■ The Right to Health Nationally and Internationally – How Do They Compare? 30 minutes
4. **TASK 3.4** ■ General Comment 14 and the 3AQ 30 minutes

The Legal and Policy Framework of the Right to Health in Polarus (1 hour)

5. **TASK 3.5** ■ Legal and Policy Provisions on the Right to Health in Polarus 30 minutes
6. **TASK 3.6** ■ Availability, Accessibility, Acceptability and Quality (3AQ) in Polarus (including Gallery Walk) 30 minutes

Governments’ Obligations as an Analytical Tool (1 hour, 15 min.)

7. **TASK 3.7** ■ The Government’s Obligations related to the Right to Health 30 minutes
8. **TASK 3.8** ■ The Government’s Obligations & its Health Budget 45 minutes

Transparency and Participation in Rights Terms (15 min.)

9. **TASK 3.9** ■ Access to Information and Participation as Rights 15 minutes
THE LEGAL FRAMEWORK OF THE RIGHT TO HEALTH AND GOVERNMENT OBLIGATIONS

Duration of session: 1 hour, 40 minutes

1. TASK 3.1 ■ Value Added by a Rights Framework 10 minutes

- Explain that good number of civil society groups work on budgets and many are interested in using human rights to focus and frame their budget work. Ask if there are groups in the room who are similarly interested.

- Explain that groups who are interested in using a human rights framework for their budget work must see that such a framework would add value to their existing work. What value might they see it would add?

- Refer participants to TASK 3.1 ■ Value Added by a Rights Framework in their workbooks. Ask participants to work at their tables for 5 minutes discussing the pros and cons of using a human rights framework. They can use the space in their workbook to note down the principal points made.

- Ask in plenary for some of the points groups came up with. The “pros” of using a human rights framework could include: 1) Using human rights law, in national or international law, grounds the budget work in obligations the government legally has to meet; 2) Human rights carry moral weight. Adding the technical expertise of budget work to a moral argument can make for quite strong, in part because so unexpected, arguments. The “cons” of using a human rights framework could include: 1) Arguments that could be seen as neutral and technical could start to be seen as “political” if human rights language is used; 2) Governments may feel comfortable talking about technical budget issues, but are often quite uncomfortable talking about human rights. This can create tensions with government.
2. **Task 3.2 ■ What is the Right to Health?**

- Facilitator should write at the top of a flip chart sheet, “The Right to Health should mean…”
- Explain that our understanding of rights evolves over time as people respond to experiences, reflect on how they feel about different things that happen, and what they think is important if they are to feel respected as human beings. Human rights are, in essence, about protecting and enhancing human dignity. National and international law bearing on human rights should reflect these collective experiences and feelings. Before turning to national and international human rights law then, it would be useful for participants to reflect themselves on what they believe the right to health should mean. **What should be guaranteed as part of the right to health?**
- Participants should, working individually, reflect on the question, and note down four guarantees they feel should be part of a “right to health.” After 5 minutes, they should share their proposals with others at their table. Are there elements that two or more participants at the table believe are essential? Which guarantees seem essential to the most number of people? Where a participant is the only person at the table to mention a specific guarantee, they should explain to others at their table the rationale for their choice. After 10 minutes’ discussion, the table should write their four top guarantees on Post-Its. These should then be put up on the flip chart sheet headed “The Right to Health should mean…..” They can use the boxes set out in **Task 3.2 ■ What is the Right to Health?** in their Workbooks to record their thoughts or the thoughts of their group.
- Read out the guarantees written on the Post-Its, putting together those that are the same. Explain that they will next be looking at national and international law guaranteeing the right to health. They will be able to see the extent to which that law reflects what people in the workshop feel is important within a guarantee of the right to health. Evolution in human rights law can happen when enough people feel that a right should include specific guarantees that are not currently recognized as essential to human dignity – if they have the political power to bring about the change!

3. **Task 3.3 ■ The Right to Health Nationally and Internationally — How do they compare?**

- Participants were asked, as part of their pre-program homework, to track down provisions in their national constitutions on the right to health. This task is an opportunity to review those provisions and compare their guarantees with guarantees in international law, specifically in
the International Covenant on Economic, Social and Cultural Rights (ICESCR).

- Ask participants to turn to **Task 3.3 ■ The Right to Health Nationally and Internationally — How do they compare?** in their Workbooks. If there are multiple participants from one country, they can work together. In the space provided, they should write any provisions in their national constitutions that relate to the right to health.

- Having transcribed the national provisions, they should read article 12 of the ICESCR (provided in the Workbook), and consider which of the two provisions is stronger in guaranteeing the right to health. They should note their thoughts in their Workbooks. Provide 10 minutes for this reflection.

- In plenary, ask a few participants to talk about their findings and their reasoning as to which provisions are stronger.

- A few important points to be made here:
  1) The more detailed the provisions, in general, the stronger the guarantees. Otherwise, there can be disagreement about the meaning of the more vague terms;
  2) If national standards are stronger, then normally an organization should use those standards in their research and advocacy;
  3) If international standards are stronger, and the government has ratified the relevant international treaty, then an organization in this situation should generally cite the relevant international standards;
  4) In general, international standards related to the right to health will be considerably more detailed than national constitutional guarantees, and thus will generally be stronger.

- Often in discussions about health care and health systems, mention is made of the importance of universality and equity. A right to health approach includes both universality and equity, but goes beyond this more common approach by addressing issues beyond simply health care and in guaranteeing access to quality health care to all as a right.

**Task 3.4 ■ General Comment 14 and the 3AQ 30 MINUTES**

- Explain that the UN Committee on Economic, Social and Cultural Rights (CESCR) was the committee established to oversee implementation of the ICESCR by countries that have ratified it. They review and comment on the reports submitted by governments every five years on their implementation of the treaty provisions. As part of their efforts to clarify for governments how best they can implement the Covenant, the Committee occasionally produces “General Comments” (GCs). Some of their GCs focus on specific articles in the ICESCR, spelling out in considerable detail their interpretation of the article. This they do
on the basis of their experience with the treaty as well as input from UN specialized agencies (such as WHO), civil society groups, and others. Their fourteenth General Comment (General Comment 14) focuses on the meaning of ICESCR article 12 on the right to health.

**READING 3.1 ■ GENERAL COMMENT 14 ON THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH** in their Workbook gives the full text of General Comment 14.

- General Comment 14 is quite lengthy and detailed, and for those working in the area of health is well worth reading through all the way. However, at the same time there are certain provisions that are particularly important for the purposes of the training workshop. Among those are paragraphs 7-12.

- Participants should spend 10 minutes reading paragraphs 7-12. In the space provided in their workbooks under **TASK 3.4 ■ GENERAL COMMENT 14 AND THE 3AQ**, they should summarize (not transcribe) what the GC has to say about availability, accessibility, acceptability and quality (known in short as 3AQ). They can spend 15 minutes doing this.

- Ask if there are any questions. Stress that the 3AQ standards are very helpful in identifying situations where the right to health may be at risk. Ask for examples from their own countries where they think one or more of the 3AQ standards might not be met. There should be lots of such examples offered.

- Finally, it is important to point out that General Comment 14 doesn’t only talk about health care. It gives a central place to the social determinants of health. Ask if participants can define the social determinants of health. *(A definition from WHO is on the next page).* Also ask participants where they see reference to the social determinants of health in GC 14.
**Definition of the Social Determinants of Health**

To improve the health conditions of the world population and increase equity in health a social determinants perspective is crucial. In fact, the circumstances such as poverty, poor schooling, food insecurity, exclusion, social discrimination, bad housing conditions, and deficient sanitation in early childhood and poor work opportunities in adulthood are all major determining factors of inequality both among and within countries in terms of health and disease. In addition, more often than not our health care systems are also part of the problem, due to them being influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, race and place of residence are all closely linked to people’s access to, experiences of and benefits from health care. *(Source: WHO, Closing the Gap in a Generation, Executive Summary.)*
TASK 3.1 ■ VALUE ADDED BY A RIGHTS FRAMEWORK
**Task 3.2 ■ What is the Right to Health?**

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**Health & Budgets Training Workshop**

**Facilitator's Manual**

**Task 3.3  ■ The Right to Health Nationally and Internationally – How to They Compare?**

Provisions in your national constitution on the right to health

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The International Covenant on Economic, Social and Cultural Rights on the right to health:

**Article 12**

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.

Which is stronger? Why?

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**Task 3.4 - General Comment 14 and the 3AQ**

Look at Reading 3.1 and summarize what General Comment says about availability, accessibility, acceptability and quality:

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1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.  

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services”. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, while article 12.2 enumerates, by way of illustration, a number of “steps to be taken by the States parties ... to achieve the full realization of this right”. Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples’ Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. However, the reference in article 12.1 of the Covenant to “the highest attainable standard of physical and mental health” is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe

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and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties’ implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties’ obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee’s experience in examining States parties’ reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties’ obligations.

8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of “the highest attainable standard of health” in article 12.1 takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual’s health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying...
determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs.9

Article 12.2 (a). The right to maternal, child and reproductive health

14. “The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a))10 may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care,11 emergency obstetric services and access to information, as well as to resources necessary to act on that information.12

Article 12.2 (b). The right to healthy natural and workplace environments

15. “The improvement of all aspects of environmental and industrial hygiene” (art. 12.2 (b)) comprises, inter alia, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population’s exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health.13 Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment.14 Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. “The prevention, treatment and control of epidemic, endemic, occupational and other diseases” (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States’ individual and joint efforts to, inter alia, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services15

17. “The creation of conditions which would assure to all medical service and medical attention in the event of sickness” (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health
education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

**Article 12. Special topics of broad application**

**Non-discrimination and equal treatment**

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

**Gender perspective**

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

**Women and the right to health**

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality
and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness.\(^\text{17}\)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children.\(^\text{18}\) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health.
Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

**Indigenous peoples**

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, the Committee deems it useful to identify elements that would help to define indigenous peoples’ right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

**Limitations**

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community’s major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

**II. STATES PARTIES' OBLIGATIONS**

**General legal obligations**

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind.
(art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.20

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties’ obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.21

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party’s maximum available resources.22

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote.23 The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs. Furthermore, obligations to respect include a State’s obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.24

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people’s participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

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35. Obligations to protect include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people’s access to health-related information and services.

36. The obligation to fulfil requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritious safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services.

37. The obligation to fulfil (facilitate) requires States inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.
International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 21, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.26

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.27 States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8,
on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee’s view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in
the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and
human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly
incumbent on States parties and other actors in a position to assist, to provide “international
assistance and cooperation, especially economic and technical”\textsuperscript{29} which enable developing
countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties
(Part II), a dynamic process is set in motion which facilitates identification of violations of the
right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is
important to distinguish the inability from the unwillingness of a State party to comply with
its obligations under article 12. This follows from article 12.1, which speaks of the highest
attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each
State party to take the necessary steps to the maximum of its available resources. A State which
is unwilling to use the maximum of its available resources for the realization of the right to
health is in violation of its obligations under article 12. If resource constraints render it
impossible for a State to comply fully with its Covenant obligations, it has the burden of
justifying that every effort has nevertheless been made to use all available resources at its
disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be
stressed, however, that a State party cannot, under any circumstances whatsoever, justify its
non-compliance with the core obligations set out in paragraph 43 above, which are non-
derogable.

48. Violations of the right to health can occur through the direct action of States or other entities
insufficiently regulated by States. The adoption of any retrogressive measures incompatible
with the core obligations under the right to health, outlined in paragraph 43 above, constitutes
a violation of the right to health. Violations through acts of commission include the formal repeal
or suspension of legislation necessary for the continued enjoyment of the right to health or
the adoption of legislation or policies which are manifestly incompatible with pre-existing
domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to
take necessary measures arising from legal obligations. Violations through acts of omission
include the failure to take appropriate steps towards the full realization of everyone’s right to
the enjoyment of the highest attainable standard of physical and mental health, the failure to
have a national policy on occupational safety and health as well as occupational health services,
and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene
the standards set out in article 12 of the Covenant and are likely to result in bodily harm,
unnecessary morbidity and preventable mortality. Examples include the denial of access to
health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.
54. The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people’s participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party’s obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children’s Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of
restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties’ reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States’ obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non-governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including
assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

NOTES

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.
2. In its resolution 1989/11.
3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee’s General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women’s health, respectively.
4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).
6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.
7. See paras. 18 and 19 of this General Comment.
8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.
9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: primary health care typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; secondary health care is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; tertiary health care is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.
10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.
11. Prenatal denotes existing or occurring before birth; perinatal refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); neonatal, by contrast, covers the period pertaining to the first four weeks after birth; while post-natal denotes
occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: “Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being”, as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

14. ILO Convention No. 155, art. 4.2.

15. See para. 12 (b) and note 8 above.

16. For the core obligations, see paras. 43 and 44 of the present General Comments.


18. See World Health Assembly resolution WHA47.10, 1994, entitled “Maternal and child health and family planning: traditional practices harmful to the health of women and children”.

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, para. 43.

21. See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to facilitate and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere.


25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with
essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).


27. See para. 45 of this General Comment.


29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, para. 9.
5. **Task 3.5 ■ The Legal and Policy Framework on the Right to Health in Polarus** 30 minutes

- Divide participants into four groups, according to the guidelines mentioned earlier. In summary, participants in a group should have a mix of knowledge and skills, so that each group has within it the capacities necessary to do the tasks assigned to them. Those with greater knowledge and skills in necessary areas are expected to help others in their group when they are struggling.

- **The aim of this task** is to introduce the country of Polarus to participants and to help them examine the legal framework that governs health care in Polarus.

- Explain that, from this moment on, all the participants have become honorary citizens of the Republic of Polarus.

- Each participant should receive a Polarus Sourcebook. Explain that this sourcebook tells them more about their new country, and contains lots of important information they will use throughout the workshop.

- Ask the participants to turn to **Task 3.5 ■ The Legal and Policy Framework of the Right to Health in Polarus** in their Workbooks. Invite them to read the requirements that General Comment 14 imposes on governments beyond the 3AQ. They should use these standards to examine the Polarus health framework. Working at their tables, each group should identify, to the extent possible:
  
  (a) the legal provisions and
  
  (b) the policy provisions

  that the government of Polarus has adopted that address these elements of the right to health. Groups will also reflect on the difference between the legal provisions and policy
provisions.

- After 15 minutes, invite two groups to volunteer to present their findings and discuss.

**NOTES FOR FEEDBACK**

- Legal frameworks express the commitment of the state, regardless of which particular government or administration is in power. Legal provisions have to be adopted by the legislative branch of government, and change only occasionally.

- Policy frameworks may change from one administration to another, and can be influenced by targeting the executive branch of government. They provide the details for how the government plans to comply with its legal obligations.

- Highlight that it is always important to see if there are legal provisions pertaining to vulnerable groups, and particularly regarding issues of equity.

- The General Comment says that the government must have a national health strategy and action plan or program. The strategy and action plan provide the big picture of what the government hopes to do and relates those “hopes” directly to specific programs and budgets.

**6. TASK 3.6 ▪ AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY IN POLARUS ▪ 30 MINUTES**

- Divide participants into the four Polarus groups and assign each group one of the four concepts. Ask participants to turn to **TASK 3.6 ▪ AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY IN POLARUS** in their Workbooks.

- Ask each group to look at the sections in the Polarus Sourcebook titled “Development Overview” and the “Health Background” and identify issues that seem relevant in terms of the concept which has been assigned to them.

- Ask participants to also think about potential gaps (e.g., gaps in availability, in accessibility, etc.) and the budgetary implications of their findings. Give each group a sheet of flipchart paper to write down their findings for the concept assigned to them, following the format provided in the Workbook.

- After 20 minutes, ask participants to do a gallery walk to look at what the other groups identified.
**TASK 3.5 ■ LEGAL AND POLICY PROVISIONS OF THE RIGHT TO HEALTH IN POLARUS**

The Right to Health requires governments:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable groups;
- To provide essential drugs;
- To adopt and implement a national public health strategy and plan of action including methods by which progress can be closely monitored;
- To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- To take measures to prevent, treat and control epidemic and endemic diseases;
- To provide information concerning the main health problems in the community; and
- To provide appropriate training for health personnel.

*United Nations, Committee on Economic, Social and Cultural Rights, General Comment 14*

Working in your groups, examine the “Health Policy Framework and Strategy” in your Polarus Sourcebook.

a) Identify key provisions, in the legal and the policy framework, that reflect the country’s compliance with the requirements lined out by General Comment 14, above.

b) Write down as many key elements that you can identify, distinguishing between legal provisions and policy framework.

c) Reflect on what this distinction means.

Legal provisions that relate to the Right to Health:

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___________________________________________________________________________
Policy provisions related to the Right to Health:

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___________________________________________________________________________
**Task 3.6 ■ Availability, Accessibility, Acceptability and Quality in Polarus**

**Availability:** Existence of health facilities, goods and services to meet the basic health needs of the people, including hospitals and clinics, trained medical personnel, essential drugs and so forth.

**Accessibility:** Geographical accessibility (without any discrimination or conditionality) and economic accessibility (no constraints in the form of payments for seeking health care).

**Acceptability:** Health facilities, goods and services must be appropriate for all (respectful of people’s culture and aimed at improving people’s health status).

**Quality:** Health facilities, goods and services must be scientifically and medically appropriate (skilled medical personnel, scientifically approved drugs and hospital equipment).

Working in your group, look for issues that are outlined in the “development overview” and “health background” of Polarus, taking into account the element of the right to health (availability, accessibility, acceptability or quality) assigned to your group. Identify gaps within each the element and its budgetary requirements. Use the table below to record your analysis.

<table>
<thead>
<tr>
<th>ASPECTS</th>
<th>GAPS</th>
<th>BUDGET IMPLICATIONS</th>
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<tbody>
<tr>
<td>Availability:</td>
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<th>ASPECTS</th>
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<td>Quality:</td>
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GOVERNMENTS’ OBLIGATIONS AS AN ANALYTICAL TOOL

Duration of session: 1 hour, 15 min.

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<tr>
<th>STRUCTURE OF THE SESSION</th>
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<tr>
<td>Governments’ Obligations as an Analytical Tool</td>
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<tr>
<td>5. <strong>TASK 3.7</strong> ▶ The Government’s Obligations related to the Right to Health</td>
</tr>
<tr>
<td>6. <strong>TASK 3.8</strong> ▶ The Government’s Obligations and its Health Budget</td>
</tr>
</tbody>
</table>

7. **TASK 3.7** ▶ THE GOVERNMENT’S OBLIGATIONS RELATED TO THE RIGHT TO HEALTH 30 MINUTES

- An assessment of a government’s budget using a human rights framework uses both the elements of a right (by asking: which guarantee is at risk?), and the government’s obligations vis-à-vis the right. A government’s human rights obligations – in other words, what a government is responsible to do to ensure people’s enjoyment of their rights – provide guidance on what to look for when doing budget monitoring and analysis. Obligations also provide a framework and language for advocacy.

- Refer to Slide 2 of the PPT presentation, Module 3 – The Rights Framework. A government has a number of responsibilities (obligations) vis-à-vis people’s rights. One set of these obligations has been called “generic” obligations; they are true for all rights. These are the obligations to:
  - Respect rights: A government must not interfere with people’s existing enjoyment of their rights;
  - Protect rights: A government must protect people’s rights from interference by a third party; and
  - Fulfill rights: A government must create the enabling conditions and adopt appropriate policies, plans and programs to ensure that people’s rights are being realized.

- Participants should keep this understanding in mind, and turn to **TASK 3.7** ▶ THE GOVERNMENT’S OBLIGATIONS RELATED TO THE RIGHT TO HEALTH in their Workbooks. There the difference between respect, protect and fulfill with regard to the right to health has been articulated. The chart then looks at what those three obligations mean with regard to the guarantee of “availability.”
• Ask participants to fill in the blocks of the chart for the remaining 3AQ. The purpose of this task is simply to have them become familiar with the generic obligations by writing out their implications for the 3AQ.

• Ask if participants have any questions.

• Refer to Slide 3 of the PPT for Module 3 – The Rights Framework. With regard to economic, social and cultural rights, the government has specific obligations that are set out in Article 2 of the ICESCR.

• Read article 2 from the slide deliberately, emphasizing, in particular, the underlined phrases. These are phrases that are very important for analyzing a government's budget from within a rights framework.

• Explain that the Committee on Economic, Social and Cultural Rights (CESCR) has interpreted these obligations in a number of context. Refer participants to READING 3.2 ■ SUMMARY OF GUIDANCE PROVIDED BY THE COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (CESCR) ON ICESCR ARTICLE 2 OBLIGATIONS. Allow them 10 minutes to read through the summary.

• Ask if participants have any questions.

8. TASK 3.8 ■ THE GOVERNMENT’S OBLIGATIONS AND ITS HEALTH BUDGET 45 MINUTES

• There are a number of ways that human rights relate to health budgets. Some of the various ways they relate will be addressed throughout the course. This is a “first look” introduction to budgets considered within a rights framework.

• Ask participants to turn to TASK 3.8 ■ THE GOVERNMENT’S OBLIGATIONS AND ITS HEALTH BUDGET in their Workbooks. Explain that the task includes eight very simple health and budgets scenarios, and their job is to do an initial human rights assessment based on what they have learned thus far about the 3AQ and governments’ obligations. The chart on the following page of the Workbook provides space for them to record their conclusions.

• They should first determine, if it is possible from the facts given (don’t add facts), which level of government is responsible for what has happened. Governments at all levels have human rights obligations. However, it is important to ascertain the level of government responsible for the purposes of research and advocacy.
They should then identify which of the 3AQ are involved in the situation. It may be more than one and/or there may be inadequate information to enable them to decide which are at risk.

They should then put a check (✓) in the box that corresponds to a “Failure of the” respective obligation. They may find that more than one obligation is involved.

Facilitators should visit groups as they work to ensure that they understand what they are doing, what the different obligations mean, how to apply them to a fact situation, etc.
## TASK 3.7 ■ THE GOVERNMENT’S OBLIGATIONS RELATED TO THE RIGHT TO HEALTH

“Generic” obligations:

<table>
<thead>
<tr>
<th>Right to health</th>
<th>Respect</th>
<th>Protect</th>
<th>Fulfil</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability</strong></td>
<td>Not to interfere with people’s existing enjoyment of the right to health</td>
<td>Prevent others from interfering with people’s enjoyment of the right to health</td>
<td>Enact policies, plans and programs to realize people’s right to health</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Not to interfere with the availability of health services for people</td>
<td>Prevent others from interfering with the availability of health service for people</td>
<td>Enact policies, plans and programs to ensure that health services are available</td>
</tr>
</tbody>
</table>

### Article 2 obligations:

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. …
1. The army budget has risen by 10% this year and the Parliament has allocated 2 million dollars to build a monument to the President in the capital center. Meanwhile, the government has cut back on the program subsidizing health insurance for the low-income population, citing the effects of the global economic crisis on public resources.

2. People in the rural areas of Blossom County have to walk, on average, 15 miles to the nearest health clinic; no public transportation is available. As a result, a number of people, including pregnant women, die annually due to lack of medical care. Over the course of several years, the county government has claimed it has no resources to build additional clinics. During that same time county government officials have been seen driving expensive new cars.

3. At the mid-year budget review, the government discovers that its revenues are coming in above projections. It decides to allocate the additional funds to the tourism sector, even though the Department of Health’s budget allocation was only 70% of what it requested. At the same time, child deaths from epidemic diseases are well above international averages.

4. The national government has adopted a policy encouraging the privatization of health services. It has established a National Health Commission whose mandate is to oversee contracts entered into by local governments (which are responsible for health service provision), to ensure that services are being provided at affordable rates and that all citizens have access to health care services. While the government lays out the process for the selection and work of the Commission, it fails to allocate funds for its operation.

5. The population of Blossom State is comprised of three ethnic groups. The national government allocates health funds to the states in an equitable fashion, but the quality of health services varies considerably among districts in Blossom State. Your organization learns that the State authorities have directed the infrastructure funds to building health clinics in localities largely populated by one of the three ethnic groups.

6. Each year the people living in four states of the country suffer disproportionately from infectious diseases that increase in the rainy season. Unlike in previous years when there was almost total coverage, in 2008 local health clinics in the states ran out of vaccine when only half the people had received their shots. Earlier in the years newspapers had reported that the national government had contracted with a new vaccine supplier.

7. The provincial government has introduced user fees for public health services in Leaf Province. It claims that such a step is necessary to ensure full funding of the provincial health care system. Over the next two years, a community-based organization determines that 20% of the pregnant women in the communities with which it works have not sought any pre-natal care from the clinics, as they cannot afford to pay the user fee.

8. The national government directs funds annually to state governments for the establishment and maintenance of a system of emergency vaccines. The local authorities in Lake State pocket most of the funds, with the result that vaccines are inadequate when an epidemic breaks out in the state.
<table>
<thead>
<tr>
<th>Level(s) of government with direct responsibility</th>
<th>Availability, Accessibility, Acceptability or Quality</th>
<th>Failure of the</th>
<th>Obligation of Non-discrimination</th>
<th>Obligation to Respect</th>
<th>Obligation to Protect</th>
<th>Obligation under Art. 2(1) Progressive achievement/Non-retrogression</th>
<th>Obligation under Art. 2(1) Use of maximum available resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National</td>
<td>Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x (cut insurance)</td>
<td>x (army budget +; monument)</td>
</tr>
<tr>
<td>2. County (sub-national)</td>
<td>Accessibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x (expensive cars)</td>
</tr>
<tr>
<td>3. National</td>
<td>Unclear (probably multiple)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x (funds to tourism sector)</td>
</tr>
<tr>
<td>4. National</td>
<td>Accessibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5. State</td>
<td>Availability/quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>6. National</td>
<td>Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x (possible fraud by provider)</td>
<td>x (possible vaccines more expensive)</td>
</tr>
<tr>
<td>7. Provincial</td>
<td>Accessibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>8. Local/State</td>
<td>Availability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x (state fails to protect)</td>
<td>x (corruption by local gov't)</td>
</tr>
</tbody>
</table>
READING 3.2 ■ SUMMARY OF GUIDANCE PROVIDED BY THE COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (CESCR) ON ICESCR ARTICLE 2 OBLIGATIONS

The following summarizes what the CESCR has said, to date, about the meaning of the three obligations set out in article 2 of the ICESCR.

Non-discrimination

In 2009 the CESCR produced General Comment 20, on the obligation of non-discrimination. As of the drafting of this paper, this General Comment can be considered the Committee’s “last word” on this obligation. The standards it sets out which have a potential bearing on governments’ budgets can be summarized as follows:

- Non-discrimination is an immediate and cross-cutting obligation (para. 7).
- States parties must eliminate both formal discrimination (discrimination explicitly encouraged or allowed in laws, policies, etc.) and substantive discrimination (when discrimination is not explicitly articulated in laws, policies, etc., but when the impact of the law, policies, etc., is discriminatory. In other words, de facto discrimination). (para. 8)
- To “attenuate or suppress conditions that perpetuate discrimination,” States parties may, and in some cases should, take specials measures, which, in turn, should be discontinued once substantive equality has been reached. Some positive measures, however, may need to be of a permanent nature (e.g., interpretation for ethnic minority groups)(para. 9). The CESCR recognizes that eliminating systemic discrimination will often require that greater resources be directed to traditionally neglected groups. (para. 38)
- Discrimination can be direct (i.e., “when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground,” and/or “detrimental acts or omissions on the basis of prohibited grounds where there is no comparable similar situation (e.g. the case of a woman who is pregnant)”). It can also be indirect (that is, when laws, policies or practices that are neutral on their face have a disproportionate impact on different groups). Both types of discrimination are addressed by article 2(2). (para. 10)
- Related to the obligation to protect, “States parties must … adopt measures, which should include legislation, to ensure that individuals and entities in the private sphere do not discriminate on prohibited grounds.” (para. 11)
- The Committee considers differential treatment based on prohibited grounds as discriminatory unless the justification for differentiation is “reasonable and objective.” It has said that “failure to remove differential treatment on the basis of a lack of available resources is not an objective and reasonable justification unless every effort has been made to use all resources that are at the State party’s disposition … to address and eliminate the discrimination, as a matter of priority.” (para. 13)
- All levels of government (national and sub-national) are responsible for meeting these obligations (para. 14).

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- The CESCR has said “Economic policies, such as budgetary allocations and measures to stimulate economic growth, should pay attention to the need to guarantee the effective enjoyment of the Covenant rights without discrimination.” (para. 38)
- Finally, CESCR has said that monitoring of the realization of ESC rights should assess both the steps taken and the results achieved in the elimination of discrimination. “National strategies, policies and plans should use appropriate indicators and benchmarks, disaggregated on the basis of the prohibited grounds of discrimination.” (para. 41)

Progressive Realization

The principle of progressive realization is based on an understanding that the full realization of all economic and social rights will not be achievable in a short period of time and will depend on the resources available to each State Party. At the same time, there are certain obligations that have immediate effect, regardless of resources. These include an obligation to “take steps” towards progressively realizing rights and the obligation of non-discrimination (already discussed).

Progressive realization entails two complementary obligations:

1. The obligation to continuously improve conditions. Governments must move as expeditiously and effectively as possible towards full realization of the rights in the ICESCR. The Committee also expects that the resources allocated to the realization of these rights will increase proportional to any global increase in resources.

2. The obligation to abstain from taking deliberately retrogressive measures (except under specific circumstances). A deliberate retrogressive measure may occur, for example, if a State Party:
   - Adopts legislation or policy with a direct or collateral negative effect on the enjoyment of rights;
   - Abrogates legislation or policy consistent with rights unless obviously outdated or replaced with equally or more consistent laws or compensatory measures;
   - Makes an unjustified reduction in public expenditures devoted to implementing ESC rights, in the absence of adequate compensatory measures aimed to protect injured persons.

In GC 13 (1999) the Committee says (para. 45):

There is a strong presumption of impermissibility of any retrogressive measures taken in relation to the right to education, as well as other rights enunciated in the Covenant. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are

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3 This summary was developed on the basis of CESCR General Comment 3, the Report of the United Nations Higher Commissioner for Human Rights to the Economic and Social Council, 25 June 2007, E/2007/82, and M. Magdalena Sepulveda, The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights, Antwerpen: Intersentia (2003), 319-332, which provides a thorough compilation and assessment of the CESCR's General Comments, Reports and Concluding Observations as they relate to governments' obligations under the ICESCR up until 2002. The pages cited discuss progressive realization.
fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the State Party’s maximum available resources.

The Committee has recognized that there are circumstances, such as an economic crisis or natural disaster, which require additional resources and in which the adoption of retrogressive measures or the omission to actively take steps to improve conditions is unavoidable. It has made clear, however, that there are limits to how a State may handle such a situation. It has made clear that
- “even in times of severe resource constraints whether caused by a process of adjustment, economic recession or by other factors the vulnerable members of the society can and indeed must be protected by the adoption of relatively low-cost targeted programmes.” (GC 3, para. 12)
- there is a certain minimum standard that States must respect, e.g., provision of basic needs, drinking water, food, affordable housing and health care.

In sum, a State party seeking to justify a retrogressive measure or a failure to comply with the obligation to continuously improve condition due to resource constraints must:
- Demonstrate that every effort has been made to use all resources at its disposal (including international assistance)
- Demonstrate that every effort has been made to satisfy, as a matter of priority, certain minimum obligations
- Demonstrate that particular attention has been paid to vulnerable groups, and, in particular, that the State has taken measures to prevent or ameliorate adverse consequences that vulnerable groups may suffer
- Once resource constraints disappear and the economy recovers, rescind any restrictive measures taken to reduce Covenant-related expenses and repair adverse effects on the population, in particular among vulnerable groups
- Take adequate measures to ensure that the reduction in resources does not violate the State party’s obligations.

Use of Maximum Available Resources

Over the years the CESCR through its General Comments (particularly General Comment 3), Concluding Observations and occasional other documents has set out some useful guidelines for how to interpret the obligation on governments to use the “maximum of available resources” (MAR) to realize the rights in the Covenant. The following are in brief form the principal points the Committee has reiterated over the years which have a direct or potential bearing on a government’s budget:

- MAR means that a government must do the maximum it can to mobilize resources within the country. Budget revenue would obviously be a key element in these national “resources.” The government must also do all it can to secure international assistance (which would include

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4 These points are drawn principally from M. Magdalena Sepulveda, 313-319. Other sources are the Limburg Principles and the CESCR’s “An Evaluation of the Obligation to Take Steps to the ‘Maximum Available Resources’ under an Optional Protocol to the Covenant,” E/C.12/2007/1 (10 May 2007).
Official Development Assistance (ODA)) where national resources are inadequate to realize ESC rights.

- MAR also means that governments must give due priority to ESC rights in the use of their resources. The implications for the government’s budget are that allocations and expenditures on ESC rights-related areas should be given such priority.
- Government expenditures must be efficient. Wasteful expenditures are a failure to make maximum use of available resources. This efficiency criterion would logically also apply to revenue collection.
- Government expenditures must also be effective; that is, the impact of the expenditures must be such as to actually help realize ESC rights (the obligation of result).
- Because corruption is an inefficient use of available resources, failure to curb corruption is also a failure to comply with MAR. Corruption can often be spotted through monitoring revenue, allocations and expenditures in the budget.
- Funds allocated in the budget for ESC rights must not be diverted to non-ESC rights areas, and funds allocated for ESC rights must also be fully expended.
- If the government takes a step backwards (retrogression) in the realization of ESC rights, it has the burden of proving that it has used the maximum of available resources to avoid taking such a step.\(^5\)

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\(^5\) The CESCR also uses some other indicators to guide them in assessing a government’s compliance with the MAR obligation:

- Comparing ESC rights-related expenditures vs. expenditures for non-ESC rights-related areas.
- Comparing expenditures in an area (e.g., education, health) with expenditures in the same area by countries at a comparable level of development.
- The more developed a country is, the more its citizens should be enjoying their ESC rights.
- Comparing allocations and expenditures against international indicators, such as UNDP’s indicator that the equivalent of 5% of GDP should go to human expenditures.
TRANSPARENCY AND PARTICIPATION IN RIGHTS TERMS

Duration of session: 15 minutes

<table>
<thead>
<tr>
<th>STRUCTURE OF THE SESSION</th>
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<tbody>
<tr>
<td>Transparency and Participation in Rights Terms</td>
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<tr>
<td>9. <strong>TASK 3.9</strong> Access to Information and Participation as Rights</td>
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</tbody>
</table>

9. **TASK 3.9** **ACCESS TO INFORMATION AND PARTICIPATION AS RIGHTS**

- Explain that using a rights framework with regard to a health budget does not mean looking only at the right to health, but potentially all rights.
- Ask participants to turn to **TASK 3.9** **ACCESS TO INFORMATION AND PARTICIPATION AS RIGHTS** in their Workbook. They should read the two relevant articles from the International Covenant on Civil and Political Rights (ICCPR). Working with others from their country, they should answer the questions posed.
**TASK 3.9 ■ ACCESS TO INFORMATION AND PARTICIPATION AS RIGHTS**

The following two articles are in the International Covenant on Civil and Political Rights:

**Article 19...**
2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice....

**Article 25**
Every citizen shall have the right and the opportunity...
(a) To take part in the conduct of public affairs, directly or through freely chosen representatives...

- To you have similar articles in your national constitution? In what ways are they similar? In what ways are they different? Which provide stronger guarantees?

- What relevance do these two articles have for your budget work?
MODULE 4
HEALTH INFORMATION, SYSTEMS, AND FINANCING
MODULE 4 ■ HEALTH INFORMATION, SYSTEMS, AND FINANCING

SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of module</th>
<th>4 hours, 55 minutes</th>
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<tbody>
<tr>
<td>Timing of this module</td>
<td>This module corresponds with the following sessions in the Health &amp; Budgets Training Workshop Agenda:</td>
</tr>
<tr>
<td></td>
<td>• Part of SESSION 1 on Day 2;</td>
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<td>• SESSION 2 on Day 2; and</td>
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<tr>
<td></td>
<td>• SESSION 3 on Day 2.</td>
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<td>(Note that one session is 1 hour, 45 minutes.)</td>
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<tr>
<td>Resources needed</td>
<td>• Flipchart paper and markers</td>
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<td>• Masking tape</td>
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<td>• Budget Document Name and Definition Cards</td>
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<td></td>
<td>• OBI 2010 Country Summaries for countries represented in workshop</td>
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<td></td>
<td>• Decision Tree guidelines</td>
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<tr>
<td></td>
<td>• Color Post-It notes with country names</td>
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<td></td>
<td>• Components and Management of Health System Cards</td>
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<td></td>
<td>• PowerPoint presentation: Module 4 – System for Financing Health Care in Sudan</td>
</tr>
<tr>
<td></td>
<td>• In the Participant’s Workbooks:</td>
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<tr>
<td></td>
<td>➢ TASK 4.1 ■ Health Information: Sharing Experience</td>
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<td></td>
<td>➢ TASK 4.2 ■ Barriers to Information and How to Overcome Them</td>
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<td></td>
<td>➢ TASK 4.3 ■ The Decision Tree: Government Decisions about Health Care</td>
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<td>➢ TASK 4.4 ■ The Impact of the Various Health Systems and Payment Mechanisms on Access to Health Care</td>
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<td>➢ TASK 4.5 ■ What Does My Government Commit to Provide?</td>
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<td>➢ TASK 4.6 ■ Financing of Health Care in Centralized and Decentralized Systems</td>
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<td>➢ TASK 4.7 ■ Accessing Health Care in Sunrise State, Polarus</td>
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<tr>
<td></td>
<td>➢ READING 4.1 ■ Exploring Health Information</td>
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<tr>
<td></td>
<td>➢ READING 4.2 ■ Essential Budget Documents</td>
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<td>➢ READING 4.3 ■ How to Find Budget Information</td>
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<tr>
<td>Reading</td>
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<tr>
<td>4.4</td>
<td>Strategies for Overcoming Barriers to Health and Budget Information</td>
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<tr>
<td>4.5</td>
<td>Key Components of Health Systems</td>
</tr>
<tr>
<td>4.6</td>
<td>Donor Financing in Health</td>
</tr>
</tbody>
</table>
LEARNING OUTCOMES TO BE ACHIEVED

By the end of this module, participants will have:

- Named the value of health information for budget analysis and advocacy work
- Identified the content of essential budget documents relevant for budget work;
- Listed possible barriers to accessing budget information and suggested strategies for overcoming the barriers;
- Recognized the three ways governments finance the provision of health care;
- Identified key features of different health systems and how they are organized;
- Considered and discussed the implications of the different features and payment mechanisms of health systems for universal access, the right to health and equity;
- Reviewed the various components that make up the health system; and
- Discussed the role of donors in financing the provision of health care.

STRUCTURE OF THE MODULE

Health and Budget Information (1 hour, 5 min.)

1. **Facilitator Input**: Importance of Health and Budget Information  5 minutes
2. **Task 4.1**: Health Information: Sharing Experiences  20 minutes
3. **Pair Work**: Essential Budget Documents  25 minutes
4. **Task 4.2**: Barriers to Information and How to Overcome Them  15 minutes

Health Systems and Payment Mechanisms (1 hour, 35 min.)

5. **Task 4.3**: Decision Tree–Government Decisions about Health Care  20 minutes
6. **Facilitator Input**: Three Ways Government Finances Health Care  15 minutes
7. **Task 4.4**: The Impact of the Various Health Systems and Payment Mechanisms on Access to Health Care  30 minutes
8. **Task 4.5**: What Does My Government Commit to Provide?  30 minutes

Government Management and Financing of Health Systems (2 hours, 20 min.)

8. **Facilitator Input and Brainstorm**: The Components of Health Systems  20 minutes
10. **Task 4.6**: Financing in Centralized and Decentralized Health Systems  20 minutes
11. *(Optional)* **Energizer**: Debate – Centralized or Decentralized  15 minutes
12. **Facilitator Input**: Donor Financing in Health  25 minutes
13. **Task 4.7**: Accessing Health Care in Sunrise State, Polarus  1 hour
HEALTH AND BUDGET INFORMATION
Duration of session: 1 hour, 5 minutes

<table>
<thead>
<tr>
<th>STRUCTURE OF THE SESSION</th>
</tr>
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<tbody>
<tr>
<td>1. <strong>Facilitator Input</strong>: Importance of Health and Budget Information</td>
</tr>
<tr>
<td>2. <strong>Task 4.1</strong>: Health Information: Sharing Experiences</td>
</tr>
<tr>
<td>3. <strong>Pair Work</strong>: Essential Budget Documents</td>
</tr>
<tr>
<td>4. <strong>Task 4.2</strong>: Barriers to Information and How to Overcome Them</td>
</tr>
</tbody>
</table>

1. **Facilitator Input: Importance of Health and Budget Information for Budget Work**  
   5 minutes
   - Introduce this module with a very short presentation on why both health and budget information are critical to health and budget advocacy work. Some talking points on this issue:
     - As was mentioned in the Module 3, people have a right to participate in public affairs. Civil society budget work is a form of exercising that right. In order to effectively participate, people need to have information—and they have a right to information.
     - It could be argued that reliable accessible health information is potentially the single most cost-effective and achievable strategy for sustainable improvement in health care.
     - Up-to-date, accurate, and accessible health information and data is important for the management and planning processes of government for the delivery of health services.
     - A critical aspect of this is reliable accessible information on the financial resources allocated towards health care.
     - Traditionally, budget processes have been very secretive and have involved a handful of officials in any country.
     - Since the mid-1990s, civil society groups have begun to engage in budget work but a major barrier to their work is lack of access to information.
     - More than any other sector in civil society, budget work is fundamentally dependent on “evidence-based” advocacy, i.e., budget work requires the presentation of “facts and figures” in an accurate and accessible format.
     - This dependence on facts and figures requires budget groups to access information on government budgets – something that is not very easy even today.
   - In this session, various issues on access to information and transparency will be discussed.
2. **TASK 4.1: HEALTH INFORMATION: SHARING EXPERIENCES** 20 MINUTES

- **The aim of this task** is to enable participants to recognize the value of health information in budget analysis and advocacy.
- Ask participants to turn to **TASK 4.1: HEALTH INFORMATION: SHARING EXPERIENCES** in their Workbooks.
- Invite participants to read the text boxes and to underline what is new to them or strikes them as interesting, or useful. Then ask participants to respond to the question b) in their Workbooks: *How would you summarize the value of health information for your work?*
- After 10 minutes, ask the participants to work in pairs to share where they typically go to access the health information that they need for their work. Ask them to note down on their task sheets some of the documents and sources that they shared.
- After 5 minutes, ask participants in plenary to share any insights that they might have gained for their own health and budget projects.
- Refer participants to **READING 4.1: EXPLORING HEALTH INFORMATION**.

3. **PAIR WORK: ESSENTIAL BUDGET DOCUMENTS** 25 MINUTES

- **The aim of this task** is to enable participants to review (or learn) the budget documents that are essential for their health budget work.
- Ask participants to pair up for this task. Give a set of Budget Document Name Cards to each pair of participants. Ask them to work together to match the budget document with its definition. 5 minutes for this.
- Ask participants for the definition of each budget document, in turn. Ask if there are any questions for each match of name and definition. Make sure that the following points are mentioned through the definition or otherwise discussed:
  1. The **Pre-Budget Statement** should be released by the Executive during the formulation stage of the budget process. This document is intended to disclose the parameters by which the Executive will develop its budget proposal: specifically, total estimated expenditure, total expected revenue, and amount of debt to be incurred during the upcoming budget year.
  2. The **Executive's Budget Proposal** is the draft budget which should be made available to the public before the actual budget law is passed by the legislature, so that citizens have the opportunity to provide their input into the drafting of the budget law before it is finalized and passed. It should detail the policies and priorities the government wants to pursue in the upcoming budget year, including specific allocations to each ministry and
agency. The Executive’s Budget Proposal above should contain the following information:

**Expenditure classifications**
- administrative
- functional
- economic
- program

**Revenue classifications**
- tax
- non-tax

**Debt**
- stock at the beginning and at the end of the budget year (yearly additional borrowing)
- composition of debt (different instruments, different maturities, interests, currencies, domestic vs. external)
- interest rates

**Macroeconomic information**
- different information can be relevant for different countries (e.g., oil-producing countries)
- basic information is: GDP growth, inflation, unemployment, interest rate
- changes in the macroeconomic framework can have a significant impact on the budget (on both the revenue and expenditure sides)

**Multi-annual data**
- future projections
- past data

**Public policy information**
- new policies as distinct from existing policies
- links between policies and budget
- links between budget and policies to fight poverty

3. The **Enacted Budget** is a document that is approved by the legislature and passed into law as the budget to be implemented for the upcoming fiscal year.

4. The **Citizens Budget** is a non-technical representation of the terms and the concepts in the budget that can be understood by citizens who do not have technical knowledge of budgets or fiscal policy.

5. **In-Year Reports** should be produced and made available to the public on a monthly or quarterly basis and they should report on the implementation of the budget, including the revenue, expenditure, and the debt situation of the government.

6. The **Mid-Year Review** provides a comprehensive update regarding the implementation of the budget, including a review of the economic assumptions underlying the budget and an
updated forecast of the budget outcome for the current budget year.

7. The **Year-End Report** should be produced and made available to the public by the executive branch, and it should report extensively on the government’s fiscal activities and performance for the entire budget year.

8. The **Audit Report** is the annual report issued by the Supreme Audit Institution attesting to the government’s year-end final accounts and whether public resources have been utilized effectively.

- After reviewing all of the essential budget documents, be sure to mention that the Open Budget Index, which is produced by the International Budget Partnership every two years, reflects the extent to which governments make these eight essential documents available to the public. Pass out copies to participants of the most recent OBI summary for their country, and provide them with the link to the OBI results so they can refer to it when they want to: http://internationalbudget.org/what-we-do/major-ibp-initiatives/open-budget-initiative/

- Also mention that additional (official) information that is necessary to obtain a deeper perspective regarding the budget includes:
  - Demographic information
  - Sector-specific documents (e.g., health, education, defense)
  - Sector-specific information (e.g., geographical distribution, number of teachers/doctors in different regions, epidemiologic profile of the country)
### BUDGET DOCUMENT NAME CAMDS
(Photocopy on to card and cut up)

<table>
<thead>
<tr>
<th>Pre-Budget Statement</th>
<th>Year-End Report</th>
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<tbody>
<tr>
<td>In-Year Report</td>
<td>Citizens Budget</td>
</tr>
<tr>
<td>Executive’s Budget Proposal</td>
<td>Mid-Year Review</td>
</tr>
<tr>
<td>Audit Report</td>
<td>Enacted Budget</td>
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</tbody>
</table>
| **BUDGET DOCUMENT DEFINITION CARDS**  
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<tbody>
<tr>
<td>A document that is released on a monthly or quarterly basis to report on the implementation of the budget.</td>
</tr>
<tr>
<td>A document issued by the country’s watch-dog organization that attests to whether public resources have been utilized effectively.</td>
</tr>
<tr>
<td>A document that contains a comprehensive update on the implementation of the budget, including a review of the economic assumptions underlying the budget and an updated forecast of the budget outcome for the current budget year.</td>
</tr>
<tr>
<td>A document that details the policies and priorities the government wants to pursue in the upcoming budget year, including specific allocations to each ministry and agency, and that should be made available to the public before the actual budget law is passed by the legislature.</td>
</tr>
</tbody>
</table>
4. **Task 4.2 ■ Barriers to Information and How to Overcome Them**

15 minutes

- **The aim of this task** is to have participants identify typical barriers to accessing health and budget information and develop ideas for overcoming these barriers.

- Introduce this task by highlighting the following points:
  - Budget documents maintained by national governments frequently do not disclose all the information in a format that is in line with international good practices.
  - Health information maintained by national governments frequently does not provide information in a format that is in line with international good practices.
  - However, lack of transparency in budgets is affected by many other factors.
  - This session will focus on the typical barriers to accessing information at both national and local levels as well as techniques of overcoming these barriers. The participants should draw on the case study that they have read for these discussions.

- Write up on two sheets of flipchart paper the headings “Barriers” and “Strategies for Overcoming Barriers.” In plenary, invite participants to call out some barriers.

- A typical list of barriers could include:
  - Lack of knowledge or limited knowledge on what information is kept by the government.
  - Lack of knowledge or limited knowledge on which government department keeps the information that you want.
  - Lack of knowledge or limited knowledge on which government official keeps the information that you want.
  - The government official who has the information that you need is repeatedly evasive, not available, or absent when you visit his/her office.
  - Government official(s) respond with hostility when you request information.
  - Record-keeping practices are poor and documents are not available, or only partly available, in government office(s).
  - Records are maintained in very poor condition and/or are illegible.
  - Records are voluminous and technical.
  - Records are misleading or contradictory.
  - Websites are not updated or contain very large files that are difficult to download (or there is limited access to Internet and/or it is too slow).

- Acknowledge the barriers suggested by participants and add any others from the list above. Participants can record the barriers in their Workbooks, using the left-hand column of the table under **Task 4.2 ■ Barriers to Information and How to Overcome Them**.
Now invite participants to suggest some strategies for overcoming each of the barriers. Briefly review and acknowledge the strategies emerging from the group. Sum up by confirming or highlighting the following strategies.

**IDENTIFY SYMPATHETIC OFFICIALS**

- No government is a monolith: while some public officials are hostile to civil society’s requests for information and assistance, others are extremely forthcoming.
- The latter can be critical allies in an effort to obtain information on public programs.
- To win over officials who are less forthcoming but not completely opposed, civil society groups can try to persuade them of the need for transparency, provide an example of how transparency would benefit them, and/or appeal to their egos by offering them an opportunity to showcase their work.
- One way to obtain information from hostile officials is to pressure them, by, for example, going over their heads, that is, appealing to their bosses.
- Alternatively, civil society organizations can work to build a relationship of trust with both officials who are not completely supportive as well as those who are initially hostile to them.

**USE “RIGHT TO INFORMATION” LAWS**

- Approximately 90 countries around the world have laws that guarantee citizens the right to information.
- An access to information law can be central to an organization’s strategy for conducting a social audit.
- Even if their country has such a law, however, groups will not always be able to obtain needed information.
- Information requests can run into a variety of obstacles, including claims that files are missing or that their disclosure would harm national security.
- An excellent collection of studies on access to information laws, including implementation problems, is available at [www.freedominfo.org](http://www.freedominfo.org).

**USE INDIVIDUAL AGENCY DISCLOSURE POLICIES, COURTS, AND CIVIL PetITIONS**

- In countries where there is no law guaranteeing access to information, individual agencies may sometimes have disclosure policies or charters on citizen rights that can provide for such access.
- Some countries that do not have access to information laws do have provisions or laws for access to public procurement information.
- In other countries, the national constitution may protect individual liberties that include the right to information.
Citizens have successfully used constitutional provisions to file petitions in national courts to obtain information, though this is obviously a complicated process that can take years to complete.

**Collaborate with Auditors, Legislators, and Donors**

- Public audit institutions can be an excellent source of information.
- Legislators too often have much more information on public projects than ordinary citizens do, and civil society groups may be able to obtain extensive information through a sympathetic legislator.
- Similarly, in countries that are highly donor-dependent, donor organizations may have access to information on public projects – especially the projects these donors fund.
- Donors may be very forthcoming to a social audit process given their interest in ensuring that the funds they have donated are spent properly.

**Direct Action and Campaigns**

- The pioneer of non-violent direct action, Mahatma Gandhi, encouraged the use of direct action campaigns to demand changes from the government.
- He described the government response to such a campaign as follows: “First they ignore you, then they laugh at you, then they fight you, then you win.” Organizations that are repeatedly denied information might choose a strategy that relies on direct non-violent confrontation with the government agency that denies them information.
- Such a strategy should be undertaken only after careful deliberation given its possible consequences, including violent retribution from the government.

**Keep in Mind**

- When conducting analysis and advocacy work using health and budget information, don’t jump to conclusions about the information or data that you cannot see. Be honest about the limitations of your findings, stressing that they are based on the limited information available.
- When publicly available information is limited, use this as an opportunity to demand more information so that you can have a better understanding of what is really happening with regard to the particular development issue that you are working on.
- It is valid to make your own choices and decisions regarding the use of limited data and/or incomplete information in your advocacy work, but always explain these decisions. If the government says that you are wrong, ask them to offer a more complete picture.

- Participants will find information on the points above in **Reading 4.4 • Strategies for Overcoming Barriers to Health and Budget Information** in their Workbooks.
a) Read the information below. Please underline what is new or strikes you as interesting or useful.

Lack of access to information remains a major barrier to knowledge-based healthcare in developing countries despite it being considered the information age.

The development of reliable, relevant, usable information requires cooperation among a wide range of professionals including healthcare providers, policy makers, researchers, publishers, information professionals, indexers, and systematic reviewers.

Health information is about:
- Health Status of people
- Health determinants
- Health care providers
- Health facilities and systems
- Health system components
- Health financing and expenditures

Health information is generated through:
- Events related to humans which are recorded – births, deaths, disabilities etc.
- Provision of services at health facilities that are recorded – expenditure, number of patients being seen etc.
- Surveys and studies conducted on health and related matters.

Health information can be used:
- For data analysis to identify and highlight concerns.
- To influence health policy and plans
- To improve health facility functioning and efficiency
- To identify areas of neglect and inadequacy
- To demand greater budget allocations
- To highlight failures by the government to

All of us – rich and poor, governments, companies and individuals – share responsibility of ensuring that everyone has access to information, means of prevention and treatment.

b) How would you summarise the value of health information for your health and budget work?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
c) With your partner, share where you typically go to access the health information you need for your work. We’ll hear a summary of the documents and sources you have shared in the large group.
**TASK 4.2  ■  BARRIERS TO INFORMATION AND HOW TO OVERCOME THEM**

Health information and budget information maintained by national governments frequently do not reflect international best practices for transparency in health and budgets information. What are some typical barriers that members of CSOs experience when they try to access information for their health and budget advocacy?

**Brainstorm** as many barriers as you can think of and record your ideas in the column below. What strategies can be used to overcome these barriers? Write your ideas in the column below.

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<th>BARRIERS IN ACCESS TO INFORMATION</th>
<th>STRATEGIES TO OVERCOME BARRIERS</th>
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Lack of access to information remains a major barrier to knowledge-based health care in developing countries despite it being considered the information age. The development of reliable, relevant, usable information can be represented as a system that requires cooperation among a wide range of professionals including health care providers, policy makers, researchers, publishers, information professionals, indexers, and systematic reviewers. This is a short summary of what health information is, how it is generated and where to find health information. It also includes some examples of health information sources and examples of health data international databases. Lastly, there are some suggested ways of using health information.

**What is Health Information?**

- Events, knowledge, skills, behaviors, outcomes, and actions that affect human health directly or indirectly
- Health information is the knowledge repository of all of the above in the form of data, statistics, indicators, descriptions, etc. that inform education and awareness, as well as decision-making, planning, programming, etc. about the health sector and related arenas
- Health information is thus about:
  - Health status of people
  - Health determinants
  - Health care providers
  - Health facilities and systems
  - Health system components
  - Health financing and expenditures

**How Health Information is Generated**

- Events related to humans that are recorded: births, deaths, disabilities, morbidities, certification of doctors/nurses, drug production, etc.
- Information generated through provision of services at health facilities: use statistics, provider and facility information, insurance information, expenditures, etc.
Surveys and studies conducted on health and related matters, including documentation and publication

Where to Find Health Information

- Official records and statistical publications at various levels of government
- Survey reports and publications like books and journals
- Electronic online/offline databases
- Libraries, repositories, observatories

Some Examples of Health Data

- Health Outcomes:
  - Infant and under-five mortality, prevalence of diseases
- Health Services Access/Availability:
  - Doctor to population ratio, hospital bed to population ratio, doctor to nurse ratio, health center to population ratio, private hospital to public hospital ratio
- Health Equity:
  - Health outcomes, access, resources disaggregated by stratifiers like income levels, social groups, geographic areas
- Health Production:
  - Human resources – doctors, nurses, paramedics, midwives, etc.
  - Drugs and equipment
- Health Budgets and Expenditures:
  - Per capita health expenditure, public finance as a proportion of total health expenditure, government health budget as a percentage of total government budget
  - National Health Accounts

Some Examples of Health Information Sources

- Health Ministries and their various agencies at different levels of government produce statistical compendiums, handbooks, reports, databases, records, etc.
- International agencies like the World Health Organization (WHO), the World Bank, the Organization for Economic Co-operation and Development (OECD), Action for Global Health (AFGH), the United Nations Development Program (UNDP), etc. produce data compendiums, reports, maintain online databases
- International, national, and regional surveys like Demographic and Health Surveys (DHS), the World Health Survey (WHS), and national and sub-national health surveys
• Budget and finance information on health is available with finance ministries and insurance corporations and internationally compiled by the International Monetary Fund (IMF) as Government Finance Statistics

INTERNATIONAL DATABASES – WORLD BANK

• World Bank Health home page

• World Bank: Health, Nutrition, and Population Data and Statistics
  http://datatopics.worldbank.org/hnp/

• World Bank MDG Database:

• World DataBank (data by country; data by key indicators; existing databases)

• World Development Indicators (searchable database)

Other Sources

• International Monetary Fund

• Organization for Economic Co-operation and Development Statistics (OECD.STAT):
  http://stats.oecd.org/

• European Observatory on Health Systems and Policies: http://www.euro.who.int/en/who-we-are/partners/observatory

HOW WE CAN USE HEALTH INFORMATION?

• Data analysis to identify and highlight issues and areas of concern
• To influence health policy and plans
• To help improve health facility functioning and efficiency
• To identify areas of neglect and inadequacy
• To demand greater budget allocations
• To highlight inequities and injustices within the health system
READING 4.2 ■ ESSENTIAL BUDGET DOCUMENTS

Governments should produce and make available to the public in a timely manner the following eight key budget documents:

- The **Pre-Budget Statement** should be released by the Executive during the formulation stage of the budget process. This document is intended to disclose the parameters by which the Executive will develop its budget proposal: specifically, total estimated expenditure, total expected revenue, and amount of debt to be incurred during the upcoming budget year.

- The **Executive’s Budget Proposal** is the draft budget which should be made available to the public before the actual budget law is passed by the legislature, so that citizens have the opportunity to provide their input into the drafting of the budget law before it is finalized and passed. It should detail the policies and priorities the government wants to pursue in the upcoming budget year, including specific allocations to each ministry and agency. The Executive’s Budget Proposal above should contain the following information:

  **Expenditure classification**
  - administrative
  - functional
  - economic
  - program

  **Revenue classification**
  - tax
  - non-tax

  **Debt**
  - stock at the beginning and at the end of the budget year (yearly additional borrowing)
  - composition of debt (different instruments, different maturities, interests, currencies, domestic vs. external)
  - interest rates

  **Macroeconomic information**
  - different information can be relevant for different countries (e.g., oil-producing countries)
  - basic information is: GDP growth, inflation, unemployment, interest rate
  - changes in the macroeconomic framework can have a significant impact on the budget (on both the revenue and expenditure sides)

  **Multi-annual data**
  - future projections
  - past data
**Public policy information**
- new policies as distinct from existing policies
- links between policies and budget
- links between budget and policies to fight poverty

- The **Enacted Budget** is a document that is approved by the legislature and passed into law as the budget to be implemented for the upcoming fiscal year.

- The **Citizens Budget** is a non-technical representation of the terms and the concepts in the budget that can be understood by citizens who do not have technical knowledge of budgets or fiscal policy.

- **In-Year Reports** should be produced and made available to the public on a monthly or quarterly basis and they should report on the implementation of the budget, including the revenue, expenditure, and the debt situation of the government.

- The **Mid-Year Review** provides a comprehensive update regarding the implementation of the budget, including a review of the economic assumptions underlying the budget and an updated forecast of the budget outcome for the current budget year.

- The **Year-End Report** should be produced and made available to the public by the executive branch, and it should report extensively on the government’s fiscal activities and performance for the entire budget year.

- The **Audit Report** is the annual report issued by the Supreme Audit Institution attesting to the government’s year-end final accounts and whether public resources have been utilized effectively.

Additional (official) information that is necessary to obtain a deeper perspective regarding the budget:

- Demographic information
- Sector-specific documents (e.g., health, education, defense)
- Sector-specific information (e.g., geographical distribution, number of teachers/doctors in different regions, epidemiologic profile of the country)
READING 4.3 ■ HOW TO FIND BUDGET INFORMATION

- Budget information may be available on official government websites, including:
  - the ministry of finance;
  - the ministry of planning;
  - the presidency;
  - the official statistics institute;
  - sector-specific ministries;
  - local governments; and
  - the central bank.

- Budget information may be available from international institutions, including:
  - World Bank country reports;
  - UNDP global and country reports;
  - Transparency International corruption reports; and
  - reports from other agencies working in a country.

- Budget information can be obtained by:
  - requesting information from agencies working in a country;
  - reviewing what is available in the congress or parliament, as they should have this information;
  - using a country’s access to information law, if one exists;
  - reviewing information that is available through donor agencies and multilateral allies;
  - reviewing the websites of international organizations to find information specific to a country;
  - locating and meeting with NGOs to share information and perspectives; and
  - partnering with academic institutions and research centers.
IDENTIFY SYMPATHETIC OFFICIALS

- No government is a monolith: while some public officials are hostile to civil society’s requests for information and assistance, others are extremely forthcoming.
- The latter can be critical allies in an effort to obtain information on public programs.
- To win over officials who are less forthcoming but not completely opposed, groups can try to persuade them of the need for transparency or appeal to their egos by offering them an opportunity to showcase their work.
- The only way to obtain information from hostile officials is to pressure them, such as by going over their heads, i.e., appealing to their bosses.

USE “RIGHT TO INFORMATION” LAWS

- Roughly 70 countries around the world have laws that guarantee citizens the right to information.
- An access to information law can be central to an organization’s strategy for conducting a social audit.
- Even if their country has such a law, however, groups will not always be able to obtain needed information.
- Information requests can run into a variety of obstacles, including claims that files are missing or that their disclosure would harm national security.
- An excellent collection of studies on access to information laws, including implementation problems, is available at www.freedominfo.org.

USE INDIVIDUAL AGENCY DISCLOSURE POLICIES, COURTS, AND CIVIL PETITIONS

- In countries where there is no law guaranteeing access to information, individual agencies may sometimes have disclosure policies or charters on citizen rights that can provide for such access.
- In other countries, the national constitution may protect individual liberties that include the right to information.
- Citizens have successfully used constitutional provisions to file petitions in national courts to obtain information, though this is obviously a complicated process that can take years to complete.
COLLABORATE WITH AUDITORS, LEGISLATORS, AND DONORS

- Public audit institutions can be an excellent source of information.
- Legislators too often have much more information on public projects than ordinary citizens do, and civil society groups may be able to obtain extensive information through a sympathetic legislator.
- Similarly, in countries that are highly donor-dependent, donor organizations may have access to information on public projects – especially the projects these donors fund.
- Donors may be very forthcoming to a social audit process given their interest in ensuring that the funds they have donated are spent properly.

DIRECT ACTION AND CAMPAIGN

- The pioneer of non-violent direct action, Mahatma Gandhi, encouraged the use of direct action campaigns to demand changes from the government.
- He described the government response to such a campaign as follows: “First they ignore you, then they laugh at you, then they fight you, then you win.” Organizations that are repeatedly denied information might choose a strategy that relies on direct non-violent confrontation with the government agency that denies them information.
- Such a strategy should be undertaken only after careful deliberation given its possible consequences, including violent retribution from the government.

KEEP IN MIND

- Don’t jump to conclusions about what you cannot see – be honest about the limitations of your findings, stressing that they are based on the limited information that is available.
- Use this as an opportunity to demand more information, in order to have a better understanding of what is “really” going on.
- It is valid to make your own choices and decisions regarding incomplete information, but always explain them. If the government says that you are wrong, ask them to offer a “more complete” picture.
The aim of this session is to enable participants to understand the different features of health systems and payment mechanisms.

**STRUCTURE OF THE SESSION**

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<th>Task</th>
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<tr>
<td>5. <strong>Task 4.3</strong></td>
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<td>6. <strong>Facilitator Input</strong></td>
<td>15 minutes</td>
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<td>7. <strong>Task 4.4</strong></td>
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<td>8. <strong>Task 4.5</strong></td>
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**5. Task 4.3 The Decision Tree: Government Decisions about Health Care**

- The main aim of this task is to provide the participants with an opportunity to share their understanding and experience of their health system and the various payment mechanisms involved in financing health care in their context. Another key aim is to draw the participants’ attention to the impact that these various financing mechanisms have on the health system and ultimately on people’s access to health care.

- Draw a “decision tree” on a piece of flipchart paper. Explain that when it comes to the provision of health care, there are some fundamental choices a government makes:

  1. **First Choice:** Government can decide to commit to be responsible for health or not commit to be responsible for health. If it does not commit, this means leaving citizens to fend for themselves in the market, spending their own money on private care.

  2. The key here is to make sure to distinguish between the word “commit” in abstract decision terms, and commit in actual expenditure terms and a legal framework. The decision tree is a tool for understanding the decision confronting a government. In reality, governments may avoid choosing, or may make mixed choices and this will be reflected in actual expenditure and whether or not they comply with the legal framework.

  3. **Second Choice:** If Government decides to commit, then it can decide to make or buy.

- Ask if any of the participants are familiar with “Make or Buy” decision. If anyone is familiar, allow them to describe it. If not, explain:
- “Make or Buy” decisions are those taken when, for example, a company must decide whether to produce inputs for some product itself, or to buy them from another supplier.

- This distinction is often applied to companies, but even NGOs make such decisions. For example, your NGO may require cleaning services. You must decide whether to hire a person on staff who will do the cleaning (“make”) or find a company that provides cleaning services, and pay them to come clean your office (“buy”).

- Likewise, you may make such decisions with respect to maintaining a website or producing brochures. Do you make these things inside the organization using available talent (“make”), or do you pay someone outside the organization a fee to produce these things on your behalf (“buy”)?

- Clarify that in this discussion of “make” or “buy” decisions, health care cannot be merely reduced to a commodity and emphasize that it is a public good—and it is a human right. Governments have an obligation to ensure people’s access to health. A government cannot wash its hands of the issue, saying it is entirely up to people themselves. A government may use private systems (“buy”) or a government system (“make”). A rights framework does not dictate how a government should go about guaranteeing people’s right to health. Whichever approach it uses, however, the end result must be that people have access to health and to a health care system of sound quality.

- Return to the example. Ask the group: “Can you think of an example of how ‘make’ or ‘buy’ would be relevant for a government that has decided to commit to health services for the population?”

- Depending on the level of response, provide a first example, or use an example provided by one of the participants. Either way, the first example should be built on with other examples. Three examples are: medicines, buildings (or infrastructure), and personnel.

- It may be useful to introduce the concept of insurance and discuss how insurance fits into the “make”/“buy” model. Insurance may be public or private. When the government provides insurance, then it is committing to “buy” health services.

- The government could provide a mixture of public insurance (“make”) and/or public health care services by reimbursing private providers (“buy”), or leave it to a voluntary private system in which contributions are made to private insurers either via their companies or out-of-pocket.

- Have participants fill out the remaining “branches” of the Decision Tree. 10 minutes.

- Ask for examples of goods or services provided and how they might look if the government were to “buy” them, and if it were to “make” them.
GUIDELINES FOR DRAWING THE DECISION TREE

Copy out the terms written in the boxes onto colored Post-It Notes. Have them ready to stick up on a sheet of flipchart paper – or a whiteboard – when facilitating the discussion “private” and “public” funding mechanisms for health care.

GOVERNMENT DECISIONS ABOUT HEALTH CARE

The following examples can also be written out on Post-It notes and placed on the display to show the difference between “buy” and “make.”

Medicines → Buy from pharmacy → Make in a government-owned lab

Buildings → Rent private buildings → Build/own public buildings

Personnel → Reimburse private doctors → Pay salaries to public doctors
6. **Facilitator Input**  ■  **Three Ways Governments Finance the Provision of Health Care**  ■  15 minutes

- Link the previous discussion of make (Public) and buy (Private) to a discussion about the three ways that governments finance the provision of health care, namely:
  a. The government does not commit to provide health care – PRIVATE: PRIVATE
  b. The government commits to buy health care – PUBLIC: PRIVATE
  c. The government commits to directly provide health care – PUBLIC: PUBLIC
- Write the three options above on sheets of large Post-It note paper. Using the Post-It notes, link the three options by placing the notes on a wall or flipchart paper as follows:
  a) PRIVATE: PRIVATE next to b) PUBLIC: PRIVATE;
  b) PUBLIC: PRIVATE next to c) PUBLIC: PUBLIC; and
  c) PUBLIC: PUBLIC next to a) PRIVATE: PRIVATE.
- Discuss the fact that governments may say they are doing one thing, but actually do another. For example, governments may claim that they are committed to “make” and will provide public facilities, but then the government may not actually have the resources to “make” enough health care available, leaving citizens to fend for themselves. This results in a mix of PRIVATE: PRIVATE and PUBLIC: PUBLIC.
- For example: South Africa commits to provide health care, but due to huge disparities within the health care system, the quality of health care available to the large majority of the population is of poor quality. This has resulted in the South African government drawing on PUBLIC: PRIVATE interactions, in which public money is being used to buy services from the private sector. This has included private doctors working in understaffed public facilities and private companies providing services to public facilities, such as catering and laundry. In addition, despite the South African government’s promotion of equity within the health system, division within the South African health sector between rich and poor as well as insured and uninsured have deepened. By 2003/04 the total national health expenditure captured by the private sector had risen to 62% and that for the public sector had fallen to 38%. Yet, the private sector now serves between 14 to 20% of the population with the vast majority still depending on the public sector. It is important to add here that there is provision for social insurance to cover a small proportion of the population, so the health system in itself promotes inequitable access – guaranteed health care for a small proportion and limited entitlement for the majority.
- If this does not come into the discussion, draw the participant’s attention to the various ways in which health workers are remunerated. The government may, for example, choose:
- **Capitation:** A fixed prepayment, per patient covered, to a health care provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.

- **Fee for services:** Doctors or other providers bill separately for each patient encounter or service they provide. This method of billing means that the insurance company or the government pays all or some set percentage of the fees that hospitals and doctors set and charge.

- In addition, there are various ways in which the insurance can be provided.

### 7. **Task 4.4 ■ The Impact of Various Health Systems and Payment Mechanisms on Access to Health Care**

- **The aim of this task** is to encourage participants to consider the impact that various health systems and financing mechanisms have on access to health care.

- It is important to link the previous discussion about the three ways government finances the provision of health care with a discussion on the impact that these financing mechanisms have on who is able to access health care (issues of equity and the right to health care) and how (universal access and the right to health) individuals access health care and at what cost.

- Divide the participants into pairs. Ask them to turn to **Task 4.4 ■ The Impact of Various Health Systems and Payment Mechanisms on Access to Health Care** in their Workbooks.

- Working with their partners, invite participants to discuss the question: “What impact, if any, do you think the **Private: Private, Public: Private, and Public: Public** financing mechanisms have on those accessing the health system and on what it costs them?”

- Ask the participants to write down any key points from their discussion. Allow the participants 15 minutes of discussion.

- In plenary invite the participants to share their discussions. Allow about 10 minutes for feedback.

- It is important to draw the participants’ attention to the fact that the various financing mechanisms have implications for those accessing the health care system, as well as who is being discriminated against and at what cost.

- Be sure to stress what was already mentioned: that the right to health means that governments cannot say that health care is not a concern for them. Thus the **Private: Private** option would violate people’s right to health.

- Where a government chooses to use the **Public: Private** approach, a key issue is whether the government is complying with its obligation to protect people’s right to health, by monitoring the
private provision of health care services and ensuring that private providers are making health care available, accessible, acceptable and of good quality (as guaranteed by the right to health).

- Possible examples of different approaches to health care provision could be as follows:

  **Thailand:** Public financing and a mix of public and private provision presently in contrast to a mix of public financing and out-of-pocket a decade ago with uncoordinated public and private provision. The change to complete public financing post-2002 has minimized out-of-pocket spending and regulation has reined in the private sector to the benefit of health care for the population as a whole. This has assured near universal access and equity.

  **Sri Lanka:** Statist model of public finance and public provision. Public budgets are limited and hence the system is under stress. Primary care is universally accessible with reasonable equity but at higher levels of care, people experience inequities, wait lists, corruption, etc.

  **South Africa:** Constitutionally primary health care is a right and reasonable access to primary care has been assured through public provision and financing. The impact of HIV/AIDS has hindered access, since it has not been adequately integrated under primary care due to resource constraints. Higher levels of care are insufficient in the public system and are only assured to those who are insured, those who are covered under the medical schemes because of their employment, or those who can afford it out-of-pocket. Again, there are significant inequities and lack of universal access to higher levels of care as a result.

8. **Task 4.5 ■ What Does My Government Commit to Provide?**

   **30 Minutes**

- The aim of this task is to provide participants an opportunity to compare their country context with others and to engage with the 3AQ: availability, accessibility, acceptability and quality.

- Provide participants with color-coded Post-It notes with their countries’ names on them.

- Reveal a flipchart prepared in advance with a matrix like the following. Participants will find a copy of the in their Workbooks, under **Task 4.5: What Does My Government Commit to Provide?**

- Invite the participants to place their Post-It note on the matrix where they think their governments fall within the discussion of health systems financing. Then ask them to explain their choices.
Add the following examples to the discussion:

- **Canada** has both committed to and provides universal access to health care. The Canadian health system is for the most part publicly funded and is mostly free at point of use. At the same time, most of the outpatient services are provided by private providers, pharmacies or other private entities, although most hospitals are public.

- **Mozambique** has committed to provide universal access to health care. However, due to the huge challenges and disparities within the Mozambican health system, in reality it has not achieved universal access. Despite reforms and investment in the public health system in Mozambique, about 40% of the population does not have access to these health services. In addition, there are only 3 doctors and 21 nurses for every 100,000 people in Mozambique, which means approximately 600 doctors for the entire country. Moreover there is a growing private health care system in place, resulting in a parallel private health system existing servicing a small proportion of the population.

- **Sweden** has a health care system completely financed by tax revenues and provision of all services by the state. There is no private sector and all citizens have full access to health care without exceptions. All doctors and nurses are employees and receive a salary. Access is universal and highly equitable.
- The **United States** follows a market model where most of health care is left to the individual through a predominant mechanism of financing through private insurance. Most of those in regular employment would have employers contributing to the premiums. Most provisioning is in the private sector. Public finance is about 40% of all health care, but it is targeted to the two schemes of Medicare (for elderly) and Medicaid (for poor). Despite this, nearly 50 million people in the U.S. do not have adequate access to health care.

- **Brazil** is a country in transition, rapidly moving towards universal access and equity. The country’s social insurance expansion and state coverage for the non-working has helped the Brazilian health system to achieve near universal access and reduced out-of-pocket spending.
**Task 4.3**  ■  **The Decision Tree: Government Decisions about Health Care**

Use the chart below to record ideas emerging from the discussion.

[Decision tree diagram]

- **NOT COMMIT**
  - **COMMIT**
    - **BUY**
      - Medicines
    - **MAKE**
      - Buildings
      - (Branches for other decisions)

Use the chart below to record ideas emerging from the discussion.
TASK 4.4  ■  THE IMPACT OF VARIOUS HEALTH SYSTEMS AND FINANCING MECHANISMS ON ACCESS TO HEALTH CARE

3 WAYS GOVERNMENTS FINANCE THE PROVISION OF HEALTH CARE

<table>
<thead>
<tr>
<th>Private: Private</th>
<th>Public: Private</th>
<th>Public: Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government does not commit to provide health care</td>
<td>Government commits to buy health care</td>
<td>Government commits to directly provide health care</td>
</tr>
</tbody>
</table>

Reflecting on the presentation about the three ways government finances the provision of health care, discuss the following question with your partner: “What impact, if any, do you think each of these public financing mechanisms has on those accessing the health system and on what it costs them?” Please provide examples and we’ll hear some of your responses in plenary.

PRIVATE: PRIVATE

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

PUBLIC: PRIVATE

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

PUBLIC: PUBLIC

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

How are these terms useful to you?
TASK 4.5 WHAT DOES MY GOVERNMENT COMMIT TO PROVIDE?

1. Which financing mechanism applies in your country? Place your country on the matrix below. How does this affect universal access to health care in your country? We’ll hear some of your responses in plenary.

2. How would you describe your country’s health system and financing mechanism?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. What further questions could you ask about what your government has committed to do with regard to the provision of health care?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3AQ ensured

3AQ not ensured

Public: Public  Public: Private  Private: Private
MANAGEMENT OF HEALTH SYSTEM FINANCING

*Duration of session: 2 hours, 20 minutes*

<table>
<thead>
<tr>
<th>Structure of the Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. <strong>Facilitator Input and Brainstorm:</strong> The Components of Health Systems 20 minutes</td>
</tr>
<tr>
<td>10. <strong>Task 4.6</strong> Financing in Centralized and Decentralized Health Systems 20 minutes</td>
</tr>
<tr>
<td>11. <em>(Optional)</em> <strong>Energizer:</strong> Debate – Centralized or Decentralized 15 minutes</td>
</tr>
<tr>
<td>12. <strong>Facilitator Input:</strong> Donor Financing in Health 25 minutes</td>
</tr>
<tr>
<td>13. <strong>Task 4.7</strong> Accessing Health in Polars 60 minutes</td>
</tr>
</tbody>
</table>

9. **Facilitator Input and Brainstorm: Key Components of Health Systems** 20 MINUTES

- This input amounts to an introduction to the next session. Introduce the topic by asking participants to brainstorm in plenary what they consider to be the key components that make up a health system and the bearing of each of these components on access to health care.
- If necessary, start the discussion by using personnel as an example.
- **Have the ten components written up on colored cards before you start** *(See Reading 4.5 for the list of components).* As participants call out their ideas, place the corresponding cards up on a sheet of flipchart paper. Should the participants leave out any of the components out, add them yourself and explain why they are important.
- Inform the participants that they can make notes in their Workbooks. They will also find a summary of this discussion in **Reading 4.5: Key Components of Health Systems**.

10. **Task 4.6** Financing of Health Care in Centralized and Decentralized Health Systems 20 MINUTES

- Explain that government health systems are structured with different degrees of centralization of control and financing. In order to work with the health budget and bring about change related to that budget, it is essential to know where the funding in the budget comes from—from the central government, from local revenue or from some mix—and who is responsible for expenditures and on what.
• Show the slide in the PPT file Module 4 – Example of Financing Health Care in Sudan.
  (This shows the health financing system as of 2009.) Explain what it says, which is essentially:
  - The Federal Ministry of Finance provides funding to the Federal Ministry of Health, which in
    turn provides funding to State Ministries of Health (for specific programs, such as
    immunization). The State Ministries of Finance also provide the State Ministries of Health
    with funding. The SMoHs in turn provide funding to the Health Offices in their Localities.
  - Individuals in communities pay fees to use the primary health clinics and these fees, in turn,
    are revenue for the Health Offices in the Localities.
  - Individuals in communities pay fees to use State or rural hospitals, and these fees are revenue
    for the State Ministries of Health.
  - The Federal Government runs teaching and specialized hospitals. The Federal MoH funds
    those hospitals. When individuals use those hospitals, they have to pay fees, and the latter, in
    turn, are revenue for the Federal MoH.
  - International institutions, such as UNICEF, provide funding directly to the Federal Ministry
    of Health for earmarked programs. This funding is directed by the FMoH to State MoHs as
    appropriate.
  - Some individuals (generally wealthier individuals) have private health insurance.

• Provide each country group with a sheet of flip chart paper. Ask them to discuss among
  themselves the sources of funding for primary, secondary and tertiary care in the country, and the
  flow of funds to those different levels from different sources. Once they have reached
  consensus on these issues, they should illustrate their findings on the flip chart paper.

• Ask two groups to present their charts. Ask where others see similarities and differences from
  the system in their countries. Direct participants to question 1 of Task 4.6 Financing of
  Health Care in Centralized and Decentralized Health Systems in their Workbooks.

• Participants should then turn to question 2 in Task 4.7. They should read the text in the box,
  discuss among themselves what the obligations of different levels of government mean for how
  the health care system is financed.

• The central issues that should come out are that 1) the central government should ensure that
  sub-national governments responsible for provision of health services have adequate funding to
  meet their obligations with regard to 3AQ; 2) sub-national governments should be giving
  adequate priority within their own budgets to financing of the health system; 3) the sub-national
  governments should not be discriminating, intentionally or otherwise, in the way that they
  finance the health system; and 4) the central government should ensure that the way the health
system is financed is such as to ensure that people in different provinces, states or localities are able to enjoy the 3AQ on an equal, non-discriminatory basis (in other words, the central government should ensure that poorer states are provided added funds necessary to be able to provide services on a par with the health systems in richer states).

- Depending on the time taken brainstorming the components of the health systems, proceed to the following debate as an energizer:

11. **(Optional) Energizer: Debate: Centralization vs. Decentralization**

- Divide the participants into two groups. One group will be in favor of a health system that is managed through a decentralized framework while the other group is in favor of a health system that is managed through a centralized framework.
- Ask the groups to allocate one spokesperson to put forward the advantages their group’s case.
- Allow the spokesperson 1 minute each to present their case.
- Ask the facilitators in the room to take a vote or alternatively select a committee from the participants who will vote.
- **The key aim of this energizer** is to get the participants thinking about the discussions taking place within the health sector with regard to the advantages and disadvantages of a centralized or decentralized managed health system.

12. **Facilitator Input and Discussion: Donor Financing in Health**

- Lead a discussion on the implications of donor financing of health systems on the provision of health care. Involve the participants in the discussion by posing a number of open questions to draw on their experience and for them to share their country contexts.
- Begin with questions such as:
  - Who are the main donors towards health funding in your country?
  - What impact has donor funding of health care had in your country in terms of 3AQ?
- In facilitating this discussion, draw the participants attention to some of the ways in which donor financing takes place and the dilemmas it raises, for example:
  - Conditionalities, fungibility – donors invest, countries disinvest;
  - Unpredictability and volatility;
  - Fragmentation/distortions of policy;
  - Verticalization of programs;
- Donor accountability; and
- Corruption.

- You can also draw the participants’ attention to the Paris Declaration on Aid Effectiveness, which commits signatories to five principles:

1. Ownership: Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions.
2. Alignment: Donors base their overall support on partner countries’ national development strategies, institutions, and procedures.
3. Harmonization: Donors’ actions are more harmonized, transparent, and collectively effective.
4. Managing for results: Managing resources and improving decision-making for results.
5. Mutual accountability: Donors and partners are accountable for development results.

- Draw the discussion to a close with another open question to the participants: What would you consider to be some of the key budget implications of donor financing on your government’s approach to health care financing and provision?

- Let participants know that they can find information on this topic in their Workbooks in Reading 4.6 ■ Donor Financing in Health.

13. Task 4.7 ■ Accessing Health Care in Sunrise State, Polarus

- Ask participants to gather in their Polarus groups and allocate a health system issue to each group. Note that these are national issues, not limited to Sunrise State:

  Issue 1: Availability of doctors and nurses for the public health facilities in Polarus
  Issue 2: Access to HIV/AIDS treatment in Polarus
  Issue 3: Decentralized management and decision making for public health facilities in Polarus
  Issue 4: Social health insurance in Polarus

- Refer participants to Task 4.7 ■ Accessing Health Care in Sunrise State, Polarus in their Workbooks. They are to discuss the challenges related to the issue assigned to their group and consider what can be changed to improve people’s access to their right to health.

- Each group should record their analysis in a grid like this one on a sheet of flipchart paper:

---

Grid for Analysis of Specific Health Issues in Polarus

<table>
<thead>
<tr>
<th>Key challenges relating to the issue</th>
<th>What should be changed?</th>
<th>Who is responsible for this change?</th>
<th>What will be the 3AQ impact?</th>
<th>What will be the budget implications?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Low doctor: population ratio in Polarus</td>
<td>a) Payment levels and working facilities</td>
<td>Ministry of health, ministry of finance and ministry of justice</td>
<td>Greater availability and accessibility of doctors will attract more patients to the public health system and strengthen people's confidence in them</td>
<td>Increased allocations for salary component of the budget</td>
</tr>
<tr>
<td>2. Out migration of doctors and/or spatial distribution of doctors across the country</td>
<td>Legislation relating to professional migration, licensing of doctors, compulsory public service, better salaries and facilities</td>
<td>Ministry of health and ministry of justice</td>
<td>Better availability, accessibility and quality of doctors, especially specialists, improved credibility of the public health care facilities</td>
<td>More allocations for doctor salaries, costs of recruitment of more doctors</td>
</tr>
</tbody>
</table>

• After 40 minutes, ask the participants to post their chart on the wall, and take a gallery walk to look at all of the groups' outputs.
• Clarify any questions that participants may have. Allow about 20 minutes for the gallery walk and discussion.

Model Answer

Issue Description: Availability of doctors and nurses in public health facilities:
- What is the doctor-population ratio in Polarus?
- What is the nurse-doctor ratio?
- What proportion of doctors and nurses are in the private sector and public sector?
- What is the extent of migration of doctors and nurses (brain drain)?
# Reading 4.5: Key Components of Health Systems

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health personnel</td>
<td>Doctors, nurses, managers, paramedics, support staff</td>
</tr>
<tr>
<td>1. Health facilities</td>
<td>Health centres, clinics, hospitals of different types and levels, diagnostic centres, laboratories,</td>
</tr>
<tr>
<td>3. Knowledge</td>
<td>Medical education, health education, health and medical literature, journals, databases, statistics</td>
</tr>
<tr>
<td>4. Commodities</td>
<td>Medicines, equipment, other clinical and non-clinical supplies</td>
</tr>
<tr>
<td>5. Ownership of facilities</td>
<td>Private, Government, Municipal, NGO/not for profit, missionaries, corporate, insurance</td>
</tr>
<tr>
<td>6. Insurance and social security</td>
<td>Financing mechanism, Social insurance, private insurance, employer/employee contributions, health policies and plans</td>
</tr>
<tr>
<td>7. Regulation and legislation</td>
<td>Health services related laws, accreditation mechanisms, constitutional mandates, right to healthcare, UN covenants, professional ethics</td>
</tr>
<tr>
<td>8. Health administration and management</td>
<td>Healthcare management systems, standards and protocols, guidelines, personnel policies, procurement policies, data and records systems</td>
</tr>
<tr>
<td>9. Special health programs</td>
<td>Special programs/activities, for example, on HIV/AIDS, Tuberculosis, Disability, Mental Health; subsidies/assistance for vulnerable groups</td>
</tr>
<tr>
<td>10. International health</td>
<td>International legislations, pandemic controls, donor financing, patents and trade in services, migration and brain drain, medical tourism</td>
</tr>
</tbody>
</table>
TASK 4.6 FINANCING OF HEALTH CARE IN CENTRALIZED AND DECENTRALIZED HEALTH SYSTEMS

1. Reflecting on the presentation on financing of health care systems and working with others from your country, draw a diagram illustrating the sources of and flow of funding to primary, secondary and tertiary health services in your country.
Recall the government’s obligation to use the maximum of available resources to realize the right to health, and the obligation to raise and spend its resources in a non-discriminatory way. What do these obligations mean for how national and local governments should finance the health system?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Human rights obligations apply to local governments because they are a constituent element of government or because national government has devolved powers to them. In both cases, the primary responsibility for protecting and promoting rights lies with the national government, which has the double responsibility to monitor local government performance to ensure that rights are respected, and enable local governments to perform their duties by providing them with adequate powers and resources.

- International Council for Human Rights Policy
  *Local Government and Human Rights: Doing Good Service*
  (p.20)
**TASK 4.7 ■ ACCESSING HEALTH CARE IN SUNRISE STATE, POLARUS**

1) Gather in your Polarus groups. After reading the Polarus case study (below) and relevant sections of the Polarus Sourcebook, discuss the health issue allocated to your group.

2) Copy a table like the one below onto flipchart paper and complete the table together.

3) With the other members of your Polarus group, take a walk and identify what you could research or ask about your issue based on the findings of the other groups.

4) We will see and hear each group’s findings.

Issue Description: ______________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

<table>
<thead>
<tr>
<th><strong>KEY CHALLENGES RELATING TO THIS ISSUE</strong></th>
<th><strong>WHAT SHOULD BE CHANGED?</strong></th>
<th><strong>WHO IS RESPONSIBLE FOR THE CHANGE?</strong></th>
<th><strong>WHAT WILL BE THE 3AQ IMPLICATIONS?</strong></th>
<th><strong>WHAT WILL BE THE BUDGET IMPLICATIONS?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
POLARUS CASE STUDY ■ ACCESS TO HEALTH CARE IN SUNRISE STATE

There are huge inequities in access to health care in Polarus. There is no fully organized health system that provides universal access to health care. The majority of the population is dependent on grossly inadequate public health services, characterized by under-investment, poor planning, and uneven provision of health services across Polarus’ nine states. Over the last five years, key public health indicators have shown a negative trend. The infant and under-five mortality rates increased between 2008 and 2011. Maternal mortality remains high, estimated at 456 per 100,000 live births. Efforts to address the HIV/AIDS pandemic are undermined by ineffective public education and service delivery, as well as stigmatization. In response to this situation, the Polarus government claims to have invested additional resources to strengthen primary health care services over the last few years, by setting up primary health clinics (PHCs) that provide free services. These PHCs are managed at the subnational (state) level by the District Services Program, which is within each state’s Department of Health.

In Sunrise State, your organization, which is based in Mortalia (the capital and most populous city), has been conducting research over two years with local communities in the three municipalities and five districts of Sunrise State, identifying and documenting patterns in access to health. Large-scale rural-to-urban migration of young adults to Mortalia and the two smaller cities, Obsalom and Swellentsia, caused by increasingly limited economic opportunities in rural areas, has fuelled the rapid growth in the size and number of peri-urban informal settlements around urban centers. While focusing its attention on the lack of adequate health services in both peri-urban informal settlements as well as remote rural communities, your organization has witnessed some of the most outrageous trends of the “improved” primary health care system.

The government’s claim of providing fully-functioning PHCs faces stark evidence to the contrary. From what you have seen in sprawling peri-urban informal settlements, as well as in marginalized rural communities, foundations have indeed been laid for health clinics, but in only half of these cases have such clinics actually been completed. Furthermore, where new clinics have been established, the inconsistent attendance of doctors and nurses is a major problem, as consistently attested to by residents in both interviews and focus group discussions conducted by your organization. Instead of being available on a 24/7 basis — under which conditions obstetric emergencies, for instance, could be identified and stabilized before being referred to a better equipped hospital — many clinics do not have regular hours of operation, meaning they are open only two or three days a week and/or for only a few hours each day. Your organization’s researchers observed the inconsistent attendance of medical personnel in both peri-urban and rural clinics throughout the state.

Most clinics do not have appropriately trained medical personnel and medical equipment to deal with emergencies or more complex health problems, leaving people in peri-urban informal settlements with few options beyond transporting their sick family members to hospitals in the city centers or distant suburbs, with much difficulty and sometimes at a considerable cost (due to limited transport options). In rural communities, hospitals are inaccessible due to the distances required to reach them as well as a lack of (or unreliable) public transport and poor roads.

A chronic shortage of medicines at PHCs in both rural communities and peri-urban informal settlements is another persistent challenge, making it impossible to meet the demands of the
population who come to these facilities to seek care. Common ailments such as gastrointestinal infections and diarrhea (due to poor water and sanitation facilities) can often be only partially treated, due to the lack of medicines at the PHCs. While these medicines are often available at hospitals, sometimes at a cost, they can rarely be found at PHCs, where they are meant to be provided for free. As a result, poor families have no choice but to buy medicines from expensive private dispensaries, thus further supplementing the “free services” of the government. In those cases where medicines cannot be bought over the counter – for example, medicines for people living with HIV/AIDS – regular costly visits have to made to hospitals in city centers to obtain essential medicines. People in rural areas without access to hospitals and private dispensaries are left untreated since they cannot obtain the required medicines, resulting in overall poor health, the frequent recurrence of treatable illnesses, and even death.

Your organization is a member of the national movement, Service Delivery Now (SeDeN), which has launched a permanent campaign called “Health for All Now!” to demand universal access to quality health care services in Polarus. In order to implement this campaign at the state level, your organization is demanding redress for the three key problems that you have identified in Sunrise State’s primary health care system: 1) an inadequate number of PHCs; 2) PHCs without qualified medical staff, i.e., doctors and nurses; and 3) shortages of medicines.

Your organization has had several working sessions with Sunrise State legislators on the Health Committee, informing them of your findings and requesting them to call on the Sunrise State Department of Health to take action with regard to the District Services Program that manages PHCs. The Department of Health is a “darling” of the current state government, driven by an overarching will to demonstrate economic efficiency in the resolution of the state’s health challenges. While you do not expect to bring high-ranking health department officials to the table willingly, you have some allies in the lower ranks who are concerned about infant and maternal mortality and HIV/AIDS, as well as the overall lack of connection between the health requirements of the population and the government’s investment in the health system.

In particular, you have built relationships with staff in the District Services Program (within the Department of Health) who are responsible for managing and implementing the Primary Health sub-program and are aware of the poor provision of health services in rural communities and peri-urban informal settlements. They have expressed to your organization that they continually face resource constraints in carrying out the mandate of the Primary Health sub-program.

The next step for your organization is to analyze the budgets of the Department of Health, the District Services Program, as well as the PHCs in the different districts and municipalities of Sunrise State to find out what budget problems are contributing to the poor delivery of primary health care services to peri-urban and rural communities.
READEG 4.6 ■ DONOR FINANCING IN HEALTH

CONTEXT OF DONOR FINANCING

- The Rio commitment of 0.7% of GDP of donor countries.
- Developing country health spending is anaemic: 90% of global disease burden and only 12% ($410 billion) of global health spending (5.7% of GDP and 70% out-of-pocket).
- Development assistance for health (DAH) is even more anaemic, being 3% of developing country health spending.
- DAH is 13% of total Development Assistance.
- The World Bank: Up to $70 billion additional per year is needed to meet MDG health goals.

KEY DONORS AND HEALTH FUNDING

<table>
<thead>
<tr>
<th>DONOR</th>
<th>FOCUS AREAS</th>
<th>EST. ANNUAL FUNDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORLD BANK</td>
<td>Training, Health Systems Strengthening (HSS)</td>
<td>$2.4 b/year health,</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Human Resources for Health (HRH), Training, Networks, HSS</td>
<td>$6 b/year AIDS, $638 m HSS,</td>
</tr>
<tr>
<td>GLOBAL FUND</td>
<td>HSS, training, some HRH</td>
<td>$1 b/year, $220 m HSS,</td>
</tr>
<tr>
<td>UK and IHP+</td>
<td>HSS, primary, maternal child</td>
<td>$1.77 b/year, $650 m. HSS</td>
</tr>
</tbody>
</table>

SOURCES OF DEVELOPMENT ASSISTANCE FOR HEALTH

![Development Assistance for Health by Source, 2000 and 2005](image)
Public Expenditure via Donor Funding

External resources for health as a percentage of total health expenditure – 2006 WHO

External Resources for Health: Includes all grants and loans whether passing through governments or private entities for health goods and services, in cash or in kind

Dynamics of Donor Financing

- Conditionalities
- Fungibility – donors invest countries disinvest
- Unpredictability and volatility
- Fragmentation/distortions of policy
- Verticalization of programs
- Donor accountability
- Corruption
THE PARIS DECLARATION ON AID EFFECTIVENESS

The Paris Declaration commits signatories to five principles

1. Ownership: Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions.
2. Alignment: Donors base their overall support on partner countries’ national development strategies, institutions, and procedures.
3. Harmonization: Donors’ actions are more harmonized, transparent, and collectively effective.
4. Managing for results: Managing resources and improving decision-making for results.
5. Mutual accountability: Donors and partners are accountable for development results.

SOME USEFUL LINKS

- International Aid Transparency Initiative (IATI): http://www.aidtransparency.net/
- Aid Data: Open Data for International Development: http://aiddata.org/
- Aid Effectiveness Portal: http://www.aideffectiveness.org/
- Global Partnership for Effective Development Co-operation: http://effectivecooperation.org/
- Aid Effectiveness in Health: http://www.who.int/healthsystems/gf3.pdf
MODULE 5
BUDGET ADVOCACY

PART I ■ Planning for Budget Advocacy
# MODULE 5 ■ BUDGET ADVOCACY
## PART I ■ PLANNING FOR BUDGET ADVOCACY

### SUMMARY TABLE

| Duration of this module | 9 hours, 45 minutes (Parts I, II, and III)  
<table>
<thead>
<tr>
<th></th>
<th>13 hours, 10 minutes (Budget Advocacy Group Work &amp; Presentations)</th>
</tr>
</thead>
</table>
| Structure & timing of this module | This module corresponds with the following sessions in the *Health & Budgets Training Workshop Agenda*:  
| Part I: Planning for Budget Advocacy (3 hours, 30 min.) |  
| • Part of SESSION 4 on Day 2;  
| • Part of SESSION 1 on Day 3; and  
| • Part of Session 2 on Day 3.  
| Part II: Power, Stakeholder, and Opportunity Mapping (3 hours, 30 min.) |  
| • Part of SESSION 2 on Day 4;  
| • SESSION 3 on Day 4; and  
| • Part of SESSION 4 on Day 4.  
| Part III: Media and Communications (2 hours, 45 min.) |  
| • SESSION 2 on Day 6; and  
| • Part of SESSION 3 on Day 6.  
| Part IV: Budget Advocacy Group Work and Presentations (13 hours, 10 min.) |  
| • Part of SESSION 3 on Day 6;  
| • SESSION 4 on Day 6;  
| • SESSIONS 1-4 on Day 7;  
| • SESSIONS 1-2 on Day 8; and  
| • Part of SESSION 3 on Day 8.  
| (Note that one session is 1 hour, 45 minutes.) |  
| Resources needed for PART I |  
| • Flipchart paper and markers  
| • Masking tape  
| • Polarus Sourcebooks  
| • Word Wise Web cards  
| • PowerPoint presentations:  
|   ➢ MODULE 5 – Budget Advocacy Part I – Presentation #1  
|   ➢ MODULE 5 – Budget Advocacy Part I – Presentation #2  
| • In the Participants’ Workbooks:  
|   ➢ TASK 5.1 ■ Sharpening a Budget Advocacy Objective |
- **Task 5.2** ■ Uncover the Research Agenda
- **Task 5.3** ■ Identifying Our Budget Problem and Related Budget Questions
- **Task 5.4** ■ A SMART Advocacy Objective on Health Care in Sunrise State
- **Task 5.5** ■ Assessment Form: How SMART Is This Advocacy Objective?
- **Reading 5.1** ■ Sharpening a Budget Advocacy Objective
- **Reading 5.2** ■ Evidence-based Budget Advocacy
- **Reading 5.3** ■ Research for Advocacy: OBI 2010
- **Reading 5.4** ■ Questions to Guide Budget Research
LEARNING OUTCOMES TO BE ACHIEVED

By the end of this Module, participants will have:

- Distinguished the key elements and importance of an advocacy strategy;
- Formulated a strategic objective and made it SMART;
- Appreciated the value of evidence-based advocacy;
- Recognized the need to sharpen and add substance to advocacy strategies by examining the budget dimension of development problems;
- Identified powerbrokers in the budget process;
- Developed a power map and an opportunity schedule for their advocacy plan;
- Developed SMART advocacy objectives;
- Recognized why message development is important in budget advocacy;
- Formulated a clear budget advocacy message;
- Recognized why it is important to work with the media in an advocacy campaign;
- Summarized different types of media and differentiated the roles within the news media;
- Explained various techniques for gaining media attention;
- Matched media publicity to the budget cycle;
- Considered how to gear message delivery to specific contexts and time constraints;
- Practiced building a coherent budget advocacy strategy to address a development problem; and
- Prepared and refined a budget advocacy presentation.

STRUCTURE OF THE MODULE

PART I: Planning for Budget Advocacy (3 hours, 30 minutes)

1. **BRAINSTORM: Why We Do Budget Advocacy** 10 minutes
2. **FACILITATOR INPUT: Developing a Budget Advocacy Objective** 20 minutes
3. **ENERGIZER: Word Wise Web** 15 minutes
4. **TASK 5.1 ▪ Sharpening a Budget Advocacy Objective** 20 minutes
5. **FACILITATOR INPUT: Research for Advocacy** 10 minutes
6. **TASK 5.2 ▪ Uncover the Research Agenda** 30 minutes
7. **PLENARY CHECK-IN: Back to Sunrise State** 10 minutes
8. **TASK 5.3 ▪ Identifying Our Budget Problem and Related Budget Questions** 15 minutes
9. **FACILITATOR INPUT: Adding the Budget Dimension** 15 minutes
10. **TASK 5.4 ▪ A SMART Advocacy Objective on Health Care in Sunrise State** 20 minutes
11. **TASK 5.5** □ Assessment Form: How SMART Is This Advocacy Objective?: Peer Group Feedback and Consensus 30 minutes

12. **PLENARY DISCUSSION** 15 minutes

**PART II: Power, Stakeholder, and Opportunity Mapping (3 hours, 30 minutes)**

1. **RECAP AND GOING FORWARD:** Budget Advocacy 5 minutes
2. **FACILITATOR INPUT:** Focusing Our Advocacy Plan 15 minutes
3. **FACILITATOR INPUT:** SWOT Analysis 15 minutes
4. **TASK 5.6** □ SWOT Analysis 20 minutes
5. **FACILITATOR INPUT:** Powerbrokers in the Budget Process 15 minutes
6. **TASK 5.7** □ Powerbrokers in Sunrise State 20 minutes
7. **FACILITATOR INPUT:** Stakeholder Analysis 35 minutes
8. **TASK 5.8** □ Stakeholder Analysis for Sunrise State 25 minutes
9. **FACILITATOR INPUT:** Power and Opportunity Schedule 30 minutes
10. **TASK 5.9** □ Power Mapping and Opportunity Schedule 30 minutes

**PART III: Media and Communications (2 hours, 45 minutes)**

1. **ENERGIZER:** Eliminating Jargon 10 minutes
2. **BRAINSTORM AND DISCUSSION:** Why Work with the Media? 20 minutes
3. **FACILITATOR INPUT AND DISCUSSION:** The Changing Media Environment 10 minutes
4. **TASK 5.10** □ Media Strengths and Weaknesses 10 minutes
5. **TASK 5.11** □ Media Delivery Wheel Scenarios 20 minutes
6. **INDIVIDUAL READING:** Guidelines for Working with Media 45 minutes
8. **FACILITATOR INPUT:** Working with New Media 10 minutes
9. **TAKE-A-WALK:** Sharing Experiences of New Media 20 minutes
10. **ROUNDTABLE:** Engaging with the Media – Practical Tips 20 minutes

**PART IV: Budget Advocacy Group Work & Presentations (13 hours, 10 minutes)**

1. **TASK 5.12:** Presentation of Your Budget Research Findings 5 hours, 15 minutes
2. Group Work Presentations I and Feedback 1 hour, 20 minutes
3. **TASK 5.13:** Budget Advocacy Presentations and Media Tasks 5 hours, 15 minutes
4. Group Work Presentations II and Feedback 1 hour, 20 minutes
DEVELOPING AN ADVOCACY OBJECTIVE

*Duration of session: 1 hour, 5 minutes*

**STRUCTURE OF THE SESSION**

1. **BRAINSTORM**  
20 minutes
2. **FACILITATOR INPUT**  
20 minutes
3. **ENERGIZER: Word Wise Web**  
15 minutes
4. **TASK 5.1 Sharpening a Budget Advocacy Objective**  
20 minutes

The aims of this session are for participants to:

- Understand the key elements of an advocacy strategy;
- Practice drafting strategic budget objectives; and
- Recognize the relevance and importance of developing a budget advocacy strategy.

1. **BRAINSTORM**  
10 MINUTES

Ask participants to brainstorm responses to these two questions:

- Why do we do budget advocacy?
- What do we aim to achieve with budget advocacy?

The questions may seem to say the same thing, but they are aiming for different answers. However, the answers come from participants, check that the following are covered:

- Why do we do budget advocacy? To bring about:
  - Policy, legal, and systems changes and improvements
  - Changes in power relations
  - Improved changes in transparency, accountability, and civic participation
- What do we aim to achieve with budget advocacy?
  - To ultimately improve the well-being of poor and marginalized populations
  - In this context also to help ensure that people’s right to health is more fully realized
2. FACILITATOR INPUT: DEVELOPING A BUDGET ADVOCACY OBJECTIVE  

20 MINUTES

- The aim of the facilitator input is to:
  - Introduce participants to the components of a budget advocacy strategy; and
  - Illustrate how to develop a SMART budget advocacy objective.

- Note: This input is support by the PPT file MODULE 5 – Budget Advocacy Part I – Presentation #1.

- An advocacy strategy has five components (Slide 3):
  - A strategic analysis. The workshop will address developing a strategic analysis in Module 5 - Part II, as part of the SWOT exercise.
  - An advocacy objective. Developing an advocacy objective is the principal focus of this session.
  - A stakeholder analysis. Module 5 - Part II focuses on developing a stakeholder analysis. In summary form, it is important to identify the primary audience for your advocacy as well as secondary audiences.
  - An advocacy message (development and delivery). Developing an advocacy message is addressed in Module 5 - Part III. Here participants will just be introduced to what an effective budget advocacy message should do, the three principal components of it, and considerations about messengers and mediums for delivering the message.
  - A schedule. This is also addressed in Module 5 - Part III, with a particular focus there on an opportunity schedule.

- Notes to support Slides 4-8 of the presentation are in READING 5.1 ■ SHARPENING A BUDGET ADVOCACY OBJECTIVE. Advise participants that they can find information on the content of this presentation in their Workbooks in READING 5.1.

3. ENERGIZER: WORD WISE WEB  

15 MINUTES

- Aim: To add an informal and fun dimension to the session, while also giving participants a task to reflect on their learning in the session.

- Photocopy the words of the WWW at the end of this session, and cut the sheets up so that each word is on a different piece of paper or card. This will allow participants to move the words around to form a sentence.

- Divide participants into groups of 4. There should be a full set of cards for each group. Give each group a set of WWW cards and invite them to rearrange the words to form a sentence.

- Hint to participants: The solution is a completed objective, incorporating all the SMART components.
4. **Task 5.1: Sharpening a Budget Advocacy Objective** 20 minutes

- Allocate to each group one of the following objectives:
  1. The government will increase the health budget.
  2. The government will spend enough to reduce maternal mortality.
  3. The government will increase access to primary care facilities.
  4. The Parliament will participate more in budget decision-making.

- Ask participants to turn to **Task 5.1: Sharpening a Budget Advocacy Objective** in their Workbooks. Ask the participants to sharpen their allocated objectives so that they become SMART budget advocacy objectives.

- After approximately 10 minutes, facilitate a report-back and discussion. Ask for a maximum of two volunteers to share their SMART objectives. Spend 10 minutes responding to the inputs from the two volunteers.

**Suggested answers to Task 5.1: Sharpening a Budget Advocacy Objective**

Some suggestions for how these objectives could be sharpened:

1. Government will increase its total health budget by an annual average rate of 5% over the next four years.

2. The Ministry of Health will develop and plan a program for the prevention of maternal mortality and will allocate between 1% and 2% of each of its regional budgets for this program between 2010 and 2015.

3. Over the next five years the Ministry of Health will increase the number of primary health clinics by 10%, targeting those areas of the country where the population has to travel, on average, more than 20 km. to reach a primary health clinic.

4. Within 2 years, during the discussion of the Executive’s Budget Proposal, the Parliament Budget Committee will hold public hearings on the budgets of key central government departments in the social sector (Education, Health, Welfare), in which testimony from the public and the executive is heard.

- To summarize and draw this part of the session to a close, ask participants if their SMART objectives answers all of the following questions:
  - What does the group want to achieve?
- How will they achieve it?
- Does the objective have a timeline?
- Once the group has achieved their objective, how will they be able to measure their success?
- Does the objective provide numbers, dates and amounts?
- Does it state where (geographic area)?
- Does it state who should take the action?
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TASK 5.1 SHARPENING A BUDGET ADVOCACY OBJECTIVE

Un-sharp objectives:

- The government will increase the health budget.
- The government will spend enough to reduce maternal mortality.
- The government will increase access to primary care facilities.
- The Parliament will participate more in budget decision-making.

1. Write out the Un-sharp Objective that was allocated to your group:

____________________________________________________________________________
____________________________________________________________________________

2. Rewrite the Un-sharp Objective so that it becomes a SMART Budget Advocacy Objective. Remember what SMART is all about:

   S – Specific
   M – Measurable
   A – Achievable
   R – Realistic
   T – Time-bound

The SMART budget advocacy objective is:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
**READING 5.1 ■ SHARPENING A BUDGET ADVOCACY OBJECTIVE**

- The five elements of an advocacy strategy are as follows:
  1. Strategic Analysis
  2. **Advocacy Objective**
  3. Stakeholder Analysis
  4. Advocacy Message (Development and Delivery)
  5. Schedule

- An advocacy objective should set out very clearly What, Who, When, How, and Where. It needs to state:
  1. **WHAT** action do you want government to take?
  2. **WHO** in government needs to take this action?
  3. **WHEN** should this action be taken? (i.e., at what stage in the budget process?)
  4. **HOW** should this action be taken? (i.e., how can the change that you're proposing be implemented?)
  5. **WHERE**: Which geographical areas should benefit from this action? The “where” should indicate the area(s) that have the most need, i.e., where the problem you want to address is most critical (e.g., urban slums in the capital city).

- The more information and evidence you have about your issue, the political/social/economic context, the opportunities available for engagement, and the actors involved, the clearer your objective is likely to be.

- Your advocacy objectives should be SMART. That is, each objective should be:
  - **S** – Specific
  - **M** – Measurable
  - **A** – Achievable
  - **R** – Realistic/Result-Oriented
  - **T** – Time-bound

**SPECIFIC**

- Specify the action you want government to take.

- Be as clear and specific as you can. For example, it is too vague to set a goal to provide decent primary health clinics for all. Rather, set a specific goal to prioritize the construction of primary health clinics in rural villages where there is the most need.

- Your objective should not be a statement of the problem. It should be a statement of the solution that you would like to see implemented by decision makers.
MEASURABLE

- Be as exact as possible. You must be able to measure the change that you’re advocating for.
- Provide numbers, so that you can evaluate your achievements at the end of your campaign.
- There’s an old saying: “Be careful what you wish for, it may just come true.” Therefore, clearly state the number of goods, structures, or services that you want government to deliver.
- It is not sufficient to state, for example, that government should “build more health clinics.” An increase in the number of health clinics can be very small, which is not what you intended, and still meet the vaguely stated objective.
- Keep in mind that not all problems can be solved simply by increasing service delivery, e.g., discrimination against girl children.

ACHIEVABLE, REALISTIC/RESULT-ORIENTED, AND TIME-BOUND

- Making your advocacy objective achievable, realistic/result-oriented, and time-bound means linking it directly to the stages in government’s budgeting, planning, and service delivery cycles:
  - Consider what is possible in the current context and what can realistically be achieved.
  - Always set a timeframe for the objective: this financial year, over the next three years, by 2015.
  - State how government can achieve the increases or improvements in service delivery that you are proposing.
- Keep in mind that not everything can be changed immediately. Existing programs and budgets are often rigid due to political compromises and legal obligations.
- Describe the end result (impact) and not what you plan to do (activities).
  - How will people’s lives be different because of your advocacy?
- For big and long-term goals, think about progressive realization. (For example, if you want the government build 200 new primary health clinics, propose the following: build 70 health clinics by the end of 2012, build another 70 by the end of 2013, and build the remaining 60 by the end of 2014.)
- Partners in a coalition will probably not commit to objectives that are too far out of reach.
CONDUCTING RESEARCH FOR ADVOCACY

Duration of session: 2 hours, 25 minutes

The aim of this session is to ensure that participants are able to:

- illustrate the link between advocacy and research;
- recognize that advocacy makes demands on research;
- define the problem and recognize its importance for budget advocacy development;
- make the link between identifying the problem and developing the budget advocacy objective; and
- identify which research questions to investigate to support budget advocacy.

5. Facilitator Input: Research for Advocacy 10 MINUTES

- Note: This input is supported by the PPT file MODULE 5 – Budget Advocacy Part I – Presentation #2 slides.

- The following key ingredients for successful budget work were noted from some case studies conducted by the IBP (Slide 3). Budget work that has impact requires:
  - Access to credible and timely information
  - An understanding of how to navigate the political terrain
  - An awareness of the socio-economic and political environment, and using opportunities that present themselves
  - Connecting local advocacy efforts with national-level processes and vice versa
  - Strong coalitions to build support and legitimacy
- Persistent, dedicated, year-round work
- The production of credible, timely, and accessible research
- Evidence-based advocacy

Let’s focus on the last two factors.

The notes for the Slides 4-6 of the presentation are found in **READING 5.2: EVIDENCE-BASED BUDGET ADVOCACY**.

- Slide 4: Budget Advocacy Work = Civil Society Advocacy Work + Budget Research/Analysis
- Slide 5: What is Budget Research?
- Slide 6: What Does It Mean to Do Evidence-Based Budget Advocacy?
- Slide 7: Questions to Guide Budget Research (notes for this slide found in **READING 5.4: QUESTIONS TO GUIDE BUDGET RESEARCH**)
- Slide 8: Final Points (no notes)

Participants will find information on content of this presentation in their Workbooks in:

- **READING 5.2** ■ EVIDENCE-BASED BUDGET ADVOCACY
- **READING 5.4** ■ QUESTIONS TO GUIDE BUDGET RESEARCH

### 6. TASK 5.2 ■ UNCOVER THE RESEARCH AGENDA 30 MINUTES

- Ask participants to study **READING 5.3** ■ RESEARCH FOR ADVOCACY: OBI 2010, which provides the findings of the 2010 Open Budget Survey (from the final research report).
- When all the participants have read the material, invite them to (work in small groups) and use the OBI reading to extract answers to the questions in **TASK 5.2. ■ UNCOVER THE RESEARCH AGENDA**. They should also take into account the questions to guide budget research, as set out in **READING 5.4** ■ QUESTIONS TO GUIDE BUDGET RESEARCH.
- After 20 minutes, ask the groups to reconvene and share their responses to **TASK 5.2**.
- Some points to keep in mind in facilitating this plenary discussion:
  - Ensure that participants are grasping the essential relationship between the advocacy objective and the research questions. The main learning outcome to be achieved at this point is to consolidate the idea that research questions should be grounded in an advocacy strategy. You will know that participants are acquiring this learning if they are assessing the research questions in **READING 5.4** ■ QUESTIONS TO GUIDE BUDGET RESEARCH in terms of how well these serve the advocacy objective, rather than, say, on overly technical or methodological grounds.
Another important thing to look out for is whether participants are acquiring the ability to read budget advocacy information and then, in their own minds, back track to uncover what research questions the budget advocates must have posed right at the outset to arrive at these findings. Choosing research questions is a strategic issue. It is usually not feasible (or possible) to pursue every research thread and simply to see what comes up.

This is part of understanding that there is no prescribed ‘right’ set of budget questions that must be addressed, blue print style, in every budget advocacy project. Instead, the ‘right’ research questions are the ones that will help you best to uncover what you need to know to improve the situation/solve the problem.

Much can be said about the appearance or the style of the research report in **Reading 5.3**, but this is not the main focus of this discussion. There is another (adjacent) conversation to be had about whether the researchers used language and images effectively to get their findings across. Participants may raise these issues, and it will then be important to flag this as an important theme. Assure participants that they will have several opportunities to investigate and learn more about the presentation of research findings later in the course.

However, the main focus of this task is really whether the researchers asked the right research questions, and not how well they put their findings across.

- Draw the discussion to a close by encouraging participants to read as widely as they can in the terrain of budget advocacy – even on topics or sectors that fall outside the scope of their normal work. There are always important insights to be gained when you read such research reports (and other outputs like brochures or articles) from the perspective of someone trying to learn more about how to use research for advocacy. Ask yourself: What research questions would they have posed that allowed them to generate this kind of evidence?

### 7. Plenary Check-in: Back to Sunrise State

10 MINUTES

- Remind participants about the **Polarus Case Study • Access to Health Care in Sunrise State**, which they started working on in the previous module. If necessary, ask participants to briefly read over the case study again and reconvene in their Polarus groups.

- Explain again that they will soon have to come up with a sound and compelling advocacy objective to bring about improvements to health care in Sunrise State. This objective will then form the basis for developing a powerful advocacy strategy over the next few days. As participants will see, a great deal of information gathering, research and analysis will go into this strategy development process. They will end up with an advocacy strategy that is informed by facts and figures about the health care situation in Polarus.
• Highlight the notion that a SMART advocacy objective requires some basic information and understanding of health care in Polarus. The participants were already introduced to some relevant information on the first day during the Right to Health session, as well as in Module 4.

• But now it is time to dig a little deeper. In their Polarus Sourcebooks, participants should have come across other information that could be used to inform an advocacy objective on health care. Invite participants to volunteer any suggestions in this regard, and to refer the group to the relevant parts of the Sourcebook.

• Make sure at this point that participants are aware of the following information in the Sourcebook:
  - Selected Development Data across the States in Chapter 3 (page 21).
  - Development Profile of Sunrise State in Chapter 3 (page 22).
  - All of the statistics relating to the health sector in Chapter 3 (pages 29–33).
  - Excerpts from national health policy and national health strategy in Chapter 4 (pages 34-37).
  - The outline of the various programs within state health departments in Chapter 4 (page 44).

• Use Slides 10 and 11 from the PPT file MODULE 5 – Budget Advocacy Part I – Presentation #2 to brief participants on the process of developing a SMART advocacy objective on Access to Health Care in Sunrise State.

• Slide 10:
  - The problem is “Too many people in Sunrise State do not have access to adequate primary health care services.”
  - In order to formulate an objective that is specific enough, consider these questions:
    • How do Sunrise State’s Health indicators differ from states with better indicators?
    • How do access to PHC services and the number of doctors and nurses differ between Sunrise State and other states?
    • How is this changing?
    • Why is this happening?

• Slide 11:
  - In order to formulate an objective that is measurable, consider this question:
    • Which and how many clinics, doctors, and drugs would need to be provided to address this problem?
  - In order to formulate an objective that is achievable, realistic and time-bound, consider these questions:
    • How many clinics has Sunrise State built in the past year?
• Do other states have enough health staff? Can some be moved to Sunrise State, in particular to rural areas and peri-urban informal settlements? If more health staff need to be trained, how long will this take?

• Conclude by fielding any questions of clarification about Polarus, health care, and how to use the Polarus Sourcebook. Participants should be aware that they do not need to take the budget data contained in the Polarus Sourcebook into account yet at this stage.

8. **Task 5.3 ■ Identifying Our Budget Problem and Related Budget Questions** 15 minutes

• Ask participant to work in their groups to identify the budget problem contributing to inadequate access to health care in Sunrise State.

• Participants should also discuss all the questions they would need to investigate in order to produce the evidence to support their advocacy objective.

• Refer participants to Task 5.3 ■ Identifying Our Budget Problem and Related Budget Questions to record their answers.

9. **Facilitator Input: Adding the Budget Dimension** 15 minutes

• **Note:** This input is supported by Slides 12 and 13 in the PPT file MODULE 5 – Budget Advocacy Part I – Presentation #2.

• The next step in learning about budget advocacy work is to begin looking at the development challenges we face through a budget lens.

• The group has now proposed a draft advocacy objective. Why is it necessary and how does it help to add a budget dimension to the process?

• The modules that follow will help us to add a budget dimension to our advocacy.

**Notes on Slide 12**

• In Module 6, participants will be exploring the politics, stages, and decision makers in the budget systems in Polarus. How will this knowledge help you to build an effective advocacy strategy?

• Firstly, this knowledge will help you to develop your advocacy objective even further than you have to date. It will allow you to understand what part of the budget may be contributing to the problem you want to address, as well as the solution you hope to bring about. With this understanding you can be more specific about the objective you want to achieve.
• The knowledge you gather in Module 6 will also allow you to build out other elements of your advocacy strategy. For example, you will have a better idea about who in government is responsible for the decisions affecting your objective. This is the person or persons you should target as the primary audience for your advocacy message.

• It will also allow you to identify possible enemies who might stand to lose if your advocacy objective is achieved.

• As you learn more about the politics and powerbrokers in the budget process, you will gain valuable insight into the triggers that make decision makers sit up and listen. This will help you to plan how you will frame your message later on, in order to get the reaction you want.

• Understanding the budget process allows you to be aware of the series of decisions and actions that go into the planning, budgeting and delivery of any particular government service or program. This knowledge will help you to identify when in the budget cycle you should intervene in order to impact future decisions. In this way you can begin to plan a schedule of advocacy activities against a more certain timeline.

Notes on Slide 13

• In Module 7, participants will learn how to analyze government budgets. Again, what you learn in this Module will allow you to strengthen and develop your advocacy strategy even further.

• In the first place, analyzing the budget will help you to make your advocacy objective even SMARTer. It will give you the precise information and figures you need in order to propose a very specific solution to the problem you are trying to address.

• Analyzing the budget will also help you to illustrate why and how the solution you are proposing is achievable. For example, if you can show exactly how much funds are available in a certain program, and how they can be reallocated to serve the purpose you want, your objective is clearly achievable in practical terms.

• You could add certainty and detail to the time-bound aspect of your advocacy objective. Knowing where in the budget the problem lies, means you would also be able to pinpoint when changes in the budget would have to take place in order to bring about the solution you are advocating for.

• Analyzing the budget will help you to confirm the primary audience for your advocacy. Knowing what in the budget needs to change, you can make sure you target the right decision-maker(s) who can bring about the solution you are proposing.
• As you analyze the budget, you are also gathering vital information that you will ultimately use to
develop your advocacy message and back up your arguments with facts and figures.
• Invite questions of clarification from the group. Make sure all the participants understand how
the next two modules will build on the work they have done in Module 7.
• **Important:** Ask all the participants to write down the single consolidated advocacy objective they
reached by way of consensus earlier in the session, and to have it ready for reference later in the
workshop.

### 10. **Task 5.4 ■ A SMART Advocacy Objective on Health Care in Sunrise State** 

20 minutes

• **The aim of this task** is to enable participants to develop better skills at formulating SMART
advocacy objectives by practicing doing so.
• Refer participants to **Task 5.4 ■ A SMART Advocacy Objective on Health Care in**
**Sunrise State** in their Workbooks. Working in their Polarus CSO groups, ask the participants
to formulate a SMART advocacy objective to guide their efforts to improve the health care
situation in Sunrise State.
• Give the groups 20 minutes to complete their draft proposed advocacy objective. They should
then write them up on a sheet of flipchart paper.

### 11. **Peer Group Feedback**

30 minutes

• All four of the Polarus CSO groups should be ready to proceed, with their SMART advocacy
objective written on a sheet of flipchart paper. Ask each group to pair up with another group and
present their advocacy objectives to each other.
• Draw participants’ attention to **Task 5.5 ■ Assessment Form: How SMART is this**
**Advocacy Objective?** in their Workbooks. This form provides some guiding questions to
structure their discussions of one another’s advocacy objectives. Ask the groups to take turns in
giving feedback on how SMART.
• After 15 to 20 minutes, urge the groups to proceed to the next step in the exercise. Each set of
two groups is to draft a **single** advocacy objective, drawing from the strengths of the two prior
efforts. Their united advocacy objective should be written on a new sheet of flipchart paper. At
the end, you will have two draft advocacy objectives (one from each pair of groups).
12. **REPORT BACK**  

- Invite the groups to reconvene. Among the four groups, there should now be two proposed advocacy objectives. Ask the groups to display them.
- Place another flipchart with a blank sheet of paper where everyone can see it.
- Ask each pair of groups to report back on their draft objective. Make sure that it meets all the SMART criteria.
- The information in the Polarus Sourcebook and the case study should have alerted the participants to some disturbing trends and anomalies regarding health care in Sunrise State. Their advocacy objectives should reflect the following understandings:
  - Sunrise State is an urbanized state that is struggling with rapidly growing towns and cities. Clearly the government’s program of providing primary health care through local clinics is not working as it should. There is a need to ensure such clinics are completed and functioning properly in informal urban settlements, on the outskirts of towns and cities, and in rural areas.
  - Sunrise State has a high ratio of doctors and nurses to the population it serves when compared to other states of Polarus. There appears to be a problem with organizing and managing these human resources. It could be that doctors and nurses are working mainly in secondary and tertiary hospitals, and not being spread to primary health clinics.
  - In 2003, Sunrise State had 11,874 public hospital beds. By 2008, it had 12,021 – meaning in three years the state added less than 200 additional beds to its capacity to treat patients. There is also a question of whether these beds are located at primary health clinics, or at other levels of the health system.
  - The Health Minister may see some advantage in taking the CSOs’ findings seriously, so as to be seen to be improving the health system. It may be strategic to frame their message so that it has an “economic efficiency” hook.
  - The strategic objective groups come up with at this point could be something like: *The Sunrise State government should ensure within three years that all rural and peri-urban primary health clinics in the state are fully staffed with well-trained, full-time doctors and nurses, and equipped with the medicines they need to provide primary health care.*

Try to steer the discussion towards a strategic objective that more or less coincides with the one above. Explain that this is a provisional strategic objective. It will be revised and refined over the next few days as participants learn more about the **budget dimension** of advocacy.

- Provide a brief summary of both sessions to close Part I of the Budget Advocacy module.
**TASK 5.2 □ UNCOVER THE RESEARCH AGENDA**

1. What advocacy objective do you think underpinned this research report?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2. List the main research questions that were addressed in the report.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

3. List some research questions that were not addressed in the report.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. In your opinion, does this report contain powerful evidence for advocacy? Or could the research have worked better to support the advocacy message? Use examples to explain your response.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
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   ________________________________________________________________
**Task 5.3 ▪ Identifying Our Budget Problem and Related Budget Questions (for Developing Our Advocacy Objective)**

We understand the budget problem in our case study to be:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Brainstorm a quick list of budget questions that could shed light on the problem you are trying to address:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
TASK 5.4  A SMART ADVOCACY OBJECTIVE ON HEALTH CARE IN SUNRISE STATE

Consider all of the information you have about the health care situation in Sunrise State. Then develop a draft SMART advocacy objective to direct your future work to improve health care in Sunrise State.

OUR DRAFT SMART ADVOCACY OBJECTIVE IS:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
**Task 5.5 ▪ Assessment Form: How SMART is this Advocacy Objective?**

Carefully consider the advocacy objective presented by the other group. Reflect on the following questions and provide them with fair and frank feedback.

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<tr>
<th>Guiding Questions</th>
<th>Notes</th>
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| **S** | How **SPECIFIC** is the objective?  
Does it clarify what should be done?  
Does it say who should benefit?  
Does it spell out who must take action? |
| **M** | How **MEASURABLE** is this objective?  
Does it give numbers of goods or services to be delivered?  
Will it be possible to measure whether it has been achieved? |
| **A** | How **ACHIEVABLE** is this objective?  
Does it take past health service delivery trends and government capacity into account? |
| **R** | How **REALISTIC** is this objective?  
Does it take political dynamics into account?  
Does it recognize real resource and capacity constraints? |
| **T** | How **TIME-BOUND** is this objective?  
Does it specify a deadline by when it should be achieved?  
Does it allow for progressive realization that can be monitored? |
Reading 5.2 ■ Evidence-Based Budget Advocacy

- Budget advocacy work is a unique combination of two traditions that used to be conducted quite separately, usually by very different kinds of people and organizations:
  - **Advocacy work** has been undertaken by civil society organizations (CSOs) for a long time. Historically, advocacy work has been the domain of activists and campaigners.
  - **Budget research (or analysis)** was, until not so long ago, mainly undertaken by academics and finance managers. Historically, this kind of work was seen as a technical exercise conducted by economists.
- When combining these two traditions in the field of budget advocacy work, the link that holds the two together is evidence. Evidence is the reason why advocacy work can become more powerful when it is supported by budget research, and why budget research can become more powerful when it is grounded in advocacy.
- Both advocacy and budget research become stronger and more effective when they brought together in budget advocacy work. This is because:
  - “Traditional” budget research produces findings, but these findings have little impact if they remain in academic articles and reports that very few people read. The findings from budget research have much more power and relevance if they are used strategically as evidence to inform the future decisions of policy makers and government officials.
  - “Traditional” advocacy calls for change, but these calls often fall on deaf ears. In many instances, activists and campaigners try to appeal to the morality or conscience of decision makers, i.e., they ask them “to do the right thing.” As we know, such calls can easily be rebuffed and ignored. Leaders can brush them away, saying demands are idealistic, already achieved, or unrealistic. Advocacy efforts are much more compelling and persuasive when calls for change are backed up by evidence that builds a logical argument and presents feasible solutions and alternatives.
- Many CSOs are already familiar with the advocacy side, but what does budget research bring to their advocacy agenda?

**What Is Budget Research?**

Budget research and budget analysis are the same thing; these terms can be used interchangeably. There are five main types of analytical work that are considered budget research. These are:

1. **The analysis of fiscal policy**, i.e., revenue, taxing, borrowing, investing, spending, public resource management.
2. **The analysis of a government's proposed budget allocations and revenue sources.** This analysis may be conducted from a number of angles.

   - For example, you might analyze revenue sources or budget allocations to see how they will impact on poverty or on other specific development/social problems.
   - You could also analyze revenue plans or budget allocations to see whether, or to what extent, they advance or undermine economic, social, and cultural rights.
   - The analysis may be conducted to see how revenue plans and budget allocations will impact on a specific target group, like children, people with disabilities, or the elderly. The analysis could be done from a gender perspective so as to assess whether and how budget allocations might impact women and men differently.
   - Finally, an analysis of revenue sources and budget allocations may be designed to shed light on a specific sector, like health, education, the environment, etc.

3. **Analysis of the budget process:** to assess whether and how well it allows for public participation and the quality of that participation.

4. **Analysis of budget process:** to assess how transparent it is and to what extent it upholds the right to know. This type of analysis would also typically address issues of accountability and oversight of the budget process.

5. **Monitoring the implementation** of the revenue and expenditure sides of the budget.

**What Does It Mean to Do Evidence-Based Budget Advocacy?**

- All advocacy work starts with a problem or a situation that you are trying to address.
- Doing evidence-based budget advocacy means looking at the problem that you are trying to address through the lens of the government budget to see how decisions and practices related to public resources are making the problem better or worse.
- In this way, the budget becomes an instrument through which to understand and address the problem you are trying to solve.
- Evidence-based advocacy means undertaking high quality research and analysis to generate evidence that can be used to advance your advocacy objective.
RESEARCH FOR ADVOCACY: OBI 2010

THE OPEN BUDGET INDEX 2010

- The Open Budget Index, created by the International Budget Partnership, is based on the Open Budget Survey questionnaire, which consists of a total of 123 multiple-choice questions, 92 of which inquire about the public availability, timeliness, and comprehensiveness of the eight key budget documents that all governments should provide during the budget year.
- Scores assigned to these 92 questions are used to determine an overall transparency score for each country surveyed. These scores are then compiled to create the Open Budget Index (OBI), an objective ranking of each country’s relative level of transparency.
- The remaining 31 survey questions assess the strength and effectiveness of legislatures and supreme audit institutions (SAIs) in each country.
- In 2010, the OBI compiled scores for 94 countries. (The 2008 OBI included 85 countries, and the 2006 OBI included 59 countries.) The key findings of the 2010 OBI are outlined below.

***

In 2010, 74 of 94 countries assessed fail to meet basic standards of transparency and accountability when it comes to their national budgets.
- We surveyed 94 countries and found that 40 countries release no meaningful budget information.
- The worst performers include China, Saudi Arabia, Equatorial Guinea, Senegal, and newly democratic Iraq, which provide little to no information to their citizens about how the government is spending the public’s money.
- We found that only 7 of the 94 countries surveyed release extensive budget information. Those top-tier countries are: South Africa, New Zealand, United Kingdom, France, Norway, Sweden, and the United States.

There has been nearly 20 percent improvement in the average performance of the 40 countries that have been measured over three consecutive Open Budget Surveys, which is a positive sign.
- The OBI uses objective, internationally recognized criteria to give each country a transparency score on a 100-point scale.
- We found a 9-point increase in the average OBI score (from 47 in 2006 to 56 in 2010) among the 40 countries surveyed in 2006, 2008, and 2010.
- Some of the most dramatic improvements came from previously low-scoring countries, such as Mongolia and Uganda, which still do not meet best practices but have improved over time.

Governments can improve transparency and accountability quickly and easily by publishing online all of the budget information they already produce and by inviting public participation in the budget process. Over the long term, we need a set of international norms that demand transparency.
- To see improvements in transparency, public engagement, and oversight in the short term, the International Budget Partnership recommends that:
1. governments make public all the documents they produce, which would require virtually no additional effort or cost by the governments involved but would dramatically improve the openness of budgets in large parts of the world;
2. legislatures begin to conduct public hearings on the budget; and
3. auditors establish mechanisms for getting public input on problems with specific programs and on what should be audited.

**Greater transparency enables better oversight, better access to credit, better policy choices, and greater legitimacy.**

- Without access to information legislators, auditors, civil society groups, media, and the broader public cannot effectively participate in decision making, nor can they hold the executive to account for the use of public resources.
- Transparency and public participation enhance the credibility of policy choices and the effectiveness of policy interventions.
- Lack of transparency can lead to the selection of unpopular and inappropriate programs and to corrupt and wasteful spending.
- Budget transparency can benefit countries financially, since more transparent budgets tend to have better access to international financial markets and lower borrowing costs.

**Data reveal a strong correlation between lack of transparency and accountability and countries that rely heavily on oil and gas revenue, receive significant amounts of foreign aid, and have authoritarian governments.**

- The 24 countries assessed that are dependent on oil and gas revenue had an average OBI 2010 score of just 26 out of 100.
- The 32 aid-dependent countries surveyed had an average OBI 2010 score of 30 out of 100, which is 14 points worse than countries not dependent on foreign aid.
- The 21 countries classified as "authoritarian" regimes by the Democracy Index received an average OBI 2010 score of 17 out of 100, while the 14 “full democracies” scored an average of 72.
- There are also some geographic correlations: Western Europe and the U.S. tend to be more transparent, while the Middle East and Africa tend to be less transparent, with other regions of the world falling in the middle.

**While these correlations exist, a number of notable exceptions and surprising results demonstrate that any country can achieve transparency and accountability if its government makes it a priority.**

- Notable exceptions to these correlations include: South Africa, which was the top performer of any country; India, Sri Lanka, and Ukraine, which are relatively low-income countries but perform relatively well; Colombia, Mexico, and Indonesia, which had OBI 2010 scores that were two times as high as other countries that rely on oil and gas revenue.
- While neither country is up to par, newly democratic Afghanistan scored 21 points higher than newly democratic Iraq.
- China is becoming a major donor of foreign aid, but itself is among the least transparent countries in the world, scoring just 13 out of 100.
- Saudi Arabia and Malaysia both are relatively high-income countries, but Saudi Arabia scores just 1, while Malaysia scores 39.
- Kyrgyz Republic, Liberia, and Yemen, increased their scores substantially by making available on their websites the budget reports that they have previously produced but had made available only to internal government audiences or to donors.
Questions to Guide Budget Research

1. **WHAT** is the problem that you are trying to solve?

2. **WHAT** does this problem look like in the budget or budget process?
   - Which allocations or practices cause the problem?
   - Which formulation, spending, non-spending, implementation, or information practices are at the root of it?

3. **HOW** can this problem be solved?
   - Not who caused it, but what would make it go away?
   - Is your objective stated in a SMART manner?
   - What changes are needed in budget information, the budget process, or in budget formulation or implementation?

4. **HOW** would this solution change the budget itself, the budget process, budget information, or budget implementation?
   1. State in detail, taking constraints into account.
   2. Where would money need to come from?
   3. What information needs to be released, and in what form?
   4. What institutional change is needed to support it?

5. **WHO** could make the changes that would fix this problem in the budget?
   - Conspiracy theories don’t help in assigning responsibilities.
   - Identify a specific person with this specific responsibility.

6. **WHO** could lose by fixing this problem?
   - Identify a specific person with a specific loss.
MODULE 6

HEALTH POLICY AND THE BUDGET PROCESS
MODULE 6 ■ HEALTH POLICY AND THE BUDGET PROCESS

SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of this module</th>
<th>5 hours, 25 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of this module</td>
<td>This module corresponds with the following sessions in the Health &amp; Budgets Training Workshop Agenda:</td>
</tr>
<tr>
<td></td>
<td>• Part of SESSION 2 on Day 3;</td>
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<td>• SESSION 3 on Day 3;</td>
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<td>• SESSION 4 on Day 3;</td>
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<td>• Part of SESSION 1 on Day 4; and</td>
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<td></td>
<td>• Part of SESSION 2 on Day 4.</td>
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<td>(Note that one session is 1 hour, 45 minutes.)</td>
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<tr>
<td>Resources needed</td>
<td>• Flipchart paper and markers</td>
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<tr>
<td></td>
<td>• A4 sheets of colored paper</td>
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<tr>
<td></td>
<td>• PowerPoint presentations:</td>
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<tr>
<td></td>
<td>➢ MODULE 6 – Health Policy &amp; Budget Process – Presentation #1</td>
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<td>➢ MODULE 6 – Task-What Is Causing the Problem</td>
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<td>➢ MODULE 6 – Budget Process Diagram</td>
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<td>➢ MODULE 6 – Health Policy &amp; Budget Process – Presentation #2</td>
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<tr>
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<td>• In the Participants’ Workbooks:</td>
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<tr>
<td></td>
<td>➢ TASK 6.1 ■ Analyzing Health Policy in Polarus</td>
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<td>➢ TASK 6.3 ■ What Is Causing the Problem in Sunrise State?</td>
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<td>➢ TASK 6.4 ■ When to Intervene?</td>
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<td>➢ TASK 6.5 ■ Who Is Responsible?</td>
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<td>➢ READING 6.1 ■ Transcripts of Meetings with Officials</td>
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<td>➢ READING 6.2 ■ Stages in the Budget Process</td>
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<td>➢ READING 6.3 ■ The Sequence of Budget Decisions</td>
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<td>➢ READING 6.4 ■ Factors Affecting Budget Change</td>
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</tbody>
</table>
LEARNING OUTCOMES TO BE ACHIEVED

By the end of this module, participants will have:

- Identified and examined health policy interventions;
- Recognized that there are budget issues underlying the development problems that they are trying to address;
- Read a budget and identified budget items linked to relevant policy interventions;
- Described the main role players in the policy and budget process, their functions, and their responsibilities;
- Explained the four stages of the budget process;
- Named the decision makers affecting the budget at each stage;
- Identified when in the budget process to intervene, given different kinds of budget problems and advocacy objectives;
- Considered constraints and trade-offs in the budget process; and
- Practiced analyzing budgets to find possible areas where funds could be redirected or reprioritized.

STRUCTURE OF THE MODULE

Analyzing Policies and Reading a Budget (1 hour, 55 min.)

1. **Facilitator Input**: What Is Health Policy and How to Analyze It 15 minutes
2. **Task 6.1**: Analyzing Health Policy in Polarus 35 minutes
3. **Facilitator Input**: What Do We Need to Use the Budget for Advocacy? 5 minutes
4. **Task 6.2**: Interactive Plenary Work Session: Reading the Polarus Budget 60 minutes

The Budget Process and When to Intervene (1 hour, 45 min.)

6. **Facilitator Input**: The Four Stages of the Budget Process 15 minutes
7. **Task 6.4**: When to Intervene? 20 minutes

Understanding the Budget Decisions Required to Bring about Change (1 hour, 45 min.)

8. **Facilitator Input**: A Closer Look at Budget Decision-making Sequences 15 minutes
9. **Task 6.5**: Who Is Responsible? 40 minutes
10. **Facilitator Input**: Constraints on Budget Change 5 minutes
11. **Task 6.6**: Seeking a Budget Solution 45 minutes
ANALYZING POLICIES AND READING A BUDGET

Duration of session: 1 hour, 55 minutes

**STRUCTURE OF THE SESSION**

1. **FACILITATOR INPUT:** What Is Health Policy and How Do You Analyze It? 15 minutes
2. **TASK 6.1** Analyzing Health Policy in Polarus 35 minutes
3. **FACILITATOR INPUT:** What Do We Need to Use the Budget for Advocacy? 5 minutes
4. **TASK 6.2** Interactive Work Session: Reading the Polarus Budget 60 minutes

**1. FACILITATOR INPUT: WHAT IS HEALTH POLICY AND HOW DO YOU ANALYZE IT?**

**Note:** This input is supported by slides from the PPT file **MODULE 6 – Health Policy & Budget Process – Presentation #1**.

- Introduce the session by briefly giving participants an overview of the whole of Module 6, as outlined on **Slide 2**.
- Lead a discussion to clarify the meaning of the terms “policy” and “health policy.” **Slide 3** provides two definitions to serve as a basis.
- Using **Slide 4**, clarify that health policy generally addresses at least two central aspects:
  - **Public Health**, including population, sanitation, disease control, nutrition, mortality, occupational health, and environmental health.
  - **Health Care**, which is an umbrella term referring to treatment, access, service delivery, standards, protocols, financing and accountability.
- **Slide 5** provides pointers on the main role players who shape health policy. These include:
  - The Executive or government bureaucracy
  - Members of Parliament
  - Professional bodies, insurance providers, health workers’ unions
  - Health providers and professionals
  - Epidemiologists/researchers
  - Interest groups (for example, the disabled, the elderly, people who are HIV positive)
  - Public interest organizations, CSOs, health activists
- Use **Slide 6** to discuss the various fora and processes that contribute to health policy-making, and to consider the official policy process as it is ideally meant to unfold. Be sure to highlight

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here that among the public laws that should help shape health policy are constitutional provisions as well as international treaty obligations related to the right to health. In other words, for example, if the government has ratified the ICESCR, health policy must be developed within the framework of the guarantees and obligations related to the right to health highlighted in that treaty.

- Slide 7 presents a diagram of the policy-making process. Explain the diagram⁷ to the participants.

3. Usually, policy initiatives begin with a problem or opportunity that suggests a need to create new policy.

4. After identifying the basic issue (for example, “Obesity is a growing problem among youth in Canada.”), policy-makers engage in a substantial amount of analysis (“Why are kids becoming overweight and obese? Are they eating too much? Eating the wrong kinds of foods? Are they not getting enough physical activity?”).

5. Out of this analysis comes the development of policy and program options (for example, “Young people are becoming obese because they get the wrong food and do not get enough exercise. We can educate them and their families; regulate the kind of food offered in vending machines in and near the school; work on changing the acceptability of ‘wrong’ foods; introduce mandatory daily gym programs in school; devise ways of making physical activity ‘cool.’”).

6. Eventually, a decision is made, part of a complex cycle that takes into account the impact of new policy on several levels (for example, a decision on smoking affects many government departments, including customs, finance, intergovernmental, health, Aboriginal—not to mention tobacco industry lobby groups). Influences on decisions are many and varied.

7. A new or changed policy and/or program is introduced.

8. The policy is monitored and evaluated.

2. **TASK 6.1 ■ ANALYZING HEALTH POLICY IN POLARUS**

- The aim of this task is for participants to gain some practice in analyzing policy content and build confidence in identifying components of a health policy that are relevant to their advocacy goals.

- Ask participants to work in their Polarus groups. Refer them to **TASK 6.1 ■ ANALYZING HEALTH POLICY IN POLARUS** in their Workbooks.

- After 20 minutes, gather in plenary and invite some responses from the groups.

⁷ This explanation of the diagram is taken from the publication, “You Say ‘To-may-to(e) and I Say ‘To-mah-to(e)”’: Bridging the Gap between Researchers and Policymakers, Canadian Institute for Health Information, 2004, p. 10-11.
Check to ensure that participants have identified the relevant sections of health policy in Polarus. They should be able to explain how specific policy provisions would influence access to health care. (The relevant healthy policy sections for each group will differ depending on what their advocacy objective is. Thus, you will need to check what each group’s advocacy objective is in order to verify whether they have identified the relevant sections.)

Participants’ responses should also show that they have been able to draw links between their advocacy objective and how it would impact on policy. Each group should have a clear sense of whether the existing health policy in Polarus is in alignment with what they are advocating for, or whether what they are advocating for would require a change in policy. This would make a big difference to the advocacy strategy required to bring about their desired change.

3. **Facilitator Input: What Do We Need in Order to Use the Budget for Advocacy?**  
5 MINUTES

**Note:** This input is supported by slides from the PPT file **MODULE 6 – Health Policy & Budget Process – Presentation #1.**

- Now that participants know how to consider the policy implications of the health issue they are trying to address, the next question is: *How can we use the budget to sharpen and advance our advocacy objective?*

- Use Slide 9 to take a more detailed look at what participants need to be able to do and know in order to use the budget for advocacy. This is a summary of the basic skills and knowledge that will allow them to build a budget dimension into their health advocacy work.

1. They need to know how to read the budget. They will start learning this in this session.
2. They need to determine who did what wrong in the budget process to cause the problem of concern. They will consider actors in the next session.
3. They need to determine when those actors make the relevant decisions. How else would you know when to try and influence them? Next session.
4. Find out how they make their decisions. It is important to consider decision-making sequences and trade-offs that are made in arriving at a budget. How else would you know what to ask for and how? This issue is addressed later in the Module.
5. Determine how the government might be able to fix the problem. This would involve your playing with the budget figures to find out what might address your problem.

- Explaining the skills and knowledge needed and letting them know when they will be addressed in the workshop should help position the participants so that they understand how the learning process will unfold and how the various things they are learning tie together.
4. **Task 6.2 ■ Reading the Polarus Budget** 60 MINUTES

*Note:* This input is supported by slides from the PPT file **MODULE 6 – Health Policy & Budget Process – Presentation #1** (presentation continues from facilitator input above).

- Inform participants that directions for this task are in their Workbooks as part of **Task 6.2 ■ Reading the Polarus Budget**.

- Participants should read the sections in the Polarus Sourcebook on the budget process and on inter-governmental relations, and then answer the true or false questions under b) (in their Workbooks) in plenary.

- Explain the budget system in Polarus using the metaphor of Russian dolls (Slide 10). Ask participants to call out some characteristics of these dolls. Confirm responses that highlight that the dolls all look the same, except that they get smaller, and that smaller ones fit into bigger ones.

- Explain further that just like the dolls (Slide 11):
  - All the budgets for each constitutional unit of government (National, State and Local in Polarus) use the same classification system.
  - Each smaller unit is contained in a larger one (e.g., State Health budgets as part of State Budgets).
  - But each level of government is its own complete unit (which is why you need to know the constitution and policy process in a country if you want to understand the budget).
  - Some summary tables complicate the picture (e.g., Fiscal Framework).

- Lead participants through the various spreadsheets or tables required for the questions, explaining the following key terms as you go:
  - Consolidated budget (Polarus National (Centre and State) Budget)
  - Gross domestic product
  - Consumer price index
  - Consolidated Revenue
  - Administrative, Functional, and Economic classification
  - Budgeted and Audited Expenditure

- Use the **Glossary** to confirm definitions and invite participants to make active use of the Glossary throughout the workshop.
• Using Slide 12, remind participants of the importance of the non-budget data when analyzing the budget.

• Using Slide 13, encourage them to ask the three questions before they start analyzing the budget.

ANSWERS TO QUESTIONS IN TASK 6.2: READING THE POLARUS BUDGET:
2) Decide whether each of the following statements is true or false:
   • False. The money to fund primary schools is part of states’ education budgets.
   • False. State governments each receive their total budgets from the national government and then decide what portion of their total state budget to allocate to health.
   • False. The funds used for housing construction in states come from national revenue and not from locally raised taxes.
   • True: Public works is a national function, and the national Ministry of Public Works can decide what portion of funds to spend in different states. However, once the budget is approved there are some constraints on the extent to which actual spending may deviate from planned allocations.
   • True. The Sunset State Department of Housing has the mandate to decide how to distribute its available funds across the various programs and items in its housing budget.

3) What government plans to spend is normally called an allocation.
   What government actually ended up spending is normally called an expenditure. Expenditures are typically detailed in in end-of-year reports, and it is only some months or years later that the actual audited figures are available.

4) “Administrative classification” means the figures are classified according who is responsible for spending the budget and the line items in it.

5) The difference between the health expenditure shown in the National Expenditure table and the health spending shown in the State Health Budgets is that in the case of Polarus the former includes only national expenditure happening through central government, while the state spending budgets show spending on health that happens at state level.

6) The State Budgets are an example of Administrative Classification, because they organize the budget according to the departments that are responsible for spending the budget.

7) The State Health Budgets tables disaggregate the “Health” line item in the State Budgets tables.
8) The difference between the Economic and Administrative Classification is that the former categorizes expenditure according to the kind of economic transactions involved and not by which administrative unit responsible for the expenditure.

9) **Drugs** – Goods & Services; **Nurses’ Salaries** – Salaries; **Maintenance of Clinics** – Buildings & Other Fixed Assets

10) Participants’ advocacy objective is linked to the **Sunrise State Department of Health**. The state-level government of Polorus is responsible for the budget that relates to the problem. The program in the State Department of Health that is more important for their advocacy objective is the **District Services program**, because they are interested in the lack of and quality of primary health clinics. Clinics are part of the **Primary Health sub-program** under District Services, which is the program with the main responsibility for primary health care in Polorus.
**TASK 6.1 ■ ANALYZING HEALTH POLICY IN POLARUS**

1) Gather in your Polarus groups. Look at the draft advocacy objective that you formulated at the end of Module 5. Restate it here.

Our draft advocacy objective is:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2) Which policy goals are implied by your advocacy objective?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3) Which standards/norms are articulated in or assumed by your advocacy objective? Why?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
4) Do the Polarus National Health Policy and the priorities of the National Health Strategy support the intervention that you are proposing? How and where? If not, which changes would you recommend in the policy framework?

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

5) Which other policy areas are important for your advocacy objective? Water? Roads?

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________
TASK 6.2 ■ READING THE POLARUS BUDGET

If you can't read the budget, you can't analyze it.

1) Read the following two sections (on pages 45-51) of the Polarus Sourcebook to learn more about who is responsible for what in the Polarus budget:
   - the budget process in Polarus; and
   - center-state fiscal relations.

2) Then decide whether each of the following statements is true or false (and be able to explain why):

<table>
<thead>
<tr>
<th>Statement</th>
<th>True or false?</th>
<th>Page reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The money used to fund primary schools is part of the national Education Budget.</td>
<td></td>
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<tr>
<td>The national Minister of Health decides about the size of the Health Budget in South State.</td>
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<td></td>
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<tr>
<td>Capital State can raise taxes to fund housing construction.</td>
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<td></td>
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<tr>
<td>The national government can move money between Happy and Mountain States’ Public Works Budgets.</td>
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<tr>
<td>Sunset State can move money between the line items “Compensation of Employees” and “Machinery and Equipment” in their Housing Budget.</td>
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</tbody>
</table>

3) Look at the Polarus National (Center and State) Budget on page 72. There are two kinds of figures in budgets: What government plans to spend and what it ends up spending. What terms are used in the table to refer to these two different kinds of spending?

What government plans to spend is called:

What government actually ended up spending is called:
4) Turn to the **National Expenditure** table on page 73. This is another example of a budget that presents an administrative classification. What does “administrative classification” mean?

5) What is the difference between the **National Expenditure** on health shown in the table on page 73 and the health spending shown in the **Ministry of Health State Budgets** (on pages 78-80)?

6) Are the **Ministry of Finance State Budgets** on page 75 an example of administrative, functional, or economic classification? Justify your answer.

7) For which line item in the **Ministry of Finance State Budgets** (on pages 75-77) do the **Ministry of Health State Budgets** (on pages 78-80) provide more detail on?

8) Look at the economic classification of **Ministry of Health State Budgets** in the Polarus Sourcebook (on pages 81-83). What is the difference between economic and administrative classification?
9) Under which category in an economic classification of the **Ministry of Health State Budgets** would you find spending on:

Drugs

________________________________________________________________________

Nurses’ salaries

________________________________________________________________________

Maintenance of clinics

________________________________________________________________________

10) Reflect on your own advocacy objective relating to health care in Sunrise State:

Which level of government is responsible for it?

________________________________________________________________________

Which department(s) is your advocacy objective linked to?

________________________________________________________________________

Which program in this department is the most important for your strategic objective? (Look on page 44 of your Polarus Sourcebook for descriptions of programs.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Now we know which parts of the budget to analyze!
THE BUDGET PROCESS AND WHEN TO INTERVENE

Duration of session: 1 hour, 45 minutes

<table>
<thead>
<tr>
<th>TASK 6.3 ■ Role Play: What Is Causing the Problem in Sunrise State?</th>
<th>75 minutes</th>
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</thead>
<tbody>
<tr>
<td>FACILITATOR INPUT: The Four Stages of the Budget Process</td>
<td>15 minutes</td>
</tr>
<tr>
<td>TASK 6.4 ■ When to Intervene?</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

1. **TASK 6.3 ■ Role Play: What Is Causing the Problem in Sunrise State?**

This session begins with a role play activity, followed by a debriefing in plenary.

**The aims of the role play** are:

- To encourage participants to think about the budget issues and decisions that underpin the development problems they are trying to address;
- To introduce participants to some of the players involved in the budget process;
- To enable their Polarus CSO groups to develop some suspicions and hypotheses about how the budget links to their advocacy objective.

**INTRODUCTION AND GETTING INTO ROLE (20 MINUTES)**

- Begin by getting the participants into role as members of civil society organizations in Polarus. Explain that in their organizations they have all committed to pursue the objective they agreed to earlier in the workshop. In order to understand their challenges better, they have all been told to go and investigate what is causing the health crisis in Sunrise State.
- Be clear that the participants all have the same problem as their point of departure, which is: *The provision of primary health care services in Sunrise State is not keeping up with the demand from people in need of health care in that state.*
- Their task in this role play is to find out as much as they can about what is causing this problem. The task is also outlined in the PPT file **MODULE 6 – Task-What Is Causing the Problem.**
- Refer participants to **READING 6.1 ■ TRANSCRIPTS OF MEETINGS WITH GOVERNMENT OFFICIALS ON HEALTH** in their Workbooks. It contains transcripts of interviews recently conducted by journalists with different government officials regarding the health problems in Sunrise State. Through their contacts in the media, the participants’ CSOs have been able to get hold of these transcripts from reporters at the *Polarus Times.*
• Ask participants to read carefully through the transcripts and then gather in their CSO groups. In 20 minutes time, they will have an opportunity to meet with the same officials, and ask them any questions they would like to help uncover what is causing the poor delivery of primary health care services in Sunrise State.

• Participants are to spend more or less 15 minutes in total reading the transcripts, and then meeting in their CSO groups to gather some preliminary ideas on what they will ask each of the officials. Naturally, they may review and change these questions as they learn more from each interview.

• After 5 to 10 minutes of reading, encourage the participants to gather in their groups and start planning the questions they would like to ask of the officials.

• Participants can record their questions and any other relevant information on the sheet for Task 6.3 ■ WHAT IS CAUSING THE PROBLEM IN SUNRISE STATE? in their Workbooks.

ROLE PLAY: INTERVIEWS AND REFLECTION (45 MINUTES)

• The role play is set in Polarus, and involves the participants’ visiting and interviewing four mock government officials. The officials are:
  - A senior official at the National Ministry of Finance;
  - An official at the Sunrise State Department of Finance;
  - An official from the Sunrise State Health Department; and
  - The Head of the District Services program of the Sunrise State Housing Department.

• Allocate the roles of the four government officials to four different facilitators and ask each to set up a mock office in a break-away room or corner of the training area.

• Invite the participants, in their Polarus CSO groups, to circulate amongst the officials. Only one group should visit an official at a time, and spend no more than 6 to 8 minutes with each official.

• After the groups have visited and interviewed all four officials, ask them to gather for a few minutes and reflect on what they have learned. They should try to identify as many possible explanations as they can for what could be causing the health problem in Sunrise State.

• Ask the groups to write each of their “theories” or hypotheses on a different sheet of paper.

PLENARY DISCUSSION AND DEBRIEFING (10 MINUTES)

• Spend the last 15 minutes of the role play time discussing the hypotheses generated by the groups. Gather together in plenary and invite groups to volunteer their possible explanations for the health crisis in Sunrise State.

• These are the most likely hypotheses or explanations the groups will generate:
- The National Ministry of Finance is under-funding State governments.
- The National Ministry of Finance is not borrowing enough money, which means that it can't fund states enough, and they in turn underfund their Health Departments (linked to other hypotheses, of course).
- The Sunrise State Department of Finance is under-funding its Department of Health.
- The Sunrise State Department of Health is under-spending on its budget or wasting money.
- The District Services program in Sunrise State is underfunded or wasting money.

- Write each of the hypotheses on a sheet of flipchart paper. Hang each sheet on the wall, with space in between each one. Invite the participants to cluster around the hypothesis that they think is the most likely “culprit.”
- Ask one participant from the group gathered around each hypothesis to explain why he or she thinks it is the most likely explanation for the health crisis in Sunrise State.
- This activity is meant to get the participants interested and engaged with the budget dimension of development problems. However, at this stage, they do not know enough about the budget process or the budget itself to go much further than speculate on these quite general hypotheses.
- If participants leave the activity with some suspicions that budgetary issues could be linked to their advocacy objective, then enough has been accomplished.

2. Facilitator Input: The Four Stages of the Budget Process 15 minutes

- It is important to have detailed knowledge of the budget process when you are trying to influence the budget. This involves getting to know all the players and steps involved in each stage of the budget process.
- Without this knowledge, it will be impossible to identify the most strategic and effective points to intervene.
- Always keep in mind that:
  - Different decisions are made by different people at each stage of the budget process. For example, perhaps the District Services program doesn't have enough money because the national government didn't transfer enough to Sunrise State in the first place. Then we can't really blame the poor program officer, can we? So we don't need to know only who decides what, but also how other decisions impact on them.
  - Also, and importantly, you will only have the desired impact if you intervene before the decisions you want to change are being made.
Note: The following input on the budget process is supported by the PPT file, MODULE 6 – Budget Process Diagram.

Notes on Budget Process Diagram:

- During the formulation stage of the budget process, the following steps are completed, usually under the direction of the Ministry of Finance or National Treasury:
  - The Executive undertakes a modeling of the macroeconomic framework. Economic trends are analyzed in order to project the likely macroeconomic environment for the upcoming year and over the medium-term. This involves, for example, projections about the GDP, deficit, inflation, and exchange rates in the country.
  - The Executive estimates revenue for the upcoming year and the medium-term to establish the likely size of the forthcoming budget. Revenue estimates include such categories as taxes and non-tax revenues, donor funds, etc.
  - Expenditure ceilings are set for ministries, departments and other implementing agencies (MDAs) on the basis of which they can draw up their spending plans.
  - In most countries, the government releases a pre-budget statement.
  - MDA budgets are then formulated and negotiated.
  - The budget is submitted to the country’s Cabinet for approval.

- In most countries, the formulation stage also involves planning processes and decisions at sub-national levels. For example, in Polarus:
  - The National Ministry of Finance determines the block transfers and conditional grants for all nine states.
  - In each state, expenditure ceilings are determined for the various state-level government departments, for example, the Sunrise State Department of Health.
  - These State departments formulate expenditure budgets for the coming year as well as for the medium-term, and these are submitted to State Cabinet for approval.

- To return to the national level: The budget is tabled in the National legislature, by the National Minister of Finance. State budgets are tabled in their respective State legislatures, by their respective State Finance Department Heads.

- The National and State budgets are referred to relevant legislative committees, who are mandated to review and scrutinize the Executive’s spending and revenue proposals. The committees report back to the main chambers of the legislatures.
• Amendments are made to the budgets (in those countries where legislatures have the power to make amendments).
• The budget is voted into law.
• Money is transferred to MDAs in line with the approved national and state budgets.
• Ideally, MDAs use the funds they have received for their intended purpose and deliver goods and services as agreed in the budget.
• Throughout the year while implementing the budget, MDAs produce in-year reports to show how they are spending allocated funds.
• At the end of the fiscal year, MDAs produce year-end reports to set out in full how they have spent allocated funds.
• The year-end reports of all MDAs are submitted to the Supreme Audit Institution (SAI) in the country concerned.
• The SAI conducts an audit of government spending. There are different kinds of audits and some countries undertake more extensive audits than others. In most countries, the audit would at least include an assessment of whether government spending was compliant with the budget, and whether funds are accounted for using sound financial management principles.
• The SAI prepares a report on government spending for each MDA and refers these reports to the national legislature or relevant state legislature.
• The legislatures refer the audit reports to their Public Accounts Committees (PAC) as well as other relevant committees.
• The PACs make recommendations to the legislatures about the findings of the SAI in relation to each MDA.

Participants will find the information covered during this presentation in **Reading 6.2: Stages of the Budget Process** in their Workbooks.

### 3. Task 6.4 ■ When to Intervene?

15 minutes

• **The aim of this task** is to enable participants to apply what they have learned by having them identify when in the budget process decisions are being taken that impact on diverse budget problems.
• Refer participants to **Task 6.4 ■ When to Intervene?** in their Workbooks.
• This is a plenary activity. Participants can buzz in pairs of small groups of three before calling out their answers.
- Invite the participants to consider each of advocacy issues listed on the task sheet. If necessary, clarify any concepts like “under-spending,” “wastage,” and “deficit,” and give examples for any issues that the participants find unclear.
- The answers to the questions are recorded below.
- In wrapping up this task, the main point to get across is that different decisions take place in different stages of the budget process. For advocacy to be effective, it is necessary to intervene before the decisions get taken that will impact on your advocacy objective. So if, for example, your concern is with how much money is allocated for health spending, you need to influence the budget formulation and budget approval stages.

**Answers to Task 6.4: When to Intervene?**

The interventions would best be made at the following stages of the budget process:

1. The total amount being allocated to Sunrise State: National formulation stage and National legislative stage
2. Under-spending in the Sunrise State Department of Health: State implementation stage and State audit stage
3. The size of the National Government’s deficit: National formulation stage
4. Money allocated to primary health care in the health budget: State formulation stage and State legislative stage
5. Wastage in the health budget: State/national implementation and audit stages
6. The total amount of money allocated to States: National formulation stage and national legislative stage.
**TASK 6.3 ■ WHAT IS CAUSING THE PROBLEM IN SUNRISE STATE?**

After reading the transcripts of media interviews with government officials on the health situation in Sunrise State, identify further questions you would like to pose to any or all of the officials in question. Record your questions and findings below.

**OFFICIAL FROM THE NATIONAL MINISTRY OF FINANCE**

Possible questions to ask:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**NOTES**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**OFFICIAL FROM THE SUNRISE STATE DEPARTMENT OF FINANCE**

Possible questions to ask:

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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**NOTES**

________________________________________________________________________
________________________________________________________________________
OFFICIAL FROM THE SUNRISE STATE DEPARTMENT OF HEALTH

Possible questions to ask:

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_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

NOTES

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

HEAD OF THE DISTRICT SERVICES PROGRAM, SUNRISE STATE DEPARTMENT OF HEALTH

Possible questions to ask:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

NOTES

_____________________________________________________________________
_____________________________________________________________________
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_____________________________________________________________________

## TASK 6.4 ■ WHEN TO INTERVENE?

At which stage(s) of the Polarus budget process would you intervene in if you were advocating about:

<table>
<thead>
<tr>
<th></th>
<th>ADVOCACY ISSUE</th>
<th>WHEN IN THE BUDGET PROCESS TO INTERVENE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The total amount being allocated to Sunrise State</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Under-spending in the Sunrise State Department of Health</td>
<td></td>
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<tr>
<td>3</td>
<td>The size of the National Government deficit</td>
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<tr>
<td>4</td>
<td>Money allocated to primary health care in the health budget</td>
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<tr>
<td>5</td>
<td>Wastage in the health budget</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The total amount of money allocated to States</td>
<td></td>
</tr>
</tbody>
</table>

In each case, explain your choice!
READING 6.1 ■ TRANSCRIPTS OF MEETINGS WITH GOVERNMENT OFFICIALS ON HEALTH

The media in Polarus recently published a story on the health problems in Sunrise State. Through your contacts in the media, you have been able to get the following transcripts of the meetings conducted by reporters from the Polarus Times with government officials.

MEETING WITH OFFICIAL FROM THE NATIONAL MINISTRY OF FINANCE

Reporters: Good Morning, Madam!

National Finance Official: Karibu! You are most welcome. How can I help you?

Reporters: Madam, recently there were reports of women giving birth on open fields near clinics in Sunrise State after waiting in line for hours to be treated. We are trying to understand why there is such a shortage of clinics making existing clinics so busy, and why Sunrise State doesn’t have more and better primary health care services.

National Finance Official: So, why do you want to meet with someone at the National Ministry of Finance?

Reporters: Madam, we heard a rumor that the National Finance Ministry has a poor track record in working with State governments. We wanted to get your perspective, particularly on your relationship with Sunrise State.

National Finance Official: My dear friends, let me reassure you that the National Ministry of Finance has very cordial relations with all the States. Every year, we send the States their block grants. They decide how they want to spend their money and have it approved by their state Cabinets and Parliaments.

Reporters: How much money did you transfer to Sunrise State last year?

National Finance Official: It is not that easy to answer that question. I cannot give you one figure since transfers are made in installments during the year.

Reporters: Can you tell us how much money was given in each installment?

National Finance Official: Hold on, let me consult my books! Here it is! The total budget appropriated for Sunrise State last year was 13,629 million Dinar. We sent them monies in four installments. The first installment was made in March for 4230 million Dinar, the second in June for D3050 million, the third in September for D3020 million, and the fourth in December for D3329 million.
Reporters: Do you think that was enough to provide good primary health care services in Sunrise State?

National Finance Official: That’s not my responsibility, friends. Remember that Sunrise State decides itself what to spend on health, we just give them a block grant! Try to pay attention next time I tell you something!

Reporters: But was their block grant big enough to build clinics, provide drugs and pay for doctors to run them? Some people say that the national government could borrow more to pay for the health backlog.

National Finance Official: Well, I am no health expert. And you know times are tough and we need lots of money for other things besides health. Just last week you people were complaining about spending on housing! And running a Treasury is not like playing monopoly. We can’t just go and borrow more money.

Reporters: Yes, but you didn’t answer our question. Did you give Sunrise State a large enough block grant to provide primary health care?

National Finance Official: You know you can consult the budget yourself on our lovely new website. But if you want me to do your work for you, I can tell you that we increased Sunrise State’s total state grant by more than 6 billion Dinar over the last three years. Does that look like enough to you?

Reporters: That is an impressive amount of money. Thank you very much for your time.

National Finance Official: Yes, whatever. You people love accusing us before you take the trouble to investigate. I hope you will tell the story about that 6 billion Dinar as well! Now, I’m busy, so if there is nothing else…

MEETING WITH OFFICIAL FROM THE SUNRISE STATE DEPARTMENT OF FINANCE

Reporters: Hello, sir!

Sunrise State Finance Official: Hi guys! How’s it?

Reporters: We are reporters who are investigating the situation with health care in Sunrise State. As you may be aware, there have been horrible reports lately about women giving birth while waiting to be attended to at primary health clinics. We wanted to get your perspective on why this is happening.

Sunrise State Finance Official: Look friends, these are tragic stories. My department is doing everything it can to investigate the reasons why it is happening.

Reporters: What have you found so far?
Sunrise State Finance Official: Well the biggest reason is that the National Ministry of Finance isn’t giving us enough money. Remember that we have to spend money on Housing and Education as well. Our budget only goes so far.

Reporters: So, you blame the National Ministry of Finance for the health shortage? But they say that they increased your grant by more than 6 billion Dinar over the last 3 years. That seems like a lot of money.

Sunrise State Finance Official: Well it may sound like a lot to you, but as I said we have to build houses, maintain schools, pay salaries – the list goes on and on. If you look at what people are demanding, 6 billion Dinar isn’t actually that much.

Reporters: So you don’t accept any of the blame for the health situation in Sunrise State? Are you satisfied that you are giving enough of your budget to the Department of Health? We’ve heard that their share of the state budget might be less than in other states.

Sunrise State Finance Official: Well, how much is enough? I can tell you that we have given them over 10 billion Dinar since 2005.

Reporters: So you blame the Health Department?

Sunrise State Finance Official: Blame is a strong word. I am just saying that we can’t give them more money. Not while Housing and Education are running out of money as well.

Reporters: Yes, that seems reasonable. Thank you for your time. We will try to discuss this issue with the Department of Health.

Sunrise State Finance Official: You do that. But don’t go and tell them what I said. Have a good day.

MEETING WITH SENIOR OFFICIAL, SUNRISE STATE DEPARTMENT OF HEALTH

Reporters: Knock, knock! Can we come in?

Sunrise State Health Official: Yes, of course! You don’t have to be so formal with me. Make yourselves at home!

Reporters: Thank you. A lot of people are worried about the health situation in Sunrise State. We are sure you know the stories about women giving birth outside during this bitterly cold winter.

Sunrise State Health Official: Yes, of course! I tell you, it breaks my heart! I have dedicated my life to the vision of Health for All.
**Reporters:** But why aren’t you providing more and better primary health care services? The Sunrise State Department of Finance says you are not even spending the money that you have!

**Sunrise State Health Official:** Now hang on just a minute! We provide over 12,000 beds to the sick in this state!!

**Reporters:** Yes, but is it true that you are under-spending?

**Sunrise State Health Official:** That is not really true. Some of our programs are even over-spending. It’s mainly the District Services and a few other programs that sometimes under-spend.

**Reporters:** Could you tell us how much you spent on primary health care in 2008?

**Sunrise State Health Official:** We had a budget of more than 1.7 billion Dinar for District Services! But we still have one of the highest maternal mortality rates in Polarus, for example.

**Reporters:** That is a lot. How are you planning to solve this problem?

**Sunrise State Health Official:** Well, we’re trying to get more money from the national government for our secondary and tertiary hospitals, so that we don’t have to dip into the District Services budget. But in the end we will need more money to solve this problem.

**Reporters:** So is that where the under-spending problem lies? That the hospitals in Sunrise State are draining resources from District Services?

**Sunrise State Health Official:** You will need to talk to my colleague about that. He is the Head of the District Services program. I don’t want to stick my nose into his business.

**Reporters:** OK, thank you very much then.

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**MEETING WITH THE HEAD OF THE DISTRICT SERVICES PROGRAM, SUNRISE STATE HEALTH DEPARTMENT**

**Reporters:** Good day!

**Head of District Services:** Yes, you people again. What do you want this time?

**Reporters:** We have been talking to some government people about the health crisis in Sunrise State. Many of them blame it on your program, the District Services. Can you tell us more?

**Head of District Services:** People are dying of cold and hunger, and all you worry about is your newspaper! We treated over 600,000 people last year. Why don’t you go and write that?

**Reporters:** Congratulations on your past achievements. But could we also talk about the reasons why many people still find it so hard to get treated at clinics in Sunrise State?
Head of District Services: District Services is not the only program in the health department, you know. When the hospitals are in need of money, we all suffer.

Reporters: Are you saying that money got taken from your budget to spend on hospitals?

Head of District Services: Look, I don’t know what you want me to do. In the end the Department of Health doesn’t get enough money to deal with the health challenges of this state. The rest is detail.

Reporters: But these are important details. Could you confirm that money was taken from your program’s budget to spend on hospital services?

Head of District Services: Why are you bothering me with this nonsense?! The budget figures are all on the website. If you leave me alone, maybe I could get on with my job of running health services.

Reporters: Well, thank you for your time. Good luck with this daunting task.
READING 6.2 ■ STAGES IN THE BUDGET PROCESS

It is important to have detailed knowledge of the budget process when you are trying to influence the budget. This involves getting to know all the players and steps involved in each stage of the budget process. Without this knowledge, it is impossible to identify the most strategic and effective points to intervene. Always keep in mind that:

- Different decisions are made at each stage of the budget process.
- You will only have the desired impact if you intervene before the decisions you want to change are being made.

THE FORMULATION STAGE

During the formulation stage of the budget process, the following steps are completed, usually under the direction of the Ministry of Finance or National Treasury:

- The executive undertakes a modeling of the macroeconomic framework. Economic trends are analyzed in order to project the likely macroeconomic environment for the upcoming year and over the medium-term. This exercise results, for example, in projections of the GDP, deficit, inflation, and exchange rates in the country.
- The executive estimates revenue for the upcoming year and the medium-term in order to establish the likely size of the forthcoming budget. These revenue estimates include taxes and non-tax revenues as well as donor funds from bilateral and multilateral agencies.
- Expenditure ceilings are set for ministries, departments and other implementing agencies (MDAs) so that they are able to draw up their spending plans.
- In most countries, the government releases a pre-budget statement.
- MDA budgets are then formulated and negotiated.
- The budget is submitted to the country’s cabinet for approval.
- The formulation stage also involves processes and decisions at other levels of government. For example, in the case of Polarus:
  - The National Ministry of Finance determines the block transfers and conditional grants for all nine states.
  - In each state, expenditure ceilings are determined for the various state-level government departments, for example, the Sunrise State Department of Health.
  - These State departments formulate their budgets for the medium-term, and these are submitted to the State cabinets for approval.
THE LEGISLATIVE STAGE

- The budget is tabled in the legislature, usually by the Minister of Finance.
- The budget is referred to relevant legislative committees, who are mandated to review and scrutinize the executive’s spending and revenue proposals. The committees report back to the main chamber of the legislature.
- Amendments are made to the budget (in those countries where legislatures have the power to make amendments).
- The budget is voted into law.

THE IMPLEMENTATION STAGE

- Money is transferred to MDAs in line with the approved budget.
- Ideally, MDAs use the funds they have received for their intended purpose, and deliver goods and services as agreed in the budget.
- Throughout the year while implementing the budget, MDAs produce in-year reports to show how they are spending allocated funds.
- At the end of the fiscal year, MDAs produce year-end reports to set out in full how they have spent allocated funds.

THE AUDIT STAGE

- The year-end reports of all MDAs are submitted to the Supreme Audit Institution (SAI).
- The SAI conducts an audit of government spending. There are different kinds of audits and some countries undertake more extensive audits than others. In most countries, the audit would at least include an assessment of whether government spending was compliant with the budget, and whether funds are accounted for using sound financial management principles.
- The SAI prepares a report on government spending for each MDA and refers these reports to the legislature.
- The legislature refers the audit reports to the parliamentary committee responsible for public accounts (usually called the Public Accounts Committee or PAC), as well as other relevant committees.
- The PAC makes recommendations to the chamber on the findings of the SAI in relation to each MDA.
STRUCTURE OF THE SESSION

1. **Facilitator Input**: A Closer Look at Budget Decision-making  
   15 minutes
2. **Task 6.5**: Who Is Responsible?  
   40 minutes
3. **Facilitator Input**: Constraints on Budget Change  
   5 minutes
4. **Task 6.6**: Seeking a Budget Solution  
   45 minutes

### 1. Facilitator Input: A Closer Look at Budget Decision-making  
15 MINUTES

**Note**: This input is supported by slides from the PPT file **Module 6 – Health Policy & Budget Process – Presentation #2**.

- Refer back to the role play that participants undertook in the previous session. At the end of their investigation, it would have seemed that the Head of the District Services could have been causing the poor health service delivery in Sunrise State.
- While this assumption may be true, it may also not be true, and may not best serve your advocacy objective of getting primary health services improved in Sunrise State. Often, it is possible to dig deeper in your investigation of the budget problems.
- Let’s consider why the District Services program may be under-spending or wasting funds. There are several possible answers to this question. To explore for underlying causes, it is important to look at not only where budget problems occur, but also at the entire sequence of decision-making that surrounds the problem in question.
- Use Slides 3-5 to explain each of the steps in the national and state sequences of decision-making, as well as the players responsible for decision-making at each step.
- Use the example of health officials resigning in Sunrise State over low salaries (Slide 6) to show the various decisions and decision-makers that may be causing or contributing to the problem.
- Participants will find the information covered during this presentation in **Reading 6.3 ■ The Sequence of Budget Decisions** in their Workbooks.
2. **TASK 6.5 ■ WHO IS RESPONSIBLE?**

- **The aim of this task** is to enable participants to practice identifying the key role players within government who affect budget problems and have the decision-making power to address these problems.

- Ask participants to turn to **TASK 6.5 ■ WHO IS RESPONSIBLE?** in their Workbooks.

- This is a group activity. Ask participants to work in their Polarus CSO groups.

- There is no need for each group to report back in full on their lists. Rather facilitate a less structured report-back discussion, with volunteers from the floor naming possible budget problems that came up during their discussions. Then identify the relevant decision makers together.

**ANSWERS TO TASK 6.5: WHO IS RESPONSIBLE?**

Some key points to emerge from the discussion:

- Each of the decisions taken during the budget formulation stage has a different potential impact on a problem.

- Thus, the poor delivery of health services in Sunrise State could be the result of:
  - Not enough taxes or debt, so there is not enough money available for expenditures overall; and/or
  - Of the available resources, not enough money is allocated to the states as a whole; and/or
  - Of the available resources allocated to states, not enough is allocated to Sunrise State; and/or
  - Of the resources available to Sunrise State, not enough is allocated to health; and/or
  - Of the money going to the Health Department in Sunrise State, not enough is allocated to primary health care (under the District Services Program); and/or
  - Not all the money available for the District Services’ primary health budget is actually spent; and/or
  - The funds available for health in Sunrise State are not spent efficiently.

- Consult **Slide 5 in the previous presentation** to determine who makes each of these sets of decisions.

- These different possible causes of the problem are not mutually exclusive. A good budget analysis could illustrate the extent to which each of these explanations contributes to the problem.
3. Facilitator Input: Constraints on Budget Change  

5 minutes

Note: This input is supported by Slide 8 from the PPT file MODULE 6 – Health Policy & Budget Process – Presentation #2.

- Introduce this discussion by explaining that when you are advocating for solutions that require changes in the budget, it is important to be aware of the internal constraints and complex relationships within which budgets are negotiated and set.
- Ask the participants to suggest factors that come to mind that might make it difficult to change budget decisions and practices.
- If it doesn’t come up, be sure that mention that one factor that makes it difficult to bring about changes in budgets is the fact that budgets are relatively rigid. They can’t be reinvented from scratch every year – there are always pre-existing commitments that need to be accommodated and are often non-negotiable.
- What makes budgets rigid?
  - Many budgets include a large component of salaries, which cannot readily be reduced without making far-reaching decisions regarding peoples’ jobs.
  - Many budgets are designed to fund the implementation of existing contracts, and these are difficult to change.
  - Where budgets include considerable amounts dedicated to debt repayments, pensions, and social security payments, there is little leeway to reduce or alter allocations.
- Factors such as these limit how much money can be shifted in any single financial year

Notes on Slide 8

- All budgets are based on balances and political trade-offs. The allocation of public funds is usually a competitive process where ministries and departments vie against each other for as big a slice of the resource pie as they can get. The overriding rule of the game is: “What I get is what you don’t get.”
- Therefore, whenever you are advocating for something which requires more spending on a certain sector or program, it is essential to consider where the money will come from to address the problem you want to impact.
- As part of your advocacy strategy, you will have to develop recommendations about what trade-offs could be made, and the advantages that would come with making such trade-offs.
- In addition to thinking about the implications of your proposal for the budget, it is wise to consider in advance the political costs such changes would entail. Who would stand to lose face
or status as a result of changes in allocations, for example? In other words, be sure to analyze and determine who may be opposed to your advocacy position for status or power reasons and not just simply budgetary ones.

- Participants will find the information covered during this presentation in **READING 6.4 ■ FACTORS AFFECTING BUDGET CHANGE** in their Workbooks.

### 4. TASK 6.6 ■ SEEKING A BUDGET SOLUTION

- **The aim of this task** is to allow participants to experience for themselves how difficult it can be to make trade-offs between competing needs in the budget, and to consolidate their understanding that advocacy demands should be backed up with realistic budget recommendations.

- **Refer participants to** TASK 6.6 ■ SEEKING A BUDGET SOLUTION **in their Workbooks.**

- This is a group exercise. Before the participants reconvene in their Polarus CSO groups, briefly explain the task and field any questions of clarification that may arise. Among the most frequently asked questions:
  - *Can you borrow more money?* You may borrow, you may tax more, but you still need to answer the questions about political cost.
  - *Will the Sunrise State Health Department need the additional funds every year or just over the three-year period?* An additional 50 million Dinar is needed every year, not across the 3 years.

- **If necessary, remind the participants that they have other information about Sunrise State spending in their Polarus Sourcebooks, which may be relevant to this task.**

- **After approximately 30 minutes, facilitate a plenary discussion of possible solutions emerging from the participants’ considerations.**

### WRAP-UP TO TASK 6.6: SEEKING A BUDGET SOLUTION

- **There is no single or even ideal solution to this problem** – as is the case with many real budget situations. The lack of a perfect solution for this problem therefore mirrors real life.

- To solve the problem, you could decide to call for an overall increase in spending, in which case taxpayers or donors may not support the idea.

- You could also propose taking money away from other areas of the Sunrise State budget, such as administration, health, or social development. But in each case, there will be some resistance to your proposal as the implications may be cutting civil servants’ salaries, etc.
In many cases, you might wish to spread the pain of such trade-offs over many years. The price you then pay is how long it takes to eventually arrive at a solution to the problem.

One reason why it is so difficult to propose the best solution to the problem at this point is that you don’t really know enough about the budget figures. For example, if you knew that the figures for the Office of the Prime Minister were vastly inflated or that the child nutrition project has been dormant for the last three years, your perspective on the best solution would shift. This is why budget analysis is so essential to determine the most informed solution for your advocacy objective. Participants will learn much more about this in Module 7.
**TASK 6.5 ■ WHO IS RESPONSIBLE?**

1. Within your Polarus CSO group, recollect the advocacy objective that you formulated with regard to the health situation in Sunrise State.

   _______________________________________________________
   _______________________________________________________

2. Make a list of all the possible budget decisions that could cause this problem.

   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
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3. Go back to the list you made above and specify who makes each of the decisions that you listed.

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   _______________________________________________________
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203
Task 6.6 ■ Seeking a Budget Solution

1. Study the table below. It presents selected expenditure items from Sunrise State’s budget for 2009, 2010, and 2011. All the items are for Sunrise State only, except for the Office of the Prime Minister, which is a national spending category.

<table>
<thead>
<tr>
<th>From Sunrise State budget (in D millions)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care</td>
<td>95</td>
<td>105</td>
<td>115</td>
</tr>
<tr>
<td>Salaries of health officials</td>
<td>86</td>
<td>90</td>
<td>95</td>
</tr>
<tr>
<td>Training health professionals</td>
<td>43</td>
<td>46</td>
<td>52</td>
</tr>
<tr>
<td>Child nutrition project</td>
<td>24</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Office of the Prime Minister</td>
<td>28</td>
<td>32</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>276</td>
<td>299</td>
<td>329</td>
</tr>
</tbody>
</table>

Through your budget analysis and interviews with government officials and other stakeholders, you have been able to establish the following:

- An additional 50 million Dinar would enable the Sunrise State Department of Health to considerably improve primary health care delivery.
- The proposed allocation for salaries in the health department keeps the current number of officials and only increases salaries for inflation.
- Sunrise State health workers are under-skilled and in need of training.
- The nutrition project feeds 500,000 hungry children three mornings a week.
- The Office of the Prime Minister will spend D19, D22, and D24 million on salaries alone.

2. Now consider the questions on the following page.
What trade-offs could be made to resolve the health care problem in Sunrise State?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

a. Who would need to lose money?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

b. How long would it take to solve this problem?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
## Reading 6.3 ■ The Sequence of Budget Decisions

### National Budget Decisions

<table>
<thead>
<tr>
<th>Decision</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>State or National Fiscal Framework</td>
<td>(Ministry of Finance, Donors, Central Bank)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>State or National Ministry/Department Budgets &amp; Block and Conditional Grants to States</td>
<td>(Ministry of Finance, Cabinet)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>State Programs</td>
<td>(Department Heads, Ministers)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>Economic Classification</td>
<td>(Program Managers, Department Heads)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>Budget Implementation</td>
<td>(Program Managers, Department Heads)</td>
</tr>
</tbody>
</table>

### State Budget Decisions

<table>
<thead>
<tr>
<th>Decision</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Fiscal Framework</td>
<td>(State and National Ministries/Departments of Finance, State Cabinets)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>State Ministry/Department Budgets</td>
<td>(State Departments of Finance, State Cabinet)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>State Programs</td>
<td>(Department Heads, Ministers)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>Economic Classification</td>
<td>(Program Managers, Department Heads)</td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>Budget Implementation</td>
<td>(Program Managers, Department Heads)</td>
</tr>
</tbody>
</table>
**KEY DECISION MAKERS IN THE BUDGET FORMULATION STAGE**

<table>
<thead>
<tr>
<th>Decision</th>
<th>Who decides?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much extra money will we collect in tax and donor or grant funds for the next financial year?</td>
<td>Ministry of Finance, Central Bank, Donors</td>
</tr>
<tr>
<td>How much extra money do we want to spend?</td>
<td>Ministry of Finance, Donors, Cabinet</td>
</tr>
<tr>
<td>How much money should we borrow?</td>
<td>Ministry of Finance, Central Bank, Donors</td>
</tr>
<tr>
<td>How should we divide up additional money among expenditure MDAs?</td>
<td>Ministry of Finance, Donors, Cabinet</td>
</tr>
<tr>
<td>How should we divide up additional money within MDAs (which programs)?</td>
<td>Department Heads, Ministers</td>
</tr>
<tr>
<td>On what should we spend additional money within each program?</td>
<td>Department Heads, Program Heads</td>
</tr>
<tr>
<td>Implementing the budget</td>
<td>Department Heads, Program Heads</td>
</tr>
</tbody>
</table>
READING 6.4 ■ FACTORS AFFECTING BUDGET CHANGE

When you are advocating for solutions that require changes in the budget, it is important to be aware of the internal constraints and complex relationships within which budgets are negotiated and set.

BUDGETS ARE RIGID

- One factor that makes it difficult to bring about changes in budgets is the fact that they are relatively rigid. Budgets can’t be reinvented from scratch every year – there are always pre-existing commitments that need to be accommodated and are often non-negotiable.

- What makes budgets rigid?
  - Many budgets include a large component of salaries, which cannot readily be reduced without making far-reaching decisions regarding peoples’ jobs.
  - Many budgets are designed to fund the implementation of existing contracts, and these are difficult to change.
  - Where budgets include considerable amounts dedicated to debt repayments, pensions, and social security payments, there is little leeway to reduce or alter allocations.

- Factors such as these limit how much money can be shifted in any single financial year

BUDGETS HAVE WINNERS AND LOSERS

- All budgets are based on balances and political trade-offs. The allocation of public funds is usually a competitive process where ministries and departments vie against each other for as big a slice of the resource pie as they can get. The overriding rule of the game is: “What I get is what you don’t get.”

- Therefore, whenever you are advocating for something which requires more spending on a certain sector or program, it is essential to consider where the money will come from. As part of your advocacy strategy, you will have to develop recommendations about what trade-offs could be made, and the advantages that would come with making such trade-offs.

- In addition to thinking about the implications of your proposal for the budget, it is wise to consider in advance political costs the changes you want would entail. Who would stand to lose face or status as a result of changes in allocations? In other words, be sure to analyze and determine who may be opposed to your advocacy position for status or power reasons, and not just simply budgetary ones.
MODULE 5
BUDGET ADVOCACY

PART II ■ Power, Stakeholder, and Opportunity Mapping
## MODULE 5 ■ BUDGET ADVOCACY (CONTINUED)

### PART II ■ POWER, STAKEHOLDER, AND OPPORTUNITY MAPPING

### SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of module</th>
<th>9 hours, 45 minutes (Parts I, II, and III)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13 hours, 10 minutes (Budget Advocacy Group Work &amp; Presentations)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structure &amp; timing of this module</th>
<th>This module corresponds with the following sessions in the <em>Health &amp; Budgets Training Workshop Agenda:</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Part I: Planning for Budget Advocacy (3 hours, 30 min.)</strong> ✔</td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 4 on Day 2;</td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 1 on Day 3; and</td>
</tr>
<tr>
<td></td>
<td>- Part of Session 2 on Day 3.</td>
</tr>
<tr>
<td></td>
<td><strong>Part II: Power, Stakeholder, and Opportunity Mapping (3 hours, 30 min.)</strong></td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 2 on Day 4;</td>
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<tr>
<td></td>
<td>- SESSION 3 on Day 4; and</td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 4 on Day 4.</td>
</tr>
<tr>
<td></td>
<td><strong>Part III: Media and Communications (2 hours, 45 min.)</strong></td>
</tr>
<tr>
<td></td>
<td>- SESSION 2 on Day 6; and</td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 3 on Day 6.</td>
</tr>
<tr>
<td></td>
<td><strong>Part IV: Budget Advocacy Group Work and Presentations (13 hours, 10 min.)</strong></td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 3 on Day 6;</td>
</tr>
<tr>
<td></td>
<td>- SESSION 4 on Day 6;</td>
</tr>
<tr>
<td></td>
<td>- SESSIONS 1-4 on Day 7;</td>
</tr>
<tr>
<td></td>
<td>- SESSIONS 1-2 on Day 8;</td>
</tr>
<tr>
<td></td>
<td>- Part of SESSION 3 on Day 8.</td>
</tr>
<tr>
<td></td>
<td>(Note that one session is 1 hour, 45 minutes.)</td>
</tr>
</tbody>
</table>

| Resources needed for PART II | - Flipchart paper and colored markers  |
|                            | - PowerPoint presentation: **MODULE 5 – Budget Advocacy Part II**                                      |
|                            | - In the Participants’ Workbooks:  |
|                            |   ✔ **TASK 5.6 ■ SWOT Analysis**                                                                       |
| Reading 5.5 | Powerbrokers in the Budget Process |
| Task 5.7 | Powerbrokers in Sunrise State |
| Task 5.8 | Stakeholder Analysis for Sunrise State |
| Task 5.9 | Power Mapping and Opportunity Schedule |
| Reading 5.6 | Stakeholder Mapping and Opportunity Schedule |
LEARNING OUTCOMES TO BE ACHIEVED

By the end of Part II of Module 5, participants will have:

- Identified the powerbrokers in the budget process;
- Distinguished different kinds of powerbrokers and their positions relative to their group’s advocacy objective;
- Conducted a SWOT analysis for budget advocacy;
- Generated a stakeholder analysis and map; and
- Completed a power map and an opportunity schedule.

STRUCTURE OF MODULE 5 (PART II)

Power, Stakeholder, and Opportunity Mapping (3 hours, 30 min.)

1. Recap and Going Forward: Budget Advocacy 5 minutes
2. Facilitator Input: Focusing Our Advocacy Strategy 15 minutes
3. Facilitator Input: SWOT Analysis 15 minutes
4. Task 5.6 ■ SWOT Analysis 20 minutes
5. Facilitator Input: Powerbrokers in the Budget Process 15 minutes
6. Task 5.7 ■ Powerbrokers in Sunrise State 20 minutes
7. Facilitator Input: Stakeholder Analysis 35 minutes
8. Task 5.8 ■ Stakeholder Analysis for Sunrise State 25 minutes
9. Facilitator Input: Power Mapping and Opportunity Schedule 30 minutes
10. Task 5.9 ■ Power Mapping and Opportunity Schedule 30 minutes
POWER, STAKEHOLDER, AND OPPORTUNITY MAPPING

Duration of session: 3 hours and 30 minutes

1. RECAP AND GOING FORWARD: BUDGET ADVOCACY

- **Note:** This input is supported by slides from the file MODULE 5 – Budget Advocacy Part II.
- **Slide 3: Recap.** The aim of this recap is to help position the participants, so they can better understand where they are in the budget advocacy module.
- In Module 5 – Part I, participants were introduced to the key components of an advocacy strategy: a strategic analysis, an advocacy objective, a stakeholder analysis, an advocacy message (development and delivery of a message), and a schedule.
- They also practiced developing a budget advocacy objective.
- To dig deeper in the strategic analysis component of an advocacy strategy, they examined the link between advocacy and research.
- They defined a development problem and related that to the government’s budget. They examined key research questions to pursue to support their budget analysis and advocacy.
- **Slide 4: In Module 5 – Part II,** participants will explore more fully some of these components of an advocacy strategy. As part of both a strategic analysis and a stakeholder analysis, they will look at powerbrokers in the budget process. They will also do an abbreviated SWOT for Polarus, with particular focuses on the external opportunities and threats.
- They will then do a stakeholder analysis, which is important for identifying the primary and secondary target audiences, as well as opponents of their advocacy objective. A power mapping exercise will help them refine this analysis.
- Finally, participants will develop an opportunity map, which is key for developing a schedule—the last component discussed earlier of an advocacy strategy.

2. FACILITATOR INPUT ■ FOCUSING OUR ADVOCACY STRATEGY – THE ACTORS

- **Note:** This input is supported by slides from the file MODULE 5 – Budget Advocacy Part II.
- **The aim of this input** is to explain the logic of addressing powerbrokers, stakeholders, and power maps as part of an advocacy strategy.
- **Facilitator introduction:** There is a range of issues an organization needs to consider as it seeks to better focus its advocacy objective and budget advocacy strategy. To develop an effective budget advocacy strategy, it is useful to reflect on what the organization is trying to do, whom it
is trying to influence, how it will do that, and why. Some questions an organization should ask itself are, for example:

- *Can the objective be achieved through budget advocacy?* If the organization’s concern, for example, is women’s access to abortion, the primary obstacle may not be budgetary, but social attitudes towards abortion.

- *Does our advocacy objective relate to dynamics and issues affecting the whole health sector, or only certain sub-sectors?* If the organization’s concern is access to pre-natal care, for example, the availability and functioning of primary health clinics will be a central concern. However, while the issue primarily concerns pregnant women, primary health clinics serve many other people. Thus, an advocacy objective related to improving pre-natal care which focuses on primary health care facilities can touch many other people because it can affect the availability of decent primary care facilities for them.

- *Is achieving our objective best pursued at the national, state or local levels?* If an organization is concerned, for example, about waste in the procurement of medicines in Polarus, its focus should likely be at the state level, since in that country state governments have the primary responsibility for implementation of health services in the country.

- *Would achieving our objective have a positive impact on the communities of greatest concern to us?* If an organization’s concern is the quality of staffing in health clinics in rural areas, advocating for an increase in the number of doctors in the state would not necessarily bring about the change it wants to see—if, for example, urban clinics received the largest share of the new doctors or the quality of the doctors hired is poor.

As activists working on health issues, the participants likely intuitively identify many focus points for budget advocacy. Most of the issues they work on are inter-related, but often require different actions targeting different actors/audiences, for example, the Ministry of Health, the Health Committee in the legislature, the Budget Committee, etc.

To develop a clear and effective advocacy strategy, an organization needs to be clear about who the stakeholders are with regard to its advocacy objective, because they can help it or they can hurt it. Before doing that, however, it is essential to do a solid strategic analysis of the situation within which the organization’s advocacy will take place. To practice a bit doing some of this strategic analysis, participants will work on an abbreviated SWOT.
3. Facilitator Input ■ SWOT Analysis 15 minutes

- **Note:** This input is supported by slides from the file **MODULE 5 – Budget Advocacy Part II.**
- **The aim of this input** is to set up the SWOT exercise so that participants’ SWOT work focuses on the external issues, to help develop a strategic analysis that is the first step in developing an advocacy strategy.
- **Slide 5: SWOT Analysis.** Remind participants that they have identified their advocacy objective. Normally, they would then need to develop a SWOT analysis, to assess their organization’s ability to carry the advocacy strategy through to success. (It is important to do a SWOT for each budget advocacy objective that an organization identifies, as the internal and external factors will most likely change depending on what the organization seeks to address or change). As participants most likely know, as SWOT analysis is one that looks at:
  - **Strengths:** The internal attributes of your organization that are *helpful* to achieving the budget advocacy objective.
  - **Weaknesses:** Internal attributes of the organization that are *harmful* to achieving the objective.
  - **Opportunities:** External conditions that are *helpful* to achieving the objective.
  - **Threats:** External conditions that could *hinder* the achievement of the objective.
- Organizations need to do an SWOT analysis in part to assess their organizational abilities to carry the advocacy strategy through successfully. However, they are not going to do the internal organizational strengths and weaknesses (the SW of SWOT), because they are new to their Polarus CSO and so don’t know much about its strengths and weaknesses. They are going to focus on the OT part, which refers to external conditions, an understanding of which is an integral part of a strategic analysis (the first component on the list of developing an advocacy strategy).
- Ask one or two participants to volunteer their understanding and experiences of conducting the OT part of a SWOT analysis. Ask these participants: *What are some of the challenges faced when conducting the external opportunities and challenges facing an advocacy initiative?*

4. Task 5.6 ■ SWOT Analysis 20 minutes

- **The aim of this task** is to enable participants to practice developing an organizational SWOT analysis for their draft advocacy objective.
- **Note:** **Task 5.6 ■ SWOT Analysis** focuses on identifying the *external* opportunities and threats that a civil society group may face in trying to achieve a budget advocacy objective.
- Invite participants to break into their Polarus working groups
• **Slide 6: Task 5.6.** Aided by the scheme in Slide 6 and **Task 5.6  ■ SWOT Analysis**, ask participants to develop an analysis of the external opportunities and threats their organization faces in seeking to achieve the advocacy objective identified earlier. They should consider how the opportunities and threats will affect their advocacy strategy.

• Each group should develop their **SWOT** chart on flipchart paper. Participants will have 15 minutes to develop the map.

• Invite one group to share their chart, giving a few examples of how the opportunities or threats to achieving their budget advocacy objective would help shape their strategic analysis.

### 5. **Input: Powerbrokers in the Budget Process**

15 MINUTES

• **Note:** This input is supported by slides from the file **MODULE 5 – Budget Advocacy Part II.**

• **The aim of this facilitator’s input** is to introduce participants to the principal powerbrokers in the budget process and their role in budget advocacy.

• **Input:** A well-defined advocacy strategy should reflect an organization’s knowledge of the budget process, and who the main powerbrokers in the budget process are. However, once an organization has identified the powerbrokers, they need to find out as much information about them as is possible and useful, so as to understand the extent to which different powerbrokers need to be a focus of our advocacy. Knowing about the powerbrokers will help an organization identify the stakeholders and audiences related to their advocacy strategy (the third component of an advocacy strategy).

• Which powerbrokers are most important for an organization’s advocacy will depend, of course, on the advocacy objective the organization has identified.

### SLIDE 7: POWERBROKERS IN THE BUDGET PROCESS

• The principal powerbrokers in the budget process normally are:
  - The Ministry of Finance
  - Politicians
  - Donors and international financial institutions (IFIs)
  - The legislature
  - The private sector

**Ministry of Finance:** The Ministry of Finance (MoF) has the greatest influence on the budget. It makes the decisions about what fiscal policies the government will follow and it defines the
expenditure envelope. It mediates among the requests of different Ministries and Departments. It also has overall management responsibility and authority with regard to the budget.

The power of the MoF with regard to the budget is limited by its relationship with the President and/or Prime Minister. The MoF is part of the Executive branch, and thus ultimately must comply with the wishes and priorities of the President and/or Prime Minister. The MoF’s capacity to control the budget—for example, the accuracy of its predictions and its capacity to monitor expenditures—is also limited by the technical capacity within the Ministry.

**Politicians:** Depending upon the political system (parliamentary or presidential), politicians and political parties can have differing, often significant, influences on the budget. In a parliamentary system, they can, for example, influence the Prime Minister if they are of the Prime Minister’s party. They can also put pressure on government departments or agencies to spend the budget in line with their priorities.

At the same time, the Executive needs to follow public policy goals, and thus its capacity to bend to the will of politicians is limited. Similarly, financial management legislation can put limits on the capacity of the Executive to respond to pressure from politicians. Pressure from politicians exerted through their counterparts in the legislature is also limited by the generally greater power of the MoF.

**Donors and IFIs:** Even if they do not formally have the power to decide a country’s fiscal policy and/or its expenditure envelope, because they have different capacities to influence the government’s revenue, donors and IFIs typically have quite a bit of influence on the MoF. As a result of their concern for fiscal accountability, they also tend to influence financial management legislation.

A country may, however, benefit from contributions from a range of donors, each of which has different priorities and interests. As a result, their efforts to influence fiscal policy, etc., may be pushing against each other. In such situations, the MoF generally has more room to control ultimate decisions that are made. In addition, the MoF can also point to clearly formulated public policy goals that run counter to demands from donors or IFIs. The MoF could, for example, point to its international human rights treaty commitments when the demands from IFIs would undercut the government’s ability to meet its obligations to use the maximum of available resources to realize economic, social, and cultural rights.

**Legislature:** In most countries the legislature is, by law, required to approve the Executive’s budget. They can, in theory, withhold their approval. They can also set up a process for
monitoring implementation of the budget. In addition, the Supreme Audit Institution’s report is typically reviewed by the Budget (or Public Accounts) Committee of the legislature. The legislature can pass motions acting on the SAI’s recommendations.

Of course, the legislature’s powers with regard to the budget are limited. In a parliamentary system, for example, the majority party is unlikely to challenge the Executive’s budget. Similarly, the capacity of the legislature to amend the Executive’s budget when it is sent to them for approval varies according the laws in the country. Moreover, the capacity of the legislature to review the budget in detail depends on its capacities to understand the budget. Typically, budget matters are directed to specific committees whose members often have a greater understanding of the budget. However, the latter’s capacity to act on the budget may be limited.

**Private sector:** The private sector, because of its often significant role in the economy, can have a significant voice in the budget process. In particular, it can significantly influence the budget by the taxes it contributes—or fails to contribute—to the budget. Through lobbyists, it can also influence the shape of the budget coming out of the legislature, to favor expenditures that will help it. The private sector is also central to the procurement process, and thus can influence the efficiency and effectiveness of contracts entered into by the government.

The rules under which the Executive and legislature act can, however, put some limits on the extent to which the private sector can shape the budget.

**SLIDE 8: AMONG THE POWERBROKERS**

- It is not enough to identify who the powerbrokers are in our country’s (or state’s or local government’s) budget process. We need to determine where they stand vis-à-vis our advocacy objective. Will they be allies, soft supporters, fence sitters or opponents?

- **Allies** are those actors who support your work and are able to advocate for you from within the government, legislature, etc. You may find allies in surprising places. Don’t assume that just because someone is on the other side of the political fence that s/he is an opponent.

- **Soft Supporters** are those who are on your side, but are not as active in supporting you as they could be. They may not be able to be open in their support of you. If they give you information from the inside, for example, it is essential not to jeopardize their situation.

- **Fence Sitters** are those who are undecided as to whether they support your advocacy objective. It is important to determine the source of their doubt, and work to win them over using facts, not opinions.
• **Opponents** are those opposed to your advocacy objective, often because they stand to lose if you succeed. You need to try to control their influence, perhaps through identifying supporters who can control them. Another option is to try to shift the process away from their sphere of influence or decision-making (for example, from a committee they head in the legislature).

• Have participants brainstorm on suggestions from their experiences of ways to engage powerful stakeholders. Have them explain their suggestions. The suggestions should include at least the following:
  - Develop and maintain long-term relationships
  - Invite them to join a reference group for one your projects
  - Ask your own well-connected board members to reach out to stakeholders
  - Connect with politicians through their constituencies
  - Persistent meetings and visits
  - Maintain relationships after projects for government
  - Host meetings (public or closed) to bridge the divide between civil society and government
  - Invite them to present at your training events

• **SLIDE 9** shows the above suggestions. Display it after you have finished discussing the participants’ suggestions.

• **READING 5.5 ■ POWERBROKERS IN THE BUDGET PROCESS** in their Workbooks summarizes this discussion.

**6. TASK 5.7 ■ POWERBROKERS IN SUNRISE STATE 20 MINUTES**

• Ask participants to work in their Polarus groups on **Task 5.7**. Drawing on information in their Polarus Sourcebook, and using the page in their Workbooks to record their answers, they should suggest (with reasons) who might be:
  - an ally
  - soft supporter
  - fence sitter
  - opponent

  with regard to their Polarus advocacy objective.

• They should also list one way they could engage with each of these stakeholders.
7. **Facilitator Input: Stakeholder Analysis** 35 Minutes

- **Note:** This input is supported by Slides 10 and 11 in the file MODULE 5 – Budget Advocacy Part II.

- **The aim of this input** is to introduce participants to the categories of primary and secondary audiences related to specific budget advocacy objectives.

- **Ask participants what they understand to be a stakeholder.** Here is a **definition:** a person, group, organization, member or system who affects or can be affected by an organization's actions.

- Explain to participants that once an organization has identified the powerbrokers related to the situation of concern to them, it needs to find out as much information about them and understand to what extent they need to be the target audience of our advocacy. This will depend, of course, on the advocacy objective the organization has identified.

- An organization’s advocacy efforts are defined by:
  - Different stakeholders, who will work for or against its initiative,
  - The position of the stakeholders in the *political and power environment*; and
  - Specific *windows of opportunity*.

- **SLIDE 10:** Stakeholders in an advocacy campaign can be classified into two overarching categories:
  - The **primary audience**, composed of those *persons that are actually responsible for, and have the capacity to, make the desired change happen*.
  - The **secondary audience**, comprising those who can influence or put pressure on the primary audience—by raising the profile of the topic, demanding action, publicly shaming the government, or quietly speaking behind closed doors about the merits of the organization’s proposal.

- **Ask participants to brainstorm some examples of a primary audience and a secondary audience for budget advocacy.**
  - If they cannot come up with an example, mention the Minister of Finance and an influential journalist. Which would be a primary and which a secondary audience?
  - Provide another example: A local health network and the President of the Budget Commission. Which would likely be a primary and which a secondary audience?
  - Make sure they understand the difference between primary and secondary audiences.

- **SLIDE 11:** To design an advocacy strategy that maximizes possibilities for collaboration and minimizes opposition to its advocacy objectives, an organization needs to know:
- Who its primary and secondary audiences are (as detailed as possible);
- What they want, and what they actively oppose; (i.e., who are allies, soft supporters, fence sitters, opponents);
- What power they have to affect the organization’s specific objective; and
- What opportunities for collaboration (or risks) exist with and among them.

This involves an effort to find out as much as possible about the stakeholders, not only who they are, but where they stand in the political context.

- It is fundamental for an organization to analyze its primary and secondary audiences to gather a deep understanding of who is who in its advocacy environment. The organization needs to identify, for each stakeholder:
  - Basic characteristics;
  - Party background, groups they belong to;
  - Likes and dislikes, friends and foes;
  - Specific interest in/knowledge about the organization’s advocacy objective;
  - The way they are affected by the issue that the organization’s advocacy objective tries to solve;
  - The way they will be affected by the changes the organization proposes or seeks;
  - Their capacity to make that change (or parts of it) happen;
  - Their motivation/self-interest to contribute to it; and
  - The actions the organization can develop to spur their interest.

- It is useful to synthesize this information and to update it as the political context shifts. Remember that nothing stays static and budgets very much depend on the political context and stakeholders political will.

- Gathering this information may seem like a burdensome job but it will help an organization know when, where, and with whom to interact and how to do it strategically. An organization may gather this information from observing stakeholders in meetings, reading articles about them, talking to people who know them, following their opinions, reading their articles if they write, and paying attention to what they react to and when.

- The more an organization knows about the stakeholders, the better armed it is to make its arguments. Remember that knowledge is power!

8. **Task 5.8 ▪ Stakeholder Analysis for Sunrise State ▪ 25 Minutes**

- **The aim of this task** is for participants to practice developing a stakeholder analysis based on budget advocacy objectives.
• Ask participants to gather in their Polarus groups once more and to complete Task 5.8 ■ Stakeholder Analysis for Sunrise State in their Workbooks. Refer participants to the relevant section in their Polarus Sourcebooks where they will find descriptions of Sunrise State stakeholders: Who’s Who in Sunrise State? (pp. 24-28).

• Visit the groups in turn to make sure that they are identifying accurately the primary and secondary audiences, as well as important characteristics of each audience.

• To help participants identify the correct primary and secondary audiences for their advocacy objectives, remind them that the primary audience is usually one individual (e.g., the Head of the Sunrise State Department of Health) or institution (e.g., the Sunrise State Legislature), and that this person or institution is the one that has the formal authority to make the change that they want – this person or institution is the primary decision maker.

• Secondary audiences are those people and institutions/organizations that can influence the primary audience (key decision-maker), so that the primary audience makes the change that you want. There can be more than one secondary audience.

9. Facilitator Input: Power Mapping and Identifying Advocacy Opportunities 30 MINUTES

• Note: This input is supported by Slides 12-15 from the PPT file MODULE 5 – Budget Advocacy.

• The aim of this input is to introduce participants to:
  - Analyzing the different power positions of stakeholders in relation to their organization’s advocacy objectives.
  - Building power maps that can inform their advocacy.
  - Identifying and assessing different internal and external opportunities for advocacy within and beyond the budget process.
  - Building strategic schedules for their advocacy activities.

• Input on power mapping: Once an organization has identified its most important stakeholders and classified them into primary and secondary audiences, it needs to understand
  - their levels of power to effect the changes that the organization seeks to make;
  - where their power lies in relation to other stakeholders; and
  - how the political context influences their support of or opposition to the organization’s cause.

• Power maps or relationship diagrams help provide a clear picture of these power relations and the balance of power among them,
• **SLIDE 12** defines power mapping and its purpose. The principal purpose of power mapping is to facilitate an assessment of the balance of power among different stakeholders. It helps the process of defining strategies to:
  - Build connections and coalitions among those who support our advocacy objective;
  - Identify uninvolved stakeholders who can be mobilized for our cause; and
  - Neutralize or win over those who oppose our advocacy objective.

• **SLIDE 13** is a power map (Relationship Diagram) built around Fundar’s advocacy campaign to get an earmarked budget line for HIV/AIDS in Mexico’s 2008 Federal budget. (Fundar is a Mexican civil society organization: [www.fundar.org.mx](http://www.fundar.org.mx).) [See Relationship Diagram on the following page.]
  - The power map shows where the different stakeholders stood in relation to Fundar’s advocacy objective.
  - On the right Fundar placed those who opposed their advocacy objective, on the left those who supported it, and on the bottom those that were neutral.
  - The size of the stakeholder reflects the power of the stakeholder – the bigger the size, the more power. The distance of the stakeholder from the center (the objective) reflects how close or far they stood from Fundar’s objective (how strongly or weakly they supported or opposed the objective).
  - The shaded squares represent ministries or government actors. The rectangles with dotted lines represent CSOs, and the rectangles with double, solid lines represent legislative committees. The rectangle with a single solid line is an independent federal institute.
  - The ovals represent other stakeholders (political parties and health institutes).
SLIDE 14: POWER MAPPING MATRIX

- This is another example of a power map, with the difference that it is more fluid and illustrates how it possible to mobilize stakeholders from opposition to support. [See Power Mapping Matrix on the following page.]

- It places stakeholders on a scale from high support to high opposition.

- The shade (or intensity) of the color implies the level of power – the darker the color, the more power.

- The arrows indicate whether or not the organization can mobilize them and in which direction.

- In this example, the Ministry of Finance is depicted as having a lot of power (dark color) and high opposition. This is because they usually do not want anyone to mess with the budget.

- The legislative Budget Committee is depicted as having a high level of power, because they can amend the budget, and medium opposition, because Fundar had some allies within the legislature who could help move it to at least a neutral position.

- The Federal Access to Information Institute is neutral, because they may not naturally be interested in increasing the budget for HIV/AIDS, but they are interested in transparency. If Fundar doesn’t bring transparency into its advocacy, the Institute will be neutral. If Fundar brings the transparency issue into its advocacy objective, the Institute can be moved to low or medium support.
Ask what else the participants see.

SLIDE 15: Identifying advocacy opportunities; creating an opportunity schedule

- As was already discussed in Module 6, CSOs should be knowledgeable about the budget cycle, so that they know where and when to intervene to affect the budget. At the same time, budget work is ongoing and achieving an organization’s objective can be a drawn-out process. As a result, events that occur before and after specific stages in the budget process can also be important for raising the profile of the organization’s issue, reaching stakeholders and powerbrokers, and, in general, helping achieve its budget advocacy objective.

- Ask participants to offer examples of non-budget cycle events that they have used to highlight their issue in order to move towards their budget advocacy objective. First, give an example, such as: If you are advocating for better use of resources for maternal health, you could bring this up during International Women’s Day. Get a few examples from participants, asking them to explain how they framed their issue in the context of the specific events. If not enough examples are coming forward, you could cite as examples of events, the following:
  - International Days
    - International Human Rights Day
    - International Women’s Day
    - Others?
  - National Events
    - Presidential Address to the Nation
    - National Human Rights Day
    - MDG Progress Report launch
  - Public Holidays
    - Labor Day
  - International Conferences hosted by your country or where your country will participate
International AIDS Conference

SLIDE 16: Wrap up the discussion on advocacy opportunities

- To develop a clear and effective advocacy strategy, an organization needs to define its timelines and opportunities.
- The organization needs to be prepared when the right moment to act arrives. Just as it is important that an organization carefully analyzes and maps the stakeholders, it should be very clear about the schedule for its advocacy activities. One should try not to be taken by surprise. To avoid being caught off-guard, an organization should develop a schedule of the upcoming advocacy opportunities and the kinds of activities that it may need to undertake. Such a schedule also helps it to prepare with precision and in a timely fashion!
- An organization should be aware of the political environment and budget cycle, so that it is two steps ahead in its preparations. If it is alert to what is happening in the country while also being aware of the budget cycle, it is already paying attention to key developments that may provide solid advocacy opportunities.
- An organization should take advantage of special events or dates. This was just discussed.
- An organization should use every opportunity to highlight its advocacy objective. The more visible its advocacy objective is, the more it will be discussed, and the greater the potential for momentum to develop behind the change that it wants to see.
- An organization’s evidence must be credible, its message clear, and it must be ready to jump at opportunities!

10. TASK 5.9 • POLARUS POWER MAPPING AND OPPORTUNITY SCHEDULE

30 MINUTES

- The aim of this task is to enable participants to practice how to build a power map and an opportunity schedule.
- Ask participants to gather in their Polarus groups. Provide each group with two sheets of flipchart paper, markers, and colored Post-It notes.
- Invite participants to use the flipchart paper to build a Power Map and an Opportunity Schedule based on the stakeholders selected in TASK 5.8 • STAKEHOLDER ANALYSIS FOR SUNRISE STATE and their advocacy objectives selected in Module 5 – Part I.
- Ask one group to share their products with the whole.
**Task 5.6 ▶ SWOT Analysis**

- Use the following table to analyze the external opportunities and threats (challenges) facing your Polarus organization as it seeks to achieve its draft advocacy objective.
- Complete the analysis on this task sheet first, and if you have time, assign someone from your team to copy the analysis on a sheet of flipchart paper and hang it on the wall for others to see.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
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</table>

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Internal Factors | External Conditions
TASK 5.7 ■ POWERBROKERS IN SUNRISE STATE

In your Polarus groups, complete the following:

a. Who might be an ally, a soft supporter, a fence sitter, and an opponent of your advocacy strategy?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

b. List one way you could engage with each of these stakeholders.

___________________________________________________________________________
___________________________________________________________________________
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**TASK 5.8 • STAKEHOLDER ANALYSIS FOR SUNRISE STATE**

a) Choose the 6 most relevant stakeholders for the achievement of your advocacy objective and classify them into primary and secondary audiences. When you are done, write this information on a sheet of flipchart paper to share with other participants.

**Primary Audiences:**

1. 
2. 
3. 

**Secondary Audiences:**

4. 
5. 
6. 

b) Describe the 4 most important characteristics of the stakeholders in your primary and secondary audiences. Explain how these attributes could positively influence the achievement of your budget advocacy objective.

**Stakeholder 1**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Stakeholder 2**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Reading 5.5 ■ Powerbrokers in the Budget Process

- Some of the key stakeholders that exert influence over the budget process are the ministry of finance (or treasury), politicians, bilateral and multilateral donor agencies and international financial institutions (IFIs), the legislature (parliament), and the private sector. These stakeholders act as powerbrokers who shape budget decisions in more and less overt ways.

- The Ministry of Finance has power in the areas of fiscal policy, determining expenditure envelopes, arbitration, virement, roll-overs, and financial management. Its power is limited in that its ability to influence high-level decisions depends on its relationship with the president or prime minister. The Ministry of Finance’s power is also closely linked to the extent of its technical capacity.

- Politicians have power over executive decisions, including the formulation and the implementation of the budget. Their power is limited when policy goals have been made public, and they are under public scrutiny to follow through on their promises. The power of politicians in the executive is also ideally kept in check by financial management legislation and the relative power of the legislature and the Ministry of Finance.

- Bilateral and Multilateral Donors and International Financial Institutions (IFIs) exert power in the areas of fiscal policy, the size of expenditure envelopes, and financial management legislation. Their power is limited by the diversity of contesting donor agendas and also when there are clearly formulated public policy goals in place.

- The legislature (parliament) has power over the approval of budget and should have oversight over the implementation and audit stages of the budget. Its power is limited by the nature of the political system in which it functions, and the party rules that govern its relationship with the executive. Its ability to help shape the budget is also determined by whether or not it has formal amendment powers when it comes to the budget. The legislature’s power to exercise effective oversight over budget implementation also depends on the capacity and role of legislative committees in the budget process.

- The private sector typically exerts power in the areas of taxation and tax policy, the formulation of the budget, and in the procurement of government contracts. Their power is limited by a rule-based system that governs taxation and procurement.

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8 The process of shifting an expenditure from one budget line item to another during the budget year. To prevent misuse of funds, spending agencies must normally go through approved administrative procedures to obtain permission to make such a transfer.
FRIENDS, ALLIES, FENCE-SITTERS, AND OPPONENTS OF YOUR ADVOCACY

- **Allies** are those who support your work and are usually able to advocate on your behalf from within the government, the legislature, or another power base. Allies can sometimes be found in surprising places. It can be short-sighted to assume that everyone “on the other side of the fence” is an enemy.

- **Soft supporters** are those who are marginally on your side, but not in an overt, outspoken way. For various reasons, it may be difficult for them to openly support you. However, relationships with soft supporters can be crucial in providing you with access to both information and people that may otherwise be hard to come by. When soft supporters give you “inside information,” be sure not to jeopardize them by revealing your sources.

- **Fence-sitters** are those who are undecided about your advocacy objective and neither support nor undermine it very strongly. In the case of fence-sitters, it is a useful to identify why they do not support the solution or change that you are advocating for, so that you can determine how to convince them. Remember that a logical argument with compelling evidence is more likely to win them over than moral appeals and strong opinions.

- **Opponents** are those who are openly or even secretly against your advocacy position. They are often those who would stand to lose if the change you are proposing were to be implemented. One way to try and counteract the negative impact of opponents is to seek out support among your opponents’ friends and allies. Another strategy is to shift the focal point of your advocacy strategy away from their sphere of influence or decision-making, although this may not always be possible.

PRACTICAL STRATEGIES FOR ENGAGING WITH POWERBROKERS

- Develop and maintain long-term relationships
- Invite them to join an advisory group for one your projects
- Ask your own well-connected board members for help
- Connect with politicians through their constituencies
- Regular meetings and visits to their offices
- Maintain relationships after working on projects with government
- Host meetings (public or closed) to bridge the divide between civil society and government
- Invite them to present at your training events
READ 5.6 • STAKEHOLDER MAPPING AND OPPORTUNITY SCHEDULE

STAKEHOLDER ANALYSIS

- Our advocacy efforts don’t happen in a vacuum. They are defined by:
  - different stakeholders who will work for or against our initiative;
  - their position in the political and power environment; and
  - specific windows of opportunity.

- The stakeholders of our advocacy campaign are many, but can be classified into two overarching categories:
  - The primary audience, which comprises those persons who are actually responsible for, and have the power and capacity to, make our desired change happen.
  - The secondary audience, made up of those who can influence or put pressure on the primary audience, by raising the profile of the topic, demanding action, publicly shaming the government, or quietly speaking behind closed doors about the merits of your proposed change(s).

- To design a strategy that maximizes possibilities for collaboration and minimizes opposition to our advocacy objectives, we need to know:
  - Who our primary and secondary audiences are (in as much detail as possible);
  - What they want and what they actively oppose (i.e., who are friends, allies, fence-sitters, and opponents);
  - What power they have to affect our specific objective;
  - What opportunities for collaboration (or risks of conflict) exist with and among these audiences.

- It is fundamental to analyze primary and secondary audiences to gather a deep understanding of who is who in our advocacy environment. We need to identify, for each stakeholder:
  - Basic characteristics;
  - Party background, groups they belong to;
  - Likes and dislikes, friends and foes;
  - Specific interest in/knowledge about our advocacy objective;
  - The way they are affected by the issue that our advocacy objective tries to solve;
  - The way they will be affected by the changes that we propose or seek;
  - Their power and capacity to make that change (or parts of it) happen;
  - Their motivation/self-interest to contribute to it; and
  - The actions that we can develop to spur their interest.
POWER MAPPING

- While you’re conducting your advocacy campaign, the balance of power in the political landscape can change frequently. You need a tool to be able to assess these changes, as they will have an impact on your advocacy strategy and messages.

- Power mapping helps you to define strategies to:
  - build connections and coalitions among those who support your goals
  - identify uninvolved stakeholders that can be mobilized for your cause
  - neutralize or win over those who oppose your advocacy objective and the change it seeks to trigger

Example: Relationship Diagram

![Power Mapping: Relationship Diagram](image)

Notes:

- This mapping example is taken from Fundar’s advocacy work to get an earmarked budget line for HIV/AIDS in the 2008 Federal budget in Mexico.

- The shaded boxes represent ministries, the boxes with the solid lines represent legislative committees, the boxes with the dashed lines represent CSOs, and the ovals represent other stakeholders (political party and health institutes).

- The size of the stakeholder (i.e., their box or circle in the diagram) indicates their relative power to influence the advocacy issue, which is written in the center of the diagram: “Earmarked budget for HIV/AIDS in 2008.” Thus, the bigger the box or circle, the more powerful the stakeholder.

- The distance of the stakeholder from the advocacy issue (in the center) depicts the degree of support that the stakeholder has for the advocacy issue (e.g., the farther away from the center, the less support the stakeholder has).
Example: Power Mapping Matrix

### Power Mapping Matrix

<table>
<thead>
<tr>
<th>High support</th>
<th>Medium support</th>
<th>Low support</th>
<th>Neutral/Unmobilized</th>
<th>Low opposition</th>
<th>Medium opposition</th>
<th>High opposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS program</td>
<td>Ministry of Health</td>
<td>Federal Institute for Access to Information</td>
<td></td>
<td>Budget Committee</td>
<td>Conservative Party</td>
<td></td>
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<tr>
<td>HIV/AIDS CSOs</td>
<td>Gender Committee</td>
<td></td>
<td>Health Committee</td>
<td></td>
<td>Ministry of Finance</td>
<td></td>
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</table>


**Helps us to define:**
- Degrees of **support and opposition** (column headings)
- Degrees of **power** (intensity of color; i.e., the darker, the more powerful)
- **Shifts in alignments and positions** (arrows; i.e., how the stakeholder’s position needs to be moved in to order to achieve the objective)

Adapted from: R. Ador (2005), *Doing Health Policy Advocacy at the Local Level: A Manual for Trainers*, MSH/LEAD Project, Manila, p. 49. (Note: This mapping example is also taken from Fundar’s advocacy work to get an earmarked budget line for HIV/AIDS in Mexico’s 2008 Federal budget.)
This matrix helps you to define:

- Degrees of support and opposition for the advocacy objective (column headings). Stakeholders are positioned according to the degree of their support or opposition to the advocacy objective.
- Degrees of power with regard to the advocacy objective (intensity of colors) – e.g., the darker the color, the more powerful.
- Shifts in alignments and positions (arrows) – the arrows indicate how the stakeholders’ positions need to be moved in order to achieve the advocacy objective.

**OPPORTUNITY SCHEDULE**

- There are many advocacy opportunities, in addition to the different stages in aid cycles and the budget process:
  - **International Days**
    - World AIDS Day
    - International Human Rights Day
    - International Women’s Day
    - Others?
  - **National Events**
    - Presidential Address to the Nation
    - National Human Rights Day
    - Launches of Government Reports (e.g., MDG or PRSP progress report)
    - Others?
  - **International Conferences** (hosted by your country or in which your country will participate)
    - International AIDS Conference
    - Others?

- Organize your schedule to be prepared when the right moment to act arrives.
- Be well aware of the political environment and budget and aid cycles, so as to be two steps ahead in your preparations.
- Take advantage of special events that can help to profile your advocacy campaign.
- Use every opportunity you have to highlight your advocacy objective: *This means your evidence must be credible, your message must be clear, and you must be ready to jump at opportunities!*
MODULE 7
BUDGET ANALYSIS
## MODULE 7 ■ BUDGET ANALYSIS

### SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration</th>
<th>8 hours, 55 minutes</th>
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<tbody>
<tr>
<td><strong>Timing of this module</strong></td>
<td>This module corresponds with the following sessions in the <em>Health &amp; Budgets Training Workshop Agenda:</em></td>
</tr>
<tr>
<td></td>
<td>• Part of SESSION 4 on Day 4;</td>
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<tr>
<td></td>
<td>• Part of SESSION 1 on Day 5;</td>
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<td>• SESSIONS 2-4 on Day 5;</td>
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<td>• SESSION 1 on Day 6; and</td>
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<td>• Part of SESSION 2 on Day 6.</td>
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<td>(Note that one session is 1 hour, 45 minutes.)</td>
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<tr>
<td><strong>Resources needed</strong></td>
<td>Laptop for each of the participants</td>
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<td>Pads of flipchart paper</td>
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<td>Post-It notes</td>
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<td>An everyday item that you buy in a store, e.g., a can of Coke</td>
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<td>Chocolates, sweets, or other small prizes</td>
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<td>PowerPoint presentations:</td>
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<td>➢ MODULE 7 – Introduction</td>
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<td>➢ MODULE 7 – From Analysis Back to Advocacy</td>
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<td>In the Participants’ Workbook:</td>
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<tr>
<td></td>
<td>➢ TASK 7.1 ■ Calculating Cost Per Unit</td>
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<td>➢ TASK 7.2 ■ Comparing Budgeted and Actual Expenditure</td>
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<td>➢ TASK 7.3 ■ Calculating Budget Shares</td>
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<td>➢ TASK 7.5 ■ Calculating Budget Growth</td>
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<td>➢ TASK 7.6 ■ Calculating <em>Per Capita</em> Allocations</td>
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<td>➢ TASK 7.7 ■ Diagnosing the Budget Problem</td>
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<tr>
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<td>➢ TASK 7.8 ■ Which Calculation and Chart to Use?</td>
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<td>➢ READING 7.1 ■ How to Create Charts and Graphs in Excel</td>
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<td>➢ READING 7.2 ■ Ratios and the Composition of a Budget</td>
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<td>➢ READING 7.3 ■ Inflation</td>
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<tr>
<td></td>
<td>➢ READING 7.4 ■ Measuring Budget Changes Over Time</td>
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<tr>
<td></td>
<td>➢ READING 7.5 ■ <em>Per Capita</em> Calculations</td>
</tr>
</tbody>
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LEARNING OUTCOMES TO BE ACHIEVED

By the end of Module 7, participants will have:

- Identified which calculations to undertake to investigate a range of suspected budget problems;
- Calculated cost per unit;
- Calculated over-expenditures and the amount of goods and services that could have been secured with efficient spending;
- Determined rates of under-spending;
- Recognized why they need to adjust budget amounts for inflation;
- Adjusted budget amounts for inflation;
- Measured changes in spending over time;
- Calculated per capita expenditure;
- Presented the findings of budget analysis using charts and graphs; and
- Linked budget analysis findings back to an advocacy objective.

STRUCTURE OF THE MODULE

The following hypotheses will be examined and tested during the course of Module 7. (The time allocations below are rough estimates.)

Introduction to Budget Calculations

1. Overview of the Module 15 minutes

Investigation of Hypotheses/Budget Calculations (7 hours, 35 min.)

2. Hypothesis 1 – Primary Health Clinics (PHCs) in Peri-Urban Areas of Mortalia Are Wasting Money 1 hour, 20 min.
3. Hypothesis 2 – Peri-Urban PHCs in Mortalia are Underspending 1 hour, 20 min.
4. Hypothesis 3 – Peri-Urban PHCs in Mortalia are Underfunded 2 hours, 55 min.
5. Hypothesis 4 – The Funds that District Services Provides to Peri-Urban PHCs in Mortalia Fall Short of the Per Capita Primary Health Care Spending Standard Set by the Polarus Ministry of Health 2 hours

From Budget Analysis Back to Advocacy (1 hour, 5 min.)

6. Quick Recap 5 minutes
7. Task 7.7 ■ Diagnosing the Budget Problem 15 minutes
8. Facilitator Input: Using Charts and Graphs 15 minutes
9. Task 7.8 ■ Which Calculation and Graph or Chart to Use? 30 minutes
INTRODUCTION TO BUDGET CALCULATIONS

Duration of session: 15 minutes

<table>
<thead>
<tr>
<th>STRUCTURE OF THE SESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overview of the Module</td>
</tr>
</tbody>
</table>

1. OVERVIEW OF THE MODULE  

- This introduction is supported by PPT file MODULE 7 Introduction.
- Introduce the module by reminding participants why analyzing the budget is the next logical step in the process of developing a budget advocacy strategy.
- First, review briefly how Module 6 (with its focus on understanding health policy and the budget process) has helped the participants gain a deeper and more substantial insight into the health situation in Sunrise State. For example, ask participants how the knowledge gained in Module 6 has helped them to:
  - make their advocacy objective more specific;
  - identify possible primary audiences for their advocacy message;
  - identify possible opponents and allies; and
  - begin to understand where in the budget process the problem and possible solution lies?
- By the end of Module 6, however, participants still did not have certainty about which possible problem was the main cause of poor primary health care services in peri-urban areas of Mortalia in Sunrise State. This is where budget analysis comes in.
- Spend a few minutes explaining how Module 7 will be structured. Participants will be asked to propose hypotheses as to why health care service in the peri-urban areas of Mortalia are so lacking. Their focus should specifically be on the budget; i.e., what budget shortcomings might be contributing to the poor health care service provision in the peri-urban areas.
- Remind participants of the suggested “bottom up” approach set out in the previous module. As they think about hypotheses, start at the clinic level and move up from there.
- In this module participants will be exposed to a series of budget calculation tools to address the most typical budget-related problems. It will not be possible to explore all hypotheses or all calculations.
- Once they have done a series of calculations associated with specific hypotheses, they will be asked to decide which hypotheses seem to have the strongest evidence supporting them, what they believe the principal budget problems are and where they should direct their advocacy.
Ask participants to brainstorm in their Polarus CSO groups about potential budget problems leading to poor health care services in Mortalia, going no higher up the chain than the State level. After 10 minutes, ask each group to share their top two hypotheses. They should write these down on Post-its, and put them on a flip chart at the front of the room.

Discuss the hypotheses offered by the participants. Hopefully, at least some, if not all, will more or less align with the hypotheses that will be addressed in this module. If there are hypotheses that make little sense in light of existing information, talk this through. If participants propose hypotheses that make sense, but will not be followed, explain that not all potentially valid hypotheses can be pursued. Stress, however, that it is essential in doing budget work to start with hypotheses such as these that postulate a relationship between a development problem of concern and the government’s budget. In the absence of a hypothesis, it isn’t possible to choose the approach to take in analyzing the budget—because it isn’t feasible or desirable for a CSO to do all possible analyses of a budget in the vague hope of identifying something inappropriate.

Use Slide 2 to present the four hypotheses that will be addressed in the rest of the module. They will be addressed in the order presented, which is from bottom up. Explain that these hypotheses address the most common budget-related problems—waste, under-spending and under-funding. Working on them will also allow participants an opportunity to practice using important budget analysis tools. Although the focus will be at the level of PHCs and go no higher than the State level, the same problems arise at other levels of government and the same calculations would be useful.

Over the next few sessions, participants will test these hypotheses until they have built up a compelling argument about the health problem and how to solve it. At the same time, they will be gathering evidence to back up their advocacy strategy.

The process for investigating each hypothesis will be the same. In each case, the facilitator will lead the participants through the following steps:

1. Unpacking the problem
2. Suggesting which calculations would be helpful to test the hypothesis
3. Doing the calculations
4. Articulating the findings in budget terms and in human rights terms
5. Establishing who is responsible for the problem
6. Establishing how and when it could be fixed
7. Deciding how best to illustrate/present the findings

These generic seven steps of investigation are set out on Slide 3.
• Invite questions of clarification and spend a few minutes explaining anything that participants
don’t understand that might serve as a barrier to learning. However, the investigation of the
hypotheses is probably only likely to make sense to the participants as they start working on it.
Thus, limit the discussion here to clarifying critical concepts or process points.
INVESTIGATION OF HYPOTHESES/BUDGET CALCULATIONS

*Duration: 7 hours, 35 minutes*

The budget calculations begin after the Introduction to the Module and identification of hypotheses that will be addressed. During these calculation sessions participants will put each hypothesis to the test by analyzing the relevant budget figures from Polarus. Within their roles as civil society members in Polarus, their primary task throughout the investigation is to determine which of the hypothesis (or hypotheses) is the main cause(s) of poor primary health care services in the peri-urban communities of Mortalia.

**GENERAL GUIDELINES FOR FACILITATING BUDGET CALCULATIONS**

Please note the following general facilitation notes for this part of the module:

- This manual does not provide exact time guidelines for all of the inputs and tasks involved the investigation of each hypothesis.
- Some of the hypotheses will take longer to investigate than others. Hypothesis 3 is particularly intensive and involves the introduction and practicing of a few different calculations.
- It will be up to the facilitator to keep an eye on progress and overall time use and ensure that sufficient progress is being made across the seven sessions.
- To test some of the hypotheses, certain prior calculations are assumed. When that occurs, be sure that participants bring in the results of the prior calculations.
HYPOTHESIS 1
PRIMARY HEALTH CLINICS IN PERI-URBAN AREAS OF MORTALIA ARE WASTING MONEY

Duration of session: 1 hour, 20 minutes

Note: Use the slides in the PPT file MODULE 7: Hypothesis 1 to facilitate the investigation of this hypothesis.

- The assumption here is that if the primary health clinics in the peri-urban areas of Mortalia were using their money more efficiently, more and better health care services could be made available (and the government would be better complying with its obligation to use the maximum of available resources to realize the right to health).

- The health services problem extends to all the peri-urban communities. However, SeDeN does not have the capacity to do extensive research that would include all of the PHCs in those communities. It thus decides to focus on a representative sample of three PHCs.

- Because one of the problems facing health care services is shortage of medicine, SeDeN decided to investigate the costs of key medicines purchased by those PHCs.

- The first calculation here is with regard to unit cost, specifically the unit costs of medicines purchased by the PHCs in Aljana, Corcora, and Sorulia. Important: At the end of this calculation, before getting into the second calculation the facilitator introduces new information—the result of research done by SeDeN to identify the lowest retail price of the three medicines in the Mortalia area.

- The second calculation looks at how much more the clinics paid for medicines than they needed to.

- The third calculation looks at how much more medicine each clinic could have bought had they paid the lowest price possible.

Notes on calculations (Slide 3):

- Unit costs can be defined more or less narrowly. In this example participants will be focusing narrowly. In other situations, for example, where the unit costs are those associated with the provision of beds in hospitals, more than the cost of simply the beds might be included. Included could be administrative costs, salaries of doctors, etc., because these are necessary to maintain the availability of beds for patients needing them.

- When calculating unit costs, it is important to use actual rather than budgeted expenditure, because the unit cost calculation tries to measure how government actually performs, not how it plans to perform.
The formula for unit costs is as follows:

\[
\text{Unit cost} = \frac{\text{Total expenditure}}{\text{Number of units delivered}}
\]

- First illustrate the calculation for one of the drugs (Amoxicillin) in one of the clinics:
  \[D 3,350 / 1,000 \text{ boxes} = D 3.35/\text{box}\]
- Explain that this unit cost is only useful information if you have something to compare it to.

**ANSWERS TO TASK 7.1: CALCULATING COST PER UNIT**

1. **Ask participants to calculate the unit cost for each drug in each peri-urban clinic.** This is Task 7.1 ■ Calculating Cost Per Unit in their Workbooks.

   - The correct calculations for Question 1 in Task 7.1 are:

     **Aljana:**
     - Amoxicillin: \[D 3,350/1,000 \text{ boxes} = D 3.35/\text{box}\]
     - Folic Acid: \[D 2,189/1,100 \text{ boxes} = D 1.99/\text{box}\]
     - Paracetamol: \[D 2,025/1,350 \text{ boxes} = D 1.50/\text{box}\]

     **Corcora:**
     - Amoxicillin: \[D 3,468/950 \text{ boxes} = D 3.65/\text{box}\]
     - Folic Acid: \[D 1,890/900 \text{ boxes} = D 2.10/\text{box}\]
     - Paracetamol: \[D 1,595/1,100 \text{ boxes} = D 1.45/\text{box}\]

     **Sorulia:**
     - Amoxicillin: \[D 4,140/1,150 \text{ boxes} = D 3.60/\text{box}\]
     - Folic Acid: \[D 2,708/1,220 \text{ boxes} = D 2.22/\text{box}\]
     - Paracetamol: \[D 2,320/1,450 \text{ boxes} = D 1.60/\text{box}\]

   - With regard to their findings, from these calculations it appears that the PHC in the Aljana community did a better job of procuring drugs than the PHCs in the other two peri-urban communities did.

   - Ask participants: What else might we compare these costs to? It would be possible to compare them to the costs in other PHCs, but SeDeN does not have that information. The information it can more easily get is the retail costs in pharmacies (even though PHCs should be able to get the same drugs at a lower cost, because they are buying in bulk).
2. **How much more did the clinics pay per unit than they needed to?** (Slide 5) The formula for calculating unit over-expense in this case would be:

\[
\text{Over-expense per unit} = \frac{\text{Invoice unit price} - \text{best retail unit price}}{\text{Best retail unit price}} \times 100
\]

- Have participants calculate the percentages for each drug for each PHC. The answers for calculations in section 2 in TASK 7.1 are:
  - **Aljana:**
    - Amoxicillin: \(\frac{3.35 - 2.99}{2.99} \times 100 = 12\%\)
    - Folic Acid: \(\frac{1.99 - 1.55}{1.55} \times 100 = 28.4\%\)
    - Paracetamol: \(\frac{1.50 - 1.39}{1.39} \times 100 = 7.9\%\)
  - **Corcora:**
    - Amoxicillin: \(\frac{3.65 - 2.99}{2.99} \times 100 = 22.1\%\)
    - Folic Acid: \(\frac{2.10 - 1.55}{1.55} \times 100 = 35.5\%\)
    - Paracetamol: \(\frac{1.45 - 1.39}{1.39} \times 100 = 4.3\%\)
  - **Sorulia:**
    - Amoxicillin: \(\frac{3.60 - 2.99}{2.99} \times 100 = 20.4\%\)
    - Folic Acid: \(\frac{2.22 - 1.55}{1.55} \times 100 = 43.2\%\)
    - Paracetamol: \(\frac{1.60 - 1.39}{1.39} \times 100 = 15.1\%\)

3. **How much more of each medicine would each PHC been able to buy had they bought at this best retail price?** (Slide 6)

- Explain the reasoning underlying the following formula to participants and have them do the calculation for each PHC for each drug according to the following formula:

\[
\text{Possible extra quantity of medicine} = \frac{\text{Total on invoice}}{\text{Retail unit price}} - \text{Invoice quantity}
\]
The correct calculations for section 3 in Task 7.1 are:

**Aljana:**
- Amoxicillin: \((3,350/2.99) - 1,000 = 1,120 - 1,000 = 120\) boxes
- Folic Acid: \((2,189/1.55) - 1,100 = 1,412 - 1,100 = 312\) boxes
- Paracetamol: \((2,025/1.39) - 1,350 = 1,456 - 1,350 = 106\) boxes

**Corcora:**
- Amoxicillin: \((3,468/2.99) - 950 = 1,159 - 950 = 209\) boxes
- Folic Acid: \((1,890/1.55) - 900 = 1,219 - 900 = 319\) boxes
- Paracetamol: \((1,595/1.39) - 1,100 = 1,147 - 1,100 = 47\) boxes

**Sorulia:**
- Amoxicillin: \((4,140/2.99) - 1,150 = 1,384 - 1,150 = 234\) boxes
- Folic Acid: \((2,708/1.55) - 1,220 = 1,747 - 1,220 = 527\) boxes
- Paracetamol: \((2,320/1.39) - 1,450 = 1,669 - 1,450 = 219\) boxes

Point out to participants that providing information on the medicines that *could have been* purchased had the best prices been used is a good advocacy tool, because it concretizes for the audiences what the over-expenditures mean in terms can they understand.

**Questions 4 & 5: What conclusions can you draw from your calculations?**

- Ask participants what conclusions they can draw in budget terms from their calculations. Their answers for Question 4 in Task 7.1 should include:
  - The three Mortalia peri-urban PHCs are wasting resources.
  - They are paying more for the three medicines identified in the invoices than they need to.
  - They would be able to buy significantly more medicines for the same amount of money if they were more efficient in their use of funds. Alternatively, of course, if they did not need the additional medicines, they could direct the saved funds to other areas of their program that are in need of funds.

- Ask participants how they would articulate their conclusions in human rights terms. Their answers for Question 5 in Task 7.1 should be generally along the following lines:
  - The government’s obligation to use the maximum of available resources (MAR) to realize the right to health means that the government must use funds directed to health efficiently. The three peri-urban PHCs researched are not doing so. At a minimum the government is failing to meet its MAR obligations by failing to ensure that these PHCs are spending their funds for drugs as efficiently as possible.
The only conclusion that SeDeN can draw about wasteful expenditures is with regard to the three PHCs researched. However, the findings are striking and the government should be asked to ensure at a minimum that the other peri-urban clinics are using their funds for medicines efficiently.

Illustrating the findings (Slides 9-10):

- It is possible simply to discuss with participants the kinds of charts that could be used in this instance to illustrate the findings.
- It would also be possible to spend some more time looking at bar charts in more detail (Slide 10) and showing participants how to create bar charts in Excel.
- The guidelines also appear in the Participant’s Workbooks in READING 7.1 ■ HOW TO CREATE CHARTS AND GRAPHS IN EXCEL.
**Task 7.1 □ Calculating Cost per Unit**

To work out the unit cost, you divide the total expenditure by the number of deliverables. This equals what the program paid **on average** for each thing that it delivered.

**Delivery Unit** = What a program delivers or buys (for example, hospital beds, drugs, clinics, school desks, buses, etc.)

**Cost** = What was paid for it.

The formula is:

\[
\text{Unit cost} = \frac{\text{Total expenditure}}{\text{Number of units delivered}}
\]

1. **Now work out the unit cost of each of the drugs purchased by each of the three peri-urban PHCs SeDeN looked at in Mortalia.**

   First, identify:

   a) How much was spent by Aljana PHC on
      Amoxicillin? ________________
      Folic Acid? ________________
      Paracetamol? ________________

   How much was spent by Corcora PHC on
   Amoxicillin? ________________
   Folic Acid? ________________
   Paracetamol? ________________

   How much was spent by Sorulia PHC on
   Amoxicillin? ________________
   Folic Acid? ________________
   Paracetamol? ________________

   b) How many boxes of each drug did Aljana PHC purchase?
      Amoxicillin ________________
      Folic Acid ________________
      Paracetamol ________________

   How many boxes of each drug did Corcora PHC purchase?
   Amoxicillin ________________
   Folic Acid ________________
   Paracetamol ________________
How many boxes of each drug did Sorulia PHC purchase?

Amoxicillin ________________
Folic Acid ________________
Paracetamol ________________

You now have all the figures you need to do the calculation. What are your findings? What was the unit cost of each drug for each of the PHCs? Record your findings here:

<table>
<thead>
<tr>
<th>COST PER UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>ALJANA</td>
</tr>
<tr>
<td>AMOXICILLIN</td>
</tr>
<tr>
<td>FOLIC ACID</td>
</tr>
<tr>
<td>PARACETAMOL</td>
</tr>
</tbody>
</table>

2. **How much more did the clinics pay per unit than they needed to?** The formula for in this case would be:

\[
\text{Over-expenditure per unit} = \frac{\text{Invoice unit price} - \text{best retail unit price}}{\text{Best retail unit price}} \times 100
\]

a) The best unit prices that SeDeN was able to identify were:
   - Amoxicillin: D 2.99
   - Folic Acid: D 1.55
   - Paracetamol: D 1.39

b) You just calculated the unit price for each of the drugs in each of the PHCs.

c) Using the formula provided, what are your findings?
### OVER-EXPENDITURE PER UNIT

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Aljana</th>
<th>Corcora</th>
<th>Sorulia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Folic Acid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracetamol</td>
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<td></td>
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</tr>
</tbody>
</table>

3. **How much more of each medicine would each PHC been able to buy had they bought at this best retail price?**  

Here is the formula for determining the amount of additional drugs the PHCs would have been able to buy:

\[
\text{Possible extra quantity of medicine} = \frac{\text{Total on invoice}}{\text{Retail unit price}} - \text{Invoice quantity}
\]

a) What was the total amount paid by each of the PHCs for each of the three drugs?

- **Aljana**
  - Amoxicillin
  - Folic Acid
  - Paracetamol

- **Corcora**
  - Amoxicillin
  - Folic Acid
  - Paracetamol

- **Sorulina**
  - Amoxicillin
  - Folic Acid
  - Paracetamol
b) What was the invoice quantity for each of the drugs in each of the PHCs?

Aljana

- Amoxicillin __________
- Folic Acid __________
- Paracetamol __________

Corcora

- Amoxicillin __________
- Folic Acid __________
- Paracetamol __________

Sorulia

- Amoxicillin __________
- Folic Acid __________
- Paracetamol __________

c) You now have all the information you need to calculate how much more of each drug the PHCs would have been able to buy had they bought at the retail prices SeDeN identified.

<table>
<thead>
<tr>
<th>POSSIBLE ADDITIONAL DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>AMOXICILLIN</td>
</tr>
<tr>
<td>FOLIC ACID</td>
</tr>
<tr>
<td>PARACETAMOL</td>
</tr>
</tbody>
</table>

4. What conclusions can you draw in budget terms about wastage by PHCs in the peri-urban communities of Mortalia?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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5. What conclusions can you draw in human rights terms about wastage by PHCs in the peri-urban communities of Mortalia?
READING 7.1 ■ HOW TO CREATE CHARTS AND GRAPHS IN EXCEL

CREATING A BAR CHART IN EXCEL

1. Create a simple table in the spread sheet with two or more columns.
2. The information you want at the bottom of the graph (the “X” axis) should be in the first column, while the associated data should go in the other column or columns.
3. Highlight the data in the spread sheet. Be sure to include the column headings for the data.
4. Using the Chart Wizard, choose a “Column” graph in the Standard Types tab, then highlight the first sub-type, “Clustered Column”. Click on “Next.”
5. Using the Series tab, make sure that the chart looks roughly as you would like it to. You can change any of the data areas you are using by clicking on the little red arrows next to the Name, Values, or Category (X) axis label entries. Click “Next”.
6. In the next step, enter the title of the graph, and name the X and Y axis if appropriate. (Recall that the X axis is the horizontal axis, while Y is the vertical axis.)
7. Use the Legend tab to select and format a legend for your chart if you need one, or de-select “Show legend” to make it disappear. Click “Next”, then “Finish”.
8. The final step is to format the chart.

CREATING A PIE CHART IN EXCEL

1. Create a simple table in the spread sheet with two columns, one for the category, the other for the budget figure.
2. Highlight the data in those two columns, both the budget category and the amount.
3. Click on the “Chart Wizard” icon in the standard toolbar.
4. Under Chart type, select “Pie”, then select a sub-type and click “Next.” The chart here uses a 3-D chart just to make it look somewhat more interesting to look at.
5. The program gives you the option of changing the data range for the pie chart. If you have already chosen the right cells, click “Next.”
6. Add a title, place the legend where you want it, and identify the data labels you want to use, and click “Next.” In this case, because the category name (along with the percentage value) is indicated next to each slice, there is no legend shown.
7. To display the pie chart in the Excel spread sheet you are working in, click “Finish.”
Finally, the last steps are to format the pie chart in whatever way you would like; you start this process by right clicking anywhere in the graph.

**Creating a Line Graph in Excel**

1. Create a simple table in the spread sheet with two columns.

2. The information you want at the bottom of the graph (the “X” axis) should be in the first column, while the related data should go in the other column or columns.

3. Highlight the data in the spread sheet you want to illustrate. Make sure you include the column headings for the data.

4. Using the Chart Wizard, indicate you want to draw a “Line” graph in the Standard Types tab, then highlight the first sub-type, “Simple Line”. Click on “Next.”.

5. Using the Series tab, make sure that the chart looks roughly as you would like it to. You can change any of the data areas you are using by clicking on the little red arrows next to the Name, Values, or Category (X) axis label entries. Click Next.

6. In the next step, enter the title of the graph, and name the X and Y axis, if appropriate. (Remember that the X axis is the horizontal axis, while Y is the vertical axis.)

7. In the Legend tab, you can place the legend — the part of the graph that identifies the various columns wherever you would like in the chart, or make it disappear if it is not needed. Click Next, then Finish.

9. Again, as with the pie chart, the final steps are to format the chart to make it look attractive.
HYPOTHESIS 2
PERI-URBAN PRIMARY HEALTH CLINICS IN MORTALIA ARE UNDER-SPENDING

Duration of session: 1 hour, 20 minutes

Note: Use the slides in the PPT file MODULE 7: Hypothesis 2 to facilitate the investigation of this hypothesis.

Why is under-spending a problem? (Slide 2)
- Indicates lack of capacity in a program or department.
- If a department is not spending its available funds, those funds are not being put to good use. In addition, no one else can use them either, at least not until the next financial year.

Actual and budgeted expenditure
- One way to assess under-spending is by calculating the “rate” of spending; that is, the percentage of the budgeted amount (the “allocation”) that was actually spent.
- Allocation: What the government projects at the beginning of the financial year that it will spend during the year for an MDA or program. Sometime this is titled “Budget” or “Budgeted” in an MDA or program budget. Some countries adjust these budgeted figures midway through the year and call the result “Adjusted Estimates.”
- Actual expenditure: What MDAs and programs really end up spending. Actual expenditures may be presented in a financial report before they are audited. Expenditures that have been audited are often titled “Audited Expenditures.”

Calculating the rate of spending (Slides 3 and 4)
- To calculate an MDA’s or program’s rate of spending, divide actual expenditure by the budget or allocation, and multiply the result by 100 to express the rate as a percentage:

\[
\text{Rate of spending} = \frac{\text{Actual expenditure}}{\text{Allocation or budget}} \times 100
\]

- The example on Slide 4 is the rate of spending for Salaries at the Aljana PHC in 2008. Applying the formula:
  Rate of spending = \((217,543/219,652) \times 100\), which comes to 99.0\%
This means that the Aljana PHC managed to spend 99% of its Salaries budget. In other word, almost the whole budget or allocation.

Now ask participants to try this calculation themselves by determining the rate of spending on Salaries, Goods and Services, Medicines, Medical Equipment as the total budget for each PHC that is the subject of SeDeN’s research for 2008, 2009, and 2010. This is Task 7.2 ■ Comparing Budgeted and Actual Expenditure in their Workbooks.

**ANSWERS TO TASK 7.2: COMPARING BUDGETED AND ACTUAL EXPENDITURE**

**Question 1:**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aljana PHC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>98.1%</td>
<td>99.1%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>91.6%</td>
<td>90.8%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Medicines</td>
<td>93.9%</td>
<td>90.7%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Payments for Capital Assets</td>
<td></td>
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<tr>
<td>Medical Equipment</td>
<td>91.3%</td>
<td>86.4%</td>
<td>90.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>95.7%</td>
<td>95.5%</td>
<td>95.3%</td>
</tr>
<tr>
<td><strong>Corcora PHC</strong></td>
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<td></td>
</tr>
<tr>
<td>Current Payments</td>
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<td></td>
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<td>Medical Equipment</td>
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<td>100.2%</td>
<td>100.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>97.5%</td>
<td>93.7%</td>
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<tr>
<td><strong>Sorulia PHC</strong></td>
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<td>109.4%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>
Payments for Capital Assets

<table>
<thead>
<tr>
<th></th>
<th>102.1%</th>
<th>99.8%</th>
<th>94.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.6%</td>
<td>99.2%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

Question 2:

- **Ask participants what they see in their findings in budget terms.** Their answers should include the following:
  - There is a consistent under-spending in medicines in both Aljana and Corcora PHCs.
  - Almost all of the Salaries budget is spent in all the PHCs.
  - Medical equipment is consistently under-spent in Aljana, but not in the other two PHCs.
- **Ask participants what could explain the under-spending in medicines in Aljana and Corcora.** Possible answers include: poor financial management, late disbursements, and flaws in the procurement process.
- **Highlight for participants that under- and over-spending comparisons are interesting, because they help indicate the nature of the under- or over-spending problem and where it is located (e.g., in a specific program or department-wide).**
- **An important question that therefore needs to be answered from an advocacy point of view is:** *If the peri-urban PHCs were given more funding, what would it likely be spent on?*
- **Corcora and Aljana PHCs regularly under-spend.** If they were to spend their full budgets for medicines, there would be more medications available. That, however, does not mean that the funds would be spent in an efficient manner. Which should come first: more funding or more efficient funding?

Question 3:

- **Ask participants what their findings mean in human rights terms.** Answer: The PHCs regularly underspend on medicines. The right to health guarantees access to appropriate medicines. Because Aljana and Corcora PHCs regularly fail to fully spend their budgets on medicines, and the government appears not to be pressuring them to improve the situation, it appears that they are failing to comply with their obligation to use the maximum of available resources to realize the right to health.

Illustrating the findings (Slide 7)

- **Ask participants what type of graph would be most effective for illustrating the rate of expenditure.** Answer: Bar charts are very useful for showing quite clearly where spending falls
short of allocations. It would also be possible to use line graphs, where one line is the allocation, the other the expenditure.

- The guidelines also appear in the Participant’s Workbooks in **Reading 7.1 • How to Create Charts and Graphs in Excel**.
**TASK 7.2 ■ COMPARING BUDGETED AND ACTUAL EXPENDITURE**

One way to assess under-spending is by calculating the “rate” of spending; that is, the percentage of the budgeted amount (the “allocation”) that was actually spent.

- **Allocation:** What the government projects at the beginning of the financial year that it will spend during the year for an MDA or program. Sometimes this is titled “Budget” or “Budgeted” in an MDA or program budget. Some countries adjust these budgeted figures midway through the year and call the result “Adjusted Estimates.”

- **Actual expenditure:** What MDAs and programs really end up spending. Actual expenditures may be presented in a financial report before they are audited. Expenditures that have been audited are often titled “Audited Expenditures.”

- The formula used to calculate an MDA’s or program’s rate of spending (which is expressed as a percentage) is as follows:

  \[
  \text{Rate of spending} = \frac{\text{Actual expenditure}}{\text{Allocation or budget}} \times 100
  \]

1. Calculate the rate of spending on Salaries, Medicines, Medical Equipment, and the Total Budget for the three peri-urban PHCs in Mortalia.

<table>
<thead>
<tr>
<th>Aljana PHC</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Salaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Payments for Capital Assets

| Medical Equipment |      |      |      |

### Total

<table>
<thead>
<tr>
<th>Sorulia PHC</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Payments for Capital Assets

| Medical Equipment |      |      |      |

### Total

2. What conclusions can you draw in budget terms about underspending by PHCs in the peri-urban communities in Mortalia?

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
3. What conclusions can you draw in human rights terms about underspending by PHCs in the peri-urban communities in Mortalia?
HYPOTHESIS 3
THE PERI-URBAN PRIMARY HEALTH CLINICS IN MORTALIA ARE UNDERFUNDED

Duration of session: 2 hours, 55 minutes

Note: Use the slides in the PPT file MODULE 7: Hypothesis 3 to facilitate the investigation of this hypothesis.

- One possible hypothesis about what causes inadequate health care services through, for example, a shortage of doctors and medicines in peri-urban PHCs in Mortalia is that those PHCs are underfunded. Underfunded means a program, department, ministry, or state does not receive enough funds to fulfill its duties or functions. These next parts of the program look at certain skills that are useful in testing this hypothesis.

- Explain to participants that in real world terms, it would probably not be viable to move to testing this hypothesis, when the previous calculations demonstrated under-spending by the peri-urban PHCs. In other words, it would politically be quite difficult to persuade the District Services to give more money to the peri-urban clinics when the latter are not spending all that they are already given. However, due to constraints of time, this course cannot pursue all findings to their logical conclusion, as the purpose of the course is to ensure that participants become familiar with the basics about governments' budgets and fundamental budget calculations. Doing both in a limited period of time requires the course to move quickly past points an organization should not move past in its own work.

- There are a few different ways to analyze the budget to test hypothesis 3 that would provide potentially useful information to test the hypothesis. However, to ensure that participants have some familiarity with certain fundamental budget calculations, there is not time to pursue all possible approaches. Testing hypothesis 3 will introduce participants to three such calculations:
  - Calculating shares of the budget
  - Adjusting budget figures for inflation
  - Measuring changes in the budget over time

- Determining which calculation to use to test given hypotheses generally involves a logical thinking process. Ask participants how they might test hypothesis 3. Discuss the appropriateness of the suggestions made. If no one suggests calculating what share of the overall PHC budget the peri-urban clinics get, the facilitator can make this suggestion.

- If certain approaches suggested by participants are valid, but will not be pursued in the workshop, this is the point at which to explain that time is limited in the workshop, and it will not be possible
to exhaust all realistic possibilities—although when an organization is working on a case, it should do that.

**CALCULATING BUDGET SHARES (Slides 3-4)**

- If participants have not already articulated it, explain that the purpose of calculating budget shares is to determine if the peri-urban PHCs are receiving a “fair” share of the PHC budget. The starting point for assessing “fair” would be comparing their share to the average received by PHCs in Mortalia. Explain that even with that starting point, it would likely, in reality, be necessary to ask further questions and do further calculations, because, for example, the needs of residents in peri-urban areas may be higher, or more people use the PHCs there than do people in wealthier neighborhoods who might go to private clinics.
- The formula for working out the share a particular MDA or program gets in an overall budget (as a percentage of the overall budget) is:

  \[
  \text{Share of the budget} = \frac{\text{Section of the budget}}{\text{Whole budget}} \times 100
  \]

- Remind participants that in this exercise they will be looking at what was budgeted for the PHCs, not what the PHCs spent.

- At this point, have participants refer to **Task 7.3: Calculating Budget Shares** in their Workbooks.
- Explain that to see how a PHC clinic fares compared to the average to PHCs, it will be necessary to determine the share the average PHC receives, and then the share the PHC of interest receives.
- Ask how they would determine the average share allocation for each PHC in 2008. (Answer: they would divide the total budgeted for PHCs by the number of PHCs.)

**ANSWERS TO TASK 7.3: CALCULATING BUDGET SHARES**

**Question 1:**

- First find out the total budget for PHCs in Mortalia in 2008. This information is found in Tab 3: PHC Program Budgets in the Master Data Sheet. **Answer: D 68,286,467**
- Then find out the total number of PHCs in Mortalia in 2008. This information is found in Tab 7: Sunrise # of PHCs in the Master Data Sheet. **Answer: 126**
- Ask them to do that calculation. Their answer should be: **D 68,286,467/126 = D 541,956.** This figure represents the average budget of a PHC in Mortalia.
Once participants have that average, turn to calculating the Share of the Budget.

Now ask them to calculate what share of the total Mortalia PHC budget did the average PHC in Mortalia receive in 2008. **Answer: 541,956/68,286,467 * 100 = 0.79%**

**Question 2:**

- Using **Slide 4**, the facilitator illustrates how to work out Aljana’s share of the overall PHC budget for 2008: \( \frac{347,228}{68,286,467} \times 100 = 0.51\% \). Aljana’s PHC budget is found in **Tab 2: Selected PHC Budgets** in the Master Data Sheet.

- Compare the share of the budget of the average PHC in Mortalia to the share that Aljana PHC received. What do they see already? **Answer: In 2008 Aljana’s share of the PHC budget was considerably below the average!**

- Was that just by chance or is that a consistent pattern? Does Aljana consistently get below average allocations? And what about the other PHCs?

- Have participants work in their Polarus groups to come up with budget shares for the average PHC in Mortalia and for Aljana, Corcora, and Sorulia PHCs for 2008-2011.

**Answers to Questions 3 and 4:**

<table>
<thead>
<tr>
<th></th>
<th>Aljana</th>
<th>Corcora</th>
<th>Sorulia</th>
<th>Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>.51%</td>
<td>.41%</td>
<td>.43%</td>
<td>.79%</td>
</tr>
<tr>
<td>2009</td>
<td>.39%</td>
<td>.31%</td>
<td>.32%</td>
<td>.68%</td>
</tr>
<tr>
<td>2010</td>
<td>.37%</td>
<td>.30%</td>
<td>.29%</td>
<td>.62%</td>
</tr>
<tr>
<td>2011</td>
<td>.37%</td>
<td>.22%</td>
<td>.29%</td>
<td>.56%</td>
</tr>
</tbody>
</table>

**Question 5:**

What can participants observe about their findings in budget terms?

- Participants should note that while allocations are generally going up for the budget as a whole and for the PHCs (with a couple of exceptions), the peri-urban PHCs consistently get below-average shares of the budget.

- They should also note that the share of the total Mortalia PHC budget for the PHCs considered here (the average and the three peri-urban PHCs) went down between 2008 and 2011.

- Ask participants why they think that might be. Answers should include the fact that the number of PHCs is growing, so any one PHC is going to get a smaller share of the budget.
Question 6:
What can participants observe about their findings in human rights terms?

- Participants should note that the government is violating the obligation of non-discrimination, since the peri-urban PHCs consistently receive below-average shares of the budget compared to all other PHCs, even when allocations to most PHCs are increasing as a whole. This indicates that peri-urban PHCs are being marginalized – whether intentionally or unintentionally – in terms of their budget allocations.

- The government is also not meeting its obligation of progressive achievement (or non-retrogression) of the right to health, since the shares of the total Mortalia PHC budget for the PHCs considered here (the average and the three per-urban PHCs) have consistently decreased from 2008 to 2011. To achieve progressive achievement, their budget shares should increase over time.

- Lastly, the government is not using the maximum of available resources to fulfill the right to health, since the shares of the budget that PHCs receive have decreased, even though the budget as a whole as increased over time. If the budget has increased, then the government should increase the share of the budget going to PHCs, in order to meet its obligation to use the maximum of available resources. This is especially the case if the number of clinics in Mortalia has increased over the last four years, which is likely, given high rural-to-urban migration. If there are more clinics, the government should be increasing the share of the budget to PHCs, not decreasing it.

- Participants can find out more on shares of the budget in Reading 7.2 ■ Ratios and the Composition of a Budget in their Workbooks.

Illustrating the findings

- Ask participants how they might illustrate their findings. If someone says pie chart, it would be helpful to agree that while normally pie charts are useful for illustrating shares, in this case the shares are so small that they would hardly be visible in the pie.

- It would be possible to do a bar graph or line graph comparing the three named clinics to the average PHC share. However, it may be premature at this point to illustrate this finding, as there are more calculations to do related to this hypothesis.

- The guidelines also appear in the Participant’s Workbooks in Reading 7.1 ■ How to Create Charts and Graphs in Excel.
CALCULATING REAL BUDGET GROWTH

- As was already noted, the budgets for PHCs increased from 2008 to 2011 in absolute terms (in the number of Dinars allocated). The average allocation to PHCs also increased over those years, as did the allocations for the three peri-urban PHCs (with the exception of Sorulia in 2008 and 2009). At the same time it is important to know how fast the budgets have been growing over the years. This is called the rate of growth in the budgets. Ask participants why it might be important to know the rate of growth. Possible answers: Because the budget may be growing, but growing more slowly than the populations, so the amount of money for each person would be going down, not up. Also, the budgets may be growing at different rates, so that even if Aljana’s budget is growing, it may not be growing as fast as the budget of other PHCs, and that would seem to be unfair.

- Ask participants what “nominal” budgets mean as opposed to “real” budgets. If they don’t know, they should consult their glossary. Answer: Nominal budgets are budgets that have not been adjusted for inflation, while real budgets have been. Ask why it is important to adjust figures for inflation when comparing budget figures from one year to the next. Answer: Inflation normally makes the “purchasing value” of the currency less from one year to the next, and so the same amount of money this year will likely not be able to buy the same amount of goods and services the next.

- Because of the role of inflation, when comparing budget figures from one year to the next, it is important first adjust the figures so that you are comparing real value (i.e., “purchasing value”) over time. While a nominal budget may be increasing over time, it could be that inflation is eating away at the purchasing value of the currency, so that the MDA or program is, in reality, able to buy fewer goods and services the following year, even though they look like they have more money.

ADJUSTING FOR INFLATION (Slide 5)

- Explain the consumer price index (CPI) to participants, and refer them to the glossary for the definition. The CPI figures for Polarus are included on the first page of budget and economic data in the Sourcebook, as well as in Tab 10: Polarus CPI in the Master Data Sheet.

- Explain that normally when budget figures are adjusted for inflation, they are adjusted so that the relevant past years’ budget figures are expressed in the current year’s value (or the value of the most current year that is relevant to the issue). To do this, the formula is:
Nominal value of prior year x CPI of most recent year  
\[ \frac{\text{CPI of prior year}}{\text{CPI of prior year}} = \text{Adjusted “real” value} \]  
(in most recent year value)

- Illustrate how this formula works (Slide 6) by adjusting Aljana’s budgeted figures (not audited) from 2008 to 2011 terms. **Answer:** \((\text{D } 347,228 \times 118.5)/105.7 = \text{D } 389,277\)

- Participants can find the PHC budget figures in **Tab 2: Selected PHC Budgets** in the Master Data Sheet.
  - Working in their Polarus groups, participants should adjust the budget allocations (not audited expenditures) for each of the PHCs and the average for PHCs (in Mortalia) for 2008 to 2011 to get “real” budget figures in 2011 terms.

### ANSWERS TO TASK 7.4: ADJUSTING FOR INFLATION

**Question 1:**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aljana</td>
<td>547,524</td>
<td>377,618</td>
<td>362,959</td>
<td>384,171</td>
<td>355,318</td>
<td>389,276</td>
<td>347,228</td>
</tr>
<tr>
<td>Corcora</td>
<td>324,579</td>
<td>305,964</td>
<td>294,087</td>
<td>307,019</td>
<td>283,960</td>
<td>312,383</td>
<td>278,640</td>
</tr>
<tr>
<td>Sorulia</td>
<td>435,620</td>
<td>300,136</td>
<td>288,485</td>
<td>312,556</td>
<td>289,081</td>
<td>329,719</td>
<td>294,104</td>
</tr>
<tr>
<td>Average for PHCs in Mortalia</td>
<td>825,886</td>
<td>636,977</td>
<td>612,251</td>
<td>671,581</td>
<td>621,142</td>
<td>607,586</td>
<td>541,956</td>
</tr>
</tbody>
</table>

- Participants will find notes about inflation and how to adjust for inflation in **READING 7.3 — INFLATION.**

### MEASURING CHANGES OVER TIME

- In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budget of specific PHCs has been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

- The formula for working out growth in budget amounts over time is on Slide 7:

  \[ \text{Growth in budget} = \frac{\text{Amount in most recent year} - \text{Amount in prior year}}{\text{Amount in prior year}} \times 100 \]
• As an example, calculate the growth in Aljana’s budget in nominal terms from 2008 to 2009. Note that this is Question 1 in Task 7.5: Calculating Budget Growth.

Allocation to Aljana PHC in 2008 (nominal): D 347,228
Allocation to Aljana PHC in 2009 (nominal): D 355,318

**Answer:** Growth in Aljana budget (nominal) = (355,318 – 347,228)/347,228 x 100 = **2.3%**

(Slide 8)

• Using the same formula, participants should calculate the growth in Aljana PHC’s budget in real terms (Question 2), and then the real growth in total budgets (not audited) over the three years for each of the PHCs and for the average of PHCs in Mortalia (Question 3). Have them enter their answers in Task 7.5 ■ Calculating Budget Growth in their Workbooks.

ANSWERS TO TASK 7.5: CALCULATING BUDGET GROWTH

**Question 1:** See example above.

**Question 2:**

First, adjust the 2008 Aljana PHC allocation so that it is in 2009 real terms, using the inflation formula:

**Answer:** (D 347,228 x 109.6)/105.7 = D **360,039**

Now calculate the growth of the Aljana PHC allocation between 2008 and 2009, in 2009 real terms:

**Answer:** (D 355,318 – D 360,039)/D 360,039 x 100 = **-1.31%**

**Question 3:**

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aljana</td>
<td>44.99</td>
<td>-1.71</td>
<td>-1.31</td>
</tr>
<tr>
<td>Corcora</td>
<td>6.08</td>
<td>-0.34</td>
<td>-1.72</td>
</tr>
<tr>
<td>Sorulia</td>
<td>45.14</td>
<td>-3.97</td>
<td>-5.21</td>
</tr>
<tr>
<td>Average for PHCs in Mortalia</td>
<td>29.66</td>
<td>-5.15</td>
<td>10.53</td>
</tr>
</tbody>
</table>

**Question 4:**

What are participants’ findings about real growth in Mortalia’s PHC budgets?

• The budgets for the three peri-urban PHCs decreased between 2008 and 2009, although the Average Budget for PHCs in Mortalia increased by over 10% in the same period.

• The budgets for the three peri-urban PHCs decreased between 2009 and 2010, but this time the Average Budget for PHCs in Mortalia decreased even more.
• The budgets for Aljana and Corcora increased significantly between 2010 and 2011 – each had increases of 45%, while Corcora received a mere 6% increase. The Average Budget for PHCs in Mortalia increased as well (by 30%), not nearly as much as the budgets for Aljana and Corcora.

Question 5:
What are participants’ findings in terms of human rights?
• In the periods 2008-2009 and 2009-2010 the budgets of peri-urban PHCs decreased, and in 2009-2010 the average budget also decreased. Under the obligation of progressive achievement, the government is committed to continuously improving health conditions. If the budgets for peri-urban PHCs, which serve largely poor and marginalized populations, are not increasing from year-to-year, this implies that the government is not progressively achieving the right to health for its citizens. The budgets should, at a minimum, increase to keep up with inflation. Due to rural-urban migration, the peri-urban populations in these areas are increasing each year, so the budget should also increase so that PHCs are able to serve more people.

• The budget decreases in 2008-2009 and 2009-2010 also indicate that the government may not be using the maximum of available resources to fulfill the right to health. The government must do the maximum to raise resources and must give priority in its budget to economic, social, and cultural rights, including health. If the budgets for PHCs in Mortalia decreased two years in a row, it calls into question the government’s efforts to raise enough revenue and/or to allocate it appropriately so as to sufficiently fund existing PHCs.

• The government also violated its obligation of non-discrimination (intentionally or unintentionally). In the period 2008-2009, the average PHC in Mortalia received a 10.53% budget increase, while the peri-urban PHCs’ budgets decreased. This is also the case in 2010-2011, when two peri-urban PHCs received a 45% budget increase, while the third PHC received only a 6% increase (and the average for PHCs was almost 30%). These inconsistencies in allocations raise questions about how the PHC budgets are formulated and approved.

• Participants will find more information about this for later reference in READING 7.4 ■ MEASURING BUDGET CHANGES OVER TIME in their Workbooks.
How to illustrate the findings (Slide 11)

- You might choose simply to discuss which kind of charts could be used in this instance to illustrate the findings.

- Or you could spend some more time looking at line graphs and how to create these in Excel. Note that in the illustration provided on Slide 11 the actual budget figures are used, not the growth rates!

- The guidelines also appear in Participants’ Workbooks in Reading 7.1 How to Create Charts and Graphs in Excel.
**Task 7.3 ■ Calculating Budget Shares**

The formula for calculating budget shares is:

\[
\text{Share of the budget} = \frac{\text{Section of the budget}}{\text{Whole budget}} \times 100
\]

a. What was the total PHC budget in Mortalia for 2008? ______________

How many PHCs were there in Mortalia in 2008? ______________

Using these two pieces of information, calculate the average allocation to PHCs in 2008.

What share of the total PHC budget did the average PHC receive in 2008?

b. Calculate the share of the total 2008 PHC budget allocated to Aljana PHC.

How does this share compare with the share received by the average PHC?

______________________________

______________________________

Optional Task: How would your finding for Question 2 differ if you used audited expenditure rather than the budgeted allocation?

______________________________

______________________________
c. Calculate the average share of the budget allocated to Mortalia PHCs for each year from 2008 to 2011.

d. Calculate the share of the budget allocated to the three peri-urban PHCs for each year from 2008 to 2011. Record your answers to this exercise (and to Question 3) in the chart below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Aljana</th>
<th>Corcora</th>
<th>Sorulia</th>
<th>Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. What do you observe about the budget shares of the peri-urban PHCs compared to the average share for PHCs in Mortalia? And over the years, from 2008 to 2011?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

6. How might you frame your findings about the budget shares of the peri-urban PHCs in human rights terms?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
TASK 7.4 ■ ADJUSTING FOR INFLATION

- Inflation affects the “buying power” of a given currency with the result that if, for example, certain goods or services cost D100 this year, they will likely cost more next year (e.g., D105). Thus, in comparing governments’ budgets from year to year, it is important to take inflation into account. What may look like an increase in a budget from one year to the next may, in fact, represent a decrease in “buying power.”

- When budget figures are adjusted for inflation, they normally are adjusted so that the relevant past years’ budget figures are expressed in the current year’s value (or the value of the most current year that is relevant to the issue). To make the necessary adjustment, use this formula (CPI = Consumer Price Index; see Glossary):

\[
\frac{\text{Nominal value of prior year} \times \text{CPI of most recent year}}{\text{CPI of prior year}} = \text{Adjusted “real” value (in most recent year value)}
\]

1. Adjust the budget allocations (not audited expenditures) for each of the three PHCs and the average PHC in Mortalia for 2008 to 2011 to get “real” budget figures in 2011 terms. Record your answers in the chart below:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aljana</td>
<td>547,524</td>
<td>362,959</td>
<td>355,318</td>
<td>347,228</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corcora</td>
<td>324,579</td>
<td>294,087</td>
<td>283,960</td>
<td>278,640</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sorulia</td>
<td>435,620</td>
<td>288,485</td>
<td>289,081</td>
<td>294,104</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average PHC</td>
<td>825,886</td>
<td>612,251</td>
<td>621,142</td>
<td>541,956</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**TASK 7.5 ■ CALCULATING BUDGET GROWTH (NOMINAL AND REAL)**

- When determining growth in a budget over the course of several years, it is important to first adjust the budget figures to take inflation into account. An apparent growth in a budget when nominal figures are used may prove to be shrinkage when real figures are used.

- The formula for working out growth in budget amounts over time is:

\[
\text{Growth in budget} = \frac{\text{Amount in most recent year} - \text{Amount in prior year}}{\text{Amount in prior year}} \times 100
\]

1. Calculate growth in the Aljana budget in nominal terms from 2008 to 2009:

   First, establish how much was allocated to Aljana PHC in 2008: ________________________

   Then look up how much was allocated to Aljana PHC in 2009: ________________________

   Now you have all the figures that you need in order to do the calculation. What was the **nominal** growth in the budget from 2008 to 2009? ______________________

2. Calculate real growth in the Aljana budget from 2008 to 2009:

   How much was allocated to Aljana PHC in 2008 in nominal terms? ________________

   How much was allocated to Aljana PHC in 2009 in nominal terms? ________________

   Adjust the 2008 figure for inflation (in 2009 real terms). When you do that, your budget figure for 2008 is ________________.

   Now you have all the figures that you need in order to do the calculation. What was the **real** growth in the budget from 2008 to 2009? ______________________
3. Working in your Polarus groups, fill out the following chart:

**Growth in Mortalia PHC budgets in real terms, 2008–2011**

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Aljana</td>
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<td></td>
</tr>
<tr>
<td>Corcora</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sorulia</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PHC Average</td>
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<td></td>
</tr>
</tbody>
</table>

4. What are your findings about real growth in Mortalia’s PHC budgets?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. What conclusions can you draw in human rights terms about real growth in Mortalia’s PHC budgets?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
READING 7.2 ■ RATIOS AND THE COMPOSITION OF A BUDGET

RATIOS

- Calculating a ratio means determining the relationship between two numbers. This is one of the central elements of quantitative analysis.

- Of course, we encounter ratios all the time, in areas that have nothing to do with budgets or budget analysis: “Seventy percent of those surveyed prefer Coca-Cola to Pepsi,” claims the advertisement, while two out of three Americans are overweight, lament public health officials.

- The basic calculation is this:

  \[
  \text{Share} = \frac{\text{Section}}{\text{Total}}
  \]

- Ratios are often expressed in percentage terms. So if four out of 10 people support the Love Status Quo Party, instead of saying 0.4, we say 40 percent. If their support is only four out of 100 people, we say that only four percent support the LSQP (and that some other party must have a lot more support!).

- Keep in mind that ratios can exceed one hundred percent. If, for instance, military spending is slightly greater than education spending, we might say that military spending amounts to 110 percent of education spending.

COMPOSITION OF THE BUDGET

- Working with ratios is relevant in many different contexts, but it is especially useful for applied budget work. This is because calculating ratios allows us to analyze the overall composition of a national government’s or a state’s budget.

- For example, we may want to know what share of total spending is taken up by health or military spending, or how government spending in one sector compares to other parts of the economy.
READING 7.3 ■ INFLATION

• Just as inflation erodes the earnings of families – meaning that they need to make more and more money just to break even – so inflation erodes the buying power of governments.

• To determine the impact of inflation – which would allow you to see the “real” increase in government spending over specific periods – an analyst must adjust for inflation.

THE CONSUMER PRICE (OR INFLATION) INDEX

• To adjust figures for inflation, you need to know what the inflation rate was for each of the years during the period that you are analyzing.

• The most common tool for doing this, published by most governments or by academics, is typically called the consumer price index (CPI) or sometimes the inflation index.

• The CPI is a table that has an arbitrary starting point equal to 100 (the base year). If the following year inflation runs at five percent, the index rises to 105 (100 x 1.05). If inflation the next year rises to 10 percent, the inflation index would rise to 115.5 (105 x 1.10), and so on.

• Years prior to the base year (which remember, is an arbitrary point) will show up as numbers below 100 as long as inflation was positive. If inflation had been four percent the year prior to the base year, the index would have been 96.2 (100/1.04).

WHAT DOES IT MEAN TO ADJUST FOR INFLATION?

• When you adjust for inflation, what you are really trying to do is to ensure that the value of the money you are describing in any two years is the same. We know that a Dinar in 2008 doesn’t buy as much as a Dinar did in 1998, so we want to equalize the purchasing power of the same unit of money over the two years.

• Note that we can accomplish that by inflating the nominal figure from 1998 so that it comes to equal the 2008 value of the Dinar, OR we could deflate the 2008 figure to equal the 1998 value of the Dinar. Alternatively, we could convert both figures to their value in some other year, for example, to 2003 values.

• Most of the time, it makes sense to inflate all nominal prior year figures to today’s value of money, or to the most recent year for which the consumer price index exists. This is because people are most familiar with the value of money as they experience it in the present. So, for example in
Polarus, people instinctively know what today’s Dinar is worth. It would therefore be easier for them to relate to an analysis that presents figures converted to the value of today’s Dinar.

**HOW TO ADJUST BUDGET FIGURES FOR INFLATION**

- The equation to *inflate* a prior year budget figure to today’s value is as follows:

\[
\frac{\text{Nominal value of prior year} \times \text{CPI of most recent year}}{\text{CPI of prior year}} = \text{Adjusted “real” value} \quad \text{(in most recent year value)}
\]

- It is usually important, in this and other calculations, to check that the result is logical, i.e., that it is – in rough terms – what one would expect. One of the simplest, yet most important, checks is to make sure that the new figure has moved in the direction that you expected it to (up or down).

- For example, it is easy to get confused and multiply the nominal value by the prior year’s consumer price index (CPI), and then divide by the current year’s CPI. If you do that, though, the nominal value will shrink in value. Except in the rare circumstance where an economy is marked by *deflation* – where prices fall and the value of money shrinks from year to year – adjusting for inflation should always make the earlier year’s amount larger, or the current and future year amounts smaller.

**HOW TO DEFLATE BUDGET FIGURES**

- You can also calculate current or recent expenditure amounts in the value of a prior year. In this instance, you want to *deflate* a later year’s amounts to an earlier year’s value of money.

- The equation to *deflate* (just the opposite of the equation to *inflate*) to a past year’s value is:

\[
\frac{\text{Nominal value of most recent year} \times \text{CPI of prior year}}{\text{CPI of most recent year}} = \text{Adjusted “real” value} \quad \text{(in prior year value)}
\]

- Again, the quick common sense test is that when deflating current (or future) year spending amounts to the value of money in a past year, the value should shrink.
READING 7.4 ▪ MEASURING BUDGET CHANGES OVER TIME

- One of the key analytic tools in budget work is to describe changes in variables over time. The raw numbers – “spending grew by D3 billion” – can seem meaningless given the magnitude of the amounts at issue. After all, D3 billion is a lot of money, even if it only showed a modest increase compared to a starting point of, say, D60 billion.

- Therefore, alongside reporting on changes in government spending in nominal terms, it is often useful to describe these changes in percentage terms. For many people, describing growth this way rather than in dollar (or Dinar) terms makes it easier to understand. Moreover, it allows a useful comparison between growth rates in programs of very different sizes.

- To determine the rate of increase in a program, department, or state budget, use this equation:

\[
\text{Growth in budget} = \frac{\text{Amount in most recent year} - \text{Amount in prior year}}{\text{Amount in prior year}} \times 100
\]

BE AWARE OF THE DIFFERENCE BETWEEN PERCENTAGE INCREASES AND INCREASES IN PERCENTAGE POINTS

- This is often one of the more difficult concepts for many people to grasp. For instance, imagine that in 1995 education made up 10 percent of a country’s budget, but grew to comprise 12.5 percent of the budget in 2004. So what was the percentage increase?

- The answer is not 2.5 percent. While education spending grew by 2.5 percentage points during this period, to determine the percentage increase you need to use the equation (already introduced above) for calculating percentage changes. It is:

\[
\frac{\text{Later year } \% - \text{Prior year } \%}{\text{Prior year } \%} = \text{Percentage increase}
\]

So applied to the education example:

\[
\frac{12.5\% - 10\%}{10\%} = .25 = 25\%
\]

- Clarity is extremely important when describing percentage changes. For example, if you say “Health spending as a share of total spending grew by 25 percent between 1995 and 2004,” you will be precisely accurate. Unfortunately, many people will misunderstand you, assuming that you meant that spending grew from 10 percent of total spending in 1995 to 35 percent in 2004. However, the latter interpretation would mean there was a 25 percentage point increase, not a 25 percent increase.

- Because these figures are so often misunderstood, some analysts avoid using this “percentage change of a percent” formulation.
On the other hand, as an advocate, this can be an essential message to get across. For example, say that you found out that as a share of spending, housing programs dropped from 10 percent of the budget to 8 percent over five years. This could be presented as good evidence that government officials are not using maximum available resources to expand access to housing. Describing this change as “a 20 percent drop” is a lot more powerful – although technically identical to – “a two percentage point drop.”

**Describing Percentage Changes as Fractions**

- While describing budget trends in percentage terms simplifies the data and puts changes in perspective, some percentages are more difficult to make sense of than others.

- This can be particularly true when dealing with changes greater than 100 percent. For instance, to most of us it is obvious and immediately clear that 25 percent is the same as one-quarter (1/4). However, while an increase of 100 percent doubles the original figure, an increase of 200 percent triples the original. This is not necessarily intuitive.

- A useful way to deal with this in a narrative text – and to avoid the tediousness of constantly repeating the word “percent” – is to convert the percentages into simple fractions. Thus:
  - A 23 percent change can be described as “nearly one-quarter.”
  - An increase of 53 percent can be described as “just over half.”
  - Figures around 33 percent become “one-third.”
  - Figures around 20 percent are easy to understand as “one-fifth,” etc.

When using these fractions as shorthand in a report, it is useful to also include the actual percentages in parentheses or in a figure or table.
HYPOTHESIS 4
THE FUNDS THAT THE DISTRICT SERVICES PROGRAM PROVIDES TO PERI-URBAN PHCs FALL SHORT OF THE PER CAPITA PRIMARY HEALTH CARE SPENDING STANDARD SET BY THE POLARUS MINISTRY OF HEALTH

Duration of session: 2 hours

Note: Use the PPT file MODULE 7: Hypothesis 4 to facilitate the investigation of this hypothesis.

- Explain to participants that the last calculation they will do will be on per capita—per person—allocations or expenditures, which can be very helpful in a number of regards. It can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Is the government spending the same amount on specific goods and services in different states, with regard to different population groups? Per capita calculations can be helpful in identifying potential discrimination on a range of grounds—gender, income, ethnicity, etc.

- Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies. That is the case here.

- It is important in doing per capita calculations, which involves budget and population figures, to think carefully about who the relevant population is. It normally would not make a lot of sense, for example, to assess primary education expenditures by including in the population group literate adults. To determine a per capita expenditure on primary education, it would be more useful to use the population of, for example, primary school-age children.

Per capita calculation (Slides 3-4)

- Participants are introduced to the per capita calculation of allocations (Slide 3):

\[
\text{Per capita allocation} = \frac{\text{Allocation}}{\text{Population}}
\]

- Participants can try the calculation together (Slide 4) and find the per capita allocation in nominal terms for Aljana for 2008 as follows: Per capita allocation = D 347,228 / 12,783 = D 27.16.

- This is the first part of Question 1 in Task 7.6: Calculating Per Capita Allocations (or Spending). Note that the budget figure is found in Tab 2 of the Master Data Sheet and the population figure is found in Tab 8 of the Master Data Sheet.
The logic for using nominal terms is that the Ministry of Health’s standard for per capita spending is not adjusted for inflation; it was set in 2008 and has not been changed since.

Using the 2008 population figures, participants should calculate per capital allocations for the remaining years for Aljana as well as the per capita allocations for the other two peri-urban PHCs and for the PHC average. They can work on and record their findings in **Task 7.6**

**Calculating Per Capita Allocations** in their Workbooks.

**Answers for Task 7.6: Calculating Per Capita Allocations**

**Question 1:**

Allocation to Aljana PHC in 2008: D 347,228  
2009: D 355,318  
2010: D 362,959  
2011: D 547,524  

Population of Aljana community in 2008: 12,783  
Now calculate per capita allocations for each of those years. See answers in the table for Question 2 below.

**Question 2:**

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aljana</td>
<td>42.83</td>
<td>28.39</td>
<td>27.80</td>
<td>27.16</td>
</tr>
<tr>
<td>Corcora</td>
<td>31.38</td>
<td>28.44</td>
<td>27.46</td>
<td>26.94</td>
</tr>
<tr>
<td>Sorulia</td>
<td>38.83</td>
<td>25.71</td>
<td>25.76</td>
<td>26.21</td>
</tr>
<tr>
<td>PHC Average</td>
<td>55.31</td>
<td>41.00</td>
<td>41.60</td>
<td>36.30</td>
</tr>
</tbody>
</table>

- Participants will find notes on this in **Reading 7.5** **Per Capita Calculations** in their Workbooks.

**Question 3:**

How do the per capita allocations to the three peri-urban PHCs compare to the average for PHCs in Mortalia? And to the per capita standard established by the Polarus Ministry of Health?

- The per capita allocations to the three peri-urban PHCs are consistently lower than the average for PHCs in Mortalia, by over D10-15 in most cases. The per capita standard set by the Ministry of Health for mostly urban PHCs is D50-55. Both the per capita allocations to the three peri-urban PHCs as well as the average for PHCs in Mortalia is below the per capita standard, except for the PHC Average in 2011.
Question 4:
What conclusions can you draw in human rights terms about *per capita* allocations to the PHCs in the peri-urban communities of Mortalia?

- The government is failing to use the maximum of available resources to meet its own *per capita* allocation standard for primary health care, as established by the Ministry of Health.
- The government is discriminating against peri-urban PHCs, since the peri-urban PHCs consistently receive a much lower *per capita* allocation than the average for PHCs in Mortalia. This violates the obligation of non-discrimination in providing health services to the public.
- Even though the peri-urban PHCs received lower than average *per capita* allocations, these *per capita* allocations increased from year-to-year, so there is some evidence of progressive achievement.

How to illustrate the findings (Slide 7)

- Ask participants what chart or graph would be most useful in this context. The answer would be a bar chart. If there is time, participants can create the relevant bar chart. They should be sure to include the Ministry of Health standard in their table of figures, which they will use to create the bar chart.
- If time is short, it is not necessary that they do this, since they will already have created a number of bar charts.
**TASK 7.6 ▪ CALCULATING **_**PER CAPITA ALLOCATIONS (OR SPENDING)**_

*Per capita* is Latin for per head; that is, per person.

The formula for calculating a *per capita* allocation is:

\[
\text{Per capita allocation} = \frac{\text{Allocation}}{\text{Population}}
\]

The same formula could be used to calculate spending *per capita*, simply by substituting expenditure for allocation.

1. Calculate the *per capita* allocation in 2008-2011 for primary health care for residents in the Aljana community.

   First, what was allocated to the Aljana PHC in 2008? _______
   
   2009? _______
   
   2010? _______
   
   2011? _______

   What was the estimated population of the Aljana community during these years? _______

   Now you have all the figures that you need to do the calculation:

2. Calculate the *per capita* allocations over the given years for the remaining two peri-urban PHCs and the average *per capita* allocation to Mortalia’s PHCs. Record all your answers in the following chart.

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aljana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corcora</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sorulia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC Average</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

286
3. How do the *per capita* allocations to the three peri-urban PHCs compare to the average for PHCs in Mortalia? And to the *per capita* standard established by the Polarus Ministry of Health?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

4. What conclusions can you draw in human rights terms about *per capita* allocations to the PHCs in the peri-urban communities of Mortalia?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Analysts and advocates often calculate budget data to come up with “per person” or per capita allocations (or expenditures) to allow comparisons between countries, states, localities, or facilities.

Calculating per capita allocation (or expenditure) is straightforward, as long as you know both the number of people in a population and the amount allocated (or the amount spent). The equation is:

\[
\text{Per capita allocation} = \frac{\text{Allocation}}{\text{Population}}
\]

This same formula can be used to calculate per capita spending, with the expenditure figure used instead of the allocation.

Note that when comparing allocation, spending, and population figures, it is important to pay attention to whether the budget figures are in terms of hundreds, thousands, millions, or billions. This is where a quick common sense check is useful. It is all too easy to make such a mistake unless you are being careful.

It is also important to consider what population is relevant. In the education sector, for example, per capita calculations are best done using selected population data. While it is certainly possible to measure education spending on a general per capita basis, you will get a better sense of how much is being spent if you use the number of school-aged children, for example. This principle can hold any time a program is aimed at a particular population, rather than the population at large.

While knowing how much is allocated or spent per capita on a particular service doesn’t give you a definitive insight into the quality of services people receive, it does provide a useful piece of evidence.
FROM ANALYSIS BACK TO ADVOCACY

*Duration: 1 hour, 5 minutes*

**STRUCTURE OF THE SESSION**

<table>
<thead>
<tr>
<th>1. Quick Recap</th>
<th>5 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. TASK 7.7 ■ Diagnosing the Budget Problem</td>
<td>15 minutes</td>
</tr>
<tr>
<td>3. Facilitator Input: Using Graphs and Charts</td>
<td>15 minutes</td>
</tr>
<tr>
<td>4. TASK 7.8 ■ Which Calculation and Chart or Graph to Use?</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

**Notes:** Slides for these sessions are in the PPT file MODULE 7 Summary–From Analysis Back to Advocacy.

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**1. FACILITATOR INPUT: RECAP**

- Briefly recap the logic of the learning process over the last few days, using Slide 2.
- We started by suggesting that if you want to do budget advocacy work, you need to understand the nuts and bolts of planning an advocacy strategy.
- Make sure all the participants remember the **five components of an advocacy strategy**, namely *strategic analysis, advocacy objective, stakeholder analysis, advocacy message, and schedule*.
- After formulating a draft advocacy objective about the health situation in the peri-urban areas of Mortalia (Module 5), the next steps were for participants to:
  - look into the budget process (in Module 6);
  - identify stakeholders (Module 5); and
  - learn some basic techniques for analyzing budgets (in Module 7).
- Ask the participants to summarize and explain why it was important to undertake these three areas of inquiry, and how each is supposed to contribute to building their advocacy strategies.
- Confirm that at this point participants have amassed a great deal of information about the health situation in the peri-urban communities in Mortalia through their task work in Modules 5, 6, and 7. So what is the next step?
2. **TASK 7.7 ■ DIAGNOSING THE BUDGET PROBLEM**  

- **The aim of this task** is to review the findings of the budget analysis and tie those findings back to the advocacy elements of the program.

- Working in their Polarus CSO groups, ask participants to sift through everything they have learned during Modules 5, 6, and 7 pertaining to the health care situation in the peri-urban areas of Mortalia.

- Encourage them to review and pool the most useful and relevant findings, and then make a quick **diagnosis of the main budgetary causes of the problem**. Allow around 20 minutes for this. Assure participants that they will have more time in the near future to sift through their findings again and to further refine their formulation of the problem.

- Participants can use **TASK 7.7 ■ DIAGNOSING THE BUDGET PROBLEM** in their Workbooks to record their findings and diagnosis.

- After 20 minutes, invite all of the groups to reconvene in plenary. Briefly allow each group to state briefly (remembering **ECONOMY OF WORDS**) what they think the main budget problems are affecting primary health service provision in the peri-urban areas of Mortalia. They should **not** report back on all of the findings that informed this diagnosis.

- Use **Slides 3 and 4** to highlight or confirm the most important findings that came from the budget analysis in Module 7.

**NOTES on SLIDES 3 and 4**

- In this discussion, the aim is to focus on the problem(s) contributing to the health crisis in the peri-urban areas of Mortalia, without yet moving on to the details of a solution that could work.

- Note that the wastage by the PHCs in the peri-urban areas likely contributes to the poor state of primary health care in those areas.

- The fact that the PHCs are under-spending their budgets, particularly on medicines, also likely contributes directly to the poor health services in the areas.

- The peri-urban PHCs also get a smaller share of the overall PHC budget in their district than do most other PHCs, and their budgets are growing more slowly than the average (and in some cases are shrinking).

- The District Services Program also appears to be providing allocations to the peri-urban PHCs that do not meet the standard set by the Polarus Ministry of Health. This, in turn, means that they do not have the resources that other PHCs around the city—and indeed, the country—have.
Against this background, use Slide 5 to confirm the main budgetary factors contributing to the health service problems in Mortalia. See list below under Answers for Task 7.7.

ANSWERS FOR TASK 7.7: DIAGNOSING THE BUDGET PROBLEM

Question 2: What are the main budget problems causing poor health care provision in the peri-urban areas of Mortalia?

- The peri-urban PHCs in Mortalia are wasting or under-spending their budgets.
- The peri-urban PHCs get a smaller than average share of the District Services Program’s primary health budget.
- The budget of the peri-urban PHCs is increasing at a slower rate than the budget for the average PHC.
- The District Services Program is not ensuring that PHCs receive funding that meets the Ministry of Health’s standard for funding primary health care.

NOTES on SLIDE 6 and 7:

- Ask participants who has the decision-making power to affect each of these problems. They should be well-versed with this by now. Invite people to volunteer answers from the floor for each problem using Slide 6.
- Draw the plenary discussion to a close by emphasizing how important it is to have a very clear diagnosis of the budget problems underlying a development problem that you are trying to address.
- As participants will learn in more detail when they return to Module 5: Budget Advocacy, being able to articulate the problem correctly is the first important ingredient in formulating your advocacy message. The second key ingredient is to propose a solution, and the third is to pinpoint the action you want government to take to bring about that solution.
- Slide 7 allows you to summarize and anticipate the next steps in the process, which participants will tackle when they return to Module 5 of the training workshop.

3. FACILITATOR INPUT: USING CHARTS AND GRAPHS TO ILLUSTRATE YOUR FINDINGS 15 MINUTES

- Use Slide 8 to facilitate a discussion on which charts or graphs work best to illustrate different findings. This also serves as an opportunity to review and consolidate which calculations to use.
- An important part of budget analysis is to decide which calculations to use and when to use them. This choice depends on what you are trying to demonstrate (e.g., testing hypotheses).
• The same goes for graphs and charts. Not all charts are suitable for illustrating all types of findings.

• Some general points on using charts:
  - You can’t use a single pie chart if you want to show a growth rate.
  - Line graphs or bar charts aren’t suitable for illustrating shares.
  - Watch out for the difference between percentages and percentage points.
  - Always make doubly sure that you have your thousands, millions, and billions right when you enter the data for graphs or charts.

4. Task 7.8 ■ Which Calculation? Which Chart? 30 minutes

• The aim of this task is to enable participants to review and consolidate their knowledge about which calculations are used to investigate different budget questions, while also giving them a chance to practice selecting the most effective kind of chart or graph to illustrate different findings.

• This is a plenary exercise. Invite participants to call out answers from the floor — or get them to discuss the examples in pairs or small groups first, and then decide together on the right answers to call out.

• Use Slide 9 to project the questions. Participants can also use the worksheet for Task 7.8 ■ Which Calculation? Which Chart? in the Participant’s Workbook.

Answers to Task 7.8: Which Calculation? Which Chart?:

1. Question 1: The correct answer is a) — the size of its percentage share over time. Real growth can show you how much money is actually available for a function, but it cannot help you compare the share that this allocation represents relative to other allocations or to a whole budget.

2. Question 2: A pie chart can help you to compare shares in a given year, but not over time. Bar charts or graphs are more suitable for comparisons over time and in different places/geographical areas.

3. Question 3 has two answers:
   a) You could calculate the Department of Health’s (DOH) allocation as a share of the State budget, and compare this to the share that DOHs in other states get. OR…You could calculate the per capita allocation for health in Sunrise State and compare that with per capita allocations for health in other states.
   b) When comparing nine states, a bar chart would likely be the most effective, because a bar chart allows you to show comparisons of allocations across states.
TASK 7.7 ■ DIAGNOSING THE BUDGET PROBLEM

1. Review all of the findings that you have gathered in Module 5, Module 6, and Module 7 about the health situation in the peri-urban areas of Mortalia. Extract and list the most relevant and useful findings below:

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2. Decide within your group: What are the main budget problems causing poor health care provision in these peri-urban areas?

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**TASK 7.8 ■ WHICH CALCULATION? WHICH CHART?**

1. You suspect that the share of the Sunrise State budget going to Sanitation may be shrinking. To diagnose whether this is the case, would you calculate:
   a) the size of its percentage share over time?  
   b) real growth in spending on Sanitation over time?

Which calculation would you choose and why?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

2. To show that the share of the Sunrise State budget going to Sanitation is shrinking, it would be best to use a bar chart or graph, not a pie chart. True or False? Please justify your answer.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

3. If you suspect that the Department of Health of Sunrise State is underfunded:
   a) Which calculations would you use to test this hypothesis? Why?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

b) What kind of chart or graph would you use to show your findings? Why?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
MODULE 5
BUDGET ADVOCACY

PART III ■ Media and Communications
## MODULE 5 ■ BUDGET ADVOCACY (CONTINUED)

### PART III: MEDIA AND COMMUNICATIONS

**SUMMARY TABLE**

| Duration of module | 9 hours, 45 minutes (Parts I, II, and III)  
<table>
<thead>
<tr>
<th></th>
<th>13 hours, 10 minutes (Budget Advocacy Group Work &amp; Presentations)</th>
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| Structure & timing of this module | This module corresponds with the following sessions in the *Health & Budgets Training Workshop Agenda:*  
|                      | **Part I: Planning for Budget Advocacy** (3 hours, 30 min.) ✓  
|                      | • Part of SESSION 4 on Day 2;  
|                      | • Part of SESSION 1 on Day 3; and  
|                      | • Part of Session 2 on Day 3.  
|                      | **Part II: Power, Stakeholder, and Opportunity Mapping** (3 hours, 30 min.) ✓  
|                      | • Part of SESSION 2 on Day 4;  
|                      | • SESSION 3 on Day 4; and  
|                      | • Part of SESSION 4 on Day 4.  
|                      | **Part III: Media and Communications** (2 hours, 45 min.)  
|                      | • SESSION 2 on Day 6; and  
|                      | • Part of SESSION 3 on Day 6.  
|                      | **Part IV: Budget Advocacy Group Work and Presentations** (13 hours, 10 min.)  
|                      | • Part of SESSION 3 on Day 6;  
|                      | • SESSION 4 on Day 6;  
|                      | • SESSIONS 1-4 on Day 7;  
|                      | • SESSIONS 1-2 on Day 8; and  
|                      | • Part of SESSION 3 on Day 8.  
|                      | (Note that one session is 1 hour, 45 minutes.) |
| Resources needed for PART III | • Flipchart paper and markers  
|                                | • Roundtable Media Cards (4)  
|                                | • Internet access  
|                                | • ARASA video on YouTube ([http://www.youtube.com/watch?v=MkWoKgLhDVs](http://www.youtube.com/watch?v=MkWoKgLhDVs))  
|                                | • Post-It notes of different colors (as many as possible)  
|                                | • In the Participants’ Workbooks:  
|                                | ➢ **TASK 5.10** ■ Media Strengths and Weaknesses  
|                                | ➢ **TASK 5.11** ■ Media Delivery Wheel Scenarios  
|                                | ➢ **READING 5.7** ■ Introduction to Media  
<p>|                                | ➢ <strong>READING 5.8</strong> ■ Guidelines for Working with Media |</p>
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<td>5.11</td>
<td>Some Key Media Terms</td>
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LEARNING OUTCOMES TO BE ACHIEVED

During Parts I and II of Module 5, participants learned about:

✓ The key elements and importance of an advocacy strategy;
✓ Formulating a strategic objective and making it SMART;
✓ The value of evidence-based advocacy;
✓ The need to sharpen and add substance to advocacy strategies by examining the budget dimension of development problems;
✓ Powerbrokers in the budget process; and
✓ Developing a power map and an opportunity schedule for the advocacy plan.

By the end of Part III of Module 5, participants will have built further on the knowledge and skills acquired in the previous parts of the module and will have:

• Developed SMART advocacy objectives;
• Recognized why message development is important in budget advocacy;
• Formulated a clear budget advocacy message;
• Recognized why it is important to work with the media in an advocacy campaign;
• Summarized different types of media and differentiated the roles within the news media;
• Explained various techniques for gaining media attention;
• Matched media publicity to the budget cycle; and
• Considered how to gear message delivery to specific contexts and time constraints.

STRUCTURE OF MODULE 5 (PART III)

Media and Communications

1. **ENERGIZER:** Eliminating Jargon 10 minutes
2. **BRAINSTORM AND DISCUSSION:** Why Work with the Media 20 minutes
3. **INPUT AND DISCUSSION:** The Changing Media Environment 10 minutes
4. **TASK 5.10 □ Media Strengths and Weaknesses** 10 minutes
5. **TASK 5.11 □ Media Delivery Wheel Scenarios** 20 minutes
6. **INDIVIDUAL READING:** Techniques for Getting Media Attention 45 minutes
7. **FACILITATOR INPUT:** Working with New Media 10 minutes
8. **TAKE A WALK:** Sharing Experiences of New Media 20 minutes
9. **ROUNDTABLE:** Engaging with the Media – Practical Tips 20 minutes
MEDIA AND COMMUNICATIONS

Duration of session: 2 hours, 45 minutes

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1. **ENERGIZER: ELIMINATING JARGON** 10 MINUTES

- In plenary, ask participants to identify the common jargon words that they all use regularly in the course of their work. List these words on a sheet of flipchart paper.
- Some examples are: capacity building, pro-poor, sensitize, beneficiaries, empowerment, sustainability, grassroots, etc.
- Divide groups into pairs by asking participants to cross the room to a person opposite them.
- Working in pairs, each person should have a turn, explaining his or her job, as if talking to someone at a party. But they’re not allowed to use any of the identified jargon words. The person not talking should “beep” the other person every time a jargon word is used.
- It’s a great exercise in learning how to explain oneself in simple, everyday language.

2. **BRAINSTORM AND DISCUSSION: WHY WORK WITH THE MEDIA?** 20 MINUTES

- The aim of this brainstorm and discussion is to enable participants to explore why it is important to work with the media to achieve advocacy goals.
- Introduce the brainstorm by posing the question: Why work with the media? Before inviting responses, briefly frame the question with the points outlined below.
The media play a key role in today’s society, and no advocacy or communications campaign can hope to succeed without media exposure. With any campaign, there are usually three possible objectives, and most campaigns usually combine one or more of these:

- to inform and educate;
- to change attitudes and beliefs; and
- to change behavior.

These objectives are progressively more difficult to achieve. It is easier to inform and educate than to change attitudes and beliefs. But it is even more difficult to change behavior through the media, as has been demonstrated, for example, by campaigns to prevent the spread of HIV/AIDS.

For an organization involved in budget advocacy work, this means that media campaigns will be good for creating awareness of budget-related issues and perspectives. However, to change behavior—for example, to change the decisions of policy-makers or the votes of legislators—it is not enough to use the media alone. Media activities must be part of a broader, integrated advocacy campaign.

Next ask participants to brainstorm reasons for working with the media. Write their responses on a piece of flipchart paper. Use the following information to discuss the theme further.

If any of the following reasons do not emerge from the discussion, add them to the list:

- **To communicate your perspective on the budget.** On budget day, the government will try to put the most positive spin on the budget, opposition parties will find something to criticize, and a range of individuals and organizations will have their say. Your organization will have its own view, based on your own analysis and on the key issues that you are concerned about. Unless you are able to get your views into the media, they will go unnoticed. The more frequently and prominently you can get your issues and views into the media, the more likely it is that policy makers will feel pressured to respond to them.

- **To hold the government accountable.** Your research may show that the budget figures don’t add up, or that a key program is unaffordable, or that resources for schools are disappearing before they get to their destination. Once you get this information into the media, those responsible for these problems will know that the “game is up” and that they are being watched, not only by you, but also by the public in general. An often-cited example comes from Uganda, where increased public access to information was shown to reduce the capture of public funds through corruption from 80 percent in 1995 to less than 20 percent in 2001.
- To influence policy makers directly and indirectly. It is possible that key decision-makers such as the finance minister could reconsider and make changes in the budget after coming across your research and opinions in an influential publication or program. (South Africa’s former Minister of Finance, Trevor Manuel, acknowledged at least hearing the views of callers who contributed to a radio program called “Tips for Trevor.”) But change is more likely to happen indirectly: your media exposure provides vital information or motivation to a broad range of citizens and civil society groups, and they in turn engage in advocacy activities.

- To set the agenda. In communication circles, there’s a very famous line that goes like this: “The media may not be very successful in telling people what to think, but they are stunningly successful in telling people what to think about.” This means that the media determine the issues that the public thinks and talks about. This is only common sense: if the media don’t cover a story, nobody knows about it or talks about it. The opposite is also true: once an issue receives high levels of media coverage, it is on everybody’s lips. One of the key aims of your work with the media may be to simply put an important budget-related issue firmly onto the public agenda. Journalists are bombarded by faxes and e-mails from businesses and vested interests. Nobody will start talking about the need to improve delivery of government grants or to pay attention to the problem of rural poverty, unless you can get these issues into the media.

- To frame the way in which an issue is discussed. Framing refers to the perspective from which an issue or problem is viewed. Framing is often used in persuasive messages in an effort to link an issue with people’s key beliefs or values. For example, evaluations of a government budget may differ widely, depending on people’s perspectives and beliefs. To a person who values efficiency, a successful budget is one that shows careful use of money to achieve particular aims. To a person who values equity, a successful budget is one that helps reduce inequality, even if it means sacrificing some efficiency. Often the aim of your work with the media will be to influence the frame through which people view budget policy and implementation. Everyone may agree that education is important and that many schools lack sufficient resources. You may want to ensure that the debate focuses on how existing funds can be better spent, rather than on the need to allocate more money to education.

- To ensure journalists ask the right questions. Sometimes your work with the media can be invisible to the public, but still produce powerful results. Most journalists are not comfortable with figures, and research by journalism educators has repeatedly shown that a shockingly large number of even experienced, well-educated journalists are not good with numbers. Surprisingly, many do not even understand basic concepts such as “average” or “percentage.”
By providing them with background briefings, training, and basic analyses, you can help to ensure that they do a better job of reporting on the budget and that they ask better and more probing questions when they interview decision makers. In budget work one often finds that economic and budget issues are framed in the media from the perspective of business or the elite. For example, headlines in newspapers after budget day will often focus on the tax implications for corporations or the likely impact on foreign investment, since these aspects are important to the wealthier readers that most newspapers want to attract. Because these aspects of the budget receive a lot of focus in the elite media, policy makers feel pressured to respond to these concerns. Issues of poverty generally get much less media attention, and one can only speculate how public discussion of the budget and economic policy might shift if newspapers were to carry large front page headlines highlighting the budget’s changes to pensions or the prices of staple foods, and the implications for the poor.

- **Note:** Participants will find all this information in **READING 5.7 INTRODUCTION TO MEDIA** in their Workbooks.

### 3. INPUT AND DISCUSSION: THE CHANGING MEDIA ENVIRONMENT 10 MINUTES

- Introduce the theme of this input by talking about how the media sector is becoming increasingly diverse and complex.
  - New technologies have made it easier to produce media and easier to access a wide range of media.
  - We are also seeing a dramatic change in how news is made: 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 news.
  - We’ve seen the rise of citizen journalism, blogs, media-sharing portals, etc. These have dramatic implications for the ways in which the media influences public discussion and policy makers. For example, videos posted onto YouTube are powerful lobbying tools.
  - Likewise, in a number of countries bloggers have come to 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 constantly seek innovative and effective ways to respond.

- Each type of medium has strengths and weaknesses that need to be considered.
• Ask participants what kinds of media are most common in their countries, and which can be used for budget advocacy in particular. Ask them to think about, for example, live performance, radio, television, magazines, newspapers, etc. Allow approximately five minutes for this discussion.

4. **TASK 5.10 ■ MEDIA STRENGTHS AND WEAKNESSES** 15 MINUTES

• **The aim of this task** is for participants to examine different types of media and the strengths and weaknesses of each.

• Take three sheets of flipchart paper. On the top of the first sheet, write the heading “PRINT.” At the top of the second, write “RADIO,” and at the top of the third, “TELEVISION.”

• Distribute two different colors of flashcards or pieces of paper to each of the participants. One color will be for “strengths” and the other color for “weaknesses;” for example, green for weaknesses and yellow for strengths. This means participants should get three green flashcards and three yellow flashcards apiece so that they can write the strengths of each type of media on the green cards, and weaknesses of each on the yellow.

• Ask participants to use the colored flashcards or paper to record the strengths and weaknesses of each type of media (print, radio, and television). Allow approximately 10 minutes for this task.

• Ask participants to stick their responses up on the sheet of flipchart paper with the appropriate heading.

• When most of the contributions have been posted, ask participants to walk around and read the contributions of the other participants.

• Facilitate a brief plenary discussion to summarize the various strengths and weaknesses. Look out for the points highlighted below and fill in the gaps where necessary.

• Encourage participants to record the ideas emerging from this discussion on the worksheet for **TASK 5.10 ■ MEDIA STRENGTHS AND WEAKNESSES** in their Workbooks.

**SUMMARY OF MEDIA STRENGTHS AND WEAKNESSES**

**Print** (serious newspapers in particular)

• Good for very technical information

• Good for detailed arguments

• Good for putting matters on the record. People can keep print materials for reference and reread them if they need to check details or if they didn’t fully grasp the ideas on a first reading.
• It is often possible to pay for a special insert in a major newspaper. If an organization has conducted a budget analysis and wishes to communicate a lot of detailed information, it could consider buying space.

• Print media cannot reach people who can’t read.

Radio
• Good for immediacy and interacting with the public (for example, through a live call-in show where you can take calls and respond to queries) and for providing general information about an issue
• Radio can reach those who cannot read.
• Not very good for presenting complex, detailed information, such as long lists of budget figures
• If radio listeners aren’t able to grasp something the first time they hear it, it’s too late.
• People usually listen to the radio while doing other things, so they are easily distracted and cannot concentrate on details.

Television
• Good for visual and emotional impact
• Reactions more to how you come across on TV and less to the content of what you say

Internet (and other technologies, e.g., e-mail, cell phones, social networking sites)
• Good for immediacy, interactivity, and advocacy
• Effective to coordinate like-minded groups, build international support, and mobilize activists.
• Not available as a medium to those without access to a computer, although cell phones are more widely available.

5. Task 5.11 ■ Media Delivery Wheel Scenarios 20 MINUTES

• The aim of this task is to provide participants with an opportunity to practice tailoring an advocacy message for different audiences and to consider the challenges faced when delivering messages in different contexts and timeframes.

• Input: The way in which you deliver your advocacy message will be informed by whom you are framing the message for and by when and in what context it will be delivered. The participants have already had some practice framing messages for different audiences in this workshop.

• Highlight the points below before initiating the media wheel activity:
  - To communicate with finance officials, for example, it is important to demonstrate an understanding of how things work: procedures in the finance department, financial and other
constraints faced by government, the way in which decisions are made, etc. Finance officials are regularly bombarded by wish lists presented by all sorts of individuals and groups, and they are used to filtering these out. They know there are many competing needs and claims. They are more likely to listen to someone who understands this and offers solid, evidence-based arguments to back up any proposals.

- It is also helpful to link values-based arguments to pre-existing requirements and legal frameworks. For example, “According to the Constitution the government is obliged to provide immunization for children,” rather than “It is morally wrong to deprive children of immunization.”

- If the intention is to reach the broader public in order to motivate people to join a campaign or to pressure decision makers, then simple, punchy messages are needed. Emotional messages are also an important way of reaching a general audience.

- Ask participants to arrange themselves in two circles, with one circle inside the other. Each person in the inner circle should face a partner in the outer circle.

- The people in the inner and outer circles will take turns playing the role of a particular target audience. In each pair, one person will have a scenario to present to the other player. (Scenarios are listed below.)

- The person who is in the role of the target audience does not interrupt or ask questions when the other person is presenting the scenario.

- After one minute, ask the inner circle to move one step to the right.

- The people in the outer circle then have to explain a different scenario to the new faces in front of them. After one minute, ask the inner circle to again take one step to the right.

- Inner circle participants always move to the right; outer circle participants remain in the same place.

- Repeat this until all of the scenarios have been completed. There are four scenarios, and each participant will have two opportunities to talk.

- Facilitate a brief plenary discussion, inviting participants to comment on what they or their partners managed to convey well, struggled with, found challenging, and so forth.
SCENARIO #1: INNER CIRCLE
Your campaign HEALTH FOR ALL NOW has organized a press conference to release your recent, preliminary research findings.
You are the lead researcher for this research. As you leave the press conference, a journalist from an independent TV station confronts you and asks, “Would you say that government is corrupt and does not care about health access for the poor in our country?”

You have one minute to respond to the journalist.

SCENARIO #2: OUTER CIRCLE
The word is out. Your research has received top story coverage across Polorus.
As the advocacy head of the campaign HEALTH FOR ALL NOW, you have been invited to an interview on national radio – on the “Affairs of the Nation” program – at 7:30 in the morning on a weekday.
You are at the interview. In the studio with you is the representative for Sunrise State from the national Task Team on Health Reform. The interview starts with a short introduction about the findings of your research, and then the interviewer asks, “What do you want government to do?”

You have one minute to respond to the interviewer.

SCENARIO #3: INNER CIRCLE
As the advocacy head of the campaign, HEALTH FOR ALL NOW, you have been invited to an interview on community radio. The broadcast reaches one of the local communities in Sunrise State where you’ve been working for the last two years, identifying and documenting access to health care. The show is at 3:00 on a Saturday afternoon. The interview starts with a short introduction to the story, and then the interviewer asks, “Our community is angry. We need the money. People are suffering, dying. We feel that government just does not care about us. What is HEALTH FOR ALL NOW demanding?”

You have one minute to respond to the interviewer.

SCENARIO #4: OUTER CIRCLE
As the lead researcher for the campaign HEALTH FOR ALL, you have been invited to a roundtable discussion on a national television program, “Tell It Like It Is,” on a Sunday evening at 7:00.
At the roundtable there is a budget official from the Ministry of Health, as well as the chairperson of the Health Committee in Parliament. After a short introduction to the story, the interviewer turns to you and asks, “What is HEALTH FOR ALL demanding from government?”

You have one minute to respond to the journalist.
6. **INDIVIDUAL READING: GUIDELINES TO WORKING WITH MEDIA  45 MINUTES**

The aims of this activity are to enable participants to:

- learn key techniques for gaining media attention;
- think more fully about how best to match media publicity to the budget cycle; and
- think more creatively about how a small local organization can gain national media attention.

- Ask participants to turn to **READING 5.8 ■ GUIDELINES FOR WORKING WITH MEDIA** in their Workbooks. Invite them to spend 45 minutes reading through the material.

7. **FACILITATOR INPUT: WORKING WITH NEW MEDIA  10 MINUTES**

- **Note:** Ideally you will have Internet access in order to show participants the sites referred to. If not, be sure to load the sites beforehand or save screenshots of them.

- **The aim of this activity** is to have participants:
  - Recognize that new/digital media are crucial for advocacy;
  - Address concerns that new media are only for developed countries;
  - Recognize the importance of cell phones for advocacy in developing countries;
  - List some of the most important social networking tools; and
  - Be introduced to media tools on the Internet that could be useful for budget advocacy.

- **Input:** We have mentioned the rising importance of new or digital media, but up to now, have focused mainly on mainstream/traditional or “old” media. However, it is crucial to be aware of the exciting possibilities presented by the Internet, social networking, and mobile phones in advocacy.

- The mainstream media will be with us for a long time yet, especially in developing countries, but the new digital media are rapidly changing the media scene. Even a small organization can use the Internet and cell phone technology to have a huge impact.

- Sometimes people argue that the new media are not very relevant in developing countries, as most of the population does not have access to the Internet. However, this argument does not take account of several factors:
  - It is important to differentiate audiences in advocacy. Emphasize that donors, international organizations, business people, policy makers, and journalists DO have access to and use new media more and more. If you do not use the Internet and many of the social networking tools it offers, you will not be reaching these key audiences. New media can be very effectively used to reach journalists, who in turn can give you exposure in the mainstream media.
- The rise of mobile phones and mobile Internet access. While most ordinary people do not have computers, the use of mobile phones is widespread. Ordinary people in developing countries are increasingly using mobile phones to access the Internet and social networking applications such as Facebook. In addition, even when people don’t have sophisticated phones, basic technology such as SMS/text messages can be used powerfully as a campaign or advocacy tool.

- So, what do the Internet and new media offer that mainstream media don’t?
  - The ability to tell your story and get your message across to your audience directly, without journalists as the “middlemen.”
  - An ability to cover the kinds of issues and tell the kinds of stories that mainstream journalists are often not interested in covering.
  - The power of numbers. Social networking tools make use ordinary people’s networks of friends and acquaintances to spread messages rapidly, often to vast numbers of people.

8. **Take a Walk: Sharing Experiences of New Media**  
**20 MINUTES**

- Invite participants to self-select a group of four people. Suggest that they take a walk around the workshop venue for 10 minutes – outside of the workshop room – while discussing and sharing ideas of new media. Encourage participants to share how they have used certain “new” media.

- Ask participants to discuss: *How can we use this media particularly to get across information about the budget?*

- Before they leave on their walk, share the following two examples:
  - **Facebook**: Unless you’ve been living on another planet for the past few years, chances are you know about Facebook already and have your own Facebook account. Facebook is a social networking site that allows people to link with their friends online. It can be accessed on the Internet via computers and Internet-capable mobile phones. Facebook offers powerful advocacy opportunities: you can create groups on Facebook, highlight causes, and share news, views, photographs, and more. A recent example of the power of Facebook occurred in January 2010, when women all over the world suddenly started posting their bra color as their Facebook status, apparently as a way of raising awareness of breast cancer. It seems unclear where this started; it spread virally and rapidly, an excellent illustration of the huge power of Facebook’s social networks. For more information on this see links in Reading 5.10: Sample Media in your Workbook.

- **SMS**: The plain old short message service or SMS on your mobile phone can be very powerful. It has been used to send out information rapidly to large numbers of people (either through bulk SMS services that allow you to send out a message to hundreds or even
thousands of people at the same time, or through networking, where people just keep passing messages on to their friends, and their friends, and their friends...). It has also been used to gather important information from the field (such as having activists visit clinics and send SMS messages to a central point, indicating which clinics are out-of-stock of certain essential medicines).

- There are a number of online tools that can assist you to use the power of SMS. One example is Frontline SMS, a large-scale texting tool for NGOs. Also have a look at Mobile Active, a global network of people using mobile services for development.

- Following their walk, invite one or two participants to share their experiences and ideas about how these new media can be used in budget advocacy. Be sure that participants include some of these examples of new media:

  - **Blogging:** A blog is really an online journal or diary, or even a mini-website, which allows you to express opinions; cover news; share photos, videos, and even audio recordings; and also provide links to other websites that you think are relevant for your audience and message. The most popular blogging sites are WordPress and Blogger. At either of these sites you can very quickly – and without having any technical knowledge – set up your own free blog or mini-website. If you know how to send an email, you can set up your own blog – it’s that easy! For an example of how WordPress can be used to set up a campaign website, have a look at the link in your Workbook. Also check out the IBP’s Open Budgets Blog.

  - **Citizen Journalism:** Citizen journalism refers to the fact that digital media now allows ordinary people to act as journalists. Using computers, mobile phones, digital cameras (including cameras on mobile phones), ordinary people around the world are able to produce and publish stories of importance to them. Citizen journalism can include blogs, but is not limited to blogging. Some citizen journalism sites combine citizen journalism with an editorial staff, in order to ensure stories comply with certain minimum standards. One example is Global Voices Online.

  - **Twitter:** Twitter is almost like SMS, but it’s online. It is a service that allows you to send very short messages (maximum 140 characters) to people who are “following” you. You can also sign up to follow others and get their updates, known as “tweets.” A lot of what is on Twitter is really trivial (e.g., “I am having breakfast now.”), but many people use Twitter almost like newspaper headlines: to alert their followers to news or to an interesting website or blog. They do this by providing a brief alert, followed by a link to the site in question.
- **YouTube:** YouTube allows you to create, share, and view videos online. It has a specific “channel” dedicated to non-profit groups. Many organizations have used this effectively to share advocacy messages. A good example is the Aids and Rights Alliance of Southern Africa (ARASA). The link to their video is provided in your Workbook. Also check out the IBP video on social audits in Kenya, “It’s Our Money. Where’s It Gone?”

- These are just a few of the sites and technologies available. There are many, many more, and new ones are springing up every day. It’s important to be alert and to try to keep up with new developments by reading blogs and participating in online social networks.

- Refer participants to **READING 7.9 ■ NEW MEDIA,** which includes information on some useful links.

### 9. **ROUNDTABLE: ENGAGING WITH MEDIA – PRACTICAL TIPS** 20 MINUTES

- **The aim of this roundtable** is to enable participants to practice writing and developing advocacy messages for different media.

- Refer participants to **READING 5.8 ■ GUIDELINES FOR WORKING WITH MEDIA.**

- Use four sheets of colored A4 paper to print out these four headings (*see full list of headings with bullet points below*): **WRITING A MEDIA (PRESS) RELEASE; GUIDELINES FOR PRESS CONFERENCES; GUIDELINES FOR INTERVIEWS; MAKING PRESENTATIONS.** Print each one on a different color of paper (e.g., blue, green, yellow, pink).

- Print out each of the bullet points below each heading, with each one on a separate sheet of paper.

- Use different colors of paper for each heading and related bullet points. For example, if you print “Writing a Media (Press) Release” on blue paper, then the bullet points under that heading should also be printed on blue paper.

- Arrange four tables around the workshop room and place on each table a “packet,” that is, one of the headings and the bullet points associated with it. So on one table, you will place the blue paper with the heading “Writing a Media (Press) Release” along with the bullet points printed on separate sheets of blue paper, and so forth.

- Below is an example of how to prepare the media cards, using the information about “Writing a Media (Press) Release”.

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EXAMPLE OF HOW TO PREPARE MEDIA CARDS (each text box represents a sheet of paper):

<table>
<thead>
<tr>
<th>Writing a Media (Press) Release</th>
<th>Press releases should appear on your organization’s stationery. They should try to cover all the classic questions that journalists are taught to ask in relation to the topic being addressed: who, what, when, where, how, and why.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Press releases should have short, informative headings, and should be written so as to grab the reader’s attention. It can be very effective to compose press releases according to the so-called “inverted triangle” format: the most important information in the initial paragraph(s), tailing down to the less important information lower down (such as background about the organization and more in-depth details).</td>
<td></td>
</tr>
<tr>
<td>Provide concise and interesting quotes within the body of the press release and attribute them to organizational spokespersons. For example: “The head of the Give Us Medicines campaign, Moreblessings Lopez, says, “The government has repeatedly denied that medicines are out-of-stock. Our spot check shows that shortages do exist, and we hope the government will now act quickly to ensure that these drugs are available in clinics countrywide.”</td>
<td></td>
</tr>
</tbody>
</table>

- Invite participants to walk from table to table and read the “packet” on each table. Encourage participants to walk in pairs and discuss what they read.

CONTENT FOR MEDIA CARDS:

Writing a Media (Press) Release

- Press releases should appear on your organization’s stationery. They should try to cover all the classic questions that journalists are taught to ask in relation to the topic being addressed: who, what, when, where, how, and why.
- Press releases should have short, informative headings, and should be written so as to grab the reader’s attention. It can be very effective to compose press releases according to the so-called “inverted triangle” format: the most important information in the initial paragraph(s), tailing down to the less important information lower down (such as background about the organization and more in-depth details).
- Provide concise and interesting quotes within the body of the press release and attribute them to organizational spokespersons. For example:
“The head of the Give Us Medicines campaign, Moreblessings Lopez, says, ‘The government has repeatedly denied that medicines are out-of-stock. Our spot check shows that shortages do exist, and we hope the government will now act quickly to ensure that these drugs are available in clinics countrywide.’”

- Standard information about the organization (such as the organization’s mission and key background details) should be included at the end of the press release.

- Once a press release is distributed (by fax, email, or other means), it is important to follow up with a phone call to key journalists and editors to make sure the release has been received and that it has been noticed.

- It is important to include a release date (and embargo details, if applicable), along with the name/s of the contact person/people, and associated telephone and email details, to enable journalists to follow up, if they want further information.

Guidelines for Press Conferences

- Press conferences should be held rarely. As a rule of thumb, only hold a press conference when issues are so complex that you need to provide detailed explanations as well as interaction with journalists to ensure that all questions are dealt with, or when you want to intentionally dramatize an announcement. Journalists are busy and will not attend a press conference unless the matter is especially important or dramatic.

- Press conferences should be held as close to most media organizations’ offices as possible, and at times that take into account the deadlines of the key media in which you want the news to appear.

- At the press conference, take a register of journalists who attend. This will help you track which reporters and media outlets are actually interested in your issue, as well as provide you with useful contact names and numbers. The register can also be used to identify the media that should be monitored afterwards, in order to monitor coverage.

- Press kits should be prepared beforehand and handed out to reporters. These should contain hard copies of all statements or speeches to be made at the press conference, as well as any useful background information. This should come in the form of press-friendly briefing sheets rather than long academic papers. Photographs are also a good idea. It can be a good idea to provide a CD or DVD containing photographs, background material, and short audio and video clips. However, it is important to investigate beforehand which technologies invited media have access to in order to ensure you provide material in the most useful format.

- It is a good idea to have two or three speakers, so that journalists can gain a variety of quotes and perspectives – but not too many. Journalists should not feel their time is being wasted for the
sake of letting organizational office bearers feel important. Be sure to allow enough time for
questions from the floor.

- It can be a good idea to provide opportunities for media to interview individuals who are affected
  in some way. For example, at a press conference to announce the results of research into the
  number of gun-related deaths, Gun Free South Africa arranged for some people who had lost
  family members to gun violence to be present and tell their stories. This provided powerful
  emotional content and gave a human face to the statistics presented in the research.

Guidelines for Interviews

- Ahead of any interview, it is important to be sure of the purpose of the interview.
- If the interview is requested by a journalist, it is important to find out not just the purpose of the
  interview, but also when and where it will appear, the length (size of story, number of words, time
  in minutes), when and where the interview will be held, and the name of the interviewer.
- For television and radio, it is important to know whether the interview will be live or prerecorded
  (and probably edited beforehand).
- It is advisable to settle on no more than three key points that you wish to get across during any
  specific interview, and to stick to these. For television and radio news and current affairs, answers
  to questions should generally be short and to the point – around 20 to 40 seconds. Answers
  should never exceed a minute.
- It is important to prepare key quotes or “sound bites” that are catchy and effective. Sound bites
  are short audio clips that journalists use in television and radio news reports. The standard sound
  bite used during a radio news bulletin lasts about 12 seconds; during a current affairs report,
  perhaps 30 seconds to a minute. Television news sound bites are short – 10 to 15 seconds. Thus,
  prepare punchy, memorable phrases that are 10-12 seconds long, which encapsulate a key point
  you want to make.
- Language should be kept clear and simple. Steer away from excessively complex arguments as well
  as too many facts and figures. However, two or three well-chosen statistics can be used very
  effectively. It is important, though, to think about the simplest ways of getting figures across (for
  example, say “five out of every ten people,” rather than “fifty percent of the population.”).
- It is always a good idea to provide one or two concrete examples to illustrate each key point being
  made – particularly if the points being made are relatively abstract issues of process or policy.
- Practice and preparation are key. It is a good idea to rehearse with a colleague beforehand and to
  anticipate possible negative questions and pitfalls. It is also a good idea to have someone record all
  interviews and to listen to them afterwards in order to identify mistakes or areas for improvement.
Making Presentations

- Presentations are crucial. Whether you are addressing journalists at a press conference or members of the parliamentary health committee, you need to be able to get your message across clearly and effectively. Remember also that the members of your audience hear many presentations; yours needs to stand out so that they remember it. Here are some tips:

**Preparation**

- Your presentation starts long before you stand in front of your audience. Preparation is crucially important.
- Defining the objective of your presentation. Be clear about what you want to achieve, or what you want to convey to your audience.
- What do you want them to remember? Think about ways to make your key message stick.
- Engage your audience by building on what they already know. Use familiar reference points.
- Make what you say important to your audience. Put yourself in their shoes and think about why they would care about your issue.
- People remember firsts and lasts. Pay attention to the end and the beginning.
- Give them reason to listen. Break their pattern. Present the unexpected.
- Have a strong, clear ending.

**Ensuring Impact**

- Plan your words, one idea per sentence.
- Use active verbs.
- Paint pictures: SHOW, don’t tell.
- Use the power of visual communication – use graphics, photographs, and maps to help your audience understand your research and what it means.
- Everyone has a preferred sense for learning -- make use of the five senses as much as possible. Use visuals and audio if you can.

**Delivery**

- Take control of the room. You must be in charge.
- Start with energy. Show enthusiasm.
- Position yourself in the same area as your visual aids. Don’t make your audience divide their attention between you and a screen.
- Keep looking forward. Always focus on your audience. Don’t have your back to them while you look at the screen.
- Signpost important points. You can literally say, “Now this next point is very important!”
- Consider the wider environment: Are there noises outside the room, are people too cold or too hot? Often, if you briefly acknowledge distracting factors, the audience will be able to put the distraction out of their minds and refocus on you.
- Pay attention to your voice: clarity, projection, pace, and pauses.
- Make eye contact with your audience.
- If possible, handle questions and answers before your ending, then wrap up with a strong take-home message, a definite, clear climax.

**Visual Aids**
- If you use PowerPoint, use it effectively (see below).
- Remember PowerPoint is just one possible tool among many. You don’t have to use it.
- Think about using other types of visual aids, such as flipcharts, whiteboards, and others. Be creative.
- Have handouts for your audience.

**Use PowerPoint Effectively**
- PowerPoint can be a powerful tool, but too often it is used badly, putting audiences to sleep.
- You don’t want your audience focused on the screen and not on you. Your slides should support you, not take over.
- *Don’t* write your presentation using PowerPoint. Prepare and structure your presentation and *only then* go to PowerPoint and think about how you can use slides to support your presentation.
- Keep slides simple. *Less is more!* Leave the detailed notes for the handouts. One idea per sentence. Short sentences. Maximum three sentences per slide. Some of the most effective slides can consist of just one word. Or an image.
- Be sure that any graphs and other illustrations with your budget information are clear, that they can be understood and interpreted at first glance.
- Avoid busy backgrounds, fancy colors, and other visual gimmicks. Plain black on white is often the best. Every element should support your message, not detract from it.
- Don’t be a disembodied voice in a darkened room, with everyone just staring at your slides.
- Continually bring your audience’s focus back to you. (Tip: You can use the “W” key to make the screen go white, or the “B” key to make it go black.)
- Remember that the most memorable speeches in history were given without slides. Winston Churchill, Martin Luther King, and Nelson Mandela never used PowerPoint!
**TASK 5.10 ■ MEDIA STRENGTHS AND WEAKNESSES**

What are the strengths and weaknesses of each of the following types of media?

**PRINT**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**RADIO**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**TELEVISION**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
**TASK 5.11 ■ MEDIA DELIVERY WHEEL SCENARIOS**

**SCENARIO #1: INNER CIRCLE**
Your campaign HEALTH FOR ALL NOW has organized a press conference to release your recent, preliminary research findings. You are the lead researcher for this research. As you leave the press conference, a journalist from an independent TV station confronts you and asks, “Would you say that government is corrupt and does not care about health access for the poor in our country?”

*You have one minute to respond to the journalist.*

**SCENARIO #2: OUTER CIRCLE**
The word is out. Your research has received top story coverage across Polarus.
As the advocacy head of the campaign HEALTH FOR ALL NOW, you have been invited to an interview on national radio – on the “Affairs of the Nation” program – at 7:30 in the morning on a weekday. You are at the interview. In the studio with you is the state representative for Sunrise State from the national Task Team on Health Reform. The interview starts with a short introduction about the findings of your research, and then the interviewer asks, “What do you want government to do?”

*You have one minute to respond to the interviewer.*

**SCENARIO #3: INNER CIRCLE**
As the advocacy head of the campaign, HEALTH FOR ALL NOW, you have been invited to an interview on community radio. The broadcast reaches one of the local communities in Sunrise State where you’ve been working for the last two years, identifying and documenting access to health care. The show is at 3:00 on a Saturday afternoon. The interview starts with a short introduction to the story, and then the interviewer asks, “Our community is angry. We need the money. People are suffering, dying. We feel that government just does not care about us. What is HEALTH FOR ALL NOW demanding?”

*You have one minute to respond to the interviewer.*

**SCENARIO #4: OUTER CIRCLE**
As the lead researcher for the campaign HEALTH FOR ALL, you have been invited to a roundtable discussion on a national television program, “Tell It Like It Is,” on a Sunday evening at 7:00.
At the roundtable there is a budget official from the Ministry of Health, as well as the chairperson of the Health Committee in parliament. After a short introduction to the story, the interviewer turns to you and asks, “What is HEALTH FOR ALL demanding from government?”

*You have one minute to respond to the journalist.*
READING 5.7 ■ INTRODUCTION TO MEDIA

WHY WORK WITH THE MEDIA?
The media play a key role in today’s society, and no advocacy or communications campaign can hope to succeed without media exposure. In any campaign, there are usually three possible objectives, and most campaigns pursue some combination of them:

- To inform and educate;
- To change attitudes and beliefs; and
- To change behavior.

These objectives are progressively more difficult to achieve. It is easier to inform and educate than to change attitudes and beliefs. It is extremely difficult to change behavior through the media, as has been demonstrated, for example, by campaigns to prevent the spread of HIV/AIDS.

For an organization involved in budget advocacy work, this means that media campaigns will be good for creating awareness of budget-related issues and perspectives. However, to change behavior — for example, changing the decisions of policy makers or the votes of legislators — it is not enough to use the media alone. Media activities need to be part of a broader, integrated advocacy campaign.

THE CHANGING MEDIA ENVIRONMENT

The media sector is becoming increasingly diverse and complex, and audiences are fragmenting. In most countries, the days are gone when you could get a story on national radio or TV or into a major newspaper and be assured that most people would see or hear it. At the same time, new technologies mean that it’s easier to produce media and to access a wide range of media. There’s digital TV with hundreds of channels, cell phones, new radio stations, and the Internet. We are also seeing 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, among others.

Another key trend is technological convergence. You can now watch TV and listen to the radio on your cell phone, read newspapers online, surf the Internet on your TV with the aid of a special set-top box, make phone calls from your PC, record audio using your phone or MP3 player, and reach a wide audience by posting podcasts, photos, or videos on the Internet. These have dramatic implications for the ways in which the media can influence public discussion and policy makers. Likewise, in a number of countries, bloggers have come to 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 constantly seek innovative and effective ways to respond to them.

**TYPES OF MEDIA**

Here is a (non-comprehensive) list of various types of media and various ways of classifying them. One could go further and break things down according to types of content and format. It is also important to consider the types of audiences reached by each type of media. All of these factors must be considered when planning a media campaign.

**Newspapers**
- national
- regional
- community/neighborhood
- daily vs. weekly
- “serious” vs. tabloid

**Magazines**
- from beauty to celebrity to sports to news and current affairs
- weekly, monthly, bimonthly, and quarterly
- local, regional, national, and international

**Radio**
- commercial vs. public service and community
- local, regional, national, and international
- various language services
- international broadcasters (BBC World Service, Radio France Internationale–RFI, Radio Netherlands, Voice of America, etc.)

**Television**
- free (broadcast) vs. subscription (cable/satellite)
- local/regional vs. national and international

**Live Performance**
- community-based educational drama
- industrial theatre
Internet and Social Media

- blogs
- e-mail newsletters
- citizen media and file-sharing portals (e.g., YouTube, Instagram, Pinterest)
- online newspapers, magazines, and radio stations
- organizational websites
- social media sites (e.g., Facebook, LinkedIn, Twitter)
- podcasts
- mobile phones
  - text messaging (SMS)
  - mobile Internet
  - mobile phone applications (“apps”)
  - interactive services such as instant polling and SMS-searchable databases
  - downloadable content (e.g., ringtones, videos, etc.)
  - mobizens (mobile “magazines”)

**DIFFERENTIATING AUDIENCES**

It is important to identify your key audiences and then target them through the appropriate media. Common sense goes a long way, but it is also worthwhile to do some research on the audiences of the various publications and broadcast outlets you are thinking of targeting. These days, almost all media organizations have their own websites, and one can usually find useful facts and figures there, such as target audience, audience size, and so on.

Here are some examples of audiences and media that an organization involved in applied budget work might want to target:

- **Finance officials:** weekly financial magazines, business newspapers, business inserts in major newspapers, opinion pages of major newspapers, current affairs programs, and talk shows on national radio. The Internet is becoming an increasingly important medium for this group. Weekly financial magazines are beginning to place increasing emphasis on their online versions, and some influential business and financial media operate solely online (for example, the South African-based Moneyweb): “We have decided to invest more on the Internet because that is where the market is going,” according to Rikus Delport, editor, *Finweek*, quoted in *The Media* magazine, February 2007, South Africa. It would also be important to target influential bloggers or columnists for online publications.
• Other NGOs/CSOs: specialist development publications; development supplements in newspapers or magazines; key websites or portals (e.g., 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 with substantial news and talk content; TV stations with news and public affairs programs.

MATCHING MEDIUM TO CONTENT

Each type of medium has its strengths and weaknesses, and you need to take these into consideration.

• Print (serious newspapers in particular) is good for very technical information, detailed arguments, and putting matters on record. People can keep print material for reference purposes and reread it if they need to check the details or if they didn’t understand all of the issues the first time through. If you have conducted a budget analysis and wish to communicate a lot of rather detailed information, you might consider paying for a special insert in a major newspaper.

• Radio is good for immediacy, for providing general information about an issue, and for interacting with the public (for example, through a live call-in show where you can take calls and respond to queries). It’s not very good for presenting complex, detailed information such as long lists of budget figures. The downside of radio is that if listeners aren’t able to grasp something the first time they hear it, it’s too late. People usually listen to the radio while doing other things, so they are easily distracted and cannot concentrate on details.

• Television is good for visual and emotional impact. Television viewers tend to react more according to your appearance of competence and trustworthiness and less according to the content of what you say.

• The Internet and other technologies, such as e-mail and cell phones, are good for immediacy, interactivity, and advocacy. They can be used very effectively to coordinate like-minded groups, build international support, and mobilize activists.

MATCHING CONTENT TO AUDIENCE

It is also important to tailor your content to the audience you are trying to reach. If you wish to communicate with finance officials, for example, it is important to demonstrate an understanding of how things work, for example, procedures in the finance department, financial and other constraints faced by government, the way in which decisions are made, etc. Finance officials are regularly
bombarded by wish lists presented by all sorts of individuals and groups, and they are used to filtering these out. They know there are many competing needs and claims; therefore, they are more likely to listen to people who show that they understand these constraints, and who offer solid, evidence-based arguments to back up their proposals.

It is also helpful to link values-based arguments to pre-existing requirements and legal frameworks — for example, “according to the Constitution the government is obliged to provide education for children,” rather than “it is morally wrong to deprive children of their education.”

If you wish to reach the broader public, in order to motivate people to join a campaign or to pressure decision makers, then simple, punchy messages are needed. Emotional messages are also an important way of reaching a general audience.
GUIDELINES FOR WORKING WITH MEDIA

A. TECHNIQUES FOR GAINING MEDIA ATTENTION

Make Press Calls

It is important to maintain regular contact with key journalists. Telephone conversations can be very effective in promoting a story or responding to an event or previous news coverage. Be sure to find out what the various deadlines are and to call journalists when they are not under immediate deadline pressure (this varies greatly across medium and outlet). You can greatly increase the likelihood of getting exposure if you follow up an e-mail or fax with a telephone call to ensure the journalist or editor has received or taken note of your message.

It is useful to understand the key role players:

- **Editors** are the senior editorial decision makers, but they are often caught up in management and policy issues and may not be very involved in day-to-day story assignments.

- **Sub-editors** are essentially copy editors. They check facts, grammar, and spelling, and they help lay out pages. They are not involved in news gathering.

- **News editors** are responsible for day-to-day decisions on which stories will be covered and for assigning journalists to cover stories. These are key contact people for any organization seeking news coverage.

- **Journalists/reporters** go out and interview people and cover the news. It is important to identify these key journalists and build relationships with them.

- **Specialist reporters** focus on thematic areas such as economics, finance, health, etc. It is particularly important to build relationships with reporters who specialize in areas that are of particular concern to your organization.

- **Producers (radio and TV)** are responsible for decisions on program or bulletin content, setting up interviews, etc. There is generally a hierarchy of producers, and it is important to find out which producer is the right one to talk to.

It is also important to understand the news or content cycle of the media organizations that you interact with – for example, to know what their deadlines are – to ensure that you are able to get press releases to them in time and that you schedule your press conferences at times when most journalists are able to attend. When you want to talk to journalists, it is generally best to call in the mornings (for dailies) and early in the week (for weeklies). For current affairs programs on radio and television, be sure to call well ahead of the program’s broadcast time – unless you have dramatic, breaking news to
share. Magazines are usually prepared well in advance of publication date (often months to weeks ahead), so it’s essential to contact them ahead of time.

Distribute Press Releases
There are no hard and fast rules about how often press releases should be issued, but it is important to issue a press release only when you have something new to say. They should not be sent out so often that journalists begin to see them as clutter. There is an art to writing press releases, and they should be written more or less as you would like to see the story reported. Bear in mind that newsrooms are usually under-resourced and that the media often use press releases “as is,” in unaltered form. You should include a good mix of facts and figures, as well as ready-made quotes that can be easily lifted out of the press release and repeated in the media.

Hold Press Conferences When Called For
According to A Media Relations Handbook for Non-Governmental Organizations, there are only two reasons to have a press conference: 1) when you are communicating information that is so complex that you need to interact with journalists in order to ensure clarity and 2) when you intentionally want to dramatize your announcement. When holding a press conference, timing and location are everything. A senior newspaper editor in Cape Town, South Africa once told a group of police service communications officers that he is far more likely to send a journalist to a press conference if it is within walking distance or just a short drive from the paper’s offices. Also, press conferences should be held at times when most journalists are not on or nearing deadline (unless it is very important breaking news that cannot wait).

Stage Events
Journalists tend to report on events, not issues. For example, journalists in Southern Africa have often been criticized for their tendency to report on conferences. However, this can be used to advantage by an organization seeking to get an issue into the media: invite journalists to conferences on key issues and line up interesting people to be interviewed. Marches, protests, exhibitions, festivals, parades, competitions, and the like are all good ways to generate media attention. It is important that events provide plenty of visual interest.

Participate in Talk Shows
Talk shows on radio and increasingly on TV are an excellent way to generate and influence discussion of your issue. Talk show producers are constantly looking for new and interesting ideas, so it can be a good idea to contact them, suggest talk show topics, and also offer one or two people as studio guests. Alternatively, you can call in during existing live programs to get a point across.

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Write Letters to the Editor

Letters to the editor can be a very effective way of getting a point across, particularly in response to articles or opinion pieces that have recently appeared in a particular publication. Some political parties make a regular practice of getting staff members to write letters to newspapers, under the pretext of being ordinary members of the public.

Contribute Op-Ed Articles

Many newspapers regularly publish opinion articles contributed by members of the public such as academics and NGO staff. It is important to understand the audience and style of each publication and to communicate with opinion page editors well before the desired date of publication, as most papers receive many more contributions than they could ever publish.

Provide Background Information and Briefings

It can be a good idea to hold informal media briefings, such as a breakfast or lunch, where a small group of journalists is invited to meet and talk with one or two experts on an issue. Such meetings have the two-fold benefit of helping journalists become more informed about an issue and building relationships between journalists and an organization.

A number of organizations also seek to promote improved coverage of specific issues by developing background material such as issue summaries, toolkits, and answers to frequently asked questions. For example, in South Africa the organization IDASA developed a website called “Word on the Street,” which provided background material to journalists covering local government in South Africa. (The website is no longer active, here is an article about “Word on the Street”: http://www.ngopulse.org/article/idasa-web-resource-targets-community-media). The London-based organization Panos has a site called i-Witness (panosblogs.com/iwitnesses), which contains toolkits to help journalists understand issues related to the Information Society.

Be a Good Source

- Be available: Establishing a relationship with journalists is a two-way street. If you expect them to pay attention to you and to cover your issue, you need to be available when they need you. If you are helpful and available when a journalist needs a quick quote just before deadline or some complex matter explained, they will be more likely to lend you a sympathetic ear when you need a favor.

- Be credible: Journalists need to be able to trust their sources. It is important to be sure that all information provided to the media is accurate. Often, it can be helpful to tell reporters where they can go to get the story substantiated. Do not speak on issues that you do not know enough about, even if pressured to do so.
• **Don’t become an annoyance:** Do not harass journalists or call them too often. They will start to find ways to avoid you. Be as persuasive as you can be, but if a journalist turns you down, learn to take no for an answer and don’t become rude or nasty. There are many stories competing for attention, and many reasons why a newspaper or radio station might not be able to carry your story on any particular day.

**Come Up With Interesting News Angles for Regular Events or Calendar Dates**

There are many calendar dates throughout the year that can potentially be used to publicize your issue – for example, national public holidays and internationally recognized days such as International Women’s Day, International AIDS Day, Human Rights Day, etc. Journalists are often looking for new angles for stories on or around such calendar dates. Bear in mind that coverage related to regular dates tends to be planned well in advance so communicate with potential media outlets far ahead of the desired publication or broadcast date.

**Be Aware of the News Cycle and the Budget Cycle**

It is important to think strategically and to time advocacy activities, including media exposure, so that they can have the most impact. If you want to influence the content of the national budget, it is important to engage in media activities during the budget planning phase, which is well before the day of the budget speech in the legislature. By the time the budget has been announced, it is too late. Of course, at that time you may want to add your comments on the budget and evaluate it, but if you want to bring about changes in allocations, you will have to begin working towards the next budget. Once the budget vote has been passed in the legislature, it is a good time to highlight issues such as spending capacity and obstacles in service delivery. Around the auditing and reporting period, you would probably want to focus your messages on issues of financial management in government departments.

**How Does a Small Budget Advocacy Organization Get Into the National News?**

• It can be difficult for a small local-level organization to gain national media attention, but it is not impossible. First, appearance is everything. If you put out professional press releases, use e-mail and the Internet intelligently, and show that you know what you are talking about by providing solid analysis and credible information, no one need know that your organization is small in size or has its headquarters in a small town. Many a successful media campaign has been run by one dedicated person with a computer and a fax machine.

• Use the techniques for getting media attention that are outlined above. If you can get into the minds of journalists, think like they do, and then present stories and news angles that grab them, you will have a high degree of success.
Focus your advocacy on actions and events and not processes and ideas. To most journalists, news is something that happens, that can be seen or heard, and that occurs at a specific time and place. Marches are news. Workshops are almost never news. A research survey is not news — but an event where a high-profile person announces dramatic research findings is news. A book is not news — but a book launch where a panel of prominent speakers are discussing issues raised by the book may be. The following is a good example of a newsworthy event: a South African business advocacy organization struggled to get media attention until it staged a huge event in which business leaders walked across South Africa in relays.

Finally, be sure that your messages deal with issues of national concern. If you do highlight local issues and concerns, be sure to link these to and show how they have an impact on issues that are prominent on the national agenda.

**B. WRITING A MEDIA (PRESS) RELEASE**

Press releases should appear on your organization’s stationery, so that they appear professional and so that the organization’s name, logo, and contact information are clearly visible. Press releases should try to cover all of the classic questions that journalists are taught to ask in relation to an issue that they are covering: who, what, when, where, why, and how.

Press releases should have a short, informative heading and should be written in a way that immediately grabs the reader’s attention. It can be very effective to compose press releases according to the so-called “inverted triangle” format: the most important information in the initial paragraph(s) with the least important information lower down (such as more in-depth details and the background of the organization).

For example, below are two possible opening paragraphs to a press release outlining the results of a research survey. The second is likely to have more impact than the first:

1) “The Budget Policy Group has published the results of an extensive survey on the impact of cash grants on vulnerable communities. The survey was carried out in six Southern African countries and involved interviews with over 2,000 respondents in each country. It reveals several problems with respect to the government grant system…”

2) “New research by the Budget Policy Group shows that 2 million poor people in Southern Africa are not accessing government grants. The research reveals that, despite government efforts to register eligible grant recipients, most poor people find it difficult to fulfill all of the requirements…”
The second example gets right into the key findings of the research and has a much greater chance of grabbing a journalist’s attention. In the first example, after the first paragraph you still don’t know what the research findings were.

Provide brief and attention-grabbing quotes within the body of the press release and attribute them to organizational spokespersons. For example, “The BPG’s research director, Blessings April, explains, ‘We hope this report will lead governments to reconsider the administrative requirements that potential grant beneficiaries have to fulfill.’”

Standard information about the organization should be included at the end of the press release, such as the organization’s mission and key background details.

Once a press release is distributed (by fax, e-mail, or other means), it is important to follow up with a phone call to key journalists and editors to make sure the release has been received and that it is noticed.

It is important to include a release date (and embargo details if applicable), along with the name of a contact person and associated telephone numbers and e-mail addresses to enable journalists to follow up if they want further information.

C. GUIDELINES FOR PRESS CONFERENCES

Press conferences should be held only on rare occasions. Journalists are busy and will not attend a press conference unless the matter is especially important or dramatic. As a rule of thumb, only hold a press conference when the issues are so complex that you need to provide detailed explanations and interact with journalists directly in order to ensure that all questions are dealt with. A press conference can also be held when you want to intentionally dramatize an announcement.

Press conferences should be held as close to most media organizations’ offices as possible and at times that take into account the deadlines of the key media in which you want your conference to appear.

At the press conference, make a register of journalists who attend. This will help you to track which reporters and media outlets are actually interested in your issue, as well as provide you with useful contact names and numbers. The register can also be used to identify which media should be monitored afterwards in order to track coverage.

Press kits should be prepared beforehand and handed out to reporters. These should contain hard copies of all statements or speeches to be made at the press conference as well as any useful background information. This material should come in the form of press-friendly briefing sheets rather than long academic papers. It can also be a good idea to provide a CD or DVD containing
photographs, background material, and short audio and video clips. However, it is important to investigate beforehand what technology the invited media outlets have access to so as to ensure that you provide material in the most useful format.

- It is a good idea to have two or three speakers, so that journalists can gather a variety of quotes and perspectives. However, there should not be too many speakers so that journalists feel their time is being wasted for the sake of letting organizational office holders feel important. Be sure to allow enough time for questions from the floor.

- It can be a good idea to provide opportunities for media to interview individuals who are affected in some way by your issue. For example, at a press conference to announce the results of research into the number of gun-related deaths in South Africa, the organization Gun Free South Africa arranged for some people who had lost family members to gun violence to be present to tell their stories. This provided powerful emotional content and gave a human face to the statistics presented in the research.

D. GUIDELINES FOR INTERVIEWS

- Ahead of any interview, it is critical to understand the purpose of the interview. If the interview was requested by a journalist, it is important to find out the purpose of the interview, when and where it will appear, the length (size of story, number of words, time in minutes), when and where the interview will take place, and the name of the interviewer.

- For television and radio, it is important to know whether the interview will appear live or be pre-recorded (and probably edited beforehand).

- It is advisable to settle on no more than three key points that you wish to get across during any specific interview and to stick to these. For television and radio news and current affairs programs, answers to questions should generally be short and to the point, around 20 to 40 seconds. Answers should never exceed a minute.

- It is very important to prepare key quotes or “sound bites” that are catchy and effective. The standard sound bite used during a radio news bulletin usually lasts about 12 seconds. During a current affairs report, perhaps 30 seconds to a minute. Television news sound bites are also short at 10 to 15 seconds. So prepare punchy, memorable quotes of various lengths — 10 to 12 seconds, 30 seconds, and 60 seconds — that encapsulate a key point that you want to make. A well-known example of a memorable sound bite is from the famous O.J. Simpson trial in the mid-1990s: “If the glove doesn’t fit, you must acquit!”

- Language should be kept clear and simple. Steer away from excessively complex arguments and too many facts and figures. Two or three well-chosen statistics can be used very effectively. It is
important to think about the simplest ways of getting figures across. For example, say “five out of every ten people” rather than “fifty percent of the population.” Similarly, it is a good idea to use descriptive language and images and metaphors that will resonate with the audience. For example, you might say “If we compared income to buildings, the income of the poorest Brazilians would be a doll’s house, 2 cm high, while the income of the richest would be a skyscraper reaching from the earth to the moon.” It is always a good idea to provide one or two concrete examples to illustrate each key point being made, particularly if the points are relatively abstract issues of process or policy.

- It is important never to become irritated or aggressive. When faced with a negative question, deal with it truthfully and then go on to emphasize a positive point. During live interviews it is generally possible to steer the focus back to one of your predetermined key points, even if the interviewer begins to focus on areas that you do not wish to discuss. For example, in response to a negative or critical question, you might say, “Well, our critics do say that, but that is not the real issue. The real issue is . . .”

- Practice and preparation are critical. It is a good idea to rehearse with a colleague beforehand and to anticipate possible negative questions and pitfalls. It is also a good idea to have someone record all interviews and listen to them afterwards in order to identify mistakes or areas for improvement.

E. GUIDELINES FOR MAKING PRESENTATIONS

- Presentations are crucial. Whether you are addressing journalists at a press conference or members of the parliamentary health committee, you need to be able to get your message across clearly and effectively. Remember also that the members of your audience hear many presentations – yours needs to stand out so that they remember it. Here are some tips:

**PREPARATION**

- Your presentation starts long before you stand in front of your audience. Preparation is crucially important.
- Objectives: be clear about what you want to achieve, or what you want to convey to your audience.
- What do you want them to remember? Think about ways to make your key message stick.
- Engage your audience by building on what they already know -- use familiar reference points.
- Make it important to your audience -- put yourself in their shoes and think about why they should care about your issue.
- People remember firsts and lasts – pay attention to the end and the beginning.
- Give them reason to listen: break their pattern – present the unexpected.
- Have a strong, clear ending.

ENSURING IMPACT
- Plan your words, one idea per sentence.
- Use active verbs.
- Paint pictures: SHOW, don’t tell.
- Use the power of visual communication – use graphics, photographs, and maps to help your audience understand your research and what it means.
- Everyone has a preferred sense for learning -- make use of the five senses as much as possible.
  Use visuals and audio if you can.

DELIVERY
- Take control of the room. You must be in charge.
- Start with energy: show enthusiasm.
- Position yourself in the same area as your visual aids – don’t make your audience divide their attention between a screen and you.
- Keep looking forwards – always focus on your audience – don’t have your back to them while you stare at the screen.
- Signpost important points. You can literally say, “now this next point is very important!”
- Consider the wider environment – are there noises outside the room, are people too cold or too hot? Often, if you briefly acknowledge distracting factors, the audience will be able to put the distraction out of their minds and refocus on you.
- Pay attention to your voice: clarity, projection, pace, and pauses.
- Make eye contact with your audience.
- If possible, handle questions and answers before your ending – then wrap up with a strong take-home message – a definite, clear climax.

VISUAL AIDS
- If you use PowerPoint, use it effectively (see below).
- Remember PowerPoint is just one possible tool among many. You don’t have to use it.
- Think about using other types of visual aids, such as Flipcharts, Whiteboards, and others. Be creative.
- Have handouts for your audience.

USE POWERPOINT EFFECTIVELY
- PowerPoint can be a powerful tool, but too often it is used badly, putting audiences to sleep.
- You don’t want your audience focused on the screen and not on you. Your slides should support you, not take over.

- *Don’t* write your presentation using PowerPoint. Prepare and structure your presentation and only then go to PowerPoint and think about how you can use slides to support your presentation.

- Keep slides simple. *Less is more!* Leave the detailed notes for the handouts. One idea per sentence. Short sentences. Maximum three sentences per slide. Some of the most effective slides can consist of just one word. Or an image.

- Be sure that any graphs and other illustrations with your budget information is clear: it can be understood and interpreted at first glance.

- Avoid busy backgrounds, fancy colors, and other visual gimmicks. Plain black on white is often the best. Every element should support your message, not detract from it.

- Don’t be a disembodied voice in a darkened room, with everyone just staring at your slides.

- Continually bring your audience’s focus back to you. You can use the “W” key to make the screen go white, or the “B” key to make it go black.

- Remember that the most memorable speeches in history were given without slides. Winston Churchill, Martin Luther King, and Nelson Mandela never used PowerPoint!
READING 5.9 ■ NEW MEDIA

We have mentioned the rising importance of new or digital media, but up to now, have focused mainly on traditional/mainstream or “old” media. But it is crucial to take into account the exciting possibilities presented by the Internet, social networking, and mobile phones in advocacy. The mainstream media will be with us for a long time yet, especially in developing countries, but the new digital media are rapidly changing the media scene. Even a small organization can use the Internet and mobile phone technology to have a huge impact.

- Sometimes people argue that the new media are not very relevant in developing countries, as most of the population does not have access to the Internet. But this argument does not take account of several factors:
  - It is important to differentiate audiences in advocacy. Emphasize that donors, international organizations, business people, policy makers, and journalists DO have access to and use new media more and more.
  - If you do not use the Internet and many of the social networking tools it offers, you will not be reaching these key audiences. New media can be very effectively used to reach journalists, who in turn will then give you exposure in the mainstream media.
  - The rise of mobile phones and mobile Internet access. While most ordinary people do not have computers, the use of mobile phones is widespread. Ordinary people in developing countries are increasingly using mobile phones to access the Internet and social networking applications such as Facebook. In addition, even when people don’t have sophisticated phones, basic technology such as SMS (text messages) can be used powerfully as a campaign or advocacy tool.

- So, what do the Internet and new media offer that mainstream media doesn’t?
  - The ability to tell your story and get your message across to your audience directly, without journalists as the “middle-men.”
  - The ability to cover the kinds of issues and tell the kinds of stories that mainstream journalists are often just not interested in covering.
  - The power of numbers. Social networking tools make use ordinary people’s networks of friends and acquaintances to spread messages rapidly, often to vast numbers of people.

Some examples of new media tools are:

- **Facebook** ([www.facebook.com](http://www.facebook.com)): Unless you’ve been living on another planet for the past few years, chances are you know about Facebook already and have your own Facebook account. Facebook is a social networking site that allows people to link with their friends online. It can be accessed on the Internet via computers and Internet-capable mobile phones. Facebook offers
powerful advocacy opportunities: you can create groups on Facebook, highlight Causes, and share news, views, photographs, and more. An example of the power of Facebook occurred in January 2010, when women all over the world suddenly started posting their bra color as their Facebook status, apparently as a way of raising awareness of breast cancer. It seems unclear where this started; it spread virally and rapidly, an excellent illustration of the huge power of Facebook’s social networks. For more information on this see here http://allfacebook.com/facebook-bra-color_b9596.

Subscribe to the IBP’s Facebook page
at:  http://www.facebook.com/InternationalBudgetPartnership

- **SMS:** The plain old short message service or SMS on your mobile phone can be used very powerfully. It has been used to send out information rapidly to large numbers of people (either through bulk SMS services that allow you to send out a message to hundreds or even thousands of people at the same time, or through networking, where people just keep passing messages on to their friends, and their friends, and their friends...). It has also been used to gather important information from the field (such as having activists visit clinics and send SMS messages to a central point, indicating which clinics are out-of-stock of certain essential medicines).

There are a number of online tools that can assist you to use the power of SMS. One example is Frontline SMS, a large-scale texting tool for NGOs. See http://www.frontlinesms.com/.

- **Blogging:** A blog is really an online journal or diary, or even a mini-website, which allows you to express opinions; cover news; share photos, videos, and even audio recordings; and also provide links to other websites that you think are relevant for your audience and message. The most popular blogging sites are WordPress (www.wordpress.com) and Blogger (www.blogger.com), which is a Google service. At either of these sites you can very quickly – and without having any technical knowledge – set up your own free blog or mini-website. If you know how to send an email, you can set up your own blog – it’s that easy! For an example of how WordPress can be used to set up a campaign website, have a look at: http://endforcedsterilisation.wordpress.com

Also check out the IBP’s Open Budgets Blog, which is a WordPress site:
http://openbudgetsblog.org/

- **Citizen Journalism:** Citizen journalism refers to the fact that digital media now allows ordinary people to act as journalists. Using computers, mobile phones, digital cameras (including cameras on mobile phones), ordinary people around the world are able to produce and publish stories of importance to them. Citizen journalism can include blogs, but is not limited to blogging. Some citizen journalism sites combine citizen journalism with an editorial staff, in order to ensure stories comply with certain minimum standards. One example is Global Voices Online (http://globalvoicesonline.org).
• **Twitter** ([www.twitter.com](http://www.twitter.com)): Twitter is almost like SMS, but it’s online. It is a service that allows you to send very short messages (maximum 140 characters) to people who are “following” you. You can also sign up to follow others and get their updates, known as “tweets.” A lot of what is on Twitter is really trivial (e.g., “I am having breakfast now.”), but many people use Twitter almost like newspaper headlines: to alert their followers to news or to an interesting website or blog. They do this by providing a brief alert, followed by a link to the site in question. Check out [http://twitter.com/OpenBudgets](http://twitter.com/OpenBudgets)

• **YouTube** ([www.youtube.com](http://www.youtube.com)): YouTube allows you to create, share, and view videos online. It has a specific “channel” dedicated to non-profit groups. Many organizations have used this effectively to share advocacy messages. A good example is the Aids and Rights Alliance of Southern Africa (ARASA). Have a look at their video on health budgets here: [http://www.youtube.com/watch?v=MkWoKgLhDVs](http://www.youtube.com/watch?v=MkWoKgLhDVs).

  Also check out the IBP video on social audits in Kenya, “It’s Our Money. Where’s It Gone?” [http://www.youtube.com/watch?v=z2zKXqkrF2E&feature=player_embedded#](http://www.youtube.com/watch?v=z2zKXqkrF2E&feature=player_embedded#)

These are just a few of the sites and technologies available. There are many, many more, and new ones are springing up every day. It’s important to be alert and to try to keep up with new developments by reading blogs and participating in online social networks.
African CSOs Demand an End to Medicine Stock-Outs

February 2009

Stop the Stock-Outs! Access to essential medicines for all!

Civil society organizations (CSOs) in Kenya and across east and southern Africa are coming together to launch a campaign demanding an end to stock-outs of essential medicines in public health facilities. The regional campaign is being spearheaded by Health Action International (HAI) Africa and Oxfam. National campaigns will also take place in Kenya, Uganda, Malawi, Zambia, Zimbabwe, and Madagascar.

The theme of the campaign is: Stop the Stock-Outs! Access to Essential Medicines for All!
The campaign is a call to action for African governments to meet their obligations to provide essential medicines to our people.

The World Health Organization (WHO) defines essential medicines as “those that satisfy the priority health care needs of the population...Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.”

At the World Health Assembly in 1975, our governments made a commitment to ensure these essential medicines are available in public health facilities.

Yet today, over 30 years later, at any given moment, public health facilities in Africa have in stock only about half of a core set of essential medicines. These are medicines used to treat common diseases such as malaria, pneumonia, diarrhea, HIV, TB, diabetes, and hypertension – all of which are among the highest causes of death in Africa.

According to Patrick Mubangizi, director of HAI Africa, access to essential medicines is a human right and a cornerstone of an effective primary health care system. Says Mubangizi, “Access to free or cheap essential medicines determines whether people live or die, suffer pain and discomfort, or have their ailments cured, recover from illness or endure life-long disease.”

Stock-outs are worst in rural areas and poor people are the most affected. Stock-outs force people to buy medicines at much higher prices from the private sector. More often, though, patients simply go without the medicine that they so badly need.

The campaign is calling on governments and health departments to end stock-outs now by:

- Keeping accurate stock records and holding buffer supplies of medicines in storage.
• Creating efficient distribution systems at national and regional levels.
• Giving stakeholders (such as consumer organizations) a voice in forecasting and procurement planning.
• Ending corruption in the medicine supply chain to stop theft and diversion of essential medicines.
• Living up to commitments to spend 15% of national budgets on health care.

The failure to properly stock public health clinics and pharmacies with essential medicines stems in part from economic constraints and bureaucratic obstacles. “But above all, it is a failure of political will,” says Mubangizi. If governments commit to having medicines on pharmacy shelves, they can do it.”

Launch date:

Venue:

Speakers will include:

Media will also have an opportunity to interview patients who have personal experience of medicine stock-outs.

For more information contact:

Campaign partners:
SAMPLE PRESS RELEASE 1: DRAFT RELEASE

Speaking Up for Those in Pain

Hospices across the globe will be celebrating World Hospice and Palliative Care Day on 11 October 2008. In Bedlamistan we have a strong hospice presence with 74 member hospices dotted all over the country and 54 development sites.

Hospice is a philosophy, not a building, as many people think. The philosophy holds that a person with a life-limiting illness is on a special journey and has a unique set of rights. Palliative care is the active expression of this philosophy — a special brand of holistic care that provides quality of life, dignity in death, and support in bereavement.

Most hospices operate through home-based care by visiting clients and their families in their homes. Some hospices are fortunate enough to have inpatient units, where clients can be admitted for respite, pain control, or terminal care.

According to research, one of the main fears that a dying person has is dying in PAIN.

This year, the theme for World Hospice and Palliative Care Day is “Palliative Care: A Human Right.” The Hospice and Palliative Care Association of Bedlamistan wants to highlight the right of the terminally ill to access medication for pain control. Legislation currently prohibits trained palliative care nurses from prescribing controlled medications, and access to the correct medicines is difficult for many of our clients. We are actively advocating for this to be changed, so that our clients can have their pain addressed adequately and in a timely manner by trained, professional staff.

Hospices are nonprofit organizations that rely on fundraising activities. Their services are provided free of charge.

Please support the local hospice in your area by volunteering your time or expertise, donating goods to their charity shops, or making a financial contribution.

For more information, go to www.worldday.org or call the Hospice and Palliative Care Association of Bedlamistan at 012-345-6789
**SAMPLE PRESS RELEASE 2: IMPROVED RELEASE**

“Pain relief is a human right – let nurses prescribe,” says hospice association.

The Hospice and Palliative Care Association of Bedlamistan (HPCA) is calling for health care legislation to be changed to enable trained nurses to prescribe scheduled pain-control medication.

The call comes as HPCA and its 74 member hospices join hospices around the globe to mark World Hospice and Palliative Care Day on 11 October 2008. The theme this year is “Palliative Care: A Human Right.”

HPCA believes it is the right of people with life-limiting and life-threatening illnesses to be free of pain. However, many patients struggle to gain access to the correct pain-control medicines.

Giving trained palliative care nurses the right to prescribe scheduled medication would go a long way toward alleviating this problem. HPCA CEO Dr. Liz Gwyther says, “The lack of doctors in hard-to-reach rural areas of Bedlamistan means that prescriptions for pain-killing drugs are difficult to obtain, leaving patients in unnecessary pain. Enabling trained nurses to prescribe this very safe and routine medication would alleviate untold misery.”

According to research, one of the main fears a dying person has is dying in pain. But today it is possible to control pain effectively with drugs that are safe to use and that have few side effects.

Hospice is a philosophy and an approach to care — not a building, as many people think. The philosophy holds that the person with a life-limiting illness is on a special journey and has a unique set of rights. Palliative care is the active expression of this philosophy — a special brand of holistic care that provides quality of life, dignity in death, and support in bereavement.

Most hospices operate through home-based care by visiting clients and their families in their homes. Some hospices are fortunate enough to have inpatient units, where clients can be admitted for respite, pain control, or terminal care.

Hospices are nonprofit organizations that rely on fundraising activities. Their services are provided free of charge.

For more information please contact: name of contact person, telephone, and e-mail address

See also [www.worldday.org](http://www.worldday.org).
The new MPs fund: Lessons from Kenya?

Recently, Tanzanian Members of Parliament (MPs) visited Kenya to learn from their counterparts about the operations of their Constituency Development Fund (CDF). Since 2003, Kenya has been operating a CDF under which all MPs receive funds to initiate development projects in their constituencies.

There are concerns in Kenya about the CDF. In its current formulation, the CDF violates the constitutionally required division of powers among branches of government. Under the CDF, MPs (through their nominees, who are private employees) execute works within their constituencies, and report actual expenditures incurred on CDF programmes to designated district and national government offices.

As with all public expenditures, CDF accounts are subsequently verified by the legislature. This creates a situation in which the legislature is verifying CDF accounts managed by legislators – thereby violating the principle of checks and balances and separation of powers between the executive and the legislature.

Furthermore, the CDF risks diverting MP attention from core tasks. The MPs may be too busy managing CDF monies to exercise their role of scrutinising and holding the executive to account. MPs may also let government off the hook provided government does not question the MPs use of the CDF. Finally the risk of creating parallel uncoordinated systems that causes duplication and wastage is real.

For these reasons, the CDF is a poor idea in principle. Instead of establishing a CDF in Tanzania, it would be better to strengthen local government systems. However, the Parliament is likely to go ahead and establish the CDF. In this case, it would help to take lessons from the Kenyan experience.

First, CDFs must be constructed so that the rules pertaining to project eligibility are rigorous and enforceable. While each Kenyan MP is technically allowed to implement only 20 projects in a year, some MPs have been creative in their enumeration of projects. MPs have classified 10 or more classrooms construction projects in different schools as one project or similarly classified the construction of several health centers as one “health center” project for the purposes of the CDF.

Second, district officials should be provided with adequate resources to enable them to support the CDF projects executed utilising funding provided to the MPs. In Kenya, districts typically suffer from an acute shortage of technical personnel, particularly engineers, and are often unable to effectively monitor actual CDF expenditures.

Third, CDFs must be structured to require a thorough accounting of project funds. Due to poor record-keeping by CDF managers (who are nominated by MPs), reports developed under the Kenyan CDF often record amounts advanced for individual projects rather than the amounts that were actually expended.

However, if actual expenditures are not accounted for, it is impossible to hold either local officials or MPs responsible for any irregularities that may exist in CDF projects or for the results achieved by actual CDF expenditures.

Fourth, CDF funds should be expended each year. In Kenya, though most budget authorisations are valid for just one year, CDF monies do not lapse at the end of the year; unspent funds are available for expenditure in subsequent years. Thus, there is no incentive for an MP to spend CDF money in a timely fashion. An MP can even save CDF monies for later expenditure (as in an election year).

Fifth, CDF monies should be expended within an overall district planning process. In Kenya, apart from supporting bursaries, CDF monies can only be spent on infrastructure projects (such as construction of schools, health centers, etc.).

CDF funds cannot be spent on operational costs (such as salaries for teachers, procurement of medicines at health centers, etc.). Poor coordination between the district and national planning and budgeting processes (through which operational costs are budgeted) and the CDF planning process can lead to situations in which, for example, hospitals are constructed but not functional since staffing costs were not provided in the district budgets.

Finally, the CDF program should guarantee a citizen’s right to practical and meaningful information on the projects funded through the programme.

The Kenyan CDF law does not contain any provisions guaranteeing the public’s right to access information on the programme. Thus, constituents are denied a legal basis on which to demand project records (including accounting records) from the CDF managers, which further limits public accountability for CDF monies.

If implemented, Tanzanian MPs should structure the CDF law in Tanzania so that it does not suffer from the problems experienced in Kenya. Only then will we have a reasonable chance to ensure these funds truly meet the needs of wananchi.

Vivek Ramkumar is a Program Officer with the International Budget Project:
Email: ramkumar@cbbp.org
A handout is a hand up

Needs of the poor should be seen as an economic asset, not a burden

Comment

It may be anathema to the donor community but cash really is king. Pledges like those of seed, food and fertilizer support made at the recent World Food Summit are like bandaids for the 300-million Africans living on less than a dollar a day.

In contrast to these emergency, band-aid measures, there is a growing body of evidence showing that social protection, in the form of regular, predictable cash transfers to the most vulnerable groups in society, are remarkably effective.

Some of this evidence comes from South Africa, where study after study show pensions and grants have a measurable impact on health and nutrition in recipient households. Other evidence comes from a plethora of pilot projects in neighbouring countries.

Aside from health benefits, cash transfers have enabled beneficiaries to acquire assets such as livestock and seed, freed children to attend school (rather than having to engage in trade or begging to assist their families to survive), and bolstered local economies and markets (also boosting food production by providing incentives to small-scale farmers).

But, even with all this solid evidence, policy-makers and donors remain sceptical.

In South Africa there is resistance to expanding the grants system, while in neighbouring countries international donors procrastinate by continuing to demand more evidence and more pilots.

For their part, governments in Southern Africa refuse to consider “handouts” or continue to insist that social protection is unaffordable. Ultimately, however, the question is not one of affordability but of political will.

In 2004, for example, Lesotho’s government instituted an old-age pension against the advice of international financial institutions. To make it more affordable, it made the grant amount fairly small and the age of eligibility fairly high at 70. Today, up to 77 000 pensioners and a quarter of all households benefit from the monthly grant of R200. The pension is so popular that to cancel it now would mean political suicide for the ruling party.

Lesotho shows that where there is political will, the money can be found. Surely, social protection needs to take priority over arms deals, new Parliament buildings, and any number of wasteful vanity projects.

The real question is not whether we can afford to implement or expand social protection, but whether we can afford not to. Unless we urgently implement policy options which address the needs of the poor in a manner that alleviates rather than aggravates the situation, and in a way that respects the poor as an economic asset rather than a social burden, there could be catastrophic consequences.

There are consequences for social, economic and political stability, of which recent episodes of civil unrest experienced across the continent from Senegal to South Africa may be only a glimpse.

We may, as one leading politician put it, be on the verge of a “food revolution”.

John Book is programme manager for the regional hunger and vulnerability programme (RHVP). Brett Davidson is a media consultant for RHVP

Contributors’ guidelines: Each week the M&G receives at least 10 contributions to its opinion page. Articles have the best chance of publication if they are between 750 and 800 words; anything longer must be g•omically brilliant and word perfect. Topical issues are likely to grab our attention, and we will not consider articles that respond to reports in other newspapers. Provocative and persuasive argument wins over didactics every time; style and wit also triumph over polemic. The opinion pages are planned and laid out on the Friday before publication, though exceptions can be made.
SAMPLE LETTER TO THE EDITOR

Education unit looks like a hit squad

Published Oct 05, 2008 in Times LIVE
(www.timeslive.co.za)

Every thinking SA teacher should welcome the offer of additional educational support and training (“School inspectors return, but they’ll be nicer this time,” September 28).

Naledi Pandor’s proposed National Education, Evaluation and Development Unit is, however, to be treated with the greatest skepticism. The “development” part is fine, the “evaluation” part remains cause for alarm.

After 40 years’ service in education, I’ve been either subjected to or helped to devise every teacher evaluation system known to man and none of them has worked.

More than this, they have left the teachers who suffered them feeling cheated, confused and embittered.

The minister’s super-unit, apparently answerable to her alone, is to swoop down on schools, evaluate the personnel and present a report based on the evidence of the fleeting visitation. So what’s changed between this and the old-style “panels of inquisition”?

Pandor’s unit is, moreover, to be beefed up to the extent that it has the right, summarily, to fire useless principals and teachers.

The question is — by what means can a working teacher be reasonably and fairly evaluated?

Some teachers are brilliant in the classroom and nonentities in the extramural sphere.

Trust me, innumerable attempts to make sense of an unworkable system have failed. The answer is that to be of any value, evaluation has to be painstaking, discerning and co-operative.

With teachers’ jobs on the line, not to mention salary adjustments, the proposed unit’s function would boil down to that of an educational hit squad, eliminating the underperforming and attempting only the most superficial professional assessment of the rest. — Neil Veitch, Cape Town
The caption reads:

PENS AND THONGS...

“By the way: I already need another ‘donation’ from a philanthropic organization...”
Sample Fact Sheet

FACT SHEET

THE ESSENTIAL MEDICINES CRISIS IN KENYA

According to WHO essential medicines “satisfy the needs of the majority of the population and therefore should be available at all times, in adequate amounts in appropriate dosage forms and at a price the individual and community can afford.”

Essential medicines are those needed to treat the most common diseases affecting the population, for example malaria, diabetes, HIV and pneumonia, among others. Essential medicines also include those used for important public health issues, such as reproductive health and vaccination campaigns. Countries define and maintain their own Essential Medicines List (EML) as a cornerstone of their national medicine policy and the entire health system.

Although most countries have an EML, the shameful reality remains: essential medicines are not available for everyone who needs them. The following facts detail how an ongoing crisis of essential medicines is a big killer in Kenya.

**Killer Fact: There are not enough medicines in government hospitals**

Essential medicines are available in only 50% of lower level health facilities (dispensaries and health centres) and in about 65% of hospitals in Kenya. It’s about to get worse, with the ongoing problems at KEMSA.

**Killer Fact: Kenyans cannot afford medicines**

Medicines are unaffordable to the majority of Kenyans. A typical wage-earning Kenyan who needs insulin for life would have to work between 3 and 11 days just to cover the cost for a month of insulin treatment, depending on the health facility from which he obtains it.

**Killer Fact: The cost of medicines cripples household budgets**

Medicines are often the largest health-related expense for poor families. This expense is made worse with medicines being out-of-stock in government hospitals, because families must turn to the private sector where prices are significantly higher. This burden becomes even more difficult to manage in times of increased prices for food and other commodities.

**Killer Fact: The national Essential Medicines List is outdated**

WHO recommends that countries update their national Essential Medicines List (EML) at least every five years to reflect changing public health patterns and to take into account new and improved treatments. Kenya last updated its EML in 2002. This means the list doesn’t incorporate, for example, the change in malaria treatment recommended in the 2007 national malaria policy.

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### Campaign Partners

**Kenya**
- CSIP: Community Information Service Project
- KITAP: Kenya Information Treatment Access Programme
- KEPCHA: Kenyan Pharmaceuticals and Patent Clearing Association
- EPH: External Pharmaceutical Network

**Malawi**
- Malaria Network
- Malaria Health Facility Network

**Mozambique**
- SEDA: Sanitary360 Strike

**Uganda**
- ANFA: Action Network for Health Equity and Access
- HIPS: Coalition for Health Promotion and Social Development
- HAPPO: National Forum of HIV Advocates in Uganda

**Zambia**
- AFINZ: Action Network of Zambia People Living with AIDS
- TANC: Tobacco Advocacy and Control Campaign

**Zimbabwe**
- CCUI: Community Care Initiative for Health

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For more information contact:

Email: info@stopstockouts.org
Website: www.stopstockouts.org

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The Stop Stock-outs campaign is funded by support from the Open Society Institute

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**Killer Fact: Only 5.6% of the national budget goes to health**

Kenya has twice committed to meeting the Abuja targets, in 2001 and again in 2006. These were commitments, among others, to provide 15% of the national budget towards health and to increase access to medicines for the population.

**Killer Fact: Medicine procurement and supply is not efficient**

Problems within the Kenya Medical Supply Agency (KEMSA), as well as its tense relationship with the Ministry of Medical Services are hampering the procurement and supply of medicines. At least three independent assessments have outlined these problems and recommended concrete solutions. Yet the authorities have failed to implement these recommendations. As a result, KEMSA remains dysfunctional and there is a looming crisis in the supply of medicines to health facilities.

**Killer Fact: Millions are dying from lack of medicines**

By 2015, over 10 million deaths per year (globally) could be avoided by scaling up certain health interventions, the majority of which depend on essential medicines.

**Killer Fact: Kenyans use medicines dangerously**

Because government hospitals don’t have enough medicines in stock, Kenyans are misusing the medicines they get. More than half of all medicines are prescribed, dispensed or sold inappropriately, and half of all patients fail to take them correctly. This is a crucial public health hazard, and an enormous waste of scarce resources for health and medicines.

**Killer Fact: Big Pharma prioritizes profits over Kenyans’ lives**

The revenue of the top 10 global pharmaceutical companies is more than the gross national income of the 57 lowest-income countries. The pharmaceutical industry have used the power they wield in developing countries to influence policy and undermine access to more affordable generic medicines – all this to protect their commercial interest and enormous profits.

Yet greater access to more affordable generic medicines saves lives: because they cost up to 90% less than their brand-name equivalents, generic medicines can treat more people for the same amount of money spent.

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4. www.who.int/medicines
**READING 5.11 ■ SOME KEY MEDIA TERMS**

**Blogs and bloggers:** The word “blog” is an abbreviation of “web log.” It is basically a journal or diary kept online so that it can be read by anyone using the Internet. Entries are usually presented in reverse chronological order, with the most recent entries on top. Blog entries often contain links to other blogs or websites. There are millions of blogs on the Internet, most of which are read by a small group of the blogger’s friends and family members. However, certain bloggers have become very influential in their fields. In the United States, key bloggers are read as avidly as the major daily newspapers, and their views and opinions can have widespread political impact. In Egypt bloggers were jailed for expressing anti-government views. For a good introduction to blogging and numerous examples of blogs, see www.blogger.com.

**Citizen journalism:** Some good examples are All Voices (www.allvoices.com) and OhmyNews International (http://international.ohmynews.com/).

**Mobizines:** Mobizines are magazines that can be downloaded onto cell phones. They have gained popularity particular among younger people.

**Op-ed pages:** The opinion and editorial pages of a newspaper. These pages usually contain the newspaper’s own “leader” article expressing views on one or two of the major issues of the day, columns by regular columnists, and one or more opinion articles contributed by outside contributors (e.g., business people, politicians, academics, and NGO staff).

**Podcasts:** Podcasts are audio or audio-visual files that can be downloaded and then listened to or viewed on PCs; personal music players, such as the iPod and other MP3 players; and some cell phones. Some blogs take the form of podcasts, but podcasts can also be radio programs, documentaries, commentaries, and film trailers. An example of a newspaper’s podcasts can be found at www.mg.co.za/multimedia/podcast.

**Press conference:** A conference to which members of the media are invited, called by an individual or organization for the purpose of making an important announcement.

**Press release:** A notice sent to members of the media announcing a specific item of news (an upcoming event, important new research findings, etc.) or expressing an opinion on a key issue of the day.

**Sound bite:** Sound bites are short audio clips that journalists use in television and radio news reports.
MODULE 5
BUDGET ADVOCACY

PART IV ■ Budget Advocacy Group Work & Presentations
**MODULE 5 ■ BUDGET ADVOCACY (CONTINUED)**

**PART IV: BUDGET ADVOCACY GROUP WORK & PRESENTATIONS**

### SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of module</th>
<th>9 hours, 45 minutes (Parts I, II, and III)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13 hours, 10 minutes (Budget Advocacy Group Work &amp; Presentations)</td>
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</table>

<table>
<thead>
<tr>
<th>Structure &amp; timing of this module</th>
<th>This module corresponds with the following sessions in the <em>Health &amp; Budgets Training Workshop Agenda:</em></th>
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<tbody>
<tr>
<td></td>
<td><strong>Part I: Planning for Budget Advocacy</strong> (3 hours, 30 min.) ✓</td>
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<tr>
<td></td>
<td>• Part of SESSION 4 on Day 2;</td>
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<td></td>
<td>• Part of SESSION 1 on Day 3; and</td>
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<td>• Part of Session 2 on Day 3.</td>
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<td></td>
<td><strong>Part II: Power, Stakeholder, and Opportunity Mapping</strong> (3 hours, 30 min.) ✓</td>
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<td></td>
<td>• Part of SESSION 2 on Day 4;</td>
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<td>• SESSION 3 on Day 4; and</td>
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<td>• Part of SESSION 4 on Day 4.</td>
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<tr>
<td></td>
<td><strong>Part III: Media and Communications</strong> (2 hours, 45 min.) ✓</td>
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<td>• SESSION 2 on Day 6; and</td>
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<td>• Part of SESSION 3 on Day 6.</td>
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<td></td>
<td><strong>Part IV: Budget Advocacy Group Work and Presentations</strong> (13 hours, 10 min.)</td>
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<td>• Part of SESSION 3 on Day 6;</td>
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<td>• SESSIONS 1-4 on Day 7;</td>
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<td>• SESSIONS 1-2 on Day 8; and</td>
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<tr>
<td></td>
<td>• Part of SESSION 3 on Day 8.</td>
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<tr>
<td></td>
<td>(Note that one session is 1 hour, 45 minutes.)</td>
</tr>
</tbody>
</table>

| Resources needed for Part IV | • Flipchart paper and markers |
|                            | • Internet access |
|                            | • LCD projector |
|                            | • In the Participants’ Workbooks: |
|                            |   ➢ **TASK 5.12** ■ Presentation of Your Budget Research |
|                            |   ➢ **TASK 5.13** ■ Budget Advocacy Presentations and Media Tasks |
LEARNING OUTCOMES TO BE ACHIEVED

During Parts I, II, and III of the Budget Advocacy module, participants learned about:

✓ The key elements and importance of an advocacy strategy;
✓ Formulating a strategic objective and making it SMART;
✓ The value of evidence-based advocacy;
✓ The need to sharpen and add substance to advocacy strategies by examining the budget dimension of development problems;
✓ Powerbrokers in the budget process;
✓ Developing a power map and an opportunity schedule for their advocacy plan;
✓ Developing a SMART advocacy objective;
✓ Why message development is important in budget advocacy;
✓ Formulating a clear budget advocacy message;
✓ Why it is important to work with the media in an advocacy campaign;
✓ Different types of media and the different roles within the news media;
✓ Various techniques for gaining media attention;
✓ Matching media publicity to the budget cycle; and
✓ How to gear message delivery to specific contexts and time constraints.

By the end of this last part of the Budget Advocacy module, participants will have built further on the knowledge and skills acquired in the previous parts of the module and will have:

• Practiced building a coherent budget advocacy strategy to address a development problem; and
• Prepared and refined a budget advocacy presentation.

STRUCTURE OF THE SESSION

Advocacy Group Work I: Developing Your Health & Budget Advocacy Case (6 hours, 35 min.)

5. TASK 5.12: Presentation of Your Budget Research Findings 5 hours, 15 minutes
6. Group Work Presentations I and Feedback 1 hour, 20 minutes

Advocacy Group Work II: Refining Your Health & Budget Advocacy Case (6 hours, 35 min.)

7. TASK 5.13: Budget Advocacy Presentations and Media Tasks 5 hours, 15 minutes
8. Group Work Presentations II and Feedback 1 hour, 20 minutes
ADVOCACY GROUP WORK I: DEVELOPING YOUR HEALTH BUDGET ADVOCACY CASE

Duration of session: 5 hours, 15 minutes + night work

1. **Task 5.12 ■ Preparation of Your Budget Research Findings**
   5 HOURS, 15 MIN. + NIGHT WORK

   - This task is the beginning of the Budget Advocacy Group Work.
   - Ask participants to turn to **Task 5.12 ■ Presentation of Your Budget Research Findings** in their Workbooks.
   - Clearly explain the instructions for this task and respond to any questions of clarification.
   - For further information and instructions for this task, refer to the introduction of The Sunrise State Case Study: Summary of Findings on page 375 in this Manual.
   - Assign a facilitator to work with each of the groups. Explain that each group may call on their appointed facilitator for help anytime during the process.
   - Each facilitator will need to refer to the Summary of Findings at the end of the Manual in order to guide the participants as they conduct further analyses to build their advocacy cases (based on additional calculations they perform with budget data from the Health & Budgets Master Data Sheet).
   - Using the Summary of Findings, the facilitator will be able to verify the accuracy of the participants’ findings from their analyses of the budget data in the Health & Budgets Master Data Sheet.

GROUP WORK PRESENTATIONS I AND FEEDBACK

Duration of session: 1 hour, 20 minutes

1. **Group Work Presentations I and Feedback**
   20 MINUTES EACH

   - The aim of the group work and presentations is to enable participants to consolidate all the learning of the workshop and to provide them with constructive feedback in way that deepens and strengthens their capacity for budget advocacy work.
   - It is always useful to load all the presentations onto the presentation laptop before starting the round of presentations. Groups have 10 minutes to make their presentations. Be strict about time.
   - Participants who are not presenting will act as colleagues of the organization that is presenting, giving feedback on the following issues: identification/definition of the problem, based on evidence; soundness of the solution, based on analysis; and adequacy of the SMART advocacy objective.
• Allow 10 minutes for questions from the participants not presenting and from the facilitators. Give the participants the opportunity to ask questions before the facilitators have a turn. It is usually useful to have two rounds of two questions from the participants, with a limit of one question or comment per participant and a request for participants to keep it short.
• The facilitators should provide feedback on the group presentations in relation to the criteria below:

CRITERIA FOR FEEDBACK

a. Problem statement and soundness of solution
   • Did the group identify and define the problem correctly?
   • How well did the group use information and numbers (evidence) to state its case?
   • How well did they use information and numbers to propose or point towards a solution?
   • Is the information provided correct and credible?
   • Is it clear from the presentation what the objectives of the strategy are?

b. Relevance
   • Is the information relevant for the advocacy objective?
   • Was there superfluous information?
   • Was it clear how the audience could use the information and take action to support the objectives of the advocacy strategy?
**TASK 5.12 • PRESENTATION OF YOUR BUDGET RESEARCH FINDINGS**

As core members of the campaign HEALTH FOR ALL NOW, your organization has been requested to make a presentation to your fellow campaign members about your budget research on the health care crisis in Sunrise State. The purpose of your presentation is to:

- Brief your colleagues on the main budget problem(s) that you have identified as the cause of poor health services in Sunrise State;
- Propose a solution that will address the health care crisis in Sunrise State and present evidence from your research to back up your proposed solution;
- Present a compelling and SMART advocacy objective;
- Convince your colleagues to adopt your case as an advocacy issue; and
- Explain what the advocacy objective, the target audience, and the main message of such an advocacy campaign would be.

**TASK:** Develop a presentation of your findings, solution, and advocacy strategy, which you will present to your colleagues.

**STEP 1**  
Review and reflect on all of the information that you have gathered over the last few days about the problems in access to health care in Sunrise State, particularly in peri-urban informal settlements. You should also use additional information from the Polarus Sourcebook, and explore the budget data from the other districts and municipalities of Sunrise State, which are found in the Excel file titled Health & Budgets Master Data Sheet. This will allow you to get a fuller picture of the budget problems underlying the poor delivery of primary health care services in Sunrise State, not only in peri-urban areas but also in rural areas.

**STEP 2**  
Make sure that you have clear agreement in your group about the main budget problem(s) that has caused poor health care services in Sunrise State.

**STEP 3**  
Agree on the solution that you will propose to address the health care crisis in Sunrise State. Discuss your proposed solution with the facilitator assigned to your group.

**STEP 4**  
Go back to the draft advocacy objective that you formulated in TASK 5.4: A SMART ADVOCACY OBJECTIVE ON HEALTH CARE IN SUNRISE STATE. Review and refine it in light of the information that you have gathered since then. Make sure your advocacy objective is now as SMART as it can be. (Refer to READING 5.1: SHARPENING A BUDGET ADVOCACY OBJECTIVE for guidelines on making an advocacy objective SMART.)

**STEP 5**  
Identify the target audience and define the main message of your advocacy strategy.

**STEP 6**  
Prepare a presentation of no more than 10 minutes, which you will then present to your colleagues. Make sure your presentation is accessible, clear, logical, visually pleasing, and presents a compelling argument.
BUDGET RESEARCH PRESENTATION I ■ FEEDBACK FORM

In the spirit of supportive, constructive, and honest feedback, give your perspective on the following aspects of the group’s presentation.

PROBLEM STATEMENT AND PROPOSED SOLUTION

1. Comment on how well the group identified and defined the development and budget problems.

2. Comment on how effectively the group used information and numbers (evidence) to state its case.

3. How well did they use information and numbers to propose a BUDGET solution?

4. Comment on the group’s advocacy objective. Is it a SMART budget advocacy objective?

5. Make suggestions about the relevance of the information provided. Was there any superfluous information? Gaps in information?
STRATEGY

6. Note the following about their proposed advocacy strategy:
   a. Who are the proposed primary audiences?

   b. Who are the proposed secondary audiences?

   c. Comment on their choice of audiences.

7. Are you convinced by the message of the campaign? Please explain.

8. Would you support the campaign? Please explain.
In the spirit of supportive, constructive, and honest feedback, give your perspective on the following aspects of the group’s presentation.

**PROBLEM STATEMENT AND PROPOSED SOLUTION**

1. Comment on how well the group identified and defined the development and budget problems.

2. Comment on how effectively the group used information and numbers (evidence) to state its case.

3. How well did they use information and numbers to propose a BUDGET solution?

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   c. Comment on their choice of audiences.

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6. Note the following about their proposed advocacy strategy:
   a. Who are the proposed primary audiences?
   b. Who are the proposed secondary audiences?
   c. Comment on their choice of audiences.

7. Are you convinced by the message of the campaign? Please explain.

8. Would you support the campaign? Please explain.
ADVOCACY GROUP WORK II: REFINING YOUR HEALTH BUDGET ADVOCACY CASE

Duration of sessions: 5 hours and 15 minutes + night work

1. TASK 5.13: BUDGET ADVOCACY PRESENTATIONS AND MEDIA TASKS

5 HOURS, 15 MIN. + NIGHT WORK

- Refer participants to the TASK 5.13 for this activity and explain the instructions. Respond to any questions about the task of refining their health budget advocacy presentation.

GROUP WORK PRESENTATIONS II AND FEEDBACK

Duration of session: 1 hour, 20 minutes

1. GROUP WORK PRESENTATIONS II AND FEEDBACK 20 MINUTES EACH

- The aim of the group work and presentations is to enable participants to consolidate all the learning of the workshop and to provide them with constructive feedback in way that deepens and strengthens their capacity for budget advocacy work.
- It is always useful to load all the presentations onto the presentation laptop before starting the round of presentations. Groups will present for 10 minutes each. Be strict about time.
- Before the presentation, refer participants to the BUDGET ADVOCACY PRESENTATION II: FEEDBACK FORM in their Workbooks. You may also choose to distribute loose copies of the feedback forms and/or to have some extras available.
- Again, consider the division of roles during the presentations. Here are two options:
  - Of the three groups not presenting, ask one group to act as the designated audience to whom the presenting group is directing their communication. Ask the other groups not presenting to act as friendly and supportive “feedback” providers, using the feedback forms to record their comments.
  - Ask all of the groups not presenting to act as the audience for the presenting group. Then after each presentation, take a five minute break when all the participants “step out of role.” Those who have acted as members of the audience now reflect on the group’s performance and complete the feedback forms.
- However you choose to divide the roles, the most important outcome is for all of the groups to complete their presentations in front of a mock audience and to receive constructive feedback.
- Allow 10 minutes for questions from the participants not presenting and from the facilitators. Give the participants the opportunity to ask questions before the facilitators have a turn. It is

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usually useful to have two rounds of two questions from the participants, with a limit of one question or comment per participant and a request for participants to keep it short.

- The facilitators should provide feedback on the group presentations in relation to the criteria below:

**Criteria for Feedback**

*a. Presentation Style and Strategy*

- How well did the group use its human resources strategically to present a coordinated team?
- Did the group introduce its presenters and outline their respective roles and responsibilities?
- Generally, has the group made a compelling case?

*b. Advocacy and Analysis*

- How well did the group use information and numbers (evidence) to state its case?
- Is it clear from the presentation what the objectives of the strategy are?
- How well has the group framed their message for their target audience in a compelling way?
- Is the information provided credible and accessible for this audience?
- Did the group use their opportunity to build relationships with the target audience?

*c. Relevance*

- Was the information presented relevant and well-targeted to the audience?
- Was there superfluous information? Did the group present information to the audience that the audience would obviously know already?
- Was it clear how the audience could use the information and take action to support the objectives of the advocacy strategy?
TASK 5.13 ■ BUDGET ADVOCACY PRESENTATIONS AND MEDIA TASKS

GROUP 1: PRESENTATION TO THE SeDeN SECRETARIAT ON ACCESS TO HEALTH CARE IN SUNRISE STATE

Considering all of the feedback received from your colleagues after your previous presentation, as well as any further information gathered after the presentation, refine your presentation for delivery to the Secretariat of Service Delivery Now (SeDeN). In addition, prepare a FACT SHEET to distribute to the members of SeDeN. (Fact sheets should be 2 pages maximum. Each fact should be no more than 2-4 lines. The fact sheet should use simple everyday language, explain complex subjects clearly, and convey the importance of the issue. Sentences should be short, with one idea per sentence. For further guidelines, refer to the Sample Fact Sheet in READING 5.10: SAMPLE MEDIA.

GROUP 2: INFLUENCING THE HEAD OF DISTRICT SERVICES IN SUNRISE STATE

Considering all of the feedback received from your colleagues after your previous presentation, as well as any further information gathered after the presentation, refine your presentation for delivery to the Head of District Services in Sunrise State. In addition, prepare a PRESS RELEASE that will be released the day before the meeting. (Press releases should be written in the active tense, with one thought per sentence. Key points should be made right at the top. There should be a headline that is attention-grabbing, as well as a date and a contact person listed at the end. The press release should avoid NGO-speak or jargon. For further guidelines, refer to the information on Press Releases in READING 5.8: GUIDELINES FOR WORKING WITH MEDIA as well as the Sample Press Releases in READING 5.10: SAMPLE MEDIA.)

GROUP 3: INFLUENCING THE HEAD OF THE DEPARTMENT OF HEALTH OF SUNRISE STATE

Considering all of the feedback received from your colleagues after your previous presentation, as well as any further information gathered after the presentation, refine your presentation for delivery to the Head of the Department of Health of Sunrise State. In addition, prepare an OPINION ARTICLE for the Polaris Times that explains your advocacy campaign to a broader audience. (Opinion articles should put forward a coherent and reasoned point-of-view, offer evidence for it, and be persuasive. Articles should be a maximum of 350 words, use the active tense, and avoid NGO-speak or jargon. Articles should clearly present what the problem is and offer a solution. For further guidelines, refer to the two sample Op-Ed Articles in READING 5.10: SAMPLE MEDIA.)
GROUP 4: INFLUENCING THE CHAIR OF THE HEALTH COMMITTEE IN THE SUNRISE STATE LEGISLATURE

Considering all of the feedback received from your colleagues after your previous presentation, as well as any further information gathered after the presentation, refine your presentation for delivery to the Chair of the Health Committee in the Sunrise State Legislature. In addition, develop a BLOG ENTRY that aims to generate support for your advocacy campaign among your followers, who include journalists as well as other civil society organizations. (For further information on blogs and an example of a campaign blog, refer to READING 5.9: NEW MEDIA.)
**Budget Research Presentation II ■ Feedback Form**

In a spirit of supportive, constructive, and honest feedback, give your perspective on the following aspects of the other group’s presentation.

<table>
<thead>
<tr>
<th>Feedback Questions</th>
<th>Wow, truly amazing! You made a great impact with this aspect.</th>
<th>Well done, although it could do with a bit more work.</th>
<th>Good try, but this aspect needs a lot more attention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How clearly did this group get their advocacy message across?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How effectively did this group use budget analysis to back up their advocacy message?</td>
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<tr>
<td>3. How well did this group communicate with their audience?</td>
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<td></td>
</tr>
<tr>
<td>4. How logical was this group? Did their conclusions make sense and hang together?</td>
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<td></td>
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<tr>
<td>5. How attractive or eye-catching was the presentation of this group’s information?</td>
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<tr>
<td>6. Did this group make clear what they wanted their audience to do now to improve the situation?</td>
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</table>

Other comments:

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**Budget Research Presentation II ■ Feedback Form**

In a spirit of supportive, constructive, and honest feedback, give your perspective on the following aspects of the group’s presentation.

<table>
<thead>
<tr>
<th>Feedback Questions</th>
<th>Wow, truly amazing! You made a great impact with this aspect.</th>
<th>Well done, although it could do with a bit more work.</th>
<th>Good try, but this aspect needs a lot more attention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How clearly did this group get their advocacy message across?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How effectively did this group use budget analysis to back up their advocacy message?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. How well did this group communicate with their audience?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How logical was this group? Did their conclusions make sense and hang together?</td>
<td></td>
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Other comments:

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<th>Feedback Questions</th>
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</table>

Other comments:
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MODULE 8
EVALUATION, CERTIFICATION, AND CLOSURE
EVALUATION, CERTIFICATION AND CLOSURE

Duration of session: 1 hour and 5 minutes

SUMMARY TABLE

<table>
<thead>
<tr>
<th>Duration of this module</th>
<th>1 hour, 5 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of this module</td>
<td>This module corresponds with the following session in the Health &amp; Budgets Training Workshop Agenda:</td>
</tr>
<tr>
<td></td>
<td>• Part of SESSION 3 on Day 8</td>
</tr>
<tr>
<td></td>
<td>(Note that one session is 1 hour, 45 minutes.)</td>
</tr>
<tr>
<td>Resources needed</td>
<td>• Evaluation forms</td>
</tr>
<tr>
<td></td>
<td>• Ball of string</td>
</tr>
<tr>
<td></td>
<td>• Participants’ certificates</td>
</tr>
</tbody>
</table>

LEARNING OUTCOMES TO BE ACHIEVED

By the end of this session, participants will have:

• provided feedback on the workshop, training materials, and their learning experience;
• evaluated and closed the workshop;
• begun building a new network of health budget advocates with their fellow participants; and
• gained a sense of accomplishment through their participation in the workshop.

STRUCTURE OF THE MODULE

1. Completing Evaluation Forms 20 minutes
2. Building a Network of Budget Advocates 30 minutes
3. Certification and Closure 15 minutes

1. **Completing Evaluation Forms 20 MINUTES**

• Ask participants to complete the evaluation questionnaires, which they received in the first session of the workshop.
• After 20 minutes, collect the questionnaires from all of the participants.
• Hand the evaluations to the designated IBP host facilitator.
2. **Building a Network of Health Budget Advocates**  

30 MINUTES

- **The aim of this closing activity** is to consolidate a sense of connectedness amongst the participants and facilitators, and to provide a useful metaphor for talking about the network relationship.

- Ask participants and facilitators to arrange themselves, with their chairs, in a closed circle.

- Explain that the ball of string will be passed or thrown to one participant or facilitator at a time.

- You can start by holding onto a piece of string and then passing it to someone in the circle. When you pass the ball of string say something complimentary/positive about the person whom you are passing the string to, for example, “Alicia, I admire your leadership skills and ability to organize.” Alicia (who probably says thank you) then holds onto a piece of string and passes the ball onto another person in the circle, saying something appreciative about the person has she passes the ball.

- Continue until everyone is connected and holding onto a piece of string, and the ball has been returned to the facilitator. Each person will receive the ball of string once only.

- Be mindful of persons who have not received the piece of string – this usually becomes evident, and sometimes awkward, when 5 or so persons are still left. Gently point out who has not yet received the string.

- As soon as the ball has been returned to you, ask people to start pulling gently onto their string and to follow how this changes the connection, the web and network that the group has created.

- Explain that, similarly, after everyone has returned to their work and their countries, the network that has been created through this workshop will only continue if we nudge each other and communicate with each other to remind ourselves of the work that we can achieve.

- Ask participants to drop the string and pass onto the facilitator.

3. **Certification and Closure**  

15 MINUTES

- Congratulations! You have successfully completed the IBP Health & Budgets Training Workshop.

- Hand certificates to participants one by one.

- Some participants like having their pictures taken when they receive their certificates.

- And there will probably be lots of group picture requests, too!
SAMPLE EVALUATION FORM
Health & Budgets Training Workshop

1. Please rate your overall experience of the training, in terms of how well it responded to your needs and expectations.

<table>
<thead>
<tr>
<th>Poor</th>
<th>Below Average</th>
<th>Average</th>
<th>Good</th>
<th>Excellent</th>
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</thead>
</table>

COMMENTS: ________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

2. Please rate each of the modules according to their usefulness. (Circle one of the following: very useful, somewhat useful, or not useful.)

<table>
<thead>
<tr>
<th>Module</th>
<th>Module Title</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions &amp; Goals of the Workshop</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>2</td>
<td>Civil Society Budget Work: Strategies &amp; Impacts</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>3</td>
<td>The Rights Framework</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>4</td>
<td>Health Information, Systems, and Financing</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>5</td>
<td>Budget Advocacy (Parts I, II, III)</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>6</td>
<td>Health Policy and the Budget Process</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>7</td>
<td>Budget Analysis</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
<tr>
<td>8</td>
<td>Budget Advocacy Group Work &amp; Presentations</td>
<td>Very useful, Somewhat useful, Not useful</td>
</tr>
</tbody>
</table>

3. Which tasks/exercises do you feel were most useful in helping you to understand and apply the concepts discussed during the workshop? Please explain why.

4. Were there any tasks/exercises in the workshop that you found were not useful? If yes, please explain.
5. Now that you have completed the workshop…

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>a)</td>
<td>Do you feel better prepared to develop different hypotheses (or theories) about possible budget problems that contribute to poor health service delivery? If yes, how do you feel better prepared?</td>
<td></td>
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</tr>
<tr>
<td>b)</td>
<td>Do you feel better prepared to identify which types of health and budget information you need in order to test your hypotheses about the budget problems underlying poor health service delivery? If yes, how do you feel better prepared?</td>
<td></td>
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</tr>
<tr>
<td>c)</td>
<td>Do you feel better prepared to determine which calculations that you need to use to test your hypotheses about the budget problems underlying poor health service delivery? If yes, how do you feel better prepared?</td>
<td></td>
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</tr>
<tr>
<td>d)</td>
<td>Do you feel better prepared to use the findings (evidence) from your health budget analysis to construct a credible advocacy argument and to design a targeted, strategic advocacy plan? If yes, how do you feel better prepared?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Briefly, what is your assessment of:
   a) the flow of the workshop (i.e., the sequencing of the content, topics, and exercises)?

   b) the training materials (Participants' Workbook, Polarus Sourcebook, presentations, etc.)?

   c) the facilitation of the workshop?

7. Is there anything that you would you suggest that we do differently the next time we run this training workshop?

8. Any other comments?

Name (optional):

THANK YOU!
THE SUNRISE STATE CASE STUDY: SUMMARY OF FINDINGS
THE SUNRISE STATE CASE STUDY:
SUMMARY OF FINDINGS

The purpose of this summary is to provide facilitators with some information on possible calculations that the participants could perform and draw conclusions from, in addition to the example calculations performed in Module 7: Budget Analysis for Mortalia, as well as summaries of findings for each hypothesis and each district/municipality in Sunrise State.

These findings are accompanied by two Excel spreadsheets – 1) Health & Budgets: Summary Data Tables for Hypotheses, which shows summary data across all districts/municipalities for each of the four hypotheses, and 2) Health & Budgets: Calculations for Summary of Findings, which details the calculations performed for each hypothesis.

This section is divided into three parts:

1. **Summary of Findings by Hypothesis**, in which a summary of findings of all eight districts/municipalities is shown for each of the four hypotheses (supported by the Excel spreadsheet, Health & Budgets: Summary Data Tables for Hypotheses).

2. **Summary of Findings by District/Municipality**, in which a summary of findings from all four hypotheses is shown for each of the remaining seven districts/municipalities (Mortalia is not shown here since the findings are outlined in Module 7).

3. **Detailed Findings by District/Municipality and Hypothesis**, in which detailed calculations are shown for each hypothesis under each district/municipality, similar to the process outlined in Module 7 for Mortalia (supported by the Excel spreadsheet, Health & Budgets: Calculations for Summary of Findings).

In the hypothesis exposition in Module 7, the calculations were done using information from the city of Mortalia, Sunrise State’s largest municipality. The sets of calculations that follow explore data from the remaining seven districts/municipalities in Sunrise State. Two of them (Obasalom and Swellentsia) are municipalities like Mortalia, with mixed rural-urban demographics, and the remaining five districts are largely rural with some small towns.

During the Budget Advocacy Group Work sessions of the workshop, participants will be given time to analyze the additional data in the Health & Budgets Master Data Sheet to identify other budget problems that contribute to the poor provision of health services in Sunrise State. They will have the opportunity to decide for themselves what data they want to explore to build evidence for their budget advocacy case.

For each of the districts and municipalities in Sunrise State, the Health & Budgets Master Data Sheet contains information for three selected Primary Health Clinics (PHCs). The three selected PHCs (numbered 1, 2, and 3) are representative of the demographics of the districts/municipalities themselves. For example, in the two smaller municipalities (Obasalom and Swellentsia), the three selected PHCs are in peri-urban informal settlements, as in Mortalia. In the mostly rural districts, the three selected PHCs are in rural communities (as opposed to towns). The purpose of selecting peri-urban clinics and rural clinics is to show whether clinics in traditionally marginalized communities are
treated differently in budget terms (and also whether they perform differently) compared to the
average clinic in each district/municipality.

This summary of findings is not meant to be exhaustive, but is provided to give the facilitators
guidance as they support the participants during the Budget Advocacy Group Work sessions. The
purpose of these sessions in the workshop is for participants to explore budget data and gather
additional evidence, through budget analysis, to build their budget advocacy case to present in the
plenary sessions at the end of the workshop.
**SUMMARY OF FINDINGS BY HYPOTHESIS**

(supported by the Excel spreadsheet, *Health & Budgets: Summary Data Tables for Hypotheses*)

**Hypothesis 1: Primary health clinics are wasting money (YES)**

To assess whether clinics were wasting money, we first looked at the unit cost paid by three selected clinics in each district for three essential medicines (amoxicillin, folic acid, and paracetamol) for the year 2008. After that, we compared the unit costs paid by the clinics to the lowest available retail prices for the same three medicines in 2008. Lastly, we calculated the amount of additional medicines that could have been purchased by each clinic if they had purchased the medicines at the lowest available retail prices.

The key findings for this hypothesis, based on analysis of data from all eight districts/municipalities in Sunrise State (including Mortalia), are as follows:

- Moderate to significant over-expenditure on essential medicines in the majority of PHCs in 2008, which means the selected PHCs are wasting their budgets;
- Only two clinics out of the 24 selected clinics (8%) paid around the same price as the lowest available retail prices: one peri-urban clinic in Obsalom paid an average of only 1% above the lowest available retail prices for the three essential medicines, and a rural clinic in Zofara paid an average of only 4.6% above the lowest available retail prices; and
- The most wasteful clinics were found in rural Astria district, where one clinic could have purchased an additional 1,400 boxes of medicines if it had paid the lowest available retail prices. The other two clinics could have purchased an additional 700+ boxes each.

**Hypothesis 2: Primary health clinics are underspending (NO)**

To assess whether clinics were underspending, we looked at the rate of spending by the three selected clinics in each district on Salaries, Goods & Services, Medicines, and Medical Equipment for the years 2008, 2009, and 2010, using budgeted allocations and audited expenditures.

The key findings for this hypothesis, based on analysis of data from all eight districts/municipalities in Sunrise State (including Mortalia), are as follows:

- Slight underspending by the three selected clinics in each district/municipality across most line items in 2008;
- Moderate to significant over-expenditure in each of the four line items across all clinics in 2009 and 2010, which raises a red flag about budget implementation in many clinics; and
- Underspending on the Medicines line item by most clinics in 2008, while at the same time many clinics overpaid for three essential medicines in that year (See Hypothesis 1).

**Hypothesis 3: Primary health clinics are underfunded (YES)**

To assess whether clinics were underfunded, we looked at the budget for each clinic as a share of the District Services' Primary Health budget, and also compared the share received by each clinic to the
average share received by clinics in the same district. This was done for the years 2008 to 2011. We then looked at the growth (in real terms) of each clinic’s budget compared to the average budget growth of all clinics in the same district, for three periods: 2008-2009, 2009-2010, and 2010-2011.

The key findings for this hypothesis, based on analysis of data from all eight districts/municipalities in Sunrise State (including Mortalia), are as follows:

- Budget shares of the three selected clinics in each district/municipality were below the average share received by clinics in each district over the period 2008 to 2011, meaning that peri-urban and rural clinics receive lower than average budget shares;
- In six out of the eight districts/municipalities (75%), the budget shares of the selected clinics were half (or less) of the average share received by clinics in each of those districts, indicating that peri-urban and rural clinics receive significantly smaller budget shares than the average clinics in the same districts/municipalities;
- Budget shares of the selected primary health clinics (as well as the average budget shares) in all districts/municipalities decreased from 2008 to 2011;
- The periods 2008/09 and 2009/10 showed decreased budget growth among the majority of primary health clinics; and
- The period 2010/11 showed increased budget growth across all primary health clinics.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health (YES & NO, depending on the District/Municipality)**

In order to assess whether primary health clinics were underfunded in terms of their per capita budgets, we calculated their per capita budgets and then compared them to the national Ministry of Health’s recommended standard for per capita spending for primary health care. These standards come from the Polarus National Health Strategy (2007-2013), which provides recommended per capita spending for clinics in mostly urban areas (50-55 Dinars), mixed rural-urban areas (40-45 Dinars), and mostly rural areas (30-35 Dinars).

The key findings for this hypothesis, based on analysis of data from all eight districts/municipalities in Sunrise State (including Mortalia), are as follows:

- Per capita budgets of the three selected primary health clinics in each district were below the average per capita budgets for primary health clinics in each district, meaning that peri-urban and rural clinics receive lower than average per capita budgets;
- Selected PHCs in six districts/municipalities had their budgets increase between 2008 and 2011 (Astria, Chotral, Lemauri, Mortalia, Obsalom, and Swellentsia - 3 rural, 1 urban, 2 mixed rural-urban);
- Selected PHCs in two districts, Trelis and Zofara (both rural), as well as in Mortalia (urban), saw a drop in their per capita budgets in 2010 after a two-year increase (in 2008 and 2009);
- Selected clinics in Astria, Mortalia, Obsalom, Swellentsia, and Zofara (2 rural, 1 urban, 2 mixed rural-urban) had per capita budgets below the MOH standard for primary health care spending from 2008 to 2011, meaning that 62.5% of selected clinics in Sunrise State (peri-urban and rural) had per capita budgets below the government’s own standard;
• Astria and Zofara (rural) had per capita budgets within or above the MOH standard for primary health care spending in 2011; and
• Selected clinics in Chotral, Lemauri, and Trelis (all rural) had per capita budgets within or above the MOH standard for primary health care spending over the four years.
SUMMARY OF FINDINGS (FROM HYPOTHESES 1 TO 4) BY DISTRICT/MUNICIPALITY

Astria District (rural)

- The 3 selected rural clinics in Astria District performed very poorly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of 30% on the medicines.
- If the 3 rural clinics had purchased the 3 essential medicines at the lowest available retail prices, they could have bought an average of 974 more boxes of medicines in 2008, which indicates extremely wasteful spending.
- In 2008, all 3 rural clinics slightly underspent on Medicines, although they all overpaid significantly for 3 essential medicines in the same year.
- In 2008 and 2009, the 3 rural clinics spent their budgets well, with no significant under- or over-spending.
- In 2010, all 3 rural clinics overspent their budgets on all line items, primarily on Medicines, Medical Equipment, and Salaries. In terms of total clinic budgets, the 3 clinics overspent by an average of about 20%.
- The 3 rural clinics were underfunded from 2008 to 2011, compared to the average budget shares for clinics during the same time period.
- Budget shares for the 3 rural clinics (as well as the average for clinics) decreased from 2008 to 2011.
- The 3 rural clinics experienced decreases in their budgets in the periods 2008/09 and 2009/10. However, in 2010/11, all 3 rural clinics had significant increases in their budgets.
- Per capita budgets for the 3 rural clinics were below the average per capita budget for clinics from 2008 to 2011.
- Per capita budgets increased between 2008 and 2011 for all clinics (rural and average) in Astria District.
- The 3 rural clinics’ per capita budgets fell below the MOH standard (D30-35) for rural clinics for all years except 2011.

Chotral District (rural)

- The 3 selected rural clinics in Chotral District performed poorly in procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of 20% on the medicines.
- If the 3 rural clinics had purchased the 3 essential medicines at the lowest available retail prices, they could have bought an average of 640 more boxes of medicines in 2008, which indicates very wasteful spending.
- In 2008, one of the three rural clinics underspent on Medicines, while the other two spent slightly over 100% of their Medicines budgets. At the same time, all 3 rural clinics overpaid significantly on 3 essential medicines in the same year.
- In 2008, the 3 rural clinics had no significant under- or over-spending of their budgets. The highest over-expenditure was on Salaries.
In 2009, the 3 rural clinics spent on average slightly over 100% of their total budgets. The highest over-expenditure was on Salaries.

In 2010, the 3 rural clinics overspent their total budgets. All budget lines were overspent in all 3 clinics, primarily on Salaries, Medical Equipment, and Goods & Services.

Budget shares of the 3 rural clinics were below the average budget shares for clinics from 2008 to 2011.

Budget shares for the 3 rural clinics (as well as the average for clinics) decreased from 2008 to 2011.

The 3 rural clinics had decreases in their budgets in two periods: 2008/09 and 2009/10.

In 2010/11, all 3 rural clinics had increases in their budgets; these increases were close to or above the average budget increase for clinics.

Per capita budgets for the 3 rural clinics were below the average per capita budget for clinics from 2008 to 2011.

Per capita budgets increased for all clinics (both rural and average) between 2008 and 2011.

The 3 rural clinics’ per capita budgets were within or above the MOH standard (D30-35 per capita) for rural clinics, except for the Chotral 2 clinic in 2010.

**Lemauri District (rural)**

- The 3 selected rural clinics in Lemauri District performed fairly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of about 10% on the medicines.

- If the 3 rural clinics had purchased the 3 essential medicines at the lowest available retail prices, they could have bought an average of 339 more boxes of medicines in 2008, which indicates wasteful spending.

- In 2008, all 3 rural clinics underspent on Medicines. All 3 clinics also overpaid for three essential medicines in the same year.

- In 2008, the 3 rural clinics underspent their budgets on most line items. There was only one significant instance of overspending: on Salaries.

- In 2009, the 3 rural clinics overspent their total budgets. No significant underspending.

- In 2010, the 3 rural clinics significantly overspent their total budgets. All budget lines were overspent in all 3 clinics. The highest over-expenditures were on Medicines, Goods & Services, and Medical Equipment.

- Budget shares of the 3 rural clinics were almost half of the average budget share for clinics from 2008 to 2011.

- Budget shares for the 3 rural clinics (as well as the average for clinics) decreased from 2008 to 2011.

- The 3 rural clinics had decreases in in their budgets in the 2009/10 period; these decreases were greater than the average decrease in budgets.

- In the periods 2008/09 and 2010/11, the 3 rural clinics all had significant increases in their budgets; these increases were close to or above the average increase.

- Per capita budgets for the 3 rural clinics were below the average per capita budget from 2008 to 2011.
• Per capita budgets increased for all clinics (rural and average) between 2008 and 2011.
• The 3 rural clinics’ per capita budgets were above the MOH standard (D30-35 per capita) for rural clinics, especially in 2011, when their per capita budgets were twice the MOH standard.

Obsalom Municipality (mixed rural-urban)

• The 3 peri-urban clinics in Obsalom Municipality performed fairly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of 10% on the medicines.
• If the 3 peri-urban clinics had purchased the 3 medicines at the lowest available retail prices, they could have bought an average of 327 more boxes of medicines, which indicates wasteful spending.
• In 2008, the 3 peri-urban clinics underspent their budgets on most line items.
• In 2008, all 3 peri-urban clinics underspent on Medicines. All 3 peri-urban clinics also overpaid for 3 essential medicines in the same year.
• In 2009, the 3 peri-urban clinics overspent their total budgets. The worst overspending was on Salaries and Goods & Services.
• In 2010, the 3 peri-urban clinics significantly overspent their total budgets. The highest over-expenditures were on Salaries and Medicines.
• Budget shares of the 3 peri-urban clinics were below the average budget share for clinics from 2008 to 2011. Two out of the three clinics had budget shares that were almost half of the average budget share.
• Budget shares for the 3 peri-urban clinics (as well as the average for clinics) decreased from 2008 to 2011.
• In 2008/09, two out of the 3 peri-urban clinics had budget decreases. In 2009/10, all 3 peri-urban clinics had decreases in their budgets. In 2010/11, the 3 peri-urban clinics all had significant increases in their budgets; two of the 3 peri-urban clinics had increases similar to the average budget increase.
• Per capita budgets of the 3 peri-urban clinics were below the average per capita budget for clinics from 2008 to 2011.
• Per capita budgets increased for all clinics (peri-urban and average) between 2008 and 2011.
• The 3 peri-urban clinics’ per capita budgets were below the MOH standard (D40-45 per capita) for mixed rural-urban clinics from 2008 to 2011.

Swellentsia Municipality (mixed rural-urban)

• The 3 peri-urban clinics in Swellentsia Municipality performed fairly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of about 10% on the three medicines.
• If the 3 peri-urban clinics had purchased the 3 medicines at the lowest available retail prices, they could have bought an average of 360 more boxes of medicines, which indicates wasteful spending.
• In 2008, the 3 peri-urban clinics underspent their budgets on most line items.
• In 2008, all 3 peri-urban clinics underspent on Medicines. All 3 clinics also overpaid by an average of about 10% on 3 essential medicines in the same year.
In 2009, the 3 peri-urban clinics overspent their total budgets. The highest overspending was on Salaries and Medicines.

In 2010, the 3 peri-urban clinics significantly overspent their total budgets. All budget lines were overspent, with the highest over-expenditures on Salaries, Goods & Services, and Medicines.

Budget shares of the 3 peri-urban clinics were below the average budget share for clinics from 2008 to 2011. Two of the 3 peri-urban clinics had budget shares that were almost half of the average budget share.

Budget shares for the 3 peri-urban clinics (as well as the average for clinics) decreased from 2008 to 2011.

The 3 peri-urban clinics had decreases in their budgets in the period 2009/10; the average budget of clinics also went down. In 2010/11, the peri-urban clinics all had significant increases in their budgets; one clinic had an increase above the average budget increase for clinics; the other two had below-average increases.

Per capita budgets for the 3 peri-urban clinics were below the average per capita budget for clinics from 2008 to 2011.

Per capita budgets increased for all clinics (peri-urban and average) between 2008 and 2011.

The 3 peri-urban clinics’ per capita budgets were below the MOH standard (D40-45 per capita) for mixed rural-urban clinics from 2008 to 2011. The average per capita budgets were below the standard in all years except 2011.

**Trelis District (rural)**

- The 3 rural clinics in Trelis District performed poorly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of 15% on the medicines.
- If the 3 rural clinics had purchased the 3 medicines at the lowest available retail prices, they could have bought an average of 510 more boxes of medicines, which indicates very wasteful spending.
- In 2008, the 3 rural clinics underspent their budgets on most line items. The highest rate of underspending was on Goods & Services.
- In 2008, all 3 rural clinics slightly underspent on Medicines. All 3 clinics also overpaid by an average of 15% on the 3 essential medicines in the same year.
- In 2009, the 3 rural clinics spent on average 100% of their total budgets. The highest overspending was on Goods & Services.
- In 2010, the 3 rural clinics significantly overspent their total budgets as well as all budget lines. The highest over-expenditures were on Salaries, Medicines, and Medical Equipment.
- Budget shares of the 3 rural clinics were below the average budget share for clinics from 2008 to 2011. The budget shares of two out of three of the rural clinics were half (or less) of the average budget share for clinics from 2008 to 2011.
- Budget shares for the 3 rural clinics (as well as the average for clinics) decreased from 2008 to 2011.
- The budgets of the 3 rural clinics and the average budget for clinics increased in 2008/09. The 3 rural clinics had significant decreases in their budgets in 2009/10. The average budget of clinics also decreased significantly, but not by as much as the 3 rural clinics. In 2010/11, the 3 rural
clinics had significant increases in their budgets; two had increases above the average budget increase for clinics, and one had a below-average increase.

- Per capita budgets for the 3 rural clinics were below the average per capita budget for clinics from 2008 to 2011.
- Per capita budgets increased between 2008 and 2011, except for a sharp dip in 2010, for the 3 rural clinics as well as the average for clinics.
- The 3 rural clinics’ per capita budgets were well above the MOH standard (D30-35 per capita) for rural clinics from 2008 to 2011. In 2011, the budgets of the 3 rural clinics and the average budget for clinics were over twice the MOH standard.

**Zofara District (rural)**

- The 3 rural clinics in Zofara District performed poorly in terms of procuring 3 essential medicines (amoxicillin, folic acid, paracetamol) at the lowest available prices, meaning they overspent by an average of 13% on the medicines.
- If the 3 rural clinics had purchased the 3 medicines at the lowest available retail prices, they could have bought an average of 401 more boxes of medicines. This indicates very wasteful spending. However, one of the clinics procured the 3 medicines for less than the lowest available retail price.
- In 2008, two of the three rural clinics spent all of their Medicines budgets, yet they significantly overspent on 3 essential medicines in the same year. The other clinic spent underspent its Medicines budget and paid less than the lowest available retail prices on the 3 essential medicines that year.
- In 2008, the 3 rural clinics both under- and overspent their budgets on different line items. The highest rate of underspending was on Salaries, and the highest rate of overspending was on Goods & Services.
- In 2009, the 3 rural clinics slightly overspent their total budgets. The highest rate of overspending was on Goods & Services.
- In 2010, the 3 rural clinics significantly overspent their total budgets as well as all of their budget lines. The biggest overspending was on Goods & Services, Medicines, and Medical Equipment.
- Budget shares of the 3 rural clinics were below the average budget share for clinics from 2008 to 2011. The budget shares of two out of the three clinics were half (or less) of the average budget share for clinics from 2008 to 2011.
- Budget shares for the 3 clinics (as well as the average for clinics) decreased from 2008 to 2011.
- In 2008/09, the budgets of all 3 rural clinics increased, while at the same time the average budget for clinics decreased. In 2009/10, the budgets of the 3 rural clinics decreased more than the decrease in the average budget for clinics. In 2010/11, all 3 rural clinics had budget increases that were higher than the average budget increase for clinics.
- Per capita budgets for the 3 rural clinics were below the average per capita budget for clinics from 2008 to 2011.
- Per capita budgets increased between 2008 and 2011, except for a small dip in 2010, for the 3 rural clinics as well as the average for clinics.
- The 3 rural clinics’ per capita budgets were below the MOH standard (D30-35 per capita) for rural clinics from 2008 to 2010. In 2011, the budgets of the 3 rural clinics and the average budget for clinics were within or above the MOH standard.
DETAILED FINDINGS BY DISTRICT/MUNICIPALITY AND HYPOTHESIS
(supported by the Excel spreadsheet, Health & Budgets: Calculations for Summary of Findings)

1. Astria District (rural)

Hypothesis 1: Primary health clinics are wasting money

1. Unit cost for essential medicines

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th></th>
<th>Astria 1</th>
<th>Astria 2</th>
<th>Astria 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 2.53/box</td>
<td>D 3.86/box</td>
<td>D 2.53/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 2.30/box</td>
<td>D 2.29/box</td>
<td>D 2.02/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 1.70/box</td>
<td>D 1.77/box</td>
<td>D 1.75/box</td>
</tr>
</tbody>
</table>

From these calculations, it appears that the PHC in the Astria 2 community is not doing well in terms of procuring medicines at the lowest prices, in comparison with the other PHCs.

2. Over-expenditure on each medicine compared to the lowest available retail prices

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Astria PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Astria 1</th>
<th>Astria 2</th>
<th>Astria 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>21.1%</td>
<td>84.7%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>37.7%</td>
<td>37.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>16.4%</td>
<td>21.2%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

| Average | 25%      | 47.6%    | 20.7%    |

Average of 3 Clinics: 31%

It is clear that all three Astria PHCs overspent by a significant percentage on the three essential medicines compared to the lowest retail prices at local pharmacies. In particular, Astria 2 is paying much more than the other two PHCs. The procurement process used by these PHCs appears ineffective, since it failed to find the lowest prices for these medicines. This is clearly a waste of resources.
3. Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price (highest impact due to change of prices)

<table>
<thead>
<tr>
<th></th>
<th>Astria 1</th>
<th>Astria 2</th>
<th>Astria 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>216 boxes</td>
<td>835 boxes</td>
<td>233 boxes</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>347 boxes</td>
<td>343 boxes</td>
<td>227 boxes</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>215 boxes</td>
<td>239 boxes</td>
<td>268 boxes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>778 boxes</strong></td>
<td><strong>1,417 boxes</strong></td>
<td><strong>728 boxes</strong></td>
</tr>
</tbody>
</table>

**Average of 3 Clinics: 974 boxes**

**Conclusions:** The over-expenditure on medicines identified above is expressed as the number of extra boxes that could have been purchased if the clinics had purchased the medicines at the lowest available retail price. In particular, Astria 2 could have purchased over 800 more boxes of Amoxicillin had they purchased it at the lowest available retail price. Astria 1 could have purchased 247 more boxes of Folic Acid, and Astria 3 could have purchased 268 more boxes of Paracetamol. All three clinics had significant amounts of over-expenditure on these three medicines, given the number of extra boxes of medicine that they could have purchased if they had paid the lowest available retail price. This raises a major red flag about the procurement process in each of the three clinics.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

<table>
<thead>
<tr>
<th></th>
<th>Astria 1</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>117.1%</td>
<td>94.8%</td>
<td>104.7%</td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td>113.2%</td>
<td>108.0%</td>
<td>99.2%</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td>124.8%</td>
<td>110.6%</td>
<td>99.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>133.8%</td>
<td>96.6%</td>
<td>117.3%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117.8%</strong></td>
<td><strong>98.5%</strong></td>
<td><strong>104.5%</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Astria 2</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>113.3%</td>
<td>113.0%</td>
<td>93.4%</td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td>125.9%</td>
<td>112.1%</td>
<td>90.9%</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td>121.2%</td>
<td>105.8%</td>
<td>93.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>127.5%</td>
<td>95.6%</td>
<td>113.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118.8%</strong></td>
<td><strong>110.5%</strong></td>
<td><strong>95.0%</strong></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>122.5%</td>
<td>93.0%</td>
<td>102.9%</td>
<td></td>
</tr>
<tr>
<td>Goods and Services</td>
<td>108.3%</td>
<td>110.2%</td>
<td>89.7%</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td>105.8%</td>
<td>101.2%</td>
<td>95.8%</td>
<td></td>
</tr>
<tr>
<td>Payments for Capital Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>145.2%</td>
<td>97.2%</td>
<td>100.2%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>120.9%</td>
<td>98.2%</td>
<td>98.3%</td>
<td></td>
</tr>
</tbody>
</table>

| Average RoS on Total Budgets | 119% | 102.4% | 99.3% |

Some conclusions from the above table are as follows:

- In 2010 there was over-expenditure in all line items across the three PHCs. The other two years reflect a mix of over-expenditure and under-expenditure among the different line items.
- Almost all of the allocations for Salaries, Medicines, and Medical Equipment were spent in all of the PHCs.
- There is not necessarily a pattern of underspending for a specific line item or PHC.

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Astria.

<table>
<thead>
<tr>
<th>Astria 1</th>
<th>Astria 2</th>
<th>Astria 3</th>
<th>Astria Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>6.70%</td>
<td>5.57%</td>
<td>5.64%</td>
</tr>
<tr>
<td>2009</td>
<td>6.22%</td>
<td>4.59%</td>
<td>5.11%</td>
</tr>
<tr>
<td>2010</td>
<td>5.96%</td>
<td>4.55%</td>
<td>5.24%</td>
</tr>
<tr>
<td>2011</td>
<td>5.81%</td>
<td>4.33%</td>
<td>4.63%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the selected clinics in Astria are below those of the average share received by PHCs in Astria (in each year).
- The average budget share received by PHCs decreased from 2008 to 2011.
- The budget shares of the selected clinics in Astria also decreased from 2008 to 2011.
Based on the above data, it appears that the selected clinics are not receiving a fair share of the district Primary Health funds. This situation may have consequences in the provision of health services for those selected clinics.

2. Real Growth (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th>PHC</th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astria 1</td>
<td>48.77%</td>
<td>-7.14%</td>
<td>2.24%</td>
</tr>
<tr>
<td>Astria 2</td>
<td>45.26%</td>
<td>-3.77%</td>
<td>-9.30%</td>
</tr>
<tr>
<td>Astria 3</td>
<td>34.65%</td>
<td>-0.46%</td>
<td>-0.33%</td>
</tr>
<tr>
<td>Astria Average PHC</td>
<td>38.76%</td>
<td>-3.05%</td>
<td>-0.89%</td>
</tr>
</tbody>
</table>

Some conclusions are:
- There were decreases in real terms for the budget for all (selected and average) clinics in Astria for two consecutive periods.
- In the 2010-2011 period, all clinics have a budget increase in real terms.

As a broad conclusion of this hypothesis, the selected clinics do not receive their “fair” share of the District Services’ Primary Health budget. The data also shows a decrease in the amount (in real terms) of the budgets to the selected clinics over a two-year period. The lack of sufficient budgets for those clinics could result in poor quality health services.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polaris Ministry of Health**

Excerpt from the Polaris National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
</tbody>
</table>
This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

### Per capita budget of selected clinics in Astria (and the average among Astria clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astria 1</td>
<td>D 41.63</td>
<td>D 26.90</td>
<td>D 27.87</td>
<td>D 26.29</td>
</tr>
<tr>
<td>Astria 2</td>
<td>D 44.59</td>
<td>D 29.51</td>
<td>D 29.51</td>
<td>D 31.37</td>
</tr>
<tr>
<td>Astria 3</td>
<td>D 37.98</td>
<td>D 27.11</td>
<td>D 26.21</td>
<td>D 25.36</td>
</tr>
<tr>
<td>Astria Average PHC</td>
<td>D 48.59</td>
<td>D 33.65</td>
<td>D 33.40</td>
<td>D 32.50</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The per capita budgets of the selected clinics were below the average per capita for clinics in Astria from 2008 to 2011.
- The per capita budgets for all clinics increased from 2008 to 2011. The average per capita budget for clinics in Astria also increased during this period.
- Astria is a mostly rural district (3.92% of Sunrise State’s population in 2008). The three selected clinics’ per capita budgets were below the MoH standard (D 30-35 per capita) for all years except 2011.

Again, there seems to be insufficient budget allocations for the selected clinics to provide quality health services to the population. The MoH standard is a clear indicator of this situation.
2. Chotral District (rural)

Hypothesis 1: Primary health clinics are wasting money

1. Unit cost for essential medicines

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th></th>
<th>Chotral 1</th>
<th>Chotral 2</th>
<th>Chotral 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 2.27/box</td>
<td>D 2.55/box</td>
<td>D 3.58/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 2.75/box</td>
<td>D 2.31/box</td>
<td>D 2.28/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 1.84/box</td>
<td>D 2.22/box</td>
<td>D 1.73/box</td>
</tr>
</tbody>
</table>

Some conclusions are:
- No single PHC is paying the highest price for more than one medicine. (For example, Chotral 1 pays the highest price for Folic Acid, Chotral 2 pays the highest price for Paracetamol, and Chotral 3 pays the highest price for Amoxicillin.)
- Chotral 3 paid the lowest price for two out of the three medicines (Folic Acid, Paracetamol).
- Chotral 2 paid higher prices for two out of the three medicines. It’s possible that this is due to a poor procurement process at the clinic.

2. Over-expenditure on each medicine compared to the lowest available retail prices

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Chotral PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Chotral 1</th>
<th>Chotral 2</th>
<th>Chotral 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>-5.0%</td>
<td>6.7%</td>
<td>49.8%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>35.5%</td>
<td>13.8%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>17.2%</td>
<td>41.4%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

Some conclusions are:
- With the exception of Chotral 1’s price for Amoxicillin, all of the medicines were purchased at a price higher than the best retail price.
- For each medicine, there is one PHC paying 35% to 50% above the best retail price. (For example, Chotral 1 pays 35.5% more for Folic Acid, Chotral 2 pays 41.4% more for Paracetamol, and Chotral 3 pays 48.9% more for Amoxicillin.)
- Chotral 2 and 3 are getting the worst prices in comparison with the best retail prices.
3. Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price (highest impact due to change of prices)

<table>
<thead>
<tr>
<th></th>
<th>Chotral 1</th>
<th>Chotral 2</th>
<th>Chotral 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>-53 boxes</td>
<td>66 boxes</td>
<td>505 boxes</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>322 boxes</td>
<td>131 boxes</td>
<td>136 boxes</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>223 boxes</td>
<td>439 boxes</td>
<td>150 boxes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>492 boxes</strong></td>
<td><strong>636 boxes</strong></td>
<td><strong>791 boxes</strong></td>
</tr>
</tbody>
</table>

Average of 3 clinics: 640 boxes

Some conclusions are:
- For each medicine except Amoxicillin in Chotral 1, the PHCs could have bought significantly more medicines if they had paid the lowest available retail prices. This raises a major red flag for the procurement process in each of the three clinics.
- Chotral 3 is the clinic that could have bought the most extra boxes of medicines.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

<table>
<thead>
<tr>
<th>Chotral 1</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>131.7%</td>
<td>101.1%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>107.5%</td>
<td>111.3%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Medicines</td>
<td>116.7%</td>
<td>101.2%</td>
<td>88.1%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>125.0%</td>
<td>96.2%</td>
<td>98.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123.7%</strong></td>
<td><strong>103.2%</strong></td>
<td><strong>98.7%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chotral 2</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>109.3%</td>
<td>114.8%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>120.6%</td>
<td>102.5%</td>
<td>104.5%</td>
</tr>
<tr>
<td>Medicines</td>
<td>109.6%</td>
<td>106.0%</td>
<td>101.2%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>101.6%</td>
<td>100.4%</td>
<td>101.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111.6%</strong></td>
<td><strong>109.0%</strong></td>
<td><strong>98.3%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chotral 3</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>103.6%</td>
<td>107.7%</td>
<td>114.3%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>122.8%</td>
<td>99.1%</td>
<td>110.9%</td>
</tr>
</tbody>
</table>
Some conclusions from the tables are:

- In 2010 all line items of the 3 PHCs were overspent, compared to some underspending in 2008.
- There is little underspending over the three years for all of the PHCs and line items.
- Medicines show a trend of increased spending over the three years for all PHCs. Based on the conclusions of the previous hypothesis (i.e., that funds were wasted by paying higher prices for three essential medicines in 2008), it’s possible that the funds that were overspent have also been wasted. Although there is no data for spending on essential medicines by the three clinics for the years 2009 and 2010, so this would require further investigation.

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Chotral.

<table>
<thead>
<tr>
<th></th>
<th>Chotral 1</th>
<th>Chotral 2</th>
<th>Chotral 3</th>
<th>Chotral Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2008</strong></td>
<td>5.66%</td>
<td>4.50%</td>
<td>4.33%</td>
<td>9.09%</td>
</tr>
<tr>
<td><strong>2009</strong></td>
<td>5.69%</td>
<td>4.12%</td>
<td>4.72%</td>
<td>9.09%</td>
</tr>
<tr>
<td><strong>2010</strong></td>
<td>4.61%</td>
<td>3.66%</td>
<td>4.00%</td>
<td>7.69%</td>
</tr>
<tr>
<td><strong>2011</strong></td>
<td>4.98%</td>
<td>3.73%</td>
<td>3.92%</td>
<td>7.69%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the selected clinics in Chotral are below the average budget share received by PHCs in Chotral.
- The average budget share received by PHCs in Chotral went down from 2008 to 2011.
- The budget shares of the selected clinics in Chotral also went down from 2008 to 2011.

It is clear the selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.
2. Real Growth (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th>PHC</th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chotral 1</td>
<td>59.79%</td>
<td>-22.79%</td>
<td>6.48%</td>
</tr>
<tr>
<td>Chotral 2</td>
<td>50.45%</td>
<td>-15.36%</td>
<td>-3.11%</td>
</tr>
<tr>
<td>Chotral 3</td>
<td>44.69%</td>
<td>-19.19%</td>
<td>15.28%</td>
</tr>
<tr>
<td>Chotral Average PHC</td>
<td>47.98%</td>
<td>-19.37%</td>
<td>5.74%</td>
</tr>
</tbody>
</table>

Some conclusions are:
- In the period 2009-2010, there were decreases in real terms in the budgets for all selected clinics in Chotral, as well as in the average among clinics in Chotral.
- In the 2010-2011 period, all clinics had a budget increase in real terms, which was close to or above the average.

As a broad conclusion of this hypothesis, the decrease in the budget share that selected PHCs received from the District Services’ Primary Health budget, and the fluctuations of real growth in the same budgets over a three-year period points to a question of priority on how the budget is distributed and allocated among PHCs.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health**

Excerpt from the Polarus National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
<tr>
<td>Urban-Rural mix</td>
<td>40-45</td>
</tr>
<tr>
<td>Mostly Rural</td>
<td>30-35</td>
</tr>
</tbody>
</table>
This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

Per capita budget of selected clinics in Chotral (and the average among Chotral clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chotral 1</td>
<td>D 54.16</td>
<td>D 32.58</td>
<td>D 40.61</td>
<td>D 36.78</td>
</tr>
<tr>
<td>Chotral 2</td>
<td>D 43.91</td>
<td>D 28.05</td>
<td>D 31.89</td>
<td>D 31.74</td>
</tr>
<tr>
<td>Chotral 3</td>
<td>D 46.98</td>
<td>D 31.21</td>
<td>D 37.16</td>
<td>D 31.09</td>
</tr>
<tr>
<td>Chotral Average PHC</td>
<td>D 58.51</td>
<td>D 38.00</td>
<td>D 45.36</td>
<td>D 41.37</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The per capita budgets of the selected clinics were below the average per capita budget for clinics in Astria from 2008 to 2011.
- The three selected clinics – as well as the average per capita budget for clinics in Astria – had increases in their per capita budgets over the 4-year period, except for a decrease in 2010.
- Chotral is a mostly rural district (4.32% of Sunrise State’s population in 2008). The selected clinics were in between or above the MoH standard (D30-35 per capita), except for Chotral 2 in 2010.
3. **Lemauri District (rural)**

**Hypothesis 1: Primary health clinics are wasting money**

1. **Unit cost for essential medicines**

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th></th>
<th>Lemauri 1</th>
<th>Lemauri 2</th>
<th>Lemauri 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 3.32/box</td>
<td>D 4.32/box</td>
<td>D 3.46/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 2.86/box</td>
<td>D 2.70/box</td>
<td>D 2.94/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 2.33/box</td>
<td>D 2.53/box</td>
<td>D 2.13/box</td>
</tr>
</tbody>
</table>

Some conclusions are:
- Lemauri 2 paid the highest prices for Amoxicillin and Paracetamol.
- The lowest prices paid are distributed among the three selected PHCs.

2. **Over-expenditure on each medicine compared to the best retail price available**

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Lemauri PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Lemauri 1</th>
<th>Lemauri 2</th>
<th>Lemauri 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>-1.8%</td>
<td>27.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>20.7%</td>
<td>13.9%</td>
<td>24.1%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>3.6%</td>
<td>12.4%</td>
<td>-5.3%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>7.5%</strong></td>
<td><strong>18%</strong></td>
<td><strong>7.1%</strong></td>
</tr>
</tbody>
</table>

Some conclusions are:
- Lemauri 1 (for Amoxicillin) and Lemauri 3 (for Paracetamol) are paying lower prices than the lowest available retail price.
- Lemauri 2 is paying more for all three medicines, compared to the lowest available retail prices.
- All PHCs paid more for Folic Acid, compared to the lowest available retail price.

3. **Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price (highest impact due to change of prices)**
Some conclusions are:

- Lemauri 2 could have bought the highest number of extra boxes of medicines. This is a red flag for the procurement process of this PHC, indicating significant wastage of funds.
- The procurement processes of Lemauri 1 and 3 should also be looked into, given that they had overspending on medicines as well.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

<table>
<thead>
<tr>
<th>Lemauri 1</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>128.1%</td>
<td>109.1%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>116.2%</td>
<td>98.8%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Medicines</td>
<td>143.3%</td>
<td>106.3%</td>
<td>91.3%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>120.1%</td>
<td>106.6%</td>
<td>99.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>123.6%</td>
<td>105.8%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lemauri 2</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>121.5%</td>
<td>114.4%</td>
<td>102.4%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>131.7%</td>
<td>109.2%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Medicines</td>
<td>114.1%</td>
<td>101.5%</td>
<td>85.5%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>112.1%</td>
<td>105.3%</td>
<td>76.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>123.0%</td>
<td>111.6%</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lemauri 3</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>112.1%</td>
<td>98.9%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>138.6%</td>
<td>118.4%</td>
<td>115.9%</td>
</tr>
<tr>
<td>Medicines</td>
<td>128.4%</td>
<td>100.1%</td>
<td>94.5%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>138.7%</td>
<td>96.5%</td>
<td>88.1%</td>
</tr>
</tbody>
</table>
Some conclusions from the tables are:

- In 2010 all line items across the 3 PHCs were overspent.
- There is relatively little underspending over the three years for all PHCs and line items. Some exceptions are: medicines and medical equipment for Lemauri 2 in 2008, and medical equipment for Lemauri 3 in 2008. All other spending is above 90%.
- In 2008 Lemauri 2 underspent by almost 15% on medicines. However, the clinic paid higher prices for medicines compared to the lowest available retail prices in the same year (See Hypothesis 1).

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Lemauri.

<table>
<thead>
<tr>
<th></th>
<th>Lemauri 1</th>
<th>Lemauri 2</th>
<th>Lemauri 3</th>
<th>Lemauri Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>7.18%</td>
<td>5.72%</td>
<td>6.52%</td>
<td>12.50%</td>
</tr>
<tr>
<td>2009</td>
<td>7.76%</td>
<td>6.09%</td>
<td>6.52%</td>
<td>12.50%</td>
</tr>
<tr>
<td>2010</td>
<td>6.83%</td>
<td>5.37%</td>
<td>5.58%</td>
<td>11.11%</td>
</tr>
<tr>
<td>2011</td>
<td>6.11%</td>
<td>4.76%</td>
<td>4.98%</td>
<td>10.00%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the three selected clinics in Lemauri are almost half of the average share received by Lemauri PHCs over the three years.
- The average budget share received by Lemauri PHCs has decreased from 2008 to 2011.
- The budget shares of the three selected clinics in Lemauri have also gone down from 2008 to 2011.

It is clear the three selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.

2. **Real Growth** (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).
In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lemauri 1</td>
<td>45.32%</td>
<td>-16.13%</td>
<td>31.83%</td>
</tr>
<tr>
<td>Lemauri 2</td>
<td>43.88%</td>
<td>-15.93%</td>
<td>29.80%</td>
</tr>
<tr>
<td>Lemauri 3</td>
<td>44.72%</td>
<td>-18.45%</td>
<td>22.15%</td>
</tr>
<tr>
<td>Lemauri Average PHC</td>
<td>46.08%</td>
<td>-15.29%</td>
<td>22.02%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- In the period 2009-2010, there were decreases in real terms in the budgets for all selected clinics in Lemauri, as well as in the average among clinics in Lemauri.
- For the 2008-2009 and 2010-2011 periods, all clinics had a budget increase in real terms, and almost all of them were above the average increase.

As a broad conclusion of this hypothesis, the decrease in the budget share that selected PHCs received from the District Services' Primary Health budget, and the fluctuations of real growth in the same budgets over a three-year period points to a question of priority on how the budget is distributed and allocated among PHCs.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health**

Excerpt from the Polarus National Health Strategy (2007-2012):

*Primary health clinics*: All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
<tr>
<td>Urban-Rural mix</td>
<td>40-45</td>
</tr>
<tr>
<td>Mostly Rural</td>
<td>30-35</td>
</tr>
</tbody>
</table>

This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to
achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

Per capita budget of selected clinics in Lemauri (and the average among Lemauri clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lemauri 1</td>
<td>D 73.03</td>
<td>D 48.30</td>
<td>D 55.42</td>
<td>D 40.54</td>
</tr>
<tr>
<td>Lemauri 2</td>
<td>D 72.37</td>
<td>D 48.34</td>
<td>D 55.33</td>
<td>D 41.11</td>
</tr>
<tr>
<td>Lemauri 3</td>
<td>D 65.57</td>
<td>D 43.55</td>
<td>D 51.38</td>
<td>D 40.57</td>
</tr>
<tr>
<td>Lemauri Average PHC</td>
<td>D 89.69</td>
<td>D 59.01</td>
<td>D 67.03</td>
<td>D 52.98</td>
</tr>
</tbody>
</table>

Some conclusions are:
- The per capita budgets of the three selected clinics were below the average per capita budget (received by clinics in Lemauri) over the period 2008-2011.
- There was an increase in the per capita budget for each clinic from 2008 to 2011.
- Lemauri is a mostly rural district (3.37% of Sunrise State’s population in 2008), and the selected clinics were above the MoH standard (D 30-35 per capita).
4. **Obsalom Municipality (mixed rural-urban)**

**Hypothesis 1: Primary health clinics are wasting money**

1. **Unit cost for essential medicines**

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th>(2008)</th>
<th>Obsalom 1</th>
<th>Obsalom 2</th>
<th>Obsalom 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 2.73/box</td>
<td>D 1.73/box</td>
<td>D 1.81/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 1.44/box</td>
<td>D 1.68/box</td>
<td>D 1.52/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 1.21/box</td>
<td>D 1.43/box</td>
<td>D 1.14/box</td>
</tr>
</tbody>
</table>

Some conclusions are:
- Obsalom 2 paid the highest prices for Folic Acid and Paracetamol.
- The lowest prices paid are distributed among the three selected PHCs.

2. **Over-expenditure on each medicine compared to the best retail price available**

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Obsalom PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Obsalom 1</th>
<th>Obsalom 2</th>
<th>Obsalom 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>38.6%</td>
<td>-12.2%</td>
<td>-8.1%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>5.9%</td>
<td>23.5%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>7.1%</td>
<td>26.5%</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>17.2%</strong></td>
<td><strong>12.6%</strong></td>
<td><strong>1.5%</strong></td>
</tr>
</tbody>
</table>

Some conclusions are:
- Obsalom 1 paid a significantly higher price for Amoxicillin, compared to the lowest available retail price. The clinic paid more for all three medicines.
- Obsalom 2 is paying about 25% more for both Folic Acid and Paracetamol.
- All PHCs paid higher prices for Folic Acid compared to the lowest available retail price.

3. **Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price (highest impact due to change of prices).**
Some conclusions are:

- Obsalom 1 and 2 could have bought significantly more boxes of medicine. This is a major red flag for the procurement processes of these PHCs, indicating wastage of funds.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

<table>
<thead>
<tr>
<th>Obsalom 1</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>134.9%</td>
<td>113.5%</td>
<td>100.2%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>115.8%</td>
<td>104.6%</td>
<td>99.3%</td>
</tr>
<tr>
<td>Medicines</td>
<td>113.5%</td>
<td>96.3%</td>
<td>82.8%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>117.1%</td>
<td>105.8%</td>
<td>94.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127.3%</strong></td>
<td><strong>110.0%</strong></td>
<td><strong>99.3%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obsalom 2</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>121.2%</td>
<td>110.2%</td>
<td>103.8%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>121.6%</td>
<td>106.5%</td>
<td>99.6%</td>
</tr>
<tr>
<td>Medicines</td>
<td>142.3%</td>
<td>106.8%</td>
<td>95.5%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>122.9%</td>
<td>103.4%</td>
<td>104.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121.5%</strong></td>
<td><strong>108.3%</strong></td>
<td><strong>102.5%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obsalom 3</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>118.3%</td>
<td>127.1%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>120.4%</td>
<td>128.6%</td>
<td>99.3%</td>
</tr>
<tr>
<td>Medicines</td>
<td>136.6%</td>
<td>105.8%</td>
<td>88.8%</td>
</tr>
<tr>
<td><strong>Payments for Capital Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>97.5%</td>
<td>112.2%</td>
<td>93.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116.2%</strong></td>
<td><strong>125.5%</strong></td>
<td><strong>91.1%</strong></td>
</tr>
</tbody>
</table>
Average RoS on Total Budgets

<table>
<thead>
<tr>
<th></th>
<th>121.7%</th>
<th>114.6%</th>
<th>97.6%</th>
</tr>
</thead>
</table>

Some conclusions from the table are:

- In 2009 and 2010, all line items across the 3 PHCs were overspent (except for Medicines in Obsalom 1 in 2009 and Medical Equipment in Obsalom 3 in 2010).
- All line items were underspent in Obsalom 3 in 2008.
- Obsalom 1 underspent by 17% on Medicines in 2008. However, the clinic paid higher prices for medicines compared with the lowest available retail prices in the same year (See Hypothesis 1).

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

   The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Obsalom.

<table>
<thead>
<tr>
<th>Obsalom 1</th>
<th>Obsalom 2</th>
<th>Obsalom 3</th>
<th>Obsalom Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1.19%</td>
<td>0.92%</td>
<td>1.04%</td>
</tr>
<tr>
<td>2009</td>
<td>1.08%</td>
<td>0.84%</td>
<td>0.84%</td>
</tr>
<tr>
<td>2010</td>
<td>1.00%</td>
<td>0.85%</td>
<td>0.88%</td>
</tr>
<tr>
<td>2011</td>
<td>0.92%</td>
<td>0.74%</td>
<td>0.80%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the three selected clinics in Obsalom are below the average budget share received by PHCs in Obsalom in all four years.
- The budget shares of Obsalom 2 and 3 were almost half of the average budget share received by PHCs in Obsalom from 2008 to 2011.
- The average budget share received by PHCs in Obsalom decreased between 2008 and 2011.
- The budget shares of the three selected clinics in Obsalom also decreased between 2008 and 2011.

It is clear the selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.

2. **Real Growth** (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been
underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsalom 1</td>
<td>43.89%</td>
<td>-11.37%</td>
<td>8.70%</td>
</tr>
<tr>
<td>Obsalom 2</td>
<td>35.98%</td>
<td>-3.41%</td>
<td>9.92%</td>
</tr>
<tr>
<td>Obsalom 3</td>
<td>42.21%</td>
<td>-0.22%</td>
<td>-3.07%</td>
</tr>
<tr>
<td>Obsalom Average PHC</td>
<td>45.18%</td>
<td>-9.47%</td>
<td>9.22%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- In the period 2009-2010, there were decreases in real terms in the budgets for all selected clinics in Obsalom, as well as in the average among clinics in Obsalom.
- Obsalom 3 had two periods of budget decreases in real terms (2009-2010 and 2008-2009).
- For the 2010-2011 period, all clinics had a budget increase in real terms, and two out of three clinics received an increase similar to the average budget increase for clinics in Obsalom.

As a broad conclusion of this hypothesis, the decrease in the budget share that selected PHCs received from the District Services’ Primary Health budget, and the fluctuations of real growth in the same budgets over a three-year period points to a question of priority on how the budget is distributed and allocated among PHCs.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health**

Excerpt from the Polarus National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
<tr>
<td>Urban-Rural mix</td>
<td>40-45</td>
</tr>
<tr>
<td>Mostly Rural</td>
<td>30-35</td>
</tr>
</tbody>
</table>

This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across
states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

Per capita budget of selected clinics in Obsalom
(and the average among Obsalom clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsalom 1</td>
<td>D 28.44</td>
<td>D 19.00</td>
<td>D 20.62</td>
<td>D 18.30</td>
</tr>
<tr>
<td>Obsalom 2</td>
<td>D 27.09</td>
<td>D 19.15</td>
<td>D 19.08</td>
<td>D 16.74</td>
</tr>
<tr>
<td>Obsalom 3</td>
<td>D 29.29</td>
<td>D 19.79</td>
<td>D 19.09</td>
<td>D 18.99</td>
</tr>
<tr>
<td>Obsalom Average PHC</td>
<td>D 39.84</td>
<td>D 26.38</td>
<td>D 28.04</td>
<td>D 24.76</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The per capita budget of the three selected clinics was below the average per capita budget over all four years.
- The per capita budget of all clinics increased over the four-year period.
- Obsalom is mixed rural-urban district (21.66% of Sunrise State’s population in 2008), and all three selected clinics had per capita budgets below the MoH standard (D 40-45 per capita) from 2008 to 2011.
5. Swellentsia Municipality (mixed rural-urban)

Hypothesis 1: Primary health clinics are wasting money

1. Unit cost for essential medicines

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th></th>
<th>Swellentsia 1</th>
<th>Swellentsia 2</th>
<th>Swellentsia 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 2.13/box</td>
<td>D 1.93/box</td>
<td>D 2.41/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 1.52/box</td>
<td>D 1.46/box</td>
<td>D 1.38/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 1.23/box</td>
<td>D 1.35/box</td>
<td>D 1.18/box</td>
</tr>
</tbody>
</table>

Some conclusions are:
- Each of the PHCs paid the highest price for one of the three drugs.
- Swellentsia 3 paid two of the lowest prices (for Folic Acid and Paracetamol).

2. Over-expenditure on each medicine compared to the best retail price available

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Swellentsia PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Swellentsia 1</th>
<th>Swellentsia 2</th>
<th>Swellentsia 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>17.7%</td>
<td>6.6%</td>
<td>33.1%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>11.8%</td>
<td>7.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>5.1%</td>
<td>15.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Average</td>
<td>11.5%</td>
<td>9.8%</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

Average for 3 Clinics: 11%

Some conclusions are:
- All PHCs were paying prices above the lowest available retail price.
- Amoxicillin was the medicine that the clinics paid significantly more for, compared to the lowest available retail price.
- Swellentsia 3 paid close to the lowest available retail price for Folic Acid and Paracetamol, but then paid one-third more for Amoxicillin.

3. Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price
Some conclusions are:
- All three PHCs, especially Swellentsia 1 and Swellentsia 3, could have bought significantly more boxes of Amoxicillin, if they had paid the lowest available retail price for it.
- Swellentsia 1 could have bought a lot more Folic Acid, and Swellentsia 2 could have bought a lot more Paracetamol.
- Although Swellentsia 3 paid the lowest prices for two medicines, it had the highest number of possible additional boxes of medicines that it could have bought, due to the high cost of the Amoxicillin that it purchased.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.
Some conclusions from the tables are:

- In 2008 there was underspending across all line items and PHCs, except for one line item of the Swellentsia 2 clinic (Salaries), which was overspent by 8%.
- In 2009 there was primarily overspending across all PHCs, except for the Swellentsia 2 clinic, which slightly underspent on Goods & Services as well as Medical Equipment.
- In 2010 there was overspending across all line items and PHCs.
- The Swellentsia 1 clinic had the highest overspending in both 2009 and 2010.
- The three PHCs underspent on medicines in 2008, and as reported in Hypothesis 1, they also overpaid for three essential medicines in that same year.

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Swellentsia.

<table>
<thead>
<tr>
<th></th>
<th>Swellentsia 1</th>
<th>Swellentsia 2</th>
<th>Swellentsia 3</th>
<th>Swellentsia Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1.77%</td>
<td>1.26%</td>
<td>1.47%</td>
<td>2.78%</td>
</tr>
<tr>
<td>2009</td>
<td>1.50%</td>
<td>1.23%</td>
<td>1.32%</td>
<td>2.56%</td>
</tr>
<tr>
<td>2010</td>
<td>1.50%</td>
<td>1.26%</td>
<td>1.38%</td>
<td>2.50%</td>
</tr>
<tr>
<td>2011</td>
<td>1.47%</td>
<td>1.17%</td>
<td>1.19%</td>
<td>2.38%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the three selected clinics in Swellentsia were below the average budget share received by PHCs in Swellentsia over the period 2008 to 2011.
- The budget shares of Swellentsia 2 and 3 were almost half of the average budget share received by PHCs in Swellentsia.
- The average budget share received by PHCs in Swellentsia decreased from 2008 to 2011.
- The budget shares of the three selected clinics in Swellentsia also decreased from 2008 to 2011.
It is clear the selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.

2. Real Growth (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th>Swellentsia 1</th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46.53%</td>
<td>-4.67%</td>
<td>-3.21%</td>
</tr>
<tr>
<td>Swellentsia 2</td>
<td>38.17%</td>
<td>-2.30%</td>
<td>11.23%</td>
</tr>
<tr>
<td>Swellentsia 3</td>
<td>29.71%</td>
<td>-0.55%</td>
<td>2.21%</td>
</tr>
<tr>
<td>Swellentsia Average PHC</td>
<td>42.45%</td>
<td>-7.11%</td>
<td>5.27%</td>
</tr>
</tbody>
</table>

Some conclusions are:
- In the period 2009-2010, there were decreases in real terms in the budgets for all selected clinics in Swellentsia, as well as in the average among clinics in Swellentsia.
- Swellentsia 1 had two periods of budget decreases in real terms (2009-2010 and 2008-2009).
- For the period 2010-2011 all clinics had a budget increase in real terms, but only Swellentsia 1 had an above-average budget increase (46.53% compared to the average of 42.45%).

As a broad conclusion of this hypothesis, the decrease in the budget share that selected PHCs received from the District Services’ Primary Health budget, and the fluctuations of real growth in the same budgets over a three-year period points to a question of priority on how the budget is distributed and allocated among PHCs.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health**

Excerpt from the Polarus National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
</tbody>
</table>
This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government's investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

### Per capita budget of selected clinics in Swellentsia
(and the average among Swellentsia clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swellentsia 1</td>
<td>D 34.77</td>
<td>D 22.81</td>
<td>D 23.02</td>
<td>D 22.94</td>
</tr>
<tr>
<td>Swellentsia 2</td>
<td>D 35.18</td>
<td>D 24.47</td>
<td>D 24.10</td>
<td>D 20.90</td>
</tr>
<tr>
<td>Swellentsia 3</td>
<td>D 31.57</td>
<td>D 23.39</td>
<td>D 22.63</td>
<td>D 21.36</td>
</tr>
<tr>
<td>Swellentsia Average PHC</td>
<td>D 41.28</td>
<td>D 27.85</td>
<td>D 28.86</td>
<td>D 26.44</td>
</tr>
</tbody>
</table>

Some conclusions are:
- The per capita budgets of the three selected clinics were below the average per capita budget from 2008 to 2011.
- The per capita budget increased for each clinic over the period 2008 to 2011.
- Swellentsia is mixed rural-urban district (14.5% of Sunrise State’s population in 2008), and all three PHCs had a per capita budget below the MoH standard (D 40-45 per capita) across the four-year period.
6. **Trelis District (rural)**

**Hypothesis 1: Primary health clinics are wasting money**

1. Unit cost for essential medicines

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th></th>
<th>Trelis 1</th>
<th>Trelis 2</th>
<th>Trelis 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>3.98</td>
<td>3.91</td>
<td>4.26</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>4.57</td>
<td>4.14</td>
<td>3.78</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>3.05</td>
<td>3.33</td>
<td>3.07</td>
</tr>
</tbody>
</table>

Some conclusions are:

- Each of the PHCs paid the highest price for one of the three medicines (Trelis 3 paid the highest price for Amoxicillin; Trelis 1 paid the highest price for Folic Acid; and Trelis 2 paid the highest price for Paracetamol).
- Each of the PHCs also paid the lowest price for one of the three medicines (Trelis 2 paid the lowest price for Amoxicillin; Trelis 3 paid the lowest price for Folic Acid; and Trelis 1 paid the lowest price for Paracetamol).
- This shows inconsistency in the amounts that each clinic paid for different types of medicines – paying too much for one medicine, but paying a low price for another.

2. **Over-expenditure on each medicine compared to the best retail price available**

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Trelis PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Trelis 1</th>
<th>Trelis 2</th>
<th>Trelis 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>-1.7%</td>
<td>-3.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>33.2%</td>
<td>20.7%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>20.1%</td>
<td>31.1%</td>
<td>20.9%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>17.2%</strong></td>
<td><strong>16.1%</strong></td>
<td><strong>12.1%</strong></td>
</tr>
</tbody>
</table>

Some conclusions are:

- Trelis 1 and Trelis 2 paid a lower price than the lowest available retail price for Amoxicillin. Trelis 3 paid only slightly above the lowest available retail price for Amoxicillin.
- Trelis 3 bought all three medicines at higher prices than the lowest available retail prices.
- All three PHCs bought Folic Acid and Paracetamol at higher prices than the best available retail prices.
3. Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price

<table>
<thead>
<tr>
<th></th>
<th>Trelis 1</th>
<th>Trelis 2</th>
<th>Trelis 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>-17 boxes</td>
<td>-34 boxes</td>
<td>53 boxes</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>300 boxes</td>
<td>186 boxes</td>
<td>116 boxes</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>268 boxes</td>
<td>364 boxes</td>
<td>293 boxes</td>
</tr>
<tr>
<td>Total</td>
<td>551 boxes</td>
<td>516 boxes</td>
<td>462 boxes</td>
</tr>
</tbody>
</table>

Average of 3 Clinics: 510 boxes

Some conclusions are:
- All three of the PHCs could have bought a lot more medicines, if they had paid the lowest available retail prices for them. This is a red flag for the procurement processes of these PHCs, indicating wastage of funds.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

<table>
<thead>
<tr>
<th>Trelis 1</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>138.0%</td>
<td>106.2%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>122.4%</td>
<td>93.4%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Medicines</td>
<td>121.5%</td>
<td>100.5%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Payments for Capital Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>116.6%</td>
<td>102.6%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Total</td>
<td>131.5%</td>
<td>102.4%</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trelis 2</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>121.9%</td>
<td>92.4%</td>
<td>115.0%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>112.8%</td>
<td>112.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Medicines</td>
<td>126.9%</td>
<td>97.1%</td>
<td>99.1%</td>
</tr>
<tr>
<td>Payments for Capital Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>126.9%</td>
<td>92.4%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Total</td>
<td>119.9%</td>
<td>97.6%</td>
<td>103.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trelis 3</th>
<th>2010 RoS</th>
<th>2009 RoS</th>
<th>2008 RoS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>128.0%</td>
<td>101.4%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>113.8%</td>
<td>87.7%</td>
<td>89.1%</td>
</tr>
</tbody>
</table>
Some conclusions from the tables are:

- In 2008 there was underspending in almost all line items of the three PHCs, except for Trelis 2, which overspent on salaries by 15%.
- In 2009 there was a mix of overspending and underspending across the three PHCs.
- In 2010 there was overspending by all three PHCs on all line items, especially by Trelis 1.
- The three PHCs underspent on medicines in 2008, and as reported in Hypothesis 1, they also overpaid for three essential medicines in that same year.

### Hypothesis 3: Primary health clinics are underfunded

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Trelis.

<table>
<thead>
<tr>
<th></th>
<th>Trelis 1</th>
<th>Trelis 2</th>
<th>Trelis 3</th>
<th>Trelis Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>10.20%</td>
<td>7.59%</td>
<td>8.69%</td>
<td>16.67%</td>
</tr>
<tr>
<td>2009</td>
<td>10.76%</td>
<td>8.35%</td>
<td>8.61%</td>
<td>16.67%</td>
</tr>
<tr>
<td>2010</td>
<td>8.28%</td>
<td>7.01%</td>
<td>6.87%</td>
<td>14.29%</td>
</tr>
<tr>
<td>2011</td>
<td>7.46%</td>
<td>5.89%</td>
<td>6.14%</td>
<td>12.50%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the selected clinics in Trelis were below the average budget share received by PHCs in Trelis from 2008 to 2011.
- The budget shares of Trelis 2 and 3 were half (or less) of the average budget share received by PHCs in Trelis over the four-year period.
- The average budget share received by PHCs in Trelis decreased over the period 2008-2011.
- The budget shares of the selected clinics in Trelis also decreased over the same four-year period.

It is clear the selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.
2. **Real Growth** (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trelis 1</td>
<td>41.81%</td>
<td>-26.03%</td>
<td>12.00%</td>
</tr>
<tr>
<td>Trelis 2</td>
<td>32.14%</td>
<td>-19.24%</td>
<td>16.79%</td>
</tr>
<tr>
<td>Trelis 3</td>
<td>40.69%</td>
<td>-23.22%</td>
<td>5.12%</td>
</tr>
<tr>
<td>Trelis Average PHC</td>
<td>37.63%</td>
<td>-17.54%</td>
<td>6.15%</td>
</tr>
</tbody>
</table>

Some conclusions are:
- For the period 2008-2009, only Trelis 3 had a below-average budget increase.
- In the period 2009-2010, there were decreases in real terms in the budgets of all three PHCs, and these decreases were more than the decrease in the average budget for PHCs in Trelis.
- For the period 2010-2011, only Trelis 2 had a budget increase in real terms that was lower than the increase in the average budget for PHCs in Trelis.

As a broad conclusion of this hypothesis, the decrease in the budget share that selected PHCs received from the District Services’ Primary Health budget, and the fluctuations of real growth in the same budgets over a three-year period points to a question of priority on how the budget is distributed and allocated among PHCs.

**Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health**

Excerpt from the Polarus National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
</tbody>
</table>
This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

<table>
<thead>
<tr>
<th>Urban-Rural mix</th>
<th>40-45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Rural</td>
<td>30-35</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The per capita budgets of the three selected clinics were below the average per capita budgets received by PHCs in Trelis from 2008-2011.
- In 2010 the per capita budgets of the PHCs decreased by over 10 Dinars, after having increased in both 2008 and 2009.
- Trelis is a rural district (2.84% of Sunrise State’s population in 2008), and all three PHCs had per capita budgets above the MoH standard (D 30-35 per capita) over the four-year period. The average per capita budget received by PHCs in Trelis was also above this standard, in some cases by over 30 Dinars (in 2011).
7. Zofara District (rural)

**Hypothesis 1: Primary health clinics are wasting money**

1. Unit cost for essential medicines

For this calculation, the data come from official invoices: the prices paid by each PHC for each medicine and the number of boxes of each medicine that the PHCs received.

<table>
<thead>
<tr>
<th>(2008)</th>
<th>Zofara 1</th>
<th>Zofara 2</th>
<th>Zofara 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>D 2.47/box</td>
<td>D 2.28/box</td>
<td>D 1.79/box</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>D 1.70/box</td>
<td>D 2.08/box</td>
<td>D 1.40/box</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>D 1.40/box</td>
<td>D 1.65/box</td>
<td>D 1.37/box</td>
</tr>
</tbody>
</table>

Some conclusions are:
- Zofara 1 paid the highest price for Amoxicillin.
- Zofara 2 paid the highest prices for Folic Acid and Paracetamol.
- Zofara 3 paid the lowest price for all three medicines.

2. Over-expenditure on each medicine compared to the best retail price available

For this calculation, you can use additional information provided by research that SeDeN conducted to gather retail prices of the three essential medicines from local pharmacies near each clinic. Based on the best retail prices that SeDeN found, you can calculate the percentages by which the three Zofara PHCs overspent on medicine, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Zofara 1</th>
<th>Zofara 2</th>
<th>Zofara 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>35.0%</td>
<td>24.6%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>4.9%</td>
<td>28.4%</td>
<td>-13.6%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>6.9%</td>
<td>26.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>15.6%</strong></td>
<td><strong>26.3%</strong></td>
<td><strong>-3.7%</strong></td>
</tr>
</tbody>
</table>

Some conclusions are:
- Zofara 1 and Zofara 2 paid higher prices than the lowest available retail prices for all three medicines (especially Zofara 2).
- Zofara 3 paid slightly more for Paracetamol compared to the lowest available retail price, and paid less than the lowest available retail price for Amoxicillin and Folic Acid.
- All PHCs paid higher prices for Paracetamol than the lowest available retail price.
3. Possible additional medicines (boxes) that could have been bought if the clinic paid the lowest available retail price

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Zofara 1</th>
<th>Zofara 2</th>
<th>Zofara 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>381 boxes</td>
<td>241 boxes</td>
<td>-24 boxes</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>56 boxes</td>
<td>267 boxes</td>
<td>-174 boxes</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>92 boxes</td>
<td>307 boxes</td>
<td>58 boxes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>529 boxes</td>
<td>815 boxes</td>
<td>-140 boxes</td>
</tr>
</tbody>
</table>

Average of 3 Clinics: 401 boxes

Some conclusions are:
- Zofara 1 and 2 could have significantly more boxes of medicines, indicating extreme wastage in the procurement process.
- Zofara 3 actually saved money on medicines in its procurement process, equivalent to 140 boxes of medicines.

**Hypothesis 2: Primary health clinics are underspending**

Determining the rate of spending (RoS) on Salaries, Goods and Services, Medicines, and Medical Equipment, using budgeted allocations vs. audited expenditures.

### Zofara 1

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>119.0%</td>
<td>99.2%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>125.4%</td>
<td>107.5%</td>
<td>112.5%</td>
</tr>
<tr>
<td>Medicines</td>
<td>117.3%</td>
<td>99.6%</td>
<td>98.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>122.1%</strong></td>
<td><strong>101.9%</strong></td>
<td><strong>93.2%</strong></td>
</tr>
</tbody>
</table>

### Zofara 2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>126.7%</td>
<td>104.6%</td>
<td>111.9%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>140.3%</td>
<td>110.5%</td>
<td>102.5%</td>
</tr>
<tr>
<td>Medicines</td>
<td>137.1%</td>
<td>101.8%</td>
<td>103.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132.3%</strong></td>
<td><strong>106.3%</strong></td>
<td><strong>107.0%</strong></td>
</tr>
</tbody>
</table>

### Zofara 3

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>125.2%</td>
<td>107.5%</td>
<td>101.5%</td>
</tr>
<tr>
<td>Goods and Services</td>
<td>139.9%</td>
<td>120.9%</td>
<td>115.6%</td>
</tr>
</tbody>
</table>
**Health & Budgets Training Workshop**
**Facilitator’s Manual**

<table>
<thead>
<tr>
<th>Medicines</th>
<th>119.3%</th>
<th>98.5%</th>
<th>86.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments for Capital Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>153.6%</td>
<td>94.1%</td>
<td>102.3%</td>
</tr>
<tr>
<td>Total</td>
<td>133.6%</td>
<td>108.7%</td>
<td>105.2%</td>
</tr>
</tbody>
</table>

| Average RoS on Total Budgets | 129% | 105.6% | 101.8% |

Some conclusions from the tables are:

- In the year 2008 only two line items were underspent by more than 10 percent – Salaries in Zofara 1 and Medicines in Zofara 3.
- For the years 2009 and 2010, there was overspending in almost all line items across the 3 PHCs, with the exceptions of Zofara 1 and 3 in 2009.
- Zofara 2 overspent significantly on medicines in 2010. From Hypothesis 1, we also know that the clinic paid higher prices for three essential medicines in 2008, but we don’t have data for 2009 and 2010.
- On the other hand, Zofara 3 underspent by almost 14% on medicines in 2008, and in that same year, paid the lowest (procured) prices for three essential medicines, two of which were bought for less than the lowest available retail price (See Hypothesis 1).

**Hypothesis 3: Primary health clinics are underfunded**

1. **Share of the budget** (total budget for each PHC as a share of the District Services’ Primary Health budget, compared to the average share received by PHCs in each district, by year)

The purpose of calculating budget shares is to determine if each PHC is receiving a “fair” share of the district’s Primary Health budget. The starting point for assessing “fair” would be to compare each PHC’s share of the Primary Health budget to the average share received by PHCs in Zofara.

<table>
<thead>
<tr>
<th></th>
<th>Zofara 1</th>
<th>Zofara 2</th>
<th>Zofara 3</th>
<th>Zofara Average PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>5.71%</td>
<td>3.97%</td>
<td>4.66%</td>
<td>9.09%</td>
</tr>
<tr>
<td>2009</td>
<td>5.34%</td>
<td>4.08%</td>
<td>4.39%</td>
<td>8.33%</td>
</tr>
<tr>
<td>2010</td>
<td>4.71%</td>
<td>3.46%</td>
<td>3.63%</td>
<td>7.69%</td>
</tr>
<tr>
<td>2011</td>
<td>4.28%</td>
<td>3.08%</td>
<td>3.42%</td>
<td>6.67%</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The budget shares of the selected clinics in Zofara were below the average budget share received by PHCs in Zofara from 2008 to 2011.
- The budget shares of Zofara 2 and 3 were half (or less) of the average budget shares received by PHCs in Zofara from 2008 to 2011.
- The average budget share received by PHCs in Zofara decreased from 2008 to 2011.
- The budget shares of the three selected clinics in Zofara also decreased over the same period.
It is clear the selected clinics are not receiving a fair share of the District Services’ Primary Health budget. This situation may have consequences for the provision of quality health services for those selected clinics.

2. Real Growth (growth in each PHC’s total budget compared to the average growth of PHC budgets in the district, for the periods 2008-2009, 2009-2010, and 2010-2011).

In addition to knowing the share a PHC has relative to the overall PHC budget, it could also be useful to know if the budgets of specific PHCs have been growing. In other words, the PHC may have been underfunded in the past, but perhaps the government is increasing the budget at a significant rate to make up for past neglect. It might also be important to know if the budget of a specific PHC is growing faster or slower than other PHCs. Are certain PHCs being neglected, compared to other PHCs?

<table>
<thead>
<tr>
<th></th>
<th>2010-2011</th>
<th>2009-2010</th>
<th>2008-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zofara 1</td>
<td>49.85%</td>
<td>-15.12%</td>
<td>0.78%</td>
</tr>
<tr>
<td>Zofara 2</td>
<td>46.67%</td>
<td>-18.24%</td>
<td>10.55%</td>
</tr>
<tr>
<td>Zofara 3</td>
<td>55.21%</td>
<td>-20.23%</td>
<td>1.34%</td>
</tr>
<tr>
<td>Zofara Average PHC</td>
<td><strong>42.99%</strong></td>
<td><strong>-11.09%</strong></td>
<td><strong>-1.37%</strong></td>
</tr>
</tbody>
</table>

Some conclusions are:
- For the period 2008-2009, the budgets of all three PHCs increased, while at the same time there was a decrease in the average budget received by PHCs in Zofara.
- In the period 2009-2010, there were decreases in real terms in the budgets of all three PHCs, and these decreases were more than the decrease in the average budget for PHCs in Zofara.
- For the period 2010-2011, all three PHCs had budget increases in real terms that were higher than the average budget increase for PHCs in Zofara.

As a broad conclusion of this hypothesis, the decrease of the share of the selected PHCs budget and the fluctuations of real growth of the same budgets points to a question of priority on how the budget is distributed and allocated across years among PHCs.
Hypothesis 4: The funds that the District Services Program provides to PHCs fall short of the per capita primary health care spending standard set by the Polarus Ministry of Health

Excerpt from the Polarus National Health Strategy (2007-2012):

**Primary health clinics:** All clinics will be strengthened in line with recommendations from quality of care monitors. Training for health care providers in the clinics will be enhanced. The Ministry of Health (MoH) will aim to ensure that PHCs are allocated funds necessary to ensure access to quality primary health care services on the following bases:

<table>
<thead>
<tr>
<th>Category</th>
<th>PHC per capita (Dinars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Urban</td>
<td>50-55</td>
</tr>
<tr>
<td>Urban-Rural mix</td>
<td>40-45</td>
</tr>
<tr>
<td>Mostly Rural</td>
<td>30-35</td>
</tr>
</tbody>
</table>

This calculation can, for instance, give an idea of how much a government is investing in certain goods and services, allowing a CSO to assess whether the government’s investment is adequate to achieve the stated purpose. It can also be helpful in comparing allocations and expenditures across states or population groups. Per capita calculations can also be useful in assessing whether a government is living up to a certain standard that may be in national law or set by international agencies.

**Per capita budget of selected clinics in Zofara**
(and the average among Zofara clinics) from 2008 to 2011:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zofara 1</td>
<td>D 37.15</td>
<td>D 23.83</td>
<td>D 27.02</td>
<td>D 25.85</td>
</tr>
<tr>
<td>Zofara 2</td>
<td>D 37.45</td>
<td>D 24.54</td>
<td>D 28.89</td>
<td>D 25.20</td>
</tr>
<tr>
<td>Zofara 3</td>
<td>D 32.87</td>
<td>D 20.36</td>
<td>D 24.56</td>
<td>D 23.37</td>
</tr>
<tr>
<td>Zofara Average PHC</td>
<td>D 42.71</td>
<td>D 28.71</td>
<td>D 31.08</td>
<td>D 30.39</td>
</tr>
</tbody>
</table>

Some conclusions are:

- The per capita budgets of the three selected clinics were below the average per capita budgets for clinics in Zofara over the four-year period.
- The year 2010 showed a drop in per capita budgets, after a two-year increase in per capita budgets in 2008 and 2009.
- Zofara is a rural district (5.05% of Sunrise State’s population in 2008). In 2011 all three PHCs had a per capita budget above the MoH standard (D 30-35 per capita). From 2008 to 2010, their per capita budgets were below the MoH standard.
GLOSSARY OF TERMS
<table>
<thead>
<tr>
<th><strong>A</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Administrative Classification</strong></td>
</tr>
<tr>
<td><strong>Adult Lifetime Risk of Maternal Death</strong></td>
</tr>
<tr>
<td><strong>Antenatal (or Prenatal) Surveys</strong></td>
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<tr>
<td><strong>Antiretroviral Therapy (ART)</strong></td>
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<tr>
<td><strong>Appropriation</strong></td>
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<tr>
<td><strong>Auditor-General (Supreme Audit Institution)</strong></td>
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<thead>
<tr>
<th><strong>B</strong></th>
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<tbody>
<tr>
<td><strong>Behavioral Factors</strong></td>
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<tr>
<td><strong>Biological Factors</strong></td>
</tr>
<tr>
<td><strong>Budget Cycle</strong></td>
</tr>
<tr>
<td><strong>Budget Deficit</strong></td>
</tr>
</tbody>
</table>

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<tr>
<th><strong>C</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Capital Expenditure</strong></td>
</tr>
</tbody>
</table>
### Catastrophic Health Expenditures
Out-of-pocket payments for health can cause households to incur catastrophic expenditures, which in turn can push them into poverty. The need to pay out-of-pocket can also mean that households do not seek care when they need it. An analysis of 108 surveys in 86 countries has revealed that catastrophic payments are incurred by less than 1% of households in some countries and up to 13% in others. Up to 5% of households are pushed into poverty.

### Commodities
Medicines, equipment, other clinical and non-clinical supplies

### Conditional Grant
Allocations of money from one sphere of government to another that are conditional on certain services being delivered or on compliance with specific requirements. These funds cannot be used for another purpose.

### Consumer Price Index
The Consumer Price Index (CPI) reflects the price of a representative basket of consumer goods and services. This measures the impact of inflation on the average consumer.

### Contingency Fund (or Contingency Reserve)
A fund or a budget provision set aside within the annual budget total, to be allocated later, designed to meet unforeseen changes in external circumstances. In medium-term budgeting, contingency and policy reserves are used to provide flexibility and to avoid premature expenditure commitments, with progressively bigger reserves in the totals set aside for later years.

### Cultural and Societal Norms and Values
The behavioral expectations and cues within a society or group. They are the rules that a group uses for appropriate and inappropriate values, beliefs, attitudes and behaviors. These rules may be explicit or implicit. They have also been described as the customary rules of behavior that coordinates our interactions with others.

### Deficit
The amount by which total expenditure exceeds total revenue

### Direct Causes of Maternal Death
Include any complications that arise during pregnancy, childbirth or the post-partum period that relate directly to the woman being pregnant. These could flow from any intervention, omission or incorrect treatment she received, or from a chain of events resulting from any of the above. The most common direct causes of maternal death are hemorrhage (excessive bleeding), obstructed labor, infection, preeclampsia and eclampsia (which are hypertension-related disorders specific to pregnancy) and unsafe abortions.

### Direct Taxes
Taxes charged on the taxable income of individuals and legal entities.
### Economic Classification
The classification of expenditures (or expenses) and the acquisition/disposal of assets into economic categories, which emphasize the economic nature of the transaction (salaries, interest, transfers, etc.).

### Education
One of the most important factors shaping people’s social position includes education. With regard to health and wellbeing it is critical to understand how access to education affects different population groups, and how this knowledge may help identify and promote effective policies and institutional changes to reduce health inequalities derived from varying access to adequate education.

### Epidemic
Is the rate a disease reaches unexpectedly high levels, affecting a large number of people in a relatively short space of time.

### Ethnicity/Race
A construct originally intended to discriminate between “innately” different groups allegedly belonging to the same overall “race,” is now held by some to refer to groups allegedly distinguishable on the basis of “culture;” in practice, however, “ethnicity” cannot meaningfully be disentangled from “race” in societies with inequitable race relations, hence the construct “race/ethnicity.”

### Expenditure
Government spending of money, or the amount of money spent.

### External Debt
Debt owed to creditors outside the country. This includes debt owed to private commercial banks, debt owed to other governments, or debt owed to international financial institutions such as the IMF and World Bank.

### Fiscal Policy
Policy on tax, spending and borrowing by government.

### Functional Classification
The classification of expenditure (as well as expense) transactions and acquisitions/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.

### Gender
Refers to a social construct regarding culture-bound conventions, roles, and behaviors for, as well as relationships between and among, women and men and boys and girls.
**Governance**  
Governance is the activity of governing. It relates to decisions that define expectations, grant power, or verify performance. It consists either of a separate process or of a specific part of management or leadership processes. Institutions like governments at different levels administer these processes and systems. Thus it is the web of institutions and processes through which social, economic and political decision-making in a country takes place.

**Gross Domestic Product (GDP)**  
Total value of final goods and services produced in the country during a calendar year. GDP per person is the simplest overall measure of income in a country. Economic growth is measure by the change in GDP from year to year.

| **H** |
|---|---|
| **Health Administration and Management** | Health care management systems, standards and protocols, guidelines, personnel policies, procurement policies, data and records systems |
| **Health Care** | The programs, services, procedures, therapies and interventions that treat and care for individuals with diseases, injuries and disabilities. |
| **Health Disparities** | Differences in health status that occur among population groups defined by specific characteristics. |
| **Health Equity** | The absence of unfair, unjust, unnecessary and avoidable differences in health among population groups defined socially, economically, demographically or geographically |
| **Health Facilities** | Health centers, clinics, hospitals of different types and levels, diagnostic centers, laboratories, |
| **Health Gradient** | The association between socioeconomic position and health across the whole population, including groups in different social strata. |
| **Health Inequality** | The generic term used to designate differences, variations and disparities in health achievements and risk factors of individuals and groups that may not imply moral judgments and may result from a personal choice that would not necessarily evoke moral concern. |
| **Health Personnel** | Doctors, nurses, managers, paramedics, support staff |
| **Health System** | A health system is the organization and the method by which health care is provided. In practice, these systems vary widely from one country to another. |
## I

**Incidence**
Is the number of new infections which over a time period

**Incidence Rate**
is the number of infections per specified unit of population in a given time period. Rates can be per 1,000, per 10,000 or per million

**Income**
Money received, especially on a regular basis, for work or through other means such as social welfare programs.

**Indirect Causes of Maternal Death**
Include complications that arise when the pregnant woman suffers from a previous disease, or developed a disease during pregnancy, which is not caused by the pregnancy but is aggravated by it. For example, women with malaria, HIV, tuberculosis, existing cardiac or renal diseases face particular risks during pregnancy.

**Insurance and Social Security**
Financing mechanism, social insurance, private insurance, employer/employee contributions, health policies and plans

**International Health**
International legislations, pandemic controls, donor financing, patents and trade in services, migration and brain drain, medical tourism

## K

**Knowledge**
Medical education, health education, health and medical literature, journals, databases, statistics

## L

**Line Item**
An item in a departmental budget that refers to the amount of money allocated within a program or sub-program

## M

**Material Circumstances**
Include determinants linked to the physical environment, such as housing (relating to both the shelter itself and its location), the financial means to buy healthy food, warm clothing etc. And the physical working and neighborhood environments. Depending on their quality these circumstances both provide resources for health and contain health risks.

**Maternal Mortality or Maternal Death**
Is the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Rate (MMRate)</td>
<td>This is the number of <em>maternal deaths</em> in a given period per 100 000 <em>women of reproductive age</em> during the same time-period.</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (MMR)</td>
<td>This is the number of <em>maternal deaths</em> during a given time period per 100 000 <em>live births</em> during the same time-period.</td>
</tr>
<tr>
<td>MDA</td>
<td>Ministries, Departments, and Agencies</td>
</tr>
<tr>
<td>Mother-to-Child Transmission (MTCT)</td>
<td>Can occur during pregnancy, at the time of delivery, or postnatally through breastfeeding. Over 90% of new infections in infants and young children occur through MTCT</td>
</tr>
<tr>
<td>Nominal Terms</td>
<td>Actual monetary value in terms of the purchasing power of the day (at current prices). Nominal terms do not take into account the effect of inflation on the real value of money. Government budgets are in nominal terms and do not adjust totals for inflation. See Real Terms</td>
</tr>
<tr>
<td>Occupation</td>
<td>One of the most important factors shaping people’s social position includes employment and working conditions. With regard to health and wellbeing it is critical to understand how employment relations affect different population groups, and how this knowledge may help identify and promote worldwide effective policies and institutional changes to reduce health inequalities derived from these employment relations.</td>
</tr>
<tr>
<td>Out-of-Pocket Payments (OOP)</td>
<td>This represents the share of the expenses that the patient or the family pay directly to the health care provider, without a third-party (insurer, or state). This usually means that the family has to bear the costs, without risk sharing or solidarity mechanisms involved, and without the possibility to spread the cost over time.</td>
</tr>
<tr>
<td>Ownership of Facilities</td>
<td>Private, government, municipal, NGO/not for profit, missionaries, corporate, insurance</td>
</tr>
<tr>
<td>Pandemic</td>
<td>describes epidemics of world-wide proportions such as influenza in 1918 or HIV/AIDS</td>
</tr>
<tr>
<td>Per Capita Income</td>
<td>Total national income divided by total population, which gives you the average income per person.</td>
</tr>
<tr>
<td>Policy</td>
<td>A policy is typically described as a deliberate plan of action to guide decisions and achieve rational outcome(s). However, the term may also be used to denote what is actually done, even though it is unplanned. For example, the health policy of a</td>
</tr>
</tbody>
</table>
government reflects its understanding of the health situation and recommends actions to be taken to improve the situation for the larger benefit of society. Similarly when the government does not take any proactive interest in the health issues affecting people we may still say the government has a health policy — one of deliberate inaction.

**Prevalence**
Is the absolute number of infected people in a population at a given time – it is a still photograph of current infections. HIV prevalence is given as a percentage rather than as a rate.

**Prevalence Rate**
Is the percentage of the population which exhibits the disease at a particular time (or averaged over a period of time).

**Primary Health Care**
The Principal vehicle for the delivery of health care at the most local level of a country’s health system. It is essential health care, made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it.

**Psychosocial Factors**
For example, negative life events, job strain, stressful living circumstances (high debt) and (lack of) social support, copying styles, violence, ethnic conflicts different social groups are exposed to different degrees of experiences and life situations that are perceived as threatening, frightening and difficult to deal with. This partly explains the long-term patterns of social inequalities in health.

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

**R**

**Real Terms**
Value measured in terms of the purchasing power of money at a particular time. For instance, GDP may be measured in constant 2008 prices by taking the devaluing effect of inflation into account. See Nominal Terms

**Regulation and Legislation**
Health services related laws, accreditation mechanisms, constitutional mandates, right to health care, un covenants, professional ethics

**Resource Allocation**
The process of deciding what is needed to carry out an activity and providing for those needs. This can include making provision for financial resources (money), capital resources (such as buildings and computer hardware) and staff resources (including the number of staff needed and the skill mix required).
Revenue
Government's annual income collected from taxes on salaries, profits etc.

Social Cohesion
A term used in social policy, sociology and political science to describe the bonds or "glue" that bring people together in society, particularly in the context of cultural diversity. Social cohesion is a multi-faceted notion covering many different kinds of social phenomena.

Social Determinants of Health
The specific features of and pathways by which societal conditions affect health and that can potentially be informed by action. Can be grouped into sixteen broad categories: socio-economic and political context, governance, policy, cultural and societal norms and values, social position, education, occupation, income, gender, ethnicity/race, biological factors, material circumstances, social cohesion, psychosocial factors, behaviors and health-care system.

Social Equity in Health
The absence of unjust health disparities between social groups, within and between countries.

Social Position
Is the position of an individual or a group in a given society and culture. The position accorded is a reflection of the importance that society gives to that individual or group. For example, the position of a priest, a businessman, an untouchable, a teacher, a caste or ethnic group. Social position influences the social status an individual or a group enjoys in a particular society.

Socio-Economic And Political Context
The social, economic and political environment and conditions which currently exists in a country and its historical basis. For example, the social stratifications and consequent discrimination that persists, the conditions of poverty, access to resources, existence of political freedoms, democratic functioning, political participation, the macroeconomic and social policy frameworks.

Special Health Programs
Special programs/activities like HIV/AIDS, tuberculosis, disability, mental health, subsidies/assistance for vulnerable groups.

Structural Determinants of Health
This refers specifically to the components that influence people’s socioeconomic position in any given society that generates or reinforce the health opportunities/outcomes of social groups based on their socioeconomic position. The most important structural stratifiers include: income, education, occupation, social class, gender, race/ethnicity.
User Fees  Direct charges to users for health services - Proponents of user fees suggest that fees could make the health system more efficient by guiding demand to cost-effective health care at the appropriate levels. Further, they could improve equity if revenues generated from fees are allocated to addressing the health needs of the poor. Others, though, argue that this reallocation is not guaranteed, and in the absence of exemption policies or other forms of financial protection, user fees actually price the poor out of the market for health care.

Virement  The process of transferring an expenditure from one line item to another during the budget year. To prevent misuse of funds, spending agencies must normally go through approved administrative procedures to obtain permission to make such a transfer.

Warrant  A release of all or (more commonly) a part of the total annual appropriation on a quarterly or monthly basis that allows a line ministry or spending agency to make commitments.