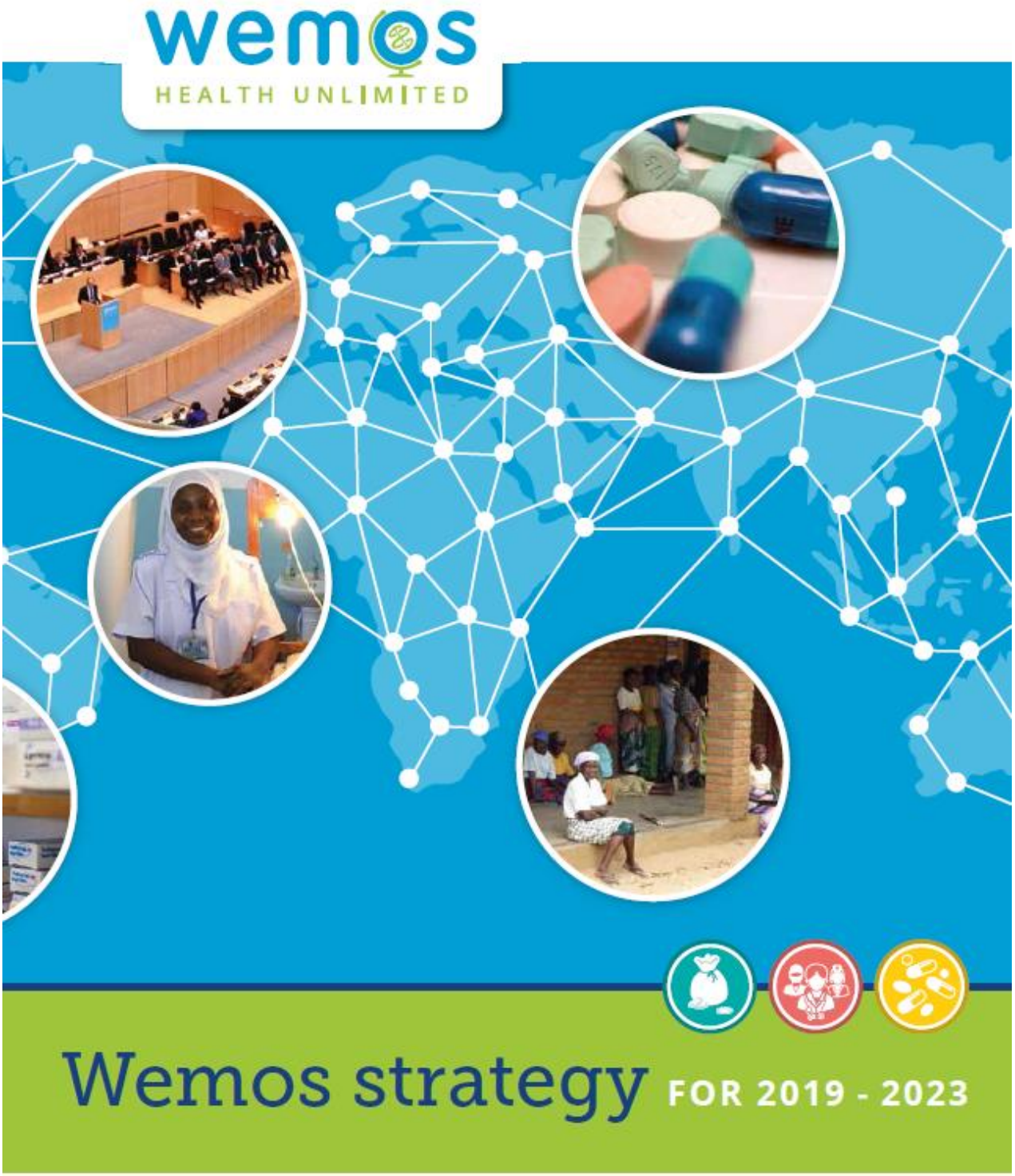

MAY 2019 – EXTENDED VERSION

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LIST OF ABBREVIATIONS

CSO	Civil society organisation
DAH	Development assistance for health
EMA	European Medicines Agency
EU	European Union
GAVI	Global Vaccine Alliance
GDP	Gross domestic product
GF	Global Fund
GFF	Global Financing Facility
HR	Human resources
HRH	Human resources for health
ILO	International Labour Organization
IMF	International Monetary Fund
LMICs	Low- and middle-income countries
MMI	Medicus Mundi International
ODA	Official development assistance
OECD	Organisation for Economic Cooperation and Development
PME	Planning, monitoring and evaluation
SDG	Sustainable Development Goals
UHC	Universal health coverage
US	United States of America
WHO	World Health Organization

> The right to health concerns us all, everywhere in the world.

INTRODUCTION

This strategic plan for 2019-2023 is a revised version of our strategic plan for 2016-2020, taking account of recent developments in global health and our response to these issues. In adopting this strategy, we seek to foster health worldwide in a structural and sustainable manner.

We advocate the right to health for all; access to health services and protection against threats to health. We were founded 40 years ago by a group of Dutch medical students who believed that medical interventions in low- and middle-income countries (LIMCs) can be effective only if the underlying causes of health problems are addressed. Since then, we have acquired an international reputation for our **rights-based and systemic approach** to health. We target policy-makers and politicians, but also reach out to the public at large.

We believe in using our knowledge base to build bridges, raise awareness of urgent health issues among policy-makers both in the Netherlands and abroad, and strengthen the voices of partner organisations and those without easy access to healthcare.

GLOBAL HEALTH

'Global health' is the term used to describe health issues arising from interdependencies resulting from globalisation, with cross-border causes and consequences. Global health is becoming a growing topic of debate in foreign policy, in contexts of development cooperation, trade and investment, national security and diplomacy.

Our work is guided by the '**health in all policies**' approach promoted by the World Health Organisation (WHO). Against this background, we address structural social injustices and related health inequities, raise awareness about the right to health and advocate policies in support of this right. An essential part of our work is closely **monitoring, scrutinising and addressing power imbalances:** between and within countries, between powerful transnational corporations and citizens, and in the governance of global economic, financial and health institutions.

SDGS AND UNIVERSAL HEALTH COVERAGE

The United Nations 2030 Agenda for Sustainable Development, with its Sustainable Development Goals (SDGs), sets a clear framework for international action to achieve the right to health for all. There are 17 SDGs targeting different sectors, with an overall commitment to leaving no-one behind. SDG 3 addresses good health and well-being, and sets specific targets for ending deaths from preventable causes worldwide. The key to attaining the health goal is target 3.8: achieving universal health coverage (UHC), including financial risk protection, equitable access to high-quality, essential healthcare services and access to safe, effective, high-quality and affordable essential medicines and vaccines for all. In addition to SDG 3, SDG 5 (fighting gender inequities), SDG 8 (promoting health employment as a driver of inclusive economic growth), SDG 10 (ensuring equitable access to health services), and SDG 17 (mobilising partners to monitor and attain the health-related goals) are particularly relevant to our work.

Power dynamics in the global health arena are shifting. The private sector is playing a more and more important role. The SDGs also call for more private-sector involvement, with SDG 17 calling for an increase in both public-private partnerships and civil-society partnerships. This poses challenges to democratic and transparent decision-making and may further fuel health inequities in case policy choices are driven by commercial rather than public interests.

Low-income countries have the highest burden of disease, but the lowest global health expenditure and the lowest number of health workers. Currently, at least half of the world's population does not have full access to essential health services.[1] On average, life expectancy in low-income countries is less than 60 years, compared with over 75 years in high-income countries.[2] Sub-Saharan Africa accommodates 16% of the world's population and accounts for 24% of the world's disease burden, but receives just 1% of global health spending and is home to only 3% of the global health workforce. Almost a quarter of African physicians received their training in low-income countries, but work in high-income countries.

GLOBAL FINANCE FOR HEALTH

While there is a continued need for additional funds for health globally, the donor landscape has changed rigorously during the past two decades. The WHO's 2017 progress report on SDG3 identified underfunding as a major cause of low health status and inequities in access to healthcare.[3] An estimated USD 274 billion of additional annual spending on health is needed by 2030 'to make progress towards the SDG 3 targets in the progress scenario, while USD 371 billion would be needed to reach health system targets in the ambitious scenario'.[4] These are daunting figures. Although spending targets differ from one country to another, it is clear that many LMICs do not have sufficient domestic resources to adequately fund health services.[5]

New forms of finance

There is a widespread move towards the adoption of new forms of 'innovative financing' and the use of public resources for leveraging private finance to invest in a range of assets (such as equities and bonds) in all sorts of different fields, including health. This trend is reflected by the World Bank's Maximising Finance for Development agenda, an approach that has been readily adopted by bilateral and regional donors. The Dutch policy document on Foreign Trade and Development Cooperation (2018) [6] also emphasises innovative types of finance and leveraging private-sector funding, in addition to existing forms of support for private-sector activity in low-income countries and emerging markets.

This trend is leading to a surge in new financial products, such as malaria and vaccine bonds, health insurance preferences, pandemic preparedness insurance, and the use of blending. Blended finance entails the strategic use of development finance for mobilising additional sources of finance. It typically combines concessional public finance such as official development assistance (ODA) with commercial finance, to fund development-related activities in LIMCs.[7] Although blended finance is often presented as being key to achieving the SDGs, the Organisation for Economic Cooperation and Development (OECD) claims there is as yet no evidence for its effectiveness.[8] The available evidence points in fact to serious limitations[9], including the high opportunity cost of subsidising private-sector activities, a shortage of compelling evidence on impact, and weak alignment with development effectiveness principles.

Another potential influential factor is the World Bank's Human Capital Project launched in October 2018. It tells policy-makers that there is a need to invest more in human capital in order to foster economic growth and encourages governments to place health funding at the heart of their plans. Although it may create an opportunity for advocating greater funding for health and health workers in particular, we have to be aware that the Human Capital Index is mired in controversy about the way in which it ranks countries and does not address disparities and inequalities within countries.

Raising more tax

A more sustainable way of bridging the financial gap for delivering the SDGs would be to raise more tax revenue from those who are most able to pay, such as corporations and their wealthy owners. Global tax losses amount to an estimated USD 500 billion annually.[10] The world's biggest pharmaceutical companies are dodging an estimated USD 3.8 billion in tax per year across 16 countries.[11] While this affects the right to health worldwide, the greatest impact is felt in countries with low public budgets. If

tax and other domestic revenues rose by 2% of gross domestic product (GDP) by 2020, this would add USD 144 billion to LMICs' resources – the equivalent of aggregate aid disbursements in 2017.[12] Unfortunately, the problem of tax avoidance and tax evasion is both well-known and persistent. The European Commission and the OECD are working on measures to remedy the problem, but progress is slow.

In promoting an increase in taxation, observers must look carefully at the people who are actually carrying the tax burden. In many countries, poverty increases after tax hikes because the focus tends to be placed on consumption taxes, which are regressive and aggravate gender inequity.[13,14] Yet these are the taxes that the International Monetary Fund (IMF) often recommends in its policy advice to low-income countries. Both IMF policy advice and programme conditionalities have been criticised in the past – and again more recently – for promoting austerity policies, thereby leading to lower government budgets and possibly impeding economic growth.[15,16] In 2010, IMF programmes began to include social spending floors, but these have not been enforced as strictly as targets to reduce budget deficits, for example. And they are often set at a level that is too low to represent a sufficient level of spending.[17]

Official development assistance (ODA)

Even with improved tax collection, 48 countries would still lack the domestic resources to fund universal health, education and social protection, and would need an extra USD 150 billion annually to meet these needs.[18] Aid can support underfunded health systems, but development assistance for health (DAH) has flatlined since 2011. After two decades of growth since 1990, it actually fell to a total of USD 37.4 billion between 2016 and 2017.[19] On average, OECD donor countries devote 0.31% of their gross national income to development assistance (USD 147 billion in 2017), a level that falls far short of the 0.7% they promised nearly 50 years ago – a pledge renewed in the SDGs. Only five countries are abiding by this pledge, and the Netherlands is not one of them.[20] If the other OECD donor countries honoured their commitment, an extra USD 1.5 trillion could be raised by 2030.[21]

There has also been a shift in the sources of development assistance from traditional bilateral donors in OECD countries towards 'non-traditional' bilateral donors such as China. We have also seen a substantial increase in capital investments in recent years. The emergence of philanthropic foundations is another trend: some 26 philanthropic foundations donated a total of USD 6.1 billion in 2017. Though this is still a modest amount compared with ODA, these 26 foundations were together the second largest funder in the health and reproductive rights sector.[22]

As a further point, in line with the trend towards mobilising private finance for development, the OECD Development Assistance Committee is reviewing the rules for classifying ODA. There is a risk that this will allow more ODA to be used for private-sector instruments. These changes are clouded in controversy, and a permanent agreement on the new rules has yet to be adopted.[23]

The three leading global health partnerships

Three public-private global health partnerships are key external funders in global health and greatly influence funding priorities. Two of them, the Global Vaccine Alliance (GAVI) and the Global Fund to fight AIDS, tuberculosis and malaria (GF), started off as vertical funds, targeting specific diseases or

aspects of the health system. In recognition of the many interlinkages between health system components, both funds increasingly incorporate health systems support and are taking steps towards funding health worker training and salaries. The relatively new Global Financing Facility (GFF) is the funding mechanism hosted by the World Bank for the UN Global Strategy for Women's, Children's and Adolescent's Health, and is becoming increasingly important as the main funder of action in relation to sexual and reproductive health and rights. The GFF takes a health systems approach and focuses on country ownership, including the meaningful engagement of all relevant stakeholders. Together with other global health actors, the 3Gs, i.e. the GAVI, the GF and the GFF, have pledged to improve alignment, coordination and accountability. The Netherlands committed funds to the GFF in 2018 and seeks to influence policy through its seats in the governance mechanisms of the 3Gs.

HUMAN RESOURCES FOR HEALTH

A special committee formed by the International Labour Organisation (ILO), the OECD and the WHO predicts a shortage of 18 million health workers by the year 2030.[24] This is due to a number of trends, such as the aging world population, as well as changing lifestyles and a global rise in the incidence of non-communicable diseases. All these trends require changes in health service delivery models and mean a greater demand for health workers. While many of the predicted 40 million new jobs that will be created will be located in higher-income countries, the burden of disease will be higher among the LMICs. Higher-income countries also offer higher salaries and better working conditions, thus creating an important pull factor on already scarce human resources for health (HRH) in LMICs.

The WHO has identified a threshold in workforce density of 4.45 health workers per 1,000 inhabitants, below which UHC is unlikely.[25] The mismatch between the **need** for health workers, calculated according to this UHC threshold, i.e. the **demand** in a given country, often defined as *a country's capacity to pay* for health workers, versus the **supply** of health workers, i.e. how many health workers are actually available, is widening in countries with the largest shortfall of workers.[26] The picture is compounded by the rise of for-profit and not-for-profit private-sector health service delivery, even in LMICs. Working in the private sector is generally regarded as more attractive, which is why many staff are leaving the public health sector. The rise in private health facilities, however, compromises the right to health of those who are not able to pay for them.

The majority of health workers are women. In particular, nursing, midwifery and community health work are female-dominated professions. Worldwide, nearly 70% of those total employed in the health sector are women.[27] However, women working in these professions are often underrepresented in national decision-making on health and in the global health debate. Urgent and sustained action on gender equity at both national and global levels is required.

At the receiving end, we also see that inadequate health service delivery disproportionately affects women and children. Sustained, adequate investment in a well-trained, motivated, supported and effectively deployed health workforce can therefore help greatly to improve the health of women and children, leading to better educational outcomes and improved household stability, including generated income.[28]

A number of international commitments and strategies have been agreed in the past decade, in recognition of the crucial importance of investing in the health workforce. The *WHO Global Code of Practice on the International Recruitment of Health Personnel* (2010) seeks to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and stresses the need to strengthen health systems. Another WHO publication, the *Global Strategy on Human Resources for Health: Workforce 2030* (2016), followed by a *five-year action plan* (2017), identifies low investment in the health workforce as one of the key challenges affecting HRH and urges countries to invest much more in health workers – not only financially, but also in terms of quality improvement and human resource-related challenges such as career prospects and gender equity.

ACCESS TO MEDICINES

Two billion people, most of whom live in LIMCs, are unable to acquire essential medicines, thus running the risk of causing major harm to their health – or even hastening their death. Growing concerns have been voiced in recent years that access to medicines is no longer just a problem affecting LMICs. It is also becoming a problem in high-income countries including the Netherlands, due to the rising prices of medicines. One of a number of cases to cause global uproar was an unexplained hike in the price of a drug originally developed to treat gallstones, but re-purposed to treat a rare metabolic disease (CTX). The emergence of a new market for this orphan disease gave the manufacturer an incentive to raise the price by a factor of 500.

The Netherlands has witnessed unprecedented prices of medicines needed by certain patient groups: children with spinal muscular atrophy need drugs costing EUR 50,000 a year; patients with cystic fibrosis need EUR 170,000 for their treatment; a new cancer drug doubled in price between 2005 and 2014. Such price increases are hard to bear, even for rich countries like the Netherlands, and jeopardise the financial sustainability of their health systems.

These high prices are caused by flaws in the system for performing research into, developing, producing and marketing medicines, as well as in intellectual property rights, patent law, trade laws and, more recently, in regulatory measures to incentivise the development of orphan drugs. Most of these laws and regulations have a global scope and impact. In other words, global action will be needed to rectify flaws in them, spurred by nation states, research institutions, and civil-society organisations (CSOs) alike.

We have a long tradition of working to improve access to medicines and scrutinising the pharmaceutical industry. Given the changing global dynamics, and the growing number of CSOs seeking to improve global access to medicines, we have been focusing more on influencing Dutch and European policy-makers. This is due in part to a development in 2016, when, during the Dutch EU presidency, the Dutch government spotlighted the affordability of medicines as a priority policy issue. This meant addressing access barriers such as high prices and unethical behaviour by pharmaceutical companies, and building coalitions with other EU member states for joint price negotiations. In taking this step, the Netherlands became the first European country to address the growing problem of the affordability of new medicines.

Even though the Dutch government no longer holds the EU presidency, it is still highly active and

influential behind the scenes. We see this as an opportunity to build on in the coming years, focusing on areas such as the public return on public investment and exploring alternative business models for drug research, development and production. Other priority areas for us remain the transparency of development costs and pricing data, the ethical behaviour of pharmaceutical companies, and democratic decision-making with maximum accountability.

Finally, the imminent Brexit-sparked move of the European Medicines Agency (EMA) to Amsterdam (scheduled for March 2019) forms an excellent opportunity for us to become more actively involved in monitoring its performance and accountability, including by taking part in consultations.

GLOBAL HEALTH GOVERNANCE

Good governance is crucial to the promotion and protection of sustainable global health. The WHO is explicitly mandated as being responsible for global health governance. However, it has seen more and more of its power ebb away as large philanthropic funders have become more important, together with the global health initiatives they support. As an ever larger share of WHO funding is earmarked by these individual funders for specific programmes and member states allow their own national health interests to prevail over the global goods debate, so the WHO's strategy and priorities are dictated more and more by its funders rather than by the member states represented on its governing bodies.[29]

Relatively new, big global health players such as China and Japan are also changing the global power dynamics by focusing their investments on infrastructure rather than on social sectors such as health. At the same time, important actors like the US and the EU (including the Netherlands) seem to be shifting their positions on global challenges. The result has been more nationalism and protectionism. This, too, is a threat to efforts aimed at advancing the world's prosperity, health and well-being.

At a national level, global health is governed by national governments, based on national policies and strategies. These are not always in line with international policies and agreements. At the same time, other institutions and policies also play a role, both positive and negative. There is now evidence to suggest that corporations can have a harmful impact on society, for example in the form of income inequality, the subversion of democracy, and environmental degradation.[30]

OUR VISION, MISSION AND VALUES

OUR VISION

Health is a universal human right. Governments must create the conditions for guaranteeing the health of all their citizens: access to health services and protection against threats to health.

OUR MISSION

We are an independent civil society organisation seeking to improve public health worldwide.

- We analyse Dutch, European and global policies that affect health and propose relevant changes.
- We hold the Dutch government, the EU and multilateral organisations accountable for their responsibility to respect, protect and fulfil the right to health.

ORGANISATIONAL VALUES

Our guiding principle is 'health as a human right' – a right that takes precedence over political and economic interests. We believe that the pursuit of health for all in this globalised era is a **shared responsibility**, that it should favour those left behind according to the **equity principle** and that it should take the health of future generations into consideration. In addition, we are aware of how policies in one area can affect, counteract with or undermine policies in another area. We strive for **policy coherence,** for example by addressing the effects of economic policies on health.

Our core values are:

- **Grounded**
  Solid, grounded in evidence, networks and alliances, and grounded in terms of understanding the broader socio-political and economic context ('health in all')
- **Critical and constructive**
  A 'critical friend', critically addressing pivotal issues, positively contributing to lasting change
- **Striving for structural change**
  Taking a long-term perspective, seeking structural, systemic solutions, persevering, determined, addressing the political dimension of health
- **A belief in global justice**
  Espousing solidarity, shared responsibility, leaving no-one behind, global action, equity

ADVOCACY APPROACH

Our work is based on five fundamental principles that we apply in all our programmes:

1) **a human rights-based approach to health;**
2) **gender and equity;**
3) **systemic change;**
4) **mutual learning and knowledge exchange, and**
5) **creating and broadening civic space.**

Our primary advocacy targets are the Dutch government, EU institutions and multilateral organisations. Indirectly, through government and global health institutions, we also encourage commercial actors to adjust their *modus operandi* when their actions hinder, counter or prevent the attainment of global health goals. We believe that solutions enabling all people to exercise their right to health are guided by global policies, and are embedded in national knowledge and experiences. For this reason, we seek to bridge the knowledge and awareness gap between the country level – where CSOs benefit from up-to-date information on global policies and developments – and the global level - where global policy debates and advocacy are better informed by country case studies. **Mutual learning and knowledge exchange** with national CSOs, and creating and broadening **civic space** in relation to global advocacy targets, are both critical to our advocacy work.

The ultimate aim of our global policy analysis and our advocacy and lobby work is to bring about real change so that all citizens can access healthcare and be protected from threats to health.

HUMAN RIGHTS-BASED APPROACH TO HEALTH

Human-rights standards and principles guide our advocacy approach. We analyse and address the inequalities, discriminatory practices and unjust power relations which are often at the heart of (health) systems failures, as well as the underlying causes preventing people from exercising their right to health.

We hold governments accountable for meeting their obligation to **respect, protect** and **fulfil** their citizens' right to health. Respecting health rights means that governments do not discriminate or take measures that prevent people from exercising their right to health, for example, by excluding certain groups from accessing health services (such as teenage girls from family planning services) or by acting contrary to the principle of the ethical testing of new drugs. The word 'protection' refers to a government's obligation to keep its population safe from harm, for example, by regulating industries that have an adverse impact on public health. A government's obligation to fulfil its citizens' right to health relates to the measures it takes to ensure UHC for its citizens, such as ensuring access to affordable medicines and trained health workers.

Concurrently, we identify and analyse conditions in which health rights are violated. This applies, for example, when medicines are so expensive as to become unaffordable for patients, or when a health system does not function due to chronic underfunding or a lack of trained health workers. We apply a

human-rights perspective to uncover underlying social inequalities and power imbalances that are often perpetuated by global economic policies and programmes. We critically review the narratives used by global actors to justify and maintain the status quo, and propose alternatives.

EQUITY AND GENDER

Health equity and gender equality are core to the SDGs' overarching principle of leaving no-one behind. Gender roles affect how people live, work and relate to each other at all levels, including in relation to the health system.

Our work is guided by the international Global Health 5050[31] initiative and the work of the Women and Health Commission.[32] These move beyond the traditional, exclusive focus on women's health, and address women's roles as both users and providers of healthcare, highlighting the potential for synergy between them.[33] We question who is missing out on access to health and why, and analyse this from a broader perspective,[34] looking at the root causes of exclusion, discrimination and differences in the quality of health and healthcare across different populations. We apply the concept of gender equity in health,[35] which means being fair in addressing different people's health needs according to their gender and specific needs, and recognising that there are differences and that resources must be allocated differentially to address unfair disparities.

Our programmes consistently pay special attention to people, communities, minorities and professions who are at risk of losing out on the right to health. We propose policy alternatives to achieve equity: they are designed to prevent unfair, avoidable differences arising from poor governance, corruption or cultural exclusion.

SYSTEMIC CHANGE

Ultimately, achieving UHC requires not simply addressing power imbalances that perpetuate inequalities, but also actively promoting systemic changes - political, economic and social – both in individual countries and globally.

We use the WHO health systems framework[36] (see figure 1) as a conceptual framework for identifying and addressing health system failures. We focus explicitly on three of the six building blocks in the framework:

1) a steady health financing system;
2) a well-performing health workforce; and
3) access to essential medicines.

These three areas are most strongly influenced by global developments and power relations. Global governance is mainstreamed throughout our work. We acknowledge that a strong health information system and good health services are essential for the effective operation of a health system. However, these are not our explicit focus as we believe that national CSOs are both well-placed and experienced

to address these aspects. Where relevant to our analysis of health systems, we build on their experiences.

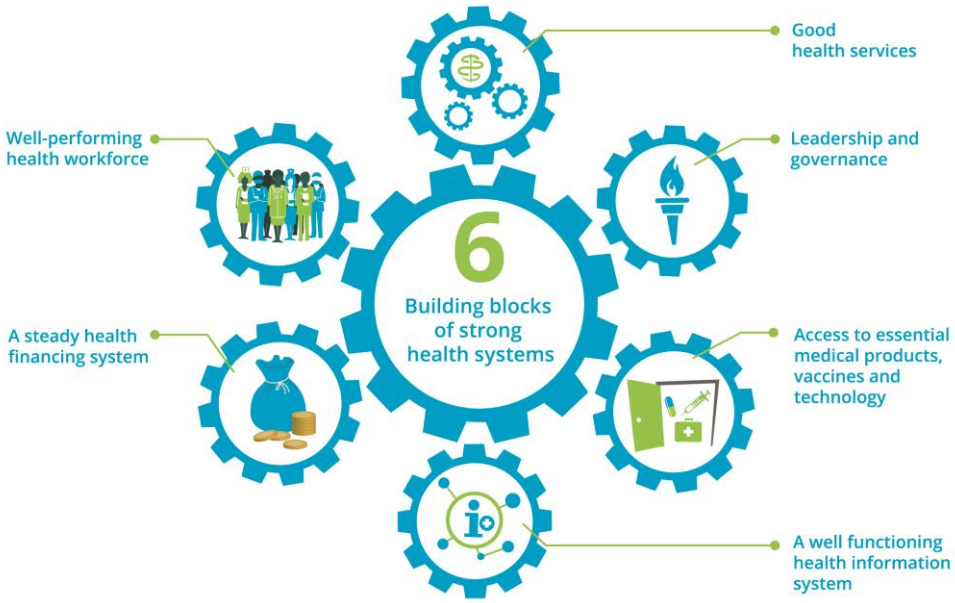


Figure 1: health systems framework

Poorly performing health systems are a direct reason why many people lack access to effective health services. Health workers in low-income countries often cannot provide adequate access to care because they are overworked, do not have the right skills, are not equipped with the right tools, do not receive supportive supervision and work in health facilities that are chronically underfunded. Patients are faced with high medicine prices and drug shortages caused by a range of financial and political barriers. A strong health system depends on the right economic, social and political conditions being in place. These may necessitate changes in decision-making and budgeting processes, new financing mechanisms, or different ways of involving stakeholders in the design, implementation and monitoring of policy.

MUTUAL LEARNING AND KNOWLEDGE EXCHANGE

Establishing equal partnerships with national CSOs is an important part of our advocacy approach. This we do through a process of dialogue, sharing knowledge on global policy debates and their significance for the country context, and finding common ground on particular policy issues. Working from this starting point, we consult stakeholders, analyse the political and policy environment, and review studies, national data and policies. We compare our findings with global policy agreements and identify areas where change is needed.

We envision our partnerships with national CSOs as a mutual learning process. Together, we develop joint advocacy messages to voice both globally and in individual countries under the leadership of national CSOs. Ultimately, partnership helps to create an open space in which national partners strengthen their capacity for advocacy and for disseminating messages based on an understanding of global issues and how they affect national policies. At the same time, this enables us to use national experiences to enrich our analysis of health-related global policies and political trends.

We work together with CSOs at various levels (i.e. national, regional and global) to synthesise findings and present them to different target audiences. Such forms of collaboration may involve:

- co-creating publications;
- creating or modifying knowledge products;
- exchanging information on and analyses of global developments and policies for joint advocacy efforts;
- giving technical advise to CSOs on lobby and advocacy strategies towards country-based global partners and donors.

We disseminate our analyses, publications and other information through our knowledge platform, which is a resource bank for global health issues (www.wemosresources.org). We also actively inform members of our network, for example by organising webinars and distributing infographics and fact sheets.

CREATING AND BROADENING CIVIC SPACE

If true change is to come about, there needs to be a deliberate shift in the power balance in favour of those who are most affected. This also applies to our advocacy approach: we acknowledge that many civil-society opinions and views are either not heard or are overshadowed by those of large international CSOs.

We create and broaden civic space in a number of ways:

1. We demystify and disentangle complex policy documents issued by global actors and work with CSOs to understand their consequences and identify potential responses.
2. We link civil-society actors with global decision-makers. This means, for example, organising meetings and events at global platforms, where civil-society actors can inform global decision-makers about critical issues and debate the need for change in a direct dialogue with them.
3. We listen to the critical opinions of national CSOs that are not heard in formal civil-society platforms. We identify these CSOs through a process of stakeholder mapping and consultation with like-minded organisations and networks. In partnership with these CSOs, we create alternative independent channels to ensure that a broader range of critical voices are heard, including those of local organisations.

By working with civil-society partners, we are able to identify discrepancies between global health policy intentions and national health outcomes, and propose alternative policy options. We use a

number of different approaches to raise awareness, set the agenda and influence opinion. These are outlined in the section below.

HOW CHANGE HAPPENS

EFFECTIVE POLICIES FOR SYSTEMIC CONDITIONS

In order for all people to be able to exercise their right to health, the right economic, social and political conditions must be in place, at both global and national levels. We believe that these conditions need to start with evidence-based national and global policies and regulations that address underlying power imbalances.

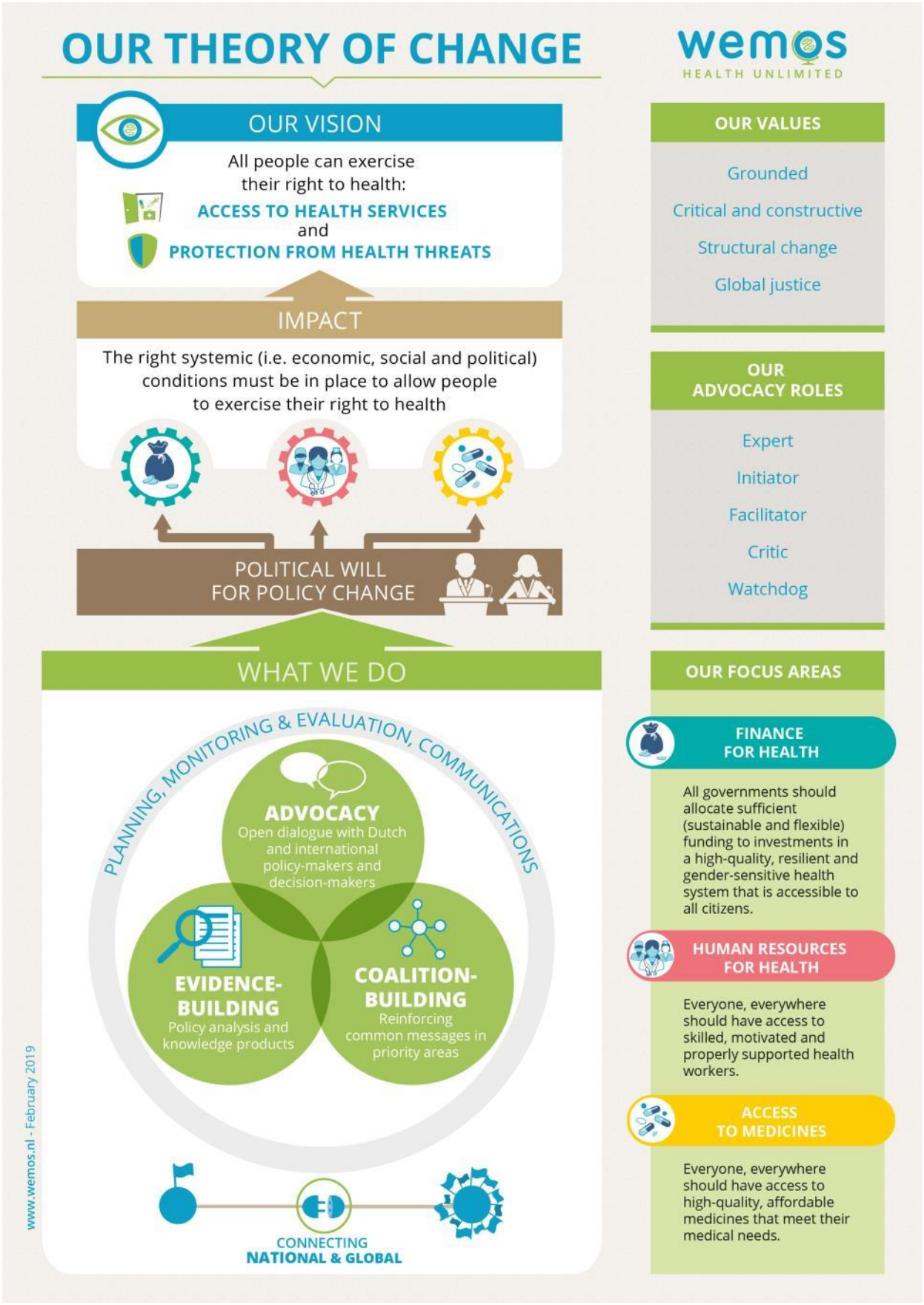
The process of policy change starts when national and global decision-makers and policy-makers come under pressure to change and, by taking **action**, demonstrate that they have the **political will** to address key health system constraints and systemic barriers. Only when politicians and decision-makers are convinced that change is needed can a coherent set of effective policies for creating the right systemic conditions be developed and implemented. Once these policies are in place, we work with and through civil-society mechanisms to hold the Dutch government and EU and global health institutions accountable for enforcing these policies, allocating sufficient funding to them and adjusting them when necessary.

Our aim is to help create the political will and action that is needed to achieve our three main goals:

- All governments should allocate **sufficient** (sustainable and flexible) **funding** to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.
- Everyone, everywhere should have **access to skilled, motivated and properly supported health workers.**
- Everyone, everywhere should have **access to high-quality, affordable medicines** that meet their medical needs.

These goals form the core of our three programmes:

1. Finance for health
2. Human resources for health
3. Access to medicines


OUR THEORY OF CHANGE
wemos
HEALTH UNLIMITED
OUR VISION
All people can exercise their right to health:
ACCESS TO HEALTH SERVICES
and
PROTECTION FROM HEALTH THREATS
IMPACT
The right systemic (i.e. economic, social and political) conditions must be in place to allow people to exercise their right to health
POLITICAL WILL FOR POLICY CHANGE
WHAT WE DO
PLANNING, MONITORING & EVALUATION, COMMUNICATIONS
ADVOCACY
Open dialogue with Dutch and international policy-makers and decision-makers
EVIDENCE-BUILDING
Policy analysis and knowledge products
COALITION-BUILDING
Reinforcing common messages in priority areas
CONNECTING
NATIONAL & GLOBAL
www.wemos.nl - February 2019
OUR VALUES
Grounded
Critical and constructive
Structural change
Global justice
OUR ADVOCACY ROLES
Expert
Initiator
Facilitator
Critic
Watchdog
OUR FOCUS AREAS
FINANCE FOR HEALTH
All governments should allocate sufficient (sustainable and flexible) funding to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.
HUMAN RESOURCES FOR HEALTH
Everyone, everywhere should have access to skilled, motivated and properly supported health workers.
ACCESS TO MEDICINES
Everyone, everywhere should have access to high-quality, affordable medicines that meet their medical needs.

HOW WE INFLUENCE CHANGE

We pursue three interrelated strategies in order to push for the change we envision:

Evidence-building

Evidence is key in informing our advocacy work. We do not have a research agenda as such. Instead, our choices of study areas are guided by the key issues outlined in our programme descriptions.

After identifying key policy debates on health, we analyse how global political and economic trends drive health policies, look at their potential impact, and decide on our priority areas and where more information is required. We define evidence-building as analysing the political and economic environment at national and/or global levels as well as reflecting on the equity implications. This we do by analysing policy documents, peer-reviewed publications and other 'grey' literature. Where relevant, we conduct in-depth analyses or case studies on specific priority topics. We regularly collaborate with research institutes and universities.

We translate the insights gained from this first stage of analysis into knowledge products. Depending on the specific target audience and its needs, we decide on the most adequate channel of communication. We produce fact sheets to help readers understand global health policies or mechanisms. We use discussion papers as a means of starting a dialogue with CSOs on specific topics. We produce animations and infographics to explain complex global health issues. We actively share these knowledge products with our partner organisations and networks, and publish them on our knowledge platform: www.wemosresources.org.

Coalition-building

We create and contribute to Dutch, European and global CSO partnerships and support national CSOs. We believe that working in harmony with other organisations helps to bring about policy change and amplifies our voice. Collaboration promotes knowledge-sharing and mutual learning, and joint advocacy messages have more power. We work with like-minded organisations who share our convictions and standpoints, but also with organisations with different backgrounds and expertise with whom we share a common aim in a certain area. In addition to forming coalitions, we also try and join task forces and expert groups that can help us to influence relevant processes.

We partner and network with other organisations working in global health in the Netherlands, Europe and worldwide. We are one of the founders of the Geneva Global Health Hub (G2H2), whose work involves sharing knowledge and launching initiatives so that CSO voices are heard during crucial international negotiations on global health policy. We founded the Health Workers for All Coalition (HW4ALL) and the Medicines Network Netherlands. We are an active member of Medicus Mundi International (MMI), Eurodad, the Civil-Society Engagement Mechanism of UHC 2030, the CSO Coordinating Group of the GFF, the People's Health Movement, Health Action International, the European Public Health Association, and others.

Advocacy

We undertake coherent advocacy aimed at decision-makers in the Dutch government, the EU and multilateral institutions such as the WHO, the World Bank and global health organisations. We strive to **create political will and engender action** based on evidence-based policy recommendations. To bolster the effectiveness of our advocacy, we seek to join key stakeholder tables, for example the Civil-Society Engagement Mechanism of UHC 2030 (a multi-stakeholder platform), the CSO Coordinating Group of the GFF, and the WHO's Global Health Workforce Network. Indirectly, we also influence national policies by working together with national CSOs.

Advocacy starts with the acquisition of information on the stakeholders involved in the particular decision-making process we want to influence. These include policy-makers, other organisations and private-sector actors. This includes analysing differences of opinion (i.e. issue management) in order to identify the positions taken by the most influential stakeholders and their arguments.

Based on our 'stakeholder mapping', we target different people and entities at different moments in time. And we choose the communication strategy that best matches the situation. There is no need to push hard against decision-makers who are already in favour of the change we are advocating. Instead, we offer any relevant support (in the form of information) they may need to strengthen their arguments. In other cases, it might be more opportune to adapt a critical, activist role and involve the general public in order to raise awareness of a particular issue.

We identify those spaces and occasions where we believe we will be capable of exerting influence, such as key events, meetings or processes, and plan our advocacy accordingly. Using a communication calendar to guide our communication efforts enables us to think ahead, adjust our strategy wherever this is needed and produce high-quality communications.

OUR ADVOCACY ROLES

We choose the most effective advocacy role depending on the nature of the situation.

EXPERT	**We present information in an accessible manner, in accordance with our audience's level of knowledge and needs. We disentangle complex information and actively share our knowledge. We also invest in our relationship with policy-makers and the media.**
INITIATOR	**We initiate processes or forge partnerships whenever we believe that this can be effective. We encourage other parties to find shared messages and jointly plan action.**
FACILITATOR	**We create and broaden civic space in order to enable other organisations and parties to make their voices heard.**
CRITIC	**We adopt a sharper and critical tone of voice to address issues of concern. We find ways to make our voice heard.**
WATCHDOG	**We monitor the implementation of agreed policies and strategies. We flag any discrepancies between commitments and practice.**

PME AND COMMUNICATION SUPPORTING OUR PROGRAMMES

Our programmes are central to our ability to achieve our mission. Planning, monitoring and evaluation (PME) and communication form an integral part of our programme goals. We measure, reflect on and learn from our successes and failures. This helps us to strengthen our strategic focus and adjust our strategy where necessary.

Our overall strategic planning and performance monitoring is guided by a framework known as the 'theory of change'. We develop a specific theory of change for each of our programmes. This enables us to adjust assumed change pathways where relevant, and at the same time creates a structure for guiding programmes towards their projected outcomes in the short, medium and long term.

We have also adopted a system known as 'outcome harvesting' to improve the collection of results. This is a qualitative method for identifying changes that helps us to decide how certain interventions or activities have helped to bring about change. Using the insights generated by outcome harvesting, we identify potential problem areas and changing contexts, and are thus able to make any necessary adjustments. This agile way of working also enables us to keep our communication strategies aligned with the specific needs of each programme.

PROGRAMMES

GEOGRAPHIC FOCUS

The Finance for Health and the Human Resources for Health programmes are geared towards five African LIMCs, i.e. Kenya, Malawi, Tanzania, Uganda and Zambia. This focus springs from our current membership of the Health Systems Advocacy Partnership,[37] and may change in the future. We work together with CSOs in these countries to effectively translate international policy into their respective national contexts, and use country-based evidence to advocate changes in Dutch, European and international policies.

The Access to Medicines programme focuses on the Netherlands and the EU. Our advocacy work is geared towards Dutch and European decision-makers. In view of the international nature of the laws and regulations we are targeting, our work also affects the global availability of affordable medicines.

FINANCE FOR HEALTH

Our focus

As we have seen, big funding gaps still need to be overcome before the health-related SDGs can be attained. Most LMICs do not raise sufficient domestic resources to achieve UHC, and are far from achieving the twin health spending targets of at least USD 86 per capita per year and at least 5% of GDP.[38]

We will seek to raise the volume of public resources devoted to health during this strategy period by:

(1) ensuring that **international aid** is both better aligned to recipients' needs and of better quality;
(2) encouraging **international financial institutions** to adopt **policies** that increase the fiscal space for health; and
(3) advocating criteria for **ODA allocation to private-sector instruments for health.**

The cross-cutting issues here are gender and equity, the accountability of multilateral and bilateral organisations, and meaningful civil-society engagement in decision-making.

International aid

Many low-income countries – including those whose fiscal space for health has been analysed by us and our partners[39] – are highly dependent on development assistance for health (DAH) to co-finance their health systems. However, DAH is often unpredictable. Moreover, there are concerns about the quality of DAH: in many cases, international agreements on aid effectiveness, donor alignment, harmonisation, mutual accountability, ownership and inclusivity[40] are not met. DAH is not always aligned with national health strategies and is hard to allocate to the strengthening of health systems, in the form of health worker salaries, for example.

Even though the 3Gs, i.e. the Global Fund (GF), the Global Vaccine Alliance (GAVI) and the Global Financing Facility (GFF), are becoming more and more incorporating health systems support, this is not enough, as indeed both the GF and the GAVI have acknowledged in recent reports. This aim is reiterated in the UN Global Action Plan for Healthy Lives and Well-being, which is due to be presented in September 2019. Along with strategic reviews and replenishment rounds for the 3Gs, the publication of this plan offers an opportunity to flag lessons learned and advocate more sustainable health funding, inclusive governance at country and global levels, and the promotion of health equity.[41,42]

A range of GFF beneficiary countries have reported that CSOs are not genuinely included in national GFF processes. CSOs are also not sufficiently represented at an international level. GFF processes are closely linked to World Bank procedures and recommendations such as accelerating private-sector investments and adopting results-based approaches to financing. Although results-based financing is designed to create financial incentives for better, more inclusive and more accessible service delivery, the evidence about its effectiveness in improving equity is mixed.[43] Moreover, it remains unclear how the GFF is planning to operationalise its desire to accord a more important role to the private sector in health – with the associated risks of fragmentation and the formation of financial barriers such as user fees.

International financial institutions

The World Bank and the IMF influence health policies and health budgets in low-income countries by:

- giving technical advice;
- influencing global debates;
- introducing new ideas;
- imposing conditionality on loans; and
- working together with global health actors such as the GF and the GFF.

It is important to closely monitor how exactly these institutions influence finance for health. Although priorities at the World Bank could shift with the appointment of a new President, the dominant priority of giving precedence to private finance over public finance is expected to remain in place.[44] The IMF previously announced that it was planning to adjust conditionality to better protect social spending and would be paying more attention to equity, but in practice it continues to emphasise fiscal discipline in its country programmes and advice.

One area in which the IMF is influential is fiscal policy, which has a direct impact on government budgets. Tax reforms and international tax competition are squeezing governments' capacity to collect sufficient domestic resources to fund their health systems and other public services. The equity and gender aspects of resource mobilisation,[45] as well as the impact of international financial institutions on countries' fiscal space for health, are still grey areas for many policy-makers and CSOs working in the health sector. More attention needs to be given to these aspects.

FISCAL SPACE FOR HEALTH

The availability of budgetary scope that enables a government to allocate resources to a desired purpose – in this case, health – without affecting the sustainability of its financial position.

Criteria for ODA allocation to private-sector health instruments

Many development actors, including the Netherlands, are both bilateral donors and influencers and shareholders or members of regional and international institutions. As such, they are expanding their programmes of financial support for 'private-sector' actors in low-income countries and emerging economies, including through the use of blended finance. Such schemes are already in use in a variety of sectors, including the health sector. While they benefit health services, evidence collected both by ourselves and by others[46] points to certain (unintended) adverse effects such as fragmentation, increased out-of-pocket spending for households, and rising costs weighing on government (national and local) health budgets. Such effects hamper progress towards longer-term goals such as UHC.

Overall goal for Finance for Health

All governments should allocate sufficient (sustainable and flexible) funding to investments in a high-quality, resilient and gender-sensitive health system that is accessible to all citizens.

Change needed

In order to achieve this goal, we will focus on bringing about the following critical changes:

- Bilateral and multilateral development partners should increase and align their ODA to co-finance UHC strategies in countries that cannot raise sufficient domestic resources, particularly those with significant HRH finance gaps.
- International financial institutions and development partners should actively support the efforts of LMICs to increase the fiscal space for health and HRH, by strengthening the national and international enforcement of tax laws and by phasing out harmful policy conditionalities that unduly limit a country's spending options.
- Development partners should apply criteria so as to ensure that, where ODA is used to promote private-sector involvement in health in LMICs, this helps the countries in question to attain development goals, does not cause harm and is in line with aid effectiveness principles.
- CSOs have both the capacity and opportunities to effectively monitor and influence finance for health at both national and international levels, and to advocate alternative financing models where appropriate.

How are we planning to push for these changes?

We intend to do the following during this strategic period to accelerate the process of change:

1. ***Evidence-building***
   We will analyse key issues and collect evidence on:

   - factors constraining the fiscal space for health that hamper the achievement of international targets and recommendations on UHC, including HRH, in focus LMICs (currently Kenya, Malawi, Tanzania, Uganda and Zambia);
   - the potential impact of the 3G health financing models on the achievement of UHC and on the funding of health worker salaries. We will focus particularly on CSO involvement, results-based financing, gender equity, private-sector involvement and debt;
   - economic policy conditionality: its implications for health spending and possible alternatives in two country case studies;
   - the effects on health outcomes for the poor of ODA support for private-sector involvement in health systems finance, governance and service delivery.

2. ***Coalition-building***
   We will develop joint advocacy positions and strategies with our CSO partners, including solutions for the following issues:

   - national and global barriers that hinder HRH investments in countries with a critical shortage of health workers (aligned with the HRH programme described below);
   - opportunities and barriers for 3G contributions to fiscal space for health in individual countries;
   - gaps in national or multilateral policy frameworks for guiding or restricting the use of ODA funds for supporting and involving the private sector in the health sector.

3. ***Advocacy***
   We will lobby governments and regional and global institutions:

   - Global advocacy: working through our international networks, we call upon global actors, i.e. multilateral and bilateral development partners, to:

     (1) adjust policy advice and conditionality so that they foster equitable finance for health and HRH;
     (2) hold the 3Gs accountable and push for reforms to advance health system funding and strengthen inclusivity; and
     (3) apply public health criteria to guide the use of ODA funds for promoting private-sector involvement.

   - National advocacy: we work together with national CSOs to align advocacy messages and strategies for boosting and improving health spending.

HUMAN RESOURCES FOR HEALTH

Our focus

A strong, effective health workforce is critical for achieving UHC. However, the health workforce is unevenly distributed across the world. The biggest staff shortages are in those countries with the highest disease burden. We know most maternal and neonatal deaths are preventable in the presence of skilled health workers; they are a key factor in reducing mortality rates. A number of factors affect health worker shortages, including insufficient training and recruitment, a higher level of demand from a growing and aging world population, and health worker migration. We look at both **push** and **pull** factors affecting health worker mobility:

Push factors

Important push factors, i.e. those factors that induce health workers to leave their jobs, are:

- low remuneration;
- heavy workloads;
- poor living conditions;
- insufficient training, leading to quality issues;
- an insecure or unsafe working environment (especially for women);
- inadequate support;
- a lack of career prospects; and
- inadequate HR management and planning.

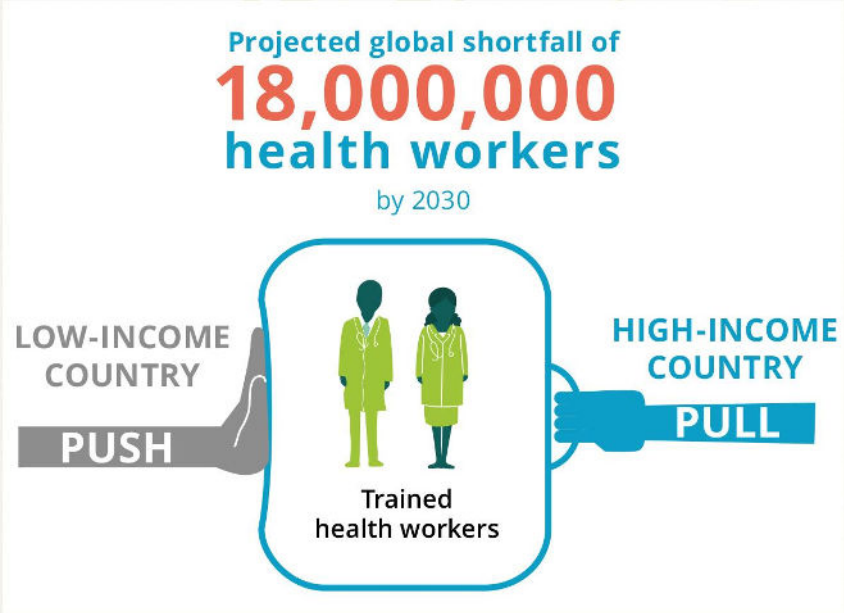
A higher level of investment is needed to remedy these issues. There are a number of dimensions involved here. First, investment is needed in numbers, i.e. in training more health workers at all levels. However, even in situations where significant numbers of health workers are trained, a lack of fiscal space can cause difficulties in absorbing them. The result is a paradoxical situation in which there is a severe shortage of health workers concurrently with a high level of unemployment among health workers. For this reason, investment is also needed in a second dimension, i.e. in the creation of jobs and in filling existing vacancies. This requires better planning and management of the health workforce, and may also need improved in-country institutional capacity. The requisite funding may be obtained by mobilising more domestic resources and by convincing bilateral and multilateral funders to re-prioritise HRH and provide bridging finance to cover recurring salary costs (as a vital element in strengthening the health workforce). Thirdly, investments are needed to boost the quality of health employment, not just with regard to salaries, but also in terms of safe and secure working conditions and career prospects.

Pull factors

It is estimated that over 40 million new health sector jobs will be created by 2030, mostly in high- and middle-income countries. Without additional investments in the health workforce, it is unlikely that these vacancies will be filled by the domestic workforce, resulting in a strong pull effect on health workers from LMICs and thus magnifying the mobility of the health workforce. It is for this reason that we advocate the development and implementation, by EU member states (including the Netherlands),

of domestic health workforce strategies to prevent and/or mitigate these pull factors on health workers from countries with critical health worker shortages.

Our guiding principle regarding health worker mobility is that we should not give with one hand (through development assistance for health from the EU or the Netherlands) and take with the other (by attracting health workers from countries with shortages). We also believe that, when foreign health workers are recruited, this should be done ethically and that their conditions of recruitment, pay and work should be the same as those applying to the domestic workforce.



In order to reduce the push factors in countries with insufficient human resources for health, we advocate more investment in the training, deployment and remuneration of health workers, and in improved health workforce planning and management. In order to address the pull factors, we continue to lobby against targeted recruitment practices adopted by national public-health services with more resources for health workers (i.e. both high-income countries and neighbouring low- and middle-income countries), and by national and international private healthcare providers and NGOs. At the same time, we need to bear in mind that health worker mobility is not a two-dimensional issue. Rather, it is an entangled web of movement, cross-fertilisation and exchange, with costs and benefits in both source and destination countries. In the currently highly politicised discourse on migration and mobility, we closely follow research on health worker flows so as to understand their implications for health systems worldwide and for people's right to health.

Although a global policy framework has been put in place, the relevant plans and commitments still have to be put into action. Our role, working in collaboration with other CSOs, is to push for the effective implementation and funding of these strategies at national and global levels. We also consider it our responsibility to raise awareness of incoherences in global policies, based on country-driven data and experiences. The bottom line in our advocacy is that spending on health workers should be considered not as a financial burden, but as a wise investment, resulting in better health, increased productivity, more jobs and thus greater income security and political stability, and less inequality. At

the same time, we continue to stress that such investments should not be driven by economic arguments alone: access to health workers is a human right and a global public good.

Overall goal for Human Resources for Health

Everyone, everywhere, should have access to skilled, motivated and properly supported health workers.

Change needed

In order to achieve this goal, we will focus on bringing about the following critical changes:

- Countries with significant HRH finance gaps should raise their domestic resources for HRH in line with global targets.
- Global actors should co-invest as donors in LMIC health workforces in line with international instruments for HRH. This includes being prepared to support health worker salaries where needed (for a certain period of time).
- Governments should invest on a long-term basis in planning and forecasting, and also in the recruitment, development, training, retention and management of the health workforce in LMICs.
- Global actors (such as the OECD, the ILO and the WHO) and governments of source and destination countries should reform existing policies and develop new policies and public finance models so as to mitigate the adverse effects of health workforce mobility and migration, in line with global recommendations.[47]

How are we planning to push for these changes?

We intend to do the following during this strategic period to accelerate the process of change:

1. **Evidence-building**
   We will analyse key issues, review existing evidence and collect new evidence on:

   - the fiscal space for HRH in Kenya, Malawi, Tanzania, Uganda and Zambia (currently our focus countries) in order to understand the key obstacles to stronger investments in HRH;
   - a political economy analysis of stakeholders at a national level (including CSOs, governments and development partners) in the field of HRH, so as to identify our lobby allies and targets;
   - national HRH policy and strategy documents and its implementation, in order to understand the national HRH challenges and opportunities for CSOs to be involved in advocacy;
   - health worker mobility and migration, in particular from a gender perspective.

2. **Coalition-building**
   We will create and contribute to global CSO partnerships and support national CSOs in relation to:

- the establishment, support and strategic use of the Health Workers for All Coalition (HW4All), including measures to ensure that the coalition is sustainable (see box);
- national and global barriers that hinder investment in HRH in countries with a critical shortage of health workers;
- critical issues regarding health workforce mobility and migration, including gender-based issues.

3. Advocacy

We will implement an advocacy plan targeting governments and regional and global institutions for the effective implementation of SDG Target 3C:

- Global advocacy: working through the HW4All Coalition and other global networks (such as MMI and G2H2), we call upon global actors to implement strategies, policies and frameworks, in particular the *WHO Global Code of Practice on the International Recruitment of Health Personnel* (2010) and the *Global Strategy on Human Resources for Health: Workforce 2030* (2016), and the *five-year action plan* (2017) for financially supporting health workers (push factors) and mobility and migration (pull factors);
- National advocacy: working together with CSOs, we translate global strategies, policies and frameworks into national contexts.

The Health Workers for All Coalition (HW4All) represents global, regional and local groups of CSOs, academic institutions, and professional health workers' associations and unions. The coalition advocates access to health workers for all in order to exercise the right to health and achieve UHC. We host the Secretariat of the Health Workers for All Coalition. Visit the website: https://www.healthworkersforallcoalition.org/

ACCESS TO MEDICINES

Our focus

A growing number of drugs are marketed at extremely high prices. This trend undermines the financial sustainability of the health system and hence compromises the right to health and equal opportunities for leading a healthy life. We believe that six critical errors in the current system need to be addressed:

1. In general, pharmaceutical companies are free to set drug prices.
2. Although drug development is financed partly with public money, very few conditions are attached to this in terms of the transparency of the pricing mechanism, and the affordability and accessibility of the products developed with public financing.
3. Current regulatory and patent systems provide market exclusivities (i.e. monopolies) that enable pharmaceutical companies to make excessive profits.
4. Governments (notably the Dutch government) do not have sufficient control over drug prices.
5. There is a lack of transparency about development costs and pricing.
6. Decisions on the evaluation of medicines are influenced by the pharmaceutical industry and are not always based on genuinely impartial scientific evaluations.

71% of the overall EMA budget for 2000 consisted of fees charged to the pharmaceutical industry[48]. Today, fee income accounts for over 83% of the EMA budget. The EMA's increasing dependency on payments from the pharmaceutical industry, taken in conjunction with the pharmaceutical industry's omnipresence in advisory committees and other regulatory bodies, poses a risk to the agency's independence.

We advocate better conflict of interest management by the EMA and the national drug regulators in the EU, i.e. the Dutch Medicines Evaluation Board. The EMA must operate as a genuinely impartial and effective scientific agency that guarantees the reliable evaluation of the safety, quality and efficacy of medicinal products in the EU.

We need better rules and regulations, including rules on fair intellectual property rights and responsible licensing. As a society, we need to underline the fact that the pharmaceutical industry is an industry that produces goods that are essential for life rather than an industrial sector that generates high profits for investors.

Overall goal for Access to Medicines

Everyone, everywhere should have access to high-quality, affordable medicines that meet their medical needs.

In order to achieve this goal, we will focus on bringing about the following critical changes:

- The Dutch government should develop and propose more stringent legislation to create fair pricing models for medicines, and adopt requirements for transparency in pricing and cost at both national and EU levels. Alternative business models for the financing of R&D in relation to drugs should be developed and promoted.
- In order to guarantee the availability and accessibility of medicines, the Dutch government should set conditions regulating the way in which universities and other institutions use public funding for medical research and development; these should include conditions on the transfer of knowledge and intellectual property to the commercial sector.
- Dutch policy-makers should have the political will to counteract the pharmaceutical industry lobby and check the undue influence exerted by the pharmaceutical industry over decisions taken by the Dutch government, the Dutch Medicines Evaluation Board and the EMA.
- In order to inform decision-making procedures, the EMA should fully disclose all elements related to the development of medicines, including sources of funding and data on clinical trials.

How are we planning to push for these changes?

We intend to do the following during this strategic period to accelerate the process of change:

1. **Evidence-building**
   We will analyse key issues and collect evidence on:

   - developments in Dutch drug policy, including the Dutch position on EU policy;
   - the policies pursued by and the operation of the EMA and national drug regulators;
   - the use of Dutch public funds for research and development in relation to high-priced medicines;
   - funding mechanisms for drug development and alternative business models;
   - the impact of the pharmaceutical industry and the undue influence it exerts over public policy-making, for example by the Dutch Medicines Evaluation Board and the EMA.

2. **Coalition-building**
   We will develop joint advocacy positions and strategies with our CSO partners, including solutions for the following issues:

   - As a founder member, and the current coordinator, of the Dutch Medicines Network, we will seek to achieve alignment with the European Alliance for Responsible R&D and Affordable Medicines. We will agree on alternative business models based on fair pricing principles, standards of transparency in relation to the cost and pricing of medicines, more effective and efficient drug assessment procedures, and the collection of data on conflicts of interests at the EMA and national medicine regulators;
   - Working together with the European Alliance for Responsible R&D and Affordable Medicines, we share experiences in order to align advocacy strategies and produce shared messages.

3. Advocacy

We will lobby the Dutch government and Dutch MPs and MEPs for:

- more stringent legislation to create fair pricing models for medicines both within the Netherlands and throughout the EU, including regulations on the way in which universities use public funding for medical R&D;
- the independence of the Dutch Medicines Evaluation Board and the EMA.

We will:

- distribute a constant stream of evidence-based press releases, opinion pieces (in print and on-line), social media activities and contacts with (specialist) journalists;
- publish infographics, fact sheets and position papers targeting the general public, partner organisations and policy-makers.

ORGANISATION AND GOVERNANCE

We are constituted as a non-profit-making foundation under Dutch law ('*stichting*'), with a managing director and a supervisory board. Our principal asset is our professional, dedicated staff with their varied range of backgrounds in public and global health, political science, medicine and communications. We invest in the development of our staff, so that they can update their technical skills and are in a position to continuously monitor and respond to the changing external environment.

In 2018, we consolidated and focused our programmes and sought to ensure that there were at least three team members working on each programme. This was designed to increase coherence and cross-learning, reduce fragmentation and improve the quality of our advocacy work. The programme teams are also closely involved in planning, management and fundraising activities.

For the majority of our work, we receive funding in different thematic areas from the Dutch Ministry of Foreign Affairs. We also receive funds from a number of philanthropic foundations and from a group of very loyal individual donors. In order to strengthen our core activities, become less dependent on a single funder and fulfil a proper role as a global health advocate, we wish to further expand our funding base to include national and international donors, institutional donors, lotteries and foundations.

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[37] From 2016 to 2020, Wemos is part of the Health Systems Advocacy Partnership (HSA Partnership). In this partnership we cooperate with AMREF Health Africa, African Centre of Global Health and Social Transformation (ACHEST), Health Action International (HAI) and the Dutch Ministry of Foreign Affairs. We build capacity and create policy space so civil society can engage and hold governments, private companies, and other stakeholders to account in delivering equitable, accessible, and quality sexual and reproductive health and rights.
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https://www.chathamhouse.org/publication/shared-responsibilities-health-coherent-global-framework-health-financing
[39] www.wemosresources.org
[40] http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm
[41] 2016 – 2019 Mid-Term Review report, November 2018. Gavi the vaccine alliance.
[42] 'Report on RSSH investments in the 2017 – 2019 funding cycle', October 2018, TRP, The Global Fund.
[43] 'Performance-based financing in low-income and middle-income countries: isn't it time for a rethink?', Paul et al in BMJ Global Health 2018;3. Doi: 10.1136/bmjgh-2017-000664
[44] World Bank financing priorities and lending structure for global health
[45] Different forms of taxation can have differential aspects on population groups by socio-economic status and gender. The IMF in its policy advice tends to recommend value added tax or reduction of subsidies on, for example, fuel or agricultural inputs. These affect the incomes of lower income groups and of women – who more often than men carry the responsibility of buying food for their families – relatively more than those of higher income groups. See also "Short-changed: How the IMF's tax policies are failing women" (2018), ActionAid.
[46] https://eurodad.org/files/pdf/1546956-history-repppeated-how-public-private-partnerships-are-failing-.pdf and
https://www.oxfam.org/sites/www.oxfam.org/files/bn-dangerous-diversion-lesotho-health-ppp-070414-en.pdf
[47] This includes trade unions and governments should be involved when pursuing bilateral labour agreements that include new skills partnerships for health workers
[48] 'The European Medicines Agency is still too close to industry'. Garattini S. in BMJ 2016;353:i2412.
Doi: https://doi.org/10.1136/bmj.i2412