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Global Health in the Age of COVID-19: Responsive Health Systems Through a Right to Health Fund

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Abstract

We propose that a Right to Health Capacity Fund (R2HCF) be created as a central institution of a reimagined global health architecture developed in the aftermath of the COVID-19 pandemic. Such a fund would help ensure the strong health systems required to prevent disease outbreaks from becoming devastating global pandemics, while ensuring genuinely universal health coverage that would encompass even the most marginalized populations. The R2HCF's mission would be to promote inclusive participation, equality, and accountability for advancing the right to health. The fund would focus its resources on civil society organizations, supporting their advocacy and strengthening mechanisms for accountability and participation. We propose an initial annual target of US$500 million for the fund, adjusted based on needs assessments. Such a financing level would be both achievable and transformative, given the limited right to health funding presently and the demonstrated potential of right to health initiatives to strengthen health systems and meet the health needs of marginalized populations—and enable these populations to be treated with dignity. We call for a civil society-led multi-stakeholder process to further conceptualize, and then launch, an R2HCF, helping create a world where, whether during a health emergency or in ordinary times, no one is left behind.

Imagine a world where advocates successfully moved governments to greatly increase health systems funding and ensure that those health systems were equitable and of good quality, and where civil society and the public could monitor progress and hold their governments accountable. Health systems would be well resourced and universally accessible, and they would have sufficient numbers of health workers operating in environments safe for themselves and their patients. Imagine that advocacy and broad public and government understanding of people's right to water and sanitation accelerated efforts to enable all people to follow good hygienic practices. And imagine that participatory policymaking, empowered community-based organizations, and regular, open dialogues with policy-makers led to trust in health information from both governmental and nongovernmental sources.

In short, imagine a world where health rights advocacy received robust support, and the core right to health principles of equality, accountability, and participation were being realized. It would have been a world better prepared to meet the immense health and social demands of the coronavirus disease 2019 (COVID-19) pandemic. And it could yet be a world that is ready to meet the next outbreak of a novel or emerging infection.

When vaccines are developed, as they will be, and made available to everyone, COVID-19 will slowly recede into the past. Yet the weak health systems, lack of sufficient hygiene, and frequent lack of trust in health and political authorities that contribute to the toll of infectious diseases will remain. As will the regular toll of disease and death these take because systems are not in place to protect people's health, especially that of the marginalized among us. For as of 2017, more than half of people globally were not covered by essential health services.[1] What is more, over a quarter of people globally did not have access to basic sanitation (2017), 10% lacked access to drinking water (2017), and slightly more than 10% did not have enough food to eat (2018).[2]

The 2019 United Nations Political Declaration on Universal Health Coverage reaffirms the human right to health.[3] Yet, more than 70 years after the Universal Declaration of Human Rights, with so many states failing to deliver quality health services to all, will still another commitment to the right to health make a difference?

Global pledges can be transformative, but only

if backed by political action and resources. In 2001, for example, the United Nations General Assembly Special Session on HIV/AIDS launched the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which has developed national health system capacities and helped save 32 million lives.[4]

Particularly as countries respond to and begin to recover from COVID-19, with its tremendous economic and social harm, it might be too big a political lift to expect the creation of a global fund for health on the multi-billion-dollar scale required to create universal health systems, however needed such a fund may be. But imagine the potential impact if the responses to COVID-19 and the Political Declaration on Universal Health Coverage led to a Right to Health Capacity Fund (R2HCF) focused on strengthening civil society's ability to advocate for the right to health, as well as fortifying the mechanisms to achieve this right—including inclusive participation, accountability, and equality. Imagine how this could help secure health for all and better prepare the world for the next disease outbreak.

Inclusive participation is critical for ensuring that health policies and programs are attuned to the realities of communities, and it empowers people to advocate for their own health. Meaningful participation respects human dignity and agency, a major contribution to well-being, and can promote affordability, accessibility, and quality. Accountability requires political leaders to answer for their failures in delivering universal health coverage (UHC). Equitable health systems leave no one behind, evincing special concern for marginalized populations.[5] An R2HCF could be a foundational component of a reimagined post-COVID-19 global health infrastructure. And it would become a powerful counterweight to nationalist populism, breathing life into the right to health, and helping restore the mutual solidarity that is ever more urgent as the world confronts the pandemic and its aftermath.

A right to health capacity fund

Mission and scope

The R2HCF's mission would be to promote inclusive participation, equality, and accountability for advancing the right to health. Funds would be directed to civil society, especially community-based organizations, to build their capacities to advocate for health rights and strengthen mechanisms to increase accountability and participation (see Box 1). These vital health funding needs receive only a miniscule proportion of health funding (discussed below). Reasons include funders' preference for supporting direct health services and not sufficiently appreciating the contributions made by advocacy efforts and accountability and participation mechanisms to improved health; a narrowing civil society space, including fundraising restrictions on human rights organizations; the sometimes oppositional nature of advocacy; and governments' reluctance to share decision-making powers or to be held accountable.

Beyond this core focus, the R2HCF might directly support health services provision for highly marginalized populations who continue to be left behind (see Box 2). The line between these two sets of activities might sometimes seem blurry; guidance on eligible activities will need to be clear. The R2HCF would aim to enable even the most marginalized populations to fall within the ambit of UHC, and it would advance the social determinants of health, including nutritious food, clean water, sanitation, safe housing, education, and gender equality.[6]

Eligibility and prioritization

The R2HCF would concentrate on entities with the least access to global health financing: community-based and grassroots organizations, and other civil society organizations. While the R2HCF would focus on lower-income countries (where health indicators are the worst and where each dollar could go the furthest), funding would also be available to civil society organizations in higher-income countries, since extreme disparities and marginalization exist there as well. As governments may themselves need right to health capacity building, civil society organizations and developing country governments could partner to jointly access funds to strengthen the capacity of governments and national human

rights institutions, such as through educating legislators and judges on the right to health. Partnerships with the government will also be key to sustaining programs that should receive government financing, such as multi-stakeholder participation and accountability mechanisms, right to health education, and any direct services for marginalized populations that the R2HCF supports.[7]

The R2HCF could develop a set of principles to prioritize grant-making, including activities that benefit especially marginalized populations, are likely to create sustained change, and are least likely to secure alternative funding.

Governance

We envision the R2HCF as an independent nonprofit organization modeled on the GFATM, GAVI, and Unitaid, perhaps based in the Global South, where most of the communities whose rights it supports would be located. Its governing structures could include governments, civil society, international institutions, and foundations. Civil society and community leaders would have a leading role in R2HCF governance. Governments on the board would have to be committed to the right to health. Both civil society input and objective assessments

Box 1. Strengthening right to health capacities: Types of activities an R2HCF would support

Advocacy
- Human rights organizations' advocacy, policy analysis, and strategic litigation
- Right to health advocacy training for community members

Community-based and -driven accountability and participation
- Local health service and other social accountability measures, such as village health committees and health facility monitors

Participatory policymaking
- Community-driven health impact assessments for policies, programs, and projects that affect the right to health, whether adversely (such as mines, fossil fuel subsidies, and deforestation) or positively (such as parks, public transportation, and healthy school meals)
- Participatory health planning to ensure that urban and other community designs promote health for all and that pandemic preparedness plans protect marginalized populations
- Participatory budgeting for health-related budgets
- Participatory processes to develop health equity programs of action*

Right to health capacity building
- Community members' and civil society organizations' capacity to participate in health policymaking processes
- Right to health literacy and education, including for community members, public officials, health workers, educators, judges, lawyers and paralegals, law enforcement officers, and journalists
- Partnerships between legal services organizations and health providers to increase patients' understanding of their rights and their access to justice
- Information exchanges on successful right to health advocacy strategies
- Government capacity to enforce standards on quality, non-discriminatory, acceptable, and accessible health care in the private sector and to carry out environmental safety testing and enforcement in marginalized communities
- National human rights institutions' capacity to investigate and resolve complaints about right to health violations

Legal empowerment
- Access to justice programs to support claims centering on the right to health

Monitoring
- Right to health monitoring, such as through national human rights institutions, parliamentary right to health investigations, and community platforms
- Public expenditure tracking of health-related budgets

In addition to funding activities such as these, the R2HCF could have targeted strategic initiatives. These could include supporting innovative mechanisms for accountability and participation and accelerated grants for right to health emergencies. The R2HCF could also reserve a small sum for technical support aimed at helping smaller organizations strengthen their financial systems and monitoring and evaluation capacity and ensure that their programming is well designed and based on best practices. Such support would help these organizations overcome key barriers to their effectiveness, namely limited capacity and experience, along with their simply having insufficient funds.†

* O'Neill Institute for National and Global Health Law, Health equity programs of action. Available at https://oneill.law.georgetown.edu/projects/tuberculosis-law-and-human-rights-project/health-equity-programs-of-action.
† Personal communication (e-mail) with Ralf Jürgens, Senior Coordinator, Human Rights, Global Fund to Fight AIDS, Tuberculosis and Malaria, March 25, 2020.

could be used to determine which governments have the requisite level of commitment. Objective assessments might involve a set of indicators with clear criteria, much as Freedom House uses in its annual assessment of the level of political rights and civil liberties in every country.[8] Global institutions such as the World Health Organization and the Office of the United Nations High Commissioner for Human Rights could be board members, along with foundations experienced in human rights advocacy and financing.

The R2HCF could be either independent or housed within an existing organization, where it could gain efficiencies by leveraging the organization's administrative, communications, and other expertise and infrastructure (such as financial auditing). One potential host organization could be the Robert Carr Fund, which strengthens civil society networks that support the health and rights of inadequately served populations—though it is focused regionally and globally, with a particular emphasis on HIV.[9] Another option is the GFATM, although its existing governance would pose challenges, among them that only three of twenty GFATM board members are from civil society and affected community.[10]

Whether independent or linked to an existing organization, the R2HCF could become part of a consortium of interested right to health funders.[11] Collaboration could enable them to best compensate for their respective limitations, share lessons, develop a joint evidence base, and share resources, such as technical guidance and expertise.

Income sources

Like other global health funding mechanisms, the R2HCF would be funded through contributions by governments, foundations, and other donors. The GFATM and other health funds may even choose to offer a small solidarity contribution, given the R2HCF's contributions to their own missions.

In addition, an innovative financing window would help ensure the fund's viability and sustainability, and could be inspired by several countries' dedicated airline ticket tax to support Unitaid.[12] Innovative funding for the R2HCF could come, for example, from willing governments levying a tax on goods, services, or profits of corporations whose activities undermine the right to health, including tobacco, alcohol, sugary beverages, and highly processed unhealthy foods. Even a very low tax rate could raise significant sums. Many governments already tax certain unhealthy products.

Filling the gap: The size of the R2HCF

Currently, data are insufficient to accurately estimate existing funding levels for civil society right to health advocacy and other functions that the R2HCF would fulfill. Indeed, the absence of

Box 2. For debate: Directly funding health initiatives to protect marginalized populations from further neglect

Should a secondary function of the R2HCF be to directly support health services for neglected populations? The R2HCF could prove a literal lifeline for politically marginalized and stigmatized populations by funding, for example:

- Syringe exchanges for users of injected drugs
- Mobile health clinics to bring health care to remote, rural villages
- Clean water for indigenous communities
- Community health centers for vulnerable migrant populations
- Community-based support for people with disabilities

However, such funding would have drawbacks and risks. Direct support for health services would reduce already inadequate funding available for the fund's core mission—civil society action and structural changes advancing participation, accountability, and equality. Further, health services that depend on the R2HCF might not be sustainable. Governments might even use the R2HCF as a justification for not providing these services themselves.

If the R2HCF were to support direct services provision, it could be accompanied by measures to mitigate these concerns, such as agreements with the governments of countries receiving this funding on co-financing and on gradually assuming and sustaining domestic funding responsibilities, ensuring a sense of ownership.

data highlights the importance of the R2HCF. It is frequently said that we measure what we value; the lack of data suggests a low global priority. We recommend that such assessments be carried out.

Nonetheless, the data points that do exist suggest both a paucity of funding and a considerable unmet need. First, the GFATM is the main multilateral funder of right to health activities, with a strategic objective to "promote and protect human rights and gender equality" and with an unprecedented Breaking Down Barriers initiative aimed at removing human rights barriers to HIV, tuberculosis, and malaria services.[13] Yet between the 20 countries that were part of this initiative and other human rights grants secured through the ordinary grant process, the GFATM invested only about $123 million toward human rights in 2017–2019, or approximately US$41 million per year.[14] While countries exceeded the GFATM's target that middle-income countries allocate at least 2.85% of HIV grants to breaking down human rights barriers, only 0.72% of tuberculosis grant funding addressed human rights, below the GFATM's 2% target.[15]

Beyond the GFATM, funding is sparse. Major foundations such as Gates, Rockefeller, and Ford do not focus on the right to health. The Open Society Foundations is the most significant foundation funder of human rights activities, with US$47 million spent on health and human rights activities in 2019.[16] The Robert Carr Fund, operating on a three-year funding cycle, provided nearly US$33 million for 2019–2021.[17] The largest foundation focused exclusively on frontline human rights activism is the Fund for Global Human Rights, which currently provides grants totaling US$9 million annually.[18] Only US$225 million in development assistance went to nongovernmental women's organizations per year in 2015–2016, including a mere US$38 million annually for those in developing countries.[19] A comprehensive review found that US$170 million was available to civil society organizations in Latin America from 2014 to 2017 for human rights activities—only 10% of which was for advocacy and lobbying.[20] Limited bilateral right to health funding is focused on sexual and reproductive health rights—vital, yet only one of many needs.

It is apparent, then, that right to health funding is far below existing and future needs. We envision an R2HCF with an initial annual target of US$500 million, which would represent a transformative infusion of new funds. While we believe that this is a reasonable target, it is not based on a rigorous data-driven assessment. The R2HCF could adjust its funding target based on demand and research to better understand the right to health funding landscape.

The economic case: The power of rights

While it might not seem it during the wave of multi-billion and even multi-trillion dollar COVID-19 rescue packages, in ordinary times, even US$500 million per year would be considered a significant investment. What is the case for the R2HCF, then, including in light of the alternative of simply increasing direct health system investments?

First, the R2HCF would be far more achievable than a health systems fund that could have a major global impact. While we strongly support massive new investments in health systems, a transformative R2HCF is possible at a much lower price. A US$500 million annual fund would vastly scale up resources for the right to health. By contrast, billions of dollars annually will be required to make significant inroads into filling health systems gaps: The funding gap to achieve the targets of the third Sustainable Development Goal (SDG), which is focused on health and includes UHC, is at least US$20–54 billion per year for low- and middle-income countries, with 75% of investments needed for health systems.[21]

Second, the R2HCF would valuably complement current domestic and international health investments. It would enhance accountability, contributing to policies that ensure the most effective and efficient use of funds, and it would ensure that policies and programs are developed through inclusive participation, tailored to people's needs and realities.

Third, advocacy can leverage new money, particularly increases in national health budgets. This is especially important because the vast majority of

funds for health systems and underlying determinants of health will come from domestic resources.

Fourth, right to health initiatives can be transformative. For example, a study in Uganda reported that using community score cards—a form of community monitoring of local health services that includes an action plan that community members and health workers develop jointly—led to a 33% reduction in child mortality.[22] A grant from the Fund for Global Human Rights was critical in securing Tunisia's first law on domestic violence.[23] The Treatment Action Campaign's social mobilization and litigation led South Africa to offer antiviral treatment for people living with HIV.

Fifth, even with vastly scaled-up health systems funding, without dedicated efforts, marginalized populations will likely be left behind. Civil society's ability to document rights violations, develop sharp analyses and recommendations, mobilize political constituencies, generate media attention, bring neglected perspectives to lawmakers, and seek accountability through courts can drive policy reform and resource allocation that new health systems funding alone might not. Even with significant new health system funds, an R2HCF would be critical to ensure health coverage that is truly universal and that systems are in place to protect marginalized and other vulnerable populations during disease outbreaks.

Finally, the R2HCF would contribute to human dignity in ways that strengthening health systems alone cannot. It would enable people to be active agents in decisions affecting their health and lives, and to be respected. The value of enabling people at the margins to experience being treated with dignity is incalculable.

Finding—and creating—political will

The chief obstacle to an R2HCF is the political will to create it. Creating a new international right to health financing mechanism of significant magnitude is a tall order. The global recession that the COVID-19 pandemic will cause will make funding scarce in the near term. Yet the global health community has demonstrated strong interest in innovative new financing models, such as the Pandemic Emergency Preparedness Facility and the Coalition for Epidemic Preparedness Innovations. And a powerful constituency would advocate for the R2HCF.

There is a growing body of evidence—including case studies, randomized control trials, literature reviews, and the forthcoming mid-term assessment of the Global Fund's Breaking Down Barriers initiative—on the public health impact of funding advocacy and other health and human rights programming.[24] And in time, the R2HCF could contribute to this evidence, with regular publications on the impact of its investments, including toward rights-based UHC and global health security.

The high-level political commitment to UHC and the commitment to improving global health security that will surely follow COVID-19 open a window of opportunity for the R2HCF, which would make major contributions to SDG3—from accountability and participation to advocacy that unleashes significantly increased and more effective domestic health funding.

In an era of nationalistic populism, civil society space is narrowing and the world is experiencing an erosion of human rights, including through growing xenophobia and discrimination. The fund could be of major interest to countries that remain deeply committed to human rights, the rule of law, and global solidarity. Funders might view the R2HCF as a powerful antidote to the nationalism and lack of global collaboration that is almost surely worsening the harms of COVID-19, from too little funding for lower-income countries to the global scramble to find manufacturers of medical equipment and supplies and win the international bidding war, rather than sharing scarce supplies equitably and based on need.[25]

The added urgency of human rights, combined with a renewed commitment to UHC and global health security, could make the R2HCF a compelling possibility. And there is a global constituency to support it—communities whose health rights are not respected, and civil society seeking to push for the right to health. We envisage civil society organizations undertaking meticulous policy

analysis, doing sustained lobbying, and campaigning in the streets to create a R2HCF. We hope for the support of major global institutions, such as the World Health Organization and the Office of the United Nations High Commissioner for Human Rights, given that the R2HCF would support their core missions.

The path ahead

Accordingly, we call on other civil society advocates, international organizations, governments, and foundations to join us in a multi-stakeholder process, one led by civil society and that includes current right to health funders, to conceptualize the R2HCF, to advocate for it, and to create it. The need to, as United Nations Secretary-General Antonio Guterres has put it, "recover better" from COVID-19, together with the political declaration on UHC, provides a vital window of opportunity to launch the fund rapidly.[26] If the transformative SDG agenda and the promises to achieve UHC by 2030 and to leave no one behind are to be more than lofty declarations, we cannot wait to develop a powerful R2HCF.

References

1. World Health Organization, *Primary health care on the road to universal health coverage: 2019 monitoring report* (Geneva: World Health Organization, 2019). Available at https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf.

2. World Health Organization, "Sanitation: Key facts" (June 14, 2019). Available at https://www.who.int/news-room/fact-sheets/detail/sanitation; United Nations, *Sustainable Development Goals: Goal 6; Ensure access to water and sanitation for all*. Available at https://www.un.org/sustainabledevelopment/water-and-sanitation/; Food and Agriculture Organization of the United Nations, International Fund for Agricultural Development, United Nations Children's Fund, et al., *State of food security and nutrition in the world 2019: Safeguarding against economic slowdowns and downturns* (Rome: Food and Agriculture Organization of the United Nations, 2019). Available at http://www.fao.org/3/ca5162en/ca5162en.pdf.

3. United Nations General Assembly, G.A. Res. 74/2, UN Doc. A/RES/74/2 (2019).

4. United Nations General Assembly, G.A. Res. S-26/2, UN Doc. A/RES/S-26/2 (2001); Global Fund to Fight AIDS, Tuberculosis and Malaria. Available at https://www.theglobalfund.org/en/.

5. Framework Convention on Global Health Alliance. Available at https://fcghalliance.org.

6. E. A. Friedman, L. O. Gostin, M. M. Kavanagh, et al., "Achieve health equity: Crafting national programmes of action for the SDG era," *BMJ* 367 (2017).

7. Personal communication (e-mail) with Ralf Jürgens, Senior Coordinator, Human Rights, Global Fund to Fight AIDS, Tuberculosis and Malaria, March 25, 2020.

8. Freedom House, *Freedom of the world research methodology*. Available at https://freedomhouse.org/reports/freedom-world/freedom-world-research-methodology.

9. Robert Carr Fund, *About the Robert Carr Fund*. Available at https://robertcarrfund.org/about-rcf.

10. Global Fund to Fight AIDS, Tuberculosis and Malaria, *Board: Members*. Available at https://www.theglobalfund.org/en/board/members/.

11. Personal communication with Ralf Jürgens (see note 7).

12. Unitaid, *About us*. Available at https://unitaid.org/about-us/#en.

13. UNAIDS, *UNAIDS 2016–2021 strategy: On the fast-track to end AIDS*. (Geneva: UNAIDS, 2015). Available at https://www.unaids.org/sites/default/files/media_aset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf.

14. Global Fund to Fight AIDS, Tuberculosis and Malaria, Office of the Inspector-General, *Advisory review: Removing human rights-related barriers: Operationalizing the human rights aspects of Global Fund STRATEGIC OBJECTIVE 3* (Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria, 2019), p. 2. Available at https://www.theglobalfund.org/media/9020/oig_gf-oig-19-023_report_en.pdf.

15. Ibid., p. 25.

16. Open Society Foundations, *Who we are: Financials*. Available at https://www.opensocietyfoundations.org/who-we-are/financials.

17. Robert Carr Fund, *Funding*. Available at https://robertcarrfund.org/funding.

18. Fund for Global Human Rights, *2017/18 Form 990*. Available at https://globalhumanrights.org/wp-content/uploads/2019/10/FY17-18-FGHR-990.pdf.

19. Organisation for Economic Co-operation and Development, Development Assistance Committee Network on Gender Equality, *Aid to gender equality and women's empowerment: An overview* (OECD DAC Network on Gender Equality, 2018). Available at https://www.oecd.org/dac/gender-development/Aid-to-gender-overview-2018.pdf.

20. Innpactia and CIVICUS, *Access to resources for civil society organisations in Latin America: Facts and challenges* (Innpactia and CIVICUS, 2019). Available at https://www.civicus.org/documents/reports-and-publications/civicus+innpactia-report_september02.pdf.

21. K. Stenberg, O. Hanssen, T. T. Edejer, et al., "Financ-

ing transformative health systems towards achievement of the health Sustainable Development Goals: A model for projected resource needs in 67 low-income and middle-income countries," *Lancet Global Health* 5 (2017), pp. e875–e887.

22. M. Björkman and J. Svensson, "Power to the people: Evidence from a randomized field experiment on community-based monitoring in Uganda," *Quarterly Journal of Economics* 124/2 (2009), pp. 735–769.

23. A. Aidoo, "Hope in action: Funding frontline advocacy around the world," Fund for Global Human Rights (December 3, 2019). Available at https://globalhumanrights.org/blogs/hope-in-action-funding-frontline-activism-around-the-world.

24. A. Hernández, A. L. Ruano, A.-K. Hurtig, et al., "Pathways to accountability in rural Guatemala: A qualitative comparative analysis of citizen-led initiatives for the right to health of indigenous populations," *World Development* 113 (2019), pp. 392–401; Björkman and Svensson (see note 22); G. Danhoundo, K. Nasiri, and M. E. Wiktorowicz, "Improving social accountability processes in the health sector in sub-Saharan Africa: A systematic review," *BMC Public Health* 18 (2018); Personal communication with Ralf Jürgens (see note 7).

25. World Health Organization, *Shortage of personal protective equipment endangering health workers worldwide* (March 3, 2020). Available at https://www.who.int/news-room/detail/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide.

26. A. Guterres, "'This is, above all, a human crisis that calls for solidarity,'" United Nations (March 19, 2020). Available at https://www.un.org/en/un-coronavirus-communications-team/above-all-human-crisis-calls-solidarity.