



**Joint Learning Agenda (JLA)  
Civil Society Capacity  
Building Programme on  
Health Financing, Universal  
Health Coverage and Budget  
Advocacy**

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Anglophone Africa  
January to December 2021

**SUMMARY REPORT**  
WACI Health

# Table of CONTENTS



1.0	Program Overview.....	3
2.0	Why is it important to support CSO engagement in Health Financing.....	4
3.0	Project Summary.....	5
4.0	Approach and Methodology.....	5
5.0	Key Results.....	6
6.0	Evaluation.....	9
7.0	Challenges.....	11
	ANNEX.....	12

## Program Overview

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The Joint Learning Agenda is a program where civil society with the leadership of two regional organizations -WACI Health and Impact Santé Afrique (ISA)- has come together with a consortium of global health initiatives (GHIs) –The Global Financing Facility, The Global Fund, The Partnership for Maternal, Newborn & Child Health, Gavi, and UHC 2030 to develop, deliver and support capacity strengthening on UHC Budget Advocacy and Accountability in Sub-Saharan Africa.

The program promotes a multi-stakeholder collaboration that, through constructive mechanisms, will hold governments and donors to account for the allocation and equitable use of funding for health.

This unique partnership leverages collaboration between the different GHIs' agendas, such as the GAP, UHC agenda and COVID-19 response, and provides a coordinated, aligned and long-term support to Civil Society engagement in these agendas.

The program is structured in two phases and three pillars.

### PHASE 1 - LEARNING:

- **PILLAR 1:**  
Regional (Anglophone and Francophone) online Training of Trainers
- **PILLAR 2:**  
In-country practical and action orientated trainings focusing on building CSO's capacity on advocacy and accountability for health financing for UHC

### PHASE 2 - SUPPORT:

- **PILLAR 2:**  
Putting learning into practice with the support of tailored capacity building, technical assistance, mentoring and grants.

There are 20<sup>1</sup> participating countries (Anglophone and Francophone) in which the program aims to develop a cadre of trainers who can build capacity through delivering training on health financing, UHC and budget advocacy to country level actors from civil society, media organizations and from among elected representatives and that can provide in-country support to budget advocacy and accountability activities undertaken by CSO actors as well as mentorship.

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1 10 from each sub-region: Burkina Faso, Cameroon, Côte d'Ivoire, Chad, Benin, Togo, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mozambique, Liberia, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, and Uganda.

## Why is it important to support CSO engagement in Health Financing

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Civil Society organisations (CSOs) are playing a critical role in building a strong-equity focused and people-led movement for UHC.

Multiple strategies, guidelines, and other documents exist that emphasize the need for CSOs greater role in advocacy for accessible and quality health care, including through the active participation of civil society organisations (CSOs) in multi-stakeholder platforms.

With the challenge of Sub-Saharan African countries to meet the Abuja Declaration commitments (government expenditure on health should be equivalent to at least 5% of GDP and 15% of total government expenditure), the need for addressing resource mobilisation, and especially domestic resource mobilisation, is essential to achieve universal health coverage (UHC).

From local through to national level, civil society organizations can oversee health expenditures, monitoring what is spent by national programs, district health services or even local clinics, and using their findings to call for changes to budget allocations or for how budgets are expended and prioritized; and to conduct advocacy around health spending that contribute to progress on UHC.

Civil society engagement in health financing advocacy and accountability has increased over the years. However, challenges at global- and country-level remain and have been exacerbated by the COVID-19 pandemic whereby many resources have been diverted from key health programs to address the pandemic, thereby jeopardising hard-won gains in communicable diseases and basic health services and straining already fragile health systems.

CSOs have also had to grapple with how to respond to the COVID-19 pandemic but demonstrated their added value in the Covid-19 response through community mobilisation, awareness creation and using data for evidence-based decision making.

## Project Summary

From January to March 2021, 20 trainers representing **10<sup>2</sup> Anglophone African countries** (two persons per country) were competitively selected and participated in a Regional Training of Trainers (ToT) on Health Financing, Universal Health Coverage and Budget Advocacy. The regional training was conducted by a consultant with expertise in training trainers of trainers in Health Financing.

Following the regional ToT, each country team of trained trainers was tasked to develop the in-country training work-plans including methodology, timelines, selection of participants, evaluation and budget, among other things in line with their country context, based on the knowledge they had gained as trained trainers. The workplans were submitted to WACI Health for review with feedback being provided by the consultant and WACI Health team.

The ToT Consultant, WACI Health team, and JLA partners provided ongoing technical assistance to ensure coordination and success of the programme. This was done through review of country concept notes and all related documents for each session, monitoring of trainings and review of reports for each country.

In-country trainings primarily targeted Civil Society representatives, health advocates and media. The training focused on key concepts around health financing, UHC and budget advocacy, and CSO engagement to increase advocacy in decision-making. In some countries, training featured guest appearances by Ministries of Health (MoH), Ministries of Finance (MoF), bilateral partners, and health financing experts. In some countries, government officials, particularly those from MoH and MoF, collaborated in the training by making technical presentation of health financing data and updates, and demonstrated willingness to work with civil society on health financing advocacy.

## Approach and Methodology

**Structure:** The work was structured around a 'country leadership and accompaniment model'. This means that the country trainers and civil society were in the driving seat as far as developing and adapting their plans, but WACI Health and ISA, in collaboration with associated consultants, were on hand to provide accompaniment in terms of feedback, technical support, development of materials and other tasks.

**Planning:** Led by the trainers at the country level entailed identifying country level civil society partners and broader stakeholders in health financing; understanding country profile in view of sustainability, transition, and efficiency with a focus on domestic financing and UHC; health financing needs assessment- areas where participants needed the most support; understanding civil society advocacy capacity needs. Our role was supportive and in collaboration the ToT trainers provided feedback to the country level trainers.

**Implementation of the training and continuous improvement:** This involved technical and financial support to the trained trainers for the execution of the country training plans and development of joint advocacy strategies. We fostered collaboration with national and regional experts. Depending on country context and priorities we provided support that was tailored to meet these specific needs and objectives. This also included support in identifying coordination mechanisms- existing or new coalitions advocacy platforms, working groups, and developing joint advocacy strategies.

**Review and learning:** The methodology embedded a continuous review and learning process to ensure added value and growing impact. This included group calls and one to one calls with the countries; peer to peer exchange forums between Anglophone and Francophone.

## Key Results

### Training Capacity:

Strengthening Africa-based trainers on health financing advocacy for UHC. **20 ToTs from 10 Anglophone Africa countries** means that advocates have a pool of technical resource that can support local advocacy in the priority countries. It also means that we have a pool of 20 experts (or whose expertise is growing) who can work together to support regional advocacy on health financing for UHC in Anglophone Africa.

### Advocacy Capacity:

Strengthening national level community and civil society advocacy capabilities. The training provided critical knowledge and understanding of the health financing landscape and budget making processes. In Anglophone Africa **a total of 292 civil society representatives were trained**- a cohort of highly knowledgeable trainees with the ability to impact health financing policy at the national/county level who now understand sustainable ways to finance UHC in a resource-constrained setting. Beyond these numbers, there would be a ripple effect across civil society coalitions, networks and organizations towards more effective advocacy.

In **Kenya** for example, the training happened in parallel to the national budget making process for the 2021/22 financial year. Participants had the opportunity to apply theory to practice by engaging this critical national process among several others:

- contributed input into more than 30 county budgets and reviewed processes as part of the 2021 budget cycle.
- contributed to the National Health Insurance Fund Bill (2021) by the coalition; recognition and official invitation for public hearing sent by Senate for a hearing on November 17th, 2021
- contributed to the National Transition Roadmap for sustainable health financing for UHC (2022-2030), which was approved by the Ministry of Health and adopted by Development Partners.
- developed the National Work plan for civil society advocacy to support the 47 counties for the next three years, amounting to about \$580,000

In **Ghana**, participants agreed to develop a UHC specific Toolkit in multiple languages to assist Trainers provide local citizens (i.e., stakeholders) with information that would help them understand health financing mechanisms and frameworks and processes in Ghana.

In **Nigeria**, several participants shared how participating in the training helped them in their current advocacy work. For example,

*“With the information obtained during the training on the Status of BHCPF in the States I found out that Lagos State had not fulfilled the condition of Training of Trainers before being qualified to access the PHC gateway of the BHCPF. I found out from the Lagos State Primary Health Care Board why this was the case and was informed that a memo for the TOT requesting for the sum of N86 million for the training of 100 state trainers and 1,880 Health workers was awaiting approval with the Governor for the past 2 months. We were requested to help and an advocacy message with our specific Ask and benefit to the State was sent to the Governor through a close friend. A week later the memo was approved”.* **Ayo Adebuseye, Public Health Sustainable Advocacy Initiative PHSAI, Lagos**

### Institutional Capacity:

This program has contributed to strengthening southern-leadership, women-led organizations- WACI Health and ISA- and expanded their capability to facilitate southern civil society leadership in health financing advocacy for UHC.

### Coalition Building:

UHC coalitions created/strengthened to enable more effective civil society organizing. and meet regularly meet via differing platforms like zoom or WhatsApp. The coalitions have helped strengthen civil society organizing and coordination. Some examples:

#### Uganda

Training participants agreed to join the existing Coalition on Health Financing, Research and Development (COHFRED) as a platform through which they will engage in advocacy activities concerning UHC, health financing and transparency.

#### Kenya

National civil society coalition on health financing for UHC and budget advocacy spawned and grew in membership; participants now understand regional health financing commitments

#### Ethiopia

"Ethiopian UHC Coalition" was established. The coalition has a leader, vice leader, and secretary from different CSOs. Further, a group telegram channel was created through which information is disseminated to all team members, and currently, the channel serves as the main platform for communication among the CSOs. In the future, it is planned to have different working groups in the established coalition like; evidence synthesis team; public relation team; capacity building team, etc.

#### Liberia

Liberia chose to strengthen an existing CSO network. That is, the Liberia Health CSOs Network to strengthen collective engagement on sustained health advocacy. This was preferred instead of having a splinter CSOs group for UHC which would likely be unsustainable.

#### Ghana

Ghana established a UHC coalition, a network of national civil society actors and media practitioners to advocate for UHC in Ghana.

### **Stronger linkages with public sector:**

In most countries, there was a representation of government as guest speakers in their different roles within the health financing and UHC Agenda. The involvement of the Ministries of Health, Finance, added value and enhanced dialogue between CSOs and government. This provides opportunity for CSOs to strengthen engagement and advocate for UHC and Health financing.

### **Growth in network of allies:**

These trainings created the possibility for each country to expand and grow their network of allied in health financing advocacy. This ranged from engaging and partnering with members of parliament to media to other players in the health financing advocacy space.



## Evaluation

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Evaluation of the country sessions was designed by the trained trainers with input from WACI Health and ISA and with technical assistance by a consultant.

Pre/post-test: All the countries developed and administered self-assessed confidence evaluations, periodic “pulse” surveys and carried out post training evaluations. We have summarized the findings as below:

### Self-assessed confidence scores

From a relatively high baseline (average: 3.7/5.0) participants reported an increase in their level of confidence in their knowledge and skills in all the JLA topics, increasing by 0.6 points to an overall average score of 4.3/5.0. This finding is an indication to invest on the participants regarding UHC and health financing, as it demonstrated their readiness to improve their knowledge and skill to perform their duties.

### Periodic “pulse” surveys.

These surveys asked participants to rate on a scale of 0-10 whether the objectives of the previous session had been met, and to comment on what went well and what could be improved. Because not all participants completed these surveys and because these constituted a “rolling” evaluation approach, they are superseded by the overall evaluation, and the results of these surveys are therefore not described. These were conducted by some of the countries.

## Qualitative questions

### What are the main topics or skills where you feel the training of trainers has helped you?

All of the main topics covered in the country trainings were brought up by one or more participants in their description of the country training highlights. Importantly, a number of participants also highlighted training skills and techniques and the ability to adapt technical content to civil society audiences as important elements of what they learned.

### What worked well?

Comments in the “what could have gone better” section provide a range of ideas that should be considered in future training. It is clear that there is an appetite for more in-depth investigation of most key topics. This can be achieved through the introduction of additional in-depth case studies and through the extension of time available.

### What could have worked better?

It was mentioned that more in depth investigations would have been welcome on challenges such as prioritization/ allocative efficiency, co-financing, gap analyses, role playing negotiations; and the influence of financial and technical partners particularly in ensuring sustainable funding for high cost interventions. Here are some reflections from various countries on issues that merit follow up and should inform future trainings:

- Practical advocacy sessions that change policy in real-time are highly preferred, and participants learn more when practice is mixed with theory (Kenya)
- Strategic purchasing and risk pooling not only for civil society but also politicians and

- bureaucrats who are key influencers in many of the decisions made in regards to UHC. (Uganda)
- A number of participants mentioned the need for engaging government/higher officials in a similar training, so that they could contribute for the effective advocacy. Others had highlighted presence of real cases and practical experiences to be shared with the participants, so that they could get lessons and learn from peers. (Ethiopia)
  - It would be good to provide reading articles focused on budget advocacy in a similar setting. (Malawi)
  - Have at least one practical session on monitoring in which we would select one district office and do monitoring and evaluation. (Malawi)
  - During the training it could have been better if we could go through the national budgets of the past three years. That could have given us skills on how we can analyse the national budget trend concerning the health financing (Malawi)

### Gender analysis

In total, there were 159 men and 55 women trained. All country trainings have had more male participants than female.



159 Men  
were trained



55 Women  
were trained

## Challenges

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CSOs have a wider understanding of the challenges that hinder UHC and health financing, they however **lack tools and resources** to keep the momentum.

Quite a number of participants were receiving this kind of training for the first time hence many health financing concepts some countries use were new to them. Understanding key concepts (budget cycles, national expenditures, budget advocacy) and identifying sources of information to put things into country level context including national budget formulation and tracking was a challenge to most participants before because they did not have enough knowledge.

**Inadequate access to credible data** was identified as a challenge; as credible data is crucial towards evidence-based advocacy.

The **COVID-19 pandemic** and preventive measures such as restrictions on travel and public gathering made it impossible for the physical meeting. Most countries conducted the trainings by using both virtual and physical (hybrid) thereby experiencing challenges related to poor internet connectivity.

In all countries, the **gender disparity** is very evident. The call to application was an open one, meaning everyone was encouraged to apply to join the training spot. However, from the country experience, there were more men than women who applied to be admitted into the training programme.

## Annex

### Name And Country - Trainers

Country	Trainer
Ethiopia	Endala Erko Kenea and Gelila Abrahams Tefere
Ghana	Lamont Evans and John Eliasu Mahama
Kenya	Christopher Alando and Leonora Mbithi
Liberia	Joyce Laykah Kalikpo and Emmanuel Tieh Delamy
Malawi	Olive Chipwafu Mumba and Maziko Matemba
Mozambique	Ilundi Durao de Menezes and Leila Helena Constantino
Nigeria	Olayide Akanni and Pitan Oyeyemi Temilade
Sierra Leone	Darlington John and Musa Ansumana Soko
Tanzania	Hendry Peter Samky and Lightness Charles Mlowola
Uganda	Moses Mushime and Moses Mukuru
<b>Total</b>	<b>20</b>

### Country Participation

Country	Women	Male	CSOs Represented	Media	Participation	Total participants
Ethiopia	7	12	18	Yes	Hybrid	19
Ghana	7	14	14	Yes	Hybrid	21
Kenya	41	59	42	Yes	Hybrid	100
Liberia	13	17	15	Yes	Physical	30
Malawi	7	15	20	Yes	Hybrid	22
Nigeria	11	15	26	Yes	Hybrid	26
Sierra Leone	6	19	24	Yes	Physical	25
Tanzania	12	16	28	No	Hybrid	28
Uganda	14	7	21	Yes	Hybrid	21
Mozambique	To be updated upon completion of training					
<b>Total</b>	<b>118</b>	<b>174</b>	<b>208</b>			<b>292</b>

### National Advocacy Plans

Please see this [link](#) for the country reports and country advocacy plans, and this [dashboard](#) with a matrix of top 3 advocacy objectives for each country.