

The project of a “National Health Advocacy Fund” – civil society perspectives on an enticing proposal

This document was created following a webinar hosted by the [Kampala Initiative](#) in August 2020. It aimed to present, explore and assess the proposal of a ‘National Health Advocacy Fund’, drawing on the experience, expertise and knowledge of civil society representatives in attendance.

The ‘National Health Advocacy Fund Partnership’ is a coalition working to develop a new funding mechanism for civil society advocacy for health. The project is hosted by the Joep Lange Institute. The Partnership is currently consulting with civil society, donors and leaders on this proposed initiative, it is not yet finalised or established.

We have created this document to provide a further opportunity for webinar attendees and the wider Kampala Initiative community to input their thoughts.

For more information on this webinar and the ‘National Health Advocacy Partnership’, visit the website here: <https://www.medicusmundi.org/kampalawebinars/> .

You can also watch the recording here: <https://www.youtube.com/watch?v=irkmdilw4SQ>

The information from the webinar and this document will be shared with the ‘National Health Advocacy Fund Partnership’ on 7th September.

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Actions -

Please email David Barr (davidbarr376@gmail.com) -

- If you would like to be added to a mailing list to receive updates on the development of the ‘National Health Advocacy Fund Partnership’ (NHAFP).
 - If you have successful examples of national level health advocacy (previous or current). The partnership are currently compiling examples to include in their business case to potential donors.
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Previous experiences/challenges of national level advocacy funding -

- Challenging to actively participate in the competition for funding, this takes a lot of time and certain skills are often inaccessible.
- Donors often have all the financial resources (and therefore power) - they set the agenda and yet very rarely experienced or witnessed the situation so do not know what is needed.

- There is a fear of losing funding, so often CSOs work to what the donor wants rather than what is actually needed.
- Grants are usually very prescriptive, and donors have pre-defined purpose before understanding the local context - makes it very difficult to do advocacy on issues that affect people in specific contexts.
- International NGOs now seem to be competing for the same resources with local CSOs
- International NGOs are now directly working on project implementation at the local level; making it extremely challenging for local CSOs to grow, survive and thrive.
- Uncertainty of the funding landscape due to emergent global issues such as the current health emergency.
- Grants tend not to focus on strengthening capacity of local organisations.
- Best practises identified in financing civil society have a power shift at their core - place the decision making in the hands of local communities and representatives from local civil society, e.g. through grant making that is participatory and co-created.
- Civil society members are often maneuvering in a space where governments and donors have their own priorities that do not fit their needs - funding is often not sensitive to local contexts and realities, and do not capitalise on local knowledge.
- National and subnational-level health advocacy is rarely given priority - it is always an afterthought. Generally, a lack of donors who fund advocacy.
- Funding priorities are nearly always from the global or national level downwards, never really from communities upwards.
- Funding is often short-term and project-based - often only 2-3-year cycle meaning financial citation of CSOs is precarious and discourages long-term organisational strategic planning.
- Donors expect results/outcomes - but advocacy takes a long time and is not linear. It can often take a lot longer than expected, particularly when a health issue is new or controversial.
- Research into CSO funding is often written in the global north missing voices and experiences of CSOs in the south.
- Very little funding available for the pre-work that goes into advocacy, e.g. engaging different stakeholders/building relationships.
- Also, very little funding for long-term advocacy which does not have clear set timescales (such as changing the constitution in Uganda to include the right to health).
- Full indirect/administrative costs are rarely covered, making it challenging to fulfill grant reporting costs and manage financial requirements.
- There is a hierarchy of CSOs where the more well-established organisations get funding, but the smaller grassroots organisations (who are often much more connected to community needs) do not.
- Funding is based on the interest of the donor and the donor dictates what advocacy to engage in.

Specific case studies/examples of experience of national level health advocacy

- Managed to get the Ugandan Government to recognise maternal health as a constitutional right after taking them to court. The process took 9 years, some donors supported for short periods of time during this, but they managed to keep mobilising local sources to fund it/keep advocacy going (from Kenneth intervention).
- International Health Partnership hosted a fund between 2012-2016, hosted by the WHO and managed by Oxfam GB and Oxfam Germany. Approach of the fund was bottom up and tailored to local needs. For example, in Uganda they used the resources to influence intellectual property policy framework, influenced the Industrial Property Act to incorporate TRIPS flexibilities to enable production of generic medicines of which 90% of Ugandans depend on, and used the resources to help establish a civil society engagement mechanism on service delivery. These were their own ideas, the funding came in and supported them (from Kenneth intervention).
- Civil Society advocacy supported Nigeria's exit from polio meningitis and successful emergence as a polio free country (Lizzy Igbine, Nigeria).
- Civil Society working on nutrition in Nigeria, have succeeded in making our government look towards ANH (Agriculture Nutrition and Health) as a means of supporting national health indexes. Although the CSOs have no funding for ANH we are thriving from our own singular resource in doing our work. To attain UHC there is an urgent need for funding for ANH advocacy, capacity building and community outreach and establishing home gardens as a base to treat stunting and wasting in our communities. Funds are highly needed to correct cases of malnutrition in post Covid-19 intervention.

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Considerations, ideas and thoughts for the NHAFFP -

- In many places, governments are not receptive to CSOs, or are actively restricting CSO space
- Important to include capacity building as a priority, especially capacity building on resource mobilisation, sustainability and advocacy capabilities
- Ideally capacity building on resource mobilisation will enable organisations to delivery their advocacy without being 'trapped' in the funding cycle
- Important to have ongoing discussion with 'recipients' and potential 'recipients' around challenges in advocacy funding and be adaptable to this
- Advocacy grants needs to be flexible and adaptive to the current situation - there should not be a one size fits all model
- Grants also need to be long term - at least 3-5 years - to allow for longer-term strategizing and sustainable advocacy, and give sufficient resources for this time period
- Consider funding standalone advocacy programmes
- Consider funding that enables experimentation and innovation
- The fund may need a theory of change which ultimately country level advocates can draw down from to be able to track outcomes
- The fund needs to have demonstrable impacts that are also sustainable. These should be driven by grassroots groups

- Grantees/CSOs need to have some sort of accountability as a part of this
- It would be great to the NHAFP to have resources to bring grantees together to exchange and learn from one another (OSF do this)
- Support technical training for CSOs to build their knowledge of health budget and accounting.
- The fund could reach out to local groups and consider funding them at a local level (one attendee noted that in Uganda they have rotary clubs and Lions clubs). This could be proactive, ensuring smaller organisations are not excluded from application processes
- Focus should be around achieving the right to health - furthermore, the priority issues in achieving the right to health should be determined by local CSOs, not donors or international CSOs
- Grantees are eligible based on need - many CSOs cannot access funding
- Should be new money, not repurposed money taken from other funds
- Specific focus on advocacy, not service delivery as many other funds do focus on this
- Resources from the fund to reach grassroots groups
- We need to learn more/conduct more research into what funding models really work for CSOs, from the CSO perspective
- Academia can play a role in helping with research, but also in M&E of advocacy and validation of best practices. A learning agenda is as important as M&E.
- The fund could be co-created from the outset with CSOs, to ensure it meets their needs - should be a partnership.
- CSO engagement could be comprised of CSOs from different countries/regions and from different levels (global, regional, national, local)
- Set priorities of the fund in a transparent manner, tracking the priorities of the fund and promoting transparency and access to information
- Fund needs to keep in mind reporting needs, taking into account that advocacy progress is difficult to measure and progress is often slow
- Many CSOs are working in repressive contexts making it very challenging (and sometimes unsafe) to engage in advocacy - could the fund provide some support and protection for CSOs working in this context?
- Ensuring that there is no nepotism in terms of who received grants
- Overcome health advocacy siloes (such as HIV, TB, mental health etc...)
- Focus on funding advocacy that works with the needs of the most marginalised/vulnerable
- Organise workshops with leadership and civil society

Questions posed for the NHAFP -

- How will National Health Advocacy fund partnership elevate the voices at grassroots?
- How do we get communities to be actively involved in NHAF and also hold CSOs accountable?

- Under UHC how can we improve advocacy at the grassroots because primary health care is basically grassroots intervention?
- We had a discussion under the Global Fund and a consultant said communities do not have capacity to monitor and advocate for accountability. What is your take on this?
- How do we classify CSOs? In my years working in the social development space, CSOs are in classes. When funds come into African countries, there are CSOs that are highly favored but there are those that are actually at the grassroots level doing the work but are not favored in accessing the fund. How do we ensure that grassroots CSOs also can access funding?
- How do we cover Countries where advocacy is difficult to be delivered due to certain laws or policies?
- It would also be great to get a better understanding of the funding mechanism that Kenneth spoke about (the one managed by Oxfam GB/Germany). These examples (and lessons learned) will help us build a better mechanism!
 - There is a review of earlier rounds of it available at: https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Key_Issues/Civil_Society_Engagement/Health_Policy_Action_Fund_Review.Dalberg.Dec2013.pdf
Also happy to help connect with previous grantees (Jessica Hamer, Health Poverty Action)
 - The Advance Family Planning initiative of Johns Hopkins Bloomberg School of Public Health issued a relevant overview of options for local ownership, sustainability, and grant-making: <https://www.advancefamilyplanning.org/new-options-brief-calls-global-funding-effort-support-local-advocacy>. It is the result of consultations with 170 experts in Africa, Asia, Europe and the United States and an extensive literature review (Beth Fredrick)