Strategies, tactics and approaches

# Conducting and evaluating national civil society advocacy for reproductive, maternal and child health

World Health Organization

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# Contents

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# Abbreviations

| | |
|---|---|
| AFP | Advance Family Planning |
| AHEAD | Advancing Healthy Advocacy for Reproductive Health |
| APPG | All-party parliamentary group |
| ARROW | Asia/Pacific Resource and Research for Women |
| BRICS | Brazil, Russia, India, China and South Africa |
| CPD | Committee on Population and Development |
| CSO | Civil society organisation |
| DSW | Deutsche Stiftung Weltbevoelkerung |
| EPF | European Parliamentary Forum |
| EU | European Union |
| FP | Family planning |
| GAVI | Global Alliance for Vaccines and Immunisations |
| GFATM | Global Fund to fight AIDS, Tuberculosis and Malaria |
| GSWACH | Global Strategy for Women and Children's Health |
| HIV/AIDS | Human immunodeficiency virus/Acquired immunodeficiency syndrome |
| HLSP | Health & Life Sciences Partnership |
| ICPD | International Conference on Population and Development |
| IPPF | International Planned Parenthood Federation |
| LAPM | Long-acting and permanent methods |
| MAMA | Mobile Alliance for Maternal Action |
| MDG | Millennium Development Goal |
| MP | Member of Parliament |
| MTEF | Mid-term expenditure framework |
| OBI | Open Budget Initiative |
| ODA | Official development assistance |
| PMTCT | Preventing mother-to-child transmission |
| PPD | Partners in Population and Development |
| NGO | Non-governmental organization |
| RMCH | Reproductive, maternal and child health |
| SRHR | Sexual and reproductive health and rights |
| SWAp | Sector-wide approach |
| TAC | Treatment Action Campaign |
| WHO | World Health Organization |
| WHRAP-SA | Women's health and rights advocacy partnership in South Asia |
| WRA | White Ribbon Alliance |

# 1. Introduction

## 1.1 Role of civil society for advocacy

Partnership between governments, donors, the private sector and civil society has increasingly gained traction among international development cooperation partners since the Paris Declaration on Aid Effectiveness[1] first articulated principles of alignment and harmonization and greater country ownership of development in 2005. The involvement of civil society institutions is crucial to this process. Their voice of accountability for community health needs is essential to ensure universal coverage and equitable access to reproductive, maternal and child health (RMCH). The advocates' role in framing issues, bringing together constituencies, and monitoring international and national commitments were among the topics discussed at a WHO technical consultation entitled "Civil Society Advocacy for Reproductive, Maternal and Child Health", held in Glion, Switzerland, on 14–16 May 2012.

As the Geneva (GVA) successors to the Millennium Development Goals are being debated, and high-profile initiatives and partnerships have emerged globally around the issues of RMCH, the role of civil society advocacy has gained increased prominence on the global stage. Civil society advocates and initiatives in the area of RMCH include: the Partnership for Maternal, Child and Newborn Health (launched in September 2005); the UN Global Strategy on Women and Children's Health (GSWACH, launched in September 2010); the Alliance for Reproductive, Maternal and Newborn Health (launched in September 2010); and the Family Planning Summit held in London, United Kingdom in July 2012.

### *1.1.1 What is civil society?*

In a WHO document[2], civil society is defined as "the social arena that exists between the state and citizen, and is not part of the state or the market (for-profit sector)." Civil society represents an autonomous social sphere of interactions in which individuals and groups form many types of voluntary associations and networks in order to formulate and articulate their civic interests, negotiate conflict and provide and use services. Civil society interactions allow people to engage in activities that aim to benefit the society at large. Civil society delineates norms and facilitates networks that can be trusted by the population in order to initiate coordinated public action aimed at improving social well-being. Civil society organizations (CSOs) generally emerge from civil society, although in some cases they may have links with the state and/or business corporations. CSOs generally emerge from the community, neighbourhoods, or the work arena within the context of social and other networks. CSOs provide an institutional vehicle, beyond the ties of immediate family, to satisfy shared necessities or interests, and to collectively relate to the state.

It is clear from this definition that CSOs are not a homogenous entity, but comprise a wide variety of organizations that have varying levels of engagement with the government and a range of institutional capacities. CSOs include non-governmental organizations (NGOs), epistemic

1 Paris declaration on aid effectiveness, 2005 (http://www.oecd.org/document/18/0,3746, en_2649_3236398_35401554_1_1_1_1,00.html#Paris, accessed on 22 January 2014).

2 Lowenson R. *Annotated bibliography of selected research on civil society and health*. World Health Organization (WHO) and Training and Research Support Centre (TARSC), 2003 (http://http://www.tarsc.org/WHOCSI/, accessed 22 January 2014).

communities (such as medical association networks), trade unions, faith-based organizations, and organizations representing disease constituents (such as people living with HIV/AIDS). Within a given community or country, there may be international civil society organizations, national civil society organizations, subnational and community-level movements, and local operations of international civil society organizations.

### *1.1.2 What is advocacy?*

Advocacy, as it is used in this report, is an organized, deliberate, systematic and strategic process intended to bring about a new or revised social or economic policy or programme.

## 1.2 Reproductive, maternal and child health

The topics within reproductive, maternal and child health comprise different interventions and have various constituency groups, although work has been done to define collectively an integrated package of essential interventions, commodities and guidelines.[3] Within the overall package of RMCH, certain factors are more politicized than others – for example, safe abortion is criminalized in some countries. Certain RMCH advocacy initiatives might need to be carried out independently, but finding synergies and mutually beneficial advocacy avenues between elements of RMCH is important. For the purpose of this consultation, RMCH was understood to cover the continuum of care needed to achieve the Millennium Development Goals 4 & 5 (MDG4 and MDG5), which aim to reduce child mortality and improve maternal health, respectively. The consultation affirmed the need for universal health coverage with explicit attention to RMCH.

## 1.3 Framework for political priority for global health initiatives

In order to advocate for any topic, it is important to understand why some global health issues attract political support and subsequent funding, whereas others remain neglected. Burden of disease is only one among many determinants of priority. For example, pneumonia and diarrhoeal diseases cause the largest proportion of child mortality in developing countries, but have traditionally received low levels of funding support. One framework[4] uses evidence from global health case-studies to explain differential attention to certain global health issues, as illustrated in Table 1 below.

3 *Essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health: a global review of the key interventions related to reproductive, maternal, newborn and child health.* The Partnership for Maternal, Newborn and Child Health, 2011 (http://http://www.who.int/pmnch/knowledge/publications/201112_essential_interventions/en/, accessed on 22 January 2014).

4 Shiffman J. and Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *The Lancet*, 2007; 370:1370–1379.

**Table 1. Framework on determinants of political priority for global health initiatives[5]**

| Category | Description | Factors shaping political priority |
|---|---|---|
| Actor power | The strength of individuals/ organizations concerned with the issue | 1. ***Policy community cohesion***: the degree of coalescence among a network of individuals/organizations that are centrally involved with the issue at the global level<br>2. ***Leadership***: the presence of individuals capable of uniting the policy community and inspiring action<br>3. ***Guiding institutions:*** the effectiveness of organizations or coordinating mechanisms with a mandate to lead the initiative<br>4. ***Civil society mobilization***: the extent to which grassroots organizations have mobilized to press international and national political authorities to address the issue |
| Ideas | The ways in which those involved with the issue understand and portray it | 5. ***Internal framework***: the degree to which the policy community agrees on a common and coherent definition of, causes of, and solutions to, the problem<br>6. ***External framework***: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources |
| Political contexts | The environments in which actors operate | 7. ***Policy windows***: opportunities when global or national conditions align favourably for an issue, presenting opportunities for advocates to influence decision-makers (for example, following natural disasters or elections)<br>8. ***Global governance structure***: the degree to which norms and institutions operating in a sector provide a platform for effective collective action |
| Issue characteristics | Features of the problem | 9. ***Severity***: the size of the burden relative to other problems, which contributes to how serious an issue is perceived; credible indicators help to demonstrate severity<br>10. ***Tractability***: the extent to which the problem is believed to be surmountable<br>11. ***Danger***: the degree to which the problem is perceived to pose a threat (particularly to the more wealthy)<br>12. ***Contentiousness***: the degree to which a problem is likely to cause disagreement or division and to which it can either inhibit progress or inspire action to confront opponents<br>13. ***Culpability***: the degree to which those with the condition are perceived to be responsible for having acquired it<br>14. ***Allure***: the attractiveness of the issue, which influences those who want to be champions for the cause |

Each of the factors is neither sufficient on its own nor necessary in order to provide traction on an issue. There are also other factors that could impact on political priority – for example, the value system assigned to any health topic (based on a human rights framework). Health issues will gain priority due to an interplay of different factors, and political systems are dynamic, changing over

5 Adapted from Shiffman and Smith (see footnote 4) and Dr Shiffman presentation at the WHO technical consultation.

time. However, while acknowledging these complexities, this framework can be useful to gather evidence and analyse the historical priority accorded any particular health issue (HIV/AIDS for example, which features many of these factors), and help to inform advocates about successful ways to frame RMCH issues.

## 1.4 Report structure

This report is structured around four key themes: (i) working to influence health sector policy and programmes at national and local levels; (ii) working to influence national policy: parliamentarians and legislative processes; (iii) supporting national and subnational civil society advocacy: programme managers' experience; and (iv) assessing advocacy impact and monitoring performance. It draws upon the presentations and discussions of the May 2012 technical consultation meeting in its review of each theme.

Each section begins with an introduction, followed by a short summary of the experiences presented in the plenary discussions, in turn followed by a section analysing emerging lessons. Each section ends with future directions for action.

# 2. Working to influence health sector policy and programmes at national and local levels

## 2.1 Introduction

Having a strong global framework for action on RMCH is important, and it affects country-level priorities as well as allocation of funds by donors and national authorities. Since governments agreed to the Programme of Action of the International Conference on Population and Development (ICPD) in 1994, the Millennium Development Goals in 2000, and Every Woman Every Child in 2010, organizations worldwide have used those commitments to mount grassroots and global advocacy campaigns. A strong connection needs to be made between international policies and what happens at the national and subnational levels. Information flow has to go both ways: CSOs can provide national-level data and case-studies to support global policy change; and international players can carefully track international commitments of funding and whether they become actual expenditures on the ground.

Increasingly, the locus of decision-making in many countries is shifting from national to district level. The decentralization of policy-making, fiscal authority and service provision means that local-level individuals/organizations are critical gatekeepers for implementing national government policies. These groups are key actors in information-gathering and holding their governments to account to respond to the aspirations of citizens and agreements made on international commitments. There is a need to work with communities, local-level CSOs and local government officials in order to strengthen accountability skills and entitlement awareness of all concerned. The role of various actors at the local level is key to discussing issues of inequity, since so much of the disparities in health services and indicators (around gender, wealth, age, ethnicity and caste) are very visible at the local level. The experiences below provide examples, emerging lessons and some future directions for actions aimed at influencing health sector policy and programming at national and local levels.

## 2.2 Experiences

### *2.2.1 Using budget analysis as part of CSO advocacy*

The International Budget Partnership (IBP) is an international NGO focusing on issues of budget transparency, accountability and citizen participation in budget processes and decision-making. IBP works with partners in the development of a global budget transparency index (Open Budget Index) to measure the extent of budget transparency around the work. IBP also supports nationwide and local-level CSOs through technical assistance to support their budget analysis and advocacy efforts. A key element of their work is to document the impact of CSO engagement with budgets in order to demonstrate how effective CSO monitoring efforts can bring about change. One example is from the late 1990s, when the South African government argued that it could not afford to introduce drug-based prevention and HIV/AIDS treatment regimes because they were too expensive. CSOs, working under the umbrella of the Treatment Action Campaign (TAC), produced an affidavit containing evidence from a costing exercise of Nevirapine, showing that by providing Nevirapine, the government could save US$ 45 000 every six months in treatment costs. The affidavit also included a provincial health budget analysis showing under-

expenditure of US $63 million in 2000. The impact was an 18-fold increase in HIV spending, leading to 80% of women now receiving HIV care through public sector PMTCT programme[6].

Another example of successful CSO budget analysis and advocacy is currently developing in the United Republic of Tanzania, where a local CSO (Sikika) has analysed mid-term expenditure frameworks (MTEF) and health budget allocations to show that an inordinately high proportion of the budget is being spent on workshops, vehicles and allowances. The Prime Minister of Tanzania has ordered government ministries to consult before spending money on workshops and reduce the number of expensive vehicles. Media outreach has raised the profile of this issue. In a follow-up analysis, data indicate a 22% reduction in non-priority spending (2009–2010), and a 13% decrease the following year. Sikika continues to monitor where the additional money is going and how it flows, with a focus on human resources and medicines[7].

### *2.2.2 Advocating for maternal health in India using a rights-based approach.*

In 2006, the White Ribbon Alliance (WRA) in India embarked on a social accountability programme to mobilize citizens. The central aim of the programme was to generate demand for rights, entitlements and better services. Another aim was to leverage intermediaries to support the demands of poor and marginalized women via dialogue and engagement. Such intermediaries include the media, celebrity champions, elected representatives and grassroots CSOs. Various tools were utilized for this, including public hearings, checklists, verbal autopsies, and community scorecards. For example, public hearings involve local-level health officials, elected leaders, mass media, community representatives and local women participating in a dialogue about the local services. Some encouraging results include the establishment of vigilance committees with self-help groups of women and the media, operationalizing the defunct blood bank in a district hospital and making a remote health subcentre functional. The facility checklists involve monitoring of facilities through quick surveys (based on Indian public health standards) and individual interviews. The information collected through the surveys is then collated and shared with policy-makers, community members and the media. The information can be used for advocacy at the local level to formulate specific asks. Verbal death autopsies are conducted by trained teams (consisting of a health professional, a media member, an elected representative, and a WRA member). The teams use the findings to initiate dialogue, assisting communities in avoiding similar deaths in the future and generating public pressure where there are issues at the health provider/facility level.

### *2.2.3 Designing large-scale mobile social communities in southern Africa*

The Praekelt Foundation's work in southern Africa uses mobile phone technology to deliver information, manage dialogue between peers and promote behaviour change. Ultimately, it enables users – many of whom are young people – to become better advocates for their own health care, and become educators for their peers. "Young Africa Live", which was established in

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6 *South Africa: the treatment action campaign fights government inertia with budget advocacy and litigation*. International Budget Partnership ( http://internationalbudget.org/wp-content/uploads/LP-case-study-TAC-summary.pdf, accessed on 22 January 2014).

7 *Sikika Tanzania: Sikika uses budget analysis to advocate for the reduction of unnecessary expenditures*. International Budget Partnership (http://internationalbudget.org/wp-content/uploads/Profile-of-Sikika-Tanzania-2011.pdf, accessed on 22 January 2014).

2009, is an existing sexual health platform, using mobile phone technology in Kenya, South Africa and the United Republic of Tanzania. In South Africa alone, there are currently approximately one million unique users, with an average of almost 95 000 monthly comments sent by its members. The Praekelt Foundation is currently designing "MAMA" (the Mobile Alliance for Maternal Action), a new platform for maternal health based on public–private partnership. By providing more maternal health information and peer-to-peer interaction, MAMA aims to strengthen demand for higher quality services, increase knowledge of reproductive rights, recognize barriers to health-service seeking, and promote healthy decisions such as antenatal care. MAMA is an informative, entertaining mobile web platform where mothers can find useful information and connect with other mothers. Social features such as 'liking', commenting and chat rooms encourage a high level of engagement. User-generated content through chat rooms encourages peer-to-peer interaction.

### *2.2.4 Involvement of civil society organizations in Zambia*

Many CSOs in Zambia have united to form a partnership with the government through the Sector Advisory Group, which meets regularly to provide a platform for discussing all health issues in the country. The CSOs have targeted interactions with parliamentarians, the First Lady, faith-based organizations, the House of Chiefs and the media around health topics. Although CSOs are not always viewed positively by the government, they have been successful in supporting the government in introducing a Safe Motherhood Week in Zambia, creating a separate budget line for RMCH and commodities in the national budget and helping launch the President's national campaign for Accelerated Reduction of Maternal Mortality in Zambia.

## 2.3 Emerging lessons

### *2.3.1 The complex relationship between CSOs and governments*

Creating a culture of social accountability, in which the government acknowledges weaknesses in the health-care system, takes time and resources. Civil society's legitimacy in proactively demanding health system improvements is often questioned. Although there is a tension between CSOs and governments, particularly when the former attempt to hold the latter to account, it is simplistic to say that governments always see NGOs as a threat. Often, civil society has been an ally to governments, for example in assisting in skills development and helping governments understand public expectations. CSOs help to create and sustain a culture of accountability. Even though the relationship between CSOs and the government can be complex, eventually the governments begin to see CSOs as equal counterparts with whom a dialogue can occur about health-care improvements. Indeed, understanding this positive role of CSOs, governments in many industrialized countries today directly fund CSOs, including those engaged in advocacy.

### *2.3.2 Complications related to CSOs being both service providers as well as advocates*

CSOs play a central role as health service providers, often for the most neglected and stigmatized aspects of RMCH (such as abortion or HIV/AIDS prevention and treatment). The capacity of CSOs to advocate effectively for their areas of work is enhanced by their position as experts with

experience, but it is also constrained by the fact that they have to operate as service providers because they need government permissions, approval, or even support to maintain their service-provision role. To be simultaneously a critic and partner of the government is challenging at the best of times.

### *2.3.3 The need for accountability of all parties*

National governments are increasingly relying on domestic revenues to finance health care, and donors are shifting towards budget support and use of national government systems for the implementation of official development assistance (ODA). The channeling of ODA funds through national government systems increases the authority of the government institutions over resource allocation. This can present a challenge for civil society to engage with the government at multiple levels in order to assure accountability. In that context, development partners have the responsibility to align their funding priorities with national health goals and plans, but avoid circumstances in which their funds are used as a substitute for national funds. Another party increasingly involved in supporting development projects, that also needs to be accountable, is the private sector. There are several examples of governments working to expand the involvement of the private sector in funding RMCH through innovative financing, such as a mobile phone tax in Gabon and a special AIDS levy in Zimbabwe.

### *2.3.4 Opportunities and challenges of using budget analysis as a tool*

Budget analysis can be an important way of building an advocacy case. The potential for change using budget analysis and advocacy as a tool to bring about greater accountability is great. There are examples where public spending becomes more aligned to public priorities (e.g. in the United Republic of Tanzania above, and the case of emergency obstetric care in Mexico[8]); other examples include using budget accountability to reduce corruption and leakage (e.g. with the India Dalit budget and Commonwealth Games expenditure[9]). Despite the huge potential of this tool, CSOs still face many challenges in implementing this approach, including: (i) lack of access to reliable budget information because it is either not produced or not disclosed by governments; (ii) the limited number of CSOs that have the capacity and resources to implement this work sustainably; and (iii) lack of a culture of accountability regarding public budgets in many countries around the world. Nevertheless, there is an increasing critical mass of citizens around the world engaging in this work and creating new opportunities despite the challenging environments.

8 International Budget Partnership and International Initiative on Maternal Mortality and Human Rights, *The missing link: advanced budget work as a tool to hold governments accountable for maternal mortality reduction commitments*, May 2009 (http://righttomaternalhealth.org/resource/the-missing-link, accessed on 22 January 2014).

9 *Tracking funds for India's most deprived: the story of the national campaign for Dalit's human rights' – "Campaign 789"*. International Budget Partnership (http://internationalbudget.org/publications/tracking-funds-for-indias-most-deprived-the-story-of-the-national-campaign-for-dalits-human-rights-campaign-789/, accessed on 22 January 2014).

## 2.4 Future directions for working to influence health sector policy and programmes at national and local levels

### *2.4.1 Support a culture of accountability*

The common challenge faced by CSOs in attempting to encourage social accountability occurs in settings where a culture of accepting constructive criticism is absent. When confronted by advocates, those in power may engage in reprisal instead of redressing the problem. Reprisal can, and has, occurred in many forms following efforts to promote accountability. In fragile, repressive and conflict-affected states, fear is ever more present, and citizens may have to deal with non-government entities who are in power (including warlords). It is also challenging to implement social accountability in areas where citizens are unaware of their rights and entitlements, or where such rights and entitlements have not been established in law. In many countries, women have historically had very limited access to decision-making; this further weakens their position to hold the government to account for RMCH services. In all settings there needs to be a safe space – free from the threat of reprisals – where the disenfranchised can talk to the powerful. Intermediaries, such as civil society and the media, can help to provide citizens the confidence and greater awareness of their rights.

### *2.4.2 Strengthen the capacity of local CSOs to use accountability tools*

The accountability tools discussed above include budget analysis and advocacy, facility check-lists, verbal autopsies to analyse maternal deaths, and public hearings. The tools can be replicated and adapted to different scenarios and contexts, but collecting such data and analysing the information properly requires sustained capacity building and training. It also needs ongoing support (including financial support) in order to ensure sustainability. In addition, indications on how to use the information are needed – for example, by feeding it back to the government, providing it to local parliamentarians, getting it articulated by champions such as local celebrities, or passing it to local and national media.

### *2.4.3 Promote access to information to support greater budget accountability*

According to the Open Budget Survey[10], only 20 out of 94 countries (21%) provide enough budget information to enable independent budget analysis; another 33 countries provide some information, while 41 countries (almost half) provide only minimal information to perform a budget analysis. In order to be able to conduct a budget analysis, greater pressure must be exerted on governments to produce and publish budget information, starting with making public the key budget documents that they already produce. The Open Budget Initiative (OBI) recommends that government produce and publish a "citizen's budget" (a version of the budget that can be widely understood by common people). The governments should also producing and make public all audit reports. In addition, countries should move towards legislation that ensures access to information such as Freedom of Information Bills, which exists in only some countries (e.g. Chile and Mexico).

10 This is a comprehensive analysis that evaluates whether governments give the public access to budget information and opportunities in order to participate in the budget process at the national level. The total of 94 countries comes from the Open Budget Survey 2010 (http://internationalbudget.org/what-we-do/open-budget-survey/, accessed on 22 January 2014).

### *2.4.4 Harness the strength of mobile technology responsibly*

The example of using mobile phone platforms shows the potential power of mobile technology, especially in terms of reaching young people and populations on a very large scale. Another way of using mobile technology innovatively is to establish community accountability tools such as checklists for facilities and stock-outs of medicines that can then be fed back to the national authorities or the media. While there are advantages to such approaches, there are also risks in such areas as ensuring privacy, guarding against consumer exploitation on the part of private companies, and ensuring that information conveyed in this manner is accurate. Safeguards related to these issues must be built into the design of such systems.

### *2.4.5 Address inequity at the local level*

There is massive inequity with regard to RMCH services and indicators. The greatest inequities in most countries are between the poorest and wealthiest quintiles, and between those living in rural and urban areas. Inequity related to youth, ethnicity, disability, HIV status and marital status are also important. A key element of national advocacy towards the health sector should be exploring or proposing ways to overcome disparities at the local level. Examples of topics relevant to local-level advocacy include: tracking budget allocations and expenditures at district and subdistrict levels and advocating that government facilities include youth-friendly service provision that also addresses the needs of unmarried women and men.

# 3. Working to influence national policy: parliamentarians and legislative processes

## 3.1 Introduction

Advancing progressive public policy in support of the RMCH agenda requires the involvement of those in power. Depending on how democratic a setting is, parliamentarians have varying levels of authority to enact policy affecting RMCH goals. Members of Parliament (MPs) can also influence the allocation of funding through their role in the budgetary process. Parliamentarians are the principle vehicles for translating political will into policy. Hence, they are able to hold the government to account for both national and international commitments, create a conducive political environment, and generate media visibility around an issue. This section details some experiences of working with parliamentarians, lessons learnt and recommendations for moving forward.

## 3.2 Experiences

### *3.2.1 The European Parliamentary Forum on Population and Development (EPF) study tours*

Since 2000, EPF has been organizing an average of 3–4 educational study tours per year. The tours normally run for a week with a delegation of European parliamentarians (either multi-country or national), journalists and parliamentary staff. The study tours enable the team to see firsthand examples in the host country of sexual and reproductive health and rights (SRHR) issues, and thus to deepen the team's knowledge and concerns related to the topic. This experience builds expertise and commitment, and strengthens their confidence to advocate for SRHR. The study tour also builds a relationship of trust between MPs and EPF's capacity building work, and itself forms part of a wider continuum of regional advocacy activities. EPF continues to foster MP activism through parliamentary actions, speaking engagements, media visibility, and, where appropriate, promotes individual MPs as leaders on the topic. In a tribute to North–South partnership, the host organizations gain external validation for their work, and have the opportunity to advocate for their own objectives through joint media events or directly through the access to European MPs.

### *3.2.2 African Regional Office of Partners in Population and Development*

African Regional Office of Partners in Population and Development (PPD), Africa Regional Office, works through strategic partnerships, collaborations and networking with a view to improving the policy environment for family planning and reproductive health and increasing funding, investment, and visibility for the area. In addition to the MDGs and ICPD's Programme of Action, there are Africa-specific policy frameworks for SRHR, including the Maputo Plan of Action and the Abuja Declaration. Governments need to be held accountable for implementing these commitments. One tool used by PPD to help increase visibility of these frameworks and encourage implementation is the Abuja scorecard, which helps track African Union Member States' Commitment of allocating 15% the government budget for the health sector. Some of the achievements in Uganda that PPD has been a part of include:  a policy change in the Ministry of

Health that allows community health workers to provide depot-medroxyprogesterone acetate (DMPA); a 3-fold increase in the 2010 budget for family planning commodities; and follow-through action to ensure timely release of funds so that government allocation was actually translated into expenditure.

### *3.2.3 The Reproductive Health Bill in the Philippines*

In mid-2012, a Reproductive Health Bill was pending in both houses of the Philippine Congress. The Philippine legislature's Committee on Population and Development (CPD) is a CSO that works closely with pro-reproductive health legislators with a view to helping the bill's sponsors to coordinate tactics in managing the passage of the bill. Partnership between the CSOs and legislators has included providing CSO staff to legislators and providing updated legislative headcounts. The Reproductive Health Bill has faced strong opposition from the Roman Catholic Church and faith-based CSOs as well as delaying tactics by opposing legislators.

## 3.3 Emerging lessons

### *3.3.1 Understanding the profile of parliamentarians*

Parliamentarians all over the world have to deal with myriad of issues. In general, maternal and child health are relatively easy issues for parliamentarians to support. However, SRHR also includes areas that can be politically sensitive, which means that some parliamentarians will find it difficult to embrace and support all topics within SRHR. On the other hand, in principle, parliamentarians are committed to improving the health and welfare of the people they represent and need actionable solutions with political mileage that fit within the notion of public welfare. Parliamentarians are almost invariably politically ambitious and thus need public experiences to cultivate their own visibility. Also, parliamentarians are usually generalists who are very short on time. Therefore, clearly articulated demands or positions, with well-packaged evidence are essential for successful advocacy aimed at them.

### *3.3.2 Identifying parliamentary constituents to work with*

In order to maximize effectiveness, it is important to identify initially parliamentarians who are favourable towards, or hold neutral views with respect to, RMCH. These groups of MPs are likely to be receptive to the advocacy messages about RMCH. Those whose views clash with advocacy messages are probably not worth investing in, although understanding the different opinions held by non-responsive parliamentarians can help to refine the advocacy messages. Conducting study tours is relatively expensive, so it is important to identify appropriate participants. Many parliamentarians have a limited legislative tenure, but their period of influence often extends beyond their elected term, given that they work with networks of political elites. Working with parliamentarians also involves working closely with the staff of individual parliamentarians. Such people can provide continuity and institutional memory, and can be more constant, more accessible and yet highly influential in terms of identifying opportunities, developing tactics and understanding the opposition. Working with locally elected representatives at district level is also important, as is engaging with the media.

### 3.3.3 Building mechanisms to support legislative change

Advocacy yields results when it is consistent and sustained. In order to achieve sustainability in advocacy, organizations such as national public health institutions need to be strengthened such that they have greater capacity and skills to collect appropriate data and develop an evidence base for consistent advocacy. The creation of superstructures to parliament – "guiding organizations", to use Shiffman's phrase[11] – is another means of supporting sustainability in advocacy. Examples of guiding organizations include the National Women's Forum of Parliamentarians in Uganda, the All-Party Parliamentarian's Groups (APPG) on Population and Development in most European countries, and regional forums of parliamentarians.

### 3.3.4 Understanding and engaging with the opposition

If advocates have a good understanding of opponents and their power base, they will be better able to respond to both challenges and opportunities that arise. The diversity and strength of the opposition is too often underestimated. Advocates can also be encouraged to think more broadly and inclusively to expand their network of allies, consider social and political opportunities that may influence the policy-making process, and identify alternative strategies and tactics for reaching the end goal. Engagement with certain sectors of the opposition can also be a winning tactic.

### 3.3.5 Judging the course of action or inaction carefully

Sometimes, raising an issue within policy and public media circles is harmful rather than beneficial. For example, providing oral contraceptive pills in different doses as emergency contraception through health care services may not need a change in current laws, but raising it as an advocacy issue could lead to opposition and policy restrictions. In other cases, inaction over a topic seemingly unrelated to RMCH – e.g. decentralization or cuts in government staff salaries – can harm the very topics advocates are trying to address.

## 3.4 Future directions for working to influence national policy through parliamentarians and legislative change

### 3.4.1 Clarity in making advocacy requests

Strategic and clear demands with concise, sound and well-packaged evidence-base have the best chance of success. Technical briefs that bring both statistics and case-studies as evidence are useful. Providing feedback to policy-makers on how they articulate their position, and how to refine the messages, is constructive.

11 Shiffman J. and Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *The Lancet*, 2007; 370:1370–1379.

### *3.4.2 Importance of remaining flexible*

Because the political landscape can change quickly and dramatically, advocacy CSOs have to be adaptive, pragmatic and swift in their responses. New legislators may need to be briefed quickly on the latest information and evidence regarding the advocacy message.

### *3.4.3 Working with a variety of constituents relevant for legislative change*

Officials at the local level, parliamentarians at the national level, and elected or appointed representatives at the regional level are all relevant for legislative change. It is equally important to engage with the political staff of parliamentarians as they can have a key role in influencing the parliamentarians and other elected officials.

### *3.4.4 Working closely with the media*

Most people obtain most of their information from the mass media. The public narrative in the mass media develops into a set of expectations that influences the issues people think their government should address. Working with supportive media, especially around elections, can influence party platforms and candidates' positions.

# 4. Supporting national and subnational civil society advocacy: programme managers' experience

## 4.1 Introduction

There are a variety of instruments through which donor countries provide financial support to developing countries. Development partners can provide funding through: (i) bilateral support to governments, including project assistance, general budget support and sector-wide approaches (SWAps); (ii) multilateral support, including contributions to the United Nations organizations, the World Bank, the European Union and other multilateral international bodies such as Global Alliance for Vaccines and Immunizations (GAVI) and Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); (iii) direct transfer of funds to national and international NGOs; and (iv) direct transfer of funds to research/academic institutions.

Development partners vary with regard to how they account for and report on foreign aid assistance, as well as to the degree to which they require accountability from recipients on the use of the funding. The advent of new donors onto the scene (for example, from the BRICS countries – Brazil, Russia, India, China and South Africa) further complicates the issue of understanding how much aid flows where and to whom. There are attempts being made to increase accountability, especially for RMCH. For example, the Commission on Information and Accountability for Women's and Children's Health has been established under WHO's chairmanship as recommended by the Global Strategy for Women's and Children's Health. The Commission has presented 10 recommendations to improve accountability in countries and globally. The focus is on the 75 countries which together account for more than 95% of all maternal and child deaths in the world.

A significant amount of European donor funding to national governments is based on global commitments to accountability and country ownership, as articulated in Paris, Accra and Busan[12]. Optimizing civil society engagement in government and donor decision-making processes is more recently being recognized as necessary to assure democratic ownership of development processes and to increase accountability and sustainability of development results. At the Busan High-Level Forum on Aid Effectiveness (November–December 2011), there was greater recognition of the role of civil society in the development process – viz. paragraph 22: "Civil society organisations play a vital role in enabling people to claim their rights, in promoting rights-based approaches, in shaping development policies and partnerships, and in overseeing their implementation. They also provide services in areas that are complementary to those provided by states".[13]

CSOs in low- and middle-income countries need to better understand international decision-making with regard to aid allocations and its impact on their ability to influence policies and funding for RMCH. Supporting the strengthening of CSOs includes working with them on a

12 Paris Declaration on Aid Effectiveness (2 March 2005); Accra Agenda for Action, 3rd High-Level Forum on Aid Effectiveness (4 September 2008) (http://www.oecd.org/document/18/0,3746, en_2649_3236398_35401554_1_1_1_1,00.html#Paris, accessed on 22 January 2014).

13 *Busan Partnership for Effective Development Co-operation. Fourth High Level Forum on Aid Effectiveness, Bbusan, Republic of Korea, 29 November-1 December 2011.* (http://www.oecd.org/dac/effectiveness/fourthhighlevelforumonaideffectiveness.htm, accessed on 22 January 2014).

variety of capacity-building needs, as well as increasing funding support available to grassroots CSOs. The experiences below show different means of doing so.

## 4.2 Experiences

### *4.2.1 The Flexi-fund for small grants to CSOs*

The International Planned Parenthood Federation (IPPF) has administered four rounds of small grants (< US$ 10 000) to support grassroots CSOs to conduct advocacy activities. The four rounds of grants have been based on the following themes: young people; sexual rights; MDG5b; and implementing the Berlin Call to Action/Strategic Options for NGOs. The Flexi-fund has demonstrated the large demand for training and capacity building among CSOs – 1754 applications have been submitted and 61 grants made. The demand from local/district level has been the highest (compared with from regional and national-level CSOs), and the largest proportion of applications came from Africa and South Asia.

### *4.2.1 Regional innovations in East Africa and South Asia*

Deutsche Stiftung Weltbevoelkerung (DSW), a German advocacy organization, has established Advocacy Learning Hubs supporting capacity strengthening in East and West Africa. DSW's advocacy capacity building has focussed on strengthening the capacity of local NGOs to apply for European Union funds, and to advocate more effectively toward in-country decision-makers (national and district governments, donor delegations and coordination mechanisms) to address the challenges presented by decentralized decision-making. DSW's techniques include: in-person and online training and technical assistance; implementing advocacy actions as part of the learning process; continuous feedback on knowledge management to improve the responsiveness of the capacity-building approach; civic education; district and national-level budget analysis; mutual learning and coordinated intervention; training leaders to train others; and management for effectiveness. DSW Advocacy Learning Hubs combine in-person training workshops with online training and supporting national networks for joint implementation of action plans over extended periods of time. Training methods include extended learning over many months, with mentoring and technical assistance on advocacy actions. Much of the capacity strengthening is conducted through South-to-South sharing and learning, with regional experts training trainers.

The Women's Health and Rights Advocacy Partnership in South Asia (WHRAP-SA) consists of five national NGOs from Bangladesh, India, Nepal and Pakistan, with ARROW (Asia-Pacific Resource and Research Centre for Women) as the regional partner, and the Danish Family Planning Association as the international partner. Their approach is to work simultaneously at local, national, regional and global levels to advocate for marginalized women's sexual and reproductive health and increased government accountability. Healthy peer pressure between neighbouring countries supports advocacy efforts nationally. The connections between all levels in terms of information flow and strategy development helps to strengthen the process and achieve better outcomes, so that the collective whole is greater than the sum of its parts.

### 4.2.2 *Advocacy for long-acting and permanent methods of contraception (LAPM) in Indonesia*

Indonesia's contraceptive prevalence rate has been stalled for several years at 60%. The majority of methods used are injectables and oral pills; the use of LAPM has actually declined by 50%. The Advance Family Planning (AFP) project in Indonesia focused its advocacy on one clear aim: increasing resources for, and reducing the regulatory barriers to, the use of LAPM nationally and in the districts where AFP is active. AFP established a range of capacity-building measures for the local CSOs it works with on using specific techniques for advocacy: Net-map (to map actors, influences, and links between actors); Strategies Smart Charts™ (for advocacy planning); reproductive health costing (to project costs); and proposal writing (to support the sustainability of small CSOs). Directing advocacy efforts at both national and district levels has been mutually supportive. For example, the central government has restored LAPM to a high-priority position and the national maternal health insurance scheme now provides LAPM post partum. Within the two AFP districts, in 2012, there has been a budget increases of 31% and 51%, respectively. In one of the districts, the actual use of LAPM has increased by 56%. The involvement of the private sector as an advocacy target has also yielded positive outcomes, with 25 companies now committed to providing LAPM to their workforce as part of an overall health package of care. Despite the challenges of obtaining data at the district level and dealing with a large number of decision-makers locally, the approach has proven successful and there are plans to scale it up in 500 additional districts.

## 4.3 Emerging lessons

### 4.3.1 *Local contextualization is key*

The RMCH framework will vary across contexts and organizations. Thus, the agenda for advocacy has to be set by individual CSOs according to local needs and the organization's focus and comparative advantage. Consequently, capacity building needs will vary as well. Nonetheless, the WHO technical consultation identified key cross-cutting areas for training which would benefit most civil society advocacy organizations.

### 4.3.2 *Capacity-building for what?*

Capacity-building topics for CSOs include:

- Articulating clear advocacy asks through strategic direction and planning
- Using budget analysis and tracking
- Using other accountability tools (such as verbal autopsies, Spitfire, facility assessments, scorecards)
- Establishing wider networks and coalitions
- Knowledge management/communication techniques
- Institutional and governance capacity of the CSO
- Working within a policy environment
- Working with the media
- Reporting on progress with their advocacy work (monitoring and evaluation).

### 4.3.3 *Need for release of more funding through flexible and simple mechanisms*

One of the key characteristics of the IPPF Flexi-fund is that the application form is very simple, recognizing that small CSOs – particularly at district level – do not have the resources to dedicate staff/time to proposal writing. Reporting requirements are also simple, although experience has shown that CSOs tend to over-report, with strong narratives about their activities. Funds are provided quickly, acknowledging that advocacy usually occurs in a rapidly changing environment.

### 4.3.4 *Capacity building takes time*

The experiences described above all support the fact that capacity building is not a one-off issue of a single training, but involves the establishment of an ongoing relationship and long-term engagement. Capacity building for advocacy is much harder to do than capacity building for service delivery and is more challenging to measure. This is particularly the case for countries without strong democratic traditions. Financial support for CSOs needs to be designed with a long time-frame in mind.

## 4.4 Future directions for supporting national and subnational civil society advocacy from programme managers' experience

### 4.4.1 *Creating capacity-building programmes that go beyond training*

High-quality training, using strong trainers and locally-adapted training manuals that adhere to best practices, is one important component of capacity building. Providing ongoing support through peer support, technical exchange, leadership investment (including by mentoring while conducting advocacy) is part of the wider continuum of capacity building needed for an organization to succeed.

### 4.4.2 *Establishing defined points of entry at both national and global processes for civil society*

The formal input of civil society into national and global-level policy-making remains limited. CSOs are often not given a place at the table (for example, when governments are negotiating SWAps with donors). The global framework to formalize civil society participation has now been established by the Busan meeting. It remains for governments and donors to permit it to be implemented.

### 4.4.3 *Tailoring CSO-support programme to the local context*

Allow local CSOs to define the topics on which they wish to advocate under the wide RMCH umbrella. Provide the opportunity for them to identify their capacity-building needs. Support them in focusing on advocacy per se as opposed to information and education campaigns.

# 5. Assessing advocacy impact and monitoring performance

## 5.1 Introduction

Policy change often results from a complex interplay of multiple forces and cannot be easily traced back to any single advocacy effort. Policy change is not a linear process: advocates can gather evidence, package it effectively, convey it persuasively to decision-makers, maintain sufficient constituency pressure, and thus influence decision-making processes that bring about public policy change. But often, the work of advocates involves a more complicated series of feedback loops, content adjustments and shifts in nuance or messaging. Long periods can occur with very little motion in the policy arena, punctuated with bursts of rapid action due to changing circumstances in the macro political/economic environment. Similarly after a policy has been adopted, its implementation may be partial, complete or stalled as administrators grapple with other priorities.

Policy change processes rarely, if ever, go as predicted. A key policy-maker champion may lose his/her position or get embroiled in a scandal; or a change in the economic climate may mean that a funding request suddenly becomes unrealistic. Conversely, a news report – for example, about the prevalence of unintended pregnancies – can propel a legislative proposal into the headlines and make its passage possible. An unexpected input from a significant development partner could cause a recipient government to change its policy in response to potential funding. CSO advocates – and their funders – need to be willing and able to respond quickly.

These complex and interactive set of activities which make up advocacy do not lend themselves well to traditional evaluation approaches involving linear logical frameworks or methods of analyses adopted from quantitative science (e.g. randomized control trials and quasi-experimentation). Tools traditionally used in the evaluation of health activities can actually hinder advocacy evaluation and limit the effectiveness of the advocacy efforts themselves.[14]

Development partners are increasingly drawing upon results-based management principles, in part as a response to the need for improved accountability and shifts away from input-based aid. Currently, the monitoring and evaluation of civil society advocacy is caught between the need to respond to the imperatives of results-based management paradigms and the unpredictable nature of interventions aimed at influencing complex political processes. Experiences below describe contemporary approaches to evaluation advocacy through different conceptual frameworks.

## 5.2 Experiences

### *5.2.1 Using "realist evaluation"*

The Advancing Healthy Advocacy for Reproductive Health (AHEAD) project (funded by WHO and implemented by DSW) administered small-scale grants in Bangladesh, the Philippines and Uganda as part of a larger project that aimed to strengthen CSO capacity to participate in budget allocation processes. The objectives of the project were clear: (i) to increase CSO capacity to advocate for increased sexual and reproductive health (SRH) budget allocations; (ii) to increase

14 Teles S. & Schmitt M. The elusive craft of evaluating advocacy. *Stanford Social Innovation Review*, 2011; May: 39–43 (http://www.hewlett.org/uploads/documents/Elusive_Craft.pdf, accessed on 22 January 2014).

CSO participation in national planning and budget processes; and (iii) to develop linkages with champions and alliances to support SRH advocacy. Following the implementation of the action plans by the CSOs, Health & Life Sciences Partnership (HLSP) conducted independent evaluations of each country-based project, using a "realist evaluation"[15] approach.

A realist evaluation approach assumes that social programmes are complex and that the dynamic interaction between context and mechanisms is pivotal in determining outcomes. A key question for realist evaluations is 'what works for whom in what contexts?' Understanding context requires a review of: dynamic stakeholder interactions; the organizational, institutional and policy environment; and the wider social, economic and political context. Understanding mechanisms requires tracking interventions and processes in relation to this context. Realist evaluations are also based on the principle that social programmes are "theories incarnate" – i.e. they are informed by hypotheses (often implicit) about the nature of social change. Realist evaluations must make these hypotheses explicit and assess their validity. An important objective of realist evaluations is, therefore, to strengthen social theory to improve future programme design. The realist evaluation of the AHEAD project applied all of the above concepts using mixed method approaches. Findings were synthesized within a meta-analysis to identify common factors in success, challenges and lessons in order to contribute to theories of effective budget advocacy.

### *5.2.2 Measuring "champion-ness"*

This type of evaluation is based on developing verifiable measures that help to track the activities of a champion over time. The aim is to help advocates determine more precisely which champions are moving towards greater support for their cause and how best to encourage even more "champion-ness." The Aspen Institute monitored members of the US Congress following an overseas learning tour on RMCH; the assessment captured actions that congressmen/women did to champion the RMCH cause. They developed a hierarchy of points that one could assign to actions – for example, writing a bill that increases funding for antenatal care would gain the highest level of points; making a favourable comment about maternal health at a reception would receive fewer points. Although it is difficult to attribute the actions of a champion directly to an overseas learning tour, it is plausible that an overseas learning tour can contribute to a wider change in behaviour and practices by the champion. Using the results from the tool, donors could see the value of their commitment to overseas learning tours; they were also increasingly able to provide support to champions regarding their advocacy.

This "champion-ness" tool has also been adapted and is being applied to the Global Leaders' Council for Reproductive Health (a project of the Aspen Institute's Global Health and Development programme). This tool scores aspects such as whether the leader demonstrates interest in RMCH issues, promotes awareness, advocates for policies and so on. This tool uses Internet search engines and follows social media to track actions by the leader. The ease of accessing information online in many contexts, particularly through the social media, supports the adaptation of such a tool to other advocacy projects.

15 The term realist evaluation is drawn from: Pawson R. & Tilley N. *Realistic evaluation*. London, Sage Publications, 1997.

### 5.2.3 *Using a theory of change framework to assess social justice advocacy*

Using the case-study of reproductive rights policies in South Africa, Klugman[16] offers a theory of change framework for social justice advocacy. The framework also identifies seven broad outcome categories against which activists, donors and evaluators can evaluate progress or lack thereof:

1. changes in organizational capacity
2. changes in the breadth and capacity of the base of support for an issue
3. changes in the breadth and strength of alliances
4. changes in the use of data and analysis
5. changes in the degree of coherence around a problem definition and potential policy options
6. changes in the advocates' access to and influence in policy spaces
7. changes in visibility of the issue from the perspective of the advocates.

Impacts of advocacy would be assessed in relation to changes in dominant public norms and population-level changes. Klugman depicts these categories in a flowchart to illustrate the dynamic interaction between these factors; shifts in context may open or close windows of opportunity for advocates to promote their agendas. Having these defined outcome categories can help evaluators establish a baseline and look at progress over time in some or all of the above seven areas.

## 5.3 Emerging lessons

### 5.3.1 *Understanding context is crucial to any advocacy evaluation*

Advocacy is a political process because it involves working with policy-makers and implementers to convince them to do something that they are not doing now. Politics is often non-linear, strategic and iterative; it does not lend itself to quantitative research methods or designs used to determine causality of programmatic or clinical effects. Policies depend on the norms and values of the public as well as decisions made and implemented in the political sphere, the courts and within the administration. Policy change is highly dependent on all aspects of this context, and advocates have to react quickly to situations and deal with outcomes that were not anticipated at the outset. Measuring advocacy has to align with this practice. There is an argument to be made for seeing advocacy evaluation as a craft rather than as a science.

### 5.3.2 *Not all advocacy is visible, especially within a specific time period*

Advocacy organizations use different strategies to gain access to, and respect from, policy-makers. This includes drafting questions for MPs, even penning the responses, supporting government officials with publications or guidelines, and so on. These are normally invisible means of support and the influence that an advocate wields, which if made public, would diminish the advocate's future effectiveness. Yet, evaluation needs to see visible proof to judge a

16 Klugman B. Effective social justice advocacy: a theory of change framework for assessing progress, *Reproductive Health Matters*, 2011; 19:146–162.

project. In addition, stasis and inaction are also the norm in politics. Snapshots of the project at a specific time – during an evaluation period, for example – may not reveal a full picture.

### *5.3.3 Evaluation of the advocacy process is as important as the policy change*

Many of the critical success factors of an advocacy project lie in the process of how the CSO's or coalition's capacity developed and grew during the project. For example, the judgement can be on the organization's private reputation for influence, the organizational quality of personnel, management and strategic awareness. Thus, evaluating the process of advocacy – using Klugman's seven outcomes, for example – would include assessment of the strengths and growth of the CSO or coalition in question and a contextual analysis, among other things. These outcomes are as important as evaluating the policy change itself.

## 5.4 Future directions for assessing impact and monitoring performance

### *5.4.1 Using both linear and non-linear models to evaluate and monitor advocacy*

Depending on the type of policy change that is being addressed, evaluation of advocacy efforts can selectively use either linear approaches, which include milestones and intermediate outcomes (often built around logical frameworks), or more non-linear frameworks based on more nuanced social theory which takes into account the process of advocacy and the context. The same holds true for monitoring advocacy projects: milestones and benchmarks assume linearity, whereas a compelling narrative in a monitoring report values the qualitative assessment of the political and social context within which the project is operating. When evaluating the complex process of advocacy with multiple role-players, it is important to be clear that advocacy can contribute to policy change, but policy change may not always be directly attributable to a single role-player (or group of role-players) or an advocacy effort.

### *5.4.2 Establishing an advocacy plan to define the advocacy process clearly*

Advocacy is normally a non-linear process that takes place in a dynamic context. However, it is still important to undertake activities with a clear ask and realistic aims in mind. The Advocacy Progress Planner, an online tool for advocacy planning and evaluation[17], presents a methodology to develop an advocacy plan and judge it. Creating the advocacy plan – with articulated advocacy goals and impact, audience, context, activities, inputs and benchmarks – helps to define the process.

### *5.4.3 Maintaining a long-term perspective*

Development partners and politicians value short-term results, but advocates often need a long-term perspective. Changing attitudes, maintaining momentum, altering policy and then defending the change may take years. Changes in policy also happen in increments, with achievements or backward steps forming platforms for future actions. Establishing realistic

17 *The Advocacy Progress Planner: an online tool for advocacy planning and evaluation*. Available at: http://planning.continuousprogress.org (accessed on 22 January 2014).

and achievable intermediate measures of success helps advocates see process changes and intermediate contributions to policy, such as outcomes within the seven outcome categories described above. By developing a baseline describing key dimensions of each outcome category early in the advocacy process, progress (or lack thereof) can be documented and used as a basis for reflecting on the effectiveness or otherwise of advocacy strategies.

### *5.4.4 Considering the evaluator*

Whether to use the insider's intricate knowledge of the programme to conduct an evaluation, versus using an independent evaluator with new perspectives and objectivity, is a choice that will have a bearing on the evaluation. Both internal and external evaluators are useful, often for different purposes. Ultimately, what is needed is an evaluator who works in a supportive, inclusive and independent manner to evaluate the project. The aim is to establish an evaluation that is a mutually beneficial learning process that is forward-looking and constructive. A few suggestions that would aid this process would be: to provide the opportunity to the organization being evaluated to be part of the evaluation design and have a say in the selection of the evaluator; to ensure that sufficient time and resources are available to conduct the evaluation properly; and to include a component of capacity building for advocates to be exposed to evaluation best practices.

# 6. Conclusions

Several cross-cutting themes emerged from the above perspectives on CSO advocacy in developing countries. A notable conclusion was that **RMCH involves a set of complex programmes and services, with multiple relevant policy issues within the health and other sectors, but there is a degree of coalescence: hence, localization is key.**

There are several key global partnerships and alliances around the issues of RMCH. In general, there is agreement between partners that to achieve Millennium Development Goals 4 and 5 there is a need to provide a continuum of care within the context of strengthened health systems. But the topics within RMCH are separable from one another and can also compete for resources between themselves. Historically, certain RMCH components have been more favourably viewed by policy-makers than others. Ultimately, it is the local context that is important. CSOs must decide which issues are most appropriate for them to focus on.

## 6.1 Consideration of equity issues

RMCH has to be placed within a broader development context, where structural conditions continue to affect outcomes. Inequity between and within countries remains and is in fact increasing for some RMCH-related behaviours (such as use of modern contraceptive methods by poor women or young people). Any advocacy, especially at the local level, needs to address these inequities. Advocating for the inclusion of the poor and marginalized groups in setting advocacy objectives so that their voices are heard is a key strength of CSOs.

## 6.2 Building a culture of accountability for all

Building a culture in which citizens feel entitled and enabled to demand their rights, intermediaries are respected for their role as guardians of rights, and governments assume and maintain their responsibilities as duty-bearers is the ideal. Owing to the dual service provision and advocacy role that many CSOs play, it is important to consider the difficult situations this may place them in. Although they may have to align themselves to the system, they must also be given the critical space needed to play an independent watchdog role. Transparency is not only for governments to adhere to, but for all development partners, including donor agencies, CSOs, faith-based organizations and the private sector. Organizations and constituents need to be encouraged and supported in being more clear about their contribution to the RMCH sector. Promoting an environment which allows more open disclosure of information on budgets is necessary for performing budget analyses.

## 6.3 Considering all levels within a country, due to increasing decentralization

Worldwide, the decision-making nexus has shifted from capital cities to provincial and district levels, which has vastly complicated the advocacy process. There are now multiple centres of power and decision-making and individual health indicators are often quite variable within a country. The advocacy process – including how to build capacity of organizations at each level, how to link the local with the provincial level, and the construction of several advocacy agendas rather than one central one – is now more challenging.

## 6.4 Advocacy requires clearly articulated demands, with a strategic focus and compelling evidence

Good advocacy needs a strategic focus on a key demand. It is useful to devise an advocacy plan which identifies goals for policy change, clear political and stakeholder mapping, identified points of entry, etc. Establishing a process early on in an advocacy initiative helps to present it more effectively to the authorities. The process for succeeding with the request can then be more responsive and reactive, adapting to the context.

The evidence base to support advocacy can be built around statistics and data sources that are available from a number of sources and disciplines. It is critical to present the evidence in ways that make the evidence easy to interpret and show its immediate relevance to the advocacy message. Clear packaging of information in short and easily understood formats is important for reaching out to time-strapped policy-makers. Presenting case-studies with compelling narratives, using well-articulated statistics, and establishing first-hand experience through study tours, all help nurture champions and advocates for RMCH. Advocates must be highly conversant with the data being used and must possess skills needed to answer questions or provide additional information very quickly, if needed.

## 6.5 Use social accountability tools

Budget analysis has proved to be a powerful and interesting methodology for increasing government accountability in some cases, when budget-related information is available. Rights-based approaches involving marginalized women conducting facility assessments, verbal autopsies and legal recourse have also produced a positive results. Using mobile phone technology to access populations on a large scale can also support the building of a process of social accountability. Forming regional alliances and learning hubs add value through collective action. All The above tools require careful management and continuous follow through: for example, budget analysis requires the tracking of use of resources, especially at the district level, and use of mobile platforms for information exchange requires careful monitoring.

## 6.6 Capacity building is a continuous learning process which should be localized

Capacity building for advocacy does not simply involve a one-off training. It needs to be an ongoing process of learning together and adapting to the local context. Working through regional hubs and learning hubs, as well as through South-to-South learning and collaboration, have proved to be effective. CSOs can be supported to learn more about these tools. They can also be supported with respect to more institutional management issues, including knowledge management. Ultimately, capacity-building programmes should be localized and tailored specifically to the needs of the organization in question.

## 6.7 Measurement of advocacy impact is challenging, but innovative methods are being developed

Approaches to measuring 'champion-ness', realist evaluations to conduct intermediate assessments of change, and use of models based on theories of change to track longer-term evolutions of RMCH policy and outcomes show promise. Ultimately, there are many challenges in using quantitative results related to the impact of advocacy over a short time frame. Longer-term

assessments allow for capturing non-linear effects of what is essentially an adaptive complex political process.

## 6.8 Forming partnerships between CSOs as a movement

Coalescing behind a coherent goal is necessary, and there are plenty of examples of successful national alliances and regional partnerships. But difficulties with mobilization of different constituents need to be recognized. Alliances need strong and sustained leadership. There is a need to change cultures of distrust and to recognize that not all RMCH issues will be supported by all groups. These processes may also need long-term flexible funding which enables advocates to adapt to the changing opportunities.

## 6.9 Understanding the opposition

Like those in favour of RMCH, the "opposition" is also a heterogonous entity, and reaching out to more moderate individuals or groups can help further the cause of RMCH. Understanding the opposition's strategy is also important for devising strategies and arguments to counter the opposition.

## 6.10 Promoting greater accessibility of funds for small CSOs

The transaction costs of administering large numbers of small grants are substantial and contribute to trends of awarding larger umbrella grants with relatively short time periods. Additionally, grants are often aligned with results-based management principles for monitoring and evaluation. Smaller, local grassroots organizations are challenged to apply for these types of grant.

Experience has shown that CSOs at the district-level can be very influential in conducting local-level advocacy, especially in the current increasingly decentralized environment. Often, district-level CSOs are the ones that need the most financial and capacity-building support, but ironically they have least access to such support. Intermediaries can be key in promoting increasing access to funds locally, and experience has shown that several international organizations, regional bodies, and partnerships of national organizations have the capacity and networks to administer such grants.

## 6.11 Looking forward from a historical perspective

The decades of the 1970s and 1980s saw the flourishing (in both the North and the South) of grassroots movements related to reproductive health and rights. This was both due to their national evolution and coalescing as partners, and also to the long-term support provided by several progressive foundations and organizations. The 1994 ICPD witnessed the result of this transformation of the reproductive health and rights movement, with civil society advocating for reproductive health entering the international policy-making arena. Looking at successful examples of how CSOs advocating for RMCH have worked in the past, and learning from their experiences, will help us move forward. Advocacy is an ongoing process of maintenance rather than an end point. Advocates need to continue to put forward a resonating set of ideas in order to inspire and sustain action by all stakeholders to achieve improved RMCH outcomes for all.

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