

SUSTAINING, LEARNING AND SCALING



HEALTH
SYSTEMS
ADVOCACY
PARTNERSHIP

What we have learnt

Results from the Health Systems Advocacy Partnership's learning research

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On the cover:

Shackra from Malawi *"At the age of 17 I got pregnant and dropped out of school, something that happens to more young girls in Malawi. But I got motivated to join the Youth Club to finish my school. Because I have made that choice, hopefully more young girls follow my example and finish school, which gives us more opportunities to find a job and be independent"*

Introduction

Joining together on learning research

Against the backdrop of beautiful Lake Naivasha, members of the Health Systems Advocacy Partnership (HSAP) gathered in Kenya last autumn to reflect on past successes as well as challenges, and discuss next steps. The partnership has documented over 480 outcomes and contributed to significant developments in access to quality healthcare for many across sub-Saharan Africa. Now, in its fifth and last year of implementation, the HSAP's main objective is to consider how we can sustain outcomes already achieved and ensure their impact is felt long into the future.

The partnership, formed in 2015, was conceived to support stronger health systems, which enable people in communities in sub-Saharan Africa to equitably access high-quality sexual and reproductive health services and commodities, and to enable them to realise and claim their rights, to the highest level attainable. The project aims to contribute to achieve Sexual and Reproductive Health and Rights (SRHR) by creating space for a strong civil society to engage effectively with governments, the private sector and other stakeholders accountable for health systems, to deliver equitable, accessible and high-quality SRHR services.

HSAP focuses on four of the World Health Organization's six building blocks for strong health systems, namely: human resources for health, essential health commodities, good governance and equitable health financing. SRHR cuts across sectors such as health, education and social and economic affairs. Therefore, HSAP partners aim to stimulate more cross-sectoral collaboration, which has been part of our learning research agenda. Research is a major element of the partnership, as it constitutes the core of our evidence-based lobbying and advocacy approach.

Strong and dynamic partnership relations are the foundation of the HSAP's Theory of Change (ToC), and they require continuous investment. Besides our regular exchange meetings, linking and learning was stimulated throughout 2018 through our Joint Learning Research and the development of a learning

tender. Therefore, HSAP partners invested in outcome harvesting, which enabled us to accurately document and showcase results, which, in turn, allowed us to engage in further reflections on our progress in relation to the ToC.

In 2018, each HSAP partner developed research proposals aimed at testing our core assumption; that the HSAP Partnership's approach to Health Systems Strengthening (HSS) contribute to the attainment of SRHR. Within the different research areas, partners explore diverse elements of health systems, in relation to our intervention strategies.

This digizine brings together all of the individual research projects and shares lessons learned with the intention of inspiring future investments aimed at the intersection between SRHR, health systems, and civil society engagement. It provides an overview of the learning agenda and research carried out by all partners among their stakeholders. As 2020 is the final year of the HSAP's current funding framework, specific attention is being given to sustainability, learning, and scaling up our outcomes.

This digizine serves as prelude to the HSAP End-Term Evaluation, which should incorporate a strong learning element, providing insight into best practices, sharing and learning across contexts and partners.

For now, we wish you a good reading time!

ACHEST
Amref Health Africa
Health Action International (HAI)
Wemos
Dutch Ministry of Foreign Affairs

HSAP

Focus countries

HSAP focus countries are Kenya, Malawi, Uganda, Tanzania and Zambia (and the rest of the world)



HSAP partners are :

Amref Flying Doctors/Amref Health Africa, African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI), Wemos and the Dutch Ministry for Foreign Trade and Development Cooperation.



Ministry of Foreign Affairs of the Netherlands

Table 1. HSAP Partner focus areas

Contexts	Amref	ACHEST	HAI	Wemos
Kenya	x	x	x	
Uganda	x	x	x	
Zambia	x	x	x	
Tanzania	x	x	x	
Malawi	x	x		
African Region	x	x		
Netherlands	x			x
Global	x	x		x
Building blocks				
HRH	x	x		x
Health financing	x			x
Commodities			x	
Governance	x	x		x
Strategies				
Capacity strengthening	x	x	x	x
Lobby and Advocacy	x	x	x	x
Research and Learning	x	x	x	x

HSAP in numbers

All numbers are per 1 January 2019, the data for 1 January 2020 that includes the year 2019 is forthcoming. These are reported by the HSAP Partnership on IATI. [Check](#)

430

In the lifespan of HSAP, the partnership has worked with 430 CSOs as partners in our programme and with organisations which are part of coalitions.

109

The HSAP partnership has trained 109 unique CSOs that have shown increased capacities on lobby and advocacy.

1,590

Since 2017, the HSAP Partnership has undertaken, along with its partners, 1,590 advocacy initiatives (this ranges from meetings with policy makers, events and the dissemination of research papers).

65

Stemming from the abovementioned advocacy initiatives, the HSAP Partnership's direct contribution has resulted in 65 policies, standards or legal frameworks improved.

HSAP highlights

HSAP highlight: Africa region



Scale-up of the HWM and tracing tools for doctors. ECSACON, an association of nurses, asked for a protocol, tracing nurses after Amref shared with them the idea of what they were doing with doctors. They were convinced of the purpose and requested Amref to develop a protocol and tools for them. Amref developed the protocol and awaits adoption.

HSAP highlight: Netherlands



To discuss opportunities for better alignment in the investments of Dutch MoFA, and how to collaborate on this, in January 2020, the Dutch Ministry of Foreign Affairs requested Wemos to help coordinate a joint meeting with CSOs working on the GFF, Global Fund and Gavi.

HSAP highlight: Global



Upon invitation of Amref, the World Health Organization launches the WHO guideline for CHW programmes at a side event co-organised with Amref at AHAIC 2019. This session included a high-level panel discussion.



ACHEST

Global Health Diplomacy introduced as a module taught at the School of Public Health, University of Zambia

Often, countries are caught up in very awkward situations of trying to negotiate for laws and policies on behalf of their governments for the nationals. The favorable terms of such policies are dependent on the negotiation skills of the representatives. These representatives in most cases are diplomats who are appointed to represent their countries with no definite qualification in Diplomacy and relations, and who in many times are not health experts.

How can we equip diplomats who navigate complex and changing health systems with skills and content to engage health policy makers and programme implementers?

Strategic Centre for Health Systems Metrics Evaluation (SCHEME), ACHEST partner in Zambia, attended a capacity building meeting on Global Health Diplomacy in Uganda, organised by ACHEST, and began to feel that one of the things that are not handled well in Zambia was how policy makers and Programme implementers engage with partners, development partners and bilateral agencies in presenting health sector needs. It was apparent that technical personnel in public office are not armed with skills and content to engage stakeholders at National, Regional or Global level on pertinent health matters hence the relevance of a training module in Global Health Diplomacy.

Navigating complex systems

The common challenge diplomats face is to navigate complex systems in which issues in domestic and foreign policy intertwine the lines of power and constantly influence change, and where increasingly rapid decisions and skillful negotiations are required in the face of outbreaks of disease, security threats or other issues. Zambia is not an exception.

“With that in mind we took a keen interest in how the training in Uganda was organised and as a consequence adopted a module in Global Health Diplomacy module on the Masters of Public Health programme at the University of

Zambia. We have a MPH (Master of Public Health) in health policy management that is running and this module became one of the modules used under that programme with credits embedded under the MPH.”

Prof. Michelo Charles the Head of Department School of Public Health in Zambia narrates. SCHEME became ACHEST implementing partner in Zambia and the training was part of HSAP ACHEST programme activities in Zambia.

Arising from this we received massive interest from the Ministry of Health requesting if we could run a special Global Health Diplomacy course for largely the 10 people that had just been appointed as global health ambassadors in various missions abroad. We were approached by the Minister of Health and we have run this course preparing these people to work as Global Health ambassadors on how they can be engaging and negotiating the global health

Because we are now able to communicate effectively and clearly, lives of people are saved

Engaging and negotiating global health leaders

Aware of the limitations, the Departments of Health Policy and Management; Health Systems and Implementation embraced the course. The first ever Global Health Diplomacy course was held by University of Zambia, School of Public Health in collaboration with the Zambia National Public Health Institute (ZNPPI) targeting the newly appointed Global Health Diplomats, from the Ministry of Health.

leaders by highlighting the various issues that are affecting Zambia.

Dr. Maxilla, who was one of the beneficiaries, is now based in New York. *“I have been working in the Ministry of Health for many years, sat in meetings for many years; little did I realise that there are theoretical approaches to handle these things. There is a way we could practise diplomacy, with approaches and strategies that can actually generate results. We didn’t realise that managing this is extremely*

critical in achieving outcomes that can save lives of people because we are able to communicate effectively and clearly. We have been able to invest and allocate resources because we have engaged effectively and understood each other.”

Translating research findings

For this reason, there are students who haven’t taken these modules and have expressed interest. They recommend that this course will be embedded in all MPH courses. We are currently evaluating how we can run this module as core module for all those enrolled under the MPH programme beginning of

October 2019. The first batch of beneficiaries of the course were (10) newly appointed ambassadors of global health who were sent to Brazil, India, China, South Africa, the African Union (Ethiopia), the United States and Japan.

As we can see information generation through research is very important in policy advocacy and implementation. While this is so, it is important to make sure that such research findings are translated into policy and programmes.

HSAP highlight: Uganda

ACHEST and Wemos presented their shared report on Financing Human Resources for Health to the Human Resources for Health Technical Working Group of the Ugandan Ministry of Health in May 2019. Subsequently, the Technical Working Group committed to use the research’s findings for their next HRH Strategic Planning in 2019/2020.





Amref Health Africa Community Health Workers: a solution for reaching marginalised

Advocating for laws and policies that will make community health workers accessible throughout Africa through their recognition as health professionals is a key aspect of Amref's HSAP Partnership. Research is adding momentum to the advocacy conducted through the partnership. Joint field-based surveys in Kenya, Tanzania and Malawi, and a desk study conducted by Amref and KIT Royal Tropical Institute showed that the role of these health workers in communities is important for improving attitudes toward family planning, and for increasing access to and use of modern contraceptives.

When the Millennium Development Goals (MDGs) transitioned to the Sustainable Development Goals (SDGs) in 2015, the world's governments established equality, inclusiveness and shared rights as the new foundations of economic development. This updated vision acknowledged that the poorest of the poor had benefitted far less from MDG initiatives than others and that new efforts should focus on "reaching the furthest behind first." Although the SDGs have strengthened the process of goal-setting for development, many programme planners continue to overlook the importance of expanding sexual and reproductive health rights (SRHR), which fulfils a fundamental human right and supports economic

growth. This was a major concern voiced by the UN Population Fund (UNFPA) in *Worlds Apart*, a 2017 report that emphasised reproductive health inequalities and economic inequalities are mutually reinforcing, and have the potential to trap women in a vicious cycle of poverty, diminished capabilities and unrealised potential. The consequences extend to their families, communities and countries.

Access to sexual and reproductive health (SRH) services is weakest in Sub-Saharan Africa, particularly amongst the rural poor. *Worlds Apart* not only revealed that Sub-Saharan Africa is the only region in the world whose contraceptive prevalence rate (CPR) falls far below

global averages, but also that the CPR is a gaping 16 to 17 per cent lower in rural areas compared to urban areas. Furthermore, even in countries like Senegal where access to SRH services has improved at a relatively higher rate than its neighbours and has resulted in appreciable reductions in new-born mortality, the large gap between the richest and poorest population groups remains mostly unchanged.

Research has continuously shown that investments in SRHR are essential to lifting major obstacles to sustainable development. The Guttmacher-Lancet Commission's 2018 study, *Accelerate Progress: Sexual and Reproductive Health and Rights for All*, notably estimated that investing US\$9 per capita annually would cover the total cost of fully meeting women's needs for modern contraception and providing health services recommended by the WHO for all pregnant women and new-borns. The Commission concluded that, in developing regions, this would translate into decreases of 75% in unintended pregnancies, 80% in new-born deaths and 73% in maternal deaths.

The essential link

Increasing access to SRH services and improving individuals' sexual and reproductive health and

rights, require investments in SRH service providers. Community health workers (CHWs) are service providers who are vital to achieving better health outcomes in Africa's marginalised populations, but they generally conduct their work voluntarily. African governments are not currently providing sufficient funding for CHW programmes, in part because CHWs are not part of formal health cadres in most countries. As a result, these frontline health workers often lack the training and resources they need to perform their jobs, and receive little or no pay.

Advocating for laws and policies that will make CHWs accessible throughout Africa through their recognition as health professionals is a key aspect of Amref Health Africa's contribution to the HSA Partnership. *"Community health workers are the essential link between communities and health systems,"* says Dr Joachim Osur, Director of Regional Programmes and Field Offices at Amref. He emphasises the important role of CHWs in family planning because women and girls in marginalised communities lack access to SRH services, which are part of their basic human rights. *"If we do not reach these communities to inform them about their rights, discuss misconceptions about contraceptives and provide*



Amref and its partners advocate for the integration of CHWs into national health systems as a way of ensuring they receive the training, guidance, resources, and supervision they need.

them a range of family planning commodities, we will never achieve the third Sustainable Development Goal of ensuring healthy lives and promoting well-being for all at all ages,” adds Dr Osur.

Health workers and health systems

Research conducted by Amref and the Royal Tropical Institute

distributing contraceptives, promoting family planning, and referring clients to health facilities when needed. While centred on the same theme, each country case study had its own particular focus. The results demonstrated that community trust in CHWs makes them the preferred providers of family planning services and enables

The status of CHWs as credible sources of information and services comes from the trust their communities have in them

(KIT) is adding momentum to the advocacy conducted through the HSAP Partnership. Joint field-based surveys in Kenya, Tanzania and Malawi, and a desk study conducted by KIT showed that the role of CHWs in communities is important for improving attitudes toward family planning, and for increasing access to and use of modern contraceptives.

Amref’s research concentrated on the factors that influence CHWs’ role in providing SRH counselling,

them to better address social challenges such as misconceptions about contraceptives and gender inequalities. At the same time, the studies revealed that a failure by health systems to properly formalise the role of CHWs and remunerate them are significant obstacles to sustaining community-based SRH interventions.

Field research identified enablers and obstacles

Conducted in Mangochi district, Amref’s Malawi study was particularly useful in identifying enablers and obstacles to community-based SRH services. Understanding how to assess these factors in different environments is certainly crucial for programme planning, but the overwhelming value of the Mangochi study was that it showed CHWs are themselves an enabling factor for SRH services and are indispensable in addressing local obstacles to family planning.

According to the study, one of the main barriers to family planning in Mangochi are gender norms that often encourage men to desire larger families and exert dominance in decision making on matters like contraceptive use. Widespread misconceptions about contraceptives play a significant role too. For example, one CHW said that in her community, *“They say...there is oil (in condoms) and they fear that oil can cause cervical cancer.”* Additional factors like religion and tribal affiliation were also identified.

Still, overall demand for family planning in Mangochi is strong. Most study participants cited different advantages of using contraceptives,

especially the economic benefits of healthy timing and spacing of pregnancies. These included enabling families to take better care of their children and send them to school, provide for their daily personal needs, and engage in work and community development activities. Among youth, prevention of sexual transmitted infections was important.

Counselling and promotional activities

In Kenya, the country case study explored the role of CHWs in increasing access to and uptake of contraceptive services among youth aged 18 to 24 in Narok and Homabay Counties. Similar to the study in Malawi, female and male respondents in both counties referred to multiple beliefs related to the use of contraceptives that exist in the community. These included that they cause diseases, infertility, foetal body deformations, pregnancy complications, stillbirths or bearing two or more children. Many mentioned infertility occurring after using contraceptives. The findings in Kenya showed that the role of CHWs entailed creating awareness, sharing information, counselling, distribution of male condoms and referring to health facilities for other contraceptive methods. In Malawi, CHWs were successful in sharing information through counselling and

promotional activities that helped community members reconsider obstructive norms and beliefs, and were equally supportive in providing discretion to those who feared the consequences of using contraception. In a number of instances in Malawi, CHWs reported meeting women late at night to administer doses of the injectable contraceptive, Depo Provera, without their husbands' knowledge.

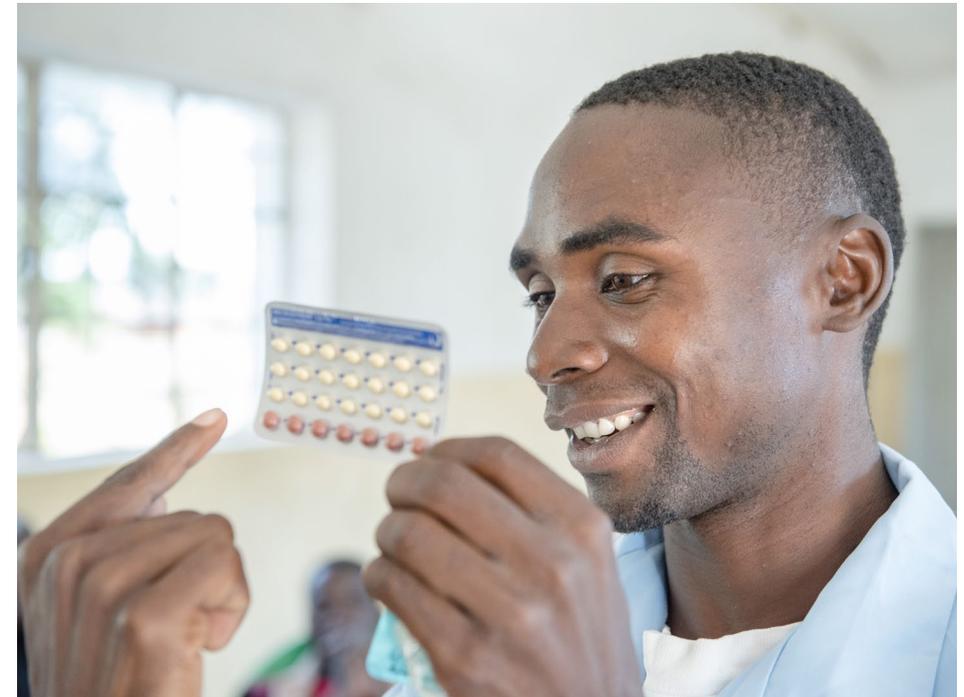
The status of CHWs as credible sources of information and services comes from the trust their communities have in them. *"They are good people because they keep our secrets,"* related a 19-year-old woman in Mangochi. Her comments point directly to another conclusion of UNFPA's *Worlds Apart* report: common barriers to SRHR such as concerns about privacy and confidentiality, stigma about contraceptives or sexuality, fear of rejection by service providers and cost are more intense for younger people. Trust in CHWs and their ability to navigate obstacles are mainly a product of their being selected by the communities they serve and usually living there; all in sharp contrast to less familiar nurses and other health workers at distant facilities. As it seeks to expand its cadre of CHWs, the Government of Malawi is notably prioritising the

selection of health volunteers that reside in their catchment area.

Health systems challenges to community-based family planning

Amref and its partners advocate for the integration of CHWs into national health systems as a way of ensuring they receive the training, guidance, resources, and supervision they need. However, even when a good policy structure exists for CHWs, there's no guarantee that governments will formalise their role in the health system. For example, although Kenya has a series of relevant national policies and guidelines for CHWs to conduct SRH activities, local programme coordinators and managers interviewed there by Amref were not always aware of them.

When government funding for community health programmes is limited, non-governmental organisations (NGOs) become a powerful complementary source for supporting CHWs. Coordinating their involvement can be challenging, though. One informant interviewed in Malawi estimated that Mangochi district had as many as 30 NGO partners for community-level SRH, but complained, *"They're confined in one place; they aren't distributed."* His commentary was



Amref's research concentrated on the factors that influence CHWs' role in, for example, promoting family planning.

further reinforced by Amref's findings that only half of the CHWs in its study area in Malawi had received donor-supported training on how to administer Depo Provera. Untrained CHWs who needed to refer their clients to another CHW or the nearest health facility reported confusion and loss of confidence by the community.

The study in Malawi also highlighted the consequences when health systems fail to provide a continuous supply of quality-

assured commodities to distributors. Community members and CHWs both reported periodic interruptions in contraceptive availability, usually affecting the most popular methods. When stock-outs of their preferred method occurred, women were urged to change to another, further reducing their confidence in SRH services and sometimes causing them to discontinue using family planning.

No fair pay, no fair play

Perhaps the most complex systems-level challenge in improving the sustainability of community-based health programmes is motivating CHWs to remain in their posts over the long term. Evidence has consistently demonstrated that monetary incentives are essential to increasing CHW retention, including a 2018 study in Kenya which showed that attrition was as high as 33% among CHWs that received little or no pay. While it is clear that few CHWs in Africa receive the equivalent of a salary, current approaches to payment lack

standardisation between countries and even communities. In fact, one CHW might not be compensated at all and another might receive money from multiple sources. Two of the five country governments in the desk review conducted by KIT had active policies for paying CHWs, but NGOs in all of the countries usually provided monetary incentives to the programmes they supported and some communities also compensated their CHWs.

Most of all, the question of paying CHWs is about reducing competing priorities. Key informants in Amref's

Tanzania assessment explained that CHWs often have to limit the time they spend providing health services in favour of revenue-generating activities like farming. One Tanzanian CHW who had received relatively higher compensation for his health work noted, *"When I receive money, I use it to provide for my family and my wife also feels comfortable with the community work that I am doing."* In this sense, it is important to remember that CHWs generally work in and are members of poor communities, so continuous earnings are vital to survival.

"From the conclusions found in this research, it is clear that the next step is strengthen the health systems to optimise the performance of community health workers as champions of sexual and reproductive health rights," affirms Dr Joachim Osur.

Reinforcing advocacy with evidence

Amref's research has added to growing evidence on the impact of community health workers on their communities and has reinforced the principle that achieving SRHR means formalising the role of CHWs in national health systems and remunerating them. CHWs, as individuals trusted by the communities, reduce barriers to sexual and reproductive rights. Their role is essential to achieve better health outcomes in marginalised communities by promoting family planning and adapting services so they can be delivered at the times and in the places that meet people's needs.

HSAP highlight: Malawi

In the follow up of the implementation of the HRH strategy, the HRH Coalition successfully advocated to increased payment of overtime to nurses. This was done through the coalition providing input to the strategy. This is a national Malawian policy and increasing it would increase the motivation of the nurses.





This is Dorothy from Malawi. She is a Community Health Worker who provides sex education.



‘Young people should know what is happening to their bodies’

“As a youth-friendly focal person, I go to youth clubs and meet with youth from age 10 to 24, to discuss issues important to them, including their needs on sexual and reproductive health. For example, tell them about the changes they are making as they are growing up. They should know what is happening to their bodies. In addition, we provide contraceptive methods. We need them to lead a healthy life, so in order for them to have a healthy life – they need contraceptives like pills, we also provide condoms. I also go to the schools, and I provide them the same information.”

Information that can be provided to old people is not the same as to young people. Of course, it may be the same thing, but the way you are providing the information may differ from one group to another, so we provide the information according with the group I am talking to at that time, in my case young people.

Several years ago, the people in the community didn’t know everything about contraceptives. As of now, the information has been provided and people here are aware of contraceptive methods and want to use them. Unfortunately, the methods they want to use are not always in stock, so I provide them with a different method available at that time, until the one they want is available.

To get the contraceptive methods the youth come here to the youth corner in the Lulanga health centre. Single day in a week, usually on Friday we have a healthy corner. During that day, we talk about it and involve youth. A lot of youth comes here to access the services. Whatever the problem may be. Even if they have an STI, they can come here for treatment. They know they can come here if they need to, for advice, for condoms or pills. I’m here for the whole week.”

Stiya is a Health Surveillant Assistant and youth-friendly focal person in Lulanga, Malawi



HEALTH ACTION INTERNATIONAL (HAI)

Improving Health Systems Policies & Practices

HAI's learning agenda research set out to investigate the relevance of our contextualised model of informed advocacy in multi-actor settings, by asking key stakeholders, and especially recipients of any intervention about its value in promoting SRHR. The findings suggest that stakeholder engagement in a 'dialogue and dissent' space is a crucial factor that facilitates development and implementation of evidence-based policies.

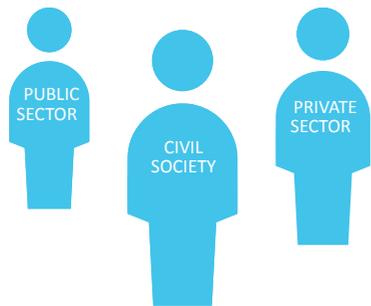
How does research on SRH lead to evidence-based policy-change that impacts on people's lives?

HAI uses its research expertise to build an evidence base on access to SRH commodities in Uganda, Kenya, Tanzania and Zambia. Since 2017, together with in-country partners Access to Medicine Platform Kenya, HEPS Uganda, UMATI Tanzania and MeTA Zambia, the price, availability and affordability of more than 50 SRH commodities, as well as perceived barriers to accessing them, are measured annually by HAI across public, private and mission facilities. These research results are an important tool to create a better understanding of the scope and causes of access barriers for SRH commodities among public, private and civil society sector stakeholders. These stakeholders include Ministries of Health, National Drug Authorities, national medicine stores and authorities, national

pharmaceutical societies, distributors and manufacturers, UNFPA, the WHO and national NGOs working on SRH. Each in-country partner works with these groups for advocacy at the policy level. Our partners have established Medicines Transparency Alliance (MeTA) multi-actor platforms, which comprise of a civil society secretariat and a number of stakeholders from the public and private sectors, and also includes WHO, UNDP, UNFPA etc. At MeTA meetings, through discussing the research findings and sector-specific challenges about the medicines supply chain, policy solutions are developed to improve access to SRH services and commodities.

This learning agenda research set out to investigate how relevant this type of research-advocacy is found to be by key stakeholders.

So, where and from whom do key in-country stakeholders receive information on SRH? And have the advocacy messages from the knowledge products based on the commodities research reached our target stakeholders?



The stakeholders: public sector, civil society and private sector.

Knowledge sharing is key in getting information

Stakeholders from the public sector, the private sector and civil society shared that one of the most important ways of learning about the SRH situation in their country is through knowledge sharing amongst each other. This is often done through meetings, personal contact, fact sheets, policy briefs, as well as through the media. The kind of information shared is often based on research conducted by

civil society organisations on a topic the organisations thought needed to be brought to the attention of the public and private sectors.

“Number one is reports done by partners. There is a very beautiful research that Dorothy and the organisation [Access to Medicines Platform Kenya] did. And you can see their facts. That is very, very key because it is scientific. It has been proven. So, we rely a lot on studies, and researchers, and reports produced by partners.”
– NGO member, Kenya

Another example is the photo essay documenting a successful campaign on pre-eclampsia initiated based on data showing magnesium sulphate availability was very low in health facilities across Uganda [read more: haiweb.org/preeclampsia/]. At the end of the campaign, Members of the Ugandan Parliament presented a paper about the challenges of managing pre-eclampsia, which led to an investigation of this issue by the Ministry of Health and a pledge for providing more funding to make magnesium sulfate accessible. When sharing research and the advocacy messages based on the evidence, stakeholders emphasised the importance of tailoring the messaging to the different targeted stakeholder groups. For example, if

you are talking to a community, the way of conveying your message will be very different from when you talk to a supply chain specialist.

“...one of the Members of Parliament said: “those things you say for us, we don’t understand. Because for us, our basic education is near secondary six.” That is a qualification for a member of parliament. “So, you need to be able to bring your information to our level, in order for us to understand it.” – CSO member, Uganda

HSAP highlight: Zambia

The Ministry of Health in Zambia has taken up the recommendation from HAI’s 2017 Sexual and Reproductive Health Commodities report that Central Medical Stores (MSL) should procure commodities themselves, instead of through the Ministry of Health. MeTA Zambia, HAI’s in-country partner, shared these recommendations and continued advocating for the same over the years until late 2019, when the Procurement Bill was signed. In November 2019, the procurement function was transferred to the new Zambia Medical Stores Agency as one of its core functions.



More than one barrier to overcome

When stakeholders were asked about the barriers to accessing SRH services and commodities in their countries, they listed six main issues:

1. Stock-outs
2. Supply chain issues
3. Administrative and procurement
4. Lack of (continued) staff training
5. Lack of human resources
6. Lack of youth services

in these results, as it provides stakeholders with a picture of the current access situation in health facilities across the three sectors. The interviewed stakeholders, who function at the national level, are aware of the same barriers as the healthcare workers, who function at the community level. The same thing can be seen for recommendations to improve

*Health policy...
It's complicated like a puzzle,
but together we can view it as a whole*

The SRHC reports published annually by HAI and in-country partners [see link to the reports on the [website](#)], which study SRHC barriers and are based on the experiences of healthcare workers, identified barriers similar to those above. The reports mention, for example, stock-outs, supply chain issues, procurement issues and lack of staff training as barriers to access. The reports further showed the actual availability, affordability and frequency of stock-outs occurring in health facilities. The strength of the research lies

access to medicines. Both the stakeholders as well as the reports emphasise the importance of strengthening and improving the supply chain, with a specific focus on the timely and complete supply of ordered commodities. Other recommendations made by both the reports and the stakeholders relate to community sensitisation, client education, and continued training of staff.

Identifying facilitating factors and taking action

Knowing what the barriers are, and having ideas on how to improve access to SRH services and commodities, the next step is to take action. So what are the facilitating factors for implementing evidence-based policies, according to stakeholders?

1. Multi-stakeholder engagement

Stakeholders believed that one of the key factors facilitating the development and implementation of evidence-based policies is multi-stakeholder engagement. Multi-stakeholder engagement, consisting of collaborative efforts between the public sector, the private sector and civil society, is needed to improve access to SRH services and commodities. For instance, the public sector might be the primary entity responsible for ensuring adequate access to healthcare for the population, but oftentimes there are still gaps and insufficiencies in providing these services. When there is engagement with the private sector, the private sector can fill these gaps for the time period that the public sector is unable to do so. In this situation, civil society has an important role to play as a watch dog to bring attention to such gaps, and to advocate for improvements to fill these gaps.

A quote from one of the stakeholders:

"[...] it requires a multi-stakeholder engagement, both between the private sector, public sector, civil society, all that. [...] So, it also involves a lot of partnership, work in close collaboration with the Ministry of Health, NGOs and other stakeholders, who we know at the end of the day will enable us to meet that objective."
– Supply chain specialist, Uganda

2. Collaboration for advocacy

Civil society stakeholders also emphasised the importance of working together with other national groups working in the same SRH space as a tool for policy change. They believed that when they share their message, and advocate for it together, their message becomes stronger and is more likely to be heard. An example of such a collaboration is the Lake Basin MeTA Kenya CSO Alliance on SRHR which consists of 24 CSOs and was set up to increase the voices of CSOs, consolidate their bargaining power at decision making tables and get recognition from the various county governments. The network has been part of the planning committee for the Universal Health Coverage Conference and mobilised other CSOs to draft and present a CSO position paper on UHC. Another example

HSAP highlight: Kenya

For the past two years, together with Access to Medicines Platform (Kenya), HAI has provided selected CSOs with a series of trainings. In 2019 this training focused on budget tracking and analysis for advocacy purposes. As a result of this training, one of the CSO trainees has established a network - the Pepea Innovation hub - on SRH commodities and budget advocacy, and community sensitization on SRH. This network championed a 20% increase in the health budget, earmarked to improve health infrastructure by upgrading maternity wings and purchasing delivery equipment in five wards.



of the power of collaborative advocacy is that in Uganda, as a result of HEPS Uganda and other CSOs' joint advocacy, Members of Parliament from the National Health Committee proposed and worked on a private members bill, which led to the approval of the National Health Insurance Scheme Bill (NHIS) by the Cabinet.

"If you do it individually then you may not go an extra mile. You can be stopped somewhere along the way. But if you work in collaboration with others, likeminded organisations, then you know that you will probably get somewhere. And maybe, we will see much more impact if it is from a wider group." – NGO member, Uganda

Another example of the importance of collaborations is illustrated through this quote:

"[...] we are always there to tag into the expertise of organisations that have worked on this for years. In Uganda, it is actually HEPS Uganda that a number of us rely on when it comes to essential medicines and commodities. [...] They have established relationships with key stakeholders that can be seen to move a number of issues in this area." – NGO member, Uganda

3. Knowledge sharing

Similarly, stakeholders also believed more can be achieved when you are working together. If you are working together with different organisations, each organisation can focus on a different part of the problem. An example is if each organisation researches a different part of the SRH access problem, when you bring the research of all the organisations together, you can create a far more detailed picture of the policy landscape than when each organisation is working individually and in silos. Also, each organisation might have expertise or a network that another organisation might not have, and to avoid duplication or reinventing the wheel, it is much more efficient to combine efforts and work together.

"We cannot do it alone. If we know there are other NGOs out there that work for the same thing, we should work together. [...] If another one can say: "Hey, these commodities are not there", it can only help us give a full picture; you see? And then we can go to the government and say: "You see this, the community needs this and it is not there." – NGO member, Uganda

4. Community engagement

Community engagement and empowerment were also believed to be important tools. Stakeholders believe in the importance of the power of the voices of the people, and that empowering communities through sensitisation on their rights to access SRH services and commodities, and collaboratively identifying the barriers that impede access, can be used to advocate for better access. The key is to use the power of the communities' voices for advocacy.

"What we've realised is: a lot is going on. Reportedly for the benefit of the community. Yet, their voices, their concerns, their priorities are not being taken into consideration. So we are trying to sensitise them around the same, and just trying to create that platform where they can engage the government to share their concerns and their needs." – NGO member, Kenya

What have we learned?

Through this research we have learned the ways in which stakeholders gain knowledge on the SRH situation in their respective countries, and what they believe are facilitating factors for implementation of evidence-based policies or policy changes that will improve access to SRH services and commodities. This research has validated the MeTA framework, and could guide the work of others in ways in which to engage with stakeholders from different sectors.

There is a consensus amongst stakeholders that multi-stakeholder engagement is one of the crucial factors that facilitates development and implementation of evidence-based policy changes. In line with this, the research showed that the MeTA platforms to facilitate multi-stakeholder engagement for SRH, and members see the use of evidence as valuable tools to improve access to SRH services and commodities. We should therefore continue using the MeTA platforms in our work to engage with stakeholders.

The results indicate that the advocacy messages as presented in the knowledge products by HAI have broken through in the policy field. Multiple stakeholders

referenced the Ugandan and Kenyan SRHC reports, policy briefs and fact sheets as sources they refer to when assessing their country's SRH situation. Moreover, the dissemination methods we are currently using are the same ones the stakeholders mentioned to be useful. These methods included personal contact and meetings, such as the MeTA platforms, and knowledge products such as fact sheets and policy briefs. The media was also seen as an important knowledge-sharing mechanism. We cannot conclude that the stakeholders' knowledge necessarily comes from the knowledge products shared by us. However, it seems that the current strategies are in line with what stakeholders perceive to be their sources and methods of knowledge. It is therefore advisable to continue promoting knowledge dissemination and partnerships with others. Interesting for the work of HAI would be to evaluate individual knowledge products to find out what knowledge products are deemed most useful by different stakeholders. This could be valuable to know when undertaking future advocacy efforts.

Related to this, an important thing to consider when advocating, is the language and tools you use. In other words, you need to tailor



Pregnant women at a health facility in Uganda have their blood pressure measured.

your message to your audience. This is a crucial component and something that can be taken even more into consideration in our work in the HSAP partnership and when we are developing knowledge products and advocacy strategies.



WEMOS

A critical eye on the Global Financing Facility for strengthening health systems

The Global Financing Facility (GFF) is the main global funder of reproductive, maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) programmes and policies. At Wemos we critically follow the developments of this relatively new financing mechanism. Together with other civil society organisations (CSOs) we look at how GFF's processes and investments affect the health systems of countries receiving funds.

Does our lobby and advocacy approach contribute to better planning, implementation and effective funding of SRHR interventions by the GFF in countries?

The Global Financing Facility and health systems strengthening

The [Global Financing Facility](#) (GFF), created in 2015, is an innovative financing model for the UN Secretary General's [Every Woman Every Child Global Strategy](#) (2016-2030). It is hosted by the World Bank and designed to set in motion a machinery of new funding sources that is aligned to a national investment plan. Its multi-donor Trust Fund issues grants to eligible countries that are matched with a loan from the International Bank for Reconstruction and Development (IBRD) or a credit or grant from the International Development Association (IDA), issued by the World Bank. The GFF has become the main global funder of reproductive,

maternal, neonatal, child, adolescent health and nutrition (RMNCAH-N) programmes and policies.

Health systems strengthening lies at the core of the GFF investments. Sufficient, equitable, reliable and effectively channeled health financing is essential to achieving quality sexual and reproductive health services. Similarly, a fit-for-purpose, educated, motivated and supported health workforce is essential for the attainment of SRHR. Health professionals provide services and counselling for safe pregnancies and deliveries, safe abortion and post-abortion care, as well as prevention and treatment for STIs (including HIV), cancers of the reproductive system, and

sexual and reproductive disorders. All GFF country investment cases are built around ensuring sufficient health financing and addressing the huge health worker shortages.

Gathering, collating and sharing information on GFF implementation

Together with like-minded CSOs and NGOs in HSAP focus countries, Wemos gathers and collates information on GFF implementation in country in order to identify how the investment cases contribute to stronger health systems for better SRHR services and programmes. We closely collaborate with these organisations to strengthen capacity for continuous monitoring, analysis of results and development of country-specific lobby messages. We develop knowledge products and hold webinars on our findings, which we share widely through [social media](#), our [website](#), and our [knowledge platform](#). Wemos is an active contributor to the [GFF Civil Society Coordinating Mechanism](#) (GFF CSCM), and the [GFF Community of Practice](#) of the Dutch ShareNet, as well as the [Civil Society GFF Resource and Engagement Hub](#) (the GFF Hub).

Wemos takes a lead role to provide feedback to the Dutch Government, as well as the GFF Secretariat and other donors to the GFF. We raise



THE GLOBAL FINANCING FACILITY

FACT SHEET | MARCH 2019

This fact sheet gives an overview of the background, purpose and governance of the Global Financing Facility.

THE ISSUE

The Global Financing Facility (GFF) came to life in 2015 to financially support the UN Secretary-General's Every Woman Every Child (EWEC) Strategy (2016-2030) for "end preventable maternal and child deaths and improve the health and quality of life of women, children and adolescents by 2030". The funding gap in Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH-N) is more than USD 33 billion per year. The GFF aims to close this global financing gap by increasing the available domestic, external, and private sector financial resources that are allocated to RMNCAH-N. It is a platform intended to bring together stakeholders in RMNCAH-N from all different parts of society. It does so at international and national level.

A NEW INTERNATIONAL FUND FOR EVERY WOMAN, EVERY CHILD

At international level, the GFF is hosted by the World Bank and its multi-donor Trust Fund issues grants to eligible countries. 67 low- and lower-middle countries with high disease burden and unmet need in sexual and reproductive health and rights are eligible. Currently, 27 of these countries receive GFF funding.

GRANTS AND LOANS

GFF grants are linked to an IDA/IBRD loan for RMNCAH-N issued by the World Bank (see box). To date, every USD 1 per grant is matched by an average of USD 7 of the associated loan. This ratio of 7:1 has increased over the last years from 4:1 at the start of GFF. Grants vary between USD 10 million to USD 60 million for the period of 3 to 4 years. Criteria for determining the exact amount are population, need and gross national income. In 2018, the GFF Trust Fund was replenished with USD 3 billion. During 2019, this money will be used to roll-out the GFF in 8-10 additional GFF eligible countries, while the broader aim is bringing the GFF to the total of 50 countries, accounting for over 90% of the identified financing gap in RMNCAH-N.

March 2019

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Factsheet on GFF



GFF country papers



critical questions such as: Do the GFF investments truly benefit children, adolescents, and women and structurally improve their SRHR? Is the GFF strategy in line with the concept of Universal Health Coverage (UHC) and its objective to leave no one behind? Are local CSOs sufficiently involved in the development and implementation of this global financing scheme?

Our main goal is to provide critical support to identify solutions based on input from the country partners. We do this by developing policy recommendations to the GFF and its funders on GFF structures and implementation modalities based on analysis of country experience and mobilising African and international CSOs to share knowledge and develop joint positions.

Our assumption is that by developing a strong evidence-base on how GFF is implemented in countries, we can develop convincing arguments - with and through CSO partnerships - to influence the direction and decisions of the GFF, and track how this mechanism can best contribute to SRHR.

Outputs and outcomes: using outcome harvesting as a methodology

We have been able to directly track outputs and outcomes of our work over the past two years. We identify three main areas of outcomes.

1. Meeting a great need for information

We have discovered that there is an enormous demand from civil society as well as from donors for up to date information on GFF implementation at country level. Our knowledge products have been widely shared and circulated amongst donor governments, including the Netherlands, the European Commission, Sweden (SIDA), Norway (Norad), and the United Kingdom (DFID). These GFF [Investors Group members](#) play an important role in GFF decision-making and have used our findings as input for the discussions. As an example, in 2018, Wemos was invited to participate in an internal review session of the Dutch Ministry of Foreign Affairs on the Dutch contribution to the GFF mechanism and the Netherlands' role as member of the GFF investment group.

2. Fruitfully engaging with the GFF

Our [open letter](#) preceding the [GFF Replenishment Meeting](#) - which aimed to raise additional funding

for the expansion of the GFF to 50 countries - in November 2018, was endorsed by 50+ organisations and was publicly acknowledged by the GFF management during the meeting. The letter outlined several critical issues regarding lack of CSO engagement in key processes, failure to address health worker shortages and shortfalls



Joint open letter to GFF Secretariat, 5 november 2018

in the GFF financing model. The GFF Secretariat and the World Bank are actively engaging with Wemos and our partners on these topics. This occurs both during bilateral discussions, as well as during a [panel discussion](#) at the World Bank 2019 Spring Meeting.

As a result of these discussions, the GFF Secretariat has agreed that the GFF must develop a guideline on payment of health worker salaries and monitor the results-based framework approach more rigorously. Similarly, Wemos has continuously expressed concern to the GFF Secretariat and to members of the Investors Group that the GFF is expanding too rapidly to new countries

without learning lessons from the front-runner countries. Consequently, in the April 2019 Investors Group meeting it was decided that the rollout to new countries would be decreased from 15 to only 9 new countries, citing the need to take lessons learned better into account.

3. Stimulating mutual learning and capacity strengthening

Our collaboration with country-based CSOs in Kenya, Malawi, Tanzania and Uganda to analyse GFF investment cases and monitor

instrumental for civil society to learn from different country experiences.

The GFF Civil Society Coordinating Group consists of civil society at regional, global and national levels that align their resources and actions to ensure meaningful civil society engagement in the GFF at the international level, and to provide support to civil society working in GFF countries. The group has used the Wemos GFF factsheet and country assessments for their civil society capacity building workshop

Wemos organised an information exchange workshop in Lilongwe in June 2019, through which 11 Malawian CSOs became better informed about the Global Financing Facility (GFF) and how to be part of the GFF Investment Case development and discussions. After this workshop, Malawian CSOs MANASO and JournAIDS asked the Malawian government for draft documents on the Malawian Investment Case of the GFF. They also requested for space to engage in discussion about this investment case with the GFF liaison officer based at the Malawian government.

implementation, has sparked lively discussions at country and African region level. In some countries, the process has brought together civil society groups that were previously not working together, like in Malawi. Our analyses have also been

on analysing GFF investment cases and analysing GFF funded projects, which was held prior to the Investor's Group meeting in November 2019. The GFF Hub, a multiyear initiative that serves as a virtual forum on public information on GFF to support

CSOs, has also recently reached out to Wemos to provide long-term technical assistance on GFF monitoring in a number of countries.

Pinpointing critical issues on GFF processes and presenting recommendations

The strength of our approach is that it enabled us to identify critical issues on GFF processes and present recommendations to achieve better provision of (sexual and reproductive health) services at country level. Connecting the national and the global level, to build strong evidence and open up space for civil society involvement, proved key to our success.

The main focus of our discussions has been on how to improve the GFF financing model, how to address main health systems barriers such as acute health worker shortages and how to have a more inclusive involvement of civil society in decision-making. The starting points of these discussions have been the GFF policies and the investment cases.

What we haven't achieved yet as national and global civil society is to address the more controversial topics such as abortion, contraceptives for youth, or services for LGBTQ populations that are often not included in investment cases.

Civil society hasn't challenged GFF and national governments to better translate social and cultural determinants of sexual and reproductive health into objectives, activities or indicators in the country investment cases. The same goes for the rights perspective, which could be reinforced in language as well as in the objectives of the programme. Civil society needs to encourage the GFF Secretariat to take a more active role in the development of country investment cases in order to influence the type of programmes and services funded through GFF.

Learnings: understand the facts, encourage the discussion, continue the criticism

Three main learnings can be distilled from this research:

1. It is important to understand the context: in practice, policy often plays out differently than intended.
2. It is both needed and effective to encourage discussion within civil society.
3. We should continue challenging the GFF and its funders to improve SRHR programmes.

Understanding the context and how policy often plays out differently in countries is the starting point for meaningful improvements. Abstract policy discussions will not lead to any meaningful change if not embedded in reality. Joint

HSAP highlight: Tanzania

Sikika, one of Wemos' collaborating partners from Tanzania, provided input to the recommendations provided by the Dutch GFF Community of Practice to the Dutch delegation of the MoFA to the GFF Investors Group Meeting, in November 2019. Sikika furthermore indicated that the final set of recommendations are essential also at country level in order to influence policy-level discussions on the GFF in Tanzania.



assessments conducted by national and global civil society provide a more complete picture and more realistic recommendations.

As civil society it is important not to be trapped in an 'echo chamber' of similar opinions. Arguments become stronger by listening to and embracing different national and global viewpoints. Informed opinions become more audible through partnerships, both within the formal structures, such as the GFF Civil Society Coordinating Group, and informal coalitions, like the one formed around the open letter.

GFF's decision makers are open to dialogue and willing to adjust course. It is crucial that recipient and donor governments, as well as civil society, continue to challenge GFF to achieve the best SRHR outcomes for the citizens of countries receiving GFF funding. This includes expanding the focus from service-provision to actions that ensure human rights perspective and address the social and cultural determinants of health.

Find out more on Wemos' work on [GFF](#).

ABBREVIATIONS

ACHEST	African Centre for Global Health and Social Transformation
AMAMI	Association of Malawian Midwives
AMCOA	Association of Medical Councils of Africa
CBO	Community-Based Organisation
CHW	Community Health Worker
CSO	Civil Society Organisation
DHO	District Health Office
FP	Family Planning
GFF	Global Financing Facility
GHD	Global Health Diplomacy
HAI	Health Action International
HEPS	Coalition for Health Promotion and Social Development
HRH	Human Resources for Health
HSAP	Health Systems Advocacy
HSS	Health Systems Strengthening
HW4All	Health Workers for All
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MeTA	Medicines Transparency Alliance
MTR	Mid-term review
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoFA	Dutch Ministry of Foreign Affairs
MP	Member of Parliament
NGO	Non-Governmental Organisation
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHC	Sexual and Reproductive Health Commodities
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	WHO World Health Organization

COLOPHON

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