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Evidence, Innovation and Practice

End-Term Evaluation of Health System Advocacy Partnership Programme

Final Report

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working for health and development

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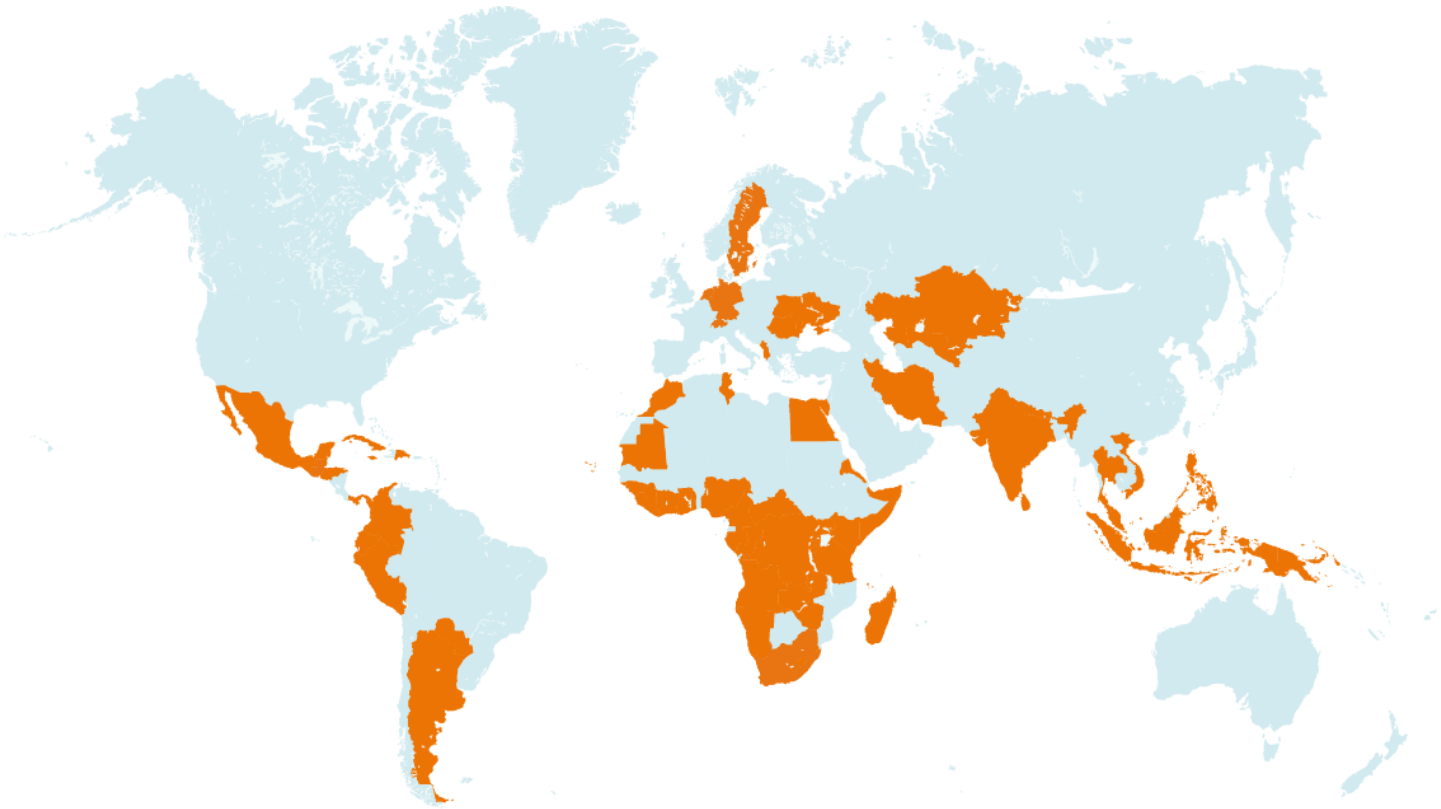


ResultsinHealth | Zijlbaan 46, 2352 BN Leiderdorp | The Netherlands
T. +31 (0)71 760 1200 | office@resultsinhealth.org | www.resultsinhealth.org

Table of Contents

List of Abbreviations i

List of Tables / Figures ii

Executive Summary iv

1 Introduction 1

1.1 The Health Systems Advocacy Partnership Programme 1

1.2 Theory of Change 2

1.3 HSAP End-Evaluation Objective and Scope of Work 3

1.3.1 Evaluation objective 3

1.3.2 Scope of work 4

2 Evaluation Framework 5

2.1 Evaluation Questions 5

2.2 Target Audience and Use of Findings 7

2.3 Geographical coverage 7

3 Evaluation Methodology 8

3.1 Evaluation Approach 8

3.2 Evaluation Phases 8

3.3 Data Collection Process 8

3.3.1 Data collection process per context 8

3.3.2 Data collection tools 9

3.4 Evaluation Respondent 10

3.5 Sampling Strategy 11

3.6 Online Training and Piloting 11

3.7 Data Collection Timeframe 12

3.8 Quality Assurance 12

3.9 Data Management 12

3.10 Outcome Harvesting and Story Collection Process 12

3.10.1 Substantiation process 12

3.10.2 Story collection process 14

3.11 Data Analysis 15

3.12 Ethical Consideration 15

3.13 Limitations of the Evaluation 16

4 Finding 1: Outcome Harvesting and Story Collection using Sprockler Tools 18

4.1 Outcome Harvesting: Findings on Outcomes Harvested and Substantiated 18

4.1.1 Overall outcome harvesting findings 20

4.1.2 Reflection on the TOC and its usefulness for analysis 23

4.2 Sprockler Stories Report 24

4.2.1 Overall collected story findings 24

4.2.2 Thematic areas of collected stories 24

4.2.3 Similarity between stories and outcomes 29

4.2.4 Type of Actors 29

4.2.5 Link between stories and TOC 30

5 Finding 2: Content 32

5.1 Effectiveness of Capacity-Strengthening Efforts 32

5.1.1 Focus, strategy and advocacy results of the capacity strengthening efforts 32

5.1.2 Strengths and weaknesses of the HSAP capacity strengthening efforts 37

5.1.3 Supporting and hampering factors of capacity strengthening 38

5.2 The Effectiveness of the Advocacy Approaches 39

5.2.1 Effectiveness of Advocacy approaches 39

5.2.2 Negative outcomes and unintended outcomes 46

5.2.3 Roles and contribution of external factors/actors in achieving advocacy outcomes 46

5.2.4 Strengths and Weakness of HSAP's advocacy 49
5.3 Relevance towards HSS and SRHR 51
5.3.1 Relevance towards HSS and SRHR (combined) 51
5.3.2 Relevance towards HSS 51
5.3.3 Relevance towards SRHR 52
5.3.4 Linkages between HSS and SRHR 53
5.4 Lessons Learned on Gender and Inclusivity, Collaboration and Governance, Visibility/Legitimacy and HSS & SRHR Advocacy 55
5.4.1 Gender and inclusivity 55
5.4.2 Collaboration and governance 57
5.4.3 Linkage levels 59
5.4.4 Visibility/legitimacy 60
5.4.5 Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS 61
5.5 Sustainability of the HSAP Programme 61
5.5.1 Mechanisms in place to sustain advocacy outcomes: HSS, SRHR, and advocacy capacity 62
5.5.2 Governance mechanisms to sustain advocacy efforts 63
6 Discussion, Conclusion and Recommendations 65
6.1 Discussion 65
6.1.1 Achievement of HSAP's TOC 65
6.1.2 Effectiveness 65
6.1.3 Relevance 68
6.1.4 Lessons learned 68
6.1.5 Sustainability 68
6.2 Conclusion 69
6.3 Recommendations for Future Programmes 69

List of Abbreviations

ACHEST	African Centre for Global Health and Social Transformation
AMAMI	Association of Malawian Midwives
AMNH	The African Media Network on Health
AR	Annual Reflection
AtMP	Access to Medicines Platform
CBO	Community-based Organization
CHW	Community Health Worker
CSO	Civil Society Organization
DHO	District Health Office
EALA	The East African Legislative Assembly
FP	Family Planning
GFF	Global Financing Facility
HAI	Health Action International
HEPS	Coalition for Health Promotion and Social Development
HF	Health Financing
HLM	High-Level Meeting
HRH	Human Resources for Health
HSAP	Health Systems Advocacy Partnership
HSS	Health System Strengthening
HW4All	Health Worker for All
HWM	Health Worker Migration
IDI	In-depth Interview
IOB	*Directie Internationaal Onderzoek en Beleidsevaluatie* (Policy and Operations Evaluation Department of MoFA)
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Trans, and/or Intersex
MedRap	Medicines, Research and Access Platform
MeTA	Medicine Transparency Alliance
MoFA	Ministry of Foreign Affairs of The Netherlands
MoH	Ministry of Health
MTR	Mid-term Review
NGOs	Non-Government Organisations
OH	Outcome Harvesting
PwD	People with Disability
RMNCAH	Reproductive, Maternal, New-born, Child and Adolescent Health
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SRH	Sexual Reproductive Health
SRHC	Sexual Reproductive Health Commodities
SRHR	Sexual Reproductive Health and rights
TOC	Theory of Change
ToR	Term of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
VoIP	Voice over internet protocol
WHO	World Health Organisation

List of Tables / Figures

Table

Table 1; List of HSAP Contracted Partners and geographic implementation areas 1
Table 2: Location visited during data collection 7
Table 3; Data collection process by context 9
Table 4; Respondents per context 10
Table 5: Result sampling strategy 11
Table 6; List of outcomes harvested and substantiated per context (until February 2020) 18
Table 7; Number of credible outcomes compared to the number of substantiated outcomes 19

Figures

Figure 1; Visualisation of the Theory of Change above the accountability threshold 2
Figure 2; Visualisation of the Theory of Change below the accountability threshold 3
Figure 3; Outcomes per context 20
Figure 4; Outcome category for entire HSAP 21
Figure 5; Outcome category per context 21
Figure 6; Outcome category per actor for entire HSAP 22
Figure 7; Outcome category main Consortium Partner 22
Figure 8; Stories collected per country 24
Figure 9; Thematic area per country context 25
Figure 10; Actor new per context 30
Figure 11; TOC category per context 31
Figure 12; Intended and unintended outcomes 46
Figure 13; Outcome relevance of HSS and SRHR 54
Figure 14; Respondents' responses about collaboration 58

Code and terminology references used in this report

Codes for Outcomes and Stories collected

The evaluation team used a five digits code (e.g. 32667) indicate substantiated outcomes codes for the outcomes and for the stories. The five digits codes correspond to the codes used in the Interactive Sprockler reports (for Outcomes and Stories). The interactive reports can be accessed using protected passwords (managed by the HSAP Programme Desk).

Terminology

In this report, the evaluation team used three terminologies to refer to the word 'partner':

- HSAP Consortium Partners:
  - Amref, HAI, Wemos and ACHEST
- Contracted Partners:
  - Kenya: Amref Kenya Office, KOGS, Kenya Access to Medicines Platform
  - Zambia: Amref Zambia Office, SAfAIDS, Zambia Medicines, Research and Access Platform (MedRAP)
  - Malawi: Amref Malawi Office, AMAMI

    - Uganda: Amref Uganda Office, HEPS, ACHEST
    - Tanzania: Amref Tanzania Office, Sikika, Chama cha Uzazi na Malezi Bora Tanzania (UMATI)
- Participating organisations:
    - Partners: those who received capacity-strengthening interventions from the Contracted Partners, e.g. local CSOs and media.
    - Networking partners: those who did NOT receive capacity strengthening, but are collaborating or engaging with the HSAP programme in networks.

CSOs: organizations that received the capacity-strengthening intervention (the targets of the capacity-strengthening activities).

Executive Summary

INTRODUCTION

The Health Systems Advocacy Partnership (HSAP) programme, funded by the Dutch government, began in 2016 and will run until the end of 2020. HSAP's goal was to enable people to realize their right to the highest attainable sexual and reproductive health (SRH) in five African countries (Kenya, Malawi, Tanzania, Uganda, Zambia). This was done through interventions within these five countries, as well as in the Netherlands, at the global and regional level. Malawi and Tanzania joined in the second year (2017). The programme aimed to contribute to achieving 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. The HSAP envisaged that creating a strong health workforce, improving access to SRH commodities (SRHC), and investing in sustainable structures for health financing (HF) and governance, equitable access to high-quality SRHR services would be achieved.

HSAP Consortium Partners include Amref, the African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI), Wemos and the Dutch Ministry for Foreign Trade and Development Cooperation. The four core programme strategies include capacity strengthening of civil society organizations (CSOs), research, public awareness raising, and lobbying and advocacy.

EVALUATION OBJECTIVE, FRAMEWORK AND METHODOLOGY

The objective of this evaluation was to determine HSAP programme progress toward achieving the objectives for capacity strengthening of individual CSOs, CSO networks, communities, media, and HSAP programme partner and CSO advocacy results mainly on policymaking and implementation processes and level of policymaker support.

For the evaluation, based on the TOR, there were 4 proposed sets of main questions related to:

1. Relevance of individual CSO, CSO networks/platforms, community, and media capacity strengthening by HSAP partners
2. Effectiveness of advocacy approaches by HSAP partners, CSOs, and communities in achieving results. Focus within results on improved support of decision makers and involvement of CSOs and HSAP partners in policymaking processes
3. Lessons learned from the two abovementioned areas, linking advocacy issues from local, national, and global levels and vice versa, and addressing gender and inclusivity and relevance
4. Soundness of the mechanisms in place for HSAP outcome sustainability

The main methods used for data collection included a desk review, participatory outcome mapping, harvested outcome substantiation, story collection, in-depth interviews, and group interviews or focus group discussions (FGD). The evaluation team also used HSAP outcomes harvested from 2018 to February 2020 on capacity-strengthening and advocacy results for substantiation.

Evaluation respondents included HSAP Consortium Partners and Contracted Partners in each country (Amref Health Africa Kenya, Kenya-KOGS, Kenya-AtMP - Access to Medicines Platform; Amref Health Africa Zambia, SafAIDS, and Zambia MedRAP or Medicines Research and Access Platform; Amref Health Africa Malawi, AMAMI; Amref Health Africa Uganda, ACHEST and HEPS; Tanzania-Sikika, Amref Health Africa Tanzania and UMATI). Participating organisations included CSOs (received capacity-strengthening interventions from Contracted Partners [e.g., local CSOs and media]) and networking partners. Evaluation respondents included: harvesters, substantiators of specific outcomes (selected for demonstrable experience and expertise in the selected outcome area and no relationship with the programme), story-tellers (capacity-strengthening beneficiaries selected at random from list of CSOs,

CSO networks or platforms, and media provided by Contracted Partners) and informants (internal and external, not linked to a specific outcome).

Data collection took place from January until mid-May 2020, in all contexts. Appropriate ethical clearances were secured. The global consultant visited 3 countries (Kenya, Malawi and Uganda), and together with each national consultant conducted data collection. For the non-visited countries, Tanzania and Zambia, national consultants were recruited to collect data on the ground.

Outcomes to be substantiated were selected based on SMART criteria. Substantiation of selected outcomes and stories of change was conducted. Harvesters and substantiators completed an online Sprockler tool for each selected outcome. Stories of change were also collected from CSOs, that received capacity-strengthening training, through individual or group interviews and recorded using an online Sprockler tool.

A framework analysis approach was used to categorise and the analyse was done for the context and HSAP programme levels. Detailed reports for each context were written using Sprockler data and NVivo coded data. In each context, data from harvesters, substantiators, outcomes and stories from various key informant groups were triangulated for commonalities and differences. The main evaluation report was written based on detailed country reports.

FINDINGS: OUTCOME HARVESTING AND STORIES OF CHANGE

Outcome Harvesting

All outcomes harvested up to February 2020 were analysed; 69 outcomes in 6 contexts (African region, Global, Kenya, Malawi, The Netherlands, and Uganda) were substantiated. The evaluation team analysed and interpreted all available responses and assessed the credibility of each substantiated outcome. Sixty-four outcomes were found to be sufficiently credible (above a threshold of 75%; thus, all 240 outcomes were deemed credible with an overall average of sufficiently credible outcomes of 93%) and were used in this end-term evaluation. Of the 240 harvested outcomes, 87 (36%) were categorised as short-term, 63 (27%) as long-term and 90 (37%) as close-to-impact, which according to the TOC, was above HSAP's accountability ceiling. The close-to-impact level included improved and adopted policies and budgets, as well as policy implementation.

Stories of Change

In total, 126 stories were collected in Kenya, Uganda, Malawi, Tanzania and Zambia. To reveal community empowerment activities, storytellers reflected on work they had done during or after involvement with the HSAP or HSAP partners. Questions included the following. Did a person or group (or organisation, network, community or government) do something differently or for the first time due to their advocacy efforts? If yes, what changed? Most stories mentioned SRHC supplies including Family Planning (FP), which contrasted with the HSAP programme outcomes where the stories focused more on SRHC and gender/youth.

Harvested outcomes were often focussed on policy support and change including HSS (e.g., a health bill for paying CHWs). The HSAP views these policies as paving the way for more specific SRHR policies later on. Cross-cutting themes of gender, inclusivity and youth, and civil society space and participation were often selected as additional thematic areas. These stories stemmed from advocacy at a community level, and were based on the challenge's communities face, when generally focusing on specific target groups (e.g., young girls), and SRHR awareness raising in schools.

FINDINGS: CONTENT

Capacity-strengthening strategies and results

There were 295 CSOs (international non-governmental organizations [NGOs], national and local citizen NGOs, media/journalists, foundations, networks, and coalitions) capacitated by HSAP Consortium Partners during programme implementation (2016-2019). Capacity-strengthening efforts were conducted in all contexts (except The Netherlands). Global, regional, and country efforts were based on four strategies: (1) CSO capacity strengthening (Contracted and Network partners); (2) building (existing) platforms and networks by providing financial support and technical assistance; (3) engaging with media; and (4) amplifying community voices by strengthening existing CSO advocacy work in the community. Each HSAP Consortium Partner had agreed to focus of capacity strengthening, however in practice there was overlap during programme implementation.

Results of the CSO capacity-strengthening strategy. The evaluation showed that by strengthening CSO capacity, there was significantly improved knowledge on SRHR and/or HSS and increased knowledge and skills for lobbying and advocacy at national and district/county levels. The majority of the respondents indicated that their capacity training had led to increased CSO lobbying and advocacy capacity to contribute to improved SRHC supplies (including FP commodities), inclusion of young people, a strengthened health work force and improved working conditions.

Results of the capacity-strengthening of (existing) platforms and networks strategy. The evaluation found increased evidence-based lobbying and advocacy capacity of multi-stakeholder networks and platforms at the country level (HSAP TOC Mid-term Outcome). This strategy was proven to be successful in helping the CSOs networks/platform make demands of policymakers and have a more united voice heard by policymakers. HSAP accompanied CSO networks in advocacy at the district and county levels, made connections with local county policymakers and encouraged meaningful participation in policy processes on both sides, which has proven to be successful.

Results of engaging with media strategy. HSAP harvested outcomes and collected stories confirmed the success of this strategy, which contributed to the HSAP mid-term outcome: increased media attention for HRH, SRHC, HF and governance in 5 focus countries.

Results of amplifying community voices strategy. Collected stories showed there was increased HSS and SRHR knowledge among community members, and CSOs reported a catalytic effect on community members, who had started holding their leaders accountable; the communities were increasingly able to demand their rights. In all country contexts, HSAP civic education in communities and with community representatives (youth platforms, health committees, or leaders) enlightened participants to directly advocate for and demand their rights.

Achievement of HSAP's TOC

HSAP's approach to CSO and other stakeholder capacity strengthening, lobbying and advocacy has produced positive results. TOC pathways have generated solid advocacy results by consistent investment in developing and exploiting evidence for advocacy activities. HSAP's efforts to support communities to establish and demonstrate leadership and facilitate multi-stakeholder platforms have been successful in action. Media, parliamentary, CSO, network and government engagement has taken place, thus allowing communities to assert and claim their rights. HSAP use of established entry points with all levels of decision makers for community engagement has been productive. In particular, shared knowledge of HSS and SRHR as well as political and policymaking processes has allowed for results across communities.

Capacity building efforts for HRH, governance, HF and SRHC in all contexts and actions with HSAP partners have substantially contributed to strong advocacy results. The evaluation found HSAP's TOC pathways were valid and actions were complementary and reinforcing. The bottom-up approach ensured accountability, and sustained and effective dialogue and dissent on the focus topics within communities and between communities and relevant governments and authorities.

The selected literature confirmed the effectiveness of HSAP strategies, e.g. generating credible evidence, promoting effective leadership and networking and appropriately placing the network in political arena to participate in budget and policy decisions. HSAP has demonstrated unique community engagement, and empowered communities to speak up, participate in government processes and hold authorities accountable for appropriate services.

Effectiveness of advocacy approaches

HSAP started outcome harvesting in 2018 (3rd year of programme). Malawi and Tanzania were added in 2017 (focus was policy support instead of implementation due to short implementation period).

HSAP outcomes were notable, and in some cases, impressive for the short implementation period; 66% of achieved change was due to local (and then national) government involvement with support, policy adoption and budget implementation. Sub-national level outcomes were most tangible. National, regional and global advocacy efforts were irregular and required constant adaptation to changing contexts. Global and regional contexts had increased stakeholder engagement for HSS and SRHR outcomes. Only the global context had policymaker support outcomes. Few negative and unintended outcomes were harvested and although this is inherent to outcome harvesting, it can create bias since substantiators are often people who know the programme and outcomes well and have even benefitted from the programmes.

HSAP contributed to increased CSO capacity and visibility at several levels: sub-national level –a more legitimate voice in the communities and recognition by local governments and global and regional— for example increased CSO and youth-positive initiatives. However, systematic capacity building of country-level CSOs to meaningfully engage in regional and global advocacy as a strategy to amplify their national advocacy lagged. HSAP partners were recognised for their expertise, which was complementary, however, partners mainly worked autonomously (with some exceptions). Collaborations within and across contexts generally started in the 3rd year of implementation.

Relevance toward HSS and SRHR

HSAP partners had a varied focus and opinion on the relevance of HSS, SRHR or both. Changes for HSS were more relevant in the global context. In the Dutch context and some country contexts (e.g., Kenya and Uganda), changes were relevant for both HSS and SRHR. HSAP was successful in securing HSS and SRHR issues in (local) policies and budgets. HSAP predominantly focused on the supply side of HRH, SRHRC, HF and facility improvement and less on social and cultural factors, e.g., gender issues and poverty underlying health inequity.

The relevance of HSAP's outcomes for beneficiaries was not explicit. No evidence was found that HSAP raised their voices loudly on gaps and injustices of contentious HSS and SRHR issues. HSS systemic issues needed urgent action related to funding, governance, leadership and accountability. Governments could have been held to account for poor HSS and SRHR outcomes in their countries. Advocacy outcomes were predominantly achieved in enabling environments. HSAP may have taken strategic advantage of existing opportunities or support (community or policymakers), and exploited good relationships.

Lessons Learned

Gender mainstreaming and inclusivity or engagement strategies were not evident in HSAP programming at the start; almost all Contracted Partners stated this was a missed opportunity. Gender mainstreaming efforts depended on the context.

Stakeholders in planning. There was no evidence of women, girls, youth or marginalized groups being included in HSAP programme or activity development; but, in some contexts, HSAP did try to include women in public meetings. HSAP teams struggled to operationalise meaningful youth participation.

Relevance women/girls. Across contexts, Contracted Partners and substantiators indicated advocacy interventions and outcomes were very relevant for women and girls (without distinction between the two). Outcomes of HSS benefit were indirect or suggestively beneficial**;** effects were undocumented.

Relevance to PwD, other marginalised groups and LGBTI was not evident**.** These groups were considered as part of the general population benefiting from HSS and SRHR improvements. Most global and Dutch substantiators stated more focus was required on the needs of these groups.

Collaboration suffered from unclarity of roles, and a lack of coordination, strategic planning, and process reports; there was a lacuna of documentation for advocacy and lessons learned. Partners generally worked autonomously to achieve outcomes.

Governance challenges included: unclear roles in the partnership agreement, lack of transparency in decision making about partner budget allocations, missing budgets for coordination activities at a context level so each organisation had to financially invest in coordination according to partners. ACHEST (only Consortium Partner not in The Netherlands) had participation challenges. Governance at national levels was challenging in the beginning, without structure for communication, coordination or joint planning.

Complementarity and autonomy were highly exercised at national levels, but not used by Contracted or Consortium Partners to amplify each other's work or work in partnership. Some topics were ignored in advocacy and opportunities were missed. In Uganda and Malawi, efforts were duplicated.

Southern leadership autonomy was felt to reflect the penholder's proportionately greater power for budget and decision making and unequal participation at the highest governance level (Northern dominance). Contracted Partners believed the penholder's decision to discontinue the partnership after 2020 was a top-down decision since they were not involved.

Linkage levels. Contracted Partners felt national/regional/global connections were not as strong as they could have been and noted a disconnect with the global level. Despite HSAP attempts to inform country-level partners, the partners felt insufficiently involved in global advocacy. Collaborations across levels were successful in advocacy for CHW recognition. National and regional partner synergies were felt in Kenya more than other contexts.

Visibility/Legitimacy of CSOs increased significantly due to HSAP, and this was confirmed by both substantiators and storytellers. CSO capacity strengthening led to more successful advocacy, which increased their visibility at national, regional and global levels. HSAP partner expertise and evidence-based advocacy was highly recognised by governments, media, CSOs and other institutions. They were frequently requested to provide information or input, which increased their visibility. However, CSO increased visibility can also be a disadvantage where civic space is more restricted.

Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS was a missed opportunity, since HSAP uniquely joined two fields that predominantly operate in isolation.

Sustainability of the HSAP Programme

Sustainability was not extensively discussed within the HSAP or with donors. Contracted Partners in some country contexts believed that collaborations and relationships would continue after HSAP ends. The evaluation showed that the HSAP programme engendered several sustainable models by improving policies (national level) on HRH, HF, SRHC and CHW strategies working through MoH TWGs; aligning HSAP advocacy strategy with government agendas; targeting existing health care system structures (CHWs and health assistants) that still need strengthening; and working with Youth Parliaments. Contracted Partners were positive about the sustainability of HSAP work, but expressed disappointment it would not continue in its current form. They noted significant investment and learning was just now yielding fruit and 5 years were too short to build a flourishing partnership for advocacy results. Scepticism about CSO work continuing without HSAP financial support remained.

EVALUATION LIMITATIONS

No systematic review of all implemented activities and outputs was conducted, rather, the focus was on determining how implemented activities and outputs contributed to outcomes. Research was largely based on the HSAP programme's documentation and interviews, which may have created potential positive bias. To mitigate bias: (1) data was triangulated across methods and various respondents; (2) information from respondents were not linked to specific outcomes; (3) information about a specific outcome by more than one respondent were compared for outcome credibility; and (4) data about weak and strong aspects, missed opportunities and lessons learned across respondent groups were examined to ensure that negative and positive outcomes were harvested and substantiated. The evaluation findings pertain only to activities up to early 2020; thus, potentially important outcomes later this year are not considered. Unexpected outcomes were not well identified. Data collection was impacted by COVID-19 travel restrictions and limitations. Data collection changed to remote methods (phone/VoIP interviews) with other challenges (limited connectivity) and face-to-face analysis occurred online.

CONCLUSION

HSAP made progress toward achieving its objectives related to capacity strengthening of individual CSOs, CSO networks, communities, and media. Advocacy by HSAP partners and CSOs across contexts showed results. Notable outcomes included policy adoption, budget and policy implementation (especially for HRH), governance, HF and SRHC. HSAP's TOC pathways were valid. Advocacy strategies contributed to substantiated mid- and long-term outcomes, e.g., multi-stakeholder engagement in HSAP priority themes and policymaker support for policy change. These pathways included the use of evidence for advocacy, creation and facilitation of multi-stakeholder platforms, engagement with media, parliamentarians, CSOs, networks and governments and building their capacity, empowerment of communities to claim their rights and the use of valuable entry points with decision makers at all levels. Approaches were complementary and mutually reinforcing. HSAP contributed to CSO increased capacity, visibility and legitimacy, which enabled their involvement in dialogue and dissent with their governments and other stakeholders.

Missed opportunities—more mileage in advocacy results would have been possible if HSAP partners had operated as a partnership, instead of autonomously. The potential of an HSAP presence at various levels and contexts and complementary partner expertise could have been exploited. However, HSAP's governance and programme structures lacked budget coordination and mechanisms for joint planning and strategizing. Conceptual thinking about linkages between HSS and SRHR and that HSS leads to improved SRHR were present, but not fully operationalised. The operationalisation of gender transformation by addressing marginalization and exclusion and social determinants of poor SRHR outcomes were not a focus of HSAP.

RECOMMENDATIONS

1. Develop and implement governance structures and advocacy strategies to ensure consistency across levels and themes.
2. Build stronger connections across sub-national, national, regional and global levels to amplify advocacy and voices. Establish coordination mechanisms to oversee linkages. Exploit complementarity within HSAP. Amplify messages at various levels, and reinforce HSAP's status as a partnership instead of a group of individual organisations.
3. Continue capacity strengthening of CSOs and media at all levels utilising HSAP's expertise in HSS and the link with SRHR and effective advocacy approaches.
4. Apply thorough gender analysis in programme design and gender-transformative approaches in interventions. Document intervention effects on women, girls and marginalised groups. Involve beneficiaries in the design, implementation and monitoring of the programme.
5. Consider social determinants of SRHR, and inequalities including gender inequality leading to poor SRHR outcomes and limited update of services. Pay attention to intersectionalities that impact exclusion, marginalization and health inequities faced by some groups in society.
6. Develop a strong narrative on how HSS improves SRHR and vice versa.
7. Continue to increase CSO visibility while being cognisant of their possible vulnerabilities due to restrictive civic space. When this is the case, provide these CSOs with support.
8. Invest in building a partnership by examining internal power dynamics, building mutual trust, and establishing joint coordination mechanisms, strategies, planning and joint reporting.
9. Develop exit strategies for each context given that HSAP will cease to exist as a partnership, and to ensure achievement sustainability.

1 Introduction

1.1 The Health Systems Advocacy Partnership Programme

The Health Systems Advocacy Partnership (referred to in this report as HSAP) programme, a five-year initiative, was started in 2016, and will be completed at the end of 2020. This programme is funded by the Dutch government. The ultimate goal of the HSAP was to enable people to realize their right to the highest attainable sexual and reproductive health (SRH) (impact), by strengthening health systems. The project aimed to contribute to achieving sexual and reproductive health and rights (SRHR) by creating space for a strong civil society to effectively engage with governments, the private sector and other stakeholders accountable for health systems, and deliver equitable, accessible and high-quality SRHR services. The HSAP envisaged that by focusing on creating a strong health work force, improving access to SRH commodities (SRHC), and investing in sustainable structures for health financing (HF) and governance, equitable access to high-quality SRHR services would be achieved. The partners used four core strategies: capacity strengthening of civil society organizations (CSOs), research, public awareness raising, and lobbying and advocacy.

The HSAP is comprised of Amref (penholder), the African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI), Wemos, and the Dutch Ministry for Foreign Trade and Development Cooperation (MoFA). Since 2016, the programme has been active in three countries, Kenya, Uganda, and Zambia, the broader African region, The Netherlands and internationally. In 2017, the HSAP extended its work to Malawi and Tanzania. By the end of 2019, the HSAP had worked with approximately 600 unique CSOs, and almost 300 of these had participated in capacity-strengthening activities. The overview of the lead organization of Contracted Partners in each country can be seen in the table below.

Table 1; List of HSAP Contracted Partners and geographic implementation areas

Country	Contracted Partners	Areas where the HSA Partnership programme is implemented
Kenya	Amref Health Africa Kenya	National level: Nairobi District level: Homa Bay, Siaya, Kajiado, Narok Kisumu, Isiolo, Kakamega, Mombasa, Makueni, Meru, Nakuru, Kwale, and Kiambu
	ACHEST/KOGS	
	HAI/ AtMP - Access to Medicines Platform	
Uganda	Amref Health Africa Uganda	National level: Kampala District level: Soroti, Serere, Kabale, Dokolo, Lira, and Kisoro
	ACHEST	
	HAI/HEPS	
Zambia	Amref Health Africa Zambia	National: Lusaka District level: Ndola, Kabwe, Chililabombwe, Kitwe, Luangwa, Chongwe, Lusaka, Livingstone, Choma, Mufulira, Chirundu Kafue, Mumbwa, Chipata, and Mongu
	ACHEST/SAfAIDS[1]	
	HAI/MedRap – Medicines, Research and Access Platform	
Malawi	Amref Health Africa Malawi	National: Lilongwe District level: Mangochi, Ntchisi and Chitipa
	ACHEST/AMAMI	
Tanzania	Amref Health Africa Tanzania	National level: Dar es Salaam / Dodoma District level: Shinyanga DC, Msalala, and Kishapu
	ACHEST/Sikika	
	HAI/UMATI	

[1] ACHEST changed its contracting partner in Zambia in 2019. Initially, the partner was the University of Zambia. Due to low performance, the contract was ended, and ACHEST now has a new contract with SAfAIDS.

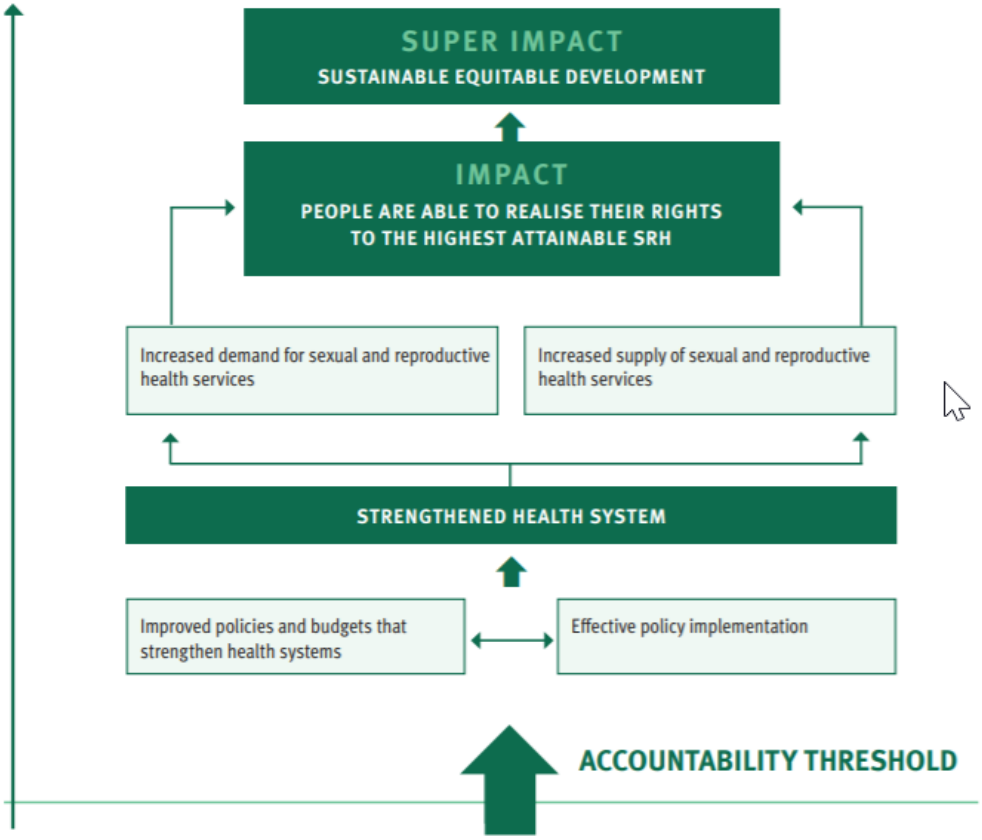
1.2 Theory of Change

There are three premises in the overall HSAP programme Theory of Change (TOC): (1) improving SRHR requires strong health systems; (2) strengthening health system building blocks from the bottom up should be focus of health system strengthening (HSS) approaches; and (3) meeting accessibility, affordability, quality and acceptability criteria requires linking health system building block reforms to an SRHR agenda.

For health systems to meet HSAP TOC criteria related to accessibility, affordability, quality and acceptability, barriers on the supply and demand sides of health systems must be confronted and managed. HSAP's vision is that strong, sustainable, equitable and inclusive health systems can be achieved by improving policies that strengthen health systems and increase duty bearer accountability while empowering them to effectively implement said policies.

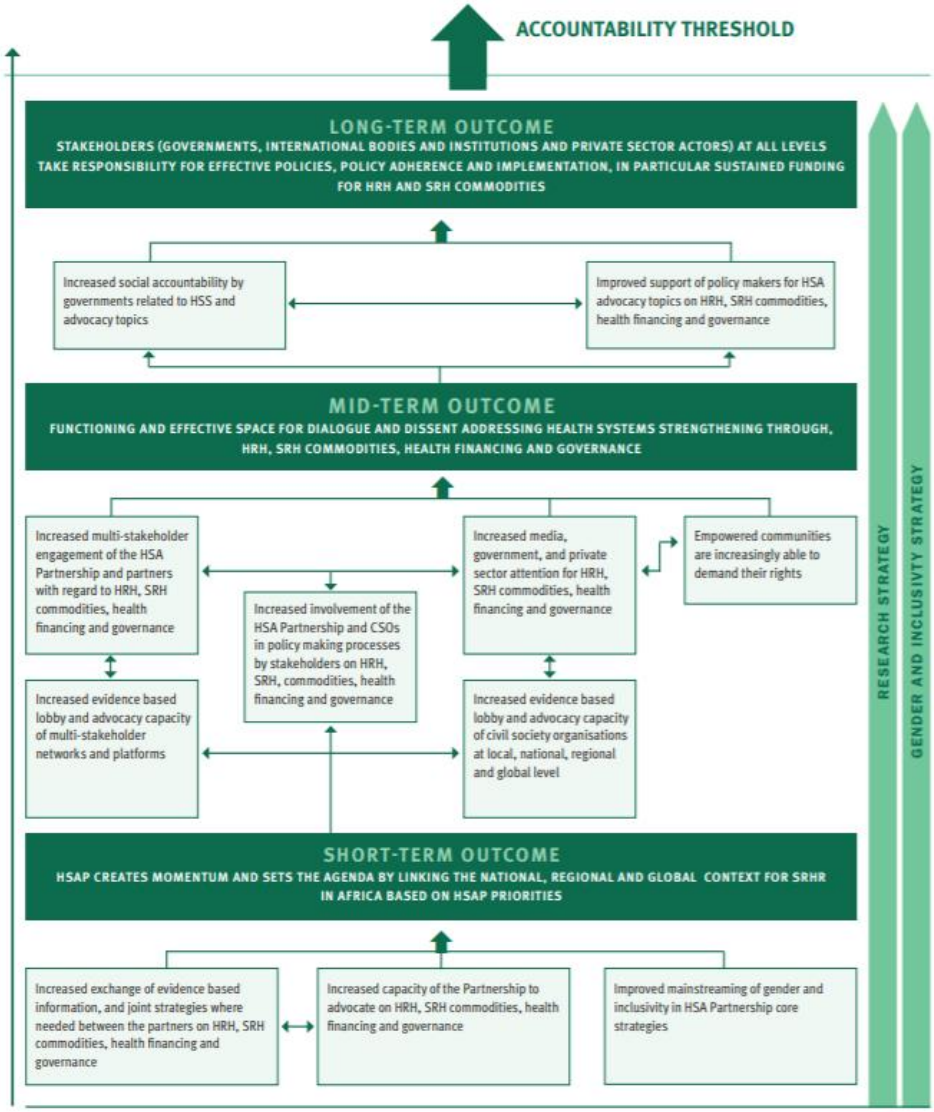
The HSAP interventions by thematic area include: human resources for health (HRH), SRHC, HF and governance.[2] Below is the overall TOC of HSAP programme[3]:

Figure 1; Visualisation of the Theory of Change above the accountability threshold



[2] ToR End evaluation of the HSAP
[3] Taken from TOC "Pushing the SRHR agenda forward by strengthening health systems: Overall Theory of Change HAS Partnership"

Figure 2; Visualisation of the Theory of Change below the accountability threshold



1.3 HSAP End-Evaluation Objective and Scope of Work

1.3.1 Evaluation objective

The main objective of this evaluation was to determine the extent to which the HSAP made progress toward achieving its objectives in the contexts of Kenya, Uganda, Zambia, Tanzania, Malawi, the African Region, The Netherlands, and globally in relation to:

1. capacity strengthening of individual CSOs, CSO networks, communities, and media, and
2. advocacy results of HSAP programme partners and CSOs (mainly involvement in policymaking and implementation processes and level of policymaker support).

The 4 main questions as specified in the Terms of Reference (ToR) are related to:

1. Relevance of individual CSOs, CSO networks/platforms, communities, and media capacity strengthening by HSAP partners

2. Effectiveness of advocacy approaches by HSAP partners, CSOs, and communities in achieving results. Focus within results on improved support of decision makers and involvement of CSOs and HSAP partners in policymaking processes
3. Lessons learned from the two abovementioned areas, linking advocacy issues from local-national-global levels and vice versa, and addressing gender and inclusivity and relevance
4. Soundness of the mechanisms in place for HSAP outcome sustainability

1.3.2 Scope of work

The scope of the end evaluation covered activities in 8 contexts: global, regional, country (five), and The Netherlands. The evaluation included project activities from January 2016 (project start) until February 2020. The evaluation focused on receivers at various levels, i.e., individual CSOs, CSO networks or platforms, communities, media, decision makers (mainly local and national governments), representatives from regional or international institutions, HSAP partners, and their counterparts in the African countries.

Data collection took place, in all countries, at both national and district levels. The method of data collection varied somewhat by country. For Kenya, Uganda, and Malawi, the global consultants visited each country and together with national consultants coordinated data collection. While in Tanzania and Zambia, the data was collected only by national consultants with coordination from The Netherlands.

2 Evaluation Framework

The evaluation design adopted a participatory approach, thus encouraging meaningful participation of all project participants: individual CSOs, CSO networks or platforms, people in the communities, media, decision makers (local and national government), and representatives from regional or international institutions, and the HSAP Consortium and Contracted Partners.

In this evaluation, the evaluation team uses three terminologies to distinguish various partners involved:

- HSAP Consortium Partners:
  - AMREF, HAI, Wemos and ACHEST
- Contracted Partners:
  - Kenya: Amref Kenya Office, KOGS, Kenya Access to Medicines Platform
  - Zambia: Amref Zambia Office, SafAIDS, Zambia Medicines, Research and Access Platform (MedRAP)
  - Malawi: Amref Malawi Office, AMAMI
  - Uganda: Amref Uganda Office, HEPS, ACHEST
  - Tanzania: Amref Tanzania Office, Sikika, UMATI
- Participating organisations:
  - Partners: those who received capacity-strengthening interventions from the Contracted Partners, e.g. local CSOs and media.
  - Networking partners: those who did NOT receive capacity strengthening, but are collaborating or engaging with the HSAP programme in networks.

2.1 Evaluation Questions

1. How relevant was partner capacity strengthening by HSAP Consortium and Contracted Partners for HSAP's contribution to HSS and SRHR?

   a. To what extent have efforts to strengthen the partners' capacities:
      i. led to changes in their advocacy skills and capacities?
      ii. led to advocacy-related outcomes (intended or unintended)?

      What were the contributing and/or hampering factors for partner capacity building?

   b. To what extent did the Contracted Partners' efforts to strengthen CSO and community-based organisation (CBO) capacity to strengthen community capacity lead to:
      i. changes in the communities' empowerment to demand their rights?
      ii. intended or unintended outcomes of 'empowered communities increasingly able to demand their rights'?

      What were the contributing and/or hampering factors for capacity strengthening at a community level?

   c. To what extent have the Contracting Partners' efforts to strengthen CSO (as partners) capacities affected the legitimacy of the CSOs to be locally owned and embedded in communities/society, local norms and values (perceived as meaningful and trustworthy, and accepted in society)? What were the changes over time and the implications of the changes toward their legitimacy? What were the contributing and hampering factors for ensuring and/or strengthening CSO partner legitimacy?

2. How effective were the advocacy approaches of the HSAP partners, CSOs and communities in achieving results?
    a. To what extent have the advocacy approaches:
        i. led to improved policymaker support for the HSAP programme's advocacy topics on HRH, SRHC, HF and governance?
        ii. led to strengthened advocacy linkages between national, regional, global and Dutch policymakers (intended long-term outcome)?
    b. To what extent have the advocacy approaches improved/strengthened the involvement of CSOs and HSAP programme partners in policymaking and implementation processes (intended mid-term outcome)?
    c. To what extent have the advocacy approaches improved/strengthened the development of effective evidence-based messages being taken up by like-minded networks and organisations (mid-term outcome global context)?
    d. To what extent have external factors or actors contributed to the achievement of the outcomes (improved policymaker support for the HSAP programme's advocacy topics and strengthened linkages of advocacy between national, regional, global and Dutch policymakers)? How do these factors or actors relate to the HSAP programme's contribution to outcome achievement (successes and set-backs)?

3. What are lessons learned regarding gender/inclusivity, collaboration within the partnership linking local to global advocacy, and the linkages between HSS and SRHR?
    a. To what extent has the partnership addressed gender and inclusivity in the programme? To what extent was the partnership able to include stakeholders in the planning process? To what extent was the partnership's approach to mainstream gender and inclusivity effective? What has hampered or enabled the implementation of a gender and inclusivity lens within the HSAP programme?
    b. To what extent has there been an added value of collaboration and governance structure within the HSAP programme for achieving results? What were the challenges and successes in collaboration and the governance within the HSAP programme for achieving results?
    c. What were the collaboration successes and challenges of partners/CSOs at various levels of the advocacy chain (sub-national, national, regional and global levels)? What factors have hampered or contributed to the collaboration successes and challenges?
    d. What were the lessons learned and relevance of HSS promotion as a precondition for SRHR and advocacy for SRHR influencing HSS?

4. To what extent will the long-term outcomes that the HSAP programme has contributed to through capacity-strengthening and advocacy approaches endure past 2020?
    a. What mechanisms are in place to sustain the advocacy outcomes in terms of policymaking processes?
    b. What mechanisms are in place to sustain CSO advocacy efforts, e.g. knowledge of policy processes, accountability and implementation?

The selected and refined sub-questions above were used to develop the matrix question for this end evaluation. The detailed matrix evaluation can be found in Annex 2.

In this report, the evaluation team uses the overall HSAP TOC (as seen in Annex 3) as a reference for the analysis, also explained in Section 3.10.

2.2 Target Audience and Use of Findings

The findings in this evaluation are intended for the strategic partnerships: MoFA in its role as donor and partner, HSAP Consortium and Contracted Partners, and participating organisations. The findings will be used by the HSAP partners to determine what and how capacity-strengthening and advocacy strategies can be used for other advocacy and non-advocacy projects (current and future). The evaluation findings/report will also be shared within the strategic partnership, the External Advisory Group and *Directie Internationaal Onderzoek en Beleidsevaluatie* (IOB).

2.3 Geographical coverage

Countries visited and not visited for the End Evaluation

In consultation with the HSAP programme, the global consultants visited 3 countries: Kenya, Uganda and Malawi and together with each national consultant conducted data collection. For the non-visited countries, Tanzania and Zambia, 2 national consultants were recruited to collect data on the ground using mostly phone and/or voice over internet protocol (VoIP) interviews. Data collection in Tanzania and Zambia was mainly done via phone and VoIP due to Covid-19. Whenever possible, the national consultants also conducted face-to-face in-depth interviews (IDIs) to locally contextualize the data. The impact of Covid-19 will be explained in more detailed in the limitations section.

The following table provides information about the locations visited during data collection.

Table 2: Location visited during data collection

Context	Location
Kenya	Siaya, Kakamega, Homa Bay, Kisumu and Narok
Malawi	Chitipa, Mangochi and Ntchisi
Uganda	Kampala, Lira, Dokolo, Soroti, Serere and Kabale
Tanzania	Shinyanga
Zambia	none

3 Evaluation Methodology

3.1 Evaluation Approach

The main evaluation approach was to assess and explain the programme's progress using the anticipated outcomes in the programme's TOC. The main questions used in this evaluation were formulated based on the following: TOC outcomes, and ToR, IOB, external advisory group and HSAP Consortium and Contracted Partner questions during the inception-phase interviews. Since 2018, the HSAP has been implementing an Outcome Harvesting (OH) evaluation method. To overcome the uncertain character and often unpredictable outcomes of advocacy strategies, OH retrospectively examines activity outcomes. During the implementation process, the programme implementors kept a record of outcomes describing actors' intended and unintended, positive and negative changes, the organisation's contribution to the change and the evidence for the outcome in an OH logbook. The implementors also recorded outcome links to the TOC.

As a key source for this evaluation, the evaluation team used the HSAP harvested outcomes from 2018 to February 2020. Outcomes related to both capacity-strengthening and advocacy results were selected for validation.

For this evaluation, a mixed-method approach (largely qualitative) was applied using OH, a selection of stories of change, the Sprockler tool and additional qualitative data. Sprockler is a tool that collects a combination of qualitative and quantitative data. It was used in this evaluation for story collection and OH. OH, was applied to the following contexts: global, The Netherlands, Uganda, Malawi and Kenya.

3.2 Evaluation Phases

Following the ToR, this end evaluation was conducted in three phases: (1) inception, (2) desk research and field work and (3) data analysis and reporting. Detailed information on each phase and the deliverable can be found in annex 4.

3.3 Data Collection Process

3.3.1 Data collection process per context

The main methods used for data collection included a literature review, participatory mapping of outcomes, substantiation of harvested outcomes, story collection, IDIs, and group interviews or focus group discussions (FGD). IDIs and FGD were used for three purposes: (1) harvest existing (and new) outcomes, (2) collect stories of change, and (3) collect other relevant data to answer the evaluation questions. The document review was conducted to identify outcomes and issues for follow up and complement the results. Table 3 below, describes methods used by context.

Table 3; Data collection process by context

Data Collection Process	Context							
	Global	the Netherlands	Regional	Kenya	Malawi	Uganda	Tanzania	Zambia
Literature review	x	x	x	x	x	x	x	x
Participatory mapping of outcomes to create outcome pathways at the Annual Reflection (AR) meeting facilitated by the global consultant	x	x	x	x	-	x	-	-
Substantiation of harvested outcomes through Sprockler substantiation inquiry (through face to face) individual or group interview	x	x	x	x	x	x	-	-
Collecting stories of change gathered through a face to face group interview or online or phone interview	-	-	-	x	x	x	x	x
IDI with Consortium Partners, Contracted Partners and key informants through face to face, VoIP or phone interview	x	x	x	x	x	x	x	x

In Malawi, the participatory outcome mapping was not conducted due to time limitations for the OH workshop and the context partners inability to adequately prepare for the session prior to the workshop. In Uganda and the regional context, outcome pathways were identified during the OH workshop, but not thoroughly, also due to time limitations. Nevertheless, the evaluation team analysed of the outcome pathways and the findings clearly showed the relevance of the pathways.

In the inception report, national consultant substantiation of harvested outcomes was foreseen for Tanzania and Zambia; however, this did not happen due the evaluation team's limited resources, as well as COVID-19 (see above). In consultation with the HSAP Desk, the decision was made to reprioritize available time and resources to improve the quality of the outcomes in the logbook database. In addition, the global evaluation team did not visit these two countries, and it was not fair or wise to leave the evaluation responsibility for facilitating the OH workshops only to the national consultants.

Capacity strengthening on regional advocacy took place with CSOs at the national level and they were part of the story collection in the country contexts.

3.3.2 Data collection tools

For this evaluation, the evaluation team developed five types of data collection tools:

1. Sprockler Outcome inquiry for the HSAP programme
2. Sprockler Substantiation inquiry
3. Sprockler Story inquiry (for collecting stories of change)
4. Topic guides for IDIs (for the global, regional, country and Dutch contexts)

5. A facilitation guide on how to map and rank the (selected) outcomes during the Annual Reflection

The final data collection tools can be found in (Annex 5).

3.4 Evaluation Respondent

Respondents for this evaluation were categorised into four groups; internal substantiators, external substantiators, beneficiaries or storytellers, and (key) informants.

1. Internal substantiators harvested outcomes (harvester).
2. External substantiators, validated and deepened our understanding of existing outcomes (e.g., national and international policymakers/advocacy targets such as government staff [both policymakers and practitioners], parliamentarians, representatives from regional or international institutions, and community representatives). The external substantiators were identified by the harvester. To substantiate more outcomes and obtain a comprehensive picture of overall HSAP programmes, and in consideration of the limited evaluation resources, only one external substantiator was assigned to each outcome.
3. Capacity-strengthening receivers (partners and network partners) or storytellers, shared stories on how the capacity-strengthening activities led to advocacy-related outcomes (CSOs, CSO networks or platforms, and media).
4. (Key) informants (two groups):
    - Internal resource persons/individuals, HSAP Consortium and Contracted Partners, and MoFA[4] shared experiences about the partnership and other evaluation questions.
    - External resource persons/individuals, knowledgeable about the capacity-strengthening and or advocacy activities of the HSAP programme and well informed about the debate, evidence and practices related to HSS and SRHR, provided outcomes not listed as outcomes, highlighted issues from the external environment influencing the outcome of activities and/or were able to share perceptions about the importance of the programme.

Table 4 below shows a categorized overview of the respondents for each context.

Table 4; Respondents per context

Respondent	Context						
	Global/the Netherlands	Regional	Kenya	Malawi	Uganda	Tanzania	Zambia
Internal substantiator/ harvester	6	5	7	12	12	0	0
Substantiator	10	6	10	18	12	0	0
Capacity-strengthening beneficiaries/ storytellers	0	0	57	7	21	16	25
KII							
Internal resource persons/individuals: HSAP Consortium and Contracted Partners	5	6	3	2	13	3	3
External resource persons/ individuals	7	2	2	3	2	0	0

In this evaluation, there were overlapping respondents, since they had various roles, e.g., substantiators and external resource persons. Thus, during the substantiation interviews, respondents (substantiators) were asked questions from the KII tools in addition to questions for outcome substantiation.

[4] The MoFA was only interviewed during the inception report

3.5 Sampling Strategy

In this evaluation, sampling was used to select four key informant respondent groups: harvesters, programme-identified substantiators, storytellers and informants not linked to a specific outcome. The sampling method for selecting harvesters and substantiators is known as *non-probability*, *purposive*, *expert* sampling[5]. Outcomes to be substantiated were selected based on the following criteria: Specific, Measurable, Achievable, Realistic and Time-bound (SMART). The harvester and substantiator were selected based on their demonstrable experience and expertise in the selected outcome area (see section OH process). The storytellers were selected from CSOs, CSO networks or platforms, and media based on the list given to the evaluators by each Contracted Partner during the inception phase interview and using a purposive sampling method. Key informants not linked to a specific outcome were purposively selected by the evaluators. Below, in Table 5, is an overview of the planned versus actual result of the sampling strategy.

Table 5: Result sampling strategy

Description	Planning	Actual
Outcome harvesting	All outcomes will be used in our analysis.	All outcomes (of sufficient quality) were used in our analysis.
	20% of the outcomes will be selected for external substantiation.	20% of the outcomes per context were selected for external substantiation.
	90% of those (the subset of 20%) will need to be verified for the entire set of outcomes to be 'credible enough'.	75% of those (the subset of 20%) were verified for the entire set of outcomes to be 'credible enough'.
Stories of change	As much as possible within the boundaries of the evaluation.	As much as possible within the boundaries of the evaluation.
	Minimum total number: 50 stories	Total stories collected: 126 stories
	Minimum per context: 25 stories (Kenya, Uganda, Malawi, Tanzania, and Zambia).	The number of stories collected per context varied between 7 stories and 57
In-depth interviews:	All Consortium partners	All core partners
	All Contracted Partners	All Contracted Partners
	For the key informants: approximately 5 respondents per context; and for the substantiators and storytellers: a small number, as many as needed.	The number of key informants interviewed varied per context between 2 and 7 respondents

3.6 Online Training and Piloting

Online training was conducted for national consultants in February 2020. The training was split over two sessions: the first session focused on story collection, and was attended by 5 national consultants and the second session focused on OH, and was attended by 3 national consultants.

The tools for substantiation and story-collection inquiries were piloted including how to administer the tools in Sprockler. Based on the pilot experience, the substantiation and story inquiries were revised and finalised. The IDI tools with key informants were not piloted since in most context IDI was conducted by global consultants, also time and resources were prioritized for improving outcome quality. However, the questionnaires were discussed online with the national consultants, especially with those from Tanzania and Zambia.

[5] Outcome Harvesting: Principles, Steps and Evaluation Applications, 2018, Ricardo Wilson-Grau (Page 93)

3.7 Data Collection Timeframe

The data collection for the countries was divided into two parts—visited and non-visited countries. For visited countries, data collection took place from March 1-20, 2020. For non-visited countries, data collection took place from the beginning of April until mid-May 2020. Data for the global and Dutch contexts was collected from January-March 2020.

3.8 Quality Assurance

The following measures were taken to uphold the high quality of the study and minimize errors in the data collection and analysis processes:

1. Data collection tools were developed by the evaluators taking each context into account. A standardised approach to the evaluation was used in each country to enable comparison among findings, and questions about cross-context learning were included in all contexts.
2. Only local consultants with previous experience in qualitative data collection and with good local language and English proficiency were recruited from the five selected countries. The local consultants were trained in using the tools.
3. Virtual oversight/monitoring (email, phone, Skype, and WhatsApp) was conducted during the data collection process for troubleshooting and coordination during field work.
4. During the entire evaluation, there was regular communication among team members, the HSAP team in The Netherlands and at the country level.
5. Random checking of summary field notes was done by the global consultants.
6. Feedback, evaluation and reflections were also conducted and collected as data.

3.9 Data Management

All data collected related to the harvested and substantiated outcomes and story collection were entered into Sprockler. The Sprockler data and answers to more general questions about the programme (e.g., most important achievements, strong and weak aspects of the programme, missed opportunities and data from interviews with respondents not linked to a specific outcome), were coded and entered in NVivo. The interviews were recorded and detailed notes were taken. The tapes were used to check and update the detailed notes. Quotations presented here are based on these notes. All KII notes, recordings, and written consent forms were kept per previously agreed data retention policies. Data will be kept for a maximum of 5 years and then destroyed.

3.10 Outcome Harvesting and Story Collection Process

3.10.1 Substantiation process

At the start of the evaluation, in general, the outcome statement quality was not up to standard. Several outcome formulations were improved at the beginning of the evaluation, and a final quality check was done at the end. The evaluation team had to ensure that all outcome statements were SMART. The team assessed outcomes one by one on SMART-ness—in particular, as specific and measurable.

To deepen the evaluation team's understanding of the outcomes, OH workshops were organized for all contexts with two goals: (1) create pathways of change to understand sequence (possible causal links), and (2) nominate outcomes for substantiation. Pathways of change were created for the global, Dutch and Kenyan contexts. For regional, Malawi and Uganda contexts, the workshop emphasis was

on improving outcomes and nominating outcomes for substantiation. For the contexts where pathways were not discussed during OH workshops, the pathways were included in the analysis process by the evaluation team, and the evaluation shows clear pathway relevance. During the OH workshops, several strategies were conducted to assist harvesters in improving the quality of the outcome's statements: OH refresher session, facilitated discussion of outcome content among harvesters, and classification of outcomes (nominated for substantiation) by entering them in Sprockler.

Ultimately, substantiation was done to a sufficient level of credible accuracy and deep and broad perspectives on the outcomes to verify the legitimacy of the entire outcome set. A list of all substantiated outcomes with substantiator comments is provided in annex 7 of the evaluation report.

Outcome selection was based on nominations by HSAP Contracted Partners per context. During the OH workshops, the HSAP Consortium Partner representatives and the evaluation team jointly decided on the *most essential* outcomes contributing to the main HSAP goals. The evaluation team made the final decision on the outcomes to be substantiated. In the contexts where pathways of change were created, the most recent outcomes were selected. The feasibility of substantiation by location and travel time was also considered. During the OH workshops, HSAP Consortium and Contracted Partners entered nominated outcomes for substantiation in Sprockler. In Malawi, the use of Sprockler was challenging because of a poor internet connection (Wi-Fi and phone line). This was solved by using the Sprockler app offline. Unfortunately, uploading the responses remained challenging, so paper questionnaires were generally used and answers were later entered online in Sprockler. For the global and Dutch contexts, substantiation was done by sending a link with the online inquiry to the substantiator, and then conducting a follow-up interview by Skype or phone. For Malawi, Uganda and Kenya, the global and/or national consultant visited the substantiators in person. During this meeting, the substantiator was asked to respond to the inquiry questions. Responses were either noted directly on a device (online or offline), or written on paper to be processed later. Substantiator responses were stored in Sprockler, and linked to the respective outcomes. This made it possible to interpret the responses from the HSAP and substantiator for the same outcome.

Substantiation process

In substantiating the outcomes, each substantiator was asked assess the accuracy of the outcome and provide feedback on the outcome assigned to him/her using the Sprockler tool (outcome verification, see Annex 11). The evaluation team decided to substantiate one outcome with one substantiate, with some exceptions of several outcomes in the global, Dutch, and Malawi contexts. The decision was made by prioritizing how the resources had been used during the evaluation to substantiate more outcomes for a complete picture of the overall programmes. Thus, in total, 68 substantiators provided feedback on 69 outcomes. For Kenya, 8 outcomes were substantiated by recently published research conducted in Kajiado[6], "Watershed Partnership and The Health Systems Advocacy Partnership in Kajiado", as a reliable source for substantiation. Visiting the location wasn't necessary for verification, and the HSAP team and the evaluation team agreed to avoid the possibility of overloading the intended substantiators, since they were to be approached again for data collection.

Challenges experienced in the substantiation process

The evaluation team experienced some challenges in identifying substantiators, such as:

[6] Final Report Joint Case Study: Watershed Partnership and The Health Systems Advocacy Partnership in Kajiado, Kenya. Muturi. M, Karanja.M (2019)

- Due to a constant shift in government officers such as Ministry of Health (MoH) programme staff who knew the HSAP programme and its outcomes well, the evaluation team had to replace some substantiators; in a few cases, the successors did not know the programme well, which might have influenced the agreement level on substantiated outcomes (Kenya, Malawi).
- One government substantiator from Kenya and one from Malawi were not willing to be interviewed via phone; even though much effort was made by the (national) evaluation team to contact substantiators using various channels such as email and phone/WhatsApp messages to request their participation and send reminders.
- COVID-19 influenced the data collection process in this evaluation (see limitation section).

These challenges affected the total number of substantiated outcomes since some outcomes could not be substantiated. However, the credibility level of substantiated outcomes was still above the set threshold and COVID-19 did not have an impact on the credibility level of the overall HSAP outcomes.

3.10.2 Story collection process

The most stories were collected in Kenya (57 stories), which corresponds with the large number of CSOs involved in the Kenyan context due to their networking approach.

In Malawi, the low number of collected stories was due to the similarities of most stories with the harvested outcomes. Thus, the evaluation team decided to select stories that stood out compared the outcomes produced in Malawi to avoid duplication. The evaluation team also planned to organise a story workshop with the selected health centre committees at the village level. However, the number of invited participants was too large and it wasn't possible to split the facilitation process since the participants could not speak English (only the national consultant who facilitated the session could speak English and the local language). Thus, in the end, only one story came out.

In Uganda, 21 stories were collected among local and national CSOs and media. Three story collection workshops were facilitated by the evaluation team: one in the capital Kampala with the nationally based partners; one in Kabale, which brought together partners from Kabale and Kisoro districts; and one in Lira, which brought together partners from Lira, Dokolo, Serere and Soroti.

In Tanzania, 16 stories were collected with the CSOs. The national consultant was able to travel to Shinganya and had face-to-face meeting with 7 CSOs in Shinyanga and Dar es Salaam before the travel restriction was imposed and the national consultant had to resort to interviewing people by phone.

In Zambia, initially, story collection was supposed to be face-to-face interviews using Sprockler. However, due to the COVID-19 pandemic, online interviews were conducted either through Skype, regular phone calls or Zoom. There was a total of 25 stories collected from CSOs located in multiple districts of the country. The Sprockler questionnaire and guidelines were emailed to all the organisations that participated in the capacity building. This was to afford the respondents an opportunity to go through the questionnaire prior to the interview.

In Zambia, the evaluation team experienced challenges in collecting stories. Below are some examples:

1. Low response rate: some of the contacts' details did not have valid email addresses, either because of spelling issues or some had changed their addresses;
2. Poor phone networks: respondents were spread across the country and some lived in typical rural areas, so connectivity was a challenge. Interviews lasted longer than expected since calls were

dropped several times during the interviews. This was even worse for internet-based calls such as Zoom, Skype and WhatsApp.

3. Lack of access to Internet: most CSOs do not have easy access to internet.
4. Double work: questionnaires were printed and completed for each interview, and later typed into Sprockler. This resulted in a significant increase in the effort required for this evaluation.

3.11 Data Analysis

A framework analysis approach was used to categorise results. The coding framework for the NVivo data base was based on the evaluation questions, the programme priority themes, the mid-term and long-term outcomes of the overall TOC and the context. The coded data was then entered in NVivo and analysed per context for each main evaluation question related to relevance, effectiveness, lessons learned and sustainability. The analysis was done for the context and HSAP programme levels. Detailed reports for each context were written (see annex 6) using the Sprockler data and the coded data from NVivo. In each context, data from harvesters and substantiators, outcomes and stories and from various key informant groups were triangulated for commonalities and differences.

Based on the detailed country reports, the main evaluation report was written. Findings across contexts were analysed to identify commonalities, differences and unique findings for each of the evaluation questions.

Throughout the report, achieved outcomes were assessed for plausible CSO/CBO contributions, improved decision maker support, and CSO and HSAP partner involvement in policymaking processes, as well as to identify the most beneficial advocacy approaches.

HSAP partners and key stakeholder interviews complemented the analysis of internal/external actors and factors that enabled/hampered achievements.

Data from the two Sprockler inquiries to substantiate outcomes and collect capacity-strengthening stories from receivers are presented in two interactive online reports. Selected report visuals are included in the narrative report.

The collected stories of capacity-strengthening receivers and responses from external substantiators were used to assess harvested outcome credibility and to understand contributions by the HSAP and other actors or factors that enabled or hampered achievements.

3.12 Ethical Consideration

General consideration

The data collection process for the HSAP end evaluation had minimal ethical risk. No secondary patient data and/or data collection from vulnerable groups or minority groups who may not have been fully capable of providing consent was included. The data collected was used for the sole purpose of the evaluation and will not be used for other purposes. One minor risk applied to data from professionals. If confidentiality was broken, the participant's reputation might have been affected.

The evaluation report does not include data that could lead to respondent identification. Notes or recordings of data collected and consent forms were kept on password-protected computers and hard copies were kept by the principal evaluators in a locked suitcase until transferred to the RiH office where they were kept in a locked cabinet.

Informed consent was obtained from all the respondents.

The evaluation team identified that ethical approval was required for Kenya. For Malawi and Uganda, the team received information that since it was a project evaluation activity, ethical approval was not needed, and the evaluation team could obtain an exemption letter for the evaluation protocol. Thus, the evaluation team only submitted the evaluation protocol and accompanying tools. Whilst for Tanzania and Zambia, it was unclear if the evaluation team needed to apply for ethical review or not, and only at the end of January 2020 was the evaluation team informed that for both countries, ethical approval was required.

This initial information was not complete and the evaluation team needed significant time to gain clarity on the required procedures from each country (for example, what kind of documents were needed, to which organization the ethical review should be sent, the fee and payment procedures, etc.), and execute them remotely. Some of the challenges were logistical. For example, properly hard copies of the documents needed to be submitted to specific offices in Africa.

Finally, at the beginning of March 2020, the evaluation team received ethical approval for Kenya and at the end of March for Zambia. For Tanzania, ethical approval was provisionally granted.

3.13 Limitations of the Evaluation

- The evaluation did not include a systematic review of all implemented activities and outputs; but instead focused on outcomes and determined how implemented activities and outputs contributed.
- The research was largely based on the HSAP programme's documentation and interviews with people involved in the programme. This may have created positive bias. To mitigate bias, data was triangulated across methods and interview groups. In particular, information from respondents not linked to a specific outcome and information about a specific outcome by more than one respondent were compared for outcome credibility. In addition, data about weak and strong aspects, missed opportunities and lessons learned across respondent groups are examined to ensure that not only positive outcomes were harvested and substantiated.
- The evaluation findings were based on data limited to early 2020. This may have led to important outcomes that emerged later in 2020 being missed, and risked that the evaluation did not do justice to the full programme implementation. Unexpected outcomes were not well identified. Only a few hampering factors were identified to indicate that the situation could have been worse if not for the HSAP programme.
- To harvest unexpected and negative outcomes, in each context harvesters were asked to think about or identify any outcomes that could have been missed. In the Sprockler inquiry, all substantiators and harvesters were asked to identify if the outcome was intended or unintended. Few to no negative outcomes[7] were harvested by the HSAP programme (further information on efforts by the evaluation team to harvest negative outcomes and identify missed opportunities can be seen in section 4).
- Impact of COVID-19 pandemic on the evaluation:

[7] A negative outcome is not simply one that does harm to something or somebody, but it is a change in a social actor's behaviour that undercuts, weakens, impairs or otherwise undermines the purpose of the intervention.

The data collection phase of the evaluation was significantly impacted by travel restrictions and limitations. The travel restrictions happened at the end of data collection in Uganda and Malawi. For Tanzania and Zambia, the travel restrictions heavily influenced the data collection process for conducting KIIs and collecting stories of change both at the national and sub-national levels. To mitigate these effects, the evaluation team changed some of the data collection methods to remote methods (phone/VoIP interviews), which posed distinct challenges (limited connectivity). COVID-19 also meant that people working in public health-related fields were not easily accessible for interviews leading to delayed or missed responses and interview cancellation in Uganda. COVID-19 also created a more difficult process for the analysis, which is usually done face to face, but in this case the evaluation team adjusted to online meetings for data analysis.

4 Finding 1: Outcome Harvesting and Story Collection using Sprockler Tools

4.1 Outcome Harvesting: Findings on Outcomes Harvested and Substantiated

This section presents the findings of the OH. The evaluation team analysed all outcomes harvested until February 2020, as well as the substantiated outcomes in 6 contexts (African region, Global, Kenya, Malawi, The Netherlands, and Uganda)[8].

The table below lists the number of harvested outcomes per context listed from the HSAP OH logbook and extra outcomes harvested during the evaluation entered directly by the harvesters in Sprockler, the number of substantiated outcomes, and the percentage. The percentage for each context is equal to or higher than 20%, thus meeting the agreed sample percentage.

Table 6; List of outcomes harvested and substantiated per context (until February 2020)[9]

Context	Number of outcomes	Number of outcomes substantiated	Percentage of outcomes substantiated
African region	24	6	25%
Global	31	10	32%
Kenya	60	18	30%
Malawi	44	16	36%
The Netherlands	18	7	38%
Uganda	60	12	20%
Total	**240**	**69**	**28.75%**

The list of substantiators can be found in annex 8.

The evaluation team analysed and interpreted all available responses and came to a final assessment about whether or not each of the 69 outcomes was sufficiently credible. Below are the findings:

- 4 outcomes were: (a) not verified by the substantiators, or (b) the credibility of the outcomes was doubtful, and could not be sufficiently assessed by the evaluators, or (c) core elements of either the outcome and/or the contribution was not confirmed and/or required adaptation. These outcomes were not analysed and so they were deleted from the evaluation. The list of these outcomes can be found in Annex 9.
- 7 outcomes were mainly substantiated, but one or more minor details were recommended for adaption. The details did not change the core of the outcome or the contribution. Adaptations were made as needed, including outcomes that substantiators marked as 'partially agreed' and requested additional information. The evaluation team assessed these outcomes as sufficiently credible. The list of these outcomes can be found in Annex 9.
- One outcome in the Dutch context was suggested to be an output since the meeting concerned had not yet taken place; therefore, the outcome was deleted from the total outcome set.

[8] The substantiation of outcomes was not done in Tanzania and Zambia due to the prioritization to best use the evaluator team's limited resources to improve the quality of the outcomes in the logbook database. The global evaluation team did not visit the two countries, and it was not fair or wise to leave the responsibilities for OH workshops facilitation only to the national consultants. Thus, it was decided the data collection in Tanzania and Zambia would only cover stories of change collection among capacity-strengthening receivers and KIIs with local Consortium Partners and sub-contracted partners.

[9] The HSAP stored all harvested outcomes in Excel in a logbook, and these were kept up to date by the PME Officer Partnership Desk. This logbook contains more than 240 outcomes. However, only the set of 240 outcomes was considered by the evaluators. The rest of the outcomes were of insufficient quality according to the evaluators' judgement.

- 59 outcome statements were fully substantiated and there was no need to make changes in the outcome statements. These included the 8 Kenyan outcomes that were substantiated by the Kajiado case study report.

The table below contains the number of credible outcomes compared to the number of substantiated outcomes. The intention, as stated in the inception report, was to reach a percentage of sufficiently credible outcomes of 90%.

Table 7; Number of credible outcomes compared to the number of substantiated outcomes

Context	Number outcomes substantiated	Number outcomes sufficiently credible	Percentage outcomes sufficiently credible	Credible enough (within the 90%)?
African region	6	6	100%	Y
Global	10	10	100%	Y
Kenya	18	17	94%	Y
Malawi	16	13	81%	N
The Netherlands	7	7	100%	Y
Uganda	12	12	100%	Y
Total	**69**	**64**	**92,75%**	**Y**

A total of 64 outcomes were found to be sufficiently credible. The list of the complete outcomes with detailed descriptions can be seen in Annex 10. In the Inception report, a threshold was set based on the OH book: *Outcome Harvesting: Principles, Steps, and Evaluation Applications* by Ricardo Wilson-Grau, which informed the evaluators' intention to have at least 90% of the substantiated outcomes assessed as sufficiently credible (fully agreed upon by substantiation) for each context individually. In hindsight, this threshold was extremely high considering the complex nature of this multi-country lobbying and advocacy programme. For such complex programmes it is not evident that external people, often policymakers, will agree to the outcomes presented, regardless of their accuracy. There might have been other political, and often hidden, reasons for substantiators to partly agree or disagree with the outcomes or the HSAP contributions claimed. Therefore, the evaluation team consulted with the OH experts to set an adequate threshold for a complex project like the HSAP; based on similar advocacy programmes, also funded by the MoFA, it would have been more suitable to have a lower threshold of substantiated outcomes (for example, 75%).

With this in mind, the evaluation team considered that the overall percentage of 93% met the more reasonable threshold, and even though for Malawi, the percentage was lower (81%), it was above 75%. **Conclusion:** Overall, 240 outcomes were sufficiently credible for primary use in this end-term evaluation.

Process of analysis and interpretation

The evaluation team asked the respondents (HSAP representatives during the outcomes entry, and the substantiators during their responses-to-outcomes entry) to classify the outcomes according to the HSAP TOC categories for the evaluation. They were given a single-choice question—classify the corresponding TOC outcome category, and the corresponding actor type. The evaluation team also concluded that the outcomes still had varying quality, even after refinement during the OH workshops. Approximately 5% of the statements remained insufficiently SMART, and were removed from the set and overall analysis. Examples of outcomes with insufficient quality were:

- ‘Developed and delivered petition to the speaker of Kabale district local government to improve the status of Maziba HC IV.’
- ‘CSOs after being trained on SMART advocacy are sharing experiences and outcomes.’

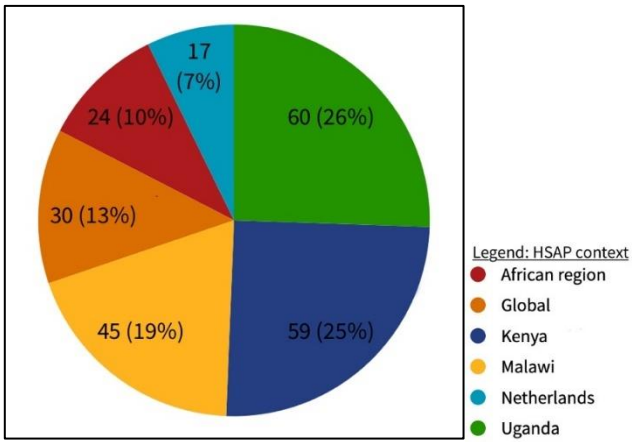
The locations and dates for these activities were missing. Most importantly, there was no description of a change—before and after.

An example of a good quality outcome was: ‘In August 2018, the District Health Office filled one Senior Nursing Officer position in Kwera HCIII, which was vacant after the facility’s Nursing Officer left for further studies and never returned.’

4.1.1 Overall outcome harvesting findings

The extensive OH findings can be found in the OH Visualizer Report[10]. In this report, the evaluation team presents the main highlights of the OH findings. This evaluation considered 240 reported outcomes by the HSAP between 2018-2019 in: Malawi, Uganda, Kenya, The Netherlands, and global and regional contexts (see figure 3 below).

Figure 3; Outcomes per context



The following chart shows the kind of outcomes harvested by the HSAP[11]. The categories are similar to the TOC outcome categories. The HSAP TOC distinguished levels of outcomes: short-term, mid-term, and long-term outcomes, and one level above the accountability ceiling—outcomes close to impact. The following categories were used for outcome categorisation and analysis in this report:

Mid-term level:

- Increased capacity
- Increased involvement of multiple stakeholders
- Increased attention

Long-term level: Improved support of policymakers

Level close to impact (above accountability ceiling):

- Improved policies and/or budgets adopted by policymakers

[10] The link and password will be sent separately to the HSAP Desk coordinator

[11] HSAP did not harvest outcomes related to the short-term TOC outcomes on purpose, since this concerned the functioning of the partnership itself and was beyond scope of this evaluation.

- Policy implementation

For a reflection on the usability of the TOC and adaptations made for this analysis, see section below.

Of the 240 outcomes, 87 (36%) of the harvested outcomes were categorised as short-term level and 63 (27%) as long-term level. That left 90 (37%) outcomes as close-to-impact level, which according to the TOC, was above HSAP's accountability ceiling. The close-to-impact level includes improved and adopted policies and budgets, as well as policy implementation. In consultation with the Dutch MoFA, HSAP regarded these outcomes as above their accountability ceiling, therefore, it can be concluded that HSAP achieved goals beyond their expectation. The TOC states HSAP's vision as: 'by improving policies that contribute to strong health systems, improving the accountability of health systems duty bearers and enabling them to implement policies effectively, strong, sustainable, equitable and inclusive health systems can be realized'. This logic is common in lobbying and advocacy programmes and for HSAP, the evaluation team saw that policies and budgets had been adopted and implemented. To what extent this led to strong, sustainable, equitable and inclusive health systems remains uncertain. To determine this would require an impact study, which was beyond the scope of this evaluation.

Figure 4 below depicts the number and percentage per outcome category for the entire HSAP programme (the colours represent the outcome categories); Figure 5 shows the number of outcomes per context, whereby every dot represents an outcome. Figure 6 contains the type of actors that changed for the entire HSAP and Figure 7 identifies the Consortium Partner that mainly contributed to the outcome.

Figure 4; Outcome category for entire HSAP

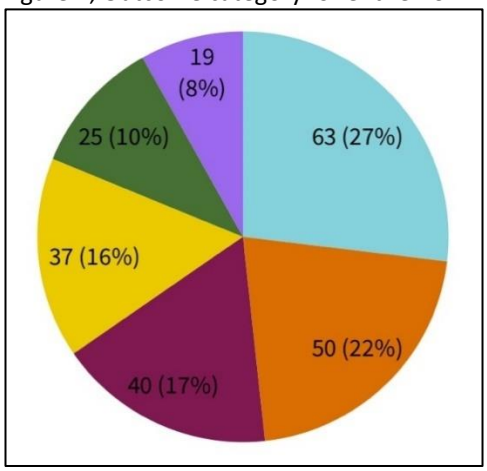


Figure 5; Outcome category per context

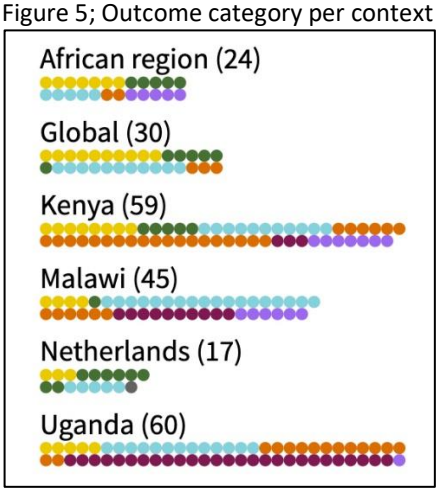


Figure 6; Outcome category per actor for entire HSAP

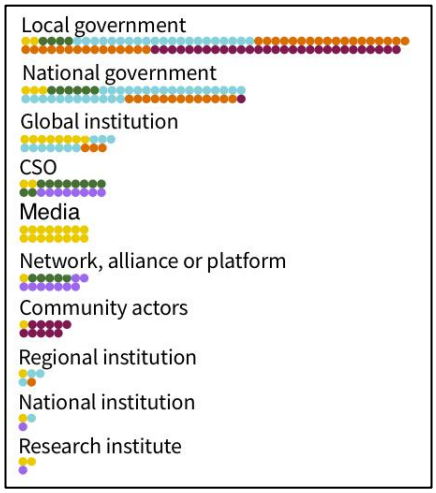
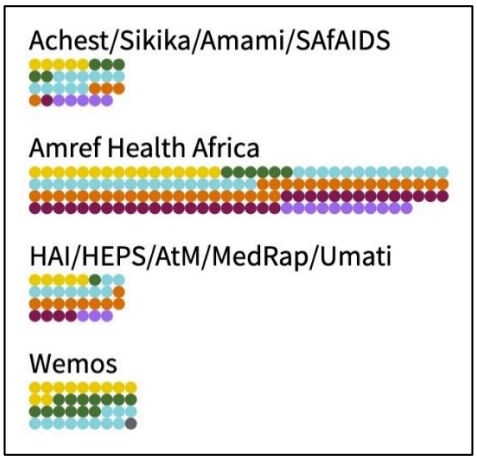


Figure 7; Outcome category main Consortium Partner



The evaluation team interpreted the above figures as follows. Figure 4 shows that there were few (19) outcomes whereby CSOs or networks increased lobbying and advocacy skills or conducted advocacy actions, which is not surprising or worrying after four years of programming. These types of outcomes are often reported at the start of a programme, but as the programme progresses, increased lobbying and advocacy skills and actions contribute to more advanced outcomes, and can frequently be found in the contribution descriptions. Since this was anticipated, the evaluation team collected stories from CSOs and media to obtain additional information on capacity strengthening (see chapter 5).

Figure 5 demonstrates that most outcomes were harvested in Kenya (59) and Uganda (60). This was expected since the two country contexts were established when HSAP started in 2016. These countries had the largest in-country teams, sub-contracted CSO harvested outcomes, and had an established programme when HSAP started OH in 2018. In Kenya, a set of outcomes described how the local government demonstrated their support for HSS and/or SRHR, but even more outcomes were about how the government had adopted new or improved policies and budgets. In Uganda, these types of outcomes also occurred, but to a lesser extent. In Uganda, most outcomes were about tangible action taken by local government, and thus were proof of policy implementation. In Malawi, a young programme, most outcomes described how government support had increased. Increased support often precedes adopted policies, so this trend is encouraging. Hopefully, this support will translate into policy changes in the near future.

Improved policy support given by local or national governments was reflected in 10/22 global institutional outcomes with signs of improved policy support (see Figure 6). Increased involvement of multiple stakeholders was found in every context, except Uganda. In the Netherlands and at a global level, these even formed half of all outcomes, thus indicating the HSAP's focus on multi-stakeholder processes. In Kenya, several multi-stakeholder outcomes occurred at a district level. The Kenya programme was successful in bringing multiple stakeholders together through their networking approach.

In addition to many outcomes harvested at the local government level (see Figure 6), multiple national government outcomes gave signs of increased policymaker support, and policymakers adopting new or adjusted policies or budgets, mostly in The Netherlands. In Uganda, policymaker support-related outcomes happened at a national level, and to a lesser extent in Kenya and Malawi. In the three

country contexts, 13 outcomes described how the national government adopted policies or budgets. In Malawi, 4/6 outcomes demonstrating policy or budget changes were at the national level.

Local government and community actors, such as professionals working in health facilities, community health committees and young people's initiatives (such as Youth Parliaments), also implemented policies (see Figure 6). In other words: they undertook actions to improve the health system at the community level, or improve SRHR services to youth. This is a strong sign of how communities are able to demand their rights, and go one step beyond: they not only demand their rights, but also take action.

When examining Figure 7, which shows the outcome categories that the Consortium Partners contributed to, all is according to expectation. All Consortium Partners contributed to outcomes related to increased attention and support of policymakers, which are common outcomes in lobbying and advocacy programmes. Wemos contributed most notably to multi-stakeholder engagements at the global level. The three Consortium Partners that were active in the country contexts contributed to improved and adopted policies and budgets.

4.1.2 Reflection on the TOC and its usefulness for analysis

After the evaluation team conducted the analysis based on the TOC outcome categorisations and actors, a few remarks are necessary for the TOC's usability. The evaluation team adjusted the TOC categories to draw sound conclusions. The logic of the TOC (how short-term outcomes lead to long-term outcomes, etc.) remained largely intact. Annex 12 includes a table with the original HSAP TOC outcome categories and actors, and the adapted categories and actors. The analysis in this chapter, as well as throughout the report, was done with the use of these adjusted categories. Theories of Change are living documents that require adjustment throughout the programme lifetime. Therefore, it is not concerning that these adjustments were made by the evaluation team. It is hoped that lessons are drawn from this adjustment exercise for future programming.

Originally, categorisation of outcomes was done by HSAP Consortium Partners. Their choice of outcome and actor category was often motivated from the partnership perspective, instead of the actor/subject of the outcome. For example, the actor categorisation was often 'HSAP', when it should have been another actor (e.g., the local government). The HSAP members also often selected 'MT-increased multi-stakeholder engagement with regard to Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance', which was a broad category and widely applicable. The evaluation team applied this category only if several stakeholders were indeed involved.

In general, other TOC categories were often more applicable for the change described in the outcome. The category 'social accountability' was rarely selected by the HSAP. The evaluation team found this was an overarching goal, rather than an observable change of a targeted actor. Therefore, it was removed from the list of categories for the analysis. Additional actor categories appeared during the analysis, which were not part of the predefined list of actors, such as community actors (individuals, professionals, committees or facilities). The lack of a category for community actors can indicate that it wasn't foreseen in the TOC that community actors are also 'advocacy targets' who can be influenced to take action (implement policies), even though the TOC states: 'the HSA Partnership considers citizen voice and expertise crucial for raising public awareness and increasing the demand for SRH services at community level.' Networks and alliances were also missing as a category.

Finally, the evaluation team concluded that overall logic of the TOC held true. Interestingly, many outcomes were achieved above the TOC accountability ceiling. This is a salient point of discussion for future programming.

4.2 Sprockler Stories Report

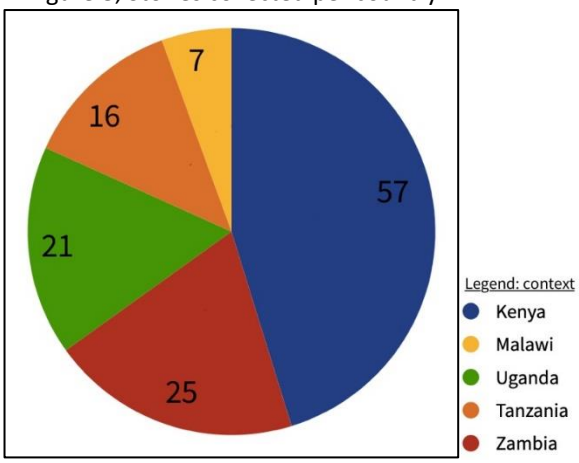
In total, 126 stories were collected in Kenya, Uganda, Malawi, Tanzania and Zambia during the evaluation. This document includes an overview of the key trends and patterns observed in the responses to the story inquiries per country. Each full story can be read in the Story Report Visualizer[12].

The storytellers were asked to reflect on the work they had done during or after their involvement with the HSAP or one of its partners. Then, they were asked if there was one person or group (including an organisation, network, community or government) that had done something differently or for the first time because of their advocacy efforts. If so, what had been the change? This was similar to asking for an outcome; the wording was adjusted and formulated in a way to provoke a story.

4.2.1 Overall collected story findings

The harvested outcomes already contained some outcomes at the CSO level, but none at a community level. The stories were meant to reveal what had happened at a community level. The Figure 8 below provide information how many stories collected in each country. A list of all storyteller organizations is provided in annex 13 of our report.

Figure 8; Stories collected per country



4.2.2 Thematic areas of collected stories

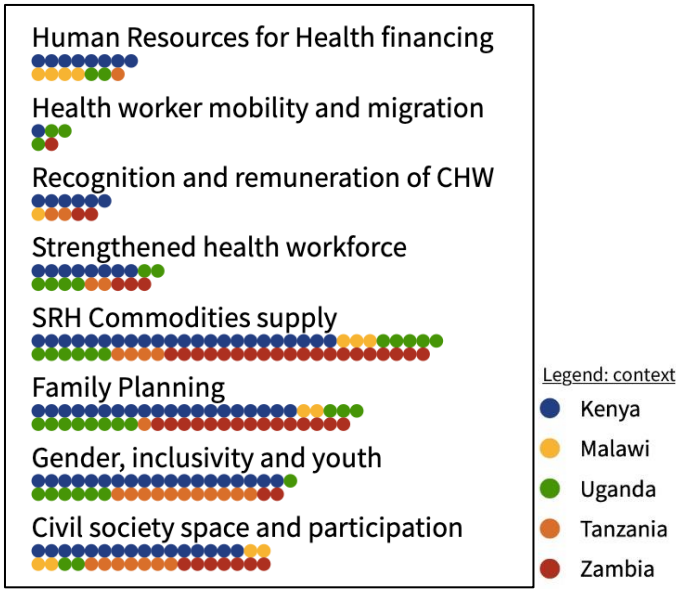
Storytellers indicated which thematic area their story belonged to. They could choose multiple answers (see Figure 9 below). Most stories were about SRHC supplies (including FP). However, since many stories focused only on FP (and not other SRHC supplies), the evaluation team decided to single out FP-related stories. These stories focused more on SRHC supplies and gender/youth, whereas in the HSAP programme outcomes analysis, these topics were mentioned less often. This is not surprising because harvested outcomes are often focussed on policy support and policy change, which was about HSS (e.g., a health bill including payment of community health workers (CHWs). The HSAP views these policies as paving the way for more specific SRHR policies later on. First, broad health policies must be established, and then amended to include specific sections on SRHR. Alternatively, advocacy can focus

[12] The link and password will be send separately to HSAP Desk Coordinator

on the budgets attached to those bills, and address SRHR budget lines within the broader health budgets.

In Figure 9 below, the bottom two options, namely gender, inclusivity and youth, and civil society space and participation, were often selected as additional thematic areas since they were cross-cutting. However, for Kenya (10 stories), Uganda (2) and Tanzania (7), *only* the gender, inclusivity and youth option was chosen, since, according to the storytellers, their story was about youth and did not fit in any other category. The stories stemmed from advocacy at a community level, and were based on the challenges faced by communities, who are often more focussed on specific target groups (e.g., young girls), and SRHR awareness raising in schools.

Figure 9; Thematic area per country context



Examples of stories as written (verbatim) by the storytellers from country contexts are presented below with examples of selected themes:

1. HRH Financing

Story from Uganda (33007)

For the first time, the Dokolo District local government re-aligned the Health Assistants (HAs) role in the District. In March 2018, the Building-community Initiatives for Development and Self-reliance (BIDS) Foundation, with support from Amref Health Africa, organized a project inception meeting at the Dokolo District Council hall and the District Health Officer (DHO) pointed out that a key challenge affecting health service delivery in the District was the high rates of absenteeism, presentism and attrition. He cited absenteeism as highest among HAs (as high as 70%) and attributed this to their oscillating movements between health facilities and sub-counties. Advocacy efforts led to joint dialogue meetings between the District Health Team, Health In-charges, Senior Assistant Secretaries and HAs. The HA role was re-aligned by ensuring that they be based at health facilities only as a permanent solution. One HA confessed that he had been absconding from duty and had made up his mind to quit drinking alcohol, concentrate on his work and help those affected by alcoholism. It was resolved that if the sub-county leaders needed support from HAs, they should put in an official request with the Health

Unit In-charges, who would allocate 10% of the Primary Health Care funds for environmental health services to be managed by the HA.

Story from Kenya (32640)

During our engagement with health system advocacy, we have had very smooth engagement with the Siaya county government on health financing. Specifically, a bulk allocation of funds for the department executive improved service delivery that had been hindered since devolution, in 2013. Post training, we started engaging with the county on improving health allocation, and addressing specific costed department plans. In 2019, we had the first costed implementation plan for FP. This necessitated constant FP commodity management and tracking in the county to avoid earlier experiences of occasional stock outs. Initially, SRHR personnel access to schools and menstrual hygiene were not easy; post training, we developed clear advocacy for schools, which resulted in easy access through the education department. Currently, we have meaningful engagement with adolescents and youths in school to address their reproductive health needs. We also did a community assessment for health needs and developed advocacy by integrated outreach and trained youth-friendly providers to address youth needs in the community. This is working well, and for sustainability, we are mentoring girls and boys as champions who accompany us during field activities. Who changes? Local government and community actors.

Story from Tanzania (33573)

The advocacy effort target was the district council. Changes achieved included a commitment by the District Council to establish a policy to facilitate health facility delivery by covering transport costs incurred by pregnant women up to 50%. Penalties for home delivery included fines to village leaders. The situation in Kishapu was cultural habits acting as a barrier for health facility delivery. For example, a pregnant woman should not travel and deliver at a health facility if she has to cross a river, and a woman's first delivery must be at home. We were aware of this because our organisation was working in 15/28 wards. Before training, we were working with Good Neighbours (CSO for maternal, new-born and child health projects) and we had a discussion with healthcare workers on causes of maternal and neonatal deaths. We used their responses to construct our advocacy agenda. After Amref training, we went to see the ward counsellors in 15 wards. They had participated in the Dodoma training, so this made it easier for us. The aim was to get their buy-in and advance our agenda to get the District Council to set aside a budget to facilitate facility deliveries for pregnant women with risk factors. The changes were ward offices arranging for pregnant women with risk factors to be required to deliver at the health facilities and cover 50% of the transport costs.

2. Recognition and renumeration of CHWs and strengthening of the health work force

Stories from Kenya (32685)

After collecting several stories from CHWs (volunteers), most counties (especially Siaya and Kisumu), have started paying stipends to the CHW volunteers and paying for their health insurance funds, e.g. NHIF.

Kenya (32690)

Some of the stories the evaluation team collected through The African Media Network on Health (AMNH) Chapter Kisumu were about the significant impact to the health sectors across counties in the Western Region. *To single out one, (on the CHWs), through the network we have managed to cover the plight of the CHWs who are the first line in the community primary health systems. Before [our efforts], they [had] never received a stipend in appreciation for what they do. But from multiple highlights on*

reporting about this, counties like Siaya and Kisumu set up a fund to ensure they receive a monthly cash stipend and health insurance.

3. SRHC supplies including FP

Stories from Zambia

A combination of stories (33610, 33611, and 33613 respectively), showed how advocacy activities by HSAP had addressed the lack of SRHC, especially for young people, and the stigmatization shown by health workers towards young people accessing SRH services, including contraceptives.

- *The approach taken in engaging communities changed from top down to bottom up. We have engaged our leaders and community members in social accountability to hold their leaders accountable. As a result, the MoH at some clinics are now providing services (including SRHC). This is because our communities now know about social accountability* (Story 33610).
- *Project entails linking services to providers, and empowering young people on how to access these services. The service providers approach has changed since they have changed their behaviour on handling young people who were stigmatised by health providers. Since we started advocating, they have now changed and are more welcoming* (Story 33611).
- *We used to receive a lot of complaints as a result of the church youth camp meetings. Some complaints were about sexually transmitted infections and FP. When young people access these services, they are stigmatised. We sensitised the youth on their rights to access SRH services and have seen an improvement in the cases received at our clinic. We have even formed a clinic youth-friendly corner where young people can access information and other SRHC* (Story ID33613).

4. Gender, inclusivity, and youth

Story from Kenya (32636)

Initially, we conducted engagements with the Siaya county government that bore no fruit. However, based on our training on advocacy skills and approaches we are meaningfully engaged with the county government in the budget-planning process. A good pointer is that youth participation in budget processes was very minimal and attendance too. We have now influenced the county (especially the budget and planning committee), to provide space for youths so their views are also captured. Last year during the Annual Development plan, the Planning and Budget committee set a day to specifically get the youths' views, which were finally factored into the current County Fiscal Strategy Paper (CFSP) developed. The number of youths attending and participating in the county budget-planning process has also increased and this is through the good advocacy strategies that we have deployed.

Kenya (32629)

Community leaders include traditional leaders, religious leaders, village elders, chiefs and sub-chiefs. After involvement with HSAP, as an organization, we integrated community dialogue sessions to cover various topics and also get feedback. Community leaders are very influential and we reached them with information on social-norm change (harmful cultural practices that need to be changed and participation in the budget-making process, the importance of having community members turn up during public participation and how their voices and contributions could help influence a change by a reduction of new HIV infections among the young people [currently on the rise] and teenage pregnancy prevalence rates—a community concern). By having these sessions in 4 sub-county wards, we have seen an increase in the people turning up for public participation forums and are able to capture the needs of the communities (e.g., when the budget proposes building more facilities, yet in reality the

community needs more personnel in the available facilities). Through the community leaders, communities have also been empowered to hold their leaders accountable and put them to task. When their leaders go to the media (e.g., radio stations), they call [us] and ask questions. The young people have also used social media platforms to engage their leaders and this has seen immediate action (e.g., when we had a damaged road leading to Ukwala town and vehicles could not pass, which interfered with business, the MCA and area MP were engaged through Facebook; in two weeks, the road was repaired and is now in good shape). Who changed? Community members changed (the young people, local leaders, women and the elderly).

Kenya (32655)

Through the capacity building from MeTa Kenya, Heart-to-Heart Smile managed to do resource mobilization and reached out to special schools; girls with disabilities are totally left out in matters of SRHR. We realised that most organisations are doing outreach to schools, but special schools are left out. So, we decided to identify special schools (about 3 rural/urban schools). In one special school, we mobilized 20 girls in a Peace Club. One of the girls functioned as our ambassador working with the CSOs. They air out their issues, so we know what to focus on. One of the interventions was giving the girls sanitary towels. The girls are sometimes sexually abused in order to get sanitary towels. Still, in our follow-up we realised that instruction is needed for the use of sanitary towels. They sometimes don't know how to use sanitary towels. They also didn't know there are different sizes. We then made small leaflets that we put in the provided sanitary towels.

5. Civil society space and participation

Tanzania (3353)

The Village Development Committee is responsible for ensuring the implementation of the decisions and policies of the ward development committee (WDC), and resident welfare. It can initiate its own development projects and implement them.

Change: *Commitment to/and construction of changing rooms for girls in primary schools. The Situation: The CSO works in two wards: Usanda and Tinde wards in Shinyanga. As part of our programme, we run student clubs in primary schools where we hold debates and assess student's school attendance as well as passing rate. We did an analysis and realized there is poor attendance among female students. We run our programmes together with teachers, and they told us female students miss classes during their menstrual periods. The existing toilet infrastructure wasn't user-friendly for female students. We started our activity by inviting few parents and school committee to a meeting to discuss the female students' poor attendance. The meeting established the need to construct female changing rooms. We did our lobbying to the village development committee, and the community, especially parents. We approached the ward counsellor and asked him what were his views on female changing rooms? We also invited him to the initial meeting, where he contributed seven (7) roofing sheets. The community committed to contributing bricks, and the village chairman promised to mobilize masons in his village to build the rooms. We had invited a few community members from each village. At the moment, four schools have built these rooms.*

Malawi (32958)

I want to talk about the community score card. In 2016, the official of the DHO initiated the use of score cards among various groups men, women, youth, etc. In 2018, the Integrated Pathways for Improving Maternal, New-born, and Child Health (InPATH) came to meet the community with support from DHO. After the meeting, a score card committee was established with two people from all interested groups

including a councillor and senior chief. The score card committee was the first to be trained in February 2018, before the Health Centre Management Committee (HCMC). The training was by Integrated Pathways for InPATH with funding from Global Affairs Canada and later, August 6-10, 2018, HCMC by InPATH. So, since the score card requires collaboration, HCMC training was a very good move. On July 19, 2019, we met Amref at Wenya ADC where they said Amref was working in 3 districts on HSS. Through Amref and the use of champions, we have achieved a lot. They encouraged us to continue using scorecards as before. Despite using scorecards from 2016, people did not own the initiatives, but with Amref orientations and trainings the people's mindset has changed and they started realising ownership of initiatives. For example, score cards help us be a watchdog at a facility level and give us a picture of our community data. There are tremendous improvements in Wenya.

Malawi (33634)

When Amref and the Ntchisi Evangelical Churches Consortium for Social Services (NECOSS) came to conduct training, they enlightened members on the management of the health facility according to the population; so, the facility should have 5 medical officers, 16 nurses and 24 HAs. But then, we had 1 medical officer, 1 nurse and 15 HAs. This affected service delivery at the facility since when the medical officer is away on other duties, patients cannot access services.

Through this training, the community realized that something must be done to address this problem. So, members discussed with NECOSS [that they had] to take the issue to the DHO's office. This happened, and then 1 medical officer and 1 nurse were posted to Kasonga health centre. So, no funding was provided, only training. But since our request was granted, this was the benefit of the training that was provided.

Regarding intention, unlike outcomes, there were more unintended changes mentioned in the stories in each country context than unintended changed mentioned in the outcomes.

4.2.3 Similarity between stories and outcomes

For both Kenya and Uganda, at least 10 outcomes were mentioned by the storytellers in their stories. For Malawi, 7 outcomes were confirmed by the 6 stories that were shared.

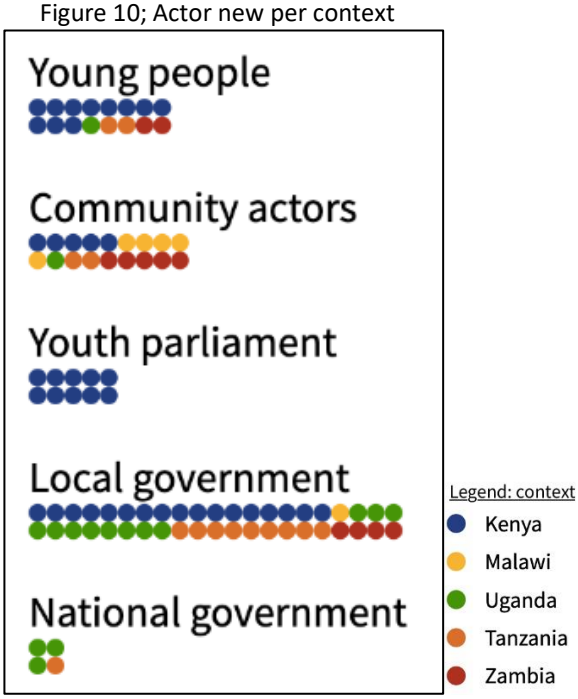
In Kenya, for one media outcome, there were 7 journalists (radio, TV, print, and online) from the AMNH Lower Eastern Chapter who confirmed this outcome through their stories. In Uganda, one media outcome was also confirmed by storytellers. In addition, several policy implementation outcomes were confirmed in Uganda, such as the reduction of high rates of absenteeism by HAs in the Dokolo District. In Malawi, three outcomes confirmed by stories were about policy implementation through the use of scorecards: one in Chitipa district and two in Ntchisi district. In Kenya, there were few outcomes describing policy implementation, but many stories described policy implementation conducted by both local government as community actors. In Kenya, outcomes harvested about the multi-stakeholder process and policy and budget changes were confirmed by several storytellers, mostly in Siaya, where outcomes were confirmed by members of the Youth Parliaments.

4.2.4 Type of Actors

The following figure shows the actors who changed, see Figure 10. The actors mentioned in this figure were the target of the advocacy (not the actor causing the change). From the Figure 10, local government was the most frequently mentioned actor that changed as a result of HSAP advocacy in the country context (based on the story findings), followed by community actors and young people. The TOC actor categories did not include any actors at the community level, so the categories used

here were formulated by the evaluation team as they emerged during the analysis process. Young people were separated from the other community actor categories, since they really stood out as a separate group, which demonstrated how HSAP reached young people specifically.

Figure 10; Actor new per context



4.2.5 Link between stories and TOC

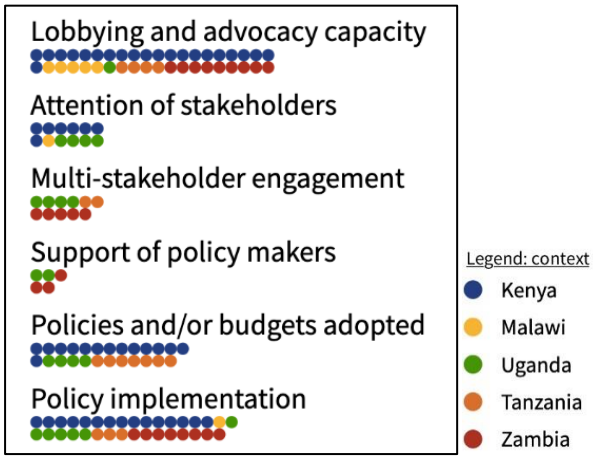
The following figure shows the extent to which HSAP has been able to realise their TOC objectives, as represented in the collected stories from 5 country contexts. It should be noted that some stories described outcomes that had already been mentioned, and were therefore used for triangulation (see section 4.2.3). Stories that described additional changes (new information) were not validated by other primary data, since this was beyond the scope of the evaluation. Therefore, the stories need to be interpreted as 'perceived changes' by the storytellers, and not as factual, since that would require further validation.

As seen in Figure 11 below, of the 126 stories, almost half were at the close-to-impact level (beyond the accountability ceiling), namely 20% adopted policies or budgets and 26% policy implementation. Many of these adopted policies or budgets, or policy implementations were conducted by local government (of the 42 stories that described changes in local government, one quarter described policy implementation), but many community actors also implemented policies and undertook tangible action (of the 16 stories about changes in young people, half were about tangible action; and of the 10 stories about changes in the Youth Parliament, 7 were about tangible action).

The rest of the stories were mid-term level outcomes: increased lobbying and advocacy capacity or actions, increased stakeholder attention and increased engagement of multiple stakeholders.

Three Ugandan stories were about national level changes, while the rest concerned local government and media. The Ugandan stories did not differ much from the outcomes that were harvested, and some were about local government implementing policies. In Tanzania, many stories were about the local government and adopted policies and/or budgets. In Zambia, many stories were about CSOs, and in Kenya, many were about the Youth Parliament and young people in general.

Figure 11; TOC category per context



5 Finding 2: Content

5.1 Effectiveness of Capacity-Strengthening Efforts

5.1.1 Focus, strategy and advocacy results of the capacity strengthening efforts

Question: 1. How relevant was the capacity strengthening of partners by HSAP Consortium and Contracted Partners for HSAP's contribution to HSS and SRHR?

a. To what extent have efforts to strengthen the partners' capacities:
   i. led to changes in their advocacy skills and capacities?
   ii. led to advocacy-related outcomes (intended or unintended)?

   What were the contributing and/or hampering factors for partner capacity building?

b. To what extent did the Contracted Partners' efforts to strengthen CSO and CBO capacity to strengthen community capacity lead to:
   i. changes in the communities' empowerment to demand their rights?
   ii. intended or unintended outcomes of 'empowered communities increasingly able to demand their rights'?

What were the contributing and/or hampering factors for capacity strengthening at a community level?

HSAP capacity-strengthening focus

Each HSAP Consortium Partner had agreed on the focus of capacity strengthening, however in practice there was overlap during programme implementation.

a. Amref: CSO capacity building and lobbying and advocacy (CHWs, health worker migration (HWM)[13] and retention, and financing for FP).
b. ACHEST: lobbying and advocacy (HRH and governance) and CSO capacity building at a global, regional, national and district levels, e.g., training for consumer score cards for social accountability and the Global Health Diplomacy Training.
c. HAI/MeTA: increasing CSO capacity to conduct evidence-based lobby and advocacy, including building an evidence base on SRHC by improving the research expertise of Contracted and Network Partners on access to SRHC in Uganda, Kenya, Tanzania and Zambia.
d. Wemos: increasing the evidence base for and developing advocacy strategies and materials to influence national and global positions on financing for health and HRH, and increasing CSO engagement in policy processes such as influencing the Global Financing Facility (GFF) and universal health coverage (UHC). Wemos capacity strengthening at a country level included assistance to countries to develop evidence-based papers and lobbying and advocacy strategies to increase CSO capacity to claim greater engagement in policy processes[14].

HSAP capacity-strengthening strategy and advocacy results

Capacity-strengthening efforts were conducted in all contexts (except The Netherlands): global, regional, and country. For the Dutch context, strengthening civil society was not seen as a priority.

[13] Except in Malawi, since this issue was not considered relevant for the Malawi situation by the Amref Malawi Office and AMAMI.

[14] Progress reports July-Dec 2018

The main focus was strengthening civil society in focused countries (KII, Consortium Partners; Inception report). There were four strategies of capacity strengthening applied by HSAP, namely:

1. HSAP strategies for capacity strengthening in lobbying and advocacy involved capacity strengthening for CSOs (Contracted and Network Partners).

There were 295 CSOs (international non-governmental organizations (NGOs), national and local NGOs representing citizens, media/journalists, foundations, networks, and coalitions) capacitated by HSAP Consortium Partners during programme implementation (2016-2019). The capacity-strengthening approaches included workshops, trainings, collaboration, network building, and mentoring, as well as mutual learning (south-south, south-north and vice versa).

The capacity strengthening activities provided to CSOs were conducted through training, mentorship and technical assistance provision for HSAP teams (Contracted and Network Partners) in lobbying and advocacy, and research and learning methodologies. Examples of trainings provided to CSOs included, but were not limited to: SMART advocacy, OH and SRHR and HSS in general, and proposal writing for fundraising.

At a global and regional level, HSAP Consortium Partners provided opportunities for CSOs to participate in global/regional forums. They supported CSOs when participating in national- and county-level technical working groups and when CSO coordination groups reviewed and strategized on policies. HSAP Consortium Partners also assisted participating countries in developing evidence-based papers and lobbying and advocacy strategies, and created space for CSOs to influence districts/counties and national and global policies[15].

In all countries, except Kenya, most CSOs who attended trainings received some funding from an HSAP Consortium Partner. In Kenya, since 2018, only one CSO was financially supported to manage all CSO activities in the HSAP network for context-specific advocacy activities, sensitisation and outreach activities and transportation refunds. This was a lesson learned from previous years when HSAP found that training was not always enough if CSOs did not have funds for advocacy.

Results of the capacity-strengthening strategy

Respondents viewed HSAP's training model as efficient since it provided training and learning processes on practical advocacy skills to large CSO groups, and combined CSOs from multiple locations, thus mixing networks. In Zambia, some CSOs found the training offered by the partnership to be 'engaging' and 'simplified' since after the training, they better understood SRHR. This made it easy for the CSOs to implement their activities after their training (KII Contracted Partners).

The findings from the collected stories and KIIs showed that by strengthening CSO capacity, the results were significantly improved knowledge on SRHR and/or HSS and increased knowledge and skills on lobbying and advocacy at national and district/county levels. Thus, this strategy has contributed in achieving the HSAP mid-term outcome: Increased evidence-based lobbying and advocacy capacity of CSOs at local and national levels. As mentioned in this quote:

> "*Amref did well in building our capacity and others. They have been very facilitative. They helped to increase our understanding of policy advocacy. They gave support and mentoring.*

[15] Source: Desk review inception report from each context

Other organisations would bash us. Amref addresses the issues with you. They have also taken us to a next level in terms of organizational capacity." (KII CSO).

Almost all CSOs trained in the HSAP programme (5 countries) engaged in both national- and/or district/county-level advocacy by applying what they had learned from HSAP Consortium Partners. In addition, the CSOs that had received training functioned at the community level, and the results of the capacity-strengthening efforts contributed to the communities' empowerment to demand their rights.

The efforts to strengthen the CSO's capacities has indeed led to capacity-related outcomes. In chapter 4, this assumption was validated by the evaluation team. Capacity strengthening was often mentioned in the contribution section (see chapter 5 on effectiveness), and the stories confirmed that the capacity-strengthening efforts contributed to the changes described in their stories.

The majority of the storytellers indicated that their capacity training had led to increased CSO lobbying and advocacy capacity to contribute to improved SRHC supplies, FP commodities, inclusion of young people, and a strengthened health work force and improved working conditions. For example, the CSOs who received training in 5 countries reported that their knowledge and understanding of concepts such as social accountability and the use of consumer score cards had improved (example from Malawi). They had learned to identify who to target (allies, messengers, staff and decision makers), how to package their advocacy message and approach stakeholders and decision makers with fitting arguments, use and collect data as evidence for advocacy, create their own advocacy strategy and prioritise their efforts, link key people, report on health issues and solution journalism and get it published, and conduct successful follow-up.

To some extent, there has been support from the Consortium Partner at the global level that has contributed to a greater CSO involvement at a national level, such as mentioned in the two substantiated global-context outcomes related to GFF. These outcomes showed an increased CSO engagement in national and health systems policy processes (see effectiveness chapter). Respondents from various countries reported increased knowledge of GFF processes and improved capacity in writing reports and strategies for advocacy. The sharing of experiences from other countries, and knowledge of global GFF guidelines and policies enabled CSOs to hold governments more accountable. (CSO respondents from 4 countries) (outcome 28434 and 28436, 28439 28432).

However, at the regional and global levels, meaningful CSO engagement in regional and global platforms and decision-making processes remained a challenge. African CSO understanding on how to conduct regional and global advocacy is limited, including how advocacy at those levels can reinforce national-level advocacy and vice versa. Despite HSAP attempts to address this gap, the programme has not been successful building CSO capacity to structurally engage at these levels as confirmed by a Contracted Partner:

"*As much as we are advocating for more African voices at regional and global level[s], the capacity gap still haunts African CSOs. So, it's also an issue that needs to be addressed; we have strong voices, we have people who are capable to connect issues both at regional and global level. Because this is one of the gaps that stills exists: not only advocacy capacity, but also the capacity to circulate issues*." (KII Contracted Partner).

2. Building (existing) platforms and networks by providing financial support and technical assistance.

CSO networks were trained in utilizing evidence and effectively engaging with the both national and district policy bearers and actively participating in public accountability forums on HSS and SRHR issues. By strengthening CSO networks and platforms, CSOs have had more opportunities for engaging in joint advocacy, which often means that they have had a stronger, common voice than if they had engaged in policy debates as individual organisations.

Examples of networks and platforms are: the Ugandan Reproductive, Maternal, Neonatal and Child and Adolescent Health (RMNCAH) CSO Coalition; the Medicine Transparency Alliance (MeTA) platforms; the GFF CSO coordination groups, the HRH Alliance - later, the Health Workers for All (HW4All) Coalition; the Watch Global action Plan group; the SRHR Alliance; White Ribbon Alliance; and the African Media Network on Health (AMNH).

One of the HSAP-strengthened networks was the Youth Parliaments[16] to address SRHR issues in Kenya, Uganda, Tanzania, and Zambia. Examples include the Ugunja Youth Parliament[17] in Siaya County (Kenya) and in Kabale, Lira, Dokolo and at the national level (Uganda), Bukombe (Tanzania), and Mufulira (Zambia). Youth voices were strengthened either through organising intergenerational dialogues at a community level, capacitating youth chairpersons, engaging adolescents in developing adolescent health messages, or supporting them when participating in regional meetings/conferences.

Results of the building (existing) platforms and networks strategy

For capacity strengthening of (existing) platforms and networks within the country contexts, the findings of the end-term evaluation were similar to the findings from the Mid-Term Review (MTR), which resulted in increased evidence-based lobbying and advocacy capacity of multi-stakeholder networks and platforms (HSAP TOC Mid-term Outcome). This strategy was proven to be successful in helping the CSOs networks/platform make demands of policymakers and have a more united voice heard by policymakers. The findings from the MTR also mentioned that HSAP helped to maintain and exploit the space that was already available in those countries, and these have provided models of good practice in targeting and tailoring capacity building, which can be shared and built on elsewhere (MTR Response 2019). The partnership has accompanied CSO networks in advocacy at the district/county levels, made connections with local county policymakers and encouraged meaningful participation in policy processes on both sides, which has proven successful.

Below are examples of efforts to strengthen platforms and networks that have proven successful:

- *Uganda, Zambia, Kenya and Tanzania*: With help from their in-country partners (HEPS Uganda, MeTA Zambia, MeTA Kenya and UMATI) HSAP applied a modified version of HAI/WHO's gold-standard methodology to measure the price, availability and affordability of more than 30 SRHC, and perceived barriers for accessing them (Source: Factsheet on HAI's Role in the HSAP). The research provided evidence-based information, thus allowing CSOs to advocate for better policies.
- *Uganda:* the RMNCAH youth coalition capacity strengthening influenced regional policy. The HSAP Uganda context team teamed up with youth-led and youth-serving CSOs in advocacy for the East African Commission's (EAC) SRHR bill. HSAP enabled the youth to attend EAC meetings in Arusha and Nairobi during which the bill was discussed and they provided a youth voice. One respondent

[16] A platform that empowers young people to advocate for their rights and hold public officials accountable for meeting their health and other socio-economic needs. Youth Parliaments foster young people's civic participation and help them become politically aware, engaged and responsible citizens (Source: https://www.amref.nl/media/files/Youth%20Parliament.pdf).

[17] Source https://www.amref.nl/media/files/Youth%20Parliament.pdf

emphasized that East African Legislative Assembly (EALA) members represent citizens. Through strengthened voices he believes things can change at the EAC level. (32911)

3. Engaging with media

HSAP has established media networks to increased media coverage of SRHR and HSS in various media at the country level. The trained media journalists, together with CSOs, independently advocated for SRHR and created awareness by writing and publishing stories on SRHR issues in the media (newspapers, radio, television) at the district and national levels.

Results of engaging with media strategy

HSAP harvested outcomes and collected stories confirmed the success of this capacity-strengthening strategy, which contributed to the HSAP mid-term outcome: increased media attention for HRH, SRHC, HF and governance in 5 focus countries. The following are examples of successful media-related advocacy from substantiated outcomes, as a result of engaging with media strategy:

- Malawi: Outcome (33361): In 2018, AMNH members of the Malawi Chapter published 63 articles on health. Most of the articles were on FP, and some on CHWs. Stories reported by the electronic media were excluded. The Nation Publications Limited topped the list in the number of articles published, seconded by the Malawi Broadcasting Corporation.
- Uganda: Outcome (32908): Since May 2019, there has been increased awareness creation on preeclampsia and its management by the media at both the national and district levels.

4. Amplifying community voices by strengthening existing advocacy work done by CSOs in the community

HSAP has strengthened the capacities of community members in 5 focus countries and empowered them through the engagement of the CSOs who received training with community members. As part of the capacity strengthening for the CSOs, they were capacitated on how to mobilize communities to demand their rights.

Results of amplifying community voices strategy.

The findings from collected stories show there was increased knowledge related to HSS and SRHR among community members, and CSOs reported a catalytic effect on community members, who had started holding their leaders accountable; the communities were increasingly able to demand their rights. In all country contexts, HSAP civic education in communities and with community representatives (youth platforms, health committees, or leaders) enlightened participants to directly advocate for and demand their rights. The changes happened at the community level, which resulted from amplifying community voices such as: setting up youth-friendly corners for easy access to SRH services and the formation of youth councils by CSOs in Zambia: *"We formed a youth-friendly corner after the training. Now youths can freely access supplies from our corner. So, our health facility has actually changed and [is] now better responding to the needs of our community" (KII CSO).* Another change shown in Uganda, was that communities now have more knowledge on how the health system works and the constraints of health workers. Specifically, the improvement was substantiated by CBOs doing something new in their communities after attending the trainings (KII, stories).

Examples of successfully amplifying community voices:

- *Zambia*: some CSOs saw significant changes in youths' knowledge on where to find SRHC (story 33639), FP facilities and supplies and are able to demand these services/products.
- *Kenya:* CSOs were better organized to engage governments and could mobilize communities to demand better service delivery (Kajiado Case Study).
- *Uganda:* The Kabale district community collected information on minimum standards at health centres and 2,206 signatures petitioning the district to improve the Maziba HC IV. The district government then ensured renovation of Maziba HC IV's theatre.

Most storytellers in the country contexts considered that the HSAP's capacity-strengthening efforts had the largest effect on the organisational/network, community and individual levels at the same time. HSAP empowered Youth Parliaments (as part of strategy 3) in several country contexts; this platform functioned at a sub-county level and so was closer to the communities. Thus, Youth Parliament training and coaching was most directly linked to community/household/facility levels.

The efforts to strengthen the CSO's capacities has indeed led to capacity-related outcomes. In chapter 4, this assumption was validated by the evaluation team. Capacity strengthening was mentioned often in the contribution section (see sub chapter 2 on effectiveness), and the stories confirmed that it was the capacity-strengthening efforts that contributed to the changes.

5.1.2 Strengths and weaknesses of the HSAP capacity strengthening efforts

This section presents the strategies/activities that did and did not work at global-, regional- and country-context levels, and the contributing and/or hampering factors for partner capacity building.

Strengths: common and unique strategies that worked well

In general, all four main strategies in capacity strengthening have proven to work well at a country level (national and sub-national) in all 5 focus countries. The capacity strengthening of individual CSOs and CSOs platforms/networks on lobbying and advocacy have been the most significant achievement, which was confirmed and acknowledged in the substantiated outcomes, stories, and KII with various respondents. The strength of the capacity-strengthening cascade identified in this evaluation was similar to the findings from the MTR. The combination of providing trainings, mentorship and (to some extent) learning across contexts and thematic areas have resulted in more effective lobbying and advocacy by CSOs compared to before they participated in the HSAP programme.

In building media's capacity, evidence from the document review (HSAP reports), showed that HSAP observed better reporting on SRHR and HSS issues at both the national and sub-national levels. The significant success of integration of the Journalist Health Course in Amref International University made this strategy sustainable and will contribute in improving the capacities of African media practitioners (journalists) in achieving the HSAP mid-term outcome: increasing media, government, and private sector attention for HRH, SRHC, HF and governance.

By providing both financial support to CSOs and media to advocate on HSAP-related themes (in Kenya, Uganda, Malawi, and Zambia) and technical assistance to platforms/networks, the 'combi-approach' proved effective in addressing the issue of a lack of resources to conduct continuous advocacy activities at national and district levels.

There were some unique strategies of applied capacity strengthening that were also successful, such as:

- *Tanzania (partially successful)*: Amref and CSOs that had been trained set up a taskforce of The Council Health Management Teams members and developed a strategic plan for identifying, absorbing and financing formally recognized district CHWs. At the district level in Shinyanga region a manual stipulating who can be engaged as a CHW and basic remuneration was created; however, at the national level, this was unrealized.
- *Malawi, Tanzania, and Zambia*: HSAP partners continue to support CSOs and network capacity with a specific focus on advocacy, including locally applicable social accountability methods (community score cards**)**. Communities identified local health system challenges and demanded improvements from duty bearers. The chosen strategy of strengthening advocacy of Contracted Partners was highly valued.
- Use of champions in the advocacy process at national and sub-national levels (also in the community). *Malawi*: White Ribbon Alliance and champions advocated for increased FP commodities budget lines and ring-fencing of FP programming budgets (32785).
  Uganda: Kigezi Women in Development facilitated community champions in Kabale to collect information on minimum standards at health centres to improve Maziba Health Centre and involve media houses to air the facility's story (32912). Strategy was effective.
- *Uganda*: CSO capacity strengthening in districts and subsequent advocacy towards district governments result—a district government official stated that their capacity had increased as well, in advocating with and funding from the central government.

Weaknesses: What did not work well

The evaluator team also identified a few strategies that did not work well based on the findings from KII and analysis of outcomes and stories. At the regional and global advocacy level, there was very limited CSOs engagement, except for advocacy on GFF-related outcomes (e.g. in Malawi) and the involvement of youth-led and youth-serving CSOs in advocacy for the EAC's SRHR bill. The lack of CSOs engagement at the regional and global levels could have been caused by the limited linkage of advocacy work done at the national level with regional and/or global levels (see effectiveness chapter).

In some countries, such as Malawi, even though there were joint meetings, exchange study events, and workshops/trainings, CSOs mentioned there had been a lack of a clear platform for learning and sharing best practices within the national HSAP partners as well as from other countries participating in the HSAP programme.

The connections between district- and national-level advocacy were not well established and capacity strengthening of district CSOs was not focused on engaging in national-level advocacy to amplify their work in the districts (in Uganda, Malawi, Zambia, Tanzania, Kenya). A strong partnership with media and CSO networks happened more at the national level rather than at the district level. For example, in Lira Uganda, two HSAP Contracted Partners worked together with various CSOs advocating for the same issues Global Forum for Development or GLOFORD through Amref and Uganda National Health Consumers' Organisation (UNHCO) through HEPS).

5.1.3 Supporting and hampering factors of capacity strengthening

The evaluation team also identified supporting and hampering factors of capacity-strengthening efforts done by HSAP, including capacity strengthening at a community level. The supporting factors included: good partnerships and engagement of CSOs and networks. The high level of commitment and enthusiasm of CSOs involved in the programme and the media played a key role in the advocacy

efforts. Hampering factors included: duplication of efforts by HSAP partners (engaging with same local partners, in Malawi and Uganda), limited or no funding available to conduct advocacy after training (Zambia and Tanzania), and a new policy relating to the CSOs that resulting in some CSOs dropping from the network (Kenya).

5.2 The Effectiveness of the Advocacy Approaches

5.2.1 Effectiveness of Advocacy approaches

Question: 2. How effective were the advocacy approaches of the HSA partners, CSOs and communities in achieving results?

b. To what extent have the advocacy approaches affected the involvement of CSOs and HSAP partners in policymaking and implementation processes?
c. To what extent have the advocacy approaches affected the development of effective evidence-based messages taken up by like-minded networks and organisations?

The outcomes of the HSAP's advocacy approaches demonstrated the HSAP partners and CSOs' capacity for empowering communities, understanding of sub-national and national government policy and budget cycle processes and thorough understanding of (political) decision making at multiple levels. HSAP used more of a dialogue than dissent approach to their advocacy; their efforts to build relationships was key to achieving results in HSS and SRHR.

One Contracted Partner summarized HSAP's approach to advocacy as follows:

> "*… our approach to advocacy is not confrontational. We strategically [choose] the people we want to work with—very big factor on how we do our advocacy. It is a big advantage, we don't confront, we dialogue. Even when we dissent, we dissent in a diplomatic way. So, it's all about informing and inspiring others through research, through knowledge, through sharing and the different capacity building approaches*." (KII Contracted Partner).

Specific HSAP approaches to advocacy included the following.

1. Evidence-based messaging and intervention through operational research and robust advocacy

HSAP was recognized and appreciated for its credible and effective advocacy using evidence from their research and experiences "on the ground". This evaluation demonstrated HSAP's unique added value to research on selected topics and the creation of evidence-based messages, which were taken up by multi-stakeholder platforms and other networks. This was an effective approach to reach decision makers since the data was considered to be reliable and the networks' amplification of the messages was convincing.

Evidence-based advocacy approaches included:

- Wemos and Contracted Partners' work in national research reports, for example, 'Mind the funding gap; who is paying health workers', in 2018. The report sparked attention from media outlets at both the national and international levels. This resulted in a request to present the report to the Parliamentary committee for health in Malawi to integrate lessons learned for implementing the newly adopted HRH strategy. In Uganda, this report was considered in the new Ugandan HRH strategic plan. Internationally, the publication was quoted in a Lancet editorial calling for sustainable investments in the health work force.

- The use of consumer score cards as a community participatory tool to engage communities in lobbying and advocacy in Malawi. Consumer score card exercises brought the demand side ('service user') and the supply side ('service provider') together to jointly identify and analyse issues underlying service delivery, and utilization problems.
- Empowered CSOs, at the sub-national level, identifying existing gaps and creating their advocacy agenda based on identified challenges. In Tanzania, this proved to be useful in winning CHW recognition and remuneration in the Shinyanga region. HSAP used the same approach to convince the government to recruit new HRH. In Malawi, HSAP identified the gaps at the Wenya health facility and advocated with the local government to address these. Within three weeks, the DHO dispatched all missing equipment (sterilizers, thermometers and a manometer) to the facility.
- HSAP helped bring evidence from the national level to discussions at a regional level, where governments experience peer pressure. HSAP helped identify commonalities and differences between countries, and gaps and best practices. This included issues about CHWs, HWM, progress made to implement the Maputo Plan of Action and SRHR—the latter related to the EAC SRHR Bill.

2. Networking and multi-stakeholder engagement in dialogue and dissent space in order to create and/or strengthen dialogue and dissent spaces at all levels

a. Engaging communities in dialogue and dissent

A key HSAP approach was to have a central role in engaging the community, health staff, and district governments (both technical and political arms) in identifying and addressing health facility gaps. Advocacy demands came from the community level—bottom up. HSAP was instrumental in bringing stakeholders together, allowing for dialogue and navigating bureaucratic decision-making processes at a district government level. They used various approaches, e.g., petitions, intergenerational dialogues, site visits for district governments and committees to view the situation on the ground, or involving media to report on dire situations. This was a bottom-up approach to accountability and local authorities were receptive. A political leader at a sub-national level in Uganda explained that they had to take the community voices seriously: "*We did not want the community to lose trust in the leadership*". HSAP and partners demonstrated their brokering role in supporting rights-holders to raise their voices and duty-bearers to be accountable. As one external expert observed: "*The way HSAP is structured allows it to work with communities AND government. They work with policymakers and hold them to account at the same time*." (KII external expert regional) This was a sustainable and effective approach to facilitating dialogue and dissent where it mattered—close to people's lives and realities.

Facilitating communities to raise their needs and concerns to decision makers was not only a successful approach because governments didn't want communities to lose faith in them, but also because it made local CSOs less vulnerable when they advocated for sensitive issues or operated in increasingly restricted civic spaces, since they reflected the communities' needs.

b. Engaging CSOs, youth, parliaments and other stakeholders in dialogue and dissent

The multi-stakeholder approach was HSAP's best practice. HSAP used these platforms to share information and evidence, which were complemented by other partners. They convened meetings and established structures in which these stakeholders could gather and work together. Members had entry to decision makers at national and sub-national, regional and global levels, the private sector, media, UN agencies, global health institutions, parliamentarians, legislators, CSOs, and people at a community level. This proved HSAP's understanding of effective channels for influencing decision makers and increasing accountability. Examples include:

- CSOs: HSAP partners were part of various CSO (advocacy) networks, sharing HSAP's expertise and exploiting other CSOs' expertise. Through working with a diverse set of CSOs and specific groups such as key populations and youth, HSAP partners joined broad health and SRHR forces influencing decision-making processes. HSAP partners were instrumental in initiating the RMNCAH youth coalition in Uganda, and brought together multiple youth-led and youth-serving CSOs. HSAP initiated two regional networks, the Africa Health Accountability Platform (AHAP) and the media network, in which their role was described as "catalytic" (KII external). AHAP is an accountability platform for partners working at regional and country levels to strengthen accountability in health. HSAP partners were instrumental in (re)vitalising CSO engagement in national GFF CSO coordination committees. At a global and Dutch level, HSAP actively made use of existing platforms such as the GFF CSGG, assuming the chair of the Community of Practice for CSO influence on GFF and initiated and held the secretariat of the HW4ALL coalition, thus enabling information sharing and use of evidence-based advocacy materials.
- Parliaments: According to a member of the Ugandan Parliament, HSAP's advocacy approach helped inform Parliamentary decisions, which led to the annual SRHC budget increase from 8bn USh to 16bn USh in 2017.
- Youth: In Kenya, Youth Parliament work was considered a success; however, in Malawi, HSAP failed to meaningfully collaborate with these Youth Parliaments. In Uganda, an external expert praised HSAP's approach to let young people express their needs and issues, which were taken forward at a national level for policy change. (KII external expert)
- Media: HSAP engaged media (journalists and media houses) for airtime and publications, thus building their HSS and SRHR capacity. Journalists claimed that they were empowered with accurate HSS and SRHR information to report without bias and demonstrate gaps. In Uganda, HSAP funded and facilitated journalist visits to health facilities and to report on gaps in health service delivery. Journalists reported on contraceptives and maternal health medication theft, ambulance misuse (driver requesting excessive payment for free transport), and on the impact of an unmet need for contraceptives (stories). Journalists received multiple awards for their stories. In Kenya, the shared stories demonstrated that journalists no longer saw each other as competitors, but rather as colleagues who could join forces to create change.

The pre-eclampsia campaign in Uganda

The pre-eclampsia campaign in Uganda was a good example of involving media, Parliament, government and health facilities, by sensitizing them with evidence. This had an amplifying effect and more pregnant mothers were checked in the health facilities and this avoided unnecessary maternal deaths. HSAP supported journalist visits to health facilities to note the toll of pre-eclampsia. Media started writing about this topic, which generated interest from parliamentarians and policymakers. HSAP facilitated policymaker visits to a hospital to see stock outs of essential medicines first-hand (e.g., magnesium sulphate) and the lack equipment such as oxygen cylinders and incubators, all of which are essential for preventing pre-eclampsia. Parliament requested that the government look into this situation and this pressure resulted in funding for magnesium sulphate. In Lira, Amach Health Centre IV was provided with manometers. The campaign also sensitized communities about the dangers of pre-eclampsia resulting in an increase of pregnant women going for a check-up. The sensitization campaign was continued by the various stakeholders, including the MoH-appointed a Pre-eclampsia Ambassador[18].

[18] HSAP Working together to end the suffering of pregnant women and families – Photo Essay and KII Contracted Partner.

3. Reinforcing the link between local, national, regional and international levels in the global space and ensuring that the African voice is represented in policy dialogues at all levels, particularly to increase Southern involvement in international advocacy

An HSAP strategy was to strengthen African voices in regional and global advocacy processes by bringing national voices to these platforms and regional and global commitments to the countries for domestication. As outlined earlier, these linkages enabled the establishment of much stronger CSO involvement and increased CSO ability to hold governments accountable at a country level. In the global and Dutch contexts, enabling voices from the South to speak directly to policymakers made an impression and led to more support. HSAP's presence in sub-national levels, working with communities and local governments was a unique approach. As one external expert stated, "*Many times, advocacy organisations concentrate at a national level, not at a district level. Pressure from districts to the national level is important. That was their added value*." (KII expert).

Positive examples were as follows.

- Advocacy towards the EAC SRHR Bill demonstrated a good example of linking national and regional levels and working together with CSOs and networks to amplify voices. HSAP's approach was built around strengthening capacity at a national level for CSOs in the RMNCAH youth coalition in Uganda, set up by HSAP. The RMNCAH youth coalition developed advocacy messages in the annual Uganda Stakeholders Dialogue also attended by government. The issues discussed at the Uganda Stakeholders Dialogue were considered in the East African Audit on SRHR conducted by the regional network of CSOs, the Eastern Africa National Networks of AIDS and Health Service Organisations (EANNASO). Peer To Peer Uganda (PEERU), in turn, shared the audit and draft position paper with CSOs in Uganda and they also provided input. (R6) PEERU then presented the paper to the EAC in Arusha. Although the bill has not yet passed, the advocacy process showed good practice.
- Simultaneous advocacy took place at national, regional and global levels on HWM, with national-level studies, and advocacy towards governments to collect data. At a regional level, AMCOA launched a survey for member states to track HWM. Wemos, Amref and ACHEST raised the issue of HWM at the World Health Assembly (WHA).
- HSAP's strategy for improving GFF policies and practices was an effective strategy according to Dutch policymakers and those at a global level. Wemos's global technical assistance and support and other HSAP partner support at a national level were seen as best practices. This strategy contributed to changes in the CSO role in the countries and contributed to actions to make governments more accountable. HSAP's efforts also led the GFF to focus more on SRHR and reflect on its role in SRHR and HSS. (28433/policy maker, global org).
- Peer learning throughout the region was another approach, e.g., advocacy for FP in the National Health Insurance package in Zambia. Amref HQ shared experiences and technical expertise on this topic with Kenya and other countries including Zambian civil society. However, this evaluation did not find other examples of concrete peer learning across contexts, possibly pointing to the fact that it did not occur extensively.

HSAP's approach also had weaknesses. The weaknesses include:

- A dispersed Contracted Partner presence at regional and global levels resulted in low engagement and some HSAP themes were not reflected in certain contexts. Therefore, there was a disconnect between sub-national and national advocacy and advocacy for HSAP themes.

- Despite initiatives to bring CSOs and youth to global and regional fora, efforts to strengthen diverse CSO voices, build CSO capacity and support them when participating in regional decision-making meetings were not institutionalized or systemic.
- Engagement with regional bodies to link with national and global advocacy appeared not to have been well thought through by HSAP. One Contracted Partner reflected that although relationships were built in the course of this programme, the influence at the African Union and EAC was not optimal.
- It was unclear from the harvested outcomes and the evaluation to what extent HSAP advocated for SRHCs at regional and global levels. It was also unclear to what extent HSAP advocated for the implementation of the *WHO Global Code of Practice on the International Recruitment of Health Personnel* at a national level.

Question 2a. To what extent have the advocacy approaches led to improved policymaker support in regard to HSA advocacy topics on HRH, SRHC, HF and governance and led to strengthening advocacy linkages between national, regional, global and Dutch policymakers?

HSAP harvested 240 outcomes and for this evaluation, and 64 outcomes were substantiated. The outcomes for substantiation were selected through a consultative process and a quality check (see chapter on methodology). The abovementioned evaluation questions are addressed below in the analysis of the changes realized based on substantiation of the selected outcomes, KIIs and CSO stories, which include a selection of HSAP's work. From this data, the evaluators concluded that HSAP contributed to the changes described below; however, the extent of the contribution and significance of the changes varied.

1. Human Resources for Health (HRH)

HSAP aimed for increased political commitment to systematically improve HRH, including addressing inequitable access to health workers for vulnerable groups and people living in rural areas, the workforce's ability to treat everyone with dignity and create trust, and enable or promote these groups' demand for services. At a global level, HSAP aimed to link with civil society (networks) that push for implementation of Member State commitments that contribute to creating and maintaining sustainable health workforces[19].

Through its work on CHWs and HRH strategies and health worker deployment, HSAP has been able to achieve outcomes for their objective to increase access to health workers for people living in rural areas. This evaluation has not been able to demonstrate whether or not this strategy increased vulnerable groups' access to health workers specifically. Examples include:

- CHWs: HSAP influenced CHW recognition and renumeration at multiple levels. In Malawi, the MoH appointed an Ambassador for Community Health and in the Chipita district, the local government adopted a CHW Action Plan. In Kenya, the national government adopted a CHW financing policy to which HSAP and others had contributed. After persistent HSAP advocacy, the Community Health Service Legislative bill was adopted in Homa Bay county, which allowed for Community Health Volunteer remuneration. In Zambia, a CHW strategy was adopted.[20] At a regional level, HSAP

[19] HSAP ToC 2019 page 9-10

[20] In February 2019, the CHW platform developed a constitution to legitimise their formation driven by the CHW steering committee with financial and technical support from Amref.

contributed to the adoption of the Model Legislation on CHWs by regional bodies and organisations. In the Dutch context, HSAP advocated for the importance of CHWs at the MoFA, who then raised the issue with the WHO Executive Board.

- HRH strategies and health worker deployment: During HSAP programme implementation, the national governments in Malawi and Kenya adopted HRH strategies. In Uganda, the HRH Technical Working Group (TWG) of the MoH adopted the research findings of ACHEST/Wemos on health workforce financing for their next HRH Strategic Planning in 2019/2020-2024/25. In Malawi, after HSAP's health worker research, the government employed 520 health workers for tertiary facilities. In Malawi, Chipita and Ntchisi DHOs/ local governments developed health worker recruitment and deployment plans. At a health facility level, HSAP contributed to the redeployment and recruitment of health workers, such as in Malawi's Makanjira and Kasonga health centres and Uganda's Soroti, Serere and Kisoro districts. In Kisoro, 4 health workers and 25 midwives were recruited after HSAP advocacy.

HSAP successfully achieved their aim to link up with CSOs at a global level to push for implementation of government commitments. Examples are:

- HSAP influenced the WHO Global Code of Practice on the International Recruitment of Health Personnel with their coordination of 17 stakeholders' input through the HW4ALL coalition (the secretariat sits with Wemos). HSAP advocated for the recognition of this Code in the high-level meeting (HLM) on UHC, and the declaration now mentions the Code. At the regional level, HSAP helped develop the HWM protocol to track HWM in countries with the Association of Medical Councils of Africa (AMCOA) members. In Uganda, HSAP attracted the MoH's interest in developing an HWM policy.

2. SRHC

HSAP aimed to collaborate with in-country expertise, including civil society, to collect data to fill knowledge gaps and inform evidence-based interventions to increase access to SRHC. In addition, HSAP aimed to engage in multi-stakeholder platforms specifically created and resourced for medicines policy dialogue and dissent[21].

HSAP has been successful in bringing CSOs, government, the private sector and UN agencies together to improve access to essential medicines and conducting research that has led to evidence-based interventions. Examples include the following:

- In 4 countries[22], MeTA served as a successful platform for One Ugandan external MoH expert who praised MeTA's work, "*MeTA has been very useful in identifying the gaps and bringing them to [a] policy level. They have a sharp eye to identify; they make noise. We need that kind of partnering; they interact with the people. MeTA has really helped in bridging the gap between policy and people*."
- At a national level in various districts, HSAP conducted research about the availability and stock outs of SRHC, including FP commodities, in all countries, except Malawi. In Malawi, HSAP used consumer score cards as a social accountability method for this data. Key findings were severe stock outs and access limitations. In Malawi, a Task Force for FP was set up in the Chitipa district and in Zambia, TWGs on FP were established in the districts. In Zambia, after HSAP and others'

[21] HSAP ToC 2019 page 10.
[22] Kenya, Uganda, Tanzania and Zambia.

efforts, FP was included in national health benefits packages. In Tanzania, FP was included in the benefit package of health insurance offered by three private companies. In Uganda, HSAP successfully advocated for the purchase of manometers by Amach Health Centre IV in Lira to prevent pre-eclampsia. In the Kabale district, the local government established a youth fund for FP promotion. At a national level, the MoH approved an indicator for reporting on adverse drug effects, which was incorporated into the National Health Management Information System (HMIS) in 2019.

3. Health Financing

HSAP aimed to develop advocacy messages and train local CSOs in lobbying and advocacy aimed at encouraging governments and other stakeholders to make the necessary financial investments for health and allocate this funding in an effective and efficient way. Furthermore, HSAP set out to analyse the effectiveness of Global Health Initiatives (GHIs), and the way these programmes interact with and have an impact on health systems in regions or countries[23].

This evaluation found evidence that HSAP had contributed to increased financing for SRHR and HSS, although there were not many examples. This is understandable since advocacy for financing is cumbersome and a long-term process. Positive examples include:

- In Malawi, HSAP and partners were able to obtain a commitment by the Chief Whip of the People's Party to make a motion in Parliament proposing an increase in the FP commodities budget line and ring-fencing of the FP programming budget. Health staff and centres: In Kenya, the national government adopted a financial policy for CHWs. In Malawi, a policy was adopted to pay nurses for their overtime and HSAP mobilised resources for the construction of two health worker houses through the use of consumer score cards.

In relation to assessing the impact of Global Health Institutions, this evaluation found evidence of HSAP's active engagement with the Global Financing Facility and some examples of support for CSOs engagement, such as in Malawi. Through efforts by HSAP, CSOs had more coordinated discussions with Malawian stakeholders concerning the GFF Malawian Investment Case. HSAP coordinated the plea by 52 CSOs to GFF to improve human resource salaries and HF. In addition, through Wemos, HSAP developed case studies in collaboration with HSAP partners in Malawi, Uganda and Kenya on how CSOs were involved in GFF policies and processes at a national level. HSAP presented the results at various global meetings. The results were then translated into letters to global events (e.g. HLM on UHC and the GFF). GFF used these case studies in multiple meetings. As a result, CSOs were more included in GFF processes.

This evaluation did not find evidence of HSAP's engagement with Global Health Institutions for financing other than the GFF.

4. Governance

HSAP aimed to strengthen the capacities of local CSOs to enable them to hold governments and decision makers to account for their function and performance, including maintaining the strategic direction of policy development and implementation, regulating the behaviour of a wide range of actors, and establishing transparent and effective accountability mechanisms[24].

[23] HSAP ToC 2019 page 11.
[24] HSAP ToC 2019, page 12.

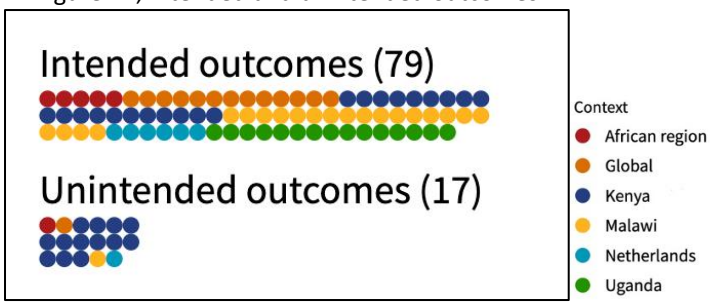
This evaluation found numerous CSO achievements holding governments to account for their function and performance in delivering on SRHR and HSS, especially at subnational levels. Accountability mechanisms have been established at a CSO level, such as AHAP and national-level multi-stakeholder and CSO networks. However, these mechanisms are largely dependent on HSAP/project funding and so the sustainability of these mechanisms is fragile (see chapter on Sustainability). Despite HSAP's efforts, in general, government accountability for performance and ensuring strengthened health systems and SRHR remains weak. This is an issue that goes beyond HSAP and is something that other Partnerships and CSOs struggle with as well.

5.2.2 Negative outcomes and unintended outcomes

There were only six negative outcomes (setbacks) identified during the evaluation: two from global context, three from country contexts, and one from a regional context. In the global context, the outcomes were about a webinar on the Code of Practice review process that was below expectations, and the GFF statement to decrease the number of new additional countries. At the country-context level, all setbacks were related to rejection or poor implementation of bills. In Kenya, three bills were rejected: (1) the newly published Kisumu health bill by CSOs in 2019 was rejected due to inadequate stakeholder engagement; (2) the Reproductive Health Bill 2014 was not passed at the national assembly despite CSO and stakeholder lobbying for the bill to be enacted, and (3) despite the Homa Bay (Kenya) CHW Bill catering for the payment of CHWs, CHWs had not yet received financial compensation. At the regional-context level, the SRHR EALA bill has not yet passed. In addition, in Kenya, the annual national budget of 14 million KES for FP was reduced and resulted in all county budgets being cut, which automatically implied that all FP and SRHR budgets also decreased.

From the 96 outcomes that were entered and classified in Sprockler by the HSAP, 79 outcomes were intended and 17 were unintended. Unintended outcomes are not uncommon in the evaluation of lobbying and advocacy programmes, since the behaviour of advocacy targets cannot be predicted. In Kenya, 22% of the outcomes entered in Sprockler (out of 59 outcomes in total), were classified as unintended. Drawing conclusions based on this percentage is impossible, since not all outcomes were entered and classified in Sprockler. Therefore, Figure 12 projects an incomplete picture. That said, the 13 unintended outcomes in Kenya were not surprising for a lobbying and advocacy programme.

Figure 12; Intended and unintended outcomes



5.2.3 Roles and contribution of external factors/actors in achieving advocacy outcomes

Question: 2.d. To what extent have external factors or actors contributed to the achievement of the outcomes?

HSAP's added value to advocacy approaches was confirmed by almost all substantiators; however, the level of contribution varied depending on external actors and factors, such as other advocacy voices from CSOs, or long-term processes towards policy change that had begun before HSAP stepped in.

The following factors and actors either contributed to or hampered HSAP advocacy outcomes, and are presented in table 8.

Table 8; Factors and Actors Contributing to HSAP Outcomes

Factors and Actors	Enabling

Receptiveness of governments and communities	*Country context*:
	• All government respondents stated HSAP added value by providing
	  ○ evidence for policy change
	  ○ information sharing
	  ○ technical expertise and funding
	  ○ community links
	  ○ community needs and demands
	• Spirit was collaboration, not competition
	• Enabling factor - engaging with sub-national governments
	  ○ more receptive to advocacy/change than national-level governments

	Sub-national level-communities: Receptive to active engagement in HSAP's participatory advocacy
Availability of funds	*Overall context* - HSAP's funding: Conducive for research, meetings with multiple stakeholders, involving media and sustaining advocacy
Existing legal and policy frameworks	*Country context*: Contracted Partners and substantiators acknowledged the conducive nature of having legal and policy frameworks in place that enabled HSAP to advocate for domestication and implementation. For example, the 2018 WHO Guidelines on CHWs sparked advocacy for CHW recognition at regional and national levels. In Siaya county, in Kenya, HSAP could advocate for the FP Costed Implementation plan because Siaya had a Health Bill to which this plan could be anchored.
Sophisticated global health infrastructure	*Global context*: HSAP became embedded in and worked with other influential organisations and programmes promoting global health (e.g., MMI, Geneva Global Health Hub (G2H2), The Partnership for Maternal, New-born and Child Health (PMNCH) as the organiser of the GFF Civil Society Coordinating Group (CSCG), and Share-Net International), which amplified HSAP's advocacy. The environment for global advocacy for HSS was both enabling and disabling in transparency and CSO participation. For example, GFF was open to CSO involvement and invited them to participate.

The following factors and actors that hampered HSAP advocacy outcomes are presented in table 9 below:

Table 9; Factors and Actors Hampering HSAP Outcomes

Factors and Actors	Hampering
Receptiveness of governments and communities	*Malawi*: HSS is not the priority compared to other health and non-health issues; SRHR (particularly FP) is not seen as a priority, hence it receives less support. *Tanzania*: To match the current administration views on (a larger) population, HSAP partners faced reluctant support from some government officials towards reproductive health, particularly FP, which hampered partners' speed in SRH advocacy that in turn, hampered the partners' speed in advancing their SRHC agendas.
	All country contexts: Governments can be receptive to HSAP's advocacy demands, but sometimes their hands are also tied, e.g., when district local governments do not have resources. With HSAP's strong cases of the gaps in health service delivery and SRHR, HSAP contributed to the sub-national governments' abilities to ask for resources from the national level.
	Malawi: Political unrest and sensitivities related to the 2019 elections in Malawi slowed implementation. *Zambia*: Partners stated the government had not been transparent in sharing information due to the absence of an Information Act. Most government officials

	saw advocacy as a political stance, and believed that some CSOs were aligned to a particular political party, especially the opposition.
Availability of funds	*Regional level*: Conducting research, convening meetings with multiple stakeholders, involving media and sustaining advocacy efforts were quite expensive. HSAP's limited resources for the regional level was a hampering factor.
Existing legal and policy frameworks	*Kenya:* Advocacy for HSS and SRHR was challenging due to a lack of a general health policy (Kajiado County).
	African regional level: Although there were conducive policy and legal structures, such as the legally binding Maputo Protocol and other peer-review mechanisms, accountability in the structure was weak. (KII external and Regional Reflection FGD report 2016).
Government capacity and resource constraints	*All country contexts*: Government staff turnover was high at all levels, which led to discontinuity in efforts or delays.
	Regional context: HSAP was confronted with a misrepresentation of issues and voices by government delegations at a regional level, when the delegation did not have adequate capacity to speak to HSS and SRHR. Delegation members changed frequently, which resulted in a disconnect in agreements at a regional level and what was represented at a global level.
	All country contexts: Governments at sub-national levels faced budgetary and fiscal constraints to adhere to HSAP's demands even if there was political will. They must lobby for resources with the national Ministries.
Regional and global political dynamics	*Regional context*: Some SRHR agenda items were sensitive in the African regional context. Governments had various perceptions and levels of implementation on SRHR and this created a challenging dynamic when they assembled at a regional level. At regional assemblies, dynamics such as language, culture, economic status and political alliances came into play, which hampered unification.
	Country context: Country governments were reluctant to come to a global consensus on HSS and SRHR issues. As a network partner based in Kenya (28439) stated: "*Many delegations from countries have bad HRH practices when it comes to adhering to the WHO Code of Practice for migration of health personnel and, therefore, they were not willing to discuss it or include it in the final document*."
	Regional context: The majority of African CSOs did not have official accreditation for global and regional meetings. This was a challenge in relation to bringing a diverse set of CSO and youth African voices to these meetings
	Global context: There was a lack of transparency in global player processes, e.g., the World Bank (in relation to GFF) and WHO for follow up of the review process of the Code of Practice, and factors influencing the implementation of globally and locally agreed upon actions.
Sophisticated global health infrastructure	*Global context*: the GFF's embeddedness in the World Bank was hampering since the GFF had to abide by World Bank rules limiting transparency (28442). Information from the GFF liaison was sometimes incomplete or the liaison was insufficiently informed about requirements and this hampered CSO involvement at the country level (28438/ INGO).

How do the external factors or actors relate to the HSAP's contribution to outcome achievement?

HSAP's outcomes and CSO stories validated HSAP's TOC pathways of change (see outcome harvesting finding). There were outcomes harvested for all mid- and long-term outcomes. The evaluation team found many outcomes that been achieved through community empowerment and social accountability. HSAP even harvested outcomes (17%) that they considered to be out of their sphere of influence ("policy implementation"). In Uganda, the majority of outcomes were related to policy implementation, and in Kenya, the outcomes were related to adoption of policies and budgets. In the global and regional contexts, most outcomes related to increased stakeholder attention to HSS and SRHR. In the Dutch context, outcomes were predominantly achieved in the engagement of multiple

stakeholders. In Malawi, outcomes were for support of policymakers, which was expected given the programme's late start

As concluded in chapter 4, the evaluation team found that HSAP consistently contributed to the outcome pathways in their TOC. HSAP increased the evidence-based lobbying and advocacy capacity of CSOs, multi-stakeholder platforms and networks at multiple levels (MT outcomes), which led to increased media, government and private sector attention for HSAP priority themes (MT outcome) and increased multi-stakeholder engagement of HSAP and partners with HSAP's priority themes (MT outcome). This led to improved support of policymakers (long-term outcome) and policy changes and implementation (close-to-impact level) on many occasions.

The Sprockler data indicated that across the programme, the most change was achieved by involving local governments followed by national governments including their support, adoption of policies and budgets and budget implementation (66% of all outcomes). Global institutions, CSOs and media followed as most targeted and leading to change.

5.2.4 Strengths and Weakness of HSAP's advocacy

Strengths of HSAP's advocacy

In addition to strengths described above, HSAP demonstrated the following advocacy strengths.

- Due to longstanding relationships before the HSAP, HSAP partners had entry to decision makers at the sub-national, national, regional and global levels. Not only did policymakers (in almost all cases) acknowledge the work of the HSAP partners in HSS/SRHR, they also approached HSAP to provide input for policies and mechanisms. HSAP partners were part of various MoH TWGs in which they brought evidence and actions to the table, e.g., Uganda. Regionally, HSAP partners participated in the CSO technical committees for the EAC SRHR bill. The EALA invited CSOs to brief them on the most contentious issues, such as surrogacy and LGBT. Amref and ACHEST approached the EALA with specific meanings of certain concepts, "*telling them that they [the concepts] are not so contentious, in fact*". (KII Contracted Partner) Dutch policymakers' participation in the board of global facilities and their appreciation of and engagement with CSOs reinforced the influence and effectiveness of both advocacy strategies.
- HSAP Consortium and Contracted Partners and CSOs had good reputations in HSS and SRHR, which substantiators and external experts at all levels recognized. HSAP partners had long-standing relationships with MoHs and local governments and they were embedded in government TWGs.

Weaknesses of HSAP advocacy

Attribution/contribution:

- HSAP was less effective in demonstrating how they had been part of ongoing advocacy processes that involved other partners. Although, in some cases, substantiators confirmed that the change would not have occurred without HSAP's contribution. This was mostly at a sub-national level where HSAP had direct influence with local governments and communities and there were fewer players operating. At national, regional and global levels, HSAP was one of many stakeholders and influencers advocating for change and advocacy that may have been ongoing for certain policy changes even before HSAP had commenced their activities (32852 policymaker). In HSAP's outcome harvesting, these nuances were not well documented.

Lack of joint advocacy strategies and mechanisms:

- There was a lack of advocacy strategies at the context level and across contexts. Advocacy appeared to have been conducted in isolation with limited consistency across themes and contexts, sometimes even within one context. Opportunities to gain mileage and amplification of advocacy were missed.
- Documentation of research and advocacy products and sharing across the partnership were weak. Not everyone seemed to be aware of the research and advocacy products produced under the HSAP umbrella. The evaluation team found it difficult to obtain some of these documents.
- In Malawi, the selection of the same CSOs at sub-national level by Contracted Partners for the same programme led to these CSOs being overloaded with too many activities and projects to conduct.
- In Tanzania, the lack of funding to be given to CSOs was seen as a missed opportunity since it restricted them in conducting advocacy after their capacity was established.

Follow up of advocacy achievements:

- There was little evidence of HSAP's efforts to pursue the complete implementation of achieved advocacy outcomes. The renumeration of Community Health Volunteers in Homa Bay county in Kenya, was ensured in the Community Health Service Legislative bill for which the HSAP had successfully advocated. However, even after the adoption of the bill, the volunteers had still not been remunerated and thus there was 'no change' for them. (KII external). In Uganda, HSAP successfully advocated for the construction of the Doctor's House in Amach Health Centre IV. However, the doctor does not reside in the house yet due to a lack of running water.
- HSAP established functioning advocacy structures that helped realise advocacy outcomes at all levels. However, most of these structures had a high dependency on HSAP and its funding, thus making them less sustainable. This was the case for the RMNCAH youth coalition, HW4ALL coalition and AHAP.

Addressing SRHR comprehensively:

- In order to improve SRHR, respondents claimed that more was needed than only focusing on the health system. For example, a newly built maternity ward does not necessarily result in pregnant teenage girls visiting the facility due to stigma. Suggestions were given for HSAP to engage in educating the youth about SRHR in communities and schools, and tackling early marriages and teenage pregnancies.

Lack of systemic changes in HSS and accountability:

- HSAP made notable achievements in HSS, however, they tended to be quite localized and not systemic. For example, in Uganda, respondents (32902/networking partner and external expert) claimed that the government should be held more accountable since improvements in HSS and SRH were too slow. One Ugandan HSS/SRHR expert indicated that HSAP should do more in governance and leadership given their track record and translating their monitoring of health facilities in the communities to advocacy at a national level where financing for health is a significant barrier for the improvement of health facilities. It was unclear to what extent the SRHC budget increase in 2017/2018 at the national level trickled down to the district level and whether or not the availability and uptake of SRHC increased.

Visibility:
HSAP as a partnership was not well known by decision makers, who relied on the individual organisations within the partnership. In Malawi, there was dissatisfaction among policymakers at the national level about the programme not being properly introduced.

5.3 Relevance towards HSS and SRHR

The relevance of the programme towards HSS and SRHR was part of the TOR[25] and a request that emerged during the inception period. The partners within HSAP had a varied focus on either HSS, SRHR or both. The overall TOC stipulated an assumption of the programme's relevance towards HSS and SRHR. Thus, in this evaluation, to proof this assumption, three forms of evidence were triangulated: outcomes substantiation, collected stories and key informant interview (KII) findings. In describing the relevance, we categorised the relevance of HSAP's outcomes and stories collected for HSS and SRHR, HSS alone, and SRHR alone. Examples of similarities and differences between contexts for the relevance of the programme for HSS and SRHR are described.

5.3.1 Relevance towards HSS and SRHR (combined)

Respondents' determination of the relevance for both HSS and SRHR varied. In a global context, changes were found to be more relevant for HSS; in The Netherlands and some country contexts (Malawi, Tanzania and Zambia) the changes were relevant for both HSS and SRHR; and in Kenya and Uganda, the changes were equally relevant for HSS and SRHR. HSAP was also successful in securing HSS and SRHR issues in (local) policies and budgets. In general, this evaluation showed that HSAP, predominantly focused the supply side HRH, SRHRC, HF and facility improvements; and less on the social and cultural factors such as gender and poverty underlying health inequity. However, in the stories that were collected in 5 country contexts, themes such as gender-based violence, teenage pregnancy, male involvement, youth-friendly services, menstrual hygiene, female genital mutilation, and early marriage occurred more often (mostly from Kenya, Tanzania and Zambia).

5.3.2 Relevance towards HSS

Focus for influencing HSS in country

Respondents in all contexts confirmed that the changes contributed to HSS on a country level. The changes focused on the following:

- increasing the number of health workers to reduce heavy workloads and increase health service uptake;
- ensuring better allocation of health budgets and funds at national and district levels (Uganda, Kenya and Malawi);
- increasing accountability and responsibility of duty bearers to address health issues and improve health centres' performance (management and committees) (Kenya and Malawi);
- improving facilities (e.g., houses for village doctors/medical assistants in Uganda and Malawi) and equipment (e.g., maternity wards and placenta pits in Malawi and Uganda);
- improving management and use of stock by health workers at a health facility level;
- increasing morale and recognition of health workers (Kenya); and

[25] The ToR mentioned: Relevance: the extent to which results of activities contribute to addressing challenges around HSS and SRHR

- improving health-related policies such as an HWM policy (in Kenya and Uganda) and the Adolescent Health Strategy (2017 – 2021) in Zambia.

Focus for influencing HSS at regional and/or global level

The relevance of the outcomes at a global level for HSS was confirmed by all relevant respondents. The primary theme of these outcomes (all by Wemos) showed a major focus on health systems, e.g., the WHO Code of Practice, case studies on HRH and HF influencing GFF policies on HRH, the push for greater alignment in the Watch Global Action Plan (GAP), and the focus on accountability in governance through greater CSO involvement. The regional outcomes related to CHW integration in the HSS, the increased evidence base for health worker availability and migration and media reports on health service delivery all showed relevance of regional outcomes for HSS.

5.3.3 Relevance towards SRHR

Focus for influencing SRHR in country

The findings from the country contexts showed changes relevant to SRHR were mostly relevant to SRH, which included creating an enabling environment for health service delivery. Examples of changes that contributed to improving SRHR at the country level are as follows:

- Improved government policies and budgets for introducing youth-friendly centres (Uganda and Kenya);
- Minimized barriers preventing pregnant women from health facility delivery (all country contexts);
- Better maternal health services, e.g., the construction or renovations of maternity wards and the availability of equipment and commodities to prevent pre-eclampsia (Uganda);
- Active and vibrant school health clubs that teach youth about SRHR (Uganda);
- Increased budgets and access to SRHR services and commodities (all country contexts);
- More awareness and knowledge on SRHR in all country contexts;
- Safe and comfortable spaces to talk about sexuality (Kenya and Uganda).

In Malawi, HSAP engaged with community leaders and elderly, who were regarded as cultural custodians, to impart knowledge on SRHR and reduce resistance from these influential people. Below is a Tanzanian case study showing how a change has benefitted girls and contributed to addressing teenage pregnancy.

STORY FROM TANZANIA [33571]:
Target Group: - Kahama DC and Shinyanga DC/TC
Organization: The Voice of Marginalized Communities (TVMC)
Changes achieved: Ending teenage pregnancy by creating bylaws at the Ward level restricting boda-boda riders from picking up female students.

In ending early child marriage, we trained MTAKUA committees on how to unearth gender-based violence in communities, and how to address the issues. Previously, there was no specific programme to guide stakeholders, and as a result, any partner could come and implement activities based on individual programmes. Initially, we went to meet with all ward officers in Sinyanga and Kahama, and discuss how we could end early marriages. As a result, the ward officers in Samuye Ward created by-laws: boda-boda riders used to pick female students and offer a ride to or from school, which is a bit far. They used that opportunity to offer the french-fries, and bites as a trap to lure the girls into having sex, thus resulting in early unwanted pregnancies. The by-laws restricted boda-boda riders to be seen riding alone with a female student; they must be accompanied by an adult. Failure to observe the law means culprits are subjected to punishment, including 50 lashes, a 5-cement bag fine and other legal procedures follow based on the criminal offence committed. We never expected these

communities to formulate and adopt such by-laws. Our programmatic intervention was to establish MTAKUA committees, then establish District Multi-Stakeholder Forums, and through these structures, the communities were able to address challenges they'd been facing and adopt locally suitable solutions. The changes achieved have started to bear fruit since six cases have been filed.

This evaluation brought forward that the broadest concept of SRHR was not applied since HSAP predominantly focused on reproductive health and less on sexual health, reproductive rights and sexual rights. This was demonstrated by their not addressing or giving only limited attention to issues around adolescent sexual health, comprehensive sexuality information and education, (un)safe abortions, health rights of marginalized groups such as lesbian, gay, bisexual, trans, and/or intersex (LGBTI) and the lifting of legal and social barriers for accessing SRHR services. From the KII findings with Consortium Partners in the country contexts (Kenya, Malawi, and Uganda), we learned potential reasons for this finding including: lack of shared advocacy agenda (particularly on SRHR), lack of partner understanding of SRHR, and the desire to work within the parameters of existing laws. In Malawi, HSAP intended to raise their credibility in regard to action on SRHR issues and so they reached out to collaborate with the SRHR alliance. This was viewed by some as a questionable gesture, since the HSAP core partners thought this direct approach may have placed too much attention on the topic.

> "*Two main thematic areas would have been enough: Governance and Human Resources. Human Resources because it helps to strengthening the health system. Now we have HSS and SRHR. HSS has to do with human resources/policies around health, so that's ok, but SRHR is too specific: some things we do are not specifically for SRHR. For example, to include SRHR in the Health Bill would require specific efforts. It is good that the thematic area is broader than SRHR, as there are so many other issues, like Universal Health Coverage*" (KII Consortium Partner).

> "*…They [Amref] took too long to get to SRHR. They did maternal health. A rights-based perspective was not that strong, and still it is not that strong. They are not a rights-focused organization yet. You can be a technical partner while you hold governments accountable*." (KII external expert)

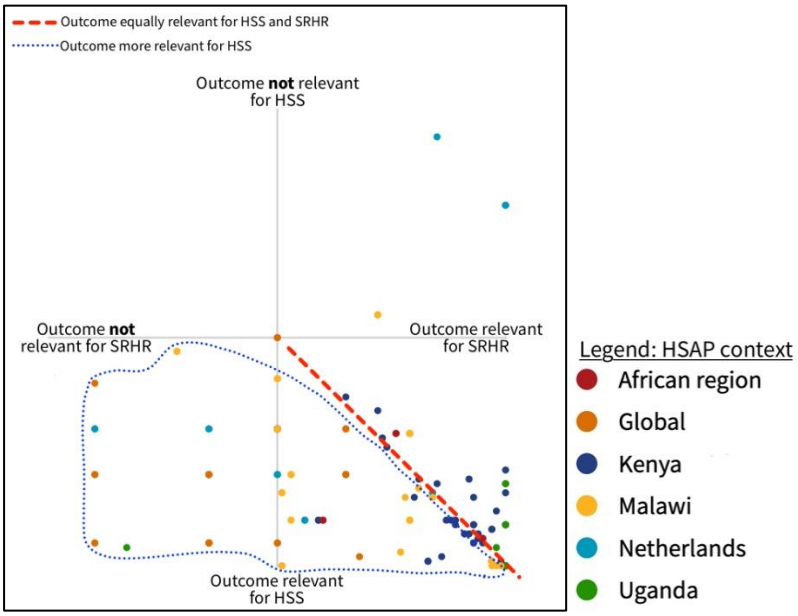
Relevance of outcomes for the SRHR at regional, global and/or the Dutch context

In the global context, the work with GFF was considered to be relevant for SRHR since it is a funding mechanism for SRHR. In the Dutch context, all substantiators agreed that the outcomes were relevant for SRHR with a direct focus on SRHR (led by Amref's outcomes), e.g. secured funding for SRHR CSO partnerships, preparing for the SRHR statement in the HLM UHC meeting and involvement in the ICPD+25 Nairobi Summit.

5.3.4 Linkages between HSS and SRHR

HSAP has worked towards strengthening health systems and changes were considered highly relevant for reproductive health services. The relevance of outcomes towards HSS and SRHR were scored by HSAP Consortium Partners by placing a dot on two bipoles (sliders)—one for HSS and one for SRHR. In Figure 13 below the two bipoles are plotted on a cross-tab: SRHR bipole on the x-axis and the HSS bipole on the y-axis (these charts can also be seen in the Sprockler Interactive report). Every dot represents an outcome. The outcomes plotted on or around the red line were found to be equally relevant for both SHRH and HSS by HSAP Consortium Partners. The outcomes plotted to the left of the red line, within the blue area, were regarded as more relevant for HSS, and to a lesser extent as relevant for SRHR.

Figure 13; Outcome relevance of HSS and SRHR



The chart demonstrates that most outcomes were regarded as more relevant for HSS than SRHR. HSAP also worked on HSS within the context of SRHR (e.g., Uganda). However, how the achievements in HSS that contributed to improved SRHR were not evident in the programme.

The HSAP TOC described how strengthening the health system was a pre-condition for SRHR and this was echoed by almost all respondents in the global and Dutch contexts. They argued that without a strong health system, including sufficient HRH and good quality HF, SRH services were not possible. HSAP also acknowledged that "*SRHR is not merely the responsibility of the health sector, but a range of societal issues and social determinants of health highly influence the implementation of the SRHR agenda*." They intended to focus equally on the demand-side by involving communities, CSOs and private and public actors. The evaluation team found evidence that these collaborations were sought at all levels. However, HSAP was unable to sufficiently demonstrate the validity of their TOC assumption that HSS is a precondition for SRHR and SRHR advocacy influences HSS.

The relevance of HSS for SRHR was not debated. However, a stronger link could have been made between the HSS interventions and their effect on SRHR by monitoring this more clearly[26]. HSAP could have made the link between SRHR and HSS more explicit by planning and following up improvements in SRHR through HSS advocacy strategies. In some cases, they actually did so, e.g., conducting surveys to increase SRHC. The relevance of increasing social accountability by using consumer score cards at a district level for SRHR was illustrated in Malawi where there was a change in the approach to improving access to contraceptives for youth as a result of feedback from consumer score cards.

With a few exceptions, in which HSS and SRHR changes were already implemented, most outcomes across all contexts were initial steps and need further effort to scale up to being 'full blown'. The question remains as to how far HSS and SRHR changes at the global and country levels have been or will be implemented to be truly relevant. The evaluation team acknowledge that this is an issue for most advocacy-oriented programmes.

[26](https://share-netinternational.org/wp-content/uploads/2019/12/narrative-review-acces-to-SRHR-quality-services.pdf; https://www.researchgate.net/publication/270004973_Sexual_and_reproductive_health_and_rights_in_changing_health_system)

5.4 Lessons Learned on Gender and Inclusivity, Collaboration and Governance, Visibility/Legitimacy and HSS & SRHR Advocacy

Question 3: What are lessons learned regarding gender/inclusivity, collaboration within the partnership linking local to global advocacy, and the linkages between HSS and SRHR?

a. To what extent has the partnership addressed gender and inclusivity in the programme? To what extent was the partnership able to include stakeholders in the planning process? To what extent was the partnership's approach to mainstream gender and inclusivity effective? What has hampered or enabled the implementation of a gender and inclusivity lens within the HSAP programme?
b. To what extent has there been an added value of collaboration and governance structure within the HSAP programme for achieving results? What were the challenges and successes in collaboration and the governance within the HSAP programme for achieving results?
c. What were the collaboration successes and challenges of partners/CSOs at various levels of the advocacy chain (sub-national, national, regional and global levels)? What factors have hampered or contributed to the collaboration successes and challenges?
d. What were the lessons learned and relevance of HSS promotion as a precondition for SRHR and advocacy for SRHR influencing HSS?

5.4.1 Gender and inclusivity

To what extent has the partnership addressed gender and inclusivity in the programme?

- There was no gender mainstreaming and inclusivity strategy, or engagement strategy in the partnership. Gender and inclusivity were not part and parcel of HSAP's programming at the beginning and almost all Contracted Partners stated this was a missed opportunity. In 2019, after the MTR, a gender specialist from Kenya was hired to guide the partnership on how to integrate gender in all activities. The consultant encountered disparate understandings of gender among HSAP partners, and integrating gender in programming and reporting was challenging in the HSAP. However, Contracted Partners indicated that the situation improved after the consultant's intervention. Gender disaggregated indicators and a special column were inserted in the reporting format and guiding questions for gender analysis in specific interventions were developed.
- Gender-mainstreaming efforts were made depending on the context including: gender-mainstreaming training for all partners, directly inviting men and women to meetings to promote women's participation, targeting female parliamentarians like the women's caucus in parliament to ensure women's advocacy needs were taken on board, ensuring community health structures included women and young people, supporting women to take leadership positions in these structures, and involving women in conducting policy audits. In Kenya, in Kajiado, there was a good example of gender mainstreaming—the country's work on a gender-mainstreaming policy (outcome 32647) cut across all other sectors, tourism, education, health, etc. HSAP trained civil servants responsible for gender in the gender-mainstreaming policy to explain what 'gender' meant (not only women).
- Given that a gender approach was only addressed late in the programme, the evaluation team could not assess the extent to which HSAP's recently introduced gender mainstreaming was effective.
- There were no indications that the programme paid attention to addressing discrimination, exclusion or intersectionalities.

To what extent was the partnership able to include stakeholders in the planning process?

- There was no evidence that HSAP included women, girls, youth or marginalized groups in the development of their programme or activities.
- In some contexts, HSAP made efforts to include women in public participation meetings. However, in Kajiado, Kenya, women were faced with challenges related to socio-cultural barriers such as distance, the lack of spousal permission to participate and time due to household and care responsibilities.
- Contracted Partners explained that gender and inclusivity were addressed by deliberately including a variety of CSOs in the CSO networks in Kenya and working together in CSO alliances representing various groups in Uganda in the RMNCAH youth coalition and at the regional level. For example, some CSOs focused on youth, marginalized women, male involvement, girls, people with disability (PwD), and LGBTI.
- A lesson learned from HSAP's work in 2018, was that HSAP teams sometimes struggle with how to operationalise meaningful youth participation. This was especially true in the two 'new' countries, Malawi and Tanzania, which had started their HSAP programme towards the end of 2017.
- However, in Uganda, meaningful efforts were made to include youth: HSAP supported youth to participate in intergenerational dialogues and district citizen hearings, and larger CSO networks at a national level (RMNCAH coalition). HSAP also supported youth to participate in African regional advocacy meetings.
- Youth were included in global meetings such as the Women Deliver conference and preparing for the ICPD+25 Nairobi Summit. In addition, the CSO push for the inclusion of adolescent SRHR in the GFF investment in countries, supported by HSAP, did refer to the need to include more vulnerable groups such as girls, PwD, LGBTQI and other marginalised groups (G4).

To what extent was HSA Partnership's approach to mainstream gender and inclusivity effective?

Relevance women/girls:

- Across contexts, Contracted Partners and substantiators indicated that their advocacy interventions and outcomes were very relevant for both women and girls. For example, SRHC supplies benefit women directly and also girls if they have access. CHW advocacy work was considered to be very relevant for woman and girls since CHWs often serve as entry points for women and girls to receive SRHR information, especially if there are legal/policy/social restrictions on FP and sexuality education. (32731) HWM was considered to affect women since they either stay behind or have to leave their homes to travel with their spouses.
- Little distinction was made between women and girls by both Contracted Partners and substantiators when applying gender analysis, although there are distinct differences between the needs of married and unmarried women, and women and girls.
- Outcomes related to HSS were of more indirect benefit or suggestively benefited women and girls.
- Even though the relevance for women and girls was indicated, the effect of HSAP's interventions on women and girls was not documented, nor were the interventions based on specific gender analyses or mainstreaming.

Relevance to PwD, other marginalised groups and LGBTI:

- HSAP did not specifically target or include PwD, other marginalised groups or LGBTI. They were considered to be part of the general population benefiting from improvements in HSS and SRHR in general. Substantiators expressed the same. In Uganda, substantiators reported that a ramp was installed to access the facilities (32904, 32931). One said they had requested disability-friendly delivery beds (32922). In Zambia and Uganda, HSAP worked together with CSOs representing PwD and in Tanzania with a CSO representing people living with HIV/AIDS, but this appeared to have been haphazard.
- For LGBTI, Contracted Partners and substantiators referred to the sensitivities surrounding this group. It was difficult to obtain information on the needs of LGBTI and reach them since they were not out in the open. In Uganda, three substantiators claimed that there were no LGBTI in their districts. One substantiator indicated that the needs and rights of LGBTI was a "taboo area in HSAP" and that no specific actions were taken to target them, given the criminalization of LGBTI in most countries. (32731) Although it is understandable that care is applied in working with LGBTI due to criminalization in the HSAP countries, there was no particular attention to LGBTI in the programme despite their specific health needs and the health inequities they face due to marginalization.
- Most substantiators at a global and Dutch level stated that more focus on the needs of these groups was required.

What has hampered or enabled the implementation of a gender and inclusivity lens within the HSA Partnership?

- Integrating a gender approach came very late in the programme when all the CSOs had already been trained and the programme was being implemented. Few meaningful results in gender and inclusivity were reported.
- Based on the KIIs responses, the Consortium and Contracted Partners' understanding of gender and inclusivity appeared to be quite limited; the gender concept was still limited concerning women's participation specifically (number, approach strategies, etc.)
- One Contracted Partner reflected that at the national and regional levels in general there was little understanding among CSOs and governments about gender beyond the biological meaning, i.e., the social construct of gender, and suggested that much could be learned from good discussions about this taking place at a global level.
- Criminalization of same sex conduct in HSAP countries limited specific advocacy and interventions for LGBTI. However, in some cases there seemed to be more leeway than HSAP took advantage of; a few substantiators recognised that LGBTI have health needs like everybody else and they were seen as part of the general population being able to access health services. One substantiator from Uganda specifically mentioned that in their health facility, key populations are specifically addressed, but not by HSAP. (32904)

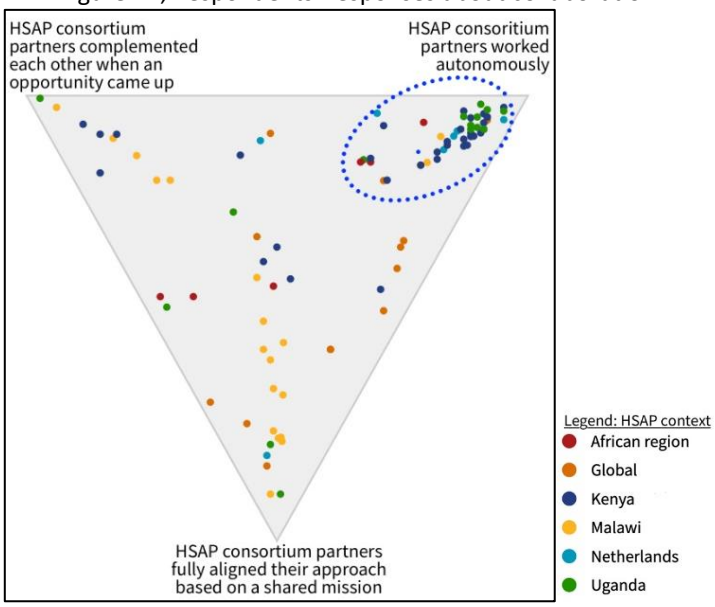
5.4.2 Collaboration and governance

Question: 3.b. To what extent has there been an added value from collaboration and the governance structure within the HSA Partnership for achieving results? What were the challenges and successes in collaboration and governance within the HSA partnership for achieving results?

Figure 14, below shows the responses of HSAP Consortium Partners to a question about collaboration leading up to one outcome. Each dot represents an outcome, whereby the dot (outcome) could be placed anywhere inside the triangle that best represented their answer. A dot placed in the middle

means that all three answers apply: it was a bit of complementarity, a bit of autonomy and a bit of a shared mission. The blue area depicts a cluster of outcomes that have been placed close to 'HSAP Consortium Partners worked autonomously'. It is highlighted because this cluster signifies that for a large of outcomes the partners worked autonomously to achieve the outcome, indicating the partnership didn't function as a real partnership in those cases.

Figure 14; Respondents' responses about collaboration



Collaboration

- Lack of strategic collaboration: Across the partnership, partner collaboration led to good results. However, it appeared that this collaboration happened in practical functions rather than strategic ones. Sprockler data showed that partners predominantly worked "autonomously". Most Contracted Partners shared that they did not work as a partnership, but rather as individual organisations pushing their own agendas under the umbrella of HSAP, despite synergies sought. Context teams really made an effort to work together and the sense of being in a partnership increased; however, one felt that the "joint" activities were still led by one partner and "some were coming along". In Malawi, there was some overlap by subcontracted partners between Amref and AMAMI and plan integration among the contracted partners was not consistent.
- Unclarity of roles: Initial communication about the project was unclear in terms of partner roles. Some Contracted Partners felt that partnerships could have gotten more mileage from their results if there had been joint planning and advocacy strategizing, and each organisation brought their thematic expertise and entry points to the decision makers.
- Lack of coordination and strategic planning: At the national levels, each organisation had their own workplan agreed upon with their counterpart in the consortium in The Netherlands or ACHEST. There were no joint context plans or funding for joint activities. The Joint Action Planning (JAP) meeting was considered to be opportunity for all partners to learn about Contracted Partners' experiences at local, national, regional and global levels. However, it did not fulfil its strategic potential; context teams planned and presented their plans, but synergies across the contexts were not made. In Kenya, in Kajiado and Kakamega, HSAP partners started to strategically collaborate after receiving funding from the Linking & Learning Fund. Since then, HSAP Contracted Partners aligned and combined their training programmes for the network.

- Reporting: Some Contracted Partners appreciated the HSAP's revised reporting structure. Others faced challenges in publishing and sharing their results, which limited capacity building on outcome harvesting and explained the lack of process reports resulting in a lack of documentation for the advocacy work and lessons learned.

Governance

- Challenges in governance mentioned by the Contracted Partners included: unclarity of roles in the partnership agreement, lack of transparency in decision making about budget allocation to partners, lack of a budget for coordination activities at a context level implying that each organisation had to invest from their own resources to coordinate, and participation challenges by ACHEST as the only Consortium Partner not based in The Netherlands.
- Governance at national levels was challenging in the beginning, without structure for communication, coordination or joint planning. The Ugandan context team established the Country Management Team, with rotating leads and monthly planning meetings. All Contracted Partners in Uganda considered this a success and stated that collaborations had improved due to this structure. The Country Management Team model was duplicated in Kenya and Zambia.
- One Consortium Partner felt that the penholder held most power in this partnership in terms of budget and decision making. Another Consortium Partner, however, felt that power was evenly distributed among partners, which delayed decision making and efficiency and would have liked to see the lead agency given more of a mandate to make decisions.

5.4.3 Linkage levels

Question: 3.c. What were the collaboration successes and challenges of partners/CSOs at various levels of the advocacy chain (sub-national, national, regional and global levels)? What factors have hampered or contributed to the collaboration successes and challenges?

- In general, Contracted Partners felt that the connections across national/regional/global were not as strong as they could have been. Contracted Partners felt a disconnect with the global level. Despite attempts to inform country-level partners, they felt they had not been sufficiently involved in advocacy at a global level by providing evidence from their countries and sending Southern voices to global discussions. At the regional level, some Contracted Partners were invited for the establishment of two regional networks (AHAP and media network), but indicated that they had not been engaged after that. Contracted Partners had also expected to assume more of the coordinating role of other HSAP partners advocating at regional levels, for contextualizing regional commitments and involvement and having input into regional advocacy. Coordination at regional and global levels was lacking. This was seen as an opportunity missed for amplifying voices and achieving advocacy results at all levels.
- Collaborations across levels were successful in terms of advocacy for the recognition of CHWs. Global Amref Health Africa developed a CHW toolkit in 2017. The toolkit was offered as a reference document by Amref Global to assist countries to develop their CHW guidelines. Other good examples included: Global Health Diplomacy training led by ACHEST that brought together regional CSOs (with Wemos participation); ACHEST and Wemos's advocacy for the HW4ALL Coalition; webinars around health work force, HF, and CSO engagement; and linkages between some Contracted/Consortium Partners, i.e. HEPS with HAI.

- Synergies between national and regional partners were felt in Kenya more than other contexts. Contracted Partners in Kenya indicated that communication between Amref HQ and Amref Kenya was better established than with other Kenyan Contracted Partners.

Complementarity

- Complementarity and autonomy were highly exercised at national levels where partners came with specific topics and worked on them together as needed. This diversity of expertise within HSAP was seen as added value by both HSAP and external partners. External respondents recognised the complementary expertise of the HSAP Contracted and Consortium Partners. HAI/HEPS/AtMP/MedRAP were recognised for their expertise in bringing stakeholders together including the private sector around Reproductive Health supply commodities, Amref for their work at the community level and for CHWs, Wemos for working on HF and global health initiatives, ACHEST/Wemos for their work on HRH and governance and ACHEST for their strong influence at the national level and penetration at the highest levels of government. Contracted Partners indicated that it was very clear to them which organisations was leading each specific topic.
- Complementarity was not necessarily used by Contracted and Consortium Partners to amplify each other's work or to work as a partnership. Some topics were left out in advocacy and possible opportunities were missed. In other cases, (Uganda and Malawi), there was duplication of efforts.
- Whether thematic areas were addressed at national, global or regional levels depended on which partner was engaged at these levels. This led to certain HSAP themes not being properly reflected if it was not in the scope of the partner's expertise. At a national level, HAI's absence in Malawi caused a lack of focus/priority on Reproductive Health supply commodities. Wemos worked remotely at a national level, and although there were efforts to establish and maintain close contact in-between 'fly-in activities', calls, email and webinars, it appeared that these strategies were not sufficient. According to a Contracted Partner in Malawi, this challenged their ability to be a meaningful contributor to the GFF process.

Autonomy / Southern leadership

- Two Consortium Partners were African, of which one (Amref Health Africa) was represented in the consortium by its Dutch office as the penholder. In terms of Southern ownership, it was felt by a few Contracted Partners that the penholder held proportionately more power for budget and decision making and there was unequal participation at the highest governance level (which is Northern dominant). ACHEST, as the African consortium member, had difficulty participating equally due to logistical constraints (calling in into meetings instead of participating in person). It was felt by a few Contracted Partners that the country-level teams had little say in partnership decisions.
- The penholder's decision in 2019, to not continue the partnership after 2020, was felt by the Contracted Partners to be a top-down decision since they were not involved. Contracted Partners were also not involved in the decision to exclude some partners in new proposals. This impacted the partnership at a country level in terms of morale.

5.4.4 Visibility/legitimacy

- Data indicates that generally, CSO visibility greatly increased due to HSAP. Both substantiators and storytellers confirmed this. CSO capacity strengthening led to more successful advocacy, which increased their visibility at national, regional and global levels. In Uganda and Tanzania, some

substantiators representing district governments explained that the visibility of HSAP's partners in the community increased and their work was credible and legitimate since they were part of the community. Globally, the contribution of Wemos and other CSOs led to a new perception of CSOs and showed the added value of CSO engagement in the GFF processes. Now four CSOs are members of the investment group and take part in GFF meetings. (28433)

- HSAP partner expertise and evidence-based advocacy was highly recognised by governments, media, CSOs and other institutions. The CSOs were frequently requested to provide information or input, which increased their visibility. Almost all substantiators were very positive about their collaborations with CSOs, both at the district and national levels. One substantiator representing the Ugandan government stated that their confidence in working with CSOs *"increased immensely"* due to HSAP's efforts to bring CSOs together, *"because they are much more organized and visible."* (32899) Through HSAP, some CSOs were able to engage in regional bodies and opportunities where they had not been before, thus raising their visibility in regional spaces. However, most substantiators knew partners in HSAP, and not HSAP as a partnership.
- The CSOs' increased visibility can also be a disadvantage, especially in settings where civic space is more restricted. Governments can monitor CSO activities closely, especially at sub-national levels where everyone is part of the same community. This can be an advantage in terms of close relationships, but it can also make it more difficult to raise sensitive issues. One Ugandan CSO based in a district explained that their strategy was to have the communities raise sensitive issues with their local governments, thus avoiding having the HSAP partner become the government's scapegoat.
- One substantiator at the global level noted that raising the visibility of Consortium Partners needed more attention: *"The visibility of partners such as Amref, ACHEST, Wemos: they are more effective in their work than in raising their visibility."* (28439)

5.4.5 Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS

Question: 3.d. What were the lessons learned related to the promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS?

Chapter 5.3 demonstrates that HSAP's advocacy was relevant for HSS and SRHR to a certain extent. However, this evaluation team did not find examples of HSAP building the evidence for their TOC claim HSS is a precondition to improved SRHR and that advocacy for SRHR influences the strengthening of health systems. The evaluation team learnt that during HSAP capacity building sessions, each partner researched this precondition. The research findings were published in May 2020[27] , which came after the date the HSAP evaluation had ended (February 2020). Therefore, the evaluation team did not include this result in their analysis. Eventually, the research results could provide data for a richer analysis of the relevance of HSAP's advocacy for HSS and SRHR, since the two fields—HSS and SRHR—generally operate in isolation, but were uniquely joined by the HSAP.

5.5 Sustainability of the HSAP Programme

Question 4: To what extent will long-term outcomes that the HSAP programme has contributed to through capacity-strengthening and advocacy approaches endure past 2020?

a. What mechanisms are in place to sustain the advocacy outcomes in terms of policymaking processes?

[27] (Source: feedback from HSAP Partnership Desk)

b. What mechanisms are in place to sustain CSO advocacy efforts, e.g. knowledge of policy processes, accountability and implementation?

In general, sustainability was not extensively discussed within the HSAP or donors. At the country and regional/global/Dutch levels, the lack of sustainability planning was acknowledged during KIIs with Consortium Partners. However, the Contracted Partners in some country contexts believed that collaborations and relationships would continue after HSAP ends. Some respondents indicated that the partnership resulted in getting to know each other and each one's complementary expertise. Contracted Partners in Uganda indicated that their work will continue through other funding and collaborating structures such as networks.

Although a positive spirit arose on the sustainability of HSAP work, Contracted Partners expressed their disappointment that HSAP would not continue in its current form. They expressed that there had been a great deal of investment and learning and that these were now yielding fruit. They indicated that 5 years was too short to build a flourishing partnership to yield advocacy results (KII, Contracted Partners, Uganda).

In regard to an exit strategy, Amref and HAI were mentioned as having a phase-out policy to ensure sustainability with handover to county governments. In the country context, the exit strategy should cover sustainability at both the national and district levels, where actual improvements to HSS and SRHR are generally made (KII, expert, Uganda).

In this section, the evaluation team discusses the mechanism in place to sustain HSAP advocacy outcomes on HSS and SRHR as well as advocacy sustainability; and the governance mechanisms to sustain CSO advocacy efforts.

5.5.1 Mechanisms in place to sustain advocacy outcomes: HSS, SRHR, and advocacy capacity

Question: 4.a. What mechanisms are in place to sustain the advocacy outcomes in terms of policymaking processes?

The evaluation team findings from the outcome substantiation process, story collection and KIIs show various mechanisms identified by respondents in the global, regional, national, sub-national, and the Dutch contexts. Respondents mentioned mechanisms of various sustainable models at the national level: improved HRH policy and legislation for HF, SRHC and CHW strategies at national and sub-national levels. However, implementation remained a concern.

The HSAP advocacy approach worked with MoH TWGs, including working groups under the GFF structures within the government, which are likely to remain. HSAP's focused advocacy is already aligned with government agendas and HSAP has already targeted existing health care system structures (CHWs and HAs), although these structures still need strengthening. Unfortunately, it is uncertain if some of these structures will remain when HSAP pulls out.

In most countries, MeTA is (co)chaired by the MoH. Incorporating MeTA within the MoH structure creates a valuable decision-making space, especially when chaired by the MoH. It is expected that the MoH will continue to use this MeTA structure after the HSAP programme ends. The MeTA in Uganda will continue to work on a wider set of commodities. HAI invested in MedRAP (Zambia) and AtMP (Kenya) by encouraging them to register as NGOs in their own right, so they might seek funding and embed themselves in the domestic civil sector (KII, Consortium partner).

In Kenya, HSAP worked with Youth Parliaments, which will likely be sustainable, since they were given the capacity to organise themselves, are self-funded and have a peer-training system for new member(s) (KII, Amref Kenya).

Below is an example of the sustainable model of Youth Parliament from Kenya:

> The Uganda Youth Parliament (UYP) functioned inconsistently during its first five years. Since 2017, Amref supported the revival of the UYP, and since then, four more parliaments have been established in the Lake Basin region. HSAP (Amref) provided training in skills, e.g., parliamentary procedures, budget advocacy, and strategies, to enhance social accountability. The parliaments have thus become self-functioning advocacy networks. Throughout the HSAP, Amref supported Youth Parliaments with small grants and mentorship, e.g., community forums.
>
> Youth Parliaments consist of volunteers, who often work for local CSOs. They are regarded as youth champions, and are trusted by the communities because they are independent and have good contacts with county officials. These CSOs often receive funding from other stakeholders to conduct their work. The Youth Parliaments have sessions in which they decide on advocacy topics the youth champions take back to their CSOs, who implement the related activities, e.g. school visits and awareness sessions in the communities.
>
> In addition, Youth Parliaments have advocated for district funding, specifically for youth activities. This has now been agreed and adopted (mid 2020), and is anchored in law. The Youth Parliaments and other parties can now send concept notes to apply for district funding.

HSAP capacity strengthening has resulted in improved knowledge and skills among Contracted Partners, CSOs, CBOs, and Network Partners on *SMART* advocacy capacities, proposal writing skills for fundraising, and social accountability, which will continue to be beneficial. In most country contexts, partnerships and networks (CSO network, media networks, Youth Parliaments, and alliances, platforms, and TWGs in SRHR and HSS) seemed to be sustainable models, and these networks are believed to remain after HSAP ends. One example is the multi-stakeholder forum organised by the UYP in Kenya, where policymakers and youth came together.

In the global, Dutch and regional contexts, the effort to form coalitions and platforms (HW4ALL, GFF CSCG, global cafes, RMNCAH platform) was in and of itself a model to sustain. However, platforms need to be maintained and continuously improved, as illustrated by a quote from HW4ALL: "*There should be a shared agreement and perspective that the coalition can be sustained beyond the financing via HSAP"* (28570/networking partner).

At a regional level, approval of the health course curriculum for journalists in the Amref International University guaranteed journalist training on SRHR and HSS sustainability. This will contribute to an increased frequency and visibility of SRHR and HSS discourses in African regional media.

In the Dutch context, funding of partnerships and secure funding for Share-Net over 5 years were identified as a basis for continued advocacy and lobbying in The Netherlands. There was a perception that participating organisations were committed to continue allocating resources for lobbying and advocacy on SRHR more than on HSS. The sustainability of advocacy with a focus on HSS was less clear and is still under discussion.

5.5.2 Governance mechanisms to sustain advocacy efforts

Question: 4.b. What mechanisms are in place to sustain CSO advocacy efforts, e.g. knowledge of policy processes, accountability and implementation?

The findings have identified examples from various contexts on the governance mechanism to sustain network, CSO and community advocacy efforts. The need to secure future funding was mentioned frequently by respondents as part of sustainability planning and how to execute it. In the global context, the HW4All coalition platform identified efforts to sustain CSO engagement by setting up a securely funded secretariat and maybe asking members to contribute. Finally, in a regional context, members of platforms, such as RMNCAH, may actively conduct fundraising to maintain the CSO platform.

Global and Dutch platforms and organisations were clear that there was a need to continue the networks since these were important mechanisms for advocacy and lobbying. For example, HW4ALL needs support to continue rallying coalition members, including the five partners in HSAP, to do their work around implementation of the Code of Practice, reduce harmful HWM, strengthen health systems through HRH absorption (28439), and work with the WHO.

Within country contexts, not all countries involved in HSAP had secured future funding for their SRHR and HSS advocacy and lobbying activities. In Zambia, most HSAP activities were embedded in the government Adolescent Health Strategy, which meant any party (e.g. organizations, donors, including government) could identity activities in the strategy to be funded, and support would be given directly to the government or CSOs. This ensured continued financial support beyond the HSAP. In Uganda, one substantiator and one storyteller mentioned that the CSOs were able to secure funding to finance their programmes as a result of capacity building provided by HSAP Consortium Partners: "*I interacted with some of the CEOs or the directors of those organizations [HSAP CSO partners]. They were able, through the capacity building we gave them and the experience they got from working with us, to get some additional funds that are going to even make some of the components that we were working on together with them keep going on or keep being supported at the district levels, and at the sub-county levels*." (KII Contracted partner AMREF, Uganda).

The sustainability issue was discussed within HSAP and mentioned in their reports several times (Kajiado Case Study, Kenya Annual Reflection Report 2018), although HSAP tried to make advocacy sustainable by including CSO capacity strengthening to make them independent after the HSAP programme ends. Nevertheless, there was scepticism about whether or not these CSOs could continue their work without HSAP financial support.

6 Discussion, Conclusion and Recommendations

6.1 Discussion

6.1.1 Achievement of HSAP's TOC

HSAP contributed significantly in realizing their overall programme TOC objectives. This evaluation shows that HSAP advocacy strategies contributed to notable outcomes related to HRH, governance, HF and SRHC across the eight contexts in which HSAP operates: Kenya, Malawi, Tanzania, Uganda, Zambia, The Netherlands, African region and global. HSAP contributed to better recognition of CHWs, and addressing HWM and deployment in health facilities. For SRHC, HSAP's efforts contributed to fewer stock-outs and better supplies and availability of FP methods and other commodities. HSAP was the significant contributor to the inclusion of CSOs in GFF processes at a national level. HSAP advocated for HF, especially in relation to FP funding. At a sub-national level, HSAP partners effectively advocated for functional facilities at health centres including youth corners where youth can receive information and services related to their SRH. HSAP's approaches to CSO and other stakeholder capacity strengthening and lobbying and advocacy have yielded fruit. The evaluation team has shown how HSAP's approaches presented in the TOC pathways have substantially contributed to good advocacy results: consistently investing in generating and using evidence for advocacy; creating and showing leadership and facilitating multi-stakeholder platforms; engaging with media, parliamentarians, CSOs, networks and governments and building their capacity; empowering communities to claim their rights; using valuable entry points with decision makers at all levels; and sharing knowledge of HSS and SRHR and political and policymaking processes. The evaluation team found that these approaches complemented and reinforced each other and that HSAP's TOC pathways were valid. The literature confirms the effectiveness of strategies such as generating credible evidence[28], effective leadership and networking[29] and positioning the network well in politics[30]. In particular, the evaluation team found that HSAP was unique in their approach of engaging with communities, and empowering them to claim their rights and demand services from authorities. This was a bottom-up approach to ensuring accountability and a sustainable and effective approach to facilitate dialogue and dissent, where it matters, close to people's lives and realities.

6.1.2 Effectiveness

HSAP started outcome harvesting in 2018, the third year of the programme. In some contexts, programme implementation had just begun, and Malawi and Tanzania were only added as programme countries in 2017. In these countries, the outcomes concentrated more on policy support and less on policy implementation, which was understandable given the short implementation period. Available data (Malawi and Tanzania) did not indicate activities in the first two years of the programme. However, HSAP outcomes were notable, and in some cases, impressive for such a short implementation period. A total of 66% of change was achieved by involving local governments followed by national governments including their support, adoption of policies and budgets and budget implementation. In countries like Uganda and Kenya, outcomes were achieved that were above

[28] Kalipso Chalkidou, Ryan Li, Anthony J. Culyer, Amanda Glassman, Karen J. Hofman and Yot Teerawattananon Health Technology Assessment: Global Advocacy and Local Realities Comment on "Priority Setting for Universal Health Coverage: We Need Evidence-Informed Deliberative Processes, Not Just More Evidence on Cost-Effectiveness". Int J Health Policy Manag. 2017 Apr; 6(4): 233–236. Published online 2016 Aug 29. doi: 10.15171/ijhpm.2016.118

[29] https://www.who.int/pmnch/topics/advocacy/jshiffmaninterview_090908/en/

[30] https://oxfamblogs.org/fp2p/what-explains-advocacy-success-in-setting-global-agendas-comparing-tobacco-v-alcohol-and-four-other-global-advocacy-efforts/

HSAP's self-indicated accountability ceiling since achieving those outcomes were considered to be beyond HSAP's sphere of influence. This was the case for policy implementation, where the evaluation team found many examples of achievement (17% of all outcomes were related to policy implementation). The outcomes at a sub-national level were the most tangible, while advocacy at national, regional and global levels were more unstable and required constant adaptation to changing contexts. In the global and regional contexts, most outcomes related to increased stakeholder engagement for HSS and SRHR, followed by policymaker support in the global context. In the Dutch context, outcomes were predominantly achieved in increased policy support and multiple stakeholder engagement.

For many outcomes substantiated in this evaluation, external respondents (substantiators) indicated that in the national, global and Dutch contexts, HSAP contributed significantly, although discerning attribution in advocacy projects remained difficult. At a sub-national level, HSAP directly influenced local governments and communities. At national, regional and global levels, HSAP's influence was more often indirect and HSAP was one of many stakeholders advocating for change. Advocacy for HSS and SRHR was ongoing and did not start with the HSAP programme. Wemos is a recognized global advocate for HSS and AMREF for improving health services and advocacy in countries. HAI is a strong player in strengthening SRHC supplies and ACHEST is recognized as a strong African voice on HRH and governance. The strength of each partner's activities continued during the HSAP programme. Furthermore, other stakeholders may have advocated for a certain policy change long before HSAP joined the endeavour. In HSAP's outcome harvesting, these nuances were rarely taken into account. This is not exclusive to HSAP; it is widely recognised that attribution of results is particularly difficult in advocacy programmes and it is difficult to find robust counterfactuals when no programmatic interventions take place[31]. Furthermore, in advocacy programmes, no single organization can claim successes related to their contributions. Many stakeholders and dynamics influence a particular advocacy outcome, and advocacy targets (mostly policymakers) may not be willing to acknowledge contributions of non-governmental players to the changes they made[32].

Few negative and unintended outcomes were harvested and this is inherent to the method of outcome harvesting. The method has a tendency to generate positive outcomes since it encourages harvesters to focus more on what has been achieved, but this can create bias. Also inherent with the OH method is that substantiators often are people who know the programme and outcomes well and even benefit from the programmes; this also creates a bias. This evaluation has taken various steps to counteract positive bias, including interviews with key informants outside the programme, IDIs to follow up/probe and triangulation of data. Through this approach, the evaluation was able to identify missed opportunities, strengths and weaknesses of the programme.

Visibility/legitimacy

HSAP contributed to increased CSO visibility at several levels, which had an effect on the CSO's legitimacy. With increased capacity, strengthened by HSAP, CSOs at a sub-national level became a more legitimate voice in the communities, which was recognized by local governments. Contracted

[31] Save the children, Monitoring, Evaluation, Accountability and Learning (MEAL) 10 Monitoring and evaluating advocacy, The Open University, https://www.open.edu/openlearncreate/pluginfile.php/128097/mod_resource/content/1/Monitoring%20and%20evaluating%20advocacy.pdf (Accessed 27-07-2020)

[32] Jones, Harry (2011) *A guide to monitoring and evaluating policy influence, Background Note*, Overseas Development Institute [Online]. Available at http://www.odi.org.uk/resources/docs/6453.pdf (Accessed 26-07-2020)

Partners in the various country contexts were recognized for their specific expertise in HSS and/or SRHR themes or influence. CSOs became more visible as an African voice at regional and global levels due to HSAP activities. However, HSAP did not sufficiently institutionalize or strategize around bringing African CSO and youth voices systematically to regional and global decision-making processes.

Community empowerment to claim their rights and demand services

HSAP has a unique approach to engaging with communities and empowering them to claim their rights and demand services from the authorities. HSAP and partners have demonstrated their brokering role in letting rights-holders raise their voices and hold duty-bearers accountable at the sub-national level. For example, HSAP's efforts to strengthen the capacity of CBOs and communities to demand improved facilities, as the evaluation team saw in Malawi, Uganda and Kenya, were important contributions to UHC. This was a sustainable and effective approach to facilitating dialogue and dissent and promoting accountability, there where it matters, close to people's lives and realities. When communities demand their rights this also makes local CSOs less vulnerable to being undermined and possible restricted in their operations if the government does not agree to their dissent, since the CSOs have community support for their work.

Linkages between global and national advocacy

One of the significant achievements of the global advocacy strategies included the linkages between global and country advocacy. The substantiator interviews showed that the inclusion of more HRH, HF and CSO engagement policies and guidelines in the GFF at the global level was at least partly a result of HSAP's strong lobbying and advocacy in global, Dutch and country contexts. Although there is a need to strengthen the global-national collaboration both ways, these linkages enabled the establishment of stronger CSO involvement and increased CSOs' ability to hold governments accountable at a country level. Other positive examples of connecting national-regional-global advocacy were on issues of CHWs and HWM. The evaluation team did not find evidence of strong connections made across levels for SRHC. Despite positive initiatives of bringing CSOs and youth to global and regional fora, systematic capacity building of country-level CSOs to meaningfully engage in regional and global advocacy as a strategy to amplify their national advocacy lagged behind in the HSAP programme.

Complementarity

HSAP partners were recognised for their expertise, which was complementary, however HSAP partners mainly worked autonomously (with some exceptions); other partners would be informed or invited, but the real advantage of their complementarity was not taken. Collaborations were sought within and across contexts, when possible, and most notably starting in the third year of implementation. HSAP could have used the potential of their presence at various levels and contexts for more gains. In the country contexts, the evaluation team observed a disconnect in advocacy objectives between sub-national and national advocacy, among country contexts, and among country contexts and regional and global levels. Exploiting these linkages could have contributed to amplifying advocacy strategies, gaining more mileage from results, reducing duplication of efforts, strengthening learning in the partnership and improving accountability of policies and commitments at several levels.

The evaluation team observed that this missed opportunity was not a matter of partner unwillingness. Strategizing as a partnership and within contexts and across levels was hampered by the governance and programme structure of the partnership. Due to unclarity in the roles in the beginning of the partnership, it took a while before mutual trust was established among partners. Power dynamics—which are inherent to partnerships—did not receive explicit HSAP attention. The partnership did not

facilitate coordination of budgets and mechanisms for joint planning (since each organization had their own work plans) or joint strategizing. That it could be done, was demonstrated by the successful joint planning and strategizing in Kenya with the funds available from the Linking & Learning fund.

HSAP had a major focus on health systems, in particular HRH, HF governance and to some extent SRHR. Many respondents assumed that the claim made in the overall TOC that HSS would lead to SRHR improvements, would prove to be true. However, while there were important achievements by HSAP, the partnership could have invested more in tracking increased systemic change, thus linking HSS more clearly to improved SRHR.

6.1.3 Relevance

The relevance of HSAP's outcomes for the beneficiaries was not made explicit by HSAP. HSAP did not address contentious subjects within HSS and SRHR, despite the severe impact on the communities HSAP serves. Examples include teenage pregnancies (it is reasonable to assume a proportion of these pregnancies lead to unsafe abortions and increased maternal deaths) and access to health services by marginalized groups such as LGBTI and PwD. The evaluation team did not see HSAP raise their voices loudly on those gaps and injustices. Within HSS, there were systemic issues that needed urgent action related to funding, governance, leadership and accountability. HSAP could have gone a step further in holding governments to account for poor outcomes in HSS and SRHR in their countries. The advocacy outcomes were predominantly achieved in enabling environments, thus indicating that HSAP strategically took advantage of opportunities when they arose or when there was a support base, either in communities or with policymakers, and exploited their good relationships with them. Although this dialogue approach can be defended, and the evaluation team saw the good results it yielded, the evaluation team also questions whether or not HSAP's symbiotic relationships with governments in some cases prevented a more dissent-based approach that would have pushed the envelope to more systemic change in society.

6.1.4 Lessons learned

The evaluation team observed that HSAP developed conceptual thinking around gender equality, the promotion of HSS as a precondition for SRHR and how SRHR advocacy contributed to HSS, especially in its TOC. HSAP adds value in the global health and SRHR landscape by focusing on bridging both. However, HSAP seemed to have struggled when operationalizing some of these concepts. The evaluation team saw a missed opportunity in enhancing gender transformation and inclusivity through this programme, as well as making a strong case for the interlinkages between strengthening the health system and improving SRHR. Advocacy for the four building blocks of HSS was done mostly in silos and SRHR advocacy predominantly focused on SRHC only. HSAP has a presence in the communities where (gender) inequality, stigma around adolescent SRHR, poor health service delivery (including access and availability of services), limited information and commodities, and poor SRHR outcomes (e.g., teenage pregnancy and unsafe abortions) intersect. While HSAP has worked on these issues (some more than others), the partnership has had difficulty addressing and presenting these people-centred realities across HSS and SRHR.

6.1.5 Sustainability

In terms of sustainability, HSAP has invested in capacity strengthening of CSOs, media, parliamentarians and governments and MeTA's becoming embedded in policy structures, e.g., Ministry of Health TWGs, coalitions and multi-stakeholder platforms and CSO coordination

mechanisms like those under the GFF. It is believed that all these structures will contribute to the sustainability of HSAP's efforts.

The results of evaluation showed that the HSAP programme engendered several sustainable models by improving national policies (national level) on HRH, HF, SRHC and CHW strategies working through MoH TWGs, aligning HSAP advocacy strategy with government agendas, targeting existing health care system structures (CHWs and HAs) that still need strengthening, and working with Youth Parliaments. Some HSAP Consortium Partners invested in sustainability/exit strategies to an extent. HAI invested capacity strengthening of MedRAP (Zambia) and AtMP (Kenya), which allowed the two groups to register as NGOs. As NGOs, they improved their fundraising and could remain the secretariats of the embedded MeTA's within MoH structures. Amref partners included a phase-out policy to ensure sustainability with handover to county governments. However, all the mechanisms put in place still depend heavily on HSAP funding and capacity, and it is questionable whether or not these efforts can or will continue after HSAP ends.

6.2 Conclusion

HSAP made progress toward achieving its objectives related to capacity strengthening of individual CSOs, CSO networks, communities, and media. They also had results in advocacy by HSAP partners and CSOs in the contexts of Kenya, Uganda, Zambia, Tanzania, Malawi, the African Region, global and The Netherlands. Notable outcomes were achieved related to policy adoption, budget and policy implementation, in particular for HRH, governance, HF and SRHC. This evaluation shows the validity of HSAP's pathways in their TOC, where advocacy strategies have contributed to substantiated mid-term and long-term outcomes such as increased multi-stakeholder engagement in HSAP priority themes and policymaker support for policy change. These pathways included the use of evidence for advocacy, the creation and facilitation of multi-stakeholder platforms, engagement with media, parliamentarians, CSOs, networks and governments and building their capacity, empowerment of communities to claim their rights and the use of valuable entry points with decision makers at all levels. These approaches were complementary and mutually reinforcing. HSAP also contributed to the increased capacity, visibility and legitimacy of CSOs, which enabled their involvement in dialogue and dissent with their governments and other stakeholders.

There were also missed opportunities. The partnership would have had more mileage in their advocacy results if they had operated as a partnership, instead of having individual organisations working autonomously on their expertise. HSAP could exploited the potential of their presence at various levels and contexts and their complementary expertise. Obstacles to do so were mainly related to HSAP's governance and programme structures that lacked budget coordination and mechanisms for joint planning and strategizing. Conceptual thinking about linkages between HSS and SRHR and that HSS leads to improved SRHR were there, but not fully operationalised. The operationalisation of gender transformation, addressing marginalization and exclusion and social determinants of poor SRHR outcomes were not a focus of HSAP.

6.3 Recommendations for Future Programmes

- Develop and implement a governance structure and advocacy strategies that ensure consistency across levels and themes. Such a strategy would include follow up on advocacy achievements to ensure implementation is taking place and people truly benefit. Strategize across the partnership

per thematic area and across themes on how advocacy can successfully achieve results in each area across all context levels (national-regional-global).

- Build stronger connections across sub-national, national, regional and global levels to amplify advocacy and voices. Establish coordination mechanisms that oversee these linkages. Make more use of complementarity within the partnership; amplify each other's messages at various levels, and reinforce HSAP's status as a partnership instead of individual organisations.
- Continue capacity strengthening of CSOs and media at all levels utilising HSAP's expertise in HSS and the link with SRHR and effective advocacy approaches. This includes operationalizing HSAP's vision of strengthening CSO and youth voices in regional and global decision-making processes.
- Apply thorough gender analysis in programme design and gender-transformative approaches in interventions. Document intervention effects on women, girls and marginalised groups. Involve beneficiaries in the design, implementation and monitoring of the programme.
- Take into account social determinants of SRHR, and inequalities including gender inequality that lead to poor SRHR outcomes and limited update of services. It is recommended to pay attention to intersectionalities that impact exclusion and marginalization. Pay attention to health inequities faced by some groups in society. Acknowledge distinct needs, such as the specific needs of girls, which are different from the needs of women. Take more advantage of possible existing leeway in addressing LGBTI health needs.
- Develop a strong narrative on how HSS improves SRHR and vice versa. The conceptual thinking on this could assist the countries to realise the SDGs. The linkages between HSS and SRHR can be made more explicit when developing advocacy strategies and collaborations between partners. More is needed than only focusing on the health system including commodities. Focus more on accountability, leadership and governance for systemic HSS change in countries.
- Continue to increase CSO visibility while being cognisant of their possible vulnerabilities due to restrictive civic space. When this is the case, provide these CSOs with support.
- Invest in building a partnership by examining internal power dynamics, building mutual trust, building in joint coordination mechanisms, strategizing, planning and joint reporting. Pay attention to power dynamics within the consortium and partnership enabling equal participation and decision making, especially from CSOs based in the global South.
- Develop exit strategies for each context given that HSAP will cease to exist as a partnership, and to better ensure achievement sustainability.

Recommendations for future OH use:

- Avoid positive bias by: instructing programme implementers to report 5 positive outcomes and 1 no-change or negative outcome and clarifying existing instructions/guidelines for reporting negative outcomes (setbacks).
- Meaningful OH requires: identifying good quality outcomes; it is important to ensure the OH process is well understood by all programme implementers and the need to provide strong evidence is emphasized; providing intensive capacity building including training, mentoring and regular review and double checking of harvested outcomes; explaining negative outcomes in detail (explain how they are related to culture, ensure it is safe to report negative outcomes, and note how negative outcomes are important for learning processes); and harvesting high-quality negative outcomes before the evaluation (if possible, and done by programme implementers) so

during the evaluation, the evaluators have adequate time to identify additional negative outcomes.

Results inHealth
Evidence, Innovation and Practice

Annexes
Final Report
End Evaluation of the Health Systems Advocacy Partnership (HSAP)

Submitted by ResultsinHealth
Date 4 September 2020

working for health and development

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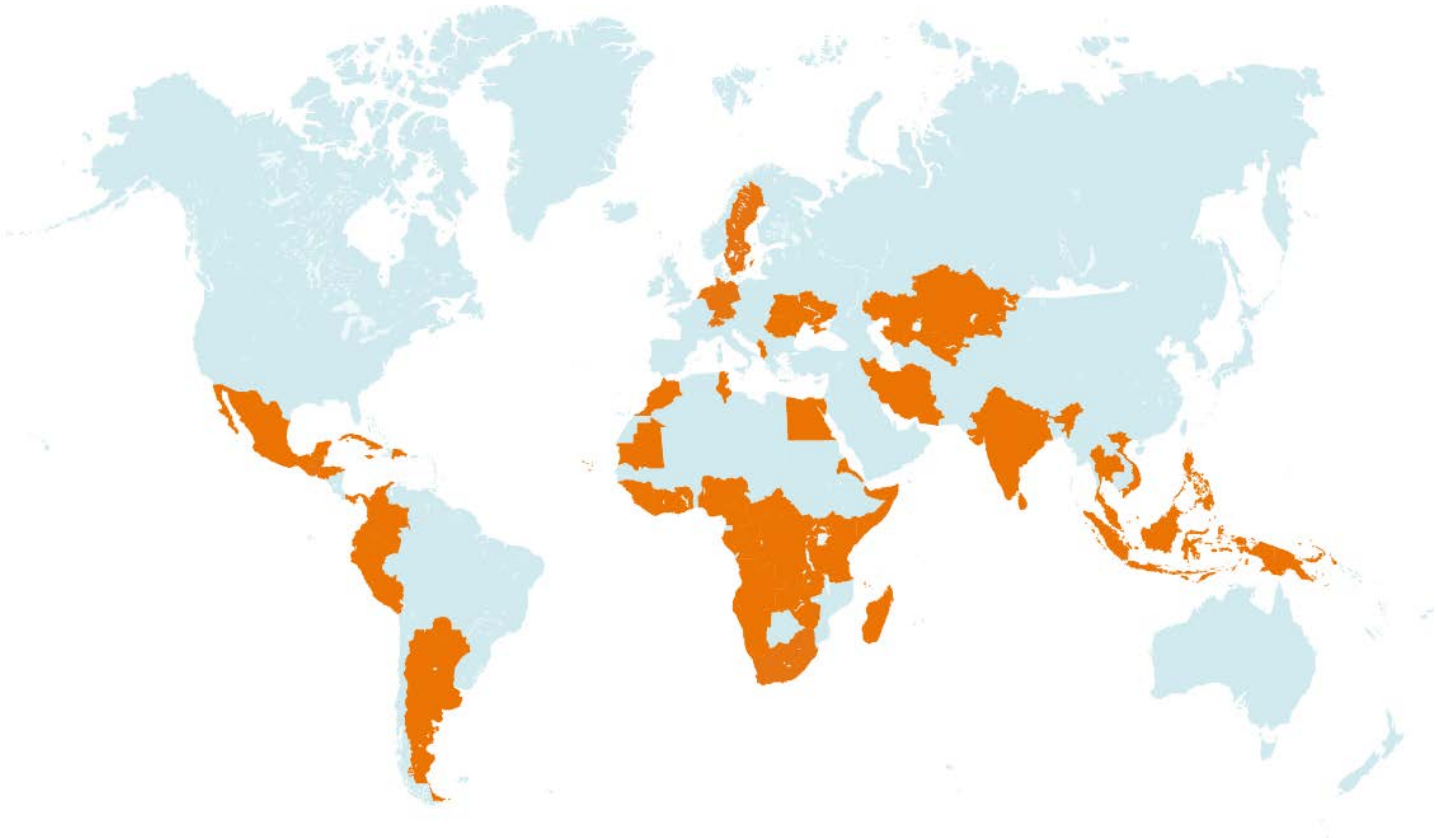


ResultsinHealth | Zijlbaan 46, 2352 BN Leiderdorp | The Netherlands
T. +31 (0)71 760 1200 | office@resultsinhealth.org | www.resultsinhealth.org

Table of Contents

Annex 1. ToR 1

Annex 2. The Evaluation Matrix 9

Annex 3. HSAP Theory of Change (Overall) 16

Annex 4. Evaluation Process 18

Annex 5. Final Data Collection Tools: Sprockler Inquiries tools (3) and Topic Guide IDIs tools 20

- 1. Sprockler tools 20
- 2. Final Topic Guide for IDI 36

Annex 6. Context reports 53

- Global and the Netherlands Context 53
- Regional Context: African Region 75
- Country Context: Kenya 86
- Country Context: Malawi 101
- Country Context: Uganda 120
- Country Context: Zambia 135
- Country Context: Tanzania 145

Annex 7. Tabulation of all substantiated outcomes with substantiator comments 152

Annex 8. List Substantiator 153

Annex 9. The detailed information of outcomes mentioned on Page 16 155

Annex 10. List of outcomes and description 156

Annex 11. Outcome Harvesting Quality Check 157

Annex 12. Original and new Actor and ToC categories 159

Annex 13. List of storytellers 162

Terms of Reference

End evaluation of the Health Systems Advocacy Partnership

Introduction

The Health Systems Advocacy Partnership is currently in the fourth year of the five year programme. An independent, external end evaluation of the program will be undertaken as a requirement by the Dutch Ministry for Foreign Trade and Development Cooperation (MoFA). This final evaluation will measure progress towards the overall goal set out in the Policy Framework by MoFA in 2016 "to strengthen the lobbying and advocacy capacity of Southern civil society organisations". Early in 2019, MoFA clarified the purpose of the end evaluation stressing the importance of both accountability and learning. The deadline for submitting the final evaluation report to MoFA is 1 December 2020.

Background information

The Health Systems Advocacy Partnership (HSA Partnership) is a five year project (2016-2020) funded by the Dutch government. The ultimate goal of the HSA Partnership is to enable communities to realize their right to the highest attainable sexual and reproductive health (impact). The project aims to contribute to achieving 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. The HSA Partnership envisages that by focusing on the creation of a strong health workforce, access to sexual and reproductive health (SRH) commodities, and investing in sustainable structures for health financing and governance, equitable access to high-quality SRHR service can be realized. This is realized by partners through four core strategies: capacity strengthening of civil society organizations, research, public awareness raising, and lobby and advocacy.

The Partnership is comprised of Amref Health Africa, the African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI), Wemos, and the Dutch Ministry for Foreign Trade and Development Cooperation. As of 2016, the Partnership has been active in three countries Kenya, Uganda, and Zambia as well as in the broader African Region, the Netherlands and at the international level (particularly the WHO). In 2017, the HSA Partnership extended its work to Malawi and Tanzania. At the end of 2018, the HSA Partnership had worked with over 400 CSOs, of which 200 CSOs participated in capacity strengthening activities in the five African countries, besides stimulating south-south and south-north learning of CSOs and vice versa. Table one provides an overview of contexts, thematic and strategic focus of the partners.

Table 1. HSA partners focus areas

	Amref	Achest	HAI	Wemos
Contexts				
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 strengtening	X	X	X	
Lobby and Advocacy	X	X	X	X
Research and learning	X	X	X	X

An external mid-term evaluation was undertaken in 2018 which focused on 6 midterm outcome indicators relating to space for dialogue and dissent for civil society organisations. Outcome Harvesting as a qualitative method has been introduced in the Partnership in 2018 to identify and document results. Outcome Harvesting is a monitoring and evaluation methodology used to identify, describe, verify and analyse the changes brought about through a development intervention. It is designed to collect evidence of change (the 'outcomes') and then work backwards to assess whether or how an organisation, programme or project contributed to that change.

Objectives of the end evaluation

The main objective of this evaluation is to determine the extent to which the HSA Partnership has made progress toward achieving its objectives in the contexts of Kenya, Uganda, Zambia, Tanzania, Malawi, the African Region, Global and the Netherlands relating to:

1) Capacity strengthening of individual CSOs, CSO networks, communities, and media, and
2) Advocacy results of HSA partners and CSOs (mainly related to their involvement in policy making processes and level of support by policy makers).

A key focus of the evaluation will be the independent, external validation of outcomes already documented by the HSA Partnership, and the identification of other outcomes (including unintended results).

The approach to the end evaluation should include a strong learning element. The evaluation should provide insight into best practices, sharing and learning across contexts and partners, enabling factors and obstacles that have hampered progress. Identifying and validating (un)successful examples will contribute to learning about how the approach of the HSA Partnership and CSOs has led to both intended and unintended results. The exercise will generate findings concerning capacity strengthening and advocacy strategies which will mainly be used for input into other (current and future) projects of the four core organizations and related partner CSOs.

The quality of the evaluation has to adhere to (a selection of) criteria set by IOB, being validity, reliability, effectiveness, and usability. For details see annex 2. Core evaluation aspects to be taken into account for this evaluation are:

- Relevance (the extent to which results of activities contribute to addressing challenges around health system strengthening and SRHR),
- Effectiveness (the extent to which objectives were realised),
- Sustainability (the extent to which results of the programme can expected to be maintained in the longer term.

Scope

- The end evaluation will cover activities in eight contexts but field-work will take place in at least 3 to-be-selected African countries (sub-national, national in the capitals, and links to international contexts). Selection and decision on the number of countries to visit will take place in the inception phase in consultation with the Partnership Desk. See annex 1 for an overview of the geographical presence of the HSA Partnership.
- The evaluation will cover the period from January 2016 (start of the project) until March 2020.

- The evaluation will focus on beneficiaries at various levels i.e. individual CSOs, networks or platforms of CSOs, communities, media, decision-makers (mainly local and national government), representatives from regional or international institutions, the HSA Partners, and their counterparts in the African countries.

Methodology

It is anticipated that the methods for assessing and explaining the progress of the program in relation to the outcomes anticipated in the programme's Theory of Change will be largely qualitative. An extensive, in-depth document review will need to be done in the inception phase and is key to understanding the complexity of the Partnership. Results collected by the Partnership through the method Outcome Harvesting are a key resource. Validation of a selection of these and other outcomes related both to capacity strengthening and to advocacy results should be part of the data collection activities.

When answering the main questions, focus should be on what factors enabled/hampered results and should provide explanations or reasons as to why this is the case. Examples and case stories should be used to show how in particular situations particular approaches worked or didn't work. Evaluators should take into account that the level of experience of CSOs with lobby and advocacy and types of advocacy they engage in is diverse. Many CSOs assess themselves as experienced in advocacy.

The involvement of the HSA partners in the contexts in the inception phase and throughout the evaluation process is key. Also the involvement of CSOs in the inception phase to include their learning/evaluation questions is important. In consultation with the context teams and HSA Partnership Desk, finalization of the evaluation questions is expected in the inception phase to enable context teams, the partners, Desk, and evaluators a thorough and common understanding of the evaluation questions.

Main evaluation questions

There are 4 proposed sets of main questions related to:

1) Relevance of capacity strengthening of individual CSOs, CSO networks/platforms, communities, and media by HSA partners.
2) Effectiveness of advocacy approaches in achieving results of HSA partners, CSOs, and communities. Focus within results on improved support of decision makers and involvement of CSOs and HSA partners in policy making processes.
3) Lessons learned related to the two above mentioned areas, linking advocacy issues from local-national-global level and vice versa, gender/inclusivity, relevance.
4) Assess the soundness of the mechanisms put in place for sustainability of the HSA Partnership outcomes.

During the design process of this ToR, sub-questions have been formulated that further "unpack" the four main research questions. During the inception phase, the consultant is expected to make a selection of questions that are most relevant for answering the research questions and to incorporate these into a comprehensive evaluation framework. The current sub-questions are listed below:

1. Relevance of capacity strengthening

- To what extent and in which situations has the HSA partners' capacity strengthening support* helped CSOs** and media to improve their capacity in lobbying and advocacy, which includes a range of skills and knowledge?

- What criteria have been used to select CSOs to cooperate with in the HSA Partnership?
- In what way has legitimacy of CSOs (e.g. representativeness, governance) been part of the selection criteria?
- How has capacity strengthening effected the legitimacy of the CSOs?
- What capacities were needed by CSOs and media to achieve results? Who contributed in what way to strengthening these capacities?
- results of CSOs and media and if so, how?
- What factors enabled or hampered the strengthening of capacities of CSOs and media by HSA partners and why? Did partnership collaboration play a role in this and how?
- Which capacity strengthening efforts of CSOs/CBOs contributed to empowering local communities to demand their right to sexual reproductive health, and how? Which did not? What factors enabled or hampered this?

2. *Effectiveness of advocacy results and approaches****

- To what extent have HSA partners seen results from their advocacy efforts? (give examples)
- To what extent have CSOs, CSO networks, communities, and media that have engaged with the HSA Partnership seen results from their advocacy efforts? (give examples)
- What advocacy tactics/approaches worked, didn't work and why?
- What factors (internal/external) blocked or hampered achieving results by HSA partners, and why? How could these be influenced? Did partnership collaboration play a role in this and how? How do HSA teams handle changing circumstances?
- What factors (internal/external) blocked or hampered achieving results by CSOs engaging with HSA partners, and why? How could these be influenced? Did partnership collaboration play a role in this and how? How do CSOs deal with changing circumstances?
- To what extent did HSA partner's involvement of national and local policy-makers in their interventions influenced decision-makers' capacity/understanding of SRHR? (give examples)

3. *Lessons learned*

- What are successes (how has the gender/inclusivity lens influenced outcomes in relation to the position of women, girls and marginalized groups?), challenges and lessons learned concerning applying a gender/inclusivity lens in both capacity strengthening as in advocacy activities which can influence results?
- In what cases did working in a partnership enhance/hamper the results of capacity strengthening and advocacy activities?
- What were successes and challenges in the collaboration (such as thematic cooperation, activities, exchange of views/information etc.) between partners/CSOs at different levels of the advocacy chain being at sub-national, national, regional and international levels?
- How do the findings of the evaluation align with core assumptions in the ToC that Health Systems Strengthening contributes to realize improved SRHR?

4. *Sustainability*

- What has been done to build sustainability into the programme?
- How have HSA partners, and beneficiaries of HSA capacity support, increased the sustainability of capacity strengthening initiatives and results?
- How have HSA partners and CSOs contributed to sustainability of spaces for dialogue and dissent (such as networks, platforms etc.) which HSA partners/CSOs have created, maintained, or supported?
- How have HSA Partners contributed to sustainability of advocacy results by HSA partners/CSOs?
- What are recommendations to improve sustainability that are feasible within the timespan of the current programme?

* Evaluating the increase in capacities includes the full range of capacity strengthening approaches such as workshops, trainings, collaboration, network building, and mentoring, as well as mutual learning (south-south, south-north and vice versa). This is particularly important when linking local advocacy issues to national and international level and vice versa.
be represented by CBOs.

*** Partners/CSOs use different tactics or methods of advocacy for example influencing legislation, setting up local platforms, national campaigns, participating in technical working groups, etc.

Phases and deliverables

Inception (Sept-Nov 2019): In-depth analysis of project documentation, eg. to ensure roles, activities, and objectives of the partners are clear, and interviews with key program staff members and (selection of) CSOs. This will result in an inception report explaining the proposed evaluation framework and detailing the methodology, data collection tools, and work plan including timeline and finalized approach to record best practices. Furthermore, a preliminary report based on the desk-study and interviews is available. Both the inception and preliminary report contribute to the refinement of the proposed evaluation questions and specify possible additional questions, based on own judgement and input from the documentation and interviews.

Desk research and field work (Dec-March/April 2020): In-depth desk research, interviews and in-country field work (during March/April) will shed light on the activities of the HSA Partnership with the CSOs, networks, and media in each country. In at least 3 countries an in-depth study will be carried out following the research plan as presented in the inception report. Deliverable is a summary of the key findings of the country studies.

Reporting (May-June 2020): Reporting and participation in the discussion of findings and recommendations with the HSA Partners. The deliverables are a draft report followed by a final report taking into account the comments of the HSA Partnership.

Roles and responsibilities

The HSA Partnership will:

a) Provide the relevant project documents for review, such as the baseline, yearly reports by the partners per context, CSO capacity assessment results (made anonymous), outcome monitoring data, mid-term review report, and a database with results to which the HSA Partnership has contributed (documented with Outcome Harvesting).
b) In consultation with the consultant set up a group of contacts for each of the contexts who will provide additional context specific information and questions that can be addressed in this assignment.
c) Plan structured feedback moments between consultants, Partnership Desk, core partners and related partner CSOs involved during the data collection to discuss the process and any challenges experienced.
d) Provide in-country logistical support for the assignment.
e) Mobilize relevant stakeholders (such as health stewards, government officials at national and district level, training institutions, media, judiciary, civil society organizations (CSOs), (multi-stakeholder) networks and partners to participate in this assignment when needed.
f) Provide opportunity for validating findings for core partners and related partner CSOs involved in the research.
g) Provide the venue and equipment for the presentation and dissemination of the findings.

Consultant team

The consultant team is responsible for the data gathering process and communication with stakeholders involved. The consultant team ensures a debriefing of preliminary results to key stakeholders within HSA (incl. CSOs) at the end of the field research, and participates in discussions on findings and recommendations with HSA staff at partnership level. The consultant team takes responsibility for a quality final evaluation report.

We would like the travelling consultant to team up with a local consultant during the field visits to each country. This local consultant should be based in the country where field work is done. Costs need to be included in the budget proposal.

We expect to see the following products as a result of this consultancy (English language):

1. An inception report, presenting
    a. A detailed understanding of the terms of reference detailing the evaluation framework, methodology, data collection tools, work plan including finalized approach to record best practices.
2. Soft copy of all data collected (excluding interview transcripts).
3. Draft and final versions of the assessment. The report should:
    a. Be jargon free, clear and written in an accessible fashion
    b. Not exceed 50 pages
    c. Include an executive summary, outline of the methodology used including limitations, findings and recommendations.
    d. Ensure the analysis is backed up with relevant data and validated, with reference to data source
    e. Ensure the recommendations are specific and include relevant details how they might be implemented
    f. Include context study reports with key findings (annexes, max. 5 pages per context)
4. A presentation for dissemination of findings and recommendations

The focal point on behalf of the HSA Partnership will be the PME Coordinator of the HSA Partnership Desk. All deliverables will be reviewed internally by the Programme Group (in which 4 representatives of the HSA Partnership organisations take place) and the PME working group (in which 4 M&E representatives of the four HSA partner organizations reside plus the PME coordinator of the HSA Partnership Desk). CSOs involved in the data collection will also be included in the review of the draft report. Furthermore, an external advisory group (EAG) will be involved in the quality control of the evaluation report and will provide a formal advice on the compliance with IOB criteria.

Budget

An indicative budget for this consultancy is €80,000 (including everything such as VAT, transport, local consultant costs, accommodation costs). The HSA Partnership will cover local transport costs in the African countries during the field visits. Taking the budget and timeline into consideration a full coverage of all national and local engagements (see annex 1) is not possible, but a sample is expected. Potential consultants are requested to provide a budget breakdown realistic to the scope but not exceeding the budget ceiling.

Timeline

	Expected output	Timeline
1	Receiving of bids for potential consultants	30 August
2	Review and interviews, selection of consultant	Week of 23 Sept
3	Negotiations, contract signing with consultant	Week of 30 Sept
4	Introductions to HSA, meeting in the Netherlands with HSA Partners and Partnership Desk.	Early Oct
5	Presentation of draft inception report to HSA Partnership Desk	End October
6	Review of draft inception report by partners and External Advisory Group	Early November
7	Presentation of final inception report to HSA Partnership Desk	End November
8	Data collection, analysis & report writing Country visits of each 2 weeks planned for March/early April	December-April 2020
9	Draft report presentation to HSA Partnership Desk	Early June 2020
10	Review of draft report by partners and External Advisory Group	End June 2020
11	Final report presentation with HSA Partnership comments incorporated	July 2020

Available documentation

The overall Theory of Change and eight context-specific Theories of Change, the original program document, the annual reflection reports, and our IATI activity file including donor reporting on outcomes can be accessed through the following link: http://www.d-portal.org/ctrack.html?search&publisher=NL-KVK-41150298#view=act&aid=NL-KVK-41150298-4100

Qualifications

Applicants may be a group of individual consultants with a designated lead, or a company providing a consultant team. The applicants should exist of a mix of international and local consultants, the latter based in the HSA African countries. Alternatively, an (international) consultant team can apply while local consultants could be recruited during the inception phase in consultation with the HSA Partnership.

Applicants must have at a minimum the following qualifications:

- Proven experience with health system strengthening;
- Proven experience in assessing multinational advocacy programs;
- Experience with qualitative evaluation methods, preferably outcome mapping or outcome harvesting;
- Understanding of the field of work HSA Partnership is engaged in;
- Strong methodological and reporting skills;
- Fluency in written and spoken English;

- Capable of working and travelling to and within the Netherlands, and experience of working in the chosen African countries.

Applications

Submission of the proposal, including a financial proposal, can be made by an individual consultant with a network of local consultants, a consulting team, or a team of individual consultants led by a coordinator. Interested parties should submit their application to kim.groen@hsapartnership.org The deadline is 30 August 2019. A select number of parties will be invited for a presentation and interview, foreseen for the week of 23 September.

Applications must include:

1. Proposal not exceeding ten pages, outlining a proposed approach, evaluation framework and methodology with time plan and budget, and an outline of the roles and responsibilities of each member of the consultancy team (including local consultants). We explicitly welcome proposals that incorporate creative methodologies to draw out and document learning and that are being able to record successes.
2. Curricula Vitae (CV) for all proposed team members.
3. Cover letter outlining how the consultant/s meet the person specification, confirmation of availability in the time frame indicated, and contact details of three professional referees.
4. An indicative budget including daily consultancy fees and an overall budget on headlines. The budget should eg. include costs for local consultants and costs for attending the introduction meeting in the Netherlands.
5. A sample of a similar piece of work previously conducted.

Main evaluation question 1: How relevant was the capacity strengthening of partners by HSA consortium and contracted partners **for HSA Partnership's contribution** to health system strengthening and SRHR?			
Sub Questions	**Method**	**Sources of information**	**Analysis**
1a. To what extend have efforts to strengthen the partners' capacities[1]: • Led to changes in their advocacy skills and capacities? • Led to advocacy-related outcomes (intended or unintended)? What were the contributing and/or hampering factors for partner capacity building?	• Harvested outcomes and participatory mapping of outcomes to create outcome pathways. • Substantiation of harvested outcomes through Sprockler substantiation inquiry (individual or group). • Collecting stories of change gathered through a group interview. • IDI with Consortium Partners, Contracted Partners and key informants	• Outcome Harvesting logbook and evidence. • Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi. • External substantiators in all contexts. • Capacity-strengthening Partners in country context and possibly Regional context. • All consortium Partners. • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda (done by global and national consultants);,and; in Tanzania and Zambia will be done by National Consultants only.	• We will plot the harvested outcomes onto the overall Theory of Change, then identify achieved, negative and unintended outcomes that correspond to the outcome -strengthening capacities of Partners. • We will examine the strength of the evidence for the intended and unintended outcomes, analyze outcome pathways and identify plausible causal linkages and alternative explanations between capacity-strengthening support and outcomes and identify how these capacities assisted to address challenges in HSS and SRHR , while considering the external substantiators' points of views. • We will interpret the capacity-strengthening beneficiaries' stories about their experiences and the effects of their newly strengthened capacity in lobbying and advocacy. • We will analyze implementation challenges, negative and unintended outcomes not identified before, hampering and enabling factors in capacity strengthening of partners and achieving the outcomes to identify lessons learned about what did and did not work and why. • We will triangulate findings between the data collection methods, informants and contexts to look for (in)consistency and relevance of capacity

[1] Partners definition can be found in the Inception Report page 7

			strengthening between country regional and global contexts.
1b. To what extent did the cotracted partners' efforts to strengthen capacities of CSOs/CBOs in strengthening the capacity of community: • Lead to changes in the communities' empowerment to demanding their rights[2]? • Lead to intended or unintended outcomes of "empowered communities increasingly able to demand their rights"? What were contributing and/or hampering factors for capacity strengthening at community level?	• Harvested outcomes, collecting stories of change gathered through and group interview. • FGDs and IDIs in selected communities to determine if any changes were experienced as a result of interventions. IDI with Consortium Partners, Contracted Partners and key informants.	• Outcome Harvesting logbook and evidence. • Community members in selected communities in country contexts. • All consortium Partners. • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	• We will plot the harvested outcomes onto the overall Theory of Change, then identify achieved negative and unintended outcomes that correspond to the intended outcome—'empowered communities are increasingly able to demand their rights'. • We will examine the strength of the evidence, then identify plausible causal linkages and alternative explanations between those outcomes and the capacity-strengthening support of CSOs/CBOs and or specified groups. • We will interpret the collected CSO/CBO stories about communities demanding their rights looking for changes and evidence for changed behavior in advocacy for access and quality of health and SRHR services and demands for accountability of duty bearers. • We will analyze implementation challenges, unintended and negative outcomes not identified before, hampering and enabling factors to identify lessons learned about what did not work and did work, and the relevance in strengthening capacity at community level. • We will triangulate between methods and respondents to look for (in)consistency.
1c. (1) To what extent have the Contracted Partners' efforts to strengthen capacities of CSOs (as partners) affected the legitimacy of the CSOs to be locally owned and embedded	• Participatory mapping of outcomes to create outcome pathways • Substantiation of harvested outcomes through Sprockler	• Outcome Harvesting logbook and evidence • Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi	• We will identify outcomes that contribute to the intended Mid-Term outcome—Increased involvement of the HSA Partnership and CSOs in policymaking and implementation processes on HRH, SRH, commodities, health financing and governance

[2] Source: Overall ToC 2019 Intended mid-term outcome, page 15

in communities/society, local norms and values (perceived as meaningful and trustworthy, and accepted in society)? (2) What were the changes over time and its implication toward their legitimacy?	substantiation inquiry (individual or group) • Collecting stories of change gathered through a group interview • IDI with Consortium Partners, Contracted Partners and key informants	• External global substantiators and those in Kenya, Uganda, and Malawi • Partners in country contexts and possibly Regional • All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda	• We will examine signs of increased visibility of contracted partners and Partners by determining the strength of the evidence, identifying causal linkages and alternative explanations and story interpretations related to increased involvement in policy making processes. • We will interpret the CSOs/CBOs' collected stories, FGDs and IDIs findings, looking for observations of perceived visibility, actions to increase ownership among all stakeholders, • We will review the substantiators' (notably government participants) responses with regard to CSO visibility meaningfulness, trustworthiness and acceptance in society. • **If time allows,** we will examine the existing reports, including baseline and endline data, to determine if there are any changes over time in the number and diversity of organisations and beneficiaries reached/involved and the groups they represent. • We will conduct a document review to see if any intended or unintended outcomes are listed that relate to the local ownership and acceptance in the partner network or other relevant groups in the society. • We will examine and seek to substantiate the evidence and contribution to any relevant outcomes identified, and factors that enabled or hampered increasing diversity and number of organisations reached by contracted partners and partners.

Main evaluation question 2: How effective were advocacy approaches of the HSA partners, CSOs and communities in achieving results?[3]			
Sub Questions	**Method**	**Sources of information**	**Analysis**
2a. To what extend have the advocacy approaches: • Led to improved policymaker support in regard to HSA advocacy topics on HRH, SRH commodities, health financing and governance • Led to strengthen advocacy linkages between national, regional, global and Dutch policymakers (intended long-term outcome)? 2b. To what extend have the advocacy approaches affected the involvement of CSOs and HSA partners in policymaking and implementation processes (intended mid-term outcome)? 2c. To what extent have the advocacy approaches affected the development of effective evidence-based messages taken up by like-minded networks and organisations (Mid Term outcome Global context)?	• Participatory mapping of outcomes to create outcome pathways. • Substantiation of harvested outcomes through Sprockler substantiation inquiry (individual or group). • Collecting stories of change gathered through a group interview. • IDI with Consortium Partners, Contracted Partners and key informants.	• Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi. • External substantiators. • Capacity-strengthening beneficiaries in country contexts and possibly Regional Context • All consortium Partners. • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	• We will differentiate results by two groups: 1) HSA consortium and contracted partners and 2) CSOs, CSO networks, communities and media. • We will specifically look for unintended and negative implications of advocacy efforts within each topic. • The evidence for the type of support received from policymakers (support in lobby and advocacy, changes in policies, guidelines, legislation, funding, implementation, etc.) within each subject area and how this was achieved. • We will examine the evidence for examples of how evidence from country, regional, Dutch and global context was shared and used to influence policy making in each context. • The evidence for changes in the number, type and way contracted partners and Partners were invited for policy-making processes, and/or conducted lobby and advocacy. • We will examine the evidence for changes over time in the way advocacy and lobby messages were developed by contracted partners and Partners, the role of context specific relevance and the evidence base across contexts for the messages.
2d. (1) To what extent have external factors or actors contributed to the achievement of the outcomes (improved policymakers support in regard for HSA Partnership advocacy	• Substantiation of harvested outcomes through Sprockler substantiation inquiry (individual or group).	• External substantiators • Capacity-strengthening beneficiaries in country contexts and possibly Regional context • All consortium Partners	• We will examine the external substantiators' responses with regard to external factors that hampered or enabled results. • Besides the analysis of causal relationships between outcomes over time, we will interpret

[3] For the next evaluation processes, we are not repeating the general text on the linking of outcomes to Theory of Changes (ToC), the inclusion of intended, unintended and negative outcomes, examining the strength of the evidence, then identify plausible causal linkages and alternative explanations between those outcomes and that we will use triangulation between methods and respondents. We will apply this to all and assume this is noted from now on.

topics and strengthened linkages of advocacy between national, regional, global and Dutch policymakers)? (2) How do these factors or actors relate to the HSAP's contribution to the outcomes achievement of improved policymakers support in regard for HSA Partnership advocacy topics and strengthened linkages of advocacy between national, regional, global and Dutch policymakers (successes and set-backs)? (3) To what extent have external factors or actors contributed to the achievement of the outcomes (the involvement of CSOs and HSA partners in policymaking and implementation processes)? (4) How do these factors or actors relate to the HSAP's contribution to outcomes achievement of the involvement of CSOs and HSA partners in policymaking and implementation processes (successes and set-backs)?	• Collecting stories of change gathered through a group interview. • IDI with Consortium Partners, Contracted Partners and key informants.	• Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	collected stories, FGD and IDI findings about how external factors contributed to results achieved.
Main evaluation question 3: What are lessons learned regarding gender/inclusivity, collaboration within the partnership linking local to global advocacy, and the linkages between HSS and SRHR?			
Sub Questions	**Method**	**Sources of information**	**Analysis**
3a. (1) To what extent has the partnership addressed gender and inclusivity in the program?	• IDI with Consortium Partners, Contracted Partners and key informants.	• Monitoring data • All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda	• We will examine intended and unintended outcomes, the responses provided by HSA Contracted Partners and key informants with a good knowledge of gender issues related to HSAP themes.

(2) To what extent was the partnership able to include stakeholders in the planning process? (3) To what extent was HSA Partnership's approach to mainstream gender and inclusivity effective? (4) What has hampered or enabled the implementation of a gender and inclusivity lens within the HSA Partnership?			• We will examine the relevance and comprehensiveness of mainstreaming gender and inclusivity within and across contexts. • We will look at implementation challenges, enabling and hampering factors in assessing context specific gender and inclusivity issues and ways these were addressed.
3b. (1) To what extent has there been an added value from collaboration and the governance structure within the HSA Partnership for achieving results? What were the challenges and successes in collaboration and governance within the HSA partnership for achieving results?	• IDI with Consortium Partners, Contracted Partners and key informants.	• All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda	• We will qualitatively analyse HSA partner interviews using an open approach, coding the answers based on the results that emerged. We will make a general distinction between issues related to complementarity and autonomy and the balance between them. • We will look at implementation challenges and successes due to working in partnership and ways these were addressed.
3c. (1) What were the collaboration successes and challenges of partners/CSOs at various levels of the advocacy chain (sub-national, national, regional and global levels)? (2) What factors have hampered or contributed to the collaboration successes and challenges?	• Participatory mapping of outcomes to create outcome pathways • Substantiation of harvested outcomes through Sprockler substantiation inquiry. • IDI with Consortium Partners, Contracted Partners and key informants	• Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi. • All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	We will qualitatively analyse HSA partner interviews and reported advocacy outcomes that make reference to the advocacy chain. • We will look at implementation challenges and successes in linking the different advocacy levels and ways of addressing these.

3d. What were the lessons learned related to the promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS?	• Participatory mapping of outcomes to create outcome pathways. • Collecting stories of change gathered through a group interview. • IDI with Consortium Partners, Contracted Partners and key informants.	• Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi. • Capacity-strengthening beneficiaries in country contexts and possibly Regional Context • All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	• We will qualitatively analyse interviews from HSA partners and key informants using an open approach, coding the answers based on the results that emerged. • We will review the narratives and advocacy messages used and look for synergies, (in) consistency and level of successes in changing external narratives. • We will look at implementation challenges and successes in the promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS, and ways of addressing these.
Main evaluation question 4: What is the sustainability of programme results, so they can be maintained in the longer term?			
Sub Questions	**Method**	**Sources of information**	**Analysis**
Sub question: To what extent will long-term outcomes that the HSA Partnership has contributed to through capacity-strengthening and advocacy approaches endure past 2020? • What mechanisms are in place to sustain the advocacy outcomes in terms of policymaking processes? • What mechanisms are in place to sustain CSO advocacy efforts, e.g. knowledge of policy processes, accountability and implementation?	• Participatory mapping of outcomes to create outcome pathways. • IDI with Consortium Partners, Contracted Partners and key informants.	• Internal substantiators (participants of Annual Reflection meeting) only in Kenya, Uganda, and Malawi. • All consortium Partners • Contracted Partners and if needed key informants in Kenya, Malawi, Uganda.	• Outcomes that are most likely to be sustained beyond a project's implementation period are those that reflect long-term changes, so we will check for: changes such as policy-making and accountability mechanisms and processes; changes in norms and values related to SRHR that underly policies (if applicable); strategic use of existing accountability mechanisms; CSO capacities to ensure continuation of advocacy activities, and; increased empowerment of communities to demand their rights. • We will analyze the reported mechanisms and observations on capacity strengthening and advocacy strategies and relate these to the documented strategies, tools and reflections.

Annex 3. HSAP Theory of Change (Overall)

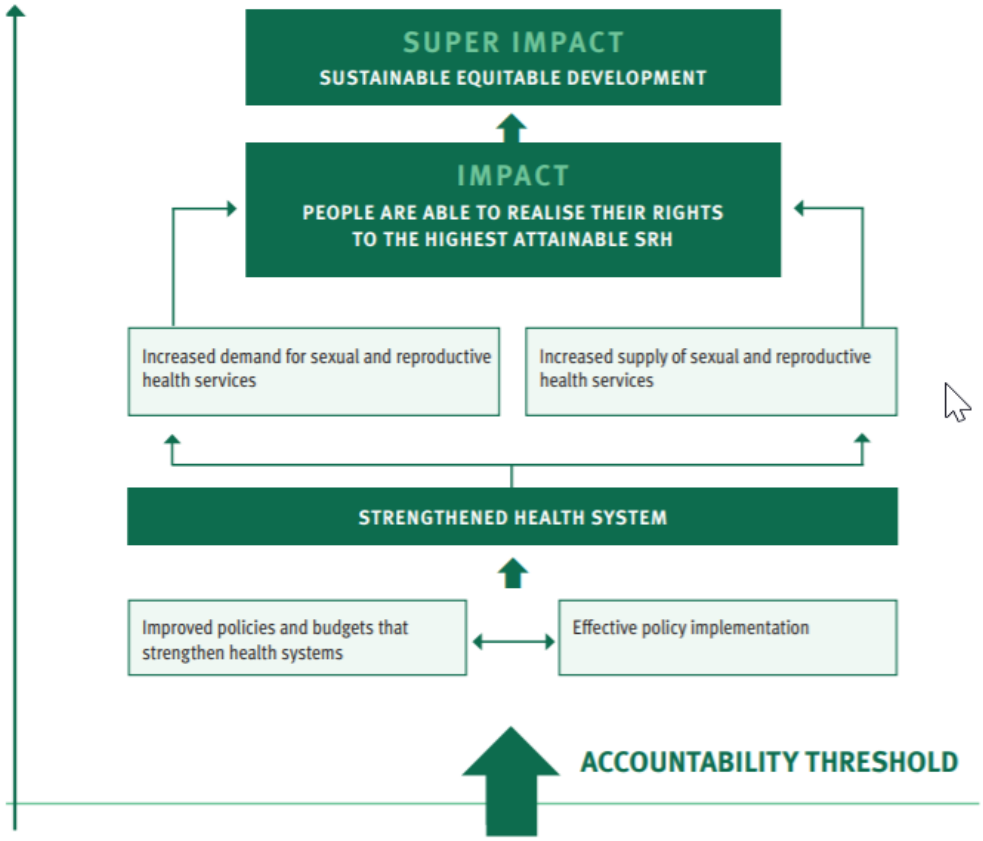


Figure 1. Visualisation of the Theory of Change above the accountability threshold

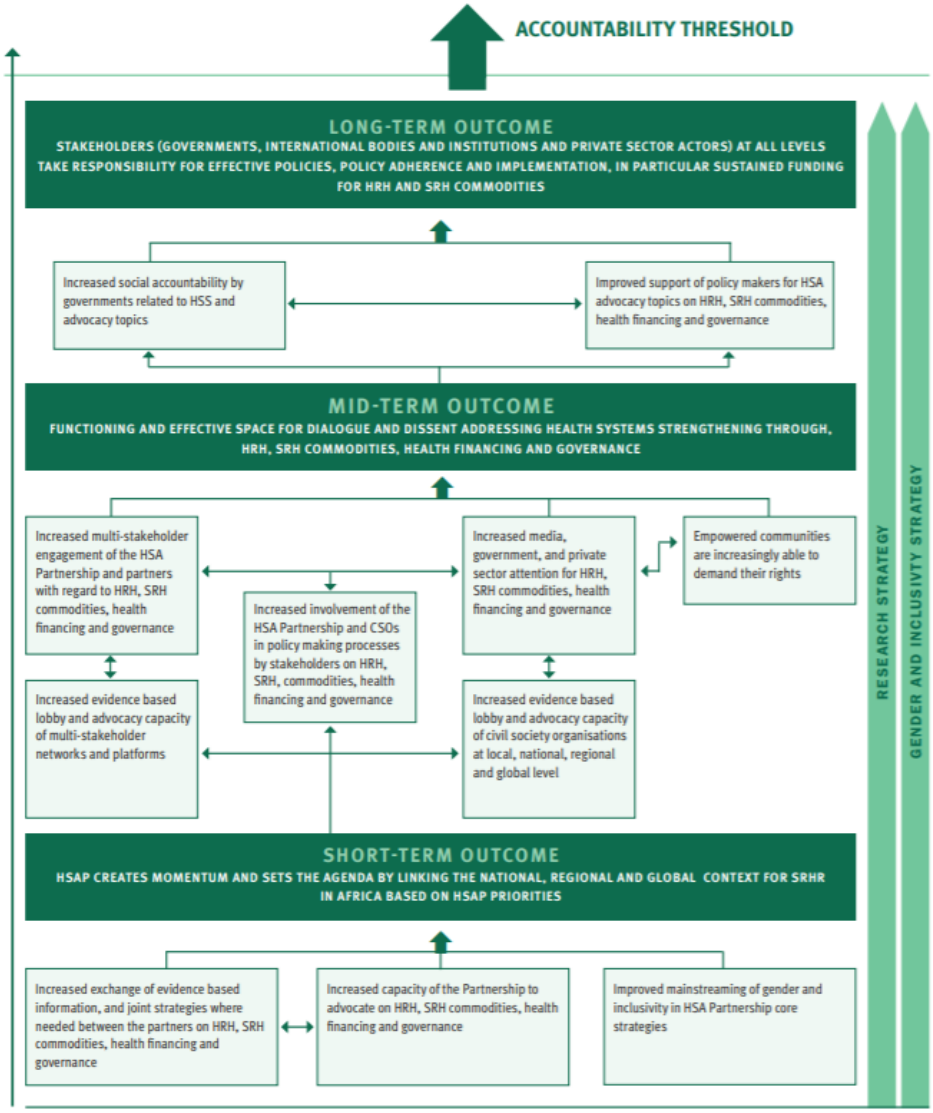


Figure 2. Visualisation of the Theory of Change below the accountability threshold

Following the ToR of this assignment, the end evaluation has three phases: (1) Inception; (2) Desk Research and Field Work and (3) Data Analysis and Reporting.

Phase I: Inception. Activities in this phase included clarification of the assignment mandate; finalisation of contractual agreements and documentation, an inception meeting (face-to-face and online), logistical preparation for the fieldwork, recruitment of national consultants and development of tools for data collection, preliminary desk research of relevant project documents, extensive IDI with all HSA Partnership contexts including key program staff members and (selection of) CSOs to provide a foundation and reference for the development of evaluation questions and the detailed methodology including the development of the data collection tools.

The evaluation team was provided access to HSA Partnership's key documentation and conducted a preliminary desk review to inform the evaluation design and inception interviews.

We conducted interviews with representatives of all HSA Partnership countries (the Country context) and the Netherlands context, Global context and Regional contexts as well as MoFA. The interviews aim to: 1) have a better understanding of the role of key actors in each context, particularly at country level; 2) obtain (additional) input on the list of CSOs in each country to whom we should talk; 3) ask respondents what the evaluators should consider for the end evaluation and 4) ask the respondents of each context for their opinions on the additional evaluation topics of efficiency, partnerships, and governance to be included in the end evaluation. For a summary of the issues raised during the interviews see annex 4. The issues considered as part of the evaluation scope were raised as additional topics and were included in the evaluation matrix (see annex 2) and the methodology under chapter 3. Governance and partnerships, as well as gender inclusivity were added and further developed and included in the evaluation matrix.

Phase I deliverables:

- Final inception report, including summary reports of all HSA Partnership contexts (Annex 4) and data collection tools (see annex 3)
- The list of three national consultants recruited in three visited countries and two national consultants in non-visited countries (including their resumes)

Phase II: Desk Research and Field Work. More in-depth desk research, piloting data collection tools, data collection process conducted. In-country field work (March 2020) will shed light on the HSA Partnership and CSO activities, networks, and media in each country.
In this second phase, the RiH evaluation team will conduct activities as follows:

- *In-depth desk research (to be conducted prior to the field work)*

Following the endorsement of the Inception Report, we performed in-depth desk research to follow the result of the preliminary desk research in the inception phase. This research supported the OH process, and include collecting data from all contexts and identifying the lessons learned during the project implementation. The desk research covered the 8 HSA Partnership contexts and provide program background and insights. Most importantly, it provide information on the outcomes to which HSA Partnership' interventions have contributed. Based on the preliminary desk review, in this phase we review more programmatic and content documents and published literature on the related topics (if necessary and if available).

- Data collection using the agreed data collection tools (for the three visited countries and the other two non-visited country, as well as for regional, global and the Netherlands context)

- Facilitation (part of) of the Country Annual Reflection Workshop as part of data collection process in the three visited countries through participatory mapping of outcomes to create outcome pathways (the detailed workshop agenda will be discussed with the HSA Partnership team).
- Remote data collection and assistance to the national consultants who will collect the data on the ground (for the two non-visited countries)
- Quality control during the data collection processes

Phase II deliverables:

- Final data collection tools (The data collection tools will be piloted prior to the data collection in the field and revised the tools accordingly)
- Summary notes of the in-depth desk review per context
- Progress report to HSA Partnership Desk on the data collection process in five countries, at regional and global levels and in the Netherlands (for Dutch context), including challenges faced during the field research to the HSA Partnership Desk in order to obtain necessary support when needed.

Phase III: Data Analysis and Reporting. During this phase, data analysis will be done using the Sprockler tool resulting in an online interactive report complemented by an integrated qualitative analysis of all data collected, triangulated across the various data collection methods and across various contexts and respondents. The data analysis will use the evaluation matrix as a guide for analysing and reporting the data. A data summary will be written and analysed, as will the draft and final reports. The structure of the draft report will be discussed with HSA Partnership.

Phase III deliverables:

- Draft Evaluation to be reviewed by the HSA Partnership and other relevant reviewers
- Final Evaluation report
- Context study reports with key findings (annexes, max. 5 pages per context)

1. Sprockler tools

Sprockler Outcome Harvest inquiry for Health Systems Advocacy partnership final evaluation

1. What is the HSA partnership context for the outcome you are registering in Sprockler now? (single choice)
   - o African region
   - o Global
   - o Kenya
   - o Malawi
   - o Netherlands
   - o Tanzania
   - o Uganda
   - o Zambia

2. Which partner mainly contributed to the outcome you are registering in Sprockler now? (single choice)
   - o Achest/Sikika/KOGS/Scheme/Amami/SAfAIDS
   - o Amref Health Africa - Flying Doctors
   - o HAI/HEPS/MeTA Umati
   - o Wemos

3. What is the title of your outcome? Use the following sentence: on DATE, this ACTOR did an ACTION, in LOCATION. (open question)

4. To what extent is the outcome specifically relevant for Sexual and Reproductive Health and Rights (SRHR)?

The outcome has no effect on SRHR at all	The outcome is specifically relevant for SRHR

5. To what extent is the outcome specifically relevant for Health Systems Strengthening (HSS)?

The outcome has no effect on the health system at all	The outcome is specifically relevant for HSS

6. Why is this outcome relevant for Sexual and Reproductive Health and Rights (SRHR) and/or Health system strengthening (HSS)? (open question)

7. What was your contribution to the outcome? (open question)

8. Which year did the outcome occur? (single choice)
   - o 2018
   - o 2019

9. Who is the actor of your outcome? (single choice)
   - o CSO part of HSA partnership: Sikika/KOGS/Scheme/Amami/SAfAIDS/HEPS/MeTA/Umati
   - o CSO (not part of HSA partnership)
   - o Global institution or organisation
   - o Local or sub-national government
   - o Media
   - o National government
   - o Private actor
   - o Regional institution/organisation (supra-national)
   - o Research/knowledge institute
   - o Other, namely: ……..

10. Which HSA partnership theme does the outcome fall under? (Please select only the most important one, but otherwise select 2 or maximum 3.) (multi-choice)
   - □ Human Resources for Health (HRH) financing
   - □ Health worker mobility and migration (incl. work on WHO Global Code of Practice on the International Recruitment of Health Personnel)
   - □ Recognition and remuneration of Community Health Workers
   - □ A strengthened health workforce and improved working conditions
   - □ Sexual and Reproductive Health Commodities (SRHC) supply
   - □ Family planning
   - □ International finance, such as Global Financing Facility
   - □ Macro-economics and health financing
   - □ Finance for Universal Health Coverage
   - □ Effectiveness of ODA (Official Development Assistance)
   - □ Governance, such as for Global Financing Facility
   - □ Gender, inclusivity and youth
   - □ Civil society space and participation

11. Which result area does the outcome best relate to? (single choice)
   - o MT-Increased evidence-based lobby and advocacy capacity of multi-stakeholder networks and platforms, at local, national, regional and global level
   - o MT-Increased evidence-based lobby and advocacy capacity of civil society organisations at local, national, regional and global level
   - o MT-Increased involvement of the HSA partnership and CSOs in policy making processes by stakeholders on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH), commodities, health financing and governance
   - o MT-Empowered communities are increasingly able to demand their rights
   - o MT-Increased media, government, and private sector attention for Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
   - o MT-Increased multi-stakeholder engagement with regard to Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
   - o LT-Improved support of policy makers for advocacy topics on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
   - o LT-Increased social accountability by government related to Health Systems Strengthening (HSS) and advocacy topics

- o Improved policies and/or budgets that strengthen health systems
- o Effective policy implementation

12. Was the outcome intended or unintended? In other words: did you intentionally take actions to achieve the outcome, or was it a surprise? (single choice)
    - o Intended
    - o Unintended

13. This outcome is …

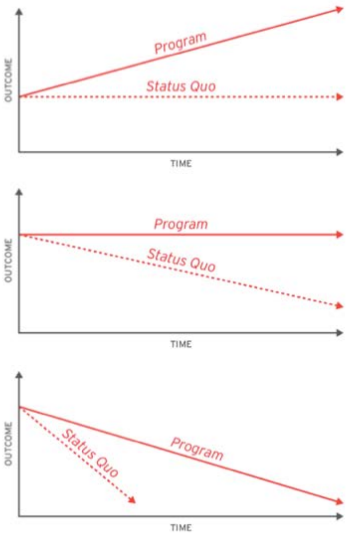
an initial step — a full-blown change

14. Could you elaborate on your previous response - why is this outcome is an initial step or a full-blown change? (open question)

15. This outcome is …

a major set-back — a huge success

16. Which graphic best represents the type of change achieved? Place a dot somewhere on one of the three graphics.



17. To what extent is the outcome relevant for girls?

The outcome has no specific effect on them at all — The outcome is specifically relevant for girls

- □ Not Applicable

18. To what extent is the outcome relevant for women?

The outcome has no specific effect on them at all

The outcome is specifically relevant for women

☐ Not Applicable

19. To what extent is the outcome relevant for LGBTI?

The outcome has no specific effect on them at all

The outcome is specifically relevant for LGBTI

☐ Not Applicable

20. To what extent is the outcome relevant for people with disabilities?

The outcome has no specific effect on them at all

The outcome is specifically relevant for people with disabilities

☐ Not Applicable

21. To what extent is the outcome relevant for other marginalized groups?

The outcome has no specific effect on them at all

The outcome is specifically relevant for other marginalized groups

☐ Not Applicable

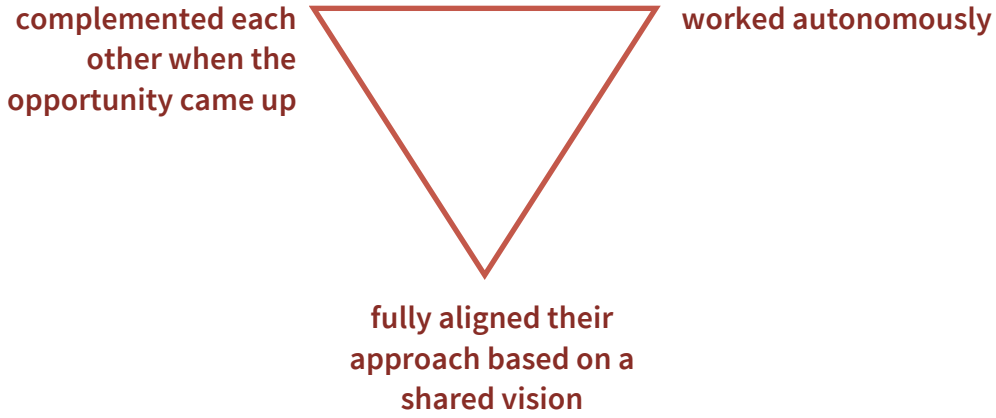
22. Could you elaborate on your previous responses – why is this outcome relevant (or not) for girls, women, LGBTI, disabled people and/or other marginalized groups? (open question)

23. To what extent was your contribution direct or indirect?

Indirect Direct

24. What is the main type of intervention that was used for this outcome: (single choice)
    - o Capacity strengthening
    - o Advocacy and lobbying
    - o Research
    - o Public awareness media

25. The outcome came about while the partners in the HSA partnership…



26. To what extend has the advocacy strategy for this outcome complimented other strategies in the HSA partnership? (open question)

27. What was the extent of HSA partnership's contribution to the outcome as compared to external actors?

Small — Big

☐ Not Applicable

28. To achieve the outcome, the external environment (actors and factors) was…

enabling — hampering

29. Could you elaborate on which other factors or actors enabled or hampered the outcome, if any? (open question)

30. How has HSA partnership, and their support to CSOs, helped to increase the visibility of CSOs?

CSOs are not any more visible than before — CSO visibility has improved immensely

☐ Not Applicable

31. What - if any - next steps can be taken to scale up efforts or build upon the outcome and who should carry these out? (open question)

33. Who could substantiate the outcome? Please mention name, email and phone number if possible. This information will not be made public. (open question)

Sprockler Substantiation inquiry for Health Systems Advocacy partnership final evaluation

1. What is the name of your organisation? (open question)
2. Please read the following outcome statement:
3. To help us assess the accuracy of the outcome, we'd like to ask to what degree are you in agreement with how the outcome is described: (single choice) o Fully agree o Partially agree o Disagree o No opinion
3a. Why do you partially agree with how the outcome is described? (open question)
3b. Why do you disagree with how the outcome is described? (open question)
3c. You indicated to have no opinion. What is the extent of your knowledge of the outcome? (open question)
4. Could you describe how HSA Partnership contributed to the outcome? Please include: did more than one organisation in the HSA partnership contribute to the outcome? If so, which ones? (open question)
5. To what extent has the advocacy strategy for this outcome complimented other activities or strategies? (open question)

6. To what extent is the outcome specifically relevant for the promotion of Sexual and Reproductive Health and Rights (SRHR)?

The outcome has no specific effect on SRHR at all	The outcome is specifically relevant for SRHR

7. To what extent is the outcome specifically relevant for Health system strengthening (HSS)?

The outcome has no specific effect on the health system at all	The outcome is specifically relevant for HSS

8. Could you elaborate on your previous responses - why is this outcome relevant (or not) for Sexual and Reproductive Health and Rights (SRHR) and/or Health Systems Strengthening (HSS)? And can you explain any difference between the two? (open question)

9. How would you rate the added value of HSA Partnership?

This outcome would have happened anyway without HSAP	The HSAP's contribution was the primary reason the outcome occurred

10. What was the extent of HSA Partnership's contribution to the outcome compared to other contributors?

Small	Big

☐ Not Applicable

11. To achieve the outcome, the external environment (actors and factors) was…

enabling	hampering

12. Could you elaborate on which factors or actors enabled or hampered the outcome in the external environment, if any? (open question)

13. This outcome is …

an initial step — a full-blown change

14. Could you elaborate on your previous response - why is this outcome is an initial step or a full-blown change? (open question)

15. To what extent is the outcome relevant for girls?

The outcome has no specific effect on them at all — The outcome is specifically relevant for girls

16. Could you elaborate on your previous response – why is this outcome relevant (or not) for girls? (open question)

17. To what extent is the outcome relevant for women?

The outcome has no specific effect on them at all — The outcome is specifically relevant for women

18. Could you elaborate on your previous response – why is this outcome relevant (or not) for women? (open question)

19. To what extent is the outcome relevant for LGBTI (lesbian, gay, bisexual, transgender and intersex people)?

The outcome has no specific effect on them at all — The outcome is specifically relevant for LGBTI

20. Could you elaborate on your previous response – why is this outcome relevant (or not) for LGBTI (lesbian, gay, bisexual, transgender and intersex people)? (open question)

21. To what extent is the outcome relevant for people with disabilities?

The outcome has no specific effect on them at all	The outcome is specifically relevant for people with disabilities

22. Could you elaborate on your previous response – why is this outcome relevant (or not) for people with disabilities? (open question)

23. To what extent is the outcome relevant for other marginalized groups?

The outcome has no specific effect on them at all	The outcome is specifically relevant for other marginalized groups

☐ Not Applicable

24. Could you elaborate on your previous response – which marginalized groups are you referring to? And why is this outcome relevant (or not) for those groups? (open question)

25. How has HSAP, and their support to CSOs, helped to improve the visibility of CSOs?

CSOs are not any more visible than before	CSO visibility has improved immensely

26. Could you elaborate on your previous response – how has HSA Partnership, and their support to CSOs, helped to improve the visibility of CSOs (if at all)? (open question)

27. What - if any - next steps can be taken to scale up efforts or build upon the outcome and who should carry these out? (open question)

28. Is there anything else that you'd like to mention? (open question)

29. Do you consent to sharing your responses you've just provided? This means your responses to the open questions will be published in an interactive report, without mention of your name or any other identifying information about you as a person. Your organisation will be identified. (single choice)
    - o Yes
    - o No

Sprockler Story inquiry for Health Systems Advocacy partnership final evaluation

1. Country:
   - o Kenya
   - o Malawi
   - o Tanzania
   - o Uganda
   - o Zambia

2. What is the name of your organisation? Please write in full. (open question)

3. Which core partner of the Health System Advocacy (HSA) partnership are you most involved with? (single choice)
   - o Achest/Sikika/Scheme/Amami/SAfAIDS
   - o Amref Health Africa - Flying Doctors
   - o HAI/HEPS/MeTA Umati
   - o Wemos

4. Did you receive any kind of funding from one of the core partners in the HSA partnership? (single choice)
   - o Yes
   - o No

Only in case question 4 is yes:

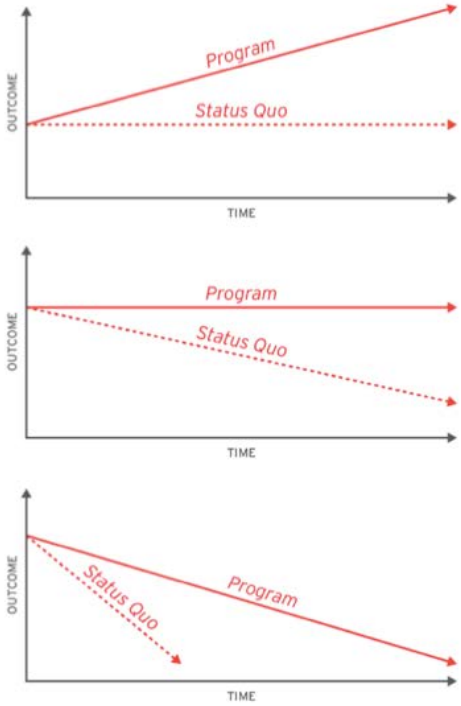
5. What was the nature of the funding you received? (open question)

6. Take a moment to reflect on the work you did during or after your involvement with the Health Systems Advocacy partnership or one of its partners. Is there ONE person or group (incl. organisation, network, community or government) that did something differently or even for the first time because of your advocacy efforts? If so, what was the change? (open question)

7. From what you've just described, who is the person or group that changed? (single choice)
   - o Another CSO
   - o Global institution or organisation
   - o Local or sub-national government
   - o Media
   - o National government
   - o Private actor
   - o Regional institution/organisation (supra-national)
   - o Research/knowledge institute
   - o Other, please specify: ……

8. Was the change intended or unintended? In other words: did you intentionally take actions to achieve the change, or was it a surprise? (single choice)
   - o Intended
   - o Unintended

9. Which graphic best represents the type of change achieved? Place a dot somewhere on one of the three graphics.



10. Which thematic area does the change relate to? (Please select only the most important one, but otherwise select 2 or maximum 3.) (multi-choice)
    - ☐ Human Resources for Health (HRH) financing
    - ☐ Health worker mobility and migration (incl. work on World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel)
    - ☐ Recognition and remuneration of Community Health Workers
    - ☐ A strengthened health workforce and improved working conditions
    - ☐ Sexual and Reproductive Health Commodities (SRHC) supply
    - ☐ Family planning
    - ☐ International finance, such as Global Financing Facility
    - ☐ Macro-economics and health financing
    - ☐ Finance for Universal Health Coverage
    - ☐ Effectiveness of ODA (Official Development Assistance)
    - ☐ Governance, such as for Global Financing Facility
    - ☐ Gender, inclusivity and youth
    - ☐ Civil society space and participation

11. Which result area does the change best relate to? (single choice)
    - o Increased evidence-based lobby and advocacy capacity of multi-stakeholder networks and platforms, at local, national, regional and global level
    - o Increased evidence-based lobby and advocacy capacity of civil society organisations at local, national, regional and global level
    - o Increased involvement of the HSA partnership and CSOs in policy making processes by stakeholders on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH), commodities, health financing and governance
    - o Empowered communities are increasingly able to demand their rights

- Increased media, government, and private sector attention for Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
- Increased multi-stakeholder engagement with regard to Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
- Improved support of policy makers for advocacy topics on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance
- Increased social accountability by government related to Health Systems Strengthening (HSS) and advocacy topics
- Improved policies and/or budgets that strengthen health systems
- Effective policy implementation

12. To what extent is the change you described relevant for the promotion of Sexual and Reproductive Health and Rights (SRHR)?

The change has no effect on SRHR at all	The change is specifically relevant for SRHR

13. To what extent is the change you described relevant for Health system strengthening (HSS)?

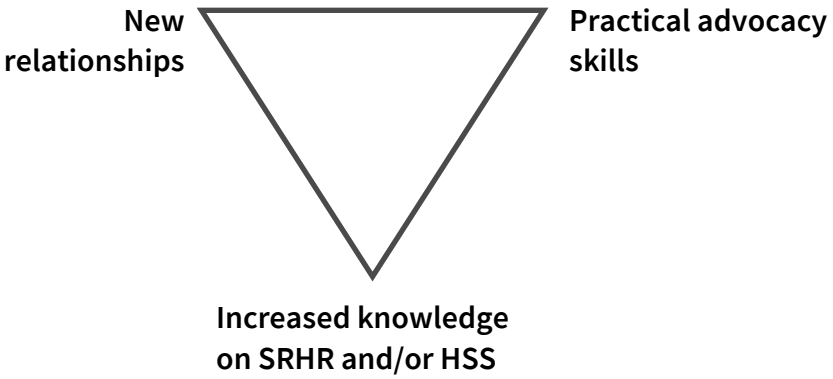
The change has no effect on the health system at all	The change is specifically relevant for HSS

14. Could you elaborate on your previous responses - why is this change relevant (or not) for Sexual and Reproductive Health and Rights (SRHR) and/or Health system strengthening (HSS)? (open question)

15. Did you participate in any capacity strengthening efforts by the HSA partnership (or one of its partners) to increase your lobbying and advocacy skills? (single choice)
    - Yes
    - No (Go to question 20)

16. Take a moment to reflect on your experiences with the HSA partnership capacity strengthening efforts. Is there ONE special moment among them that has specifically led to the change you described? If so, what made that moment so special? (open question)

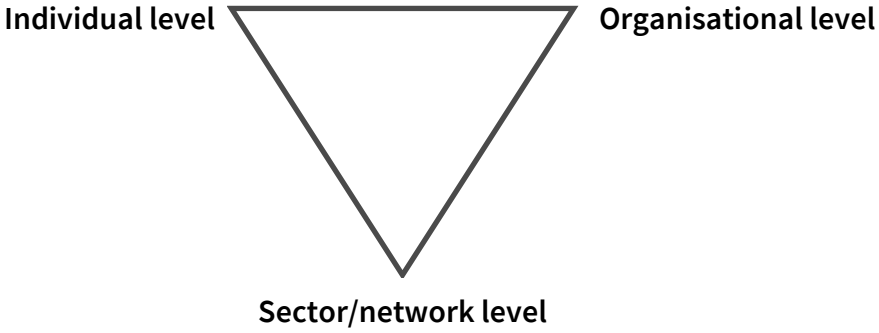
17. The moment you described best relates to: (please note SRHR stands for Sexual and Reproductive Health and Rights and HSS stands for Health System Strengthening)



18. How would you rate HSA partnership's capacity strengthening efforts to achieve the change you described?

The change would have happened anyway without HSA partnership's efforts	The efforts of HSA partnership was the primary reason the change occurred

19. At what level did HSA partnership's capacity strengthening have the biggest effect to achieve the change you described?



20. How has your involvement with the HSA partnership increased the visibility of your organisation?

We are not any more visible than before	Our visibility has improved immensely

21. What - if any - next steps can be taken in terms of capacity strengthening and who should carry these out? (open question)

22. Do you consent to sharing your responses you've just provided? This means your responses to the open questions will be published in an interactive report, without mention of your name or any other identifying information about you as a person. Your organisation will be identified. (single choice)
    - o Yes
    - o No

2. Final Topic Guide for IDI with key informants (core/consortium partners, external validators, network partners, policy makers) for Global and Regional Context

A list of general questions will be selected from the list below and details added (if needed) depending on the specific interviewee and context. This IDI topic guide will only be applicable for the Global and Regional Context.

Interviewer's introduction and instructions to interviewee
For the interviewer

- Explain the purpose of the interview.
- Ensure confidentiality again, including tape recording (this is different from the Sprockler inquiry to substantiate outcomes, since this interview will be kept confidential).

Ask if the interviewee has any questions. (Before the start of the interview, verify that an information and consent form was received by the interviewee).

- Ask the interviewee to sign the consent form.
- Start the interview.

Thank you for volunteering to take part in this assessment. You have been asked to participate because of your knowledge of the Health Strengthening Advocacy (HSA) Partnership program, their advocacy and capacity-strengthening activities, and the external environment influencing the field of Health System Strengthening (HSS) and Sexual and Reproductive Health and Rights (SRHR) (*For interviewer*: select what is most appropriate in this case). We really appreciate your input, time and effort.

Introduction: This interview is designed for someone who has already completed the online Sprockler tool.

Purpose of the interview: to add to the information you have already provided through the online Sprockler tool as the person who gave input to the validation of outcome …….. (fill in the outcome).

I have read your response and will ask questions to clarify your input further and ask for your observations that go beyond the outcome and story you have mentioned). The interview will take about 1 hour.

Note for Participant Consent: if a face-to-face interview: *one copy of the signed informed consent form should be given to interviewee and a second copy should be kept by the IDI interviewer.*

Confidentiality: Even though our conversation is being audiotaped, I would like to assure you that our discussion will be confidential. The tapes will be kept safe in a locked facility until they are transcribed; then they will be destroyed. The transcribed notes of the interview will have no information that would allow individuals to be linked to specific statements. Your name and specific organization will be named in the list of persons who have been interviewed, but not in the written transcripts or be made explicit in specific quotes or statements in the final report. Your gender and your affiliation, such as a beneficiary of a Civil Society Organization (CSO), international/multi-lateral/regional network partner or lobby and advocacy target, policy maker, community leader, parliamentarian, consortium partner, core partner, expert HSS, SRHR and 'inclusivity' will be mentioned. We expect your answers and comments to be as accurate and truthful as possible. If there are any questions or conversation topics that you do not wish to answer, you do not have to do so and this will have no implications for your job, standing or reputation. I would like you to sign a consent form to participate in this interview and

hand me the signed form now. May I tape our conversation to facilitate writing the transcript of what we both say? (if yes, switch on the recorder)

Context:	Interviewee's position:
Date (day/month/year):	Sex:
Name of organization represented by interviewee:	Name of interviewer:

No	Questions to ask	Notes to interviewer
General Question		
1	In your opinion, what are the most important achievements of the HSA Partnership in their lobbying and advocacy activities at the global/regional (select what is relevant)? These would be achievements in addition to the outcome you already commented on in the Sprockler inquiry (if relevant).	Probe: the relevance for the contexts in which the results happened, e.g. in the global or regional context. Probe for approaches most beneficial for the involvement of CSOs and HSA partners in policy processes. Probe for strategies that were most beneficial for the development of effective evidence-based messages. Probe for influences on HSS and SRHR policies and implementation processes in particular.
2	Can you specify and give examples of the results you just mentioned	Probe for examples of each result the interviewee mentions.
3	Were results, strategies, and lessons learned shared across countries? Can you give examples of how strategies and messages were developed? Any examples of what can be learned from HSA Partnership by working across contexts?	Also probe for how the strategies were developed.
Questions related to short-term/mid-term/long-term outcomes. For consortium and contracted partners, follow the ToR. For external informants, follow the above examples.		
1	• On a scale of 0-100%, to what extent was the short-term outcome/result achieved? • On a scale of 0-100%, to what extent was the mid-term outcome/result achieved? • On a scale of 0-100%, to what extent was the long-term outcome/result achieved?	Consortium/ contracted partners it is important to determine the progress made and not only focus on what was not achieved.
2	What is the evidence for each achievement? Give examples.	List each example
3	How was each outcome you just mentioned achieved? Give examples.	

4	What were the challenges to achieving each outcome you just mentioned? Hampering and contributing factors?	Probing for consortium and core partners: What was achieved as an individual organization across global and regional contexts and overall? Focus on learning: what can be learned for setting up partnerships on these challenges/issues.
5	• Which short-term outcomes were not achieved? • Which mid-term outcomes were not achieved? • Which long-term outcomes were not achieved?	Consortium and contracted partners More general with all respondents: Probe for opportunities missed, activities that did not lead to results or led to negative results
6	What influenced the achievement of the each outcome internally and externally? Can you give examples?	
7	What is your opinion about the importance of shared lobbying and advocacy strategies and agendas? How has the lack of these strategies influenced agendas? In cases where agendas were shared, did this improve outcomes? If yes, how?	Consortium/consortium partners. For network partners: probe further into examples of shared or complementary lobbying or advocacy agendas with a HSA Partnership partner and how this influenced results.
8	What do you think about complementarity and autonomy in the partnership? Probe for complementarity and how the lobbying or advocacy on one topic (chosen by one partner) actually complemented the lobbying and advocacy topic of another partner.	Consortium partners
9	Has the fact that not all partners are active in the global or regional contexts influenced the complementarity of the advocacy activities? If yes, how?	Consortium partners
10	To what extent did the HSA Partnership adapt to changing contexts? Did advocacy approaches change during the implementation period and if so, how and why?	
Questions related to Theme: Linkage of global-regional-national context		
1	Can you explain to what extent the strengthening capacity of contracted partners, partners and network partners has translated into their improved involvement in influencing policy at the global and regional levels and vice versa?	
2	To what extent have issues and voices at a local level become a focus in the regional/global agenda? Please give examples.	

3	To what extent have global events influenced a country's agenda setting? Please give examples.	
4	To what extent did global and regional advocacy support national advocacy agendas?	
5	To what extent are international policies, bills, guidelines, or new insights shared with partners in countries? How are these shared?	
6	Please explain if there is a process for selecting representatives to be present at regional and global meetings and guidance or observations of how they share their new learning back in country. Is there a monitoring process for this? If yes, please give an example.	
7	Are the results of the partner interventions combined with the partner's focuses at other levels? For example, how does GFF combine their global lobbying with GFF lobbying in country? Are shared messages and strategies developed? How are they developed?	
8	Please share successful examples of linking advocacy at the local, national and global levels. What have been hampering factors? Have there also been missed opportunities?	
Questions related to Theme: Legitimacy		
1	Please give examples of the visibility of the HSA Partnership in the latest international and regional events? Has this visibility increased over time?	
2	Please give an overview of the groups that the contracted partners and partners are representing. Do they represent diverse and marginalized groups? Are the groups locally embedded and autonomous? To what extent has HSA Partnership's involvement made a change in this situation and how has it made a change?	
3	To what extent has the CSOs' involvement with HSA Partnership changed how the CSOs are perceived by other CSOs, policy makers and communities? Please give examples? How did this happen?	
Questions related to Theme: Governance and Partnerships		
1	See questions 7, 8 and 9 (Questions related to short-term/mid-term/long-term outcomes)	
2	What were the successes and challenges in collaborating with all the consortium and contracted partners in your country's context? What were the lessons learned?	
	How would you describe the role of the Ministry as a partner in this partnership?	
3	What was the added value of the collaboration and governance structure in the HSA Partnership (if any) for achieving results?	
Questions related to Theme: Gender and Inclusivity		
1	To what extent has the HSA Partnership addressed gender and inclusivity in the lobbying, advocacy and capacity strengthening of the HSA Partnership? How was gender	Explore if needs assessments were conducted and how if yes, how they were addressed. Explore the

	considered when developing and implementing advocacy strategies and capacity building? What approaches were chosen? To what extent have the approaches been successful? What were the hampering factors and lessons learned?	women's participation and leadership position in lobbying and advocacy and the decision-making processes in the HSA Partnership program.
2	Tell me about any strategies that worked (or did not work) for ensuring that the voices and engagement of women, girls and other marginalized groups was achieved in in activities and outcomes? What has hampered or contributed to the inclusion of a gender and inclusivity lens in the HSA PARTNERSHIP program?	
Questions related to theme: Mutual influence of HSS and SRHR		
1	To what extent has the HSA Partnership contributed to a strengthened narrative on the importance of HSS for SRHR in policy documents and decisions?	
2	What were the challenges and lessons learned related to HSS and SRHR influencing the improvement of each other?	
Questions related to theme: Sustainability		
1	To what extent has the HSA Partnership contributed to mechanisms you think may endure past 2020? • Mechanisms to sustain policy and implementation processes on HSS and SRHR? • Mechanisms to sustain advocacy and lobbying by partners and networking partners?	Probe for examples, and how they influenced the mechanisms and why? Think of knowledge on policy and implementation processes and accountability.

Final Topic Guide for IDI with key informants (external substantiators, network partners, parliamentarians, technical staff and project managers from MoFA and consortium partners from the Dutch Context[4]

A list of general questions will be selected from the list below and details added (if needed) depending on the specific interviewee and context.

Interviewer's introduction and instructions to interviewee.

For the interviewer

- Explain the purpose of the interview.
- Ensure confidentiality again, including tape recording (this is different from the Sprockler inquiry to substantiate outcomes, since this interview will be kept confidential—but the name and organization will be listed in the report as respondents).

Ask of the interviewee has any questions. (Before the start of the interview, verify that an information and consent form was received by the interviewee).

- Ask the interviewee to sign the consent form.
- Start the interview and the tape recording.

Thank you for volunteering to take part in this interview. You have been asked to participate because of your knowledge of the Health Strengthening Advocacy (HSA) Partnership program, their advocacy and capacity-strengthening activities, and the external environment influencing the field of Health System Strengthening (HSS) and Sexual and Reproductive Health and Rights (SRHR) in the Netherlands (*For interviewer*: select what is most appropriate in this case). We really appreciate your input, time and effort.

Introduction: This interview is designed for someone who already completed the online Sprockler tool. We would like to add your information as the person who gave input to the validation of outcome ……. (fill in the outcome). I have read your online responses and will ask questions to clarify your input further and ask for your observations that go beyond the outcome and story you have already mentioned. This interview will take about 1 hour.

The purpose of the interview

1. To explore the relevance, effectiveness and contribution of HSA Partnership to the field of HSS and SRHR in middle- and low-income countries through advocacy and lobbying in the Netherlands, as part of the end evaluation RiH is conducting.
2. For project managers of MoFA: The purpose of the interview is to explore your perspective on the relevance effectiveness, governance and partnership and lessons learned related to the HSA Partnership program.

Note for Participant Consent: if a face-to-face interview: *one copy of the informed consent form should be given to interviewee and a second copy should be kept by the IDI interviewer.*

[4] Please note that this tool is developed for interviews with the funder, partner and lobbying target MoFA and Dutch network partners and external substantiators. Some Dutch network partners and lobbying targets, such as GFF, are in the global as well as Dutch domain and we will adapt the specific questions accordingly.

Confidentiality Even though our conversation is being audiotaped, I would like to assure you that our discussion will be confidential. The tapes will be kept safe in a locked facility until they are transcribed; then they will be destroyed. The transcribed notes of the interview will have no information that would allow individuals to be linked to specific statements. Your name and specific organization will be named in the list of persons who have been interviewed, but not in the written transcripts or be made explicit in specific quotes or statements in the final report. Your gender and your affiliation, such as Dutch network partner or lobbying and advocacy target, policy maker, parliamentarian, consortium partner, expert HSS, SRHR, gender and inclusivity will be mentioned. We expect your answers and comments to be as accurate and truthful as possible. If there are any questions or conversation topics that you do not wish to answer, you do not have to do so and this will have no implications for your job, standing or reputation. I would like you to sign a consent form to participate in this interview and hand me the signed form now. May I tape our conversation to facilitate writing the transcript of what we both say? (if yes, switch on the recorder)

Context:	Name of organization represented by interviewee:
Date (day/month/year):	Respondent's position or role in the context of HSA Partnership:
Name of interviewer:	Sex:

No	Questions to ask	Notes to interviewer
General Question for the Dutch Context		
1	In your opinion, what are the most important achievements of the HSA Partnership in their lobbying and advocacy activities at the global/regional (select what is relevant)? These would be achievements in addition to the outcome you already commented on in the Sprockler inquiry (if relevant).	Probe: the relevance for the contexts in which the results happened, e.g. Dutch policy, practices of Dutch network partners, or global context. Probe for approaches most beneficial for the involvement of CSOs and HSA partners in policy processes. Probe for strategies that were most beneficial for the development of effective evidence-based messages. Probe for the influences on HSS and SRHR in particular.
2	Can you specify and give examples of the results you just mentioned?	Probe for examples for each result mentioned.
Questions related to short-term/mid-term/long-term outcomes. For consortium partners, follow the ToC for the Netherlands. For external informants, follow the above examples.		
1	• On a scale of 0-100%, to what extent was the short-term outcome/result achieved?	**Consortium partners**

	• On a scale of 0-100%, to what extent was the mid-term outcome/result achieved? • On a scale of 0-100%, to what extent was the long-term outcome/result achieved?	it is important to determine the progress made and not only focus on what was not achieved.
2	What is the evidence for each achievement? Give examples.	List each example
3	How was each outcome you just mentioned achieved? Give examples.	
4	What were the challenges to achieving each outcome you just mentioned? Hampering, contributing, and external factors?	Focus on learning: what can be learned for setting up partnerships on these issues.
5	• Which short-term outcomes were not achieved? • Which mid-term outcomes were not achieved? • Which long-term outcomes were not achieved?	Consortium partners/MoFA More general with all respondents: Probe for opportunities missed, activities that did not lead to results or led to negative results
6	What influenced the achievement of the outcomes internally and externally? Can you give examples?	
7	What is your opinion about the importance of shared lobbying and advocacy strategies and agendas? How has the lack of these strategies influenced agendas? In cases where agendas were shared, did this improve outcomes? If yes, how?	Probe further into examples of shared or complementary lobby or advocacy agendas with a HSA Partnership partner (or between network partners) and how this influenced results.
8	How has the Dutch advocacy agenda been set? To what extent were national advocacy priorities and voices taken into account?	
9	What do you think about complementarity and autonomy in the partnership? Probe for complementarity and how the lobbying or advocacy on one topic (chosen by one partner) actually complemented the lobbying and advocacy topic of another partner.	Consortium partners, technical staff MoFa
10	Has the fact that not all partners are active in the Dutch context influenced the complementarity of the advocacy strategy? If yes, how?	Consortium partners
11	To what extent did the HSA Partnership adapt to changing contexts? Did advocacy approaches change during the implementation period and if so, how and why?	
Questions related to Theme: Linkage of Dutch-Country context		
1	Can you explain if strengthening the capacity of contracted partners, partners and network partners by HSA Partnership has translated into improved involvement of these CSOs in	

	influencing policy at the Dutch level and vice versa? If yes, how has that translated into improved involvement?	
2	To what extent did Dutch advocacy support advocacy activities at national, regional and global levels? Can you give examples?	
3	Can you give examples of how issues and voices at the country level become a focus in the Dutch agenda?	
Questions related to theme: Legitimacy		
1	Can you give examples of the visibility of the HSA Partnership in the latest Dutch and international events? Has this visibility increased over time?	
2	Were advocacy interventions combined with the focus of other partners at other levels? For example, were messages or shared strategies developed for the Dutch parliament? How has this worked?	
3	Have the HSS and SRHR advocacy and lobbying strategies of HSA Partnership changed how the consortium and contracted partners are perceived by others? If yes, then in what way has it changed the perception? If no, then why not? What factors have influenced this situation?	Probe for various groups: Dutch CSO, policy makerr
Questions related to Theme: Governance and Partnerships		
1	How would you describe the role of the Ministry as a partner in this partnership?	Consortium and MoFA Probe: If and how did the relationship as a partner contribute to the HSA Partnership's achievements?
2	What were the successes and challenges of this partnership? What lessons were learned?	Consortium and MoFA
3	What was the added value of this collaboration and governance structure in HSA Partnership (if any) for achieving results?	Consortium and MoFA
Questions related to Theme: Gender and Inclusivity		
1	To what extent has the HSA Partnership addressed gender and inclusivity in their lobbying and advocacy and capacity-strengthening activities? What approaches were chosen? To what extent have these approaches been successful? What were the hampering factors and lessons learned?	Probe for women's participation and leadership position in lobbying and advocacy and their roles in decision-making processes in the HSA Partnership program. How were gender issues identified and addressed?
2	Tell me about strategies that worked (or did not work) for ensuring that the voices and engagement of women, girls and other marginalized groups was achieved in in activities and outcomes?	
Questions related to theme: Mutual influence of HSS and SRHR		
1	Has HSS strengthened SRHR in the Dutch/global context? If yes, then how? If no, then why not?	Probe for the contribution of the HSA Partnership.

2	Has SRHR strengthened HSS? (probe for the contribution of HSA Partnership) Can you give an example? If yes, then how has it strengthened HSS? If no, then why not?	
	To what extent has the HSA Partnership contributed to a strengthened narrative on the importance of HSS for SRHR in policy documents and decisions?	
3	What were the lessons learned related to HSS and SRHR influencing the improvement in each other? In general, and for the HSA Partnership in particular.	Probe for the validity for these assumptions, examples, experiences, opinions.
Questions related to theme: Sustainability		
1	To what extent has the HSA Partnership influenced mechanisms for sustaining the results the HSA Partnership has contributed to that you think may endure past 2020? • Mechanisms to sustain policy and implementation processes? • Mechanisms to sustain advocacy and lobbying by partners and networking partners?	Probe for examples, and how they influenced the mechanisms and why?

Final Topic Guide for IDI with key informant (Contracted Partners, Participating Organizations, External validators, network partners, media, policy makers) for Country Context

A list of general questions will be selected from the list below and details added (if needed) depending on the specific interviewee and context. This IDI topic guide will only be applicable for the Country Context.

Interviewer's introduction and instructions to interviewee
For the interviewer

- Explain the purpose of the interview.
- Ensure confidentiality again, including tape recording (this is different from the Sprockler inquiry to substantiate outcomes, since this interview will be kept confidential).

Ask if the interviewee has any questions. (Before the start of the interview, verify that an information and consent form was received by the interviewee).

- Ask the interviewee to sign the consent form.
- Start the interview.

Thank you for volunteering to take part in this assessment. You have been asked to participate because of your knowledge of the Health Strengthening Advocacy (HSA) Partnership program, their advocacy and capacity-strengthening activities, and the external environment influencing the field of Health System Strengthening (HSS) and Sexual and Reproductive Health and Rights (SRHR) (*For interviewer*: select what is most appropriate in this case). We really appreciate your input, time and effort.

Introduction: This interview is designed for someone who has already completed the online the Sprockler tool.

Purpose of the interview: to add to the information you already provided through the online Sprockler tool as the person who gave input to the validation of outcome …….. (fill in the outcome).

I have read your response and will ask questions to clarify your input further and ask for your observations that go beyond the outcome and story you mentioned). The interview will take about 1 hour.

Note for Participant Consent : if a face-to-face interview: *one copy of the informed consent form should be given to interviewee and a second copy should be kept by the IDI interviewer.*

Confidentiality: Even though our conversation is being audiotaped, I would like to assure you that our conversation will be confidential. The tapes will be kept safely in a locked facility until they are transcribed, then they will be destroyed. The transcribed notes of the interview will contain no information that would allow individual subjects to be linked to specific statements. Your name and specific organization will be named in the list of persons interviewed but not in the transcripts or be made explicit for specific quotes and statements in the report. Your gender and type of respondent, such as beneficiary CSO, international/multi-lateral/regional network partner or lobbying and advocacy target, policy maker, community leader, parliamentarian, consortium partner, core partner, expert HSS, SRHR, gender and inclusivity will be mentioned. We expect your answers and comments to be as accurate and truthful as possible. If there are any questions or conversation topics that you do not wish to answer, you do not have to do so and this will have no implications for your job, standing or reputation. I would like you to sign a consent form to participate in this interview and hand me the

signed form now. May I tape our conversation to facilitate writing the transcript of what we both say? (if yes, switch on the recorder)

Context:	Name of organization represented by interviewee:
Country (only for Country Context):	Respondent's position:
District:	Sex:
Date (day/month/year):	Name of interviewer:

No	Questions to ask	Notes to interviewer
General Question for the Country Context		
1	In your opinion, what are the most important achievements of the HSA Partnership in their lobbying and advocacy activities at the global/regional (select what is relevant)? These would be achievements in addition to the outcome you already commented on in the Sprockler inquiry (if relevant).	Probe for the relevance for the contexts in which the results happened Probe for approaches most beneficial for the involvement of CSOs and HSA partners in policy processes. Probe for strategies that were most beneficial for the development of effective evidence-based messages. Probe for influences on HSS and SRHR policies and implementation processes in particular.
2	Please specify and give examples of the results you just mentioned.	Probe for examples of each result the interviewee mentions.
3	Were results, strategies, and lessons learned shared across countries? Can you give examples of how strategies and messages were developed? Please give examples of what can be learned from the HSA Partnership in working across contexts.	Also probe for how the strategies were developed Probe for approaches that were most beneficial for the involvement of Participating Organizations (CSOs) and contracted partners in policy processes. Probe for what strategies were most beneficial for the

		development of effective evidence-based messages.
Questions related to short-term/mid-term/long-term outcomes (Follow ToC of each country and the ToR). For external informants, follow the above examples.		
1	• On a scale of 0-100%, to what extent was the short-term outcome/result achieved? • On a scale of 0-100%, to what extent was the mid-term outcome/result achieved? • On a scale of 0-100%, to what extent was the long-term outcome/result achieved?	To be answered by contracted partners and Participating Organizations, network partners and media, and if relevant, government officials It is important to determine the progress made and not only focus on what was not achieved.
2	What is the evidence for the achievement? Give examples.	List for each example
3	How was each outcome you mentioned achieved? Give examples.	
4	What were the challenges and contributing factors to achieving each outcome you just mentioned?	Probing for contracted partners, partners and network partners: What was achieved as an individual organization across contexts and together? Focus on learning: what can be learned for setting up partnerships on these challenges/issues.
5	• Which short-term outcomes were not achieved? • Which mid-term outcomes were not achieved? • Which long-term outcomes were not achieved?	Contracted partners and if relevant, partners and/or network partners More general with all respondents: Probe for opportunities missed, or activities that did not lead to results or led to negative results
6	What influenced the achievement of the outcomes internally and externally? Can you give examples?	
7	What is your opinion about the importance of shared lobbying and advocacy strategies and agendas? How has the lack of these strategies influenced agendas? In cases where agendas were shared did this improve outcomes? If yes, how?	Contracted partners and partners and/or network partners For network partners: probe further into examples of shared or complementary lobbying or advocacy agendas

		with an HSA Partnership partner and how this influenced results.
8	What do you think about complementarity and autonomy in the partnership? Probe for complementarity and how the lobbying or advocacy of one topic (chosen by one partner) actually complemented the lobbying and advocacy topic of another partner.	Contracted partners
9	Has the fact that not all HAS Partnership core partners are active in your context influenced the complementarity of the advocacy strategy in Malawi? If yes how?	Contracted partners, only for Malawi (HAI does not work in Malawi)
10	How did the media health desk engage in dialogue on SRHR at the national/district level (please select the level where respondent works)? Give examples. What were the challenges and supporting factors?	Contracted partners, media, and network partners, if relevant
11	Has the multi-stakeholder mechanism successfully promoted the accessibility of commodities (MeTA) and anchored this in the MoH? Give an example. What were the challenges and supporting factors?	Contracted partners, MeTA members, and government official, if relevant
12	To what extent did the HSA Partnership adapt to changing contexts? Did advocacy approaches change during the implementation period and if so, how and why?	
Questions related to Theme: Linkage of global-regional-national context		
1	Please explain to what extent the strengthening capacity of contracted partners, partners and network partners has translated into their improved involvement in influencing policy at the global and regional levels and vice versa?	Contracted partners, partners, and network partners
2	To what extent have issues and voices at a local level become a focus in the regional/global agenda? Please give examples.	Contracted partners, partners, and network partners
3	To what extent have global events influenced a country's agenda setting? Please give examples?	Contracted partners, partners, and network partners
4	To what extent did global and regional advocacy support national advocacy agendas?	
5	To what extent are international policies, bills, guidelines, or new insights shared with partners in countries? How are these shared?	Contracted partners, partners, and network partners
6	Please explain if there is a process for selecting representatives to be present at regional and global meetings and guidance or observations of how they share their new learning back in country. Is there a monitoring process for this? If yes, please give an example.	Contracted partners, and government official
7	Are the results of the partner interventions combined with other partner's focuses at other levels? For example, how does GFF combine their global lobbying with GFF lobbying of in country? Are messages and shared strategies developed? How are they developed?	This question will only be asked if applicable Contracted partners, government official

7	Please share successful examples of linking advocacy at the local, national and global levels? What have been hampering factors? Have there also been missed opportunities?	This question will only be asked if applicable Contracted partners and government official
Questions for Regional Context related to Theme: Legitimacy		
1	Please give examples of how the partners' capacity has increased their ability to influence policy at a local (national/district) level?	Contracted partners, partners, network partners, and government official (if relevant)
2	Please give an overview of who the groups represent that the CSOs have selected and contracted with? Do they represent diversity and marginalized groups? Are the groups locally embedded and autonomous? To what extent has the HSA Partnership involvement made a change in this situation and how has it made a change?	Contracted partners, partners, network partners and government official (if relevant) The question about the CSOs' selection process could come here if necessary
3	To what extent has CSO involvement with the HSA Partnership changed how the CSOs are perceived by other CSOs, policy makers, and communities?	Contracted partners, partners, network partners and government official (if relevant)
Questions related to Theme: Governance and Partnerships		
1	See questions 7, 8 and 9 (Questions related to short-term/mid-term/long-term outcomes (Follow ToC of each country and the ToR)	
2	What were the successes and challenges in collaborating with all the consortium and contracted partners in your country context? What were the lessons learned?	
3	What was the added value of the collaboration and governance structure in the HSA Partnership (if any) for achieving results?	Contracted partners, partners, and network partners
Questions related to Theme: Gender and Inclusivity		
1	To what extent has the HSA Partnership addressed gender and inclusivity in the lobbying, advocacy and capacity strengthening of HSA Partnership? How was gender considered when developing and implementing advocacy strategies and capacity building? What approaches were chosen? To what extent have these approaches been successful? What were the hampering factors and lessons learned?	Contracted partners, partners, and network partners
2	What is the partners and CSOs' understanding of gender and the relevance of developing and implementing gender-sensitive programming?	
3	Can you think of any strategies that did work (or did not work) in ensuring that the voices and engagement of women, girls and other marginalized groups' is achieved in activities and outcomes?	Contracted partners, partners, and network partners
4	What marginalized groups have been included in the HSA Partnerships Program?	Contracted partners, partners, and network partners

Questions related to theme: Mutual influence of HSS and SRHR		
1	To what extent has the HSA Partnership contributed to a strengthened narrative on the importance of HSS for SRHR in policy documents and decisions?	Contracted partners, partners, and network partners
2	What were the challenges and lessons learned related to HSS and SRHR influencing the improvement of each other?	Contracted partners, partners, and network partners
Questions related to theme: Sustainability		
1	To what extent has HSA Partnership contributed to mechanisms you think may endure past 2020? • Mechanisms to sustain policy and implementation processes on HSS and SRHR? • Mechanisms to sustain advocacy and lobbying by partners and networking partners?	Probe for examples of how and why. Think of knowledge on policy and implementation processes and accountability.

Final Story collection for HSA Partnership end evaluation

Purpose: To identify cases of significant/critical changes (both positive and negative) relating to capacity strengthening. To use group discussion to collect general information, clarify details or gather opinions.

Materials: internet, participants' laptops, and flip-charts

Duration: 3 hours

Number of participants: 8-15

Facilitation: one facilitator and one note-taker

Steps:

1. The facilitator welcomes participants and everyone introduces themselves. Brief review of the project that is the focus of the evaluation. (15 min)
2. Participants are asked to individually (silently) reflect on the first story question: *Can you share a story about one special moment during the efforts of the HSA Partnership to strengthen your capacities, that has led to a change in your advocacy skills? What made this moment so special?* (5 minutes)
3. Participants briefly share their experiences in plenary. They can finish the sentence: *"A special moment for me was when …"* (20 min)
4. The facilitator briefly explains the types of changes that can be achieved through advocacy. (10 min)
5. Participants are asked to individually (silently) reflect on the second story question: Can you now share a story about one most significant change in the behavior of key individuals, organizations, communities or government that you've influenced through your advocacy efforts? This change can be a set-back or a success, or intended or unintended. (5 min)
6. Participants briefly share their experiences of change in plenary. They can finish the sentence: *"The most significant change was when …"* (20 min)
7. Participants are now asked to sit at their laptops and complete the online inquiry (45 min)
8. On the screen, the online interactive Sprockler report is projected with their responses. The facilitator selects several questions for a plenary dialogue and now probes for an interpretation of the responses: (60 min)
    - How easy was it for you to use your newly acquired advocacy skills in practice? Why was generally easy or difficult?
    - To what extent did the HSA Partnership's capacity strengthening support the change in your story? Why do you think the change would have happened even without the HSA Partnership's support? Or why was the HSA Partnership's support the primary reason the change occurred?
    - Etc. for all questions.

Global and the Netherlands Context

Global

The Health System Advocacy Partnership (HSAP) harvested 31 outcomes (6 by Amref and 25 by Wemos) for the global context. Ten outcomes harvested by Wemos (32% of all outcomes), were substantiated during this evaluation. Amref selected one outcome for substantiation at the global level, but did not provide a substantiator. Six of the seven outcomes harvested by Amref at the global level referred to the development of CHW guidelines, but evidence for the influence at a global level was not provided. The influence on CHW integration in health systems was substantiated at the NL level since most of the influence was exercised through the MoFA.

The Netherlands

The alliance harvested 18 outcomes for the Dutch context (7 by Amref and 10 by Wemos) and seven (38%) were substantiated during this evaluation (three by Wemos and four by Amref). As a result of the substantiation, one outcome in the Netherlands was removed, since it wasn't recognised as an outcome, but rather as an output.

Main overall TOC outcomes harvested and substantiated.

Improved policy support from local or national governments was also reflected in 10/22 **global institutional** outcomes with signs of improved policy support. In the **Netherlands,** and at a **global level**, **multiple stakeholder engagement** accounted for half of all outcomes, thus highlighting the HSAP focus on multi-stakeholder processes.

1. **Capacity-strengthening efforts** of Civil Society Organisations (CSOs), CSO networks, communities, and media
    - No outcomes are linked to capacity strengthening of CSOs in the Netherlands. The focus of the programme strengthening of civil society in the Netherlands was not a priority. The main focus aimed at strengthening civil society in partner countries. Both partners agreed that activities in the Dutch context were minimal. One core partner respondent explained this as follows: *'they (The Ministry of Trade and International Cooperation) want to spend the money where it is supposed to do most good, which is in the receiving countries and it is not meant to strengthen civil society in the Netherlands (inception report).'*
    - At the global level, three outcomes were indirectly influenced by HSAP CSO engagement in the Global Financing Facility (GFF) and government decision making and policies. Harvesters linked these three outcomes – (28434) creation of 'Watch the GAP' group in Uganda, (28432) support for Wemos to increase their engagement in the GFF in Tanzania, and (28436) support for the kick start of CSO engagement in GFF in Malawi – to the TOC outcome 'increased lobbying and advocacy capacity of civil society'. The evaluators thought, because capacity strengthening was indirect by the global context partner, it was a better fit with the TOC outcome of increased engagement in CSO policy processes. These outcomes are reported in full under increased engagement in policy processes in the chapter on the effectiveness of advocacy approaches.
    - All three substantiators reported increased knowledge of GFF processes and guidelines, and improved capacity in writing reports and strategies for advocacy. See for example,

- *'Wemos builds capacity in writing advocacy documents by providing feedback and pointers on how to improve, and criteria for how to review writing* (28434/CSO)
- *'Wemos sharing global information and experiences from other countries strengthened civil society.'* (28436/CSO, 28432/CSO). (See also best practice section)

2. The effectiveness of advocacy approaches

Changes in policymaker support on HRH, SRH commodities, health financing and governance

Global context outcomes

- At a global level, Wemos contributed to three TOC LT-outcomes 'improved support of policymakers for HSAP advocacy topics on HRH, SRH commodities, HF and governance. The three outcomes were fully substantiated. The outcomes were intended results of advocacy activities to influence: 1) the commitment to include a policy on HRH salaries in the GFF during a side event of the Civil Society Policy Forum of the World Bank/International Monetary Fund Spring meetings in April 2018 (28433/policy maker), 2) a reference to the code of practice on the international recruitment of health personnel (code of practice) in the Universal Health Coverage (UHC) agenda during the UN High Level Meeting (HLM) in September 2018 (28439/network partner), and 3) the code of practice for migration of health personnel on the basis of CSO input consolidated by Wemos during the second code review meeting organised by the WHO (28441/policy maker).
- The third outcome focused on the information shared during a Health Worker for All Coalition (HW4All) meeting and the formulation of the outcome was substantiated and fully agreed upon. However, the substantiation concentrated on Wemos's contribution of consolidating the feedback from 14 CSO organisations and presenting the voice of civil society for the second code review meeting. This contribution was much valued. Wemos felt that their advocacy efforts to increase transparency on the code decision making was not successful and were disappointed. They did not get answers to their questions about the code decision making that could be made public. The final review process happened in a closed meeting with an expert group representing member states.
- For a full overview of the outcomes see annex 10 of the main report.

Netherlands context outcomes

- In the Netherlands context, four contributions were linked to the LT TOC outcome improved support by policymakers. Three harvested by Amref and One by Wemos. Two Amref outcomes were intended results of advocacy activities to influence Dutch policymakers to maintain and increase support for SRHR: 1) the inclusion of a statement on SRHR by the Minister to the importance of SRHR in UHC during the UN high-level meeting in New York, in September, 2019 (29061), and 2) the Minister's €100 million increase in the Ministry of Foreign Affairs (MoFA) budget for SRHR partnerships in the Netherlands (29062). The third Amref outcome was an unintended result of advocacy activities for inclusion of CHWs in health systems and consisted of the Dutch Ministry supporting the importance and integration of CHWs in health systems at various global events (30034).
- Wemos contributed to the intended LT TOC outcome for increased policy support. Recommendations from the Community of Practice (CoP) on CSO engagement for Dutch support of the GFF were included in the MoFA's position at the GFF 9th Investors Group Trust Fund Committee meeting in November 2019 (28442).

- For a full overview of the outcomes see annex 10 of the main report.

Actors and mechanisms for change

- The actors at the global level who provide policy support for HRH and HF are global institutions such as the WHO, GFF and the UN assembly on UHC.
- The actors at the Dutch level are policymakers at the MoFA.

HSAP's global contributions

- Wemos's contributions to increasing policy support for HRH, HF and governance in global policies were rated by all substantiators as big and regarded as initial steps.
- Respondents reported that Wemos's strategies to influence policy support in the global context consisted of
  - initiating and actively engaging in networks that enabled them to draw on the input of members, develop and table consolidated documents and bring in issues for discussion at policy level meetings.
  - developing case studies of policies and practices, in collaboration with partners such as AMAMI in Malawi, and presentation of the results at various global meetings (e.g. GFF in Oslo, an outcome included in the harvested outcomes not selected for substantiation in this evaluation). The results were then published, summarised in policy briefs and fact sheets that were sent to influence global events (e.g., UN High Level meeting on UHC in New York and the GFF).
- Interview results showed that Wemos's ability to engage and consolidate CSO voices legitimises their influence and leads to invitations to sit at the policymaker tables in global organisations (e.g., the WHO second code of practice review and the Civil Society Policy Forum of the World Bank/IMF side event), thus enhancing their influence. At a country level, Amref and ACHEST complemented lobbying at a global level (28439/networking partner, 28434/CSO).
- The effectiveness of these strategies is demonstrated in the contributions recorded in the substantiator and key informant interviews:
  - Wemos coordinated CSO input in documents presented to the global institutions through multi-stakeholder platforms such as the HW4all Coalition (28439/networking partner), which also informed the consolidation of CSO contributions for the World Health Organisation (WHO) second code of practice review meeting (28441/policy maker).
  - Wemos informed the combined lobby for the code of practice on migration of country delegations by core partners active in countries (e.g., AMREF and ACHEST) (28439/networking partner).
  - Wemos coordinated the development of a letter endorsed by 52 CSOs expressing their concern about HRH salaries and HF to the GFF. They also organised and led a side event at the Civil Society Policy Forum of the World Bank/IMF, which was a direct follow up to their aforementioned letter (28433/policy maker).

Contributions the Netherlands

- Substantiators rated Amref and Wemos contributions as helpful, substantive and significant. One substantiator regarded HSAP's contribution to the increased policy support outcome as

big (29062/networking partner). Three outcomes were rated as initial steps. The increase in budget for SRHR partnerships was rated as moving towards a full-blown change.

- Amref and Wemos activities that contributed to increased policy support for HS and SRHR in the Netherlands consisted of:
  - Amref's active participation in CSO networks such as Share-Net, informal lobby groups (KII, networking partner) and
  - Wemos chairing the Share-Net organised Community of Practice CoP for CSO engagement in GFF (28398/policymaker; 28442/policymaker).
  - Amref was invited by policymakers, with two other CSOs, to participate in the preparation of the UN High Level meeting on UHC in a meeting with the Minister of Trade and International affairs. They were invited because of their ability to bring country experiences to the table (29061/policy maker, 29802 /policy maker, KII, networking partner).
  - Wemos was asked to meet with policymakers because of their country case studies and extensive global networks (28442/policy maker, 28398/policy maker).
- The contributions of Amref and Wemos were demonstrated in the substantiator and KII interviews.
  - *'In the Netherlands meetings were held preparing for the HLM. Amref contributed to this in support of the existing policy'* (29061/policy maker).
  - One networking partner found that Amref's most important contributions were increasing the budget for SRHR partnerships due to their very active role in groundwork, letters sent to MoFA influencing their strategic focus on development. Amref was seen as making a difference in the lobby group and providing leadership. (29062/networking partner)
  - One policymaker found that *'Amref gave very concrete examples of what happened in countries. The role of CHWs and their importance, presented by a CHW at the Ministry influenced our position'* Two policymakers found that the HSAP (Amref in NL and Wemos in Dublin) influenced the Dutch position on CHWs, among other influences. (30034/policy maker/28398/policy maker).
  - Two Dutch policymakers commented that case studies produced by Wemos and their in-country partners (28442/policy maker, 28398/policy maker) and Wemos's point about CSO engagement during the CoP meeting (28442/policy maker) assisted civil servants to provide substantial input in GFF board meetings (28442/policymaker) and round table replenishment meetings (28398/policy maker).

Increased multi-stakeholder engagement with regard to HRH, SRH commodities, health financing and governance.

The importance of CSO engagement for influencing the LT outcome increased policymaker support had already emerged from the contributions described above. Multi-stakeholder engagement through platforms such as the HW4All Coalition can be considered as initial steps towards change. For example, the HW4All Coalition played an important role in generating CSO input in two outcomes, the code of practice for health personnel developed by WHO (28441/policy maker) and the adoption of HRH as part of the UHC agenda (28439/networking partner).

In total eight outcomes fall in the MT outcome category 'Increased multi-stakeholder engagement of the HSA Partnership and partners with regard to HRH, SRH commodities, health financing and governance', six in the global context and two in the Netherlands. To do justice to the various ways

this engagement exists, the evaluation team made a distinction between 1) Increased engagement of stakeholders through network platforms, 2) changes in the involvement of CSO and HSA partners in policy making, 3) Increased uptake and dissemination of evidence-based materials by networking partners and 4) Increased media attention.

Increased multi stakeholder engagement through network platforms

- Two outcomes are linked to the 'Increased multi-stakeholder engagement through platforms—one in the Netherlands and one in the global context.
  - In the global context, ACHEST, Wemos and MMI established and launched the HW4All Coalition in Geneva was selected and substantiated in the global context. The HW4all coalition enabled discussions and the development of policy briefs among CSOs concerned about the HRH crisis (28439/networking partner).
  - In the Dutch context, the involvement and organisation of the global health cafes by Wemos and Amref was selected. This outcome enabled increased involvement of Dutch NGOs and policymakers in discussions on global health and HS issues (28429/networking partner).
  - For a detailed description of the outcomes see annex 10 of main report

Actors and mechanism

- The actors at the global level were the CSOs calling for the launch of the HW4All Coalition and HSAP core partners responding to the call.
- At the Dutch level, the actors were Amref and Wemos participating in the organisation of the global health platform, and the MoFA, who asked Wemos to organise the meeting about lessons learned from Ebola for epidemic preparedness.

Changes in involvement of CSOs and HSA partners in policymaking.

Four outcomes in total are linked to increased involvement in policy processes. Three in the global context and one in the Dutch context.

Global context

- An important focus of Wemos's work at the global level is informing CSOs and partners in countries such as Malawi (28436), Uganda (28434) and Tanzania (28432) about global policies and guidelines and supporting them, together with other HSAP partners, to engage in policymaking and implementation processes. An important mechanism for the involvement in policymaking processes are multi-stakeholder platforms, such as the GFF CSO coordination groups and Watch the GAP group at a country level.
- Three outcomes focus on CSO engagement in GFF and Watch the Global Action Plan (GAP) coordination groups.
  - CSO representatives created the "Watch the GAP" task group in Kampala, Uganda, to work together at both a global and a country level to amplify the CSO voice (28434/CSO).
  - Malawian CSOs became more active and better coordinated to engage in discussion with Malawian stakeholders concerning the GFF Malawian Investment Case. (outcome was changed in the substantiation inquiry during the interview by the substantiator (28436/CSO).
  - Head of Programme Health at Sikika, a contracted partner, wrote an email thanking Wemos for sharing Recommendations to the GFF 9th Investors Group meeting and

indicated that they are very important to potentially influencing the discussion on GFF at the policy level in Tanzania. (28432/CSO).

Netherlands context

- Wemos's advocacy focus on HRH, HF and CSO engagement, and in particular, their work on influencing GFF guidelines and policies, and Amref's lobby on SRHR and their experience in African countries led to MoFA invitations to provide input for policy decisions for global level organisations and meetings.
- At the Dutch level, one outcome signifies increased involvement of the HSA partnership and CSOs in the Netherlands in policymaking processes (29802/policy maker) and one was regarded more an output than an outcome but contributions are still reported here (29398/policy maker).
    - AMREF (29802) The Ministry of Foreign Affairs invited Amref to a lunch meeting with Minister Kaag in October 2019 to discuss joint priorities for the ICPD+25 Nairobi Summit. Amref attended this meeting with Minister Kaag and several high-level policymakers together with Rutgers and CHOICE for Youth and Sexuality. This was an unintended outcome.

Actors and mechanism for change

- At the global level, actors are network partners collaborating through multi-stakeholder platforms.
- At the Dutch level, the actor of the outcomes is the Dutch national government.

Wemos contributions in the global context

- The Wemos contributions at a global level were rated small (1), big (1), and in between (1), two as initial steps and one going towards full blown change by substantiators.
- Wemos's contribution to the outcomes at a global level included: 1) coordination of CSO and country government engagement on policies related to HRH and HF, 2) the generation and dissemination of evidence on gaps in HRH, HF and CSO engagement in countries including HSAP countries Malawi, Kenya, Uganda and Tanzania, and 3) sharing experiences and case studies from other countries.
    - *'Wemos had already started engaging us on the GAP back in March-April 2019, before the World Health Assembly. The theme around aid organisations distorting or supporting national governments was discussed. The lack of evidence and advocacy and minimal CSO engagement…That is where Wemos and MMI stepped in and engaged CSO. That is why we now have the secretariat in Uganda and involvement from Uganda.'* (28434/network partner)
    - *'Wemos contacted us to start working on the GFF and at the country level, we also had started to look at the GFF… they (Wemos) started to share the draft for our input. And this was very important for recommending how funds should and can be used in the country.*' (28432/network partner)
    - *'In 2018 Wemos, AMAMI and PAI supported the first CSO workshop to inform the CSOs in Malawi about their role in the GFF platform. The HSAP programme brought the CSOs together and oriented them on their role. They shared stories of other platforms. If we had not been given the information and capacity strengthening from Wemos, our involvement*

with the GFF would not have been meaningful. We would not have been looking at it as a loan but as a grant, not realizing that domestic resources were used.' (28436/network partner)

Contributions at the Netherlands level

- The outcome in the Dutch context was rated as significant and between an initial step and a full-blown change because the NGOs' involvement in direct engagement with Minister Kaag in a dialogue on this agenda was seen as unique and had not happen before (29802/policy maker).
- Amref and Wemos contributed and invited to the table based on their reputation and involvement in multiple countries.
  - *'Amref's input included bringing in the Southern perspective through their strong contexts in Africa, and they played a critical role with the CSO consultation in Kenya'*, (29802/policy maker).
  - Wemos was commended for their work on positioning the Netherlands towards global health funds and how to strengthen these funds. *'Working together with Wemos on GFF has helped the NL to shape the NL's position within the GFF.'* (28398/policymaker)

Changes in the development and dissemination of effective evidence-based messages taken up by like-minded networks and organisations.

Evidence-based materials such as case studies on HRH, HF and CSO engagement in the GFF and GAP, and global policy documents and guidelines are taken up by network partners for advocacy.

- Two outcomes in the global context were linked to like-minded organistions taking up the evidence-based messages. The contributions of both were rated small and initial steps.
- At the global level,
  - One substantiated outcome shows the importance network partners gave to briefing papers about the GFF developed by Wemos, and the desire to inform their own CSOs in various countries (28440/network partner).
  - In another outcome, briefing papers were distributed to inform the 350 CSO who are part of a digital networking group related to the GFF Civil Society Coordinating Group (CSCG), and organized by PMNCH Geneva (28438/network partner). This outcome was substantiated, but a note was made that the use of the papers could not be verified and was assumed.

Actors and mechanisms

The actors are INGOs disseminating the GFF briefing papers to inform their constituency.

Contributions

Both outcomes were considered initial steps and the contributions were not rated.

- During a webinar, Wemos shared documents on CSO involvement in the GFF in Malawi, Uganda and Kenya with Management Sciences for Health (MSH) grantees in Malawi and Uganda in response to a request from MSH. MSH wanted to inform the CSOs about the GFF, but also how CSOs can seize the opportunity to engage in the GFF funding mechanism (28440/network partner).
- Wemos developed key information resources for civil society consumption and engagement in the GFF process and shared these resources to inform attendees at the workshop of the GFF Civil Society Coordination Groups. The documents were disseminated to the 350 members of the digital platform. *'Wemos is a very active partner, very vocal and is providing key points for*

discussion'. For example, in one of the meetings with the GFF, for example, they raised the issue that CSO representation is lacking in the GFF in Malawi, Uganda and Kenya. The respondent estimated that in 2019, Wemos contributed 30% of the evidence for CSO engagement (28438/network partner).

Increased media attention of stakeholders

- Two outcomes relate to the MT-outcome 'Increased media, government, and private sector attention for HRH, SRH commodities, health financing and governance', one outcome at global level and one at the Dutch level, with a focus on media attention.'
    - Partos included Wemos/AMAMI work on fiscal space for health workers in Malawi as the first example in the "Sustainable Development Goals progress report" published by the Dutch MoFA. (28428/network partner).
    - ViceVersa, a Dutch magazine on global development, agreed to include a section on employment in the health sector in their special magazine issue on Jobs and Employment. They had not originally intended to do so. (28435/media)

Actors

The actors are a Dutch NGO who supported MoFA in producing the SDG3 report, and a Dutch magazine of an organisation advocating for global issues.

Contributions

- Wemos's contribution was based on their active lobby and advocacy on HRH and the production of relevant materials.
    - '*We needed an international example for the SDG progress report, published by the Dutch government, and many were not so concrete, thus, the Wemos example was pertinent. Wemos's positive experience and active involvement during the building change campaign also influenced the decision to include their example'*. (28428/networking partner)
    - *'Wemos approached and actively lobbied ViceVersa to include the health sector as an important generator of jobs and why investing in health workers' jobs is an enormous contribution, not only to population health, but also to the labour market and employment opportunities*.' Vice Versa interviewed the respondents suggested by Wemos and placed the article. (28435/media)

Use of evidence-based materials and messages across outcomes

Various outcomes show how CSO organisations and network partners at the country level (28436, 29432, 28434, 28428), global level (28439, 28438) and in the Dutch government (28442) have taken up evidence-based messages produced by Wemos. These outcomes have been discussed above since the outcomes themselves are related to increased policy support and involvement in policy processes. The evidence-based documents were part of the lobbying and advocacy of network partners.

- The GFF GSCG raised the issue that little evidence was available about CSO involvement in the GFF at the country level. In response, Wemos developed case studies to generate evidence on how CSOs are engaged in GFF and what the outcome is of their engagement. (28438/network partner).
- The documents produced by Wemos were used in countries to inform CSOs about the GFF CSO coordination meetings (28436/CSO, 28432/CSO), and in Kenya and Uganda to discuss the code of practice for migration of health personnel (28439/network partner), and to

inform the Dutch government in preparation for the GFF Trustfund meeting (28442/policy maker).

- The documents and messages produced by Amref on the basis of their country expertise were used by civil servants to inform their CHW messages during the WHA (30034/policy maker), influence the Ministry's discussion of the ICPD+25 (D6/policy maker), and inform the Women Deliver meeting in 2018 (external/network partner).

Changes in advocacy linkages between national, regional, global and Dutch policymakers

The outcomes mentioned here were already introduced and discussed above. Here we discuss their relevance to changing advocacy linkages between regional, global and Dutch policymakers.

The link between global and national CSOs and policymakers

- Several outcomes (28436, 28434, 28432) show the linkage between global advocacy by Wemos and national advocacy supported by HSAP partners in country:
  - The outcome on increased CSO involvement in Malawi shows how the contributions of Wemos, AMAMI and Amref in Malawi has increased CSO involvement in GFF. (See under capacity building (28436/CSO).
  - The substantiator of the outcome on Watch the Gap group shared how the side event on HF organised by Wemos and other CSOs was able to bring perspectives from multiple countries and call for solidarity. The CSO GFF papers written in 2018, and the influence of the HW4all Coalition on the code of practice gave CSOs the ability to provide their perspectives. (28434/CSO).
  - There is a gap in domestic resource mobilization and budgeting for RMNCAH and the GFF are providing options for closing the gap through an investment case. The small grant provided by us (MSH) (Wemos conducted a webinar part of this), is ensuring that CSOs have some financial support for coalition building and developing technical skills advocacy and accountability, and have regular meetings to become more effective as a group and a coalition in holding government accountable (28440/networking partner).

Linkages global, national and Netherlands context

Linkages between advocacy at the Netherlands, global and country levels are shown in Wemos's work with the GFF, for example. In the Dutch context, HSAP contributed to policy support and changes by the MoFA during meetings at the global level. Although change is happening as a result of advocacy and lobbying in the Netherlands, the impact is at a global scale. Wemos's work to influence the GFF happens in the Netherlands through their input in the CoP, presentations at the Ministry and publications of practices in various countries.

- A policymaker in the Dutch context shared that the country case studies on CSO engagement such as in Malawi, Uganda and Tanzania helped to give examples (in the GFF Trustfund meeting) of where platforms were not functioning well, and informed monitoring of CSO funding. (28442/policy maker).

Amref's strength is in presenting country examples in the Dutch context and contributing voices from the South at global events such as enabling youth from Kenya to present their perspective and experiences and learn from others during Women Deliver and the ICPD+25.

- One of the best tables in the carousel (during Women Deliver) was with the youth from Kenya (brought in by Amref). The youth used interactive role play to make the participants feel what it is like to talk with government, the lack of space in these encounters, and how they have claimed their space (KII/networking partner).

- For a meeting with Amref, AIDSfonds and the Ministry around UHC, Amref took the lead and invited someone from the South (KII networking partner)

Roles and contribution of external factors/actors in achieving advocacy's outcomes

External actors

As in all advocacy programmes, many actors play a role and results are difficult to attribute to one organisation or programme (ref). I External actors contributing to global policy support

- External actors CSO engagement in GFF
  - At the global level Wemos is working with the PMNCH secretariat who coordinates the GFF CSCG and a digital network of 350 CSO's. Wemos is an active member of this platform.
  - At country level Wemos is an important player in (re) vitalising the GFF CSO coordination group. However, they are working at a distance. External actors such as PAI, together with HSAP partners) are key in supporting the CSOs in country. Other players such as Management Services in Health (MSH) and other INGO's also support CSOs who are actively involved in the GFF CSO coordination groups.
  - At the NL an important external actor is Share-Net, a SRHR network, that is organising the CoP for CSO involvement in GFF. Wemos is holding the position of chair.
- External actors influencing HRH ad HF policies at the global level
  Examples at the global level include influential organisations in the HW4ALL Coalition such as MMI, MSH and many others as well as organisations like the people's movement. At the country level CHAI is influential in influencing HRH, and other INGOs play important roles in influencing HF.
- External actors influencing global policy on SRHR.
  Many actors influence SRHR at the global level.
- External actors influencing Dutch policy on HS
  In the Netherlands Share-Net and other Share-Net members play an active role in organising Dutch CSOs around SRHR. Other INGOs such as NEXUS in New York contributed more to drafting the UHC statement for the UHC HLM then Amref.
- Nevertheless, all substantiators agreed that the selected outcomes were influenced by the HSAP and their contributions helped to achieve the outcome.

Enabling and hampering environment

- The environment in which global advocacy for HSS is taking place is perceived as enabling since global facilities such as the GFF are open to CSO involvement and invite CSOs to participate
  - the existence of supportive individuals on the investors group who allowed Wemos to champion this cause moderate a session on GFF in Washington DC is enabling (G8/network partner).
  - However, a few respondents commented that the GFF being embedded in the World Bank is hampering it since it has to abide by World Bank rules and this is limiting transparency (28442/policy maker). Information from a GFF liaison officer can be incomplete or insufficiently informed by what is required, thus hampering CSO involvement at country level (28438/network partner).
- In addition, competition between NGO and CBO can hinder collaboration (28348/network partner).

- HSAP partners' good relationships with policymakers such as WHO at a global level and the MOH at a country level are seen as enabling (28441/policy maker; 28439/networking partner). On the other hand, these relationships can also be hampering since HSAP's close relationship with the MOH, for example, can also prevent a more critical perspective from emerging (28439/network partner).
- WHO's lack of transparency on how the next steps of the code of practice are going to be implemented and the need to monitor implementation (and how this is going to happen) are sources of concern in the HW4All Coalition (consortium partner, 28570/network partner, 28436/CSO).
- A less conducive environment for the development and implementation of policies and guidelines in particular can be the country government's commitment influencing the inclusion and wording of global policies. For example, "Many delegations from Countries have bad HRH practices when it comes to adhering to the WHO code of practice for migration of health personnel and, therefore, they were not willing to discuss it or include it in the final document.' (28439/network partner)

Despite environmental hampering factors, substantial results were achieved (28439/network partner), see for example, the acceptance of the code of practice and GFF's increasing openness to CSO engagement, although both still need full implementation (28432/CSO, 28434/CSO, 28436/CSO, 28439/network partner).

- An enabling environment for CSO engagement in global policy processes is provided with Dutch policymakers on the board of three global facilities, the GFF, Global Fund and GAVI. This creates a climate for cooperation with Dutch CSOs to become more substantial and coordinated (28398/policy maker).
- On the other hand, the global environment is strongly divided on SRHR issues with countries such as the USA coordinating responses from countries against SRHR during the UHC HLM. Although this is hindering the implementation of the ICPD plan of action, it is also galvanising the SRHR community into action, 'as there is an urgency shared'. (29062/network partner).
- The Netherlands' strong focus and commitment to SRHR makes SRHR advocacy much easier than HSS advocacy (inception report).

Best practices and set-backs of advocacy processes

Based on the perceptions of all global context respondents from Tanzania, Uganda, Malawi and Kenya and various policymakers in the Netherlands and on the global level, the most effective HSAP strategy is their advocacy strategy for improving GFF policies and practices. A best practice bringing national and global strategies together is Wemos's technical assistance and support from a global perspective, and at the national level through other HSAP partners. This strategy contributed to changes in the CSO role in the countries and contributed to actions to make governments more accountable:

- *"For example, in Malawi the CSOs became better informed and knowledgeable. For example, we first just thought that GFF was coming with a full grant. Through the HSAP programme we understood that that part of the grant would be a loan and domestic resources should be invested. Before we had no idea about these conditions. After becoming better informed about our role and the funding conditions, we started to discuss what we wanted to achieve with our domestic funding and the loan. Discuss if we wanted a loan what should it be used for. We*

wanted to hold the government accountable and ensure that the money is used for what it was meant to be used for.' (28436/CSO)

The most effective strategies noted by respondents support the abovementioned best practice.

- Collecting evidence through case studies of poorly functioning aspects of the GFF informing the global discussion (29389/policy maker), sharing experiences from other countries (28436/CSO, 28432/CSO, 28440/network partner). '*Wemos input helps. They bring different views like issues around results monitoring. Something we had not considered' (*28442/policy maker*).*
- The ongoing dialogue with CSOs, in which Wemos played a significant role, '*gave GFF the push to focus more on the SRHR agenda and have more indicators in the programme'*. It also helped to '*strengthen, improve and raise awareness of the GFF in its role in SRHR and HSS*.' (28433/policy maker).
- '*Their (Wemos) engagement at the country level to raise awareness of the GFF among CSOs and build their capacity to engage and monitor the national GFF process has been very valuable*' (28433/policy maker)

Another effective global strategy identified by substantiators was the use of platforms for consolidating CSO input for the code of practice (28441/policy maker, 28570/network partner), in the GFF CoP (28443/policy maker, KII, network partner).

Valued contributions by Amref and ACHEST at the global level were primarily their support at a country level, acting on the global agenda (such as the WHO code of practice), lobbying for implementation of policies and guidelines in country (28439/network partner, 28434/CSO) and bringing the voice of countries to the global fora and the table of policymakers in the Netherlands (29062/network partner, 29061/policy maker, 29802/policy maker).

In the Dutch context, Amref was commended for their ongoing lobby with parliamentarians (28329/network partner) and their very valuable contributions of writing letters and input during meetings based on their extensive in countries experience (28802/policy maker, KII/networking partner).

The organisation of Global Health Café's was seen as an important platform for discussions on global health and HS (28429/network partner).

Missed advocacy opportunities / what can be done better/recommendations

Very few missed opportunities were identified. The ones identified focused on the governance of the HW4ALL Coalition, a theme that could have been included as an advocacy focus and the need to monitor the code of practice at a country level.

- One area for improvement is the HW4ALL Coalition's dependence on Wemos and HSAP funding. This dependency has saved the coalition much hard work in creating a strong membership involvement in the coalition's day-to-day functions and accountability towards its members. Establishing a system of membership contributions may have made the coalition more sustainable and accountable (28570/network partner).
- Another identified missed opportunity was the involvement of the coalition in the 2020 International year of nurses and midwives (28570/network partner).
- One respondent commented that the Dutch CSOs' contributions to the content of the resolutions in preparation for HLM could be improved (29061/policy maker).

- The selection and invitations to in-country representatives influence ownership. Transparency on who is invited and why to take part in activities in the countries as well as outside are important to sustain ownership and include diverse perspectives (28438/networking partner). However, like-minded perspectives may be preferred, especially in relation to SRHR.
- For CSO engagement in the code of practice, one respondent referred to the importance of multi-stakeholder influences on the implementation of the code of practice and, therefore, the need for consultation with the private sector, and representatives of government and industry as well as CSOs (28441/policy maker)
- One respondent suggested that the inclusiveness of in-country CSOs requires constant attention and review (28438/networking partner).
- A suggestion was made to make sure recommendations are linked to how GFF can improve (28433/policy maker) and various respondents suggested that Wemos could work more with CSOs in country (28433/policy maker).
- In the Dutch context, the suggestion was made to keep lobbying parliamentarians (28429/networking partner).
- At the country level, a stronger collaboration among HSAP organisations was suggested (28434/CSO)
- The suggestion was made to look into ways CSO engagement at the global level can be improved. A need to go beyond information provision and enabling CSOs to act globally was identified.

Discussion and conclusions on effectiveness

Effectiveness of the advocacy strategies

- The greatest achievements of the global advocacy strategies include the strong linkages between global and country advocacy, irrespective of the also mentioned lack of combined planning and collaboration within the HSAP programme. These linkages enabled the establishment of much stronger CSO involvement and increased CSO ability to hold governments accountable at a country level.
- HSAP's influence on global policies related to HRH (e.g., code of practice and the GFF, including a focus on HRH salaries, CHW inclusion, and ICPD+25), and the increase in CSO engagement (e.g., GFF, UHC HLM, and WHO review code of practice) globally and in the Netherlands was clearly established during this review.
- The evaluation shows that most achievements are initial steps. How and if these initial steps lead to the actual implementation of policies and guidelines remains a question, although the commitment expressed by CSOs and policymakers to follow up and push for this was achieved and promising.
- The evaluation also shows the importance and effectiveness of the collaboration between Dutch and global policymakers and CSOs, and in this case Amref and Wemos. From the responses, it seems reasonable to conclude that the participation of Dutch policymakers in the board of GFF and their appreciation and engagement with CSOs in preparation for HLM and conferences is reinforcing the influence and effectiveness of the advocacy strategies of both.
- The mechanisms used for effective advocacy strategies include:
    - active use of existing platforms such as the GFF CSGG, the initiation of the HW4ALL Coalition and taking up the chairing of the CoP for CSO influence on GFF enabling information sharing and use of evidence-based advocacy materials, and

- support to countries researching and contributing to the development of evidence-based materials for global and national use.

- Enabling voices from the South to speak directly to policymakers made an impression and led to more support.
- The reputation and standing generated through these mechanisms improved the visibility and legitimacy of the CSO community and led to invitations for increased CSO engagement in policy processes. This in turn led to more support from policymakers.
- This evaluation clearly shows the link between the mid-term TOC outcomes leading to LT outcomes and as such confirms the pathways of the generic TOC 2019.

Enabling and hampering factors

- Most enabling factors related to HSAP's ability to receive support for their strategies from various actors.
- The hampering factors focused on the lack of transparency in global player processes such as the World Bank (in relation to GFF) and WHO (in relation to follow up on the code of practice review process), and factors influencing the implementation of globally and locally agreed actions.
- The perception that the GFF is providing an enabling environment for CSOs is an interesting perspective since one could also argue that the GFF is open to CSO involvement due to donor pressure (e.g., the Netherlands), who use Wemos and the Dutch CoP influence to determine GFF policies and guidelines. What is seen as an enabling environment can also be seen as a result of effective CSO, including Wemos, advocacy efforts.
- Despite environmental hampering factors, substantial results were achieved (28439)—see for example, the changes to the code of practice and GFF's increasing openness to CSO engagement, although both still need full implementation (28432/CSO, 28434/CSO, 28436/CSO, 28439/networking partner).

What could be done better

A few valuable contributions were made towards what could be done better.

- The first is the governance of the HW4All Coalition. Wemos leadership is very appreciated, but the dependency on HASP funding for running the secretariat is a concern. Including membership contributions and/or other changes are needed to decrease dependency on one funding source and improve accountability and member ownership.
- The Dutch CSO contribution to the actual writing of resolutions for HLM meetings and more detailed recommendations for how global facilities can improve their policy and practice in particular at country level was suggested.
- Being fully inclusive when consulting and involving CSOs is notoriously difficult and requires ongoing attention and review.
- More direct engagement of global advocates such as Wemos with country CSOs beyond information sharing and enabling national CSOs to act more visibly at the global level was recommended.
- More collaboration between organisations at a country level was recommended.

3. Relevance

A. Relevance toward health system strengthening

Global

- Review of the primary theme of the outcomes at the global level (all by Wemos) showed a major focus on health systems such as the code of practice (28439/network partner, 28441/policy maker), the HRH case studies and HF influencing GFF policies on HRH (28433/policy maker, 28435/media), the push for greater alignment in the Watch Global Action Plan (GAP) (28434/CSO), and the focus on accountability in governance through greater CSO involvement (29436/CSO, 28434/CSO, 28438/network partner, 28432/CSO, 28440/network partner). The relevance of these outcomes for HSS is confirmed by all substantiators.
- A change in narrative on HS influenced by Wemos was mentioned by two respondents. These concerned the shift of language from HRH as a cost to an HRH as an investment (28439/network partner), and the push for a more human rights-based performance-based financing (PBF) (28438/network partner).
- The relevance of the GFF for HSS was confirmed by all concerned.
  - 'Because by analysing, critiquing and informing the stakeholders on what GFF is about, you're definitely providing information and expertise on how GFF can do better in financing for health and improving health outcomes, thus strengthened health systems. (28440/network partner)
- In the Dutch context, Wemos's advocacy for improved global health facilities' policies and practices have a primary HS focus, and Amref and Wemos's focus on the global health cafes and advocacy for CHW inclusion in HS are all relevant for HS.

B. Relevance for SRHR

A direct focus on SRHR is observed by the Amref-led outcomes in the Dutch context, e.g. change in SRHR budget, and preparation for the statement on SRHR in the HLM UHC meeting and the ICHD+25. At the Dutch level, all substantiators agreed that the outcomes are relevant for SRHR.

C. Linkages between HSS and SRHR

Almost all outcomes that are regarded as relevant for HS are seen, at least potentially, as relevant for SRHR as well.

- Wemos says the following about the relevance of their work with CSO on the GFF: GFF is an important vehicle to increase funding for Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH-N) and to improve donor coordination and alignment around country-based investment cases. The GFF has committed to expanding resources for RMNCAH-N including SRHR, strengthening inclusiveness and coordination, promoting a focus on results, and taking a systems approach. By analysing the policies and guidelines of the GFF, and monitoring implementation of the GFF at country level together with country partners, like in the case of Malawi (an HSAP focus country), Wemos aims at ensuring that the GFF and its donors live up to their commitments and thereby improve SRHR outcomes.
- The evaluation shows the relevance of the GFF for SRHR, although the focus is on SRHR financing, which is highly dependent on the country governments. (See also hampering external environments for more about the GFF link with World Bank policies).

- ‘GFF is about enabling governments to use resources more efficiently to free up funds for HRH salaries. Performance-based indicators to address health worker salaries based on performance. This makes a link between HS, salaries and performance evaluations with SRHR indicators … The centre of the GFF and World Bank model is that it is a government-driven approach, the government is in the driver seat and determines the relevance of SRHR’ (28433/policy maker).

- The relevance of HSS for SRHR is argued by almost all (28570/network partner, 28438/network partner, 28442/policy maker, 28441/policy maker, 28434/CSO, 28433/network partner, 28432/CSO, 28436/CSO, 28439/network partner, 28398/policy maker, 28329/network partner, 30034/policy maker, 29802/policy maker, 29062/network partner) respondents and all three policy-support outcomes are seen as relevant for HSS and SRHR. However, the estimate of the relevance is tempered by the fact that most outcomes are a first step and that only a full-blown change would constitute a high relevance (28570/network partner)
- The relevance of HS for SRHR is based on the general argument that without a strong health system including sufficient HRH and HF, good quality SRH services are not possible (ref all of the above). A few examples are:
  - ‘access to a skilled health workforce is a key factor for both improving SRHR and strengthening health systems.’ (28570/network partner)
  - Governance influencing SRHR: ‘When we joined the GFF, the focus was not very much on SRHR. There was a concern that the funding to GFF would not go to SRHR … strengthened HS, strengthen SRHR’ (28398/policy maker).
- Various respondents, especially at country level, observed that ongoing monitoring and increased social accountability of government for improving SRHR is required. For example, CSOs observed that lobbying and advocacy is required to ensure that investments are actually benefitting SRHR.
  - ‘*fragmentation in aid, programs, policies, structures, and approach to address SRHR needs will [need to be] reduce[d] to realize outcomes especially in Women, Child and Adolescent health … don’t know yet if the results will have a big influence on SRHR’.* (28434/CSO)
  - *‘we did a social accountability survey looking at maternal and neonatal services that we then shared at district level. And with Amref at the national level together with results of the budget analysis we started advocating for more resources for RMNCH and HRH and now we are tracking if there are any changes.’* (28432/CSO)
- A clear explanation of the link between the control of infectious disease and the influence on SRHR was made by a respondent in relation to the discussion of lessons learned about the Ebola outbreak.
  - ‘*Although the session did not focus directly on SRHR, it is quite evident that weak health systems are weakened even more by shifting focus on scarce capacity to attending the outbreak…… in the longer term the impact on SRHR translates in a higher toll of lives lost in mothers and children than due to the outbreak itself.’* (28429/network partner)
- Only one respondent made a link between strengthening HS through strengthening SRHR. (28398/policy maker)
- One respondent commented on the hampering environment for HRH;
  - ‘*Many are working on governance and financing. Few are working on HRH and this is most critical*’. (28439/network partner)

D. Discussion and Conclusion for relevance

- The relevance of the outcomes at a global level for HSS is confirmed by all relevant respondents. The primary theme of the outcomes at a global level shows a major focus on health systems such as the code of practice for migration, the case studies on HRH and HF influencing GFF policies on HRH, the push for greater alignment in the Watch Global Action Plan (GAP), and the focus on accountability in governance through greater CSO involvement.
- In the Netherlands, context outcomes such as the Dutch policymakers using CoP recommendations for CSO engagement in the GFF and the Wemos case studies, the focus on increased alignment between global facilities and support for CHWs inclusion in HS and the organisation of global health cafes by Wemos and Amref are relevant for HS.
- All other activities in the Dutch context are focused on and relevant for SRHR, e.g. lobbying for budget increases for SRHR, preparation of ICPD+25 and UHC HLM.
- An important link, that is relevant for the contemporary Covid-19 epidemic, was made between infectious disease outbreaks and lack of preparedness for an epidemic in the Netherlands. This was highlighted in a global health café in 2018, when discussing the Ebola epidemic. A note was made about the need for more collaboration and learning between Dutch ministries.
- The evidence for the link between infectious disease outbreaks and SRHR emerges very clearly from the literature (lit ref)
- A critical note is the fact that most outcomes are initial steps. The question remains of how far the changes at a global level and country level have gone or will be implemented.
- The global strategies show little direct focus on SRHR. However, almost all respondents link HSS as a condition for improving SRHR. Unfortunately, improving HSS does not automatically mean SRHR improves (lit ref).

E. Recommendations (what can be done better)

- Ongoing monitoring and holding governments accountable for investing in SRH services is required to capitalise on the potential relevance of HSS for SRHR.
- The linkages between HS and SRHR can be made more explicit in the development of advocacy strategies and collaboration between partners.

4. Lessons learned on HSS&SRHR advocacy, gender and inclusivity, collaboration and governance, and visibility/legitimacy

A. Gender/inclusivity

- Gender and inclusivity has not been a major HSAP focus. In fact, only in the last year of the programme was extra attention given to this (inception report). In the Dutch context, Amref lobbying included a focus on adolescent SRHR and this can also be gleaned from their inviting Kenyan youth to' Women Deliver and their involvement in the ICPD+25 during preparations in the Netherlands and in countries. However, there is no evidence that an explicit gender analysis was included in the HSAP programming.
- Global advocacy strategies do not inlcude messages on gender and inclusivity. Gender and inclusivity is not only linked to access to services for the most vulnerable groups. This provides some insight in the attention given to decreasing discrimination and exclusion. One strategy

of country CSO advocates was referring to the need to include more vulnerable groups such as girls, people with a disability, LGBTQI and other marginalised groups and the push for the inclusion of adolescent SRHR in the GFF investment in countries (28434).

- Country governments are reluctant to address LGBTQI and the attention to people with disabilities and other marginalised groups is minimal in the HSAP programme. The most that can be said about it is that the focus depends on government and that more focus on the needs of these groups is required.

What can be done better

- 'We should have better policies on how services can reach these vulnerable populations.' (28434/CSO)

B. Collaboration

Complementarity and autonomy

- The complementarity of organisations is not well expressed in annual reports and reflection meetings where autonomy and lack of collaboration is often highlighted (Inception report).
- Eight respondents commented on the complementarity and autonomy of the HSAP programme. A consensus is that the HSAP organisations have their own focus and do not overlap. Wemos works more on HS, Amref on SRHR and CHWs and ACHEST on and CSO-contracted partners each have their own focus. Respondents substantiating various contextual outcomes have identified the complementarity between global and country actors, and within countries, although, this may have been the results of activities by various actors coming together rather than carefully planned collaboration. For example, repondents see Wemos's focus on HS and AMREF more on SRHR as complementary (28398/policy maker, 28429/network partner) and they saw Wemos and Amref working as a team in the Dutch context (28429/network partner).
- 'Partnerships worked. Multiple organisations have a distinct focus and are working in a complementary fashion on various networks providing a broader perspective. For example, ACHEST brought the Kenya Obstetrics and Gynaecologist Society. This was an important move to relate more to maternal health. HSAP's work directly with WHO is effective and brings several organisations working on HRH together' (28439/network partner).

Collaboration within the partnership linking local to global advocacy and vice versa.

- Some respondents identified the complementarity between Wemos and Amref as a link between a more global and country focus. (28398/policy maker). In practice, the effectiveness chapter shows the complementarity of the global and country advocacy in the various roles each organisations plays. Wemos informs countries, generates knowledge with CSOs in-country and Amref enables participation in CSO platforms, etc. (28432/CSO, 28434/CSO, 28436/CSO)
- 'The complementarity of Amref working at a country level and Wemos at global level is illustrated by the perception of a Dutch policymaker. *'The global discussion initiated by, amongst others, Wemos, about the inclusion of CHWs in HS (in Dublin) combined with the discussions and TA by Amref at country level helped defining regulations for inclusion of CHWs in HS. '*(28442/policy maker).

C. Visibility

- Two Dutch-based, three global-based and four country-based respondents agreed that the HSAP had contributed to a raised visibility of CSOs in various ways: 1) meeting organisation with policymakers at country and global levels, 2) sharing experiences between countries, 3) documentation of evidence in countries, and 4) increased ability to argue and show competence.
    - CSOs became more visible through the organisation of dialogue meetings between policymakers and CSOs. This was judged to be a very functional element of the programme. (28434/CSO)
    - Wemos and other CSOs' contributions led to a new perception of CSOs and showed the added value of CSO engagement. Now, four CSOs are members of the investment group and take part in the GFF meetings. (28433/policy maker)
    - *'HSAP helped to increase CSO visibility, especially across borders … discussions with partners from other countries through partnership meetings*.' (28432/contracted partner)
    - For example, in Women Deliver, youth organisations from Kenya were introduced during the World Café meeting. This brought organisations we did not know to the table and provided the space for them to explain who they are, what they do, and bring in their perspectives. (KII, network partner).
    - For example, the global health café on epidemic preparedness enabled civil society to work with WHO (28429/network partner).
    - The visibility of CSOs involved in the HW4All Coalition was at least sustained and possibly increased through greater involvement with global agencies such as WHO. (28570/network partner)
    - *'Country case studies and CSO engagement in countries increased visibility … We are more visible and recognized. The media knows us and consults us. The government knows we exist and respects us.'* (28436/CSO).
    - *'Capacities of CSO have increased to discuss global financing modalities and this was giving some increase in visibility.'* (G4CSO)
- Increased visibility and appreciation of the core partners can be deduced from the invitations they received to sit at the policy table and the appreciation of their contributions as reported under effectiveness.
    - *'There is a longstanding relationship with Wemos/ACHEST and I hope Wemos will stay involved in the review process. The follow up of the code process comes when the report is published. In the interim there is no major contact. The WHA will invite CSOs to the meeting.'* (28441/policy maker)
    - *'The presence of Amref in the meeting raised visibility of them as an NGO. I was surprised to hear that they were so active in the ICHD agenda. In the future, I see them more in the forefront.'* (29802)
- One respondent also noted that raising the visibility of core partners needs more attention.
    - *'The visibility of partners such as Amref, ACHEST, Wemos, they are more effective in their work than in raising their visibility.'* (28439)

D. Discussion and conclusions

Gender and inclusivity

Gender and inclusivity has not been a major focus of the HSAP. In fact, only in the last year of the programme was extra attention given to this (inception report). In the Dutch context, Amref lobbying includes a focus on adolescent SRHR. This can also be gleaned from their invitation of Kenyan youth to Women Deliver and their involvement in the ICPD+25 during preparations in the the Netherlands and in countries. However, there is no evidence that an explicit gender analysis was included in the programming.

Collaboration, complementarity and autonomy

- Within the HSAP programme, collaboration is more focused on autonomy in pursuing one's own issues and perspectives and little explicit joint planning in dialogue, although in the beginning, this was pursued (inception, interviews core partners).
- Amref and Wemos work well together in the Netherlands, but do not explicitly identify complementarity and connections between the themes they focus on. Partners and observers identified the linkages and complementarity, in particular, the link between Amref being more active at a country level and Wemos at a global level. Also, the diversity of each organisation's network adds multiple perspectives and enriches the collaboration.
- It appears that opportunities were missed to strengthen these potential linkages and complementarities.

Visibility

- Many respondents acknowledged a raised CSO visibility both in the Netherlands (although not everybody agreed to this) and at country and global levels.
- The ways in which visibility was increased included:
  - Meeting organisation with policymakers at country and global levels, 2) sharing experiences between countries, 3) documentation of evidence in countries, and 4) increased ability to argue and show competence.

5. Sustainability of programme results

- Sustainability has not been extensively discussed within the HSAP or with the donors. At the country and global levels, the lack of planning was acknowledged: *'We have not done much work on ensuring sustainability. For the current activities we need to find ways to sustain these at local and global level. Advocating for sufficient HRH and for RMNCH.'* (28434/CSO)
- *'The Coalition still needs to be consolidated, and there are improvements needed at all levels (governance, outreach and membership, output). This needs to be done by the Coalition itself, in a process led by the Secretariat, SC and members. Core condition is that there is a shared agreement and perspective that the Coalition can be sustained beyond the financing via HSAP.'* (28570/network partner)

A. Mechanisms in place to sustain advocacy outcomes: HSS, SRHR, and advocacy capacity

In the Netherlands, various mechanisms were identified that may contribute to the continuation of the advocacy activities of the core partners, Amref and Wemos. However, the collaboration between the core partners, as included in the consortium, will stop. At the time of writing this report, it was not clear if and how the focus of the programme on HSS will continue. Nor is it clear

how and what funding may be (potentially) available for each of the partners, e.g., in particular HAI and ACHEST who were not part of the global or Dutch contexts.

In the Dutch context, respondents thought that the Dutch Ministry would continue to fund the partnerships with a strong emphasis on advocacy and try to stop the shrinking of civil space as a priority for the partnerships. There are lots of opportunities to sustain that role. (29061/policy maker) To continue the focus on SRHR seems more secured than the focus on HSS. For example, Share-Net is funded for the next five years, women=men are funded as well as other groups that will form a basis for further advocacy for SRHR in the Netherlands (KII/network partner), providing essential resources for informal lobbying groups including staff capacity (29062/network partner).

The engagement of CSO in global health facilities is not yet completely clear, but work is being done to enable this (28442/policy maker).

Need for funding

Global platforms and organisations are clear that there is a need to continue since these are important mechanisms, but how these will be financed is not yet clear.

Suggested actions to increase sustainability

- Two respondents suggested to increase the membership of the HW4ALL platform with inclusion of the private sector and employers (28570, 28441) to increase their effectiveness.
- Another suggestion is to support CSO platforms to be able to meet regularly. The meetings to discuss the GFF require hiring a venue and that needs funding. Holding governments accountable requires travel and resources. We need to use our own meetings and build on them when we work with other programmes. Continue to monitor and give input.
- Mechanisms: Global forums provide a space for sharing and new ways to engage at a grassroots level. More opportunities are needed to share the experiences of a country at the global level, including WHO itself.

B. **Governance mechanisms to sustain CSO advocacy efforts**

The Hw4All Coalition platform and the GFF have both identified actions that need to be done to sustain CSO engagement.

C. **Discussion and Conclusions**

Sustainability has not been extensively discussed within the HSAP or with donors. The end of the programme led to the Dutch partners' hard work to form new coalitions and develop grant proposals for the next round. Very little time was left for the development and implementation of an exit strategy. At both the country and global levels, the lack of planning was acknowledged.

Various mechanisms were identified. In the Dutch context, partnership funding and secure five-year funding for Share-Net were identified as a basis for continued advocacy and lobbying. In addition, there was a perception that there was a commitment from the MoFA to continue to allocate resources for lobbying and advocacy, at least with a focus on SRHR.

The sustainability of advocacy with a focus on HS was less clear and still in discussion at the time the interviews were held.

Regional Context: African Region

1. **Capacity-strengthening efforts (of individual CSOs, CSO networks, communities, and media) done at a country context level**

A. **Strategy and focus**

- Strengthening African CSO voices on regional and global levels. *"I think this is critical, because the dialogue, particularly at the global level, has a very weak input from this particular region…."* (KII, contracted partner)
    - One example is the HSAP Uganda context team collaboration with youth-led and youth-serving CSOs in advocacy for the SRHR bill of the East African Commission, where they attended EAC meetings in Arusha and Nairobi to provide input as a youth voice.
- Diversifying and increasing CSO participation at regional and global levels. ACHEST and Wemos provided Global Health diplomacy training for CSOs.
- Building media capacity for HSS and SRHR at a regional level.
- Peer learning across countries in the African region, as done through building Zambian CSO capacity on advocacy for family planning (FP) in the National Health Insurance (NHI) package.

B. **What worked and did not work**

- Media capacity building has worked well; HSAP observed better reporting on SRHR and HSS issues in the HSAP countries. HSAP also worked towards sustainability of trained journalists through the development and establishment of the Journalism Health Course in the Amref International University.
- CSO capacity building on regional advocacy and decision-making processes has occurred, e.g. the Global Health Diplomacy training and support for youth organisations to attend EAC meetings. However, this evaluation did not find systematic CSO engagement in regional advocacy.
- Meaningfully engaged capacity strengthening in regional advocacy was appreciated, as expressed by one receiver (32911/CSO).

C. **Supporting and hampering factors**

- African CSOs' capacity to meaningfully engage in regional and global platforms and decision-making processes remains a challenge. As one contracted partner puts it, "*As much as we are advocating for more African voices at regional and global level[s], the capacity gap still haunts African CSOs. So, it's also an issue that needs to be addressed, that we have strong voices, we have people who are capable about relating issues both at regional and global level. Because this is one of the gaps that still exists. Advocacy capacity, but also the capacity to circulate issues*." This was underscored by one substantiator. (32903/networking partner)

D. **Conclusion/Reflection**

- Systematic capacity building of country-level CSOs to meaningfully engage in regional and global advocacy as a strategy to amplify their national advocacy has lagged behind in the HSAP.
- Although in some cases, peer learning across HSAP countries took place (for CHWs and Zambian NHI), this seemed not to have been an HSAP focus or priority.

2. The effectiveness of the advocacy approaches

In total, 24 outcomes were harvested by the alliance for the regional context, and 6 (25%) were substantiated during this evaluation.

A. Actual changes (outcomes)

Type of change (refer to Annex 10: HSAP outcomes substantiation)

- Two outcomes described changes in **policymaker support** for HRH, SRH commodities, health financing and governance. (32911/CSO and 32900/networking partner).
- One outcome described changes in advocacy linkages between national, regional, global and Dutch policymakers. (32731/networking partner)
- Two outcomes described changes in CSO and HSAP involvement in policymaking and implementation processes. (32907/networking partner and 32910/networking partner)
- One outcome described changes in the development of effective evidence-based messages taken up by like-minded networks and organisations. (32903/networking partner)

Roles and contribution of external factors/actors in achieving advocacy outcomes

- For regional-level advocacy, policy and legal structures in Africa, e.g., the legally binding Maputo Protocol and other peer-review mechanisms, were considered as **enabling**. Despite these structures, accountability was weak. (KII external and Regional Reflection FGD report 2016)
- Regional intergovernmental bodies, e.g., SADC and EAC, were not aware of the African-level policies and laws, and were not included by the African Union (AU) or civil society, which was a **hampering** factor. For the Maputo Protocol and Plan of Action, the AU goes directly to governments at a national level, thus losing the role regional bodies can have. (KII external)
- For the inclusion of FP in Zambia's NHI benefit package (32900/networking partner), the substantiator explained that the environment was **enabling**: "*Strengthening of new and existing spaces for dialogue. Policy development and political will. Political commitment*", and Amref thought this was enabling because there was collaboration among various actors (PAI, Zambia CSOs & MoH, CHAZ, AHAP, AMNH). "*Opposition politicians were disabled through delaying the actualization of the Bill. Factors- Presidential assent of the Bill*."
- For the African Health Journal, a platform for knowledge sharing on health services delivery, (32907/networking partner), ACHEST indicated there were **enabling** factors, including article contributions. The journal is a digital platform, and enables actors like the public and private sectors and academic professional bodies to have a voice. The substantiator mentioned publication costs were a **hampering** factor.
- Both Amref and the substantiator felt the environment was **enabling** for the development of the course (32903/networking partner), and the Association of Medical Councils of Africa (AMCOA) accepting responsibility to administer a member survey to collect recent and accurate information for tracking Health Worker Migration (HWM) (32910/networking partner). For the latter, the substantiator from the Kenya Medical Practitioners and Dentists Council, referred to Amref's support as strongly **enabling**.
- For 32731, both Amref and the substantiator agreed that the environment was **enabling**. Amref mentioned enabling actors including legal experts and consultants, members of Parliament in EALA, CSO's, MoH's SADC, ACHEST, WHO AFRO, and WHO. The substantiator gave a nuanced explanation, "*In Kenya, you can clearly see increased budget allocation. In Malawi and Tanzania CHWs are already remunerated. What worked for HSAP is having a good*

network with the policy makers. They way HSAP is structured allows to work with communities AND government. They work with policy makers and hold them to account at the same time." She also explained the **enabling** and **hampering** factors.

- Regional advocacy involves costs, mainly for advocate travel, but also for convening government delegations.
- Some aspects of the SRHR agenda are sensitive in the African regional context. Governments have various perceptions and levels of SRHR implementation and this creates a challenging dynamic when they assemble at a regional level. At regional assemblies, dynamics such as language, culture, economic status and political alliances come into play, which **hamper** unification.
- HSAP was confronted with a misrepresentation of issues and voices by government delegations at a regional level, since the delegation did not have adequate capacity to speak to HSS and SRHR. Government official turnover is high, which could also result in a disconnect between what has been agreed upon at a regional level and what is being represented at a global level. Therefore, CSO participation is important to safeguard consistencies between national, regional and global issues and agreements.
- Regional network functioning is dependent on funding and the motivation of members who join on a voluntary basis. One could look at formalizing these networks so they could attract funding and a secretariat, but this would have administrative implications. (external expert)
- A contributing factor has been donor's flexibility in this partnership. HSAP partners were able to respond to gaps and opportunities during implementation. (contracted partner)
- An **enabling** factor has been government entry points at the global level, where it can be easier to gain access compared to the national level (contracted partner)
- In general, the AU and regional bodies are interested in working with HSAP. However, involving them requires funding (they often expect HSAP to sponsor meetings, travel and per diems).[5]

Best practices and advocacy process setbacks

- Advocacy for the EAC SRHR Bill was a good example of linking the national and regional levels and working with CSOs and networks to amplify voices. HSAP's approach was built around strengthening CSO capacity at a national level to engage in regional discussions through existing structures (the RMNACH youth coalition in Uganda set up by HSAP), linking up with other regional networks (EANNASO), and the relationships established with EALA members. Advocacy messages were developed in the annual Uganda Stakeholders Dialogue organised by PEERU and also attended by government. The issues discussed at the Uganda Stakeholders Dialogue were incorporated in the East African Audit on SRHR, and EANNASO invited young people to develop a position paper for presentation to the EAC. In turn, PEERU shared the audit and draft position paper with Ugandan CSOs, who provided input. PEERU then presented the paper to the EAC in Arusha (32911). Although the bill has not yet passed, the advocacy process showed good practices.
- Although relationships were built and there were good results, penetration of regional bodies by HSAP was slow; it was a learning process. Relationships had to be built from scratch, or advocacy directed to these bodies lacked a joint strategy. In other cases, HSAP had to build relationships with other CSOs with entry to these bodies. This was one reason to create the Africa Health Accountability Platform (AHAP). (KII, 2 contracted partners)
- One respondent felt that HSAP had ambitions that were too high for their regional work, with the risk that initiatives die. One piece of advice was to build from the national level and then

[5] Regional Reflection FGD report 2016

to the regional level, especially in regard to the regional networks they had established. (external expert)

- One contracted partner reflected, "*As unprecedented results of this partnership, it created a lot of expectations from government. It is a big problem. Because the moment you to step in and want to help with a policy they want to work with you as a partner. Sometimes they are there to chair meetings but you are running the agenda. Occasionally you may not have all the money that you need to do what you want to do, you bring other CSOs who may support and sometimes may not. There are a lot of things still running with a lot of expectations that we will support it. Because we started the agenda. There are no final results, because everything leads to another. One activity leads to more expectations. So yes, it created credibility and more expectations that we may not be able to fully meet*."
- For the CHW Model Legislation, HSAP drew from the WHO CHW Guidelines and Amref toolkits. The substantiator praised HSAP's work around CHWs: "*Without HSAP it would not have been a big issue*." CHW recognition was widely accepted by the national governments in the region, but renumeration was a bottleneck. Apart from financial constraints, the model legislation was not clear on the implications of renumeration and a gender dimension was missing. According to the substantiator, if CHWs were remunerated, more men would be interested in becoming a CHW. "*So, how do you deal with the women who are willing to volunteer, but may not have the minimum education? Do you focus mainly on qualified people? Or the embeddedness in the communities and the communities believing them? Is a volunteer better?*" (32731/networking partner)
- HSAP's advocacy for the development and dissemination of the Health Worker Migration (HWM) protocol also resulted in AMCOA's members thinking through their respective legal frameworks for how other cadres of health workers are brought on board, since they also suffer from the effects of migration. (32910)
- The success of FP being included in the Zambian NHI was attributed to the diverse voices in Zambia advocating for it. Expertise and learning from other countries came through HSAP. This technical expertise opened doors at the MoH in Zambia. (32900)
- The Health Journalism Course is now launched at the Amref International University, which reflects HSAP's core messages.

Missed advocacy opportunities / lessons learned

- A lesson learned for HSAP was to find ways to navigate the regional political context, which is different from country contexts.
- There have been notable achievements at the regional level. However, advocacy results seem to be isolated from each other. Furthermore, HSAP's link to national advocacy is not clear.
- The extent to which HSAP advocated for SRHCs at regional levels was unclear from the harvested outcomes and evaluation.

B. **Advocacy approaches and strategy HSAP partners**

Advocacy strategy and focus

- A key HSAP approach has been helping bring evidence from a national level to discussions at a regional level, where governments may experience peer pressure. HSAP helped to identify commonalities and differences between countries, gaps and best practices. This was true for issues of CHWs, HWM, and progress on the implementation of the Maputo Plan of Action and SRHR, (the latter in the context of the EAC SRHR bill).
- A key HSAP advocacy approach has been bringing technical input and an agenda of "choice" to policymakers gathered at a regional level and to listen to dissenting voices. This is illustrated

by one Contracted Partner: "*I would say, although I would not have regional evidence on this, that the conflict in SRH has largely been around 1) access by youth and adolescents to family planning and 2) sex education and 3) rights to choose a sexual orientation among youth and adolescents. And we have advised them [governments] that this is a matter of learning and therefore, we have pushed very hard for them to begin to think about how to influence these groups of people about their sexual rights through better sex education programs. And these countries have now developed sex education guidelines. We cannot say that it is because of us, but the conflict was resolved. You don't have to have a law against gay rights or what. If people are better enlightened, they make better choices. And I think the discussion from this position has gone much further than merely discussing subgroups of people. But this has been our position, and our position with this particular bill is going forward by looking at how we can get a better-informed society for choices. Rather than forcing them to give rights to this one or the other one, but to put leaders in a position that they recognize everybody to make their own choices*." (KII, contracted partner)

- Seats in technical committees are another approach, such as HSAP partners participating in the CSO technical committees for the East African Community SRHR bill. The EALA invited CSOs to a briefing on the most contentious issues, e.g., surrogacy and LGBT. Amref and ACHEST approached the Assembly with specific meanings of certain concepts, "*telling them that they are not so contentious in fact*". (KII, contracted partner)
- Another strategy has been to strengthen African voices in regional and global advocacy processes: bringing national voices to these platforms and bringing regional and global commitments to the countries for national action. ACHEST engaged in creating the Geneva Health Hub (or G2H2) as a structure for CSO participation in Geneva processes, even if the CSOs don't have a physical presence there. One contracted partner observed that apart from Amref and ACHEST, there was no African presence in G2H2. The network is not yet as strong as they would have liked it to be. (KII contracted partner)
- Peer learning throughout the region has been another approach, e.g., FP advocacy in the Zambian NHI package. Amref HQ shared technical expertise on advocacy for FP inclusion in national health benefits from Kenya and other countries with Zambian civil society.
- Collaborating with multiple CSO networks at various levels was another key advocacy approach for the regional context team. By working with a diverse set of CSOs with expertise on HSS and SRHR, and specific groups, e.g., key populations and youth, HSAP partners were able to join broad health and SRHR forces and influence regional platforms and decision-making processes. This also diversified voices at the regional level: AIDS organisations used to be dominant in those spaces and are now joined by CSO voices calling for FP, youth SRHR and women's rights. This has changed how CSOs collaborate at a regional level. (KII contracted partner)
- Amref initiated two regional networks—AHAP and the media network—in which their role was described as "catalytic" (KII external). AHAP is an accountability platform for partners working at regional and country levels to strengthen accountability in health. Convening national CSOs at the regional level is expensive and cumbersome, which led to the initiative to launch a CSO network at a regional level with national chapters. AHAP focuses on community engagement, CHWs, and health finance and holds countries accountable for allocating and spending funds. Members are health and SRHR organisations with specific thematic expertise. According to an AHAP partner, *"There is no other platform nationally, or regionally that brings together a diverse set of organizations. It gives entry areas that we were not involved in, for example, in budget discussions, in engaging at system level, …. there we can achieve sustainable systematic*

impact. AHAP is a very useful platform." (KII external) AHAP has influenced and worked with medical council associations, and various agendas and initiatives such as Advance Family Planning. For Kenya, AHAP selected health financing as their contracted advocacy topic. They successfully advocated for SRHC in the Kenyan benefits package, which now includes safe abortion commodities (KII external).

What worked well and less well

- HSAP brings evidence-based advocacy and technical expertise to decision-making tables.
- HSAP strengthened diverse CSO voices, built their capacity and supported them to participate in regional decision-making meetings. However, this approach is not institutionalized or systemic.
- According to an AHAP partner, the network stagnated. He/she felt that Amref had been over ambitious with this network. "*They could have first built local chapters, then gone regional*." (KII external
- AHAP convenes health and SRHR organisations at national and regional levels. Organisations do not advocate for each other's key issues to amplify messages. However, according to an AHAP member, the network "*gives you entry in spaces where you have not been before. Amref has a very strong chair and voice, strong legitimacy. Especially in the UHC discussions. They invite us to conferences and decision-making processes, they let us speak, they don't gag us*." (KII external)
- The CHW strategy was considered to be a success for connecting linkages. Simultaneous advocacy occurred at a global level for the WHO guidelines and a national level for governments to recognise CHWs. At a regional level, HSAP engaged with AU and other partners on the same topic, with buy-in from EALA, SADC and ECSA on the Model Legislation on CHWs. In Malawi, the CHW association was established. According to Amref, the association was replicated in Zambia due to regional learning and linkages.
- A similar strategy was applied to HWM, national level studies, advocacy towards governments to collect data on HWM, and a regional level AMCOA survey for member states to track HWM. Wemos, Amref and ACHEST raised the HWM issue at the WHA.

Contributing and/or hampering factors in applying advocacy approaches/strategies

- One of the major identified challenges was the representation of a diverse set of CSOs and youth voices at the regional (and global) level in decision-making processes. This was especially true for trying to bring HSS and SRHR to the table, since it affects people in very distinct ways.
- The issue of accreditation at global and regional meetings is considered to be a challenge in relation to bringing national African voices to these meetings. ACHEST for example, does not have an official affiliation with WHO. For each regional WHO meeting they are invited, but they need to be accredited each time. At the East African Assembly, there is only one seat representing civil society. This situation hampers meaningful participation of a variety of (East) African CSOs working for HSS and SRHR. (KII contracted partner)

Missed opportunities / lessons learned in relation to advocacy strategy

- One contracted partner reflected that although relationships had been built in the course of this programme, influence at the AU and EAC had not been optimal. The programme structure was seen as a hampering factor to further penetrating these bodies.
- HSAP had not thought through how to engage with regional bodies by linking with national and global advocacy.

C. **Conclusion / Reflection**

- The regional networks created by HSAP—AHAP and media network—seemed promising, but this evaluation did not find clear follow-up network achievements or how they connected to national-level advocacy.
- Although there had been critical thinking about strengthening CSOs and youth voices at a regional level for better accountability, there was no strategy to do so.
- HSAP lacked a regional-level an advocacy strategy for expected achievements, where to put the eggs in the basket, and how to amplify national advocacy and manage government and other stakeholder expectations.

3. Relevance towards health system strengthening and SRHR

- All substantiators, Amref and ACHEST agreed that the outcomes were relevant for SRHR, although the degree varied somewhat. The relevance for HSS was unanimous—all agreed that the outcomes were highly relevant for HSS.

A. **Relevance towards health system strengthening**

- East African countries were at various levels of engagement for CHW recognition. Legislation is to be adapted at a national level, however creating the Model Legislation at an East African level was considered to be helpful for pushing domestic legislation.
- AMCOA's protocol/survey on health worker migration contributed to better data on this issue, and identified gaps in the health system. The survey was expanded from a focus solely on doctors to include other health workers.
- Through Amref International University's Journalism Health Course, students were informed about all health system building blocks and system thinking (unit 2 of the curriculum). As the substantiator put it, "*Health systems in Africa are very weak. Weakness is in each building blocks, leadership and governance, HRH, health information, financing, [and] those kind[s] of blocks. They are weak. Under health systems and research, we felt there is a strong need to strengthen that pillar through this course. In the region, health reporting has always been distorted. Journalists start reporting sensitive matters on health even COVID-19, they do a lot of exaggeration without research and data evidence. They end up scaring even the governments arm, and those working in HRH. Adequate reporting requires skills. This kind of training health communication and journalism is more appropriate. Most university that are teaching journalism, they don't have a module on health communication, which is very critical. So that journalists can communicate adequately, sensitizing data, not just having raw data. Also reporting needed without bias. Sometimes there is a bias to one certain agenda to amplify the situation. Some journalists want certain agendas funded. And most journalists focus on the negative. We would like to see journalists who are trained, who can also report on the positive aspects*." (32903/networking partner)
- The African Health Journal now reports on health service delivery. It is widely read by African health workers and policy makers.

B. **Relevance towards SRHR**

- In the process of influencing the East African Community SRHR bill, the Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO), an ACHEST partner, did a legal

and policy audit on SRHR within the East African community. This audit revealed how well (or less well) countries are fulfilling SRHR.

- Through Amref International University's Journalism Health Course, students are informed about SRHR (unit 6 of the curriculum), bioethics and health laws (unit 7). (32903/networking partner)
- The inclusion of FP in the Zambian NHI package is relevant for SRHR as the substantiator noted, "*Improved women reproductive health interventions, such as contraceptives, ensuring universal access to sexual and reproductive health care services, reducing unmet need for family planning, increasing the number of skilled deliveries, and assuring that every clinic has essential medicines available that can save the lives of mothers and children*." (32900/networking partner)

C. **Conclusion / Reflection**

All outcomes are relevant for SRHR and/or HSS. However, regional advocacy is supposedly supporting national-level advocacy and outcomes. Therefore, the direct impact on HSS and SRHR is less evident (with the exception of the FP outcome in the Zambian NHI package).

4. Lessons learned on HSS&SRHR advocacy, gender and inclusivity, collaboration and governance, visibility/legitimacy, promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS

A. Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS

- One contracted partner reflected that at a regional level, governments are still adapting to the SDG framework, which places more emphasis on the demand side of health compared to the MDGs, which were focused on the supply side. He argued that HSS is a supply-side concept that meets the demand-side SRHR goals and conceptually, governments are still becoming used to this reframing.
- One contracted partner stated that HSAP has examined how HSS and SRHR interrelate, e.g. for CHWs contracted at a community level who provide information on SRHR. The partner did conclude that HSAP has not scientifically investigated how these connections have led to results.
- One respondent reflected, "…*they [Amref] took too long to get to SRHR. They did maternal health. Rights based perspective was not that strong, still it is not that strong. They are not a rights-focused organization yet. You can be a technical partner while you hold governments accountable. They need to use the African presence to put pressure on governments. They do not do enough on that. They are project driven. They are getting there; they jump on it*." (KII external)

B. Gender/inclusivity

- The advocacy work around CHWs was considered to be very relevant for woman and girls since CHWs are often entry points for this population to receive SRHR information, especially when there are legal/policy/social restrictions on FP and sex education. (32731/networking partner)
- Health worker migration was considered to be affecting women since they either stay behind or have to leave their homes to travel with their spouses.
- The content of the Journalist Health Course is gender sensitive and the substantiator (32903/networking partner) believed the course would change the landscape for health

reporting and ensure social determinants of health, including gender dimensions[6] are included.

- The inclusion of FP in the Zambian NHI benefits package was considered to be very relevant for women and girls by both the substantiator and HSAP, since FP access will improve. The substantiator indicated that as far as he was aware, HSAP did not give specific attention to key populations or adolescents. However, he explained that the advocacy objective was to have a major outcome on FP in the benefits package and the Zambian government has special policies for adolescents and women with disabilities to have access to contraceptives without being a member of the health insurance scheme.
- One of the contracted partners admitted that they don't specifically target key populations, but do collaborate with CSOs that represent these groups and they advocate together, e.g., for the EALA SRHR Bill.
- One of the substantiators indicated that the needs and rights of LGBTI was a taboo area in HSAP and no specific actions were taken to target them given the criminalization of LGBT in most countries. (32731/networking partner)
- Other marginalized groups, such as people with disabilities, had not been targeted or specifically considered. The substantiator spoke to the HWM survey, and envisioned the inclusion of people with disabilities in the next review of the protocol.
- Contracted partners admitted that gender and inclusivity were not part and parcel of HSAP's programming at the beginning. After the MTR, a consultant from Kenya was hired to give guidance to the partnership on how to integrate gender in all activities. The consultant encountered various understandings of gender among HSAP partners and questions on the need to have a thorough analysis of gender dimensions since it was believed that universal access to services benefits everyone. HSAP was challenged on how to integrate gender in programming and reporting. However, contracted partners indicated that the situation improved after consultant's intervention. There are now gender disaggregated indicators and a special column in the reporting format. Guiding questions for gender analysis in specific interventions were developed. The extent to which HSAP focused more on inclusivity and participation looking at marginalization and inter-sectionalities is unknown.
- HSAP consortium partners concluded that gender and inclusivity were missed opportunities in HSAP since work started very late in the programme for this effort.
- One of the contracted partners reflected that at the national and regional levels, in general, there was little understanding among CSOs and governments about gender beyond the biological meaning, i.e., the social construct of gender, and suggested that much can be learned from the good discussions on this topic at a global level.

C. Collaboration and governance

- There were examples of collaboration among HSAP partners to amplify regional advocacy efforts. ACHEST and Amref invited each other to meetings and viewed each other as complementary organisations. Occasionally, collaboration was sought with Wemos for a connection with the global level. However, these collaborations appeared to be ad hoc and not part of a HSAP strategy for regional advocacy.
- One consortium partner felt that the penholder had the most power in this partnership in terms of budget and decision making. However, another contracted partner felt that power

[6] Model Curricula for Health Communication and journalism: a certificate in health reporting, Amref Health Africa 2019.

was evenly distributed among partners, which delayed decision making and efficiency and would have liked to have seen the lead agency given more of a mandate to make decisions.

- A contracted partner stated that some in HSAP felt that joint strategizing and planning was a requirement of the Dutch Ministry of Foreign Affairs and saw the benefits and need a bit later in the programme. Initially, there was a tendency for organisations to act independently. Opportunities for collaboration were missed at the start of the programme.
- Both contracted partners indicated that the partnership agreement could have been clearer in terms of role descriptions. Governance beyond the management group should have been described, thus enhancing collaborations and joint strategizing and planning. Scopes of work should have been better described to avoid competition and work duplication. Coming together as a partnership was not easy in the beginning. But as one contracted partner commented, "*in the end we learned to appreciate each other where we add value and we let others do what they did best*".
- A contracted partner indicated that this partnership model was new to them and they had learned a great deal.
- One contracted partner reflected that resource allocation among partners needed more strategic thinking. In the African Region context, both Amref and ACHEST invested their resources and each brought (youth) organisations along to regional and advocacy fora. HSAP, as a partnership, did not strategically think about how they could ensure youth and African voices would be heard at those levels by putting in place or advocating for institutional structures that would allow their participation. However, this was a learning experience, and HSAP is now creating alliances with Southern CSOs "*so that we move with a stronger voice rather than individually*".

Complementarity

- Contracted partners have indicated that the complementarity of the various organisations has been an added value. "*Diversity helps to achieve wider results*" (KII contracted partner). This goes for both ACHEST and Amref working at a regional level, and Wemos, which was acknowledged for opening doors at the global level.
- Some HSAP partners did not work at a regional level, although they had the necessary expertise on certain topics (e.g., SRHC, which is HAI/HEPS/AtM/MedRap's expertise), resulting in some issues not being properly reflected at a regional or global level. (KII contracted partner)

Collaboration within the partnership linking local to global advocacy

- Joint participation at global meetings, e.g., the session of the UN Commission on Population and Development, was considered to be fruitful in terms of learning and reaching out to governments. (KII contracted partner)
- It was remarked that coordination was lacking at a global level to integrate regional and national voices and advocacy. This was seen as an opportunity missed for amplifying voices and obtaining advocacy results at all levels. (KII contracted partner)

D. Visibility

- One of the substantiators explained that CSO visibility has increased, particularly for his/her organisation. (32911/networking partner)
- For the journalism course (32903/networking partner) the substantiator explained that the course was not meant to target CSOs, so CSOs were no more visible than before.

- For outcome 32731, networking partner, the substantiator, the gender and advocacy expert, indicated that CSOs are no more visible than before.
- Contracted partners reflected that through HSAP they had engaged in regional bodies and opportunities where they had not been able to do so before, for example, Amref and the AU. Relationships have been established and improved with the AU, EALA, ECSA, SADC, and the East, Central and Southern African health communities.

E. Conclusion / Reflection

- HSAP has not developed a strong narrative on HSS/SRHR. Conceptual thinking about this could help them realise SDGs. External partners felt that the HSAP focused more on SRH and less on rights.
- Consortium partners all agreed that there were missed opportunities due to HSAP's gender blindness in the beginning of the programme. More expertise is needed on gender as a social construct.
- HSAP's advocacy did not specifically target key populations or marginalised groups.
- There were divergent views on HSAP's decision-making model. One consortium partner considered that power was distributed unevenly within the partnership, while another consortium partner felt that the consensus model slowed down decision making. All agreed that the partnership agreement should have better described the various roles of each partner.
- Partners complemented each other, but more could have been done to amplify each other's work. There were challenges in joint strategizing and budgeting.
- Coordination could have been better between the national – regional – global levels, and for taking forward all HSAP themes at the various levels.
- Contracted partner visibility increased at a regional level. National CSO visibility improved as well when HSAP enabled them to participate in regional meetings.

5. Sustainability of programme results

A. Mechanisms in place to sustain the advocacy outcomes: HSS, SRHR, and advocacy capacity

- With the acceptance of the curriculum for Amref International University' health course, sustainability of journalist training on SRHR and HSS was ensured.

B. Governance mechanisms to sustain CSO advocacy efforts

- One contracted partner saw AHAP as a network that could continue its work beyond HSAP, but revamping the network would be a challenge since it depends on HSAP's funding (KII external)
- Contracted partners believed that their involvement in various networks enabled new opportunities.
- Contracted partners emphasized that they had collaborated before HSAP, and they believed they would continue to do so.
- One expert stated that with capacity building, one contributes to sustainability, "*knowledge remains*".

Country Context: Kenya

1. Capacity strengthening efforts (of individual CSOs, CSO networks, communities, and media) done at a country-context level

A. **Strategy and focus**

- Capacity-strengthening efforts focused on establishing and strengthening networks of CSOs, media and youth (youth parliaments). Members of the youth parliaments and media networks, are sometimes also members of other CSO networks. CSO networks are trained in utilizing evidence and effectively engage with the county's policy bearers and actively participate in public accountability forums on SRHR issues. CSOs have opportunities for engaging in joint advocacy, which often means that they have a stronger, common voice than if they engage in policy debates as individual organisations.

- Since 2018, (when they received a sub-grant), HENNET CSO has been implementing context-specific advocacy activities. HSAP had discovered earlier that training was not always adequate if CSOs did not have access to funds for advocacy.

- Many CSOs, or CBOs, in those networks also receive funding from other sources/funders/partners.

- Media, youth, and ministry officials were trained in leadership and governance. The goal was inter-sectoral synergies, e.g., setting up inter-sectorial committees (like in Kajiado—focus on improving sexual and reproductive health rights (SRHR) outcomes).

- MeTA's research helped to strengthen capacity by providing evidence-based information to allow CSOs to advocate for better policies.

- Type of CSOs: AtMP supports CSO networks including CSOs working on sexual and reproductive health, gender-based violence (GBV), women's empowerment programs, youth and adolescent networks, youth parliaments, and media. ACHEST in Kajiado included local CSOs in a network that empowers local women economically and engages men to address female genital mutilation (FGM), GBV and child marriage.

- The Ugunja Youth Parliament (UYP): a model platform for youth advocacy in Kenya, was founded in 2009, in Ugunja sub-county (Siaya County), in western Kenya. This was in response to the high prevalence rates of sexually transmitted infections and HIV/AIDSrelated deaths among youth and adolescents. Amref enhanced UYP's capacity with training on policy advocacy, social accountability, outcome harvesting (OH) and meaningful youth engagement with policy makers, legislators, and other youth parliaments to create an accountable society. This enabled UYP to narrow the gap between the community and elected leaders and allowed them to replicate the model within the county and promote an enhanced budget allocation for SRHR, youth-friendly services and development activities.

- Fourteen stories were about empowered communities being increasingly able to demand their rights. These CSOs indicated that the Youth Parliament trained them on community budget and policy cycles, and reported improved participation in local policy processes.

B. **What worked and did not work**

- An integral approach through network building worked well: this ensured that each CSO network still exercised their own 'rules/policies' for collaboration, CSO training,

accompaniment when contacting advocacy targets, and research to ensure advocacy was evidence-based. This not only strengthened the various CSO networks, but also indirectly strengthened the individual CSOs.

- The majority of the storytellers (50 out of 57) indicated they had participated in HSAP capacity-strengthening efforts to increase their lobbying/advocacy skills. They indicated that the efforts of the HSAP were the primary reason their capacity had increased.
- Storytellers mentioned the following Amref trainings were successful: smart advocacy, OH and SRHR and HSS in general. They shared that their knowledge and understanding of concepts such as social accountability, score cards, budget cycles, budget advocacy, public participation, and recognition of the difference between activism and advocacy had improved. They had learned to identify who to target (allies, messengers, staff and decision-makers), package their advocacy message, approach stakeholders and decision makers with fitting arguments, use and collect data as evidence for advocacy, create advocacy strategies and prioritise efforts, link key people, report on health issues and solution journalism and get it published, involve communities and use public participation, conduct clear communication and successful follow-up, and write policy briefs.
- Some storytellers shared about strengthened capacity that had not come directly from training, e.g., facilitating focus group discussions, attending meetings and community dialogues, and exchanges with various countries and other participants during trainings.
- Stories about how the capacity-strengthening of HSAP strengthened capacity of their own CSO:
  - Network member of AtMP Lake Region Network for SRH and Youth Parliament mentioned how the network has since been able to conduct social audits of health facilities on service delivery and resource allocation, due to budget advocacy training.
  - One CSO found additional funding through the use of evidence collected in the HSAP programme: “Out of the research by MeTA on Commodity access and availability in 2018, we used the data and the recommendations of the research to develop a concept note on a Sexual Reproductive Health Financing project that was funded by another funder for a period on six months and currently they have added the organization another funding for the next 1.5 years.”
  - One story about how the CSO is now able to conduct research on a return to school policy.
- The partnership came together on several occasions to simultaneously train large groups of CSOs from various locations, which proved to be efficient.
- Accompaniment by the HSA Partnership of CSO networks in doing advocacy at the county level has been effective: making connections with local county policymakers and encouraging the policy participation process to become meaningful from both sides: the CSOs and policymakers.

C. **Supporting and hampering factors**

- Enabling: CSOs supported each other through this networking approach; they included several types of organisations to ensure diverse groups of beneficiaries were represented.
- Hampering: one core partner explained that in one county, they had a large group of CSOs until a gag rule policy was implemented, which affected the funding of multiple CSOs. New CSOs joined the network, but this required additional HSAP training.

- Hampering: The Kenyan government began registering CSOs; one core partner explained that their CSO did not meet the government's standards and so they were deregistered. This happened to a few of the CSOs collaborating with HSAP.

D. **Conclusion/Reflection**

- The CSO Network and HSAP partnership networking approach worked well, which resulted in strengthening capacities, joint ownership, speaking with one voice, helping each other, effectively using research, and obtaining access to other sources of funding.
- Even though the influence of HSAP on the community-level work is indirect, since often CSOs continue implementing the activities according to their own mission. The capacity strengthening the CSOs received, did have a positive effect on the quality of their activities at community level.
- Youth parliaments, as one of the network models, function at a sub-county level and are closer to communities.

2. The effectiveness of the advocacy approaches

In total, 59 outcomes were harvested in Kenya by the HSA Partnership, and 17 (28%) were verified during this evaluation. 10 outcomes were substantiated by external stakeholders, out of which 9 indeed verified the outcome, and 8 were validated by the Case Study [footnote]. All 59 outcomes were achieved in 2018 and 2019. Since core partners received training on OH in 2017 and 2018, they harvested outcomes annually.

A. **Actual changes (outcomes)**

Type of change (refer to Annex 10: HSAP outcomes substantiation)

- 7 (12%) of the outcomes describe increased lobbying and advocacy capacity or actions. These regard changes of individual CSOs as well as networks.
  - 3 of the above outcomes described network/alliance formation and functioning: 1) [K6] indigenous CSOs and CBOs in Kajiado County formed an inter-ministerial CSO network named Kajiado Social Trans-formative Network (KASTNET); 2) 8 trained members formed "The AtMP Lake Basin CSO Alliance on SRHR" and co-opted other members to form a coalition of 24 CSOs (32729); 3) [32680] The AtMP Lake Basin CSO Alliance on SRHR adopted a monthly subscription for its members.
- Eight changes (14%) described **stakeholder increased attention**. Seven of those were about the media directing increased attention to HSS and/or SRHR. One change was Amref Health Africa's network formation: the AMNH Lower Eastern Chapter (20 media houses) was formed in September 2018, as well as the Nyanza chapter and the media house health desks. This resulted in improved coordination between health journalists and the county government and increased coverage on health issues in the region.
- Out of the 57 stories, 7 were shared by journalists (members of an Amref established media network). One journalist shared: *"I did a lot of stories after my involvement with the Health Systems Advocacy. The stories had an impact in the society and pushed Kenyan authorities to address the issues. One of the key stories I did was an article on Kisumu's ghost hospitals which highlighted on how health workers had deserted their facilities during the several months of strike. The article piled pressure on the County government to resolve the issue. Another story*

was on child prostitution which focused on how young girls were being exposed to the HIV virus by adults who were sexually exploiting them. The story pushed authorities to raid the sex dens and arrested several suspects while health activists also moved to rescue some of the girls with one of the organizations, also offering free HIV services to the girls."

- 5 (8%) **Increased engagement of multiple stakeholders'** outcomes were harvested. This was also shared by 4 storytellers, who shared stories about stakeholders such as health worker unions, youth, and county departments and committees, multi-sectoral committees and technical working groups.
- 11 (19%) outcomes regard **Improved support of policy makers**.
- The largest category is **Improved policies and/or budgets adopted by policy makers**, which includes 25 (42%) outcomes.
- 7 outcomes were harvested at a **national level**, out of which 3 are Improved policies adopted by the Ministry of Health (MoH), namely the launch of national Human Resources for Health and Health Infrastructure Norms and Standards to guide enumeration and renumeration in the health sector; the development of a national sustainable financing policy model for Community Health Workers (CHWs) that influenced the mobilization of resources from the national and county levels; and, the development of a Primary Health care policy guideline 2019/2023 for the implementation of Universal Health Coverage (UHC) in the country and the Community Health Services Legislation.
- 38 outcomes were harvested at the level of the **local county government**, out of which 22 are Improved policies and/or budgets adopted by policy makers. These include the following locations: Busia county, Homa Bay, Kajiado, Kisumu, Narok and Siaya.
- 14 out of the 57 (25%) CSO stories were about improved policies and/or budgets that strengthened health systems at the local (county) level.
- 3 outcomes are harvested that describe **Policy implementation**. One of these was an action taken by a local government.
    - [K2] In October 2019, the county government of Kajiado allocated and renovated a one-stop youth-friendly centre at the Rongai social hall to provide SRH services.
- Out of the stories, 15 stories (26%) were about policy implementation by community actors (youth parliament, young people or other community actors) at the community level—3 were implemented by local government.
- 5 of the 15 stories were about a reduction of teenage pregnancies in Siaya county. In 2016, prevalence in Siaya county was higher than 37%. Storytellers noted Amref's intervention contributed to the reduction to 17% in the latest reports in 2020, although they explained that HSAP wasn't the only contributor in terms of funding and provision of commodities.
    - One storyteller shared: "Through consultations, we realised that a number of girls were becoming pregnant and dropping out of school. The Ugunja Youth Parliament took its sessions to schools - both primary and secondary to get the raw data from individual learners. It emerged that majority of the girls lacked information to deal with the rampant physical changes. Some girls also lacked sanitary towels hence could easily be lured by men. The Youth Parliament brought stakeholders on board, e.g. IMPACT, Ministry of Education, […] and Security department on how to control the menace on ASRH. Some organisations […] partnered with the Youth Parliament to conduct life skills trainings to girls in school on how to conduct themselves, some supported with sanitary towels so that

they are not lured easily. Through the Youth Parliament's life-skills trainings, we have been offering sessions during school ceremonies to give talks to young girls, and boys hence the community has recognised the importance of constant engagement with the Youth Parliament. The parents have also been brought on board to be free and talk to the girls in a programme called Family Matters which helps the parents on how to relate with the girls.

- Another storyteller confirmed: *"The engagements we made with the school during school visits and session talk was the issue of teenage pregnancy, school drop outs and even early marriages that brought on board the education sector to allow some partners […] to sensitise the girls on how best they can be safe. We found it from the girls that some of the relatives, teachers and even house boys and even boda boda riders use them and even give them money, lifts, lunch to do sex. So, at [a] primary level, they [are] taught how to be safe and at secondary level they are given contraceptives, prep and pep. This has made the pregnancy rate to reduce from 35% in 2016 to 17%, which is to date."*

Roles and contribution of external factors/actors in achieving advocacy's outcomes

- Hampering: The Kajiado case study[7] reported that the lack of key policies, such as the Health Policy for Kajiado County, had delayed development of important legislation on key sub-policies for health such as the Community Health Service Bill and Reproductive Maternal and Adolescent health legislation. The Kajiado bill was an umbrella policy covering a gender bill and other program allocations.

- Two out of 9 external substantiators indicated that there were hampering factors and actors in the environment.
  - The African Institute for Development Policy (AFIDEP) requested raw data on SRHC availability, affordability and stock outs for Nairobi and Mombasa counties to use in their national report on access to FP commodities for the youth aged 14-24 years (outcome 32643). The substantiator explained that AtMP willingness to share their data was an exception. Generally, the environment is hampering, because 'most organizations don't want to share information. They don't say no, but they stall and stall. Some organizations feel that we are in competition. Some want money. Some datasets are not of sufficient quality.'
  - For the signing of the CBA for doctors by the national and county governments (outcome 32729), the environment was hampering. The substantiator explained, 'health workers need to speak the language of the people. People need to realize that if a surgeon resigns, the Kenyans suffer. If doctors say we want a training, people think doctors want it for themselves. In my own county, since 2017, the number of women that are referred to a hospital 100 km away has reduced, so that is good.'
- 7 of the 9 substantiators indicated the environment had been enabling.
  - For the extension of the Siaya Family Planning Costed Implementation plan by 1 year from 2018 - 2022 to 2019 - 2023 to include adolescent health (outcome 32645), the county already had an existing health bill (supported by Amref, where the plan was anchored). There was buy-in for the costed implementation strategy in the budget and appropriation

[7] Final Report Joint Case Study: Watershed Partnership and The Health Systems Advocacy Partnership in Kajiado, Kenya. Muturi. M, Karanja.M (2019)

committee in the county assembly due to earlier engagements with the county health management teams. The substantiator confirmed: “It went smoothly, mindset changed after HSAP did trainings and displaying the data of teenage pregnancy. They presented us a case: students did their exams lying in bed because they had just delivered a baby.”

- Regarding the launch of the Community Health Service Legislative bill in Homa Bay county (outcome 32622), the environment has been enabling according to Amref. The time was ripe. Previous legislation paved the way: The WHO 2018 policy guidelines are in line with the advocacy agenda for countries to review the scheme of service of the health workforce to include community health workers (CHWs). Guidelines and polices concerning CHWs were present at the national level that needed to be cascaded down to the county level. In 2005, level one health services were established by the government paving the way for CHWs to be recruited and trained to provide services. In 2010, the Kenya evaluation report of the Community Health Strategy implementation observed significant changes in health indicators where the community health strategy had been rolled out with financial support. Currently (2020), Amref Health Africa is working on a national legislative proposal to supersede the County Community Health Service legislation that will be the overarching law for CHWs, however, progress is slow. The political will exists. The substantiator explained that ‘66 million is not small money, to give to someone in the communities, that for me is very bold’. Homa Bay is the second county that has the Act. Not everyone was excited about community health volunteers (CHVs), even health workers (hampering factor). Some felt CHVs were taking their jobs and wanted the government to employ more health workers. ‘But,’ the substantiator explained, ‘we don’t have the money’.
- Two CHVs who were interviewed, shared that they hadn’t received payment yet and there was ‘no change’; they still do all their work for free. One CHV shared that he attended a health public participation event, and they handed out a pamphlet to provide input for the act. The explains that act would be helpful, if implemented. But instead of a stipend, CHVs believe they need formal employment, because ‘from this stipend they expect us to visit 20 household within 2 days; 1 CHV needs to serve 100 households. But this is not doable. What about our own life and family?’

Best practices and advocacy process setbacks

- HSAP’s advocacy led to changes in policy and budget at county and national levels.
- In Kajiado, there have been great successes in multi-stakeholder processes leading to policy outcomes. These successes were achieved through increased collaboration between the three core partners based on a shared vision as a result of the Linking and Learning fund.
- In the Lake Basin Region, many community-level outcomes and county-level outcomes were achieved through CSO networks and youth parliaments.
- In Narok, fewer outcomes were found, whereby the challenge was that this programme location was remote, and far from other locations. Programmes in the Lake Basin Region and Kajiado advanced more quickly due to mutually reinforcing activities of the three core partners.
- One core partner gave an example: “during an outreach activity, a member of the county assembly came and the media covered the programme. After that they did a follow-up story,

which was covered in the local language. Amref had this approach first in Nairobi, and then we did it in Kajiado county as well."

- Media networks seem to be functioning well, especially the Lake Basin Region media network. The stories shared showed a vision for network collaboration and 'tackling' issues together. Storytellers show commitment and passion for their work, and share tangible results partly due to their campaigns. Journalists don't see each other as competitors anymore, but rather as colleagues who can join forces to create change.
- Set-back: The Reproductive Health bill 2014 was not passed at the national assembly despite CSOs and stakeholders lobbying for the bill to be enacted.
- Homa Bay allocated a budget for FP; however the funds were reallocated for other activities after the budget was approved.
- In Narok county, there was a media gag. It became difficult for the media network to work on issues related to SRHR and FP due to the culture and leadership in place.
- Two core partners explained that legislation in Kenya at the national level takes a long time and thus, their work at the national level has been very difficult. "*The advocacy needs to happen at the senate and our goals will not be achieved by the end of December 2020*". HSAP has invested much time, many resources and significant support. For example, they had two meetings with the MoH Working Groups, and then there were personnel and thematic changes at the MoH. The thematic area the HSAP worked on became a subtheme of another Working Group. Now, the core partners attend just as a regular participant CSO, and the agenda is set solely by the ministry; before, HSAP set the agenda.
- One core partner explained that FP budgeting is a cat-and-mouse game with the Kenyan government. One negative outcome was a budget first at 14 million and then reduced. All county budgets were cut, so all FP and SRHR budgets automatically went down in all counties.
- There is significant transition of leadership after elections, especially when there is a new incumbent government that brings in new administrators who need training and re-orientation on project thematic areas/progress. Every time there is a new government, the legislation process has to start again since previous efforts are not recognized by the incoming government. There were changes in leadership and governments at a county level in Kisumu and Narok, and to some extent in Kajiado county. In Kaijado and Kisumu, the county assemblies changed and all civil servants as well. In Kajiado, executive staffing changes occur due to government reshuffling or following elections when much of the county leadership changes. Currently, in Narok, there is a new Minister of Health and almost everyone now has other loyalties. Once leadership changes, maternal new-born and child health legislation has to re-start; however, Homa Bay, Narok and Siaya county governors were elected for a second term.
- The Dutch embassy together with other diplomatic agencies assisted in pushing for the public benefit organisations (PBO) ACT whose objectives was to increase accountability and improve governance among CSOs, the ACT is in place, but not being implemented. Amref meets with the Dutch embassy regularly; according to one core partner *"they are really an ally"*.
- Two set-back outcomes:
    - Family Life Program Busia+E25 (CSO) - Busia County lobbied for an increased commodities budget, August 2018 (in the initial budget)—removed in final approval.

- On October 29, 2019, the newly published Kisumu health bill by CSOs was rejected due to inadequate stakeholder engagement.

Missed advocacy opportunities / lessons learned

- All core partners indicated that the lack of a joint advocacy strategy from the start was a missed opportunity.
- Core partners indicated, and the Sprockler data showed, there was significant overlap between themes. AtMP gave an example: a CSO alliance is set up to work on SRHC. Is the main theme then governance, or SRHC? Often governance and finance were combined with HRH or commodities, they were not separate thematic areas. Thus, themes don't help the partnership to focus or to make strategic choices.

B. **Advocacy approaches and strategy HSAP partners**

Advocacy strategy and focus

- The HSAP advocacy strategy in Kenya was based on three pillars: direct contacts with policy makers, capacity strengthening and accompaniment of CSO networks (including youth parliaments), and setting-up and supporting media networks.
- A clear advocacy focus was missing, although an integrated approach among partners provided a common vision for Kajiado county that proved to be successful.

What worked well and less well

- Amref's good reputation in Kenya, and their presence in communities, benefitted the programme.
- Multi-stakeholder approach worked well. The partners organised multi-stakeholder forums together. Core partners shared their contacts and had many entries to decision makers at the national government, county legislators, CSOs, and people at a community level like CHVs.
- Partners produce items like fact sheets and policy briefs together. They share their research.
- The CSO networking approach worked well, including youth parliaments and media networks.
- Less well: linkages with regional policy makers only happened through Amref. ACHEST and AtMP had no direct contacts with policy makers at regional level. Global level linkages only happened through attending global meetings, which created interactions with global policy makers.
- Media reporting is a cross-cutting result area among all the thematic areas.

Missed opportunities / lessons learned in relation to advocacy strategy

- The lack of a joint advocacy strategy was a major missed opportunity, since the three-pillar approach was successful. This approach could have been even more successful if it had been applied with more focus and with a shared vision.

C. **Conclusion/Reflection**

- The HSAP advocacy strategy in Kenya based on three pillars has been effective: direct contacts with policy makers, capacity strengthening and accompaniment of CSO networks (including youth parliaments), and setting-up and supporting media networks.
- If there had been a shared advocacy strategy, even more/better outcomes could have been achieved.

- Youth parliaments are an effective model to achieve community-level change linked to county-level policy changes. This is an effective bottom-up approach.

3. Relevance towards health system strengthening and focus for influencing HSS in country

A. Relevance towards health system strengthening

- For HSS, storytellers shared that changes in their stories were relevant because they ensured better budget and fund allocation, put more responsibility on duty bearers, increased health worker morale/recognition, and ensured better health facility effectiveness.
- For two stories about improved policies or budgets, it was clear that the change was more relevant for HSS. The first [32689] was a health worker's strike in Kisumu, where doctors, nurses and clinicians were demanding their salaries, promotion, study leave and good working environment. A legal advisor was hired through HSAP (Amref Health Africa) to simplify the CBA. The county government and health workers then came together and signed a CBA, which led to the formation of a CBA implementation committee. The second [33404] was, "After training by META on budgeting and advocacy, we were able to engage the Narok county government on the need to allocate resources towards the purchase of mother-friendly packs to be provided to mothers post-delivery. For the first time, the county allocated a budget line for this, even though in the following year they removed it." According to the storyteller, the relevance was that for many years infants and maternal health indicators remained low as a result of poor uptake of skilled delivery in the health facilities. But the budget was allocated and the number of skilled deliveries went up.
- For 2 outcomes, the relevance for HSS was considered higher than SRHR.
    - One relates to 32622 the introduction of a Community Health Service Legislative proposal in Homa Bay ounty, which aimed for CHV recognition and funding. The substantiator from the county department of health coordinating community health services, said that the relevance for SRHR was there because CHVs are trained to provide SRHR services, e.g., encouraging pregnant women to go for Ante Natal Care (ANC) services. For HSS, the CHV role is critical, since CHVs are in touch with households directly.
    - A substantiator (a representative of KMPDU), confirmed that the outcome (the signing of the CBA for doctors by the national and county governments), was supported by HSAP using toolkit development as messaging tool to share with doctors and the county governments to understand the agreement. Amref hired a legal consultant to simplify the CBA for this purpose. *He stated: "Regarding SRHR, the 'Sexual and Reproductive Health' is different from the 'Rights', which is more difficult. Regarding sexual rights education, nothing is being done. HSAP helped to increase the commodities, but still the contraceptives are not always there and there are still challenges. But regarding the Sexual and Reproductive Health the programme achieved more than intended. So, for the Health System Strengthening, I think it has been good and the advocacy has really helped*." Amref indicated the relevance for SRHR was even lower than the substantiator.
- According to one core partner two main thematic areas would have been enough: governance and human resources. *"Human resources because it helps to strengthening the health system. Now we have HSS and SRHR. HSS has to do with human resources/policies around health so that's ok, but SRHR is too specific. Some things we do are not specifically for SRHR. It is good*

that the thematic area is broader than SRHR, as there are so many other issues, like Universal Health Coverage".

B. **Relevance towards SRHR**

- Regarding SRHR relevance, storytellers said the changes they described were relevant because they were community-driven, allowed groups (e.g., youth) to communicate their needs, provided access to SRHR services and commodities; lowered sexual and gender based violence (SGBV) violations, unwanted pregnancies and infant and maternal mortality; led to more knowledge on SRHR; allowed leaders a role; created safe and comfortable spaces for SRHR talk; increased awareness, knowledge and male involvement in female health (e.g., ante-natal care).
- For one story, about improved policies or budgets, it was clear the change was more relevant for SRHR. [32659] The storyteller mentioned the Kisumu County Youth Empowerment Costed Plan, which now includes adolescents and youth, and SRHR promotion. The storyteller described, "*It has been adopted by the county and ready for implementation. We participated in the advocacy that ensured that the costed plan for the youth is adopted and implemented by the county government of Kisumu since before the there was no costed plan. Currently the plan is ready for implementation. Hence achievement*."

C. **Conclusion / Reflection**

- All outcomes are relevant for SRHR and/or HSS.
- All topics fall under the umbrella of HRH, but not all under SRHR. Core partners focussed on different topics, namely: Amref focused on HRH (Doctors and CHWs) and Health financing (FP and budget advocacy); AtMP on commodities and ACHEST on nurses.

4. Lessons learned on HSS&SRHR advocacy, gender & inclusivity, collaboration& governance, visibility/legitimacy

A. **Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS**

- One substantiator (who can be considered to be an expert), reflected that HSAP has done more on SRH and less on rights.
- One core partner indicated that HSS (human resources/policies around health) would have been sufficient, and that SRHR was too specific, since there were so many other issues, like UHC.
- SRHR probably need a more targeted approach, since it is not evident that it is improved when a health system is strengthened. This is due to norms and values, which don't change automatically when there is a sufficiently strong health system in place.

B. **Gender/inclusivity**

- A good example of work done on gender mainstreaming was in Kajiado county, where there was a focus on women and girls as the most marginalised. HSAP Kenya is working on a gender mainstreaming policy (outcome K5) to cut across all sectors including tourism, education, health, etc. When the HSAP started working in Kajiado, the county minister for gender changed and they had to start the process again. The HSAP ACHEST trained the civil servants responsible

for gender on gender-mainstreaming policy and Amref Health Africa trained the CSOs responsible for gender on gender-mainstreaming policy to explain what 'gender' means, since this was initially defined as only a woman's affair.

- From the Kajiado case study [footnote], we can conclude that, although the numbers in public participation meetings increased, the number of women diminished. Meeting venues are still far and out of reach for many citizens, some of whom are over 80km away. Kajiado is a largely patriarchal society and males make decisions for the women's meeting attendance or participation. Many women are burdened with domestic chores e.g., looking for water or firewood, cooking and looking after children and so rarely have time to attend public events.

Relevance for women, girls, LGBTI, PwD and other marginalised groups

- The relevance, according to substantiators, is highest for women and girls. For example, the issue of teenage pregnancy in Siaya county (almost 40% according to the substantiator), is equally relevant for girls and women. The substantiator made no distinction between the two, saying, "Reproductive health is by and large more for women affairs". For one outcome, the relevance was considered higher for girls—the first-ever Joint Teen Summit with 500 teenagers from all 6 sub-counties in Narok county.

- Regarding LGBTI, the HSAP didn't particularly focus on this group. Some substantiators admitted this group was 'not discussed' and nothing was done for their access to care. For the first time in Kenya, one substantiator explained, we had a place for intersex in the census, and although not many ticked this box, they were there. Many substantiators indicated that they are included in the general population.

- The same applies to PwD, although the need to specifically target PwD is generally acknowledged and talked about.

- The definition of 'other marginalized groups' is generally understood as very remote and rural communities. Some substantiators didn't consider remote communities marginalized, because there are efforts to reach them. Another substantiator said a national policy is implemented equally across the country, and thus also applies to other marginalized groups.

Hampering and/or enabling factors in implementing a gender and inclusivity lens

- Two core partners explained that gender was addressed by deliberately including a variety of CSOs in the CSO networks that represented these topics, e.g., disability and gender. For example, there are CSOs that focus on youth, marginalised women, male involvement, girls, PwD, LGBTI, and girls guides (girl scouts). One girl guide always came to AtMP meetings, became more confident, and now speaks in public. Also, Amref Health Africa supported public participation that was conscious of PwD, youth, women and even men.

- There was no gender mainstreaming and inclusivity or engagement strategy in the partnership.

C. **Collaboration and governance**

- 34 outcomes were entered in Sprockler by the HSAP. From these 34, 25 were achieved through working autonomously.

- 9 outcomes were achieved through complementarity and partly through a shared vision. 5 of those were reported in Kajiado. Although, not all Kajiado outcomes were achieved this way: there were also outcomes that were achieved through 'working autonomously' in Kajiado (3).
- One core partner indicated that collaboration was minimal in the beginning. There were no activities planned together from the inception to the implementation phase and each organisation had their own workplan. No joint advocacy strategy or communication strategy existed. The three partners invited each other and participated in each other's activities.
- One core partner explained that the programme was originally designed from the top. At first, they didn't know how to work together since the initial concept was not yet glued together.
- Synergy came after the development of a joint ToC. The funds received through the Linking and Learning fund also helped create synergy. Through the Linking and Learning fund, two activities were supported: a CSO meeting in Kajiado to review the Kajiado health bill and one dignity and ethics meeting. The inception meeting in Kajiado was conducted by Amref due to their presence in the county over many years. Amref introduced META and ACHEST to Kajiado since they had never been present in the county before. CSOs in Kajiado were introduced to ACHEST by Amref. Linking and Learning supported Kakamega and Kisumu counties where META was implementing their activities.
- Fore thematic areas, the core partners considered that they are much aligned on migration of health care workers and FP and commodities.
- Since 2019, Kenyan core partners discuss their plans during monthly country management committee meetings and through a WhatsApp group that each partner hosts in rotation. Now information flows more easily, and communication is going smoothly.
- The three core partners go to conferences together.
- Each organisation indicated they had been supported by their own head office in the Netherlands—AtMP with HAI, ACHEST with their own Dutch head office, and Amref Kenya with Amref Netherlands.
- Both AtMP and ACHEST indicated they had minimal contact with Amref Netherlands, although the joint revision of the ToC was appreciated. The reporting structure (three parts: one narrative, one technical report, and one on knowledge products) was appreciated, and reporting was performed jointly as a partnership. At first, reports were required quarterly, and later bi-annually, which was also appreciated.
- A consultant was hired to support an Advocacy and Communication strategy for the partnership, but he did not deliver and his contract had to be cancelled.
- Amref, has a communication strategy and a strategic plan including advocacy messages. For example, for CHWs, Amref's messages are the same at global, regional, national levels. The Amref regional office trained the Amref Kenya team on SMART advocacy, but this was not for the entire partnership. According to the Amref interviewees, communication with Amref Netherlands was easy, they were just one email away, or they sent a message to the WhatsApp group of the Amref advocacy department.
- According to one core partner, the three core partners used the same social media communication strategy, which came from the HSAP global level.

Collaboration within the partnership linking local to global advocacy

- Only Amref explained they linked their local/national work with the regional level.

- The other two core partners said that linking national to global did not really work. One core partner explained they didn't know who to share information with at the regional level. No information from regional or global had reached them.
- However, one core partner explained that it was possible to meet directors or the Minister of Health on the side-lines of WHA without having to go through the process of making an appointment, which made national to global linkages work well in those situations.
- Amref explained that they were able to link local to global. They launched their community-level strategy at the global level. Amref's regional coordinator for HSAP updated the Amref Kenya team on the African Union declaration.
- Amref collected information on country level and fed it to the regional level, like policy briefs, fact sheets, and evidence for the African Union and World Health Assembly.
- Some members of the local Amref Kenya team went to 'Women Deliver' event in Geneva.
- Amref also sent CHWs to these international meetings. Three youth representatives were supported as well to go to international meetings, including two members of the youth parliament and one policy maker, a former member of the youth parliament, in Siaya county.

Hampering and/or contributing factors for collaboration successes and challenges

- Hampering: no joint programme design was in place at the beginning, and no advocacy strategy per context. No gender strategy was in place either.
- Contributing: Amref took MeTA and ACHEST 'under their wing', and provided backbone in terms of reputation, contacts with policy makers at national and county levels, and being rooted in communities (also outside the HSAP).

D. **Visibility**

- The majority of the CSOs that shared stories (57 in total) indicated that the visibility of their CSO had improved immensely compared to before their involvement with the HSAP. There were a few respondents who chose the middle, not sure about the changes in visibility, and one respondent who said they were no more visible than before.
- The strengthened capacities of CSOs and CSO networks was demonstrated through the achieved results (shared in their stories), at both the county and community levels. 14 stories were shared about how CSO strengthened capacity contributed to communities' ability to demand their rights, another 14 for improved policies and budgets, and another 15 for the impact at a community level. Stories about improved policies and budgets in particular, were often achieved through policy-participation processes, thus CSOs are considered stakeholders and are more visible.
- There appeared to be a correlation between how much respondents considered that the visibility of their CSO had improved and whether or not they considered the change would have happened without the HSAP. The more the HSAP was the primary reason the change occurred, according to CSOs, the higher they reported that their visibility had increased.
- The substantiated outcomes generally concerned policy changes at the county level, which could explain why the substantiators indicated no particular effect on CSO visibility. From the substantiated outcomes, the extension of the Siaya FP costed implementation plan was the

one where CSOs were included in advocacy, and the visibility of CSOs increased according to the substantiator: *"The CSOs do normally not really have enough knowledge, but now through the support of Amref, they have knowledge and their voices are heard. For example, the youth parliament, Amref helped to change their thoughts and their practical skills to contribute to the policies and negotiation for their rights."*

- According to the Kajiado case study [footnote], the highest change in civic space in Kajiado, related to accountability, was CSO participation in government processes, local government acting on CSO demands and complaints and communities and public members pushing for government accountability.

E. **Conclusion / Reflection**

- SRHR is less prominent than HSS, and the rights in SRHR are given even less attention.
- There was no clear distinction between women and girls, although of course the distinction exists. Girls should be given more prominent attention.
- Including a variety of CSOs in the CSO networks worked well.
- The Linking and Learning fund had a positive effect on the collaboration. This could have been done from the beginning, but it was positive that there was learning and adjustments made.
- Linkages with the regional level only happened within Amref, and seemed to be positive. But no linkages were found between MeTA and ACHEST at the regional or global levels.
- All three partners indicated they had worked autonomously for most outcomes (of the 34 that were entered and rated in Sprockler).

5. Sustainability of programme results

A. **Mechanisms in place to sustain the advocacy outcomes: HSS, SRHR, and Advocacy capacity**

- All 9 substantiators shared a similar point of view on next steps definitely needed. Six referred to partnerships as key to next steps. Only one specifically referred to the current HSAP that should continue and even more partners should come on board. One mentioned the need for public-private partnerships, since the government *'can't manage'*.
- One substantiator, who substantiated the launch of the CBA for doctors, indicated that more effort from the inside is needed, instead of all ongoing efforts from the outside. He said: *"A lot of NGOs are doing things on health care; but that hasn't helped at all. Is there a practical change in the hospital? I see no changes in treatment."*
- Storytellers shared next steps for capacity strengthening they considered necessary (if any) and who should carry these out. Almost all believed the HSAP should continue.
- Many indicated that the necessary next steps are more capacity-building training to support local CSOs and other grassroot organisations; for example, steps in documentation, operations research, budgeting, monitoring and evaluation, drafting policy briefs and petition papers, budget tracking, smart advocacy, dissemination of information and governance operations.
- They also called for refresher trainings and exchanges with CSOs in other regions or countries.
- Additional next steps included more support for advocacy programme implementation; more community sensitization; the inclusion of underserved communities; ensured sustainability of youth corners, youth parliament, etc.; continued media engagement to identify gaps; more engagement with duty bearers; more networking; and the introduction of online platforms.

- Recommendations for parties to take next steps were mainly HSAP core partners, other CSOs, local and national government, international, regional and local organisations and coalitions.
- The core partners all believe some national and county legislation is now in place, which is a sustainable model. Even if the legislation isn't implemented, other NGO's can advocate for their implementation, or take county government to court or start social media campaign. For example, the Kenyan constitution requires every county to have a public participation bill. HSAP managed to have a bill about public participation adopted in Kisumu.

B. **Governance mechanisms to sustain CSO advocacy efforts**

- The youth parliament is a sustainable model, since they have been given capacity training to organise themselves; they don't receive funding for their meetings, which they coordinate themselves. They train each other when new people come in.
- The SMART advocacy training in particular created significant change. Some of the trained youth will become legislators. For example, Honourable Adala was first a member of the youth parliament, and now he is a legislator and a champion. Legislators of other counties asked for support to implement the Youth Parliament model. The director of the Youth Parliament in Siaya was asked to start-up a Youth Parliament at the national level.
- The core partners felt that CSO networking was a sustainable model. CSOs join the network voluntarily or they were paid by another organisation, but not by HSAP. The facilitation of meetings and logistics was done by CSOs, and due to the good relationships between the CSOs with the MoH, the Ministry also facilitated some of the joint network meetings.
- Also, the multi-stakeholder approach is a sustainable model. For example, the multi-stakeholder's forum organised by the UYP, where policy makers and youth came together.
- Some technical working groups included both CSOs from the network, and ministries. The HSA partners trained CSOs on writing concept notes and looking for funding and diversity. For example, Amref wrote a proposal for funding together with UYP. And a CSO focused on PwD asked for funding for a shelter, but not yet functional (as verified by evaluators on site).
- Amref has a phase-out policy to ensure sustainability. They have to hand over the programme to the county governments.
- Two CHVs who were interviewed had the following message for Amref: "help us with capacity building, organise some more sessions at community level for CHVs, and also at county level. And help to push the bill [payments for CHVs] to be implemented".

Country Context: Malawi

Introduction

Malawi joined the Health System Advocacy Partnerships (HSAP) programme in July 2017. In September, Malawi country teams developed their contextualised ToC and then conducted country baseline studies. The HSA Partnerships' programme strategies for capacity building in lobbying and advocacy in Malawi involved:

- Capacity strengthening of civil organizations society (CSOs)
- Strengthening existing platforms and CSO networks by providing financial support and technical assistance
- Engaging with media
- Amplifying community voices by strengthening existing advocacy work done by CSOs in the community. HSAP did not want to re-invent the wheel, the best HSAP would have done was to be open and acknowledge such dynamics. Otherwise, it would have given the impression that HSAP wanted to claim achievements that were directly influenced, but not performed, by the HSAP.

In implementing the HSA Partnership programme, the consortium partners included the Amref Malawi Office and AMAMI, which was sub-contracted by the African Centre for Global Health and Social Transformation or ACHEST (the lead context for Malawi).

The list of HSAP subcontracted partners in Malawi:

Contracted Organization	Participating Organizations	Geographical Areas
ACHEST	- AMAMI - SRHR Alliance - Malawi Environmental Health Association (MeHA), the National Association of Community Health Workers (CHWs)	National/Lilongwe
AMREF		National/Lilongwe
	- Human Resources for Health Coalition, which had partners such as: - The White Ribbon Alliance (WRA), - National Organisation of Nurses and Midwives of Malawi (NONM), - Malawi Environmental Health Association (MEHA), which also acts as a mother body for CHWs, - The African Media Network on Health, Malawi chapter	National/Lilongwe
	- Ntchisi Evangelical Churches Consortium for Social Services (NECOSS) - Foundation for Communication Support Services (FOCUS) - Rights Advice Centre (RAC) - The Malawi Sexual Reproductive Health Rights Alliance - a network of six Malawi-based organisations committed to improve the sexual reproductive health rights (SRHR) of everyone, especially young people in Malawi. These partner organizations are the Family Planning Association of Malawi (FPAM), Youth Net and Counselling (YONECO), Centre for Alternatives for Victimized Women and Children (CAVWOC), Centre for Human Rights and	District Level

	Rehabilitation (CHRR), Centre for Youth Empowerment and Civic Education (CYECE) and Coalition of Women Living with HIV and AIDS (COWLHA)	

1. **Capacity-strengthening efforts**

A. Strategy and focus

- Amref has focused on
  - emphasising CSO capacity building,
  - lobbying and advocacy (CHW, health worker migration and retention and financing family planning [FP]).
- The themes of the lobbying and advocacy cover
  - human resources for health (HRH): CHW recognition and remuneration, a strengthened health workforce and improved working conditions.
  - SRHR cover evidence-based advocacy to improve supplies of sexual reproductive health commodities (SRHC); evidence-based advocacy to increase SRHC and FP budgets.
  - Health financing (HF) and governance: cover international HF and governance work.
- ACHEST has focused on
  - lobbying and advocacy (HRH and governance), and
  - CSO capacity building at a national and district level, e.g. training on the use of score cards for social accountability.
- Wemos has focused on strengthening the linkages between national, regional and international advocacy in collaboration with African and international NGOs and CSOs. They analysed relevant international policies which impact on Universal Health Care (UHC) and health systems, and assessed the impact and implications of these policies in the five countries. Moreover, they translated these country case studies, including from Malawi, into effective evidence-based advocacy aimed at the Dutch government and relevant European and global institutions[8].

B. Strength and Weaknesses

Strength

- **CSO capacity building**: HSAP consortium partners continue to support the capacity of these CSOs and networks with a specific focus on advocacy, including the use of locally applicable social accountability methods using score cards (5 outcomes: 32738, 32758, 32796, 32823, and 34040). They engaged communities to identify local health system challenges and demand improvements from duty bearers. The chosen strategy of strengthening contracted partners' advocacy was highly valued by the partners since it is quite unique.
- **Lobbying and advocacy**: The strategies used by the HSA Partnerships Programme in Malawi included working with advocacy champions (Outcome 32785), and their active involvement in legislation processes, research on evidence-based advocacy, and budget advocacy. For capacity building, it can be seen that HSAP has built CSO capacity to conduct lobbying and advocacy and work with advocacy champions.

[8] https://www.wemos.nl/en/cooperation/hsa-partnership/

- **Partnerships**: HSAP partnered with existing coalitions strengthened or revitalized by HSA partners. Examples include partnering with the HRH Coalition and the SRHR Alliance in Malawi to join forces on advocacy in the areas of HRH and financing for FP services and commodities.
- **Forming new relationships**: In the stories collected from Sprockler, respondents mentioned that their increased capacities resulted in making new relationships, having more practical advocacy skills and increasing knowledge on SRHR and/or Health System Strengthening (HSS) (4 out of 7 stories: 32958, 33634, 33635, and 33637).

Weaknesses

- Despite a thriving CSO space created by the project, CSOs mentioned the lack of a clear platform for learning and sharing best practices within the national HSA partnership as well as between the Malawi partnership and the regional and global partnerships or networks[9]. The following quote illustrates:
  "There was [a] need to have external and internal learning visits to other districts and/or countries by local partners and CSO networks" (KII contracted partners).
- From KII and story findings there was no mention of continued mentorship or cross-learning within the partnership. This would be critical especially in terms of outlining mechanisms to support contextualised capacity building for CSOs.

C. Supporting and hampering factors

Supporting factors

- HSAP implementation in Malawi was reinforced by partnerships with Amref, AMAMI and strong CSOs (contracted partners) who have been working in the same three districts where HSAP works and have established capacity in community development and to some extent, advocacy. Hence, HSAP's capacity-strengthening efforts have made these CSOs much stronger and focussed on advocacy work on HSAP-related themes.

Hampering factors

- A late start to the implementation of the HSAP programme in Malawi resulted in a short timeline to achieve its objectives.
- Unrest in Malawi politics due to a violent election dispute in 2019, also affected HSAP programme implementation to some extent.

D. Conclusion on capacity strengthening efforts

- Local CSOs have been capacitated to advocate and lobby with decision makers and receive instant positive decisions/reactions from authorities on specific advocacy issues through training activities provided by HSAP consortium partners in Malawi (Amref and AMAMI) and exchange visits for sharing knowledge and experiences with Zambian colleagues. The engaged CSOs and media have been strengthened so much that their lobbying and advocacy are effective. CSOs have passed on their knowledge and skills gained from the partnership to community-level stakeholders including vulnerable populations. CSOs indicated that the training they received from Amref and AMAMI was very effective (KII, contracted partners). They mentioned that the capacity building they received will benefit more Malawians as their

[9] learning space and sharing of best practices was done through the annual planning meeting of HSA Amref partners, and exchange visits were planned for 2021 as per context design

skills and knowledge remains with them, even beyond the project in 2020. The coalitions, particularly the HRH coalition, indicated that the HSA partnership had led to the 'resurrection' of a network that had died a natural death years ago. This enhanced the coalitions' lobbying and advocacy work and as such the coalition emerged as a critical component within the project, since they added their voice to the voices of all advocates, thereby strengthening the project's relevance before policymakers.

- Although some weaknesses emerged during the evaluation, overall, there is reasonable evidence to indicate that the HSA Partnership in Malawi has been able to contribute to enabling a functioning and effective space for CSO dialogue and dissent concerned with addressing health systems advocacy at all levels of the advocacy cascade. There are strong examples of gains made to ensure that issues relevant to the HSA Partnership's advocacy agenda are being taken seriously. This is especially the case at the local country context level where communities have been empowered to demand services in Ntchisi, Mangochi and Chitipa districts. Below is summary of the results from HSAP capacity building in Malawi reflected in the outcomes (substantiated and non-substantiated) and stories: Capacity training provided to CSOs has helped to create a united front of NGOs and communities to collectively demand services from authorities (8 out 16 outcomes: 32733, 32738, 32765, 32780, 32823, 32785, 34040, and 32960).
- The partnership has helped to strengthen the capacity of community health governance structures that were already in the districts (5 outcomes: 32758, 32765, 32796, 32823, and 34040).
- CSOs managed to exploit and maintain working cordial working relationships with other NGOs and stakeholders already working in the project sites.
- Capacity for advocacy by media practitioners on SRHR and HRH has been strengthened (non-substantiated outcome: 33361 and 34157)

Lessons learned from the Outcome Harvesting exercise within HSAP

- To address the use of Outcome Harvesting (OH) as part of a capacity-building theme provided by HSAP for contracted partners in Malawi, it appears the OH process concentrated significantly on national-level successes, thus side-lining district-level successes. For example, in Ntchisi, NECOSS managed to empower the health centre management committee to engage stakeholders and set up a fund to construct houses for health workers due to be completed in June 2020 (Outcome 32823). This outcome was never harvested prior to the evaluation and was only unearthed during the evaluation.
- Policymakers were critical of what the HSA partnership had claimed to have been programme achievements, rendering the acceptability of some outcome verifications as problematic. Considering these policymakers were earmarked as substantiators, their critique of the outcomes raises questions of how realistic the HSA partners were when they harvested their outcomes. The following quotes demonstrate how sceptical and ruthless some policymakers were when asked to substantiate outcomes. *"Like I said I cannot comment on what the programme has contributed because we see them coming individually and it is not known by us that there is an HRH advocacy programme out there. We only know AMAMI on issues about midwives, White Ribbon Alliance on issues of midwives as well. Then there is also NOMN on issues about nurses in general. This HRH coalition, no I don't know them… This MK500M was government's own money including our traditional partners and not through their*

demonstrations or lobbying whatever they call it. These organisations they seem to claim and own initiatives that others are working on. I argued with them on this issue to say it was a lie that their lobbying resulted into this grant". (33722/policy maker)

- *"Your issue reminds me of what I heard also that organisations were claiming that they lobbied for increment of nurses' locum. That is very bad, because this has been a long-standing issue in the ministry and finally, we agreed with treasury to increase the rates of this locum…I have just started hearing about HRH Coalition in December, 2019. This is surprising because in my role at the HR directorate, I deal with everything that has to do with HR recruitment, remuneration including allowances or what we call locum in the health sector"*. (32855/policy maker)

2. The effectiveness of the advocacy approaches

In total, the HSAP harvested 44 outcomes for the Malawi context, of which 16 (36%) were substantiated during this evaluation.

A. Actual changes (outcomes)

Type of changes and the actors that have changed (see Annex 10 for more detailed info on each outcome substantiated)

- Changes in policymaker support on HRH, SRH commodities, health financing and governance. Outcomes: 32733, 32762, 32780, 32785, 32960 (5 outcomes)
- Changes in involvement of CSOs and HSA partners in policy implementation processes. Outcome: 32739, 32758, 32765, 32796, 32823, 33722, 34040 (7 outcomes)
- Changes in improved policies and/or budgets adopted by policy makers. Outcomes: 32851, 32852, 32855 (3 outcomes)
- Changes in MT-Empowered communities are increasingly able to demand their rights: Outcomes: 32758, 32765, 32796, 34040 (4 outcomes)

Actors that have changed:

- National/local government: 32733, 32739, 32762, 32780, 32823, 32851, 32852, 32855, 32960, 33722 (10 outcomes)
- CSOs: 32738
- Community members: 32758, 32765, 32796, 34040 (4 outcomes)
- Parliamentarian: 32785
- Outcomes related to HSS: 13 outcomes (mostly on HRH theme)
- Outcomes related to SRHR: 2 outcomes on family planning financing and commodities (32733, 32785)
- Outcome related to HSS and SRHR: 32738

Summary of the outcome description

The changes contributed by the HSA Partnerships programme in Malawi were mostly focused on the HSS theme rather than on SRHR. For the SRHR theme, the changes were only focused on the issue of family planning commodities in three districts where HSA Partnerships worked in Malawi. The HSA Partnerships consortium partners, together with contracted partners and network partners have been involved in the policy implementation processes. The also contributed to improve support of policymakers in Malawi on HRH, SRH commodities, health financing and

governance. Some of the outcomes of this were improved policies and/or budgets adopted by policy makers, mostly on HRH topic (increased number of health workers and their salaries). The actors that have changed are quite varied (government, parliamentarian, CSOs and community members). The involvement of community members has shown that the HSA Partnerships programme in Malawi has to some extent met the mid-term objective of the ToC: Empowered communities are increasingly able to demand their rights, trough the use of score cards.

- Additional changes were mentioned in the stories (7 stories collected) as the result of capacity-strengthening efforts. The stories collected from CSOs who received capacity strengthening from HSAP consortium partners (both financially supported and not) mentioned changes that happened mostly at a district level such as:
  - the improved CHW curriculum and extended duration of their training
  - the establishment of community health champions, which led to more immunisation
  - fewer home deliveries and more visits to antenatal clinics by expectant mothers
  - increased involvement of males in pregnancies
  - the establishment of a score card committee to take more ownership of initiatives
  - the posting of extra medical staff after advocacy efforts; the replacement of dysfunctional health facility equipment
  - a policy audit activity

- Stories number 5, 6, and 7 are similar with the outcomes harvested and selected to be substantiated.
- The themes of the stories were also similar to the outcome themes (maximum 3 theme options per story), namely: HRH financing (mentioned 4 times), civil society space and participation (mentioned 4 times), supplies of SRHC (mentioned 3 times), FP (mentioned 2 times) and recognition and remuneration of CHW (mentioned 1 time).
- Apart from thematic areas, the story tellers were also asked to indicate which result area the change they described best related to. They mainly shared stories related to:
- 'Increased involvement of the HSA partnership and CSOs in policymaking processes by stakeholders on HRH, sexual and reproductive health (SRH), commodities, HF and governance' (5 stories)
- 'Increased evidence-based lobbying and advocacy capacity of civil society organisations at local, national, regional and global levels' (1 story)
- 'Empowered communities are increasingly able to demand their rights' (1 story).
- Based on the 7 collected stories, the HSAP's capacity-strengthening efforts had equal effects on organisational or network levels only, at both an organisational or network level and individual level, and at all three levels: organisational or network, individual and mainly community level.

Changes in the development of effective evidence-based messages taken up by like-minded networks and organisations

- Limitation: we did not interview outsiders, thus we can only answer based on our observation that no other like-minded organization has adopted this approach.
- Roles and contribution of internal and external factors/actors in achieving advocacy outcomes (including supporting and hampering factors) – findings based on KII

- Internally: achievement of outcomes was influenced by the partners (CSOs and the media), the technical support from the regional office and Amref NL. At the district level, CSOs were empowered to demand services including HRH (together with community)
- Externally: outcome achievement was influenced by the collaboration and cordial relationship that existed between Amref and its partners and policymakers at various levels of government and a conducive political and legal environment in Malawi, as well as community acceptance of being actively engaged in the participatory advocacy led by CSOs.
- Most substantiators felt the environment enabled change, especially political support from local/district governments, except in the case of Mangochi (see hampering factors).
- The availability of HSA Partnerships funds to convene CSOs and politicians was also seen as an important enabling factor.

Best practices and set backs in the advocacy process

Best practices in changing the approach in advocacy

- The HSA Partnerships has introduced SMART (specific, measurable, achievable, realistic and time bound) advocacy and it has changed the way how NGOs work in advocacy: their advocacy/lobbying approach, strategy, and focus to be more effective.
- Example 1: In Mangochi, RAC discovered that instead of just targeting service providers, they needed to target the communities with lobbying and raising their awareness on FP in Mangochi. They also had to address myths around the use of FP, e.g., if their youth access FP services they may end up becoming permanently infertile, and it is not customary for people who are married to practice family planning because in the long run it can cause cancer. Thus, they changed their focus to be not only on the Health Centre Management Committees (HCMC), but also on targeting the community and started with awareness campaigns; this change was accepted by Amref.
- Wenya case study: This facility caters to about 15,000 people, but has only 5 Health Surveillance Assistances (HSAs), which is not up to the standard of the national community health strategy calling for 1 HSA per 1000 people. The Wenya facility is in a hard-to-reach area and the only referral facility is the Chitipa district hospital. The Wenya facility was operating without equipment, e.g., no sterilizer (so they were boiling equipment on firewood), thermometers or manometers.
- HSAP contribution: Following the HSAP's intervention and advocacy, within 3 weeks, the DHO dispatched all the aforementioned equipment to the Wenya facility. There was an ambulance that was supposed to be functional, but the ambulance service was abused. The ambulance was there, but used to pick up unauthorized passengers to make money (for the driver). The driver would go to the farthest facility (Nthalire), pick up one patient and bring 14 unauthorized passengers onboard. So, by the time the ambulance arrived at Wenya, the driver would say the ambulance was full, even though there was only one patient inside. Therefore, Wenya patients who were referred to the Chitipa hospital had to use their own transport. HSAP worked through the CSO in the area and conducted advocacy and lobbying activities on this case with the Chitipa DHO, who followed up the complaint. Now, there is a mechanism to address this problem. The CSO was given a number to call whenever the ambulance driver is found to be abusing the ambulance service. For now, the situation has been normalised.

B. Advocacy approaches and strategy HSAP partners

Advocacy strategy and focus

Evidence-based advocacy

- The use of community score cards

  The use of score cards as a community participatory tool to engage communities in lobbying and advocacy across the HSA partnership to ensure social accountability in health has become of the focus of advocacy capacity building for contracted partners and network partners. This tool has proven its effectiveness to promote social accountability (https://pubmed.ncbi.nlm.nih.gov/27784594/). In all countries where HSAP is implemented, Malawi and Tanzania use score cards as a community participatory tool to engage communities on lobbying and advocacy across the HSA partnership. Score cards are an interactive and participatory approach tool. They are used in adult learning to help participants draw out context-specific issues that can bring discussions closer to the real governance and development issues. The tool is used in Malawi and across African countries such as Ethiopia, Nigeria and other LMICs. Score cards sessions are generally designed to support local-level structures including HCMC in an effort to build their capacity to strengthen health service delivery system processes including drug monitoring among other issues through improved citizen engagement and community-driven accountability and transparency. Score cards sessions bring together the demand side ('service user') and the supply side ('service provider') to jointly identify and analyse issues underlying service delivery and utilization problems. Score cards and Participatory Action and Learning (PAL) approaches are generally employed to obtain baseline data and monitor and evaluate intervention processes and impact. Score cards as a participatory design and approach provide a powerful means of improving and enhancing practice by involving community dialogue at the very early stages of programme planning. Thus, Score cards build a basis for negotiation and partnership between researchers, resource holders and beneficiaries.
- AMAMI and Wemos undertook two research activities. Wemos initiated and conducted a Malawi case study on HRH and HF (together with AMAMI and MEHA) (Outcome 34136 and 34152). AMAMI next conducted a meta-analysis of the HRH situation in the country. The studies were disseminated to CSOs who used the studies to identify issues for further advocacy. Score cards were used to gather additional evidence for the topics/gaps/issues in the community for the community themselves (who also did the scoring of the issues) to conduct advocacy activities aimed at the government.
- The partnership in Malawi strived to ensure that evidence-based advocacy and lobbying was at the heart of every activity. It appears that the evaluation managed to answer whether or not the partners themselves were aware of the products that they produced, and whether or not the evidence they produced was equally used by the partners in lobbying and advocacy and used by other players such as policymakers in decision-making processes.

Using HSAP partners access to decision makers

- The HSA Partnership, both at the national and district levels effectively engaged with decision makers in most cases. The HSA partners were all well positioned to engage with strategic offices and knew how to approach decision makers.

- 3 national level HSA partners (AMAMI, White Ribbon Alliance and NOMN) seemed to be well known and acknowledged in their own right by policymakers.
- Policymakers/government stakeholders acknowledged the value of CSOs and partners in their role within the broad SRH and HSS arena.

Working with CSO networks and other networks such as youth parliaments, media, and parliament

- The evidence generated by the HSA partnership was widely used by the media; for example: CSOs conducted radio programmes to disseminate their findings and engaged communities and decision makers to make informed choices regarding topics as per programme agendas.
- *"We have engaged the media through conducting radio programme with the aim of reaching out to a wider community as far as issues to do with HRH advocacy particularly staff in health centres across the district are concerned*". (KII contracted partners)
- On youth parliament: HSAP Malawi has missed an opportunity to work intensively with the youth parliament (see missed opportunity section).

Empowering communities to demand their rights

- Most respondents considered the community level and the organisational or network level to have been the biggest effect of the HSA partnership's capacity-strengthening efforts (source stories in Sprockler).
- Capacity training provided to CSOs has helped to create a united front of NGOs and communities to collectively demand services from authorities.
- The partnership has helped to strengthen the capacity of community health governance structures that were already in the districts.

Linking levels: subnational – national – regional – global

- There appears to be a disconnect between the district level partners and those based at the national level within the partnership.
- One example of linking national - global
  Throughout 2018, to achieve lasting results for the abovementioned outcomes, HSA partners advocated for HRH financing. The Malawi research report, 'Mind the funding gap; who is paying health workers' was published by Wemos and AMAMI, in October 2018. The report sparked attention from media outlets at both national and international levels. This resulted in a request to present the report to the parliamentary committee for health in Malawi to integrate the lessons learned for implementing the newly adopted HRH strategy. Internationally, the publication was quoted in a Lancet editorial calling for sustainable investments in the health workforce. The HSAP's complementary lobbying and advocacy strategies for HRH aim to assure that remote communities have access to health workers for safe referrals for delivery and that young people have access to SRH information.

Strengths and Weaknesses

Strength

- The HSAP engaged well with parliamentarians/media, however their effectiveness is still not proven due to limited timeline of the programme implementation. The partnerships faced challenges acknowledged by several parties (consortium partners, contracted partners and

stakeholders) such as: coordination was not optimal (clear), or the media had to cover two consortium partners' activities, which sometimes happened at the same time.

- There were three layers of collaboration observed by the evaluators:
- Collaboration between Amref and AMAMI: good to some extent (on a practical level, they were working together, but not functioning well at a partnership level)
- Collaboration between consortium partners with the contracted partners: good/strong
- Contracted partners with other CSOs: good/strong
- Good collaboration and cordial relationships existed between Amref and its partners and policymakers at various levels of the government and there is a conducive political and legal environment in Malawi. In working with Minitry of Health (MoH), HSA Partnerships programme has worked with technical working groups established by MoH which build strong foundation to guarantee sustainability.

Weaknesses

- Introduction from HSAP
  Stakeholder engagement or project introduction that could have helped gain buy-in or much-needed political will at the outset did not work well – HSAP is not well known among HRH and SRHR key players including the MoH and international NGOs. During the substantiation, policymakers' perspectives shifted to the negative at times, as they argued that the HSA partnership approach was to introduce themselves as a national consortium of organisations working on HSS and SRHR lobbying and advocacy. They argued that this partnership was not well introduced or communicated. For example, speaking as substantiators, policymakers expressed their lack of knowledge about the existence of the HSA partnership stating that the NGOs said to be part of the consortium had never introduced themselves as such. Instead, they were working with the MoH as individual institutions as illustrated in the quote:
  "Actually, sometime last year AMAMI came separately to ask for data on how many health workers we have recruited, later White Ribbon Alliance came also separately looking for the same kind of data…So, as you can see, I know them as NGOs and not as HSAP like you are putting it. About Amref mmmm I don't think I know them…maybe I have forgotten since the HRH TWG has big membership and I cannot recall everyone…"(33722/policy)
- Similarly, on how Amref in particular conducted itself, a policy maker said:
  "We only know one (partner with the so-called HSA partnership) CSO called MEHA. The problem was that Amref did not share the partners that they were working with to the ministry. Of course, MEHA we knew it before this programme. For example, [the] Ministry has technical working groups where partners are expected to present their programmes. But they just shared what they do and not who they are working with. We just hear that they are funding some CSOs in Mangochi. If we don't know, we might not acknowledge that Amref is doing that. So, if the ministry is not aware of other CSOs we miss…"(32762/policy maker)
- As highlighted in the quotes above, it appears that the HSA partnership was either poorly introduced in the country or was never introduced at all. The autonomy of each partner is strong, however, efforts to work as a partnership are lacking: partners within the partnership in Malawi took advantage of their long service in advocacy and lobbying to continue working without regard to specifically introducing the partnership and what that might entail. This led to substantiators being surprised when outcomes were read to them as HSA partnership

achievements, and eventually they refused to verify the outcomes. This quote illustrates this assumption/observation in detail: *"I may not describe how the HSAP contributed because like I said, before we started the interview, this is the first time I hear of the existence of such a partnership. The work towards [an] HRH strategy started in mid-2017 to 2018 when the HRH TWG appointed [a] taskforce to be responsible for the development of the HRH strategy. The taskforce then developed TORs chaired by Department of Human Resource Management and Development (DHRMD). The taskforce had a core group of organisations: CHAI, GIZ, HRH2030, PEPFAR, MSF and WHO. These organisations championed the process. Amref, NOMN and AMAMI participated at times in meetings and reviewed drafts that the core group developed…these organisations you say are in the HSAP, I consider them as participants during consultations. I cannot recall specific text that I can say they contributed towards the final strategy because I wouldn't know whether they were participating as independent organisations or under a certain project as you have indicated."* (32852/networking partner)

- Poor documentation of how the partnerships worked and how to use it for (evidence-based) advocacy. It was not clear to evaluators that the CSOs within the HSA Partnership were knowledgeable about the products that the partnership had produced. More importantly, it was difficult to obtain some products such as memos (letters) for an advocacy initiative conducted in Mangochi that the HSA partnership and communities used to lobby the district health office to ensure the health facility which was closed for 21 years be opened. We were told that this product would be shared with us, but this did not happen. Similarly, we learnt that there were gender trainings conducted and that relevant reports would be shared. However, we never received these reports. We did not have examples of stakeholders (such as policymakers) requesting partnership products for their own use.
- Unavailability of needs assessment and baseline for lobbying and advocacy. It is not possible for the evaluators to conclusively say there was significant interaction between the HSA partnership with the government/MoH, or how the work of this programme was being undertaken. This includes whether or not a needs assessment and/or baseline information was sought from the MoH to inform a systematic approach to issues once the partnership embarked on advocacy and lobbying. One exception is the study conducted by Wemos and AMAMI on HRH and HF. It is important for the partners in an initiative of the magnitude of HSA Partnerships to understand the needs of the policymakers at the outset.

Contributing and/or hampering factors when applying advocacy approaches/strategies

Contributing factors

- There was evident demonstration that decision makers at the district level were supportive of the advocacy on HSS and SRHR.
- NGOs within the partnership are better placed to engage in advocacy and lobbying as per their track records.
- The partnership received reasonable support from policymakers. More specifically, there was a good working relationship between Amref and the Community Health Services Unit within the MoH where Amref supports the engagement of a community health services ambassador.
- Space for social accountability – there was active engagement of the community in participatory advocacy and lobbying using Score cards.

Hampering factors

- For Outcomes 32780, 32960, 32851, the substantiators said the environment was a strongly hampering factor (source Sprockler OH report).
- Lack of political will: Many meeting events were conducted at the same time and sometimes HSS was not a priority compared to other health and non-health issues. The DHO was not receptive to an extent that he did not grant audience time to the HSAP team.
- Meeting work plans were slowed due to political violence that emerged after the May 2019 elections. Field activities were sometimes suspended due to demonstrations. At the district level, such as Mangochi, there were long bureaucratic processes to obtain permission to develop the community structures.
- SRHR, particularly FP, is not seen as a priority by the MoH, hence it receives little support. Other HSS priority areas overshadow FP's importance. However, the challenges of poor support to SRHR puts more pressure on the HSS. For instance, early pregnancies put pressure on health facilities when treating pregnant women.
- There was discrepancy in opinions regarding the development of (some) tools and messages to be used as guidelines in implementing the project: few respondents felt that the development process was not appropriate and needs to be improved, whilst Amref mentioned that the tools that were developed and shared with partners, and those that were developed by partners were sent to Amref Malawi for review and approvals before usage
- Because Amref and AMAMI worked with the same CSOs in some districts, this caused the partners to be overloaded with too many activities and projects to conduct.
- A national issue that impacted the three districts where HSAP worked was the lack of qualified health staff inclusion in the health sector, and this was often due to fiscal and budgetary constraints.
- The HSAP observed growing political sensitivity towards advocacy and lobbying efforts for SRHR in 2018, as well as an unstable political situation in Malawi. Throughout 2018, at the national and sub-national levels, partners experienced tension in keeping governments accountable for their health resource allocation and expenditures. For example, in Malawi, CSOs noted that budget tracking was becoming increasingly sensitive in anticipation of the 2019 national elections. CSOs involved in social accountability were often portrayed as 'pro-opposition' by government officials.
- There was a lack of knowledge/skills-sharing opportunities among HSAP contracted partners who worked at the national level with the district-level CSOs.

Missed opportunities / lessons learned in relation to advocacy strategies

- There was a lack of a shared advocacy agenda (before HSAP came and this affected community development). After HSAP arrived, shared advocacy helped community development: *"There was lack of shared lobbying and advocacy between the communities and stakeholders especially NGOs before HSAP came. For example, on the issues of houses for HSAs: When we shared the problem with HSAP, together with them we invited the councillor and the DHO to discuss [the] roofing issue and finally the roofing materials for the houses were provided. I think this was possible because the way we involved the communities; and also, because we started sharing our lobbying and advocacy skills with them on issues they struggled with before. So,*

lack of share lobbying and advocacy really had an impact on the community before HSAP, as its delayed responsiveness to the needs of the community". (KII contracted partner)

- HSAP Malawi has missed an opportunity to work intensively with the youth parliament: The partnership failed to demonstrate how it engaged youth. For example, like other countries such as Kenya, Malawi has a youth parliament. Adapting the approach used in Kenya for engagement of the youth parliament in Malawi would have allowed the HSA Partnership to strengthen an effective space for dialogue and dissent for youth-focused CSOs advocating for improved HRH, SRHC, health finance and governance. In the same vein, the partnership must continue to work with the media and encourage the media practitioners trained by the project to advocate more and even beyond the life span of the project.

C. Conclusion on effectiveness

- The HSA Partnership needs to be realistic about what it can expect to achieve given that the context where it is working is quite fragmented and requires creating synergies rather than duplicating efforts. There is a huge gap between the partnership and the MoH bordering on a power dynamic on resources, and who holds the political clout or influence to change the narrative in the political space. The relationship with the MoH is quite critical since it needs to be built, strengthened and sustained at all times. Therefore, the partnership must endeavour to fill this gap by striving to follow established protocols to engage the MoH to gain its complete support for the project. The partnership must develop initial processes that will enable it to conduct clear and extensive introductory activities with the aim of establishing itself as a recognizable stakeholder in complementing efforts on HRH and SRHR, HF and governance in the country.
- Use of a social accountability tool called a 'Scorecard' seem to have enhanced the success of the initiatives at the district level. There is a need to continue to use this approach to increase the community's advocacy voice on health systems-strengthening initiatives including SRHR. The score cards are a tool or 'model' that can be scaled-up across the country and other contexts within the partnership.

3. Relevance toward health system strengthening and SRHR

A. Relevance toward health system strengthening

Focus influencing HSS in country

- The changes mentioned in the substantiated outcomes and collected stories led to more effective and timely delivery of health commodities, helped increase health worker to patient ratio and reduced heavy workloads, influenced budgeting for health at country level, resulted in better management and use of stocks by health workers at health facility level, and led to more awareness for testing pregnant women for non-communicable diseases (source: substantiators and story tellers).
- The partners have been able to secure commitments from parliamentarians for increased funding for FP services and commodities. The district health offices of Chitipa, Ntchisi and Mangochi have committed to include FP in their district implementation plans, which was not regularly featured. In Mangochi and Ntchisi, the partners managed to influence the director of health and social services to re-allocate health workers to the health centres in the districts where the HSA project is being implemented to address staff shortages. This was done as a

result of a social audit on HRH conducted at the facilities. A lobbying strategy to influence the hiring of interns to be absorbed into the system as permanent health workers was also a success.

- Regarding relevance for HSS, storytellers shared that the changes were relevant because they helped address the knowledge gap and high vacancy rate. This will lead to vibrant health structures with sufficient staff, ensure training and the establishment of health services, demonstrate that health issues are improving, the health centre management committee is working hard on improvements, and functional equipment leads to better quality services (stories Sprockler).
- MeTA does not have presence in Malawi and as a result there have been no deliberate efforts to advocate for increased access to commodities, which has been a challenge. However, efforts have been made by Amref to advocate for increased domestic funding for FP commodities both at the district and national levels. This has involved engagement with the MoH, Parliament and Ministry of Finance made possible with support from district-based sub-granted CSOs and the White Ribbon Alliance at the national level (KII, consortium partners).

Focus for influencing HSS regionally and or globally

- The White Ribbon Alliance hosted a regional meeting on FP where stakeholders had an agenda to ringfence funding towards FP budgeting in the country by drawing on lessons from the region. HSAP have attended global meetings where lessons from Malawi have been shared in the hopes of obtaining global influence on how policies and strategies are developed and implemented.

B. Relevance towards SRHR

Focus for influencing SRHR in country

- The Chitipa CSO network (Chairperson) substantiated the outcome regarding the task force formed by the Chitipa district council to champion FP financing in the district (32733/community actor). The substantiator was the only one who indicated a difference in relevance, highly relevant for HSS, but undetermined relevance to date for SRHR: *"I think because there is no any other activity happening, it is difficult to see the relevance. It will be relevant once we implement activities then we shall be able to establish link between what we do and the attainment of SRHR".*
- The changes led to a wider reach and awareness of SRHR, reduced rates of health worker absenteeism, improved government policies towards introducing youth-friendly centres, improved government budgets, inclusion of adolescents in creating the messages for their peers, prioritisation of young people's concerns, construction of placenta pits, deliveries in facilities chosen by the women themselves, SRHR commodity uptake enhanced, active and vibrant school health club lessons for youth about SRHR, and increased safe spaces (source: stories).
- There was demonstrable lack of understanding of SRHR by partners compared to their understanding of HSS (observation from consultant during data collection).
- Regarding relevance for SRHR, storytellers said that the changes were relevant because women and youth have better access to SRHR services now and show a greater preference for long-term commodities (stories Sprockler).

C. Conclusion on relevance

- In general, in Malawi, the HSA Partnerships programme has had more relevance for HSS than SRHR. Although all substantiators indicated that outcomes are equally relevant for SRHR and HSS, overall, there seems to be little information gathered on SRHR compared to HSS. This is a missed opportunity for HSA Partnerships programme, knowing that HSAP has worked with the SRHR Alliance to advocate for SRHR issues in Malawi. The SRHR Alliance could have brought much knowledge and many skills in the area of SRHR since these CSOs operate across the country.
- It was also a missed opportunity from the perspective that CSOs in the Ntchisi and Chitipa districts used scorecards that contained more SRHR-related topics for the advocacy at the district level, but in the outcome harvesting process neglected these important gains realised at the district level by concentrating only on those perceived to have been achieved at a national level. For example, in Chitipa there was a change in the approach by including awareness campaigns wherein myths about FP were addressed to a greater extent such that youths were now freely accessing FP services in a society whereas this had not been possible earlier. The HSAP engaged with leaders and the elderly in the community who are generally regarded as custodians of culture in Malawi with the aim to impart knowledge on SRHR and reduce resistance from these influential people.
- There was limited relevance found for the HSAP work on SRHR as reflected in the outcomes from substantiators and the evaluators' observations during data collection. There were 3 outcomes related to SRHR: Outcome 32733, 32738, and 32785, however outcome topics were limited to SRHR commodities (FP and HF), which are not truly focused on SRHR. The reason for this could be the lack of a shared advocacy agenda (particularly on SRHR), partners' lack of understanding of SRHR, and a strategy to include the SRHR alliance that was more of an opportunistic move by HSAP to lift their credibility on working on SRHR themes.

4. Lessons learned on HSS and SRHR advocacy, gender and inclusivity, collaboration and governance, and visibility/legitimacy

A. Gender/inclusivity

- The partners (AMAMI) applied a gender lens in CSO training using their own creativity and learning in previous projects on training for general knowledge and not necessarily as an activity to be measured as an indicator for the HSAP.
- Gender-mainstreaming efforts: Amref has organised a gender-mainstreaming training for the partners, and invite both men and women to meetings as an initiative to promote women's participation. Some activities targeted female parliamentarians, e.g., members of the women's caucus of the parliament to ensure that women's advocacy needs were taken on board. Community health structures included women and young people, and women have taken leadership positions in these structures. Women were to be involved in conducting policy audits as well.

Relevance for women, girls, LGBT, People with Disability (PwD) and other marginalised groups

- All substantiators indicated that the relevance for girls and women was high, but the reasons given did not support the level of relevance.

Hampering and/or enabling factors in implementing a gender and inclusivity lens

- Gender and inclusivity were not integrated from the beginning of HSAP programme. Based on the responses provided during KII, consortium partners and contracted partners' understanding of gender and inclusivity seemed quite limited. The concept of gender and women's involvement/participation in HSA Partnerships programme (number, strategy to approach them, etc.) was still underdeveloped.
- A lesson learned from the HSAP's work in 2018 is that HSA teams sometimes struggle with how to operationalise meaningful youth participation. This was especially true in the two 'new' countries, Malawi and Tanzania, which had started their HSA programmes towards the end of 2017.

B. **Collaboration and governance**

- Initial communication about the project was unclear in terms of the roles of various partners. Later, partners resorted to working collaboratively, although each institution remained autonomous. Although the parties seemed to come to a common understanding, complementarity was challenged by persistent misunderstandings and overlaps that were silently ignored for the sake of the project. "*When this project came, I felt like there was role confusion because at first when we were introduced to this project, our understanding was that Amref was responsible for disbursement of funding - that is Amref Netherlands. As such I did not think Amref in Malawi was implementing the project. But when we got on the ground it is when we learnt that they are also implementers in Malawi instead of us only. As such we had challenges of understanding who was going to do what and with who and when"* (KII, contracted partner).
- From KII findings, there were issues in coordination and communication among all members in the partnerships. There was almost no data shared among members, so the government received repeated requests for the same data from HSAP partner. The quarterly meeting between Amref and AMAMI did not happen regularly due to Amref's busy schedule, and uncoordinated, overlapping meetings organised on the same day by consortium partners.

Complementarity

- Complementarity and autonomy were highly visible at the national level where partners came with specific topics and worked on them together as needed. For instance, AMAMI and Amref agreed on social accountability to advocate for HRH in health facilities, which was an independent topic that each partner supported. However, there were other topics influenced by regional and global partners, that were not priority areas for the national partners. One example was the issue of doctor migration that was influenced by a regional context, but was not highly marketable in Malawi. There are few job opportunities for medical workers in Malawi in general, hence many prefer to look for employment elsewhere.
- The failure of all HSAP consortium partners to operate smoothly in Malawi influenced complementarity of the advocacy strategy.

Added value from collaboration and the governance structure

- Malawi, as a context, had three HSAP partners, namely Amref, ACHEST through the Association of Midwives in Malawi (AMAMI) and Wemos. AMAMI started its implementation almost one

year later than AMREF and this affected timely implementation of some activities. Wemos does not have an office in Malawi and remotely implemented their activities.

- Wemos's lack of an office in Malawi affected their contribution to some activities, especially for the GFF. For example, Amref, AMAMI and Wemos had planned to orient CSOs in Malawi on GFF based on Wemos's experience in other countries. Although this orientation happened, it happened too late when the writing of the investment case had already started and the orientation was expected to have been completed. Thus, Amref and ACHEST could not proceed with the orientation on their own because Wemos had the expertise.

Collaboration within the partnership linking local to global advocacy

- Global Amref Health Africa developed a toolkit for CHWs in 2017. This toolkit was offered as a reference document by Amref Global to assist countries develop their CHW guidelines. This toolkit is being used by HSAP project in Malawi to advocate for the inclusion of its 11 elements in the national guideline.
- Hampering factors that have affected linkages for advocacy include poor networking mechanisms between global and national platforms. An example is the African Health Accountability Platform that Amref initiated at a regional level with country chapters in all countries implementing the HSAP. This platform has not performed to the expected standard due to poor coordination and networking.

Challenges and successes in collaboration and governance / hampering and/or contributing factors

- The joint action planning (JAP) meetings presented an opportunity for all partners to learn from experiences at local, national, regional and global levels. At a national level, the annual planning and review meetings presented an opportunity to share experiences and strategies to implement HSAP's advocacy work.
- There was a duplication of efforts by the two key partners (Amref and AMAMI) working with the same CSOs in the project. That said, although this approach strained the CSOs, the result of this action was viewed as an enabling factor to achieve synergy.
- An overlapping of advocacy focuses between Amref and AMAMI occurred despite the agreement that Amref would focus on CHWs and AMAMI on professional health workers (doctors, clinicians, nurses, etc.). In reality, AMREF also focused on the professionals that AMAMI was assigned to.
- Some of the subcontracted partners between Amref and AMAMI were the same. For example, NGOs trained to use Score cards by AMAMI, were also used by AMREF to implement activities. The HRH Coalition is one of these 'double implementers', and that's the challenge. Both Amref and AMAMI planned for the HRH Coalition to do specific work and this work was not integrated.

C. **Visibility / autonomy / CSO's capacity strengthening affected CSO legitimacy**

- Responses from substantiators for outcome substantiation varied. The substantiator for outcome 32733/community actor had a different answer than most and indicated that 'CSO[s] are not any more visible than before', whilst the substantiator for [Outcome 32762/policy maker] indicated a moderate increased visibility for CSOs: *"We only know one CSO called*

MEHA [not the HSAP], the problem was that Amref did not share the partners that they were working with. We already knew MEHA before this programme. Ministry has technical working groups where partners are expected to present their programmes. But Amref only shared what they do and not [who] they are working with (the partners). We just hear that they funding some CSOs in Mangochi but not from Amref". For the other outcomes, substantiators indicated that CSO visibility had increased significantly.

- A similar quote on limited visibility: *"I think visibility of CSOs is minimal…To my knowledge, I didn't know that there was an organisation at district level that was getting support from HSAP to implement this until last week on 10-12 March 2020 when I went for the annual reflection meeting. I know the NGO FOCUS and I knew they had a project in Wenya. I knew but I didn't know that it was associated with HSAP. The problem is that there was no information sharing by Amref as the owners of the programme".* (32733/community actor)
- All story tellers indicated that the visibility of their CSO had improved significantly compared to before their involvement with the HSA partnership.

D. **Conclusion on lessons learned**

The lessons learned from the implementation of the HSAP programme in Malawi:

- Gender inclusivity: Gender was an added addendum in 2019, and activities were developed this year to examine gender issues. Gender came as an afterthought along the way. Apart from indications from main partners that CSOs were trained in gender and inclusivity, no evidence was found in terms of how this project has addressed the issue of gender. We received no meaningful data on inclusivity.
- Collaboration: Based on the findings from KII and evaluators' observations, it seems the collaboration between two consortium partners Amref and AMAMI happened on practical functions rather than strategic ones. Although they agreed on the separation of their advocacy focus, in reality, there was some overlap. As a result, they worked/contracted same CSOs at the district level, which in the end made the CSOs overloaded. The absence of HAI and Wemos in Malawi caused a lack of focus/priority on RH supply commodities and HRH and HF. To address this issue, Amref assumed the role to advocate for increased domestic funding for FP commodities both at the district and national levels. AMAMI and MEHA led the advocacy on HRH. Wemos had also conducted joint research with AMAMI on a case study of HRH and HF in Malawi. This study became a basis/source for CSOs to identify issues for further advocacy, including the use of score cards.
- Complementarity: Even though the collaboration between Amref and AMAMI complemented each other's work based on their experiences of agreed advocacy focus, there were some topics that were not covered by the partnerships due to the absence of HAI and to some extent Wemos. Complementarity was challenged by persistent misunderstandings and overlap that were silently ignored for the sake of the project.
- Visibility: There were mixed responses on how the partnership has increased CSO visibility. While some substantiators thought there was a significant increase in visibility, others were of the view that there was minimal visibility.

5. Sustainability of programme results

- We do not have ‘direct data’ on mechanisms in place to sustain advocacy outcomes and governance mechanisms to sustain CSO advocacy efforts from the evaluation during data collection. However, we concluded this section by using indirect data and our observations. HSAP’s relationship with the MoH showed good, but not sufficient, engagement. HSAP needs to conduct a stakeholder meeting to present their cases and their work in the 3 districts. HSAP’s advocacy focus is already aligned with the government’s agendas and HSAP has already used existing structure. Therefore, this work needs to be strengthened even more. The alignment of advocacy focus with government’s agenda helps HSAP’s sustainability strategy. HSAP also needs to follow up on the commitments that stakeholders made/mentioned/expressed in the harvested outcomes. Thus, in Malawi, HSAP has achieved important steps and well-established structures within the government, which are likely to remain. However, for some structures it is uncertain if these will remain when HSAP pulls out. The collaborations and relationships among consortium partners, contracted partners and network partners are believed to continue after HSAP ends. Further work still needs to be done to develop a sustainability plan (exit strategy) to continue the work beyond HSAP programme.

Country Context: Uganda

1. **Capacity strengthening efforts (of individual CSOs, CSO networks, communities, and media) done at a country context level**

Story collection Uganda

- Twenty-one stories of CSOs and media were collected in Uganda. The majority of the storytellers 15/21) were mainly involved with Amref as the HSAP contracted partner. Three storytellers were mainly involved with HEPS, three with ACHEST and none were involved with Wemos. Nineteen respondents indicated that they had participated at least one HSAP capacity-strengthening effort to increase their lobbying and advocacy skills. Two indicated they had not; however, they had worked with Amref and HEPS.
- Twenty participants indicated that they had received some kind of funding from one HSAP contracted partner and one indicated they had not received any funding. This person had worked mainly with ACHEST. Participants who had received funding indicated that they received sub-grants, partner donations, financial and technical support, as well as support to run activities and reimbursement for transportation, including meals and accommodation when travelling. Two respondents shared that they had received in-kind support for activity facilitation and organization.

A. **Strategy and focus**

- A large majority of the respondents indicated that they had gained practical advocacy skills, increased knowledge on SRHR and/or HSS or a combination of the two from HSAP. None of the respondents indicated that new relationships were the sole topic area in which they had gained capacity.
- The majority of the respondents indicated that the capacity training received had led to change. Several respondents mentioned training on smart advocacy, outcome harvesting and SRHR and HSS in general. They shared that their knowledge and understanding of concepts such as social accountability and score cards had improved. They shared that during these moments and trainings they had learned how to identify who to target (as allies, messengers, staff and decision makers), package their advocacy message, approach stakeholders and decision makers with fitting arguments, use and collect data as evidence for advocacy, create an advocacy strategy and prioritise efforts, link key people, report on health issues and solution journalism and getting published, and conduct successful follow-up.
- Participants were asked to identify the thematic area related to the change they had described. A maximum of three options were possible. The most frequently selected options were sexual and reproductive health commodities (SRHC) supply (11 times), family planning (FP) (11 times), gender, inclusivity and youth (7 times), and a strengthened health workforce and improved working conditions (6 times).
- All respondents indicated that the change they had described was specifically relevant for SRHR and for health system strengthening. The two respondents who did not participate in any capacity-strengthening efforts also considered the changes they had described to be extremely relevant for HSS and SRHR.
- Most respondents (18/21) indicated that the change was intended, whereas three respondents indicated that the change they had described was unintended or a surprise.

- Most respondents considered the community level and the organisational or network level to have experienced the biggest effect of HSAP's capacity-strengthening efforts. The individual level was hardly considered by the respondents.
- The majority of the respondents indicated that they believed that HSAP's efforts were the primary reason the change occurred. Two respondents were not sure whether or not the change would have happened without HSAP's efforts. Their stories related to the Health Workers Migration Policy and the development of adolescent health messages.
- The majority of the respondents indicated that the visibility of their CSO had improved moderately to immensely compared to before their involvement with HSAP.
- Storytellers were also asked to share what, if any, next steps they considered necessary for capacity strengthening and who should carry these out. Many indicated that necessary next steps include more capacity-building training to support local CSOs and other grassroot organisations, e.g., in the area of monitoring and evaluation, photography, videography or on working with youth. Other examples of next steps are more engagement with local leaders, ensured sustainability of youth corners, and continued media engagement to identify gaps. The parties that should undertake these next steps are generally, the main HSA partners, with Amref mentioned most frequently, other CSOs, local and national governments, and international, regional and local organisations and coalitions such as RMNCAH and GLOFORD.
- HSAP focused specifically on capacity strengthening of youth (organisations), as in the case of Kabale, Lira, Dokolo and at the national level. Here youth voices were strengthened either through organising intergenerational dialogues at a community level, capacitating youth chairpersons, engaging adolescents in developing adolescent health messages, and strengthening youth organisations in the RMNACH coalition. As one youth RMNACH member expressed: *"It was a very amazing opportunity for us to be part of the HSAP, it broadened the understanding for some of our work. The capacity building was impressive."* (32911/CSO)
- The capacity strengthening of the youth voice within RMNACH was also taken forward at a regional level through the support of Uganda youth organisations attending meetings at the EAC level related to advocacy for the EAC SRHR Bill in which these organisations gave input on the Bill from their youth perspectives.

B. **What worked and did not work**

- Storytellers shared that they were able to better plan and budget the available money; their work had also led to more access to health commodities and more recruitment of health workers. Regarding the relevance for SRHR, the changes had led to a wider reach and heightened awareness of SRHR, reduced rates of health worker absenteeism, improved government policies towards introducing youth-friendly centres, improved government budgets. Other changes were adolescent inclusion in creating the messages for their peers, prioritisation of young people's concerns, construction of placenta pits, women choosing which facility to deliver in, enhanced SRHR commodity uptake, active and vibrant school health clubs to teach youth about SRHR, and increased safe spaces. Regarding the relevance for HSS, the changes had led to more effective and timely delivery of health commodities, better adolescent engagement, an increase in health worker to patient ratio and reduced heavy workloads, influence on budgeting for health at the country level, better management and use

of stock by health workers at a health facility level, and more awareness for testing pregnant women for non-communicable diseases.

- HSAP partners' technical expertise both on HSS/SRHR and advocacy led to successful capacity strengthening of the CSOs and media. As one capacity receiver explained: *"Amref did well in building the capacity of us and others. They have been very facilitative. They helped to increase our understanding of policy advocacy. They gave support and mentoring. Other organisations would bash us. Amref addresses the issues with you. They have also taken us to a next level in terms of organizational capacity."* (CSO)
- Through CSO capacity strengthening in the districts and their subsequent advocacy towards district governments, one district government official stated that their capacity to advocate for issues and funding with the central government had increased as well.
- Capacity strengthening was done more jointly as a partnership at the national level with the media and CSO networks, than was done at the district level, which was Amref's main focus. This approach works well for district-level advocacy, however connections to national-level advocacy have not been well established and capacity strengthening of district CSOs have not been focused on engaging in national-level advocacy to amplify their work in the districts. Additionally, in the case of Lira, two HSAP contracted partners worked in parallel with distinct CSOs advocating for the same issues (GLOFORD through Amref, and UNHCO through HEPS).

C. **Supporting and hampering factors**

- There was a sufficient HSAP budget for capacity strengthening of CSOs and media, and contracting CSOs.
- There was strong involvement of CSOs embedded in the community, by giving them autonomy and support where needed.

D. Conclusion/Reflection

- The capacity strengthening in Uganda has been quite targeted with a small set of receivers who established long-term relationships with CSOs that proved conducive for continuous capacity building and advocacy.
- HSAP not only built CSO capacity in SRHR/HSS and advocacy, but also in organisational development, and this contributes to sustainability.

2. The effectiveness of the advocacy approaches

A. Actual changes (outcomes)

In total, the alliance harvested 60 outcomes for the Uganda context, of which 12 (20%) were substantiated during this evaluation.

Outcomes substantiated[10]:

[10] Two more outcomes were to be substantiated, however due to COVID-19 and the lock down in Uganda during field work, the planned interviews with the substantiators had to be cancelled. These two harvested outcomes are: "In May 2018, the Ministry of Health approved an indicator for reporting on adverse drug effects, which was incorporated into the National Health Management Information System (HMIS) in 2019" influenced by HEPS and "On 7 May 2019, for the first time, the Human Resources for Health (HRH) Technical Working Group (TWG) of the Ugandan Ministry of Health adopted the findings of the ACHEST/Wemos research on Health Workforce Financing in their next HRH Strategic Planning in 2019/2020-2024/25" influenced by ACHEST.

- **Changes in policymaker support on HRH, SRH commodities, health financing and governance:** outcomes 32921, 32922, 32919, 32924, 32918, 32912, 33028, 33029, 32904, 32902.
- **Changes in involvement of CSOs and HSA partners in policymaking and implementation processes:** outcome 32899
- **Changes in the development of effective evidence-based messages taken up by like-minded networks and organisations:** outcome 32908

Roles and contribution of external factors/actors in achieving advocacy's outcomes

- All substantiators felt the environment enabled change, especially political support from local/district governments.
- The availability of HSAP funds to convene CSOs and politicians was also seen as an important enabling factor.
- A staff of an HSAP implementing partner based in one of the districts explained that district governments are receptive, but their hands are also tied. "*They seriously don't have the resources". He stressed the importance of connecting with national-level advocacy with Parliament and the MoH to increase resources for district government health plans*. (CSO)
- There are examples of achievements that did not lead to full change due to hampering factors. Examples include the doctor's house and ante-natal services at the Amach Health Center 4 in the Lira district. The doctor does not reside in the house yet due to lack of running water. Mothers can be tested for pre-eclampsia with the new manometers, but because of a lack of electricity, no tests for liver or kidney function can be performed.
- A contributing factor for the Amach Health Center 4 in the Lira district: the in-charge could liaise with NGOs other than the HSAP partners (e.g., such as Plan International Uganda and TASO) to improve the health facility. This may explain why the substantiator rated HSAP's influence on the change lower than the harvester did.

Best practices and setbacks in the advocacy process

- HSAP's advocacy led to actual and tangible changes in policy, budget and implementation at district and national levels.
- Using evidence in their advocacy has led to policy changes, such as the MoH's approval of the indicator for reporting on adverse drug effects, which was incorporated into the National Health Management Information System. A second example, is the Human Resources for Health (HRH) Technical Working Group (TWG) of the Ugandan MoH's adoption of the findings of the ACHEST/Wemos research on Health Workforce Financing, which was taken on in their next HRH Strategic Planning in 2019/2020-2024/25.
- HSAP contributed to the formalisation of the RMNCAH youth coalition, which brings together youth-led and youth-serving NGOs at the national level. It is hoped this action will be replicated across districts.
- The joint advocacy by HSAP with other CSOs led to a national budget increase from 8bn to 16bn Ugandan shillings for SRHC in 2017/2018.
- One MoH external expert praised the work done by MeTA: "*MeTA has been very useful in identifying the gaps and bringing them to [the] policy level. They have a sharp eye to identify, they make noise. We need that kind of partnering; they interact with the people. MeTA has really helped in bridging the gap between policy and people. Pre-eclampsia is now a big issue thanks to them.*"
- The sensitization and involvement of national and local media has appeared to be successful. Journalists claim that they have been empowered with accurate HSS and SRHR information so they can report without bias and demonstrate gaps in these areas. The pre-eclampsia campaign is a good example of involving media, Parliament, government and health facilities,

backed by evidence, which has had an amplifying effect to motivate more pregnant mothers to be checked and thus avoid unnecessary maternal deaths.

- HSAP's advocacy in the districts resulted in tangible outcomes such as construction of buildings and other sites at health facilities (doctors' houses, maternity wards, theatres, and placenta pits); the recruitment or redeployment of health workers; the establishment of youth corners; availability of FP commodities; budget allocations for FP promotion; and availability of blood pressure machines to prevent pre-eclampsia.

Missed advocacy opportunities / lessons learned

- Respondents claimed that the government should be held more accountable since improvements in HSS and SRH are too slow. One HSS/SRHR expert in Uganda indicated that HSAP should do more in governance and leadership given their track record and translate their monitoring of health facilities in the communities to advocacy at the national level where the financing for health is a significant barrier to the improvement of health facilities. (networking partner and external expert)
- Some respondents (CSO through story, 32902/networking partner, 32955/policymaker) mentioned that to improve SRHR, more is needed than only focusing on the health system. Suggestions were given for HSAP to engage in educating the youth about SRHR in the communities and schools, and engage in tackling early marriages and teenage pregnancies. (stories, 32902/networking partner, 32922/policymaker
- The RMNACH youth coalition is an achievement, however the substantiator felt it is not yet owned by the ministry. (32899/policymaker)
- It is unclear to what extent the SRHC budget increase in 2017/2018 at the national level trickled down to the district level and whether or not the availability and uptake of SRHC increased.

B. **Advocacy approaches and strategy HSAP partners**

Advocacy strategy and focus

General

- One external HSS/SRHR expert praised HSAP for their evidence-based advocacy and involvement of young people by bringing their findings and young people's messages of need to high-level platforms. (external expert)
- Contracted partners recognize the added value of Amref and their partners working at the community level, which generated data that other partners could use for national-level advocacy.
- Another successful advocacy approach was the financing provided to bring stakeholders together at the district and national levels to share their technical expertise. HSAP has worked with CSOs, government (national and district), the private sector, communities, media and Parliamentarians. They have convened meetings and established structures in which these stakeholders could meet and work together. Examples include MeTA as a permanent structure, the First Presidential Dialogue on Quality of Health Services and community dialogues among others. As one external HSS/SRHR expert observed: "Many organisations have the will, but do not have the means. HSAP had both, they paid for workshops and meetings. This has been a big value addition of HSAP." (external expert)
- As one contracted partner explains: *"… our approach to advocacy is not confrontational. We strategically select the people we want to work with. Very big factor on how we do our advocacy. It is a big advantage, we don't confront, we dialogue. Even when we dissent, we dissent in a diplomatic way. So, it's all about informing and inspiring others through research, through knowledge, through sharing and the different capacity building approaches."*

- Both contracted partners and external experts recognized ACHEST's role as a technical hub for government, CSOs and media, especially on HRH, governance and leadership.
- HSAP has focused on having HSS and SRHR issues embedded in existing or new policy and budget structures, leaving the responsibility to duty holders to have appropriate policies and implementation to serve people's needs.

National

- An external HSS/SRHR expert recognized HSAP's role in the Technical Working groups of the MoH in which they bring evidence and actions to the table. Good examples are MeTA and the ACHEST/Wemos's study on financing of the health work force in Uganda. The latter was put into the new Ugandan human resources for the health strategic plan. (external expert)
- HSAP engaged with the Parliament's health committee in which they presented issues of SRH, the lack of youth-friendly services and youth voices being heard. With HSAP's support, a Parliamentarian health forum on the quality of health services was established. According to a member of Parliament, HSAP's advocacy approach helped to inform Parliament decisions. (32902/networking partner)
- HSAP is recognized for its involvement in national-level structures and initiatives, such as UN agencies, the GFF and Technical Working groups of the MoH. (external expert)
- Another successful approach was allowing young people to express their needs and issues taken forward at the national level for policy change. (external expert)
- HSAP engaged media, both journalists and the media houses, uilding the media's capacity on HSS and SRHR, and taking them to the field to report on gaps in health service delivery. Journalists have reported on free contraceptives and maternal health medications being taken and sold across the border with the DRC, the misuse of a free ambulance service when a driver asked for excessive payments to be transported, and the impact of the unmet need for contraceptives (stories). Journalists have received multiple awards for these stories.
- HSAP also funded the media and Parliamentarians to go to the field to see the HSS and SRHR issues at hand.
- Another approach taken in Uganda at the national level was being part of various CSO (advocacy) networks, and thus to bring HSAP's expertise and lean in to other CSO's expertise.

Community level (including communities' empowerment to demand their rights)

- A key HSAP approach has been to let a CSO, based in the district, have a central role in engaging the community, health staff, and district government (both technical and political arms) in identifying and addressing gaps at health facilities. Advocacy asks came from the bottom up (from the communities). HSAP has been instrumental in bringing stakeholders together, allowing for dialogue and navigating bureaucratic decision-making processes at the district government level. They have been able to use multiple approaches, such as petitions, intergenerational dialogues, site visits for district government and committees to see the situation on the ground with their own eyes, or involving the media to report on dire situations.
- One external HSS/SRHR expert mentioned HSAP's unique added value in their work at the community and district levels. *"Many times, advocacy organisations concentrate at [a] national level. Not at [a] district level. Pressure from districts to [the] national level is important. That was their added value."* (external expert)
- At the district level, substantiators appreciated the HSAP partners for their advocacy approaches of monitoring health facilities, mobilizing community members and health staff, and convening meetings. In these meetings they bring together district government at a political and technical level, community leaders, communities and health staff to discuss issues related to SRHR and the community health system. Communities learn to appreciate the restrictions health facilities may have, and the health facilities and district government learn about the communities' needs. HSAP partners follow up continuing to raise issues with the

district government by attending meetings, and maintaining relations and joint discussions about the district health work plans including budgets.

- Several respondents stated that HSAP has contributed to improved relations between communities, health staff, CSO partners and the district government (political and technical arms). As one district political official stated*:" They were able to bring on board all key district stakeholders. The RDC, CAO, technical staff, the council, if you can bring them together then your advocacy has been really good."* (32924/policymaker)
- One substantiator stressed the importance of having members of the political district government visit the health facilities and talk to communities, in an effort to convince the authorities to change policy and provide an improved budget. He praised HSAP for facilitating this.
- In addition to the improvement of the health system, HSAP worked towards empowering communities to know their rights and be able to demand good quality health services. HSAP partners have used petitions, citizen's hearings and intergenerational dialogues to increase citizens' voices. One substantiator explained that they had to take the community voices seriously: *"We did not want the community to lose trust in the leadership".* (32919/policymaker)
- HSAP built the capacity of personnel in-charge of the health facilities and the district governments to advocate for the institutions that fund them, the district government and the national government, respectively. One district government official confirmed this value addition of HSAP.
- Focused advocacy to improve certain health facilities complemented advocacy in other areas. With the recruitment of the in-charge in Amach Health Center 4 in the Lira district, follow-up advocacy was conducted with him and the district authorities to obtain blood pressure machines, a doctor's house, a functional theatre, placenta pits and a new ambulance, all of which materialized (except the ambulance).

What worked well and less well

- Evidence-based advocacy increased legitimacy and credibility; it makes decision makers listen.
- Facilitating communities to raise their needs and concerns to decision makers is not only a successful approach, since governments don't want communities to lose faith in them, it also makes local CSOs less vulnerable when they advocate for sensitive issues since they are reflecting the communities' needs.
- Media and Parliament have proved to be contributing to advocacy on HSS and SRHR issues.

The contributing and/or hampering factors in applying advocacy approaches/strategies

- All environments were considered to be enabling.

Missed opportunities / lessons learned in relation to the advocacy strategy

- There has been a disconnect between district- and national-level advocacy and advocacy for the HSAP themes, due to the dispersed presence of HSAP partners. Amref works at a district level, but is less focused on SRHC and governance, while HEPS and ACHEST have expertise in SRHC and governance, respectively, but engage only at the national level. For HRH, which is a theme ACHEST and Amref have advocated for at the national and district level respectively, there is no evidence in this evaluation that HSAP linked HRH advocacy between the national and district levels. In addition, the link between the country context to regional and global levels is not clear.
- There is little evidence of HSAP's efforts to see through the complete implementation of achieved advocacy outcomes.

C. **Conclusion / Reflection**

- The advocacy approaches and the results achieved demonstrate HSAP partners' capacity to empower communities, understand government policy and budget cycle processes and thoroughly understand (political) decision making at national, district, health facility and district levels.
- HSAP could strengthen linkages between districts and the national level, and between country-context levels and regional/global levels. It is unclear to what extent the SRHC budget increase in 2017/2018 at the national level trickled down to the district level and whether or not availability and uptake of SRHC increased. HSAP is in a unique position due to their presence at both the national and district levels for better accountability.
- Significant achievements were made in "hardware" , e.g., construction of buildings and sites, increased health staff, but less in "software", e.g., systemic issues in governance, and key SRHR outcomes such as teenage pregnancy.

3. Relevance towards health system strengthening and SRHR

- The substantiators regarded the relevance for SRHR and HSS as equal for all outcomes, meaning no distinction between SRHR or HSS—one is no more relevant than the other.
- All outcomes were regarded as highly relevant for SRHR and HSS.

A. **Relevance towards health system strengthening**

- An external HSS/SRHR expert praised HSAP for their focus on HSS as, *"there is no block of Uganda's health system at the moment of which we can say is doing well. These blocks are interrelated."* She continued by stating that the government is increasingly taking action especially in relation to HRH. *"I want to believe also HSAP [has] added value there".* (external expert)
- Much has been achieved in recognition of the community health workers extension programme. HSAP came in with evidence and advocacy messages. There was high-level buy-in from the government, however, the financing of the community health workers is where it has stalled.
- The MoH adopted the health worker migration policy, which is waiting for an impact assessment after which it can be tabled to the cabinet. (story)
- Substantiators confirmed that HSAP contributed to HSS strengthening through their advocacy towards having buildings or other facilities constructed so that doctors can reside near the service facilities and patients can undergo surgeries (Maziba theatre in Kabale), mothers can deliver in safe maternity wards, and placentas can be disposed of safely in placenta pits. Some substantiators indicated that improved facilities have motivated the health staff. Another advocacy area that contributed to HSS was the recruitment and balancing of health staff, including doctors, in-charges and midwives, e.g. in the Kisoro district, HSAP was able to have the district plan and budget for 4 medical officers and 35 midwives. This increased the availability and uptake of health services.
- HSAP was successful in securing HSS and SRHR issues in (local) policies and budgets, such as the construction of placenta pits in Dokolo, which were paid for from government funds.

B. **Relevance towards SRHR**

- Since Amach Health Center 4 in Lira, invested in blood pressure machines and a senior medical officer (2018), no pregnant woman has died because of pre-eclampsia. (32904/community actor)
- Substantiators confirmed that maternal and child health services in particular have improved due to HSAP advocacy efforts—recruitment of midwives, construction of maternity wards and placenta pits, and functional theatres that allow for caesarean sections.
- In Kisoro, improved FP services were reported. In Serere, the district government paid for midwife and nurse training on FP commodities, especially implants and IUDs. In Lira, due to efforts by HSAP and the district government contraceptive prevalence rate increased from 34% to 45%. However, the district government official admitted that adolescent uptake of FP is still very low. A substantiator at the national level confirmed that despite a budget for SRHC, teenage pregnancies remain high in Uganda: *"So, money is not the big problem, the major problem is behaviour change."* (32902/networking partner) The substantiator in Dokolo stated that due to established youth corners in which girls receive information about how to avoid early pregnancy, there has been a declining trend in the rate of teenage pregnancy in the district. (32918/policymaker)
- In Lira, Dokolo, Kabale and Serere, HSAP has contributed to youth corners in health facilities in which adolescents and youth can receive SRH information and services, including FP. Most facilities dedicate a certain day of the week for this group to access health services. As a substantiator explained: *"Every Tuesday of the week, we run an adolescent clinic where all teenagers come in for services without fear of being seen by their parents or relatives. In one of our community outreaches, we found a family where the mother was pregnant, the daughter was pregnant and the daughter-in-law was also pregnant. They three refused to come to hospital because of the fear to meet each other at the hospital with the same condition."* (32921/policymaker)
- There is no clear evidence that HSAP has contributed to the improved maternal health of pregnant adolescents. One district government official stated: *"[girls] below 18: we don't encourage them to get pregnant. Pregnancies below 18 years is a no-go zone… Some come to the facilities. Others, due to fear of legal issues and legal actions, remain in the communities."* (32922policymaker)
- In Kabale, laboratory tests for HIV and STDs are now in place. (32912/policymaker) In Kabale, 30 school health clubs have been established after orientation with 197 teachers and headteachers. These clubs provide SRH services in schools. (story)
- Substantiators and contracted partners stated that despite the good results, gaps still remain since not all health centres could be reached with advocacy.
- The increase of the SRHC budget is a success to which HSAP contributed. However, one external SRHR/HSS expert explained that these budgets have not been stable and need continuous advocacy. There is no evidence from this evaluation whether or not the increase of the national budget has had an effect on increasing district budgets, and more availability of SRHC. If it has had an effect, it is not clear how that happened.
- One contracted partner explained that HSAP did more for SRH and less for rights in this respect, due to sensitivities in the country and what is permissible within the law.

C. **Conclusion / Reflection**

In Uganda, HSAP contributed to both HSS and SRHR through their thematic priorities. The focus has been predominantly on HSS and "hardware" (buildings, construction, health staff, and availability of SRHCs), and with less focus on "software", such as the root causes of poor SRHR and health inequity.

4. Lessons learned on HSS and SRHR advocacy, capacity strengthening, gender and inclusivity, collaboration and governance

A. Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS

- One contracted partner indicated that they worked on HSS in Uganda within the context of SRHR. The advocacy for community health workers and around health worker migration contributed to better outcomes on SRH since these health workers also address SRH.
- An HSS/SRHR expert stated that other partnerships work on rights and issues around safe abortion in Uganda. The expert did think that HSAP could have done more in relation to safe abortion in the context of maternal health, and especially since the partnership brought together service delivery and advocacy organisations, which enables evidence-based advocacy.

B. Gender/inclusivity

- Contracted partners recognise that gender was not significantly considered at the start of the programme, although they participated in training on gender mainstreaming. It was felt that gender issues were taken on board in the activities after the training.
- All substantiators indicated that the relevance for girls and women was very high. Some outcomes impacted girls and women directly. Other outcomes, such as the doctor's house in Amach Health Center IV impacted the girls and women more indirectly. The substantiator explained: *"When you look at SRH, with a medical officer residing at HC4, he can work on post-abortion care, FP, maternal health, child health, [and] improve immunization of the girls. He can plan to have outreaches at nearby schools. If he is based there; he can visit schools to support girls in schools. He can do sensitization with girls and women on SRH."* (32921/policymaker)
- For LGBTI, the relevance was moderate, since it was a trend for all outcomes of the HSAP programme. A community actor mentioned that the health workers in the facility received training from another party outside the HSAP: *"This facility is a key population (KP) facility, we even have a KP focal person who is trained. The advocacy did not touch the KP per se, but the fact that we have a focal person and also got an orientation, anyone who comes in this category gets access to our services without any limitation. The training was outside this partnership; it was done by the School of Public Health Makerere University, but with funding from TASO. I think TASO also got the funding from [the] Global fund. When we go out to the community for an outreach, the KPs get our services without any limitation."* ((32904/community actor)
- Three substantiators claimed that there were no LGBTI in their districts. Others stated that it is difficult to obtain information on the needs of LGBTI and reach them since they are not out in the open in Uganda. One substantiator stated that he is aware that LGBTI also need SRH services and that they can access those, but that interventions are not specifically targeted at them.
- For PwD, substantiators admit that this population had not been considered as such. However, they are not discriminated against; they get equal opportunity to access the improved health services or facilities. Two substantiators mentioned that a ramp had been installed to access

the facilities (32904/community actor, 32931/networking partner). One said they had requested delivery beds that were disability-friendly (32922/policymaker).

C. **Collaboration and governance**

- Contracted partners have appreciated working together in HSAP, while also acknowledging the challenges. They indicated that they had learned much from each other and achieved a great deal. All contracted partners were proud of their Country Management Team (CMT) structure, including an MoU, leadership rotation and monthly meetings, which was copied by other contexts.
- Successes of the collaboration mentioned by the contracted partners included: clear identified roles for each partner in terms of themes and entries to advocacy targets; joint activities in which the partnership came out as one (i.e. Health Workers Symposium 2018, First Presidential Dialogue on Health 2018 and First National Health Promotion and Preventive Conference 2019); joint media orientation; and the ability to connect from a subnational to national to regional and global level.
- Challenges in the collaboration mentioned by the contracted partners included: publishing and sharing results and weak M&E systems across the partnership; limited capacity building on outcome harvesting; the lack of process reports, which resulted in a lack of documentation for the advocacy work and lessons learned; connecting the multiple contexts across levels (national/regional/international) together in advocacy and sharing information and results; time spent in the beginning getting to know each other and understanding each other's structures; and a sense of competition and duplication of work among contracted partners especially in the beginning. Also, it was generally felt that contracted partners did not work as a partnership, but rather as individual organisations pushing for their own agendas under the umbrella of HSAP, despite the synergies sought. Joint planning was difficult, since some organizations developed work plans with other partners within HSAP (i.e. Amref Uganda with Amref HQ and HEPS with HAI). There were no partnership work plans made and no funding for joint activities. The context team attempted to find a solution by presenting their quarterly reports to each other and finding activities that could be done jointly, but funded by each organisation individually. Most contracted partners felt that this increased the sense of being in a partnership, although, one felt that the "joint" activities were still led by one partner and "some were coming along". One core partner also felt that the partnership could have gotten more mileage in their results if there had been joint planning and advocacy strategizing, with each organisation bringing their thematic expertise and entry points into decision makers. These challenges led all contracted partners to believe that the partnership agreement was not well crafted.
- Challenges in governance mentioned by the contracted partners included: a sense of opaque decision making about budget allocation to partners; the lack of a coordination budget at context level, which implied that each organisation had to invest their own resources for coordination; participation challenges for one consortium partner since they were the only one not based in The Netherlands.

Complementarity

- For all outcomes, the substantiators indicated that the HSAP was the primary reason the change occurred. However, only in the case of two national outcomes (both harvested by

HEPS) was the change influenced by the cooperation of all contracted partners (32902/networking partner, 32908/networking partner). HEPS indicated that to achieve the outcome on the increase of the SRHC budget, the contracted partners complemented each other when an opportunity came up, which was confirmed by the substantiator. However, the substantiator also indicated that this achievement was realised by the efforts of many NGOs in Uganda.

- For the one substantiated media outcome (32908/networking partner), HEPS indicated that to achieve this outcome, their strategy was fully aligned with other contracted partners and based on a shared vision.
- For most outcomes, Amref indicated they worked autonomously, so their approach was not aligned with the other contracted partners based on a shared vision.
- External respondents recognised the complementary expertise of the HSAP contracted partners. HEPS was recognised for their expertise in bringing stakeholders together (including those in the private sector) around RHSC, Amref for their work at the community level and ACHEST for their strong influence at the national level and their penetration at the highest levels of government: *" … the ED [of ACHEST], when he speaks people listen, he has a very good record, he is a leader in health, the country believes in what he speaks."* (external expert)
- In terms of thematic areas, the contracted partners were recognised for their unique added value: HEPS for commodities, ACHEST for HRH and governance and Amref for community health workers. One contracted partner mentioned this has led to less fragmentation in system strengthening and service delivery in SRHR. Another contracted partner shared the first National Health Promotion and Preventive Conference in Uganda in October 2019 as an example of each contracted partner's contribution from their own expertise and the partnership coming out strongly as one.
- Complementarity was also sought across levels with ACHEST advocating for the re-creation of the Health Workers for All Coalition and suggesting Wemos lead this effort at the global level.
- Complementary roles were clear to each contracted partner with the exception of the theme health work force in which Amref and ACHEST seemed overlap in their work, which brought some friction. Having said that, for all other themes, all contracted partners indicated that it was very clear to them which organisations was leading on which specific topic.
- However, one contracted partner indicated that each partner having their specific expertise did not necessarily mean that they complemented each other and worked as a partnership. They indicated that there were challenges at the start of the programme in understanding each other's complementary roles.
- It was also mentioned by a contracted partner that letting contracted and consortium partners lead on a certain topic or at a certain level often led to minimal engagement of the other partners. This resulted in certain HSAP themes not being covered in specific advocacy events.

Autonomy

- In terms of Southern ownership, it was felt by a few contracted partners that the penholder had proportionately more power in budget and decision making and there was unequal participation at the highest governance level (which has Northern dominance). It was felt by a few contracted partners that the country level had little say in decisions concerning the partnership.
- The penholder's decision in 2019, to not continue with the partnership after 2020, was felt by the contracted partners as a top-down decision since they were not involved. Contracted partners were also not involved in the decision to not include some partners in new proposals. This impacted the partnership at the country level in terms of morale.

Collaboration within the partnership linking local to global advocacy

- In general, contracted partners felt that the connections across national/regional/global contexts were not as strong as they could have been.
- Regional-Global collaboration: a few good examples were mentioned by contracted partners: the Global Health Diplomacy training led by ACHEST brought together CSOs from the region including Wemos. There was also advocacy conducted for the Health Workers for All Coalition by ACHEST and Wemos.
- National-Global collaboration: contracted partners have felt a disconnect with the global level. Despite attempts to inform the partners at a country level, the partners felt they had not been involved in advocacy at the global level by providing evidence from their countries. There have been some examples of partners from specific countries attending the WHA, but a contracted partner felt that there had not been a concerted effort made to have Southern voices in the global discussions. Good examples were also mentioned about this situation, such as webinars on health work financing and linkages between some contracted/consortium partners within the partnership, i.e. HEPS with HAI.
- National-Regional collaboration: partners were invited for the establishment of two regional networks (AHAP and the media network), but indicated that they were not engaged after that. Contracted partners had also expected more of a coordinating role with other HSAP partners advocating at the regional level, in terms of contextualizing regional commitments and involvement and input into regional advocacy. A good example was mentioned about connecting national and regional advocacy on the theme of community health workers.
- Whether thematic areas were addressed at a global or regional level depended on which partner engaged at these levels. This led to certain HSAP themes not being properly reflected, if it was not included in the partner's expertise.
- At the JAP, strategizing was conducted per context and not per thematic area linking them to the various levels.

D. **Visibility**

- CSO visibility has improved immensely, according to all substantiators.
- Substantiators at the district level acknowledged HSAP's partners and appreciate HSAP's approach to advocacy including: their participation in the district health meetings, joint planning with district governments, their mobilizing and convening of community leaders and members such as religious and cultural leaders and youth, and their amplifying efforts of the district government through radio shows and interactions with the communities. (32921/policy maker, 32924/policy maker, 32918/policy maker and 33028/policymakers)
- At a national level, substantiators appreciated HSAP's partners in the credible evidence-based information provided by them, their regular attendance at government meetings and their role in convening meetings such as the two presidential dialogue meetings on health to solicit political support for an increase in the SRHC budget. (32902/networking partner, 32899/policymaker, and 32908/networking partner)
- One official of the MoH stated that the ministry's confidence in working with CSOs *as " increased immensely"* due to HSAP's efforts to bring together the youth-serving and youth-led organisations collaborating on RMNACH, "*because they are much more organised and visible."* (32899/policymaker)
- Some substantiators representing district governments explained that the visibility of HSAP's partners in the community has increased and their work is credible and legitimate since they are part of the community. (32924/policy maker, 32922/policy maker, and 32921/policy maker)

- At the same time, district governments are strictly monitoring CSO activities. (32919/policy maker) One CSO explained that the district governments were first resistant and sceptical about their advocacy work, but have seen the added value of working together. However, she added that close collaborations make it difficult to raise sensitive issues. Their strategy is to have the communities raise those issues with their local governments, so the HSAP partner does not become the government scapegoat. (CSO)
- A contracted partner felt that their visibility increased due to HSAP since their expertise was being recognised by the MoH who regularly asks for advice and technical input. The media also approaches HSAP contracted partners for credible information.
- Almost all substantiators knew individual organisations in HSAP well, but did not recognise HSAP as a partnership.

E. **Conclusion / Reflection**

- HSAP has worked towards strengthening health systems that can support SRHR outcomes. However, the broadest concept of SRHR has not been applied: there has been a dominant focus on FP, SRHC and maternal health.
- Gender analysis and sensitivity was not part of the programme in the beginning and this was seen as a missed opportunity. Relevance for girls/women was often described as indirect and suggestive. There were no specific interventions to have women and girls participate in the design and implementation of the programme. Youth participation was better assured.
- The needs and rights of LGBTI are sensitive due to criminalization and no intervention was specifically targeted at them. Although this is understandable from a legal point of view, LGBTI have now been completely left out.
- PwD and other marginalized groups have not been specifically targeted or taken into account, but it is felt that they benefit from the improved health system in general.
- In terms of collaboration, the CMT model that was established by the Uganda context team and replicated in other contexts was seen as a success; it helped in working more closely together in the partnership. Main challenges in the partnership have been lack of coordination of joint activities, joint budget and monitoring and evaluation. There has been a lack of coordination and strategy, also in relation to linkages with regional and global levels. In terms of Southern ownership, it was felt that the penholder held proportionately more power in terms of budget and decision-making.
- Each contracted partner is recognised for its unique thematic expertise and influence. However, this was not used to amplify each other's work or to work as a partnership. Some topics were left out in advocacy activities and possible opportunities were missed.
- The programme could have benefitted from strategizing as a partnership on how to achieve best results on the HSAP themes across the various levels instead of having each context with each partner strategize and plan separately.
- The visibility of CSOs increased through HSAP. Decision makers and partners recognised HSAP's technical expertise at all levels. CSOs in the districts were seen as legitimate and credible by some district officials. While CSOs have become more visible, HSAP as a partnership was not visible. Externals know HSAP partners, but not the partnership.

5. Sustainability of programme results

- Many respondents indicated that important steps have been made and achievements realized, but that these are first steps. Respondents in the community expressed their concerns about sustainability if the programme ends. Substantiators requested HSAP continue their work, focus on the remaining gaps in selected sites and on achievements made, and even expand to more health facilities, media houses and districts.
- Contracted partners have expressed their disappointment that HSAP is not continuing in its current form. They expressed that there have been many investments and much learning and that these are now yielding fruit. They indicated that five years is too short to build a flourishing partnership that yields advocacy results. However, some also indicated that the partnership resulted in getting to know each other and each other's complementary expertise. It is believed that relationships and collaborations will continue after the programme ends. The contracted partners indicated that their work in Uganda will continue, through other funding and structures.

A. Mechanisms in place to sustain the advocacy outcomes: HSS, SRHR, and advocacy capacity

- Contracted partners felt that the capacity building and support they offered to youth groups in the community, champions in the Parliament and CBOs contributed to the sustainability of their outcomes.
- An SRHR/HSS expert stated that sustainability must be at the district level where actual improvements to HSS and SRHR are made.

B. Governance mechanisms to sustain CSO advocacy efforts

- Contracted partners are now part of the MoH's technical working groups, which will continue after the programme ends. Due to their advocacy, the MoH has installed a Pre-Eclampsia Ambassador ensuring that the campaign for pre-eclampsia, initiated by HSAP, will continue.
- The formalisation of the youth RMNCAH coalition is seen as enabling sustainability, since the coalition can now engage in fundraising. However, one substantiator commented that the coalition is not yet fully institutionalized and the MoH has not yet taken it up fully. His wish is that every district takes up the bringing together of CSOs working on adolescent SRH to map out the areas of collaboration. (32899/policymaker)

C. Conclusion / Reflection

- HSAP has achieved important steps and well-established structures within the government, which are likely to remain. However, for some structures it is uncertain if these will remain when HSAP pulls out.
- Capacity strengthening of CSOs has led to new funding and programmes for them.
- Collaborations and relationships are believed to continue after HSAP ends.
- HSAP did not develop a sustainability plan.

Country Context: Zambia

1. **Capacity-strengthening efforts (of individual CSOs, CSO networks, communities, and media) done at country-context level**

Background info

In the Republic of Zambia, the Health Systems Advocacy (HAS) Partnership programme includes Amref Health Africa (Amref) as the penholder, MedRAP/MeTA Zambia, and the African Centre for Global Health and Social Transformation (ACHEST) represented by SafAIDS. The HSAP contributes to stronger health systems so people in sub-Saharan Africa can realise the highest attainable sexual and reproductive health and rights (SRHR). The HSAP advocates for strengthening human resources for health (HRH), access to essential sexual and reproductive health commodities (SRHC), good governance and equitable health financing. The programme model is premised on the belief that a vibrant and influential civil society is essential to initiate discussion and reform. The HSAP partners equip civil society actors with needed knowledge, technical skills and tools to develop and implement evidence-based advocacy strategies. The partners also strive to strengthen links between organizations and networks advocating for health system strengthening (HSS) to improve SRHR.

The Zambian component of the HSAP evaluation adopted two methods – interviews with community service organizations (CSOs) that had received capacity building from either SafAIDS, Amref or MeTa and key informant interviews (KII) of the institutional heads of partner organizations. A total of 25 interviews were conducted among CSOs across the country and the three partner organisations. Three KII were also conducted with the directors of SafAIDS, MeTa and Amref. All interviews were conducted online. Data from CSOs was entered into the Sprockler system and analysed using systematic coding.

Story Collection

- 25 stories were gathered in Zambia.
    - 11 of the storytellers were mainly involved with HAI/HEPS/MeTA/Umati
    - 7 worked with Amref
    - 7 were mainly involved with ACHEST/Sikika/KOGS/AMAMI/SAfAIDS.
- All respondents indicated that they had participated in some form of HSAP capacity-strengthening efforts to increase their lobbying and advocacy skills.
- 12 participants indicated that they had received some funding from one of the core partners of the HSAP; 13 indicated they had not received any funding from the core partners.
- The majority of those who had worked mainly with HAI/HEPS/MeTA/Umati had received funding, whereas the majority of those who worked with ACHEST/Sikika/KOGS/AMAMI/SAfAIDS had not.
- Participants who had received funding stated that their funding had supported advocacy, sensitization and outreach activities and transportation. They also received support for workshops for media networks and youth organisation to engage in social accountability monitoring and develop a database.

A. **Strategy and focus**

- A large majority of the respondents indicated that gains from HSAP included practical advocacy skills, increased knowledge on SRHR and or HSS. A few people selected practical advocacy skills and new relationships, or new relationships only.
- The majority of the respondents related the special moment that led to the change they described to the capacity training received. Several respondents mentioned the training on outcome harvesting, SRHR and HSS, in general. They shared that during these moments and training they had learned to identify who to target (allies, messengers, staff and decision makers), how to package their advocacy message, approach stakeholders and decision makers with fitting

arguments, use and collect data as evidence for advocacy, create an advocacy strategy and prioritise their efforts, link key people, involve communities and use public participation, conduct clear communication and successful follow-up, and write policy briefs.

- In the Republic of Zambia, the HSAP operated at national, district and community levels. Through these levels, significant achievements were scored to build the capacity of partners and CSOs to contribute to achieving improved HRH and SRHR.
- The capacity building of core partners (Amref, MeTa and SafAIDS) stemmed from their internal mutual support and support provided by other HSAP countries. The key informants generally revealed that the partners' strengths were their ability to reinforce SRHR/HSS programme expertise and complementarity. This led to partners learning from each other's strengths, collectively identifying problems and solving them. For example, MeTa had technical expertise and conducted several studies on SRHR that informed the other partners on the availability and accessibility of SRH products. Similarly, SafAIDS had strong community mobilisation skills that the entire partnership benefitted from. The partners also attended multiple capacity-building meetings that enhanced their ability to train CSOs and engage with the national government on pertinent policy issues based on evidence. The Joint Annual Programme (JAP) meetings were used to share the results of lobbying and advocacy lessons across the partnership. These lessons were used to develop strategies to advance advocacy and lobbying for SRHR and HSS. As a result, capacity was built on how to engage the media, prepare policy briefs, collect evidence and mobilise communities, all of which are important ingredients for effective advocacy and lobbying.
- Further, at the partner level, the evidence-based lobbying resulted in significant policy-related outcomes that influenced government decisions. Evidence was generated by the partners to influence decisions within the Ministry of Health (MoH) and Parliament. For example, MeTa's SRHR Survey informed the MoH's key decisions on the SRHC supply chain (e.g., contraceptives). The study revealed empirical evidence about the prices, availability, accessibility and affordability of SRHC. The results were used to advocate for better supply chain management of these commodities through Medical Stores Limited (MSL), whose mandate is to manage the medicine supply chain in the Republic of Zambia. This indicates that the partners' improved capacity not only generated, but also utilised evidence for lobbying and advocacy.
- The partners also shared their improved capacity building training for CSOs and local media. All CSOs interviewed in this evaluation indicated that they had participated in HSAP's capacity strengthening efforts to increase the CSOs lobbying and advocacy skills. Less than half the CSOs trained had received some funding from a core partner of the HSAP. The funding was meant for advocacy, sensitisation and outreach activities and transportation refunds.
- These CSOs were diverse and included media networks that created space for a strong civil society to engage effectively with the government, private sector and other stakeholders accountable for health systems. HSAP's key strategies to build CSO capacity were mainly training and, to a lesser extent, coaching. For example, MeTA trained media champions in private, public, electronic and print media at both local and national levels, SafAIDS trained CSOs in advocacy and Amref trained community health workers (CHWs). The trained media CSOs were able to independently advocate and create media stories on SRHR issues within their communities, districts and at a national level. The media groups are also part of the local media networks and work hand-in-hand with local CSOs to create awareness and inform the public on SRHC issues. The CSOs and district-level government officials were also trained in policy analysis, and how to prepare policy briefs. Most of the CSOs attested to utilising the skills they learnt in their own environments, including effectively engaging local government in policy dialogues, influencing availability of SRHC supplies, and raising awareness among community members.
- Communities were empowered in the HSAP through engagement of the trained CSOs and community members. As mentioned earlier, just about half of the CSOs indicated having received funding to conduct community sensitisation and mobilisation, thus empowering them with knowledge on SRHR. The Sprokler stories by the CBOs (both trained and untrained) pointed to

improvements in communities' abilities to demand their rights. Specifically, this improvement was substantiated by the fact the CBOs were able to do something different than they had in the past in their communities after attending the training. The following are some examples:

- For improved youth involvement, some CSOs reflected that they had seen significant changes in SRHC since they [youths] now know where to find reproductive health and family planning (FP) facilities and supplies and are able to demand these services/products. Others reported having set up youth-friendly corners where young people can easily access SRH services. *"We formed a youth friendly corner after the training. Now youths can freely access supplies from our corner. So, our health facility has actually changed and [is] now better responding to the needs of our community.*" (CSO)

- Improved participation in running of local authorities by the young people: Some CSOs have formed youth councils, so young people are represented and actively participate.
- Media networks were established by the partnership, which has resulted in increased coverage of SRHR and HSS in various types of media.
- Increased knowledge of SRHR among community members had a catalytic effect on community members, who have started holding their leaders accountable according to CSO reports.

B. What worked and did not work

- The training/capacity development was highly relevant to the CSOs since most felt that what they had learnt was applicable to their settings. They cited being better involved in lobbying and advocacy activities in their communities and at a district level. They also indicated that they were no longer seen as political rivals by politicians since they had acquired the necessary skills to navigate the political space from the HSAP.
- Partner complementarity worked well to build capacity. The HSA partner organizations possess complementary capacities. For instance, Amref specializes in community mobilization and human resources for health; ACHEST /SafAIDS bring external evidence to the partnership in the Republic of Zambia, monitoring and evaluation approaches, and human resources for health; and MeTa brings experience working with multiple stakeholders from the public, government, private sector, CSO and academia, as well as commodity expertise. This complementarity meant that CSOs trained under the partnership acquired relevant skills in advocacy and lobbying, utilisation of data and policy analysis.
- The capacity building resulted in many benefits, particularly at a community level. CSOs reported that they had seen a reduction in pregnancies, improved access to SRH services among community members, and general improvement in CHW capacity. Further, the CSOs have acquired skills that have enabled them to engage government at the local level in issues of HSS and SRHR.
- As a result of the capacity building, data indicates that there is increased recognition among CSOs of the 'power of numbers' in advocacy. Most of the CSOs interviewed alluded to the fact that due to an increase in the number of organisations conducting SRHR advocacy, there had been an improvement in service delivery and political will in terms of policy. As one CBO noted, *"a number of organisations are now doing SRHR, so when you look at pregnancy levels, they have significantly improved".*
- One core partner also agreed, *"there is strength in numbers, the more organisations we have to do advocacy at multiple levels, the better".*

C. Supporting and hampering factors

Supporting factors

- Some CSOs found the training offered by the partnership to be 'engaging' and 'simplified' as they understood SRHR better. This made it easy for them to implement certain activities after training.

- At both the national and district levels, policymakers were supportive of the interventions. This is evidenced by policies put in place by the government to support SRHR, e.g., the Adolescent Reproductive Health Strategy.
- Media engagement, and media's drive in advocacy were supporting factors. This is largely because the media was willing to work with the partners, despite SRHR/HSS not being a well 'sold' topic in the media.

Hampering factors:

- Beyond the training, fewer than half of the CSOs were able to conduct outreach campaigns due to a lack of funding. The CSOs postulated that the HSAP partners should have provided direct funding to the CSOs that had been trained so they could have 'put their skills into practice'. A few that were funded conducted SHRH sensitisation meetings in their communities.
- The capacity of most CSOs remains weak, and more effort is required if they are to engage more effectively, particularly with the private sector.
- The capacity building was successful to a large extent and resulted in effective advocacy and lobbying for SRHR services since the CSOs and policymakers became supportive of the interventions. However, more could be done to further improve the capacity of CSOs since they still remain on the fence.

2. The effectiveness of the advocacy approaches

A. Actual changes (outcomes)

Support to MoH and Parliament.

Related Outcome: *Improved support of policymakers for HSA advocacy topics on HRH, SRHC, health financing and governance*

- The HSAP has been providing support to parliamentarians through the Parliamentary Health Committee. In addition, the HSAP attracted high-level engagement, including the President, to address SRHR issues. According to one of the partners, *"we raised advocacy issues all the way to Parliament, and we have seen action being taken on the issues we have taken. Initially we didn't have good relationship on the pillar on advocacy, we engaged the Parliamentary committee on health which has now been formalized. We have now been incorporated in the technical committee of the Parliament"*. The Parliamentary committee meetings offered an opportunity for the parliamentarians to amplify the voice of the people on SRHR and enforce protective SRHR laws. As duty bearers, parliamentarian's key role in legislation, budgeting, oversight and accountability was recognised early by the HSAP. Continuous engagement of parliamentarians culminated in achieving the support of other law makers and openly discussing SRHR issues, including the possibility of a law on age-of-consent. The Zambian President gave a directive to the MoH to address important issues such as the age of consent.
- Through the MoH, the HSAP has been supportive of many government policies and strategies. For example, the HSAP supports the national-level Adolescent TWG, providing input into strategic documents like the National Adolescent Health Strategy. The National Adolescent Sexual Health (ADH) Strategy: 2017-2021 was finalized and launched by the Minister of Health in September 2017, alongside the National Health Strategic Plan 2017-2021. The ADH strategy aims to improve SRH outcomes of adolescents and young people by standardizing adolescent and youth-friendly health services and spaces; increasing access to safe ASRH/HIV services; addressing social norms, attitudes and inaccurate information through a comprehensive combination of prevention packages; and sustaining the strengthening of the enabling environment to address bottlenecks impeding access to services and information. The strategy is open for any partner to finance activities and has been used to mobilise resources for SRHR beyond the HSAP. One of the partners indicated that as a result of continued lobbying and advocacy, there has been an increase in the budget allocation for SRHR in the Republic of Zambia from less than 1% to 2.4%.

- At a district level, new TWGs have been formed on FP that are chaired by the MoH. As a result, districts are now able discuss FP issues on a regular basis, which has resulted in improved service delivery and commodities for FP. *"As a result of the training we initiated and formed the TWGs that are now chaired by MoH for sustainability".* (CBO)
- Through Amref support, a CHW strategy has been developed, which is intended to protect and support CHW interests. The strategy was developed to formalize and standardize the role of CHWs in the health sector to enable equity of access to high-impact primary health services, including SRHR. According to World Health Organisation, the Republic of Zambia is positioned to achieve its overarching CHW strategy goal to have a cost-effective, adequately trained and motivated community-based health workforce that will contribute to improved management of common and preventable health conditions in the country[11]. However, the MoH's implementation of the strategy has been slow and resulted in a stagnation of benefits. It is clear that the benefits of the policy will only be appreciated once it's implemented. In addition, there has been out migration of health care workers including those who provide essential frontline SRHR services like CHWs.

(2). Changes in advocacy linkages between national, regional, global and Dutch policymakers
Related Outcome: Increased involvement of CSOs in policymaking processes

- The changes at the national level are communicated to the sub-national levels through government, CSOs and existing TWGs. For example, the Adolescent Health TWG at the national level is mirrored at the district levels, which results in improved linkages from national to sub-national levels. Despite this improvement, many challenges still persist. For example, there is still a fragmented supply chain of commodities from the national to sub-national levels. Stock outs continue at a facility level. As one partner indicated, *"availability of supplies has been a challenge – no specific allocation from the HSAP and we have done very little in this regard. We rely on external parties to provide the commodities as the partnership does not provide these. This is unsustainable as we do not have control. Medical Stores Limited would deliver to the district and take too long to deliver the supplies to the hubs or clinics. You will have condoms expiring and young people continue to get STIs"*

(3) Changes in CSO and HSA partner involvement in policymaking and implementation processes. Changes in the development of effective evidence-based messages taken up by like-minded networks and organisations

- Some CSOs were involved in conducting research and collected data to generate evidence for advocacy and lobbying. For instance, one CSO conducted research on youth involvement and found that many youths were being discriminated against and were not able to access SRH services. Based on this data, the organisation petitioned the local council to involve youths in the municipality governing body. This led to the formation of a group called youth quasi-council, wherein youths participated in making by-laws, thereby strengthening social accountability and health systems since the youths are directly involved. This demonstrates the CSOs' increased ability to engage with local authorities in matters related to HSS and SRHR. There is also heightened attention by local authorities on SRHR. *"We were not hearing them [local authorities] talk about SRHR openly but after our discussions we saw a change. They now talk about SRHR openly and the Town Clerk has even offered to be our Matron, the entire system at the council has significantly changed".* (CSO)
- In the Sprockler inquiry, CSOs were asked what they had done differently as a result of the advocacy efforts. Examples of stories of new approaches included involving the town clerk and mayor in talks about SRHR medicines and supplies; discussing myths surrounding contraceptives, thus leading to more uptake; improving health reporting networks and reporting on health matters; improving communities' understanding of FP and providing access for their children;

11

sensitising youth on SRHR and creating more understanding between generations; engaging community members in social accountability to hold leaders accountable; changing service provider approaches in interaction with young people; and improving youth access to SRHC and services.

- These stories illustrate significant changes that occurred among the CSOs, and demonstrate their effective advocacy and lobbying interventions.
- The CSOs seem to have had the largest effect on local or sub-national government systems followed by their impact on the media. This was illustrated by the number of impact stories they shared (18 local/sub-national, 4 media, 1 private actor and 1 other CSO).
- Participants were asked about the type of advocacy model that best described the type of change achieved. Most storytellers indicated that the model that best described the type of change was positive change wherein without the programme's efforts, the status quo would have remained. One storyteller selected the second model, wherein the programme achieved no change, but without the programme's efforts, the status quo would have worsened. This storyteller mainly worked with ACHEST/Sikika/KOGS/AMAMI/SAfAIDS. The third model (not selected by any respondent) was the programme achieving a negative change, whereas without the programme's efforts the status quo would have remained.

B. Roles and contribution of external factors/actors in achieving advocacy outcomes

- What worked well, was the CSOs' good relationships with policymakers such as parliamentarians. Some policies are not supportive of LGBTIs, thus hampering their access to much needed SRHR. Condom distribution is not allowed in schools. Government staff turnover is high, which creates discontinuity in some programmes. The programme implementation was fragmented and this was a barrier to realising full benefits. For example, the partners did not merge their intervention implementation across districts. As a result, full complementary of the partners' activities was not possible.

C. **Advocacy approaches and strategy HSAP partners**

- The partnership adopted evidence-based advocacy approaches and CSO engagement to be the grassroot interface with communities so as to then empower the communities to demand their rights. These strategies proved to be effective, and resulted in the partnership achieving results.

D. Missed opportunities / lessons learned in relation to advocacy strategy

- Advocacy requires that you have adequate information, especially public documents. However, some documents are guarded by government. As one of the partners commented, *"Access to [the] information Act is still not available, which makes it difficult to access information. It is difficult for me to compel government to give me documents since this Act is not in place".*
- Most government officials see advocacy as a political stance, and that some CSOs are aligned to a particular political party, especially the opposition. This makes it hard to penetrate the political space.
- There was a lack of a coordination mechanism among the CSOs. Although there is power in numbers, sometimes the CSOs took distinct actions and were thinly spread out.

3. Relevance towards HSS and SRHR

A. Relevance towards HSS

Based on our desk review, KII and interviews with CSOs, this evaluation confirms that the HSAP is aligned with national priorities and country development plans. The HSAP either supported the development of policies and strategies or contributed directly to the implementation of these through technical assistance. In this section, we outline how the HSAP was aligned to national policies, strategies and plans. The HSAP contributed to the long-term agenda of the Republic of Zambia as

envisioned in the Vision 2030 of "A Prosperous Middle-Income Nation by 2030". The HSAP' theory of change has committed to a long-term outcome to have health system stakeholders (government, CSOs and the private sector) at district and national levels take responsibility to support Zambian right-bearers in their right to quality SRH services through effective policies, policy adherence and implementation of policies that strengthen health systems. To achieve the above, our mid-term outcome finding is that CSO partners keep Zambian health system stakeholders accountable through joint advocacy and by generating continuous evidence for better health policy (implementation). This is achieved by joining and claiming district and national spaces for dialogue and dissent. A precondition for CSOs to play an effective role is that communities and CSOs need to understand more about their SRHR and their right to hold duty bearers accountable. This outcome can only be reached if the partnership is able to generate evidence about SRHR challenges and involve key stakeholders such as the church, other CSOs and the media. These stakeholders can jointly advocate at various levels to increase the space for dialogue and dissent to contribute to the policy debate for HSS to achieve SRHR for all.

B. Relevance towards SRHR

To mobilize civil society, our short-term outcome is having a dynamic partnership with internal capacity to effectively reach the partnerships objectives.

These commitments are important if the Republic of Zambia is to attain Vision 2030. We find that the commitments have been attained through HSAP's contribution to national dialogues that put the young people at the centre of development. Alongside Vision 2030, the long-term vision of the Republic of Zambia is to end the threat of AIDS by 2030, in line with the 2016 United Nations General Assembly Special Session on Drugs Political Declaration, Sustainable Development Goals, Seventh National Development Plan (7NDP) 2017-2021, and National AIDS Strategic Framework 2017-2021. The country is working towards halting the spread of HIV and AIDS and gradually reversing the trend by 2030.

FP is a continued priority in the 7NDP, and the country's National Health Strategic Plan 2017–2021. The objectives of the National Family Planning Guidelines include initiating and sustaining measures to slow the nation's high population growth, enhance people's health and welfare, and prevent premature death and illness, especially amongst high-risk groups of mothers and children (ZDHS, 2013–2014, p. 87). The recent DHS results report that although fertility rates have generally reduced among young people aged 15-19 years, 29% have already started having children, with the rural and uneducated being the most affected. Further, contraception use remains low since 62% of teenagers still do not use contraception, thus increasing their risk of pregnancy and sexually transmitted infections (STIs). The report also points to the fact that comprehensive knowledge of HIV prevention among teenagers remain low at 43% for young women and 41% for young men (CSO, 2019). These statistics enhance the need for programmes like the HSAP that are multi-sectoral and support the uptake of contraceptives for young people.

The new National AIDS Strategic Framework (NASF) 2017-2021 focuses strongly on HIV prevention as a strategic future investment and is aligned with the Investment Framework concept proposed by the Joint United Nations Programme on HIV/AIDS (UNAIDS). The NASF emphasizes highly effective prevention interventions and efficient implementation of the HIV response through additional resource mobilisation. Another important change was that the main target group for prevention expanded from young people aged 15-24 years old (in the previous NASF) to those aged 10–24 years old in the current NASF. Furthermore, the NASF has prioritised comprehensive sexuality education, prevention, and medical and psychosocial service provision for youth aged 10–14 years. Increased access to condoms amongst sexually active youth has been envisaged for those aged 15 years and above. All these are areas of focus for the HSAP, which also supported the development of the NASF.

In December 2013, the Republic of Zambia, through the Ministry of Education, Science, Vocational Training and Early Education (MESVTEE), and the then Ministry of Community Development, Mother

and Child Health, affirmed the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African (ESA Commitment). The ESA Commitment focuses on in- and out-of-school CSE and youth-friendly health services. The ESA commitment linked CSE together with increased access to adolescent- and youth-friendly health services, including facility and community SRH services, to decrease teenage pregnancy and HIV infections in high-risk areas.

The Adolescent Health Strategy (2017 – 2021) developed with technical support from HSAP, prioritizes three main strategic components for effectively addressing adolescent health priorities. The first is the need for a strategic focus on strengthening the capacity of the health sector to deliver adolescent-responsive health services. The second strategic component addresses the need to prioritize both health promotion and demand creation with and for adolescents. The third component focuses on the need for an enabling the programme environment through strategies that strengthen leadership and governance issues to ensure the effective delivery of adolescent-responsive health services, community mobilization to promote healthy behaviours and the adolescent utilization of relevant health services. The HSAP is consistent with these strategic components and has had a catalytic effect of attracting funds for adolescent programmes. Multiple donors and NGOs are aligning their strategies to the gaps identified in the government's strategy and setting aside financial and technical support to operationalise the latter.
Corresponding to recognised national and international commitments, identifying and implementing highly effective prevention interventions is crucial for curbing new HIV infections and early pregnancies. Educational programmes on HIV and reproductive health and rights for adolescents and young people at large, can increase the demand for adolescent- and youth-friendly health services. Programmes that recognize the multisectoral overlap between the education and health sectors may be particularly impactful in meeting the age-specific SRH needs of adolescents and young people more broadly. In this regard, the HSAP recognises the multi-dimensional nature of ASRHR interventions by using a multi-sectoral approach that includes various government ministries such as Ministry of General Education, Ministry of Youth, Sport and Child Development, Ministry of Gender and MoH.
CBOs interviewed in this evaluation identified early/unwanted pregnancies, early marriages, school dropouts, STIs including HIV, peer pressure, sexual abuse cases, and drug abuse (particularly alcohol and marijuana) as pressing challenges that young people face. They also identified unsafe abortions as a problem. In line with government policies and plans, the programme has been responding to these needs, and adjusting as needed. One of the key adjustments that have been made to the programme is that while condoms are important to young people, these are not distributed in schools. This is in agreement with the Ministry of General Education policy that condoms should not be distributed to learners in schools.

4. Lessons learned on HSS and SRHR advocacy, gender and inclusivity, collaboration and governance, visibility/legitimacy

A. Gender/inclusivity
Gender mainstreaming was not a key component of the HSAP programme. There was no priority with regard to gender mainstreaming. Consequently, outcomes on gender for this programme were not strong. The partners indicated that the gender component was only introduced towards the end of the programme when all the CSO had already been trained. Although the programme targeted some CSOs that represent disadvantaged people like the blind, social inclusion remained weak and appears to have been haphazard. The partnership would have benefitted from early inclusion of gender mainstreaming and social inclusion since this was a missed opportunity.

Collaboration and governance
As indicated earlier, there was an exchange of information among partners using various platforms. The JAP review provided a platform on which partners exchanged ideas on programme performance

and areas requiring adjustment. The partnership also hosted 'linking and learning' where every partner could share their lessons and learn from each other. As one partner noted, "*shared on commodities/supplies, SafAIDS presented on advocacy flow from communities/health facilities to the national level. So partners had to learn from that as every partner would bring lessons to the table*"

Every month the partners had partnership meetings to strengthen synergies and the various programme components. Locally, the partners shared a platform on WhatsApp, where some districts and CSOs engage.

B. Visibility / Autonomy / CSO's capacity strengthening affected the legitimacy of the CSOs

From the storytellers, we found:

- The majority of the respondents indicated that the visibility of their CSO had improved immensely compared to before their involvement with the HSAP. There were a few respondents who responded in the middle, and were not sure about the changes in visibility, and a few who considered that their CSOs were no more visible than before.
- Those who had received funding were a little more positive about the increase in visibility than those who had not receive funding.
- There seems to be somewhat of a correlation between how much respondents considered that the visibility of their CSO improved and whether or not they considered that the change would have happened without the HSA.

5. Sustainability of programme results

There is high potential for the results of the partnership to be sustained. For example, the HSAP fronted young people and community structures that have continued with their activities because of ownership. Further, most of the activities of the HSAP have been embedded into the Adolescent Health strategy ,which means anyone can fund the activities since it is a national document. This ensures continued financial support beyond the HSAP.

At the national and sub-national levels, the HSAP strengthened the capacity of government workers who will continue to work in the government system beyond the HSAP. Threats to sustainability include:

1) Limited programme coverage relative to national needs – although, support to national policies and plans was done at a national level, service delivery was only done in a few districts.
2) Staff transfers for government staff create gaps in implementation.

Lessons Learnt

- Gender and social inclusion should be integrated into the programme from the beginning. This helps in documenting challenges and perfecting engagement as implementation continues.
- High-level policymakers such as parliamentarians and MoH are key to successful lobbying and advocacy.
- Communities working together can help find practical solutions to problems faced by adolescents.
- Involvement of the youth can drive change. Access to services for young people is critical—if given an opportunity to learn, young people learn and adopt easily—they can make their own decisions based on the information provided to them.
- Involvement of the media is important for the catalytic change required for meaningful advocacy and lobbying.
- Evidence is key to advocacy, and the evidence should be acceptable to a wide range of stakeholders including the government.
- There is power in numbers. There have to be more voices on SHRH and HSS to achieve meaningful change.

Conclusion and Recommendations

Conclusion

The results of the HSAP have been mixed, although the majority were attained. Challenges still remain in operationalising existing legislation as well as implementing the existing ones.

Recommendations

- Convergence is important. In order to maximise the impact, the partners need to implement activities in the same districts. Since the model is based on complementarity, it is cardinal that implementation is not fragmented in order to maximise results. This should be the focus, if there is follow-on of the HSAP
- Continue high-level political leaders engagement, such as with members of Parliament, and support of the MoH in advancing the SRHR and HSS agendas.
- Scale-up interventions by mobilising resources and supporting CSO in furtherance of their advocacy and lobbying activities. CSO capacity building should a continuous process, and not just a one-off. Beyond training, CSOs should be funded by the partners to implement 'start-up' activities.

Country Context: Tanzania

1. Capacity-strengthening efforts (of individual CSOs, CSO networks, communities, and media) done at country context level

Background info

- Tanzania joined the HSAP Programme in July 2017. In September, they developed their contextualised ToC and in early 2018 conducted a country baseline study.
- The HSAP project was launched in July 2017 and gradually became fully operational, when all three partners started working together in July 2018.
- The HSAP programme CSOs are located in five regions, Dar es Salaam, Shinyanga, Kigoma, Mtwara and Manyara.
- Each partner focused their effort in distinct issues as follows:
    - Amref advocacy efforts focused on community health workers (CHWs), health governance and family planning (FP) financing.
    - SIKIKA advocacy efforts focused on the availability and distribution of skilled healthcare workers.
    - UMATI advocacy efforts focused on availability, affordability and pricing of sexual and reproductive health commodities (SRHC).
- All three partners offered technical assistance, but not financial assistance to their beneficiaries (CSOs). Amref trained 15 CSOs, all from Shinyanga, and then continued to work with nine organizations engaged in public health interventions. Amref conducts outcome harvesting periodically for these nine organizations.
- SIKIKA trained CSOs located in Dar es Salaam, Mtwara, Kigoma and Manyara. From KII with project personnel, after the training / capacity building efforts, there was no further engagement between SIKIKA and their trained beneficiaries.
- UMATI trained CSOs located in Dar es Salaam, Manyara and Mtwara. From KII with project personnel, three CSOs were reported to have performed well and were included in the advocacy activities of the META coalition, but no financial support was provided.
- For this evaluation, the national consultant conducted only face-to-face interviews in Shinyanga, while the rest were conducted via phone due to travel restrictions or face-to-face meetings.

Story collection Tanzania

- Sixteen stories were collected in Tanzania. The majority of the storytellers (11 out of 16) were mainly involved with Amref Health Africa – Flying Doctors as a core partner of the HSA partnership. Three storytellers were mainly involved with HAI/UMATI, and two were mainly involved with ACHEST/ SIKIKA.
- Fifteen respondents indicated that they had participated in HSAP capacity-strengthening efforts to increase their lobbying and advocacy skills. One indicated they had not, and this storyteller worked mainly with ACHEST/ SIKIKA.
- All participants indicated that they had not received funding from any HSAP core partner.

A. Strategy and focus

- The majority of the respondents related their capacity training to the special moment that led to the change they described. Several respondents mentioned trainings on smart advocacy and SRHR and HSS in general. They shared that their knowledge and understanding of concepts such as social accountability, score cards, budget cycle and budget advocacy had improved. They shared that during these moments and training they had learned how to identify who to target (as allies, messengers, staff and decision makers), how to package their advocacy message, approach

stakeholders and decision-makers with fitting arguments, use and collect data as evidence for advocacy, create their advocacy strategy and prioritise their efforts, link key people, involve communities and use public participation, and conduct clear communication and successful follow-up.

- Some storytellers shared special moments not directly related to training, but which had led to capacity development anyway. Examples included facilitating focus group discussions, attending meetings and community dialogues, and exchanging information with people from various countries and other participants during the trainings.
- The majority of the respondents indicated that the capacity training they had received had led to change.
- Participants were asked to state the thematic area related to the change they described. A maximum of three options were possible. The most frequently selected option was gender, inclusivity and youth (11 changes), followed by civil society space and participation (9 changes) and SRHC supply (4 changes).
- In addition to the related thematic area, the respondents were asked about the result area related to the change they described. Respondents mainly shared stories related to: 'increased evidence-based lobbying and advocacy capacity of CSOs at local, national, regional and global levels' (7 changes); 'increased' involvement of the HSAP and CSOs in policymaking processes by stakeholders on Human Resources for Health (HRH), sexual and reproductive health (SRH), commodities, health financing and governance' (3 changes); and, 'increased social accountability by government related to Health Systems Strengthening (HSS) and advocacy topics' (3 changes).
- One example of capacity strengthening led to change among other areas. Amref and their trained CSOs set up a taskforce comprised of CHMT members and developed a strategic plan for identifying, absorbing and financing formally recognized CHWs in the districts where they were working. This approach was partially successful. At the district level in the Shinyanga region, this group created a manual that stipulated who could be engaged as a community health worker, and what would be their basic remuneration; at the national level, this is yet to be realized.

B. What worked and did not work

- In 2018, UMATI through MeTA conducted a study on SRHC to measure availability, affordability and stock-outs in six districts in Tanzania. UMATI/MeTA used the findings to draw the MoH's attention to issues with the management and supply of SRHCs that were leading to stockouts[12]. Through this intervention, the MoH committed to strengthening the supply chain by working with district medical officers through zonal medical store departments.
- At the national level, Amref managed to influence three private health insurance companies (Strategies, Resolution and Britam Insurance) to include FP in their health benefits packages, while three districts committed to allocate 3%-15% of their own district resources for FP in the FY 2019/20 plans and budgets.

C. Supporting and hampering factors

- In most cases, core partners chose to engage CSOs with footprints in their place of domicile. This made it easy for trained organizations to start navigating policymaker's corridors, because they knew them.
- A hampering factor was lack of a strategy in place by the HSA partnership to provide financial support to CSOs. According to one core partner, "*this limited their involvement to help spearhead CSO advocacy efforts*".

[12] MeTA council and Research

2. **The effectiveness of the advocacy approaches**

A. **Actual changes (outcomes)**

Changes in policymaker support on HRH, SRH commodities, health financing and governance

- The Tanzanian government made a commitment to ensure adequate availability of FeFo (oral iron and folic acid supplements) in health facilities. (KII core partner)

Changes in the development of effective evidence-based messages taken up by like-minded networks and organisations

- Joint development and sharing of advocacy messages, first within META council and then with HSAP partners. (KII core partner)
- UMATI saw the creation of META, and its participation in development of evidence-based advocacy messages as a resounding achievement in developing effective messages because of the multi-sectoral involvement of its personnel.
- *"We had diversified skills, when you look at META council, there were journalist, [and] article writers, therefore it was very easy for us to come up with messages because we had one person acting as facilitator, and with adequate knowledge within the META council*." (KII Core partner)
- Amref developed advocacy messages on CHW recognition and remuneration based on their research findings echoing the influence of incentives to CHWs' performance in FP services.
- Amref consider this a big achievement in developing effective evidence-based messages, although bottlenecks exist at the national level in achieving intended outcome.

Roles and contribution of external factors/actors in achieving advocacy outcomes

- The acceptance of insurance companies in Tanzania to include FP as one element of the health benefits package. "*We achieved to influence insurance companies to include family planning as one of the health benefit package*." (KII core partner)

Best practices and setbacks of the advocacy process

- One of the challenges identified within the partnership was that there wasn't a clear communication structure. *"Communication structure wasn't clear; Yes, we were working but it wasn't well documented. For instance, who is responsible to call for partner meetings was undocumented between partners. It would have been good to have a document stating explicitly, say, [Amref] is responsible to initiate country management meeting[s]. Though we used to conduct partner meetings, the protocol to convene a meeting wasn't documented anywhere."* (KII Core partner)

B. **Advocacy approaches and strategy of HSAP partners**

Advocacy strategy and focus

- Using evidence-backed advocacy messages helped CSOs and core partners to garner decision maker support at national and regional levels. At the regional level, CSOs were empowered to identify existing gaps and create their advocacy agenda based on identified challenges. This proved to be useful in winning CHW recognition and remuneration in the Shinyanga region. SIKIKA used the same approach to convince the government to recruit new human resources for health.

- UMATI adopted the META approach, which now has seats in technical committee meetings at the national level. "This (META) is a platform for people to discuss issues and come-up with resolutions that are easier to be implemented and meetings were chaired by someone from ministries of

health and local government, as such agendas discussed were quickly channelled to respective entry point in technical working groups within the government in any level and different areas. We really need to sustain this approach, when you put multi-stakeholders together chances of success are higher." (KII core partner)

The contributing and/or hampering factors in applying advocacy approaches/strategies

- Key factors for good achievement were collaboration with the CSOs and the partners' existing goodwill at the national level. Both core partners have been engaged in Sexual and Reproductive Health Services and commodities for many years and as such it was easy to deliver their advocacy agenda with fewer challenges.

- In Tanzania, HSAP were faced with the government's unfavourable attitude towards reproductive health services, although this was not officially communicated. This hampered the partners speed when advancing their SRHC agendas. "There is a period where in our country, because of the political situation, sexual reproductive health wasn't running well, for example when you meet members of parliament and when you speak of family planning it was treated as something very sensitive or even when you write a letter you don't have to express openly what you want. Sexual reproductive health wasn't a priority although we don't have a document saying that explicitly, but you can simply see it; it caused some delay against our initial expectations." (KII Core partner)

Missed opportunities / lessons learned in relation to the advocacy strategy

- The HSAP project did not offer financial support to CSOs as part of the intervention. CSOs and core partners felt the project missed a huge opportunity to influence change around the four pillars of health they were working on. "When you engage CSOs and build their capacity they expect you will support them financially to help move forward your agenda. Sometimes you may ask them to conduct something, but you'll find their organization doesn't have a budget for that, and makes it difficult for them to implement the way you wanted it to be done." (KII core partner)

3. Relevance for health system strengthening and SRHR

A. Health system strengthening

- In 2018, Amref Tanzania succeeded to influence the Medical council of Tanganyika (MCT) to adopt the AMCOA protocol on health worker migration. This contributes to better data and identifies HRH gaps in the health system. *"We influenced the MCT to adopt the AMCOA protocol, so it was adopted as it was signed December 2018".* (KII core partner)
- From the storytellers, participants were also asked to rate the relevance of the change they described for the promotion of SRHR and HSS. Respondents were more split regarding the question about relevance for HSS. The largest cluster of answers were located in the middle, indicating some relevance to HSS for the changes they described. Five respondents saw a low range of effect (none to very limited) on HSS and two respondents saw a specific effect on HSS. Storytellers mainly with HAI/HEPS/Me TA/UMATI were slightly more positive than those working with other partners.
- The combination of the two questions on relevance yielded a matrix image. Through this matrix, it was apparent that only one change was seen as relevant for HSS but not for SRHR.
- Some storytellers shared that the change they described had only limited relevance for HSS since it only addressed a small section of the health system. Others shared that the change was relevant because it led to more funding for health care and incorporated CHWs.

B. SRHR

- Most respondents saw a moderate relevance to SRHR for the changes they described. Some saw a large relevance and others were not sure. There was one respondent who indicated that the change had no effect on SRHR at all. This respondent mainly worked with SIKIKA/ACHEST.
- CSOs felt the changes achieved were relevant to SRHR because they created a comfortable environment at school for girls, youth and women were able to better access SRHR services, the role of CHWs was clarified, unwanted early pregnancies were reduced, adequate availability of essential medical supplies for facility delivery was provided, there was increased awareness on SRHR, adolescent girls and young women were empowered, barriers preventing pregnant women from health facility deliveries were minimized, availability of hygiene products was increased, and there was better engagement of fathers in children's health.
- One CSO mentioned,"The changes are somehow relevant for sexual and reproductive health rights because historically maternal new-born and child health were not in good shape. But numerous efforts have been made to turn the situation around, and we believe our advocacy effort is part of those efforts to improve maternal new-born and child health services. The health knowledge we provide combined with improved services and availability of workers is relevant for sexual and reproductive health rights of our beneficiaries."

4. Lessons learned on HSS and SRHR advocacy, gender and inclusivity, collaboration and governance, visibility/legitimacy

A. Gender/inclusivity

- The HSAP Programme also strengthened CSOs and CBOs and developed networks with local organizations that represent women and marginalized groups. For example, the programme built the capacity of SHDEPHA+ (The Service, Health and Development for People Living with HIV/Aids[13]). However, operationalizing gender and inclusivity in policy analysis and policy influencing is still a problem for the HSAP team.
- HSAP partners conclude that gender and inclusivity have been missed opportunities in HSAP since this work started very late in the programme.
- One of the core partners reflected that at the national and regional levels in general, there is little understanding among CSOs and governments about gender beyond the biological meaning (i.e. the social construct of gender), and suggested that much can be learned from the good discussions around this taking place at a global level.

Hampering and/or enabling factors in implementing a gender and inclusivity lens

- Core partners admitted that gender and inclusivity were not part and parcel of HSAP's programming at the beginning. After the mid term review (MTR), a consultant from Kenya was hired to give guidance to the partnership on how to integrate gender in all activities, and things improved after the consultant intervened.
- "Earlier concentration on gender was more of numbers, when you see a woman and a man you think gender has been considered, but later it was more of a focus on [the] needs of men and women are different, but even for youths (boys and girls) needs vary. So, when doing intervention for capacity building…earlier the focus was on gender equality, but currently the focus is on gender equity." (KII Core partner)

B. Collaboration and governance

[13] HSAP Annual Reflection report 2017

- One core partner felt they were the leading partner, while others in this partnership model lacked a clear leading figure / organization.
- Some core partners felt that the penholder held most power in this partnership in terms of budget and decision making. One Amref staff however felt that power was evenly distributed among partners, which delayed decision making and efficiency, and this person would have liked to see the lead agency given more of a mandate to make decisions.

Complementarity
Core partners have indicated that complimentarity among them existed and it helped in achieving their individual advocacy agenda: "One of the HSAP organization was working on health finance and in one way it covers sexual reproductive health commodities, which we were working on. This is one example how our advocacy efforts complemented one another." (KII Core Partner)

Visibility / autonomy / CSO's capacity strengthening affected CSO legitimacy
- The majority of the responding storytellers indicated that the visibility of their CSO had improved somewhat to immensely compared to before their involvement with the HSA partnership.
- There seemed to be some correlation between how much respondents considered that the visibility of their CSO had improved and whether or not they considered that the change would have happened even without HSA.
- A CSO from Shinyanga (Thubutu Africa Initiative) explained that their visibility had increased: "Involving our self with Amref has increased our social capital, it has increased our presence in the eyes of, say, RMO or DMO because now we use relevant arguing terminologies such 'score card performance'."
- A KII participant explain that CSO are now perceived by surrounding communities as coming from within: "Surrounding communities perceive our CSOs positively because they see them as helpful organizations, and whatever they do is for the benefit of the society."

5. Sustainability of programme

A. Mechanisms in place to sustain advocacy outcomes: HSS, SRHR, and advocacy capacity

Working together with the government ensures continuation of advocacy efforts: "Involving the government in the implementation of the project simplifies [the] exit process, because we can share with them how they can sustain what we have been doing. Most of the programme activities were conducted in collaboration with the government." (KII core partner)

B. Governance mechanisms to sustain CSO advocacy efforts

- One core partner said they were involving district offices to ensure the continuation of advocacy efforts by CSOs.
- Another core partner believed the HSAP interventions contributed to sustainability: "CSOs will keep on using lobby and advocacy techniques"

C. Conclusion / Reflection

- HSAP Programme also strengthened CSOs and CBOs and developed networks with local organizations that represent women and marginalized groups; for example, they built the capacity of SHDEPHA+ (The Service, Health and Development for People Living with HIV/AIDS).
- However, operationalizing gender and inclusivity in policy analysis and policy influencing is still a problem for the HSAP teams. HSAP partners conclude that gender and inclusivity have been missed

opportunities to use programs' extensive presence at the national and regional level decision making platforms to influence changes and awareness on gender issues.

- The partnership model lacked a clear leading figure / organization, and there is a need to have clearly stipulated roles and responsibility of each partner.
- Some of core partners felt that lack of financial support to CSOs limited their involvement in making close monitoring and follow-ups on capacity strengthening input made.
- Joint strategizing and budgeting could have been better between core partners for taking forward all HSAP advocacy agendas at the national and regional level.
- All CSOs agreed that their visibility increased at regional and district level, and the programme helped to build their social capital when participating in decision making meetings.
- CSOs felt changes achieved were relevant to SRHR because they created a comfortable environment at school for girls; youth and women are able to access SRHR services better; clarified the role for CHWs; reduced unwanted early pregnancy; provided adequate availability of essential medical supplies for facility delivery; increased awareness on SRHR; empowered adolescent girls and young women; minimized barriers preventing pregnant women from health facility delivery; increased in availability of hygiene products; and led to better engagement of father in child's health.
- Some of the CSOs felt that Involvement of district offices in program activities is expected to result in smooth continuation of advocacy efforts even after HSAP program ends.

Annex 7. Tabulation of all substantiated outcomes with substantiator comments

Annex 7. Tabulation
of outcome verificatio

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Annex 8. List Substantiator

No	Name
1	County deptartment of health coordinating community health sercives
2	AFIDEP African Institute of Development Policy in Nairobi
3	Siaya County Government, dept of health, sanitation and planning
4	Ministry of Education
5	Regionl Health committee Kakamega
6	KMPDU Kenya Medical Practitioners Pharmacists and Dentists Union in Nairobi
7	The Nursing Council of Kenya
8	Ministry of Health, Narok County
9	Office of the county 1st lady of Narok
10	Siaya County government
11	Chitipa CSO network (Chair person)
12	Ntchisi Evangelical Churches Consortium for social services (NECOSS)
13	Foundation for Community Support Services {FOCUS}
14	Makanjira health centre management committee
15	Wenya Health centre management committee
16	Ministry of Health
17	Mangochi district council (councillor)
18	Ministry of Health (Health centre in charge)
19	Health Centre Management Committee Kansonga
20	Health Centre Management Committee
21	Ntchisi District hospital
22	Clinton Health Access Initiative (CHAI)
23	Ministry of Health
24	Ministry of Health
25	Leader of the People's Party
26	Kansonga Health Center Management Committee
27	Chitipa District Health office
28	Dr. Richard Mugahi
29	Parliament of Uganda
30	Dr. Isaac Orec, Amach HCIV, Lira District
31	New vision
32	Kabale district/Maziba HC IV
33	Dokolo DHOs Office
34	Soroti RDC
35	Mr. Edmond Aceka, Assistant District Health Officer for MCH, Lira District
36	Odongo Eugene, DHE Dokolo
37	Serere Chief Administrative Officer
38	Kabale District Youth Council Chairperson
39	Kisoro DHO'S Office
40	Winfred Lichuma, Gender and Advocacy Expert
41	Centre for Reproductive Health and Education
42	Amref International University
43	Stellenbosch university
44	Kenya Medical Practitioners and Dentists Council
45	Peer To Peer Uganda (PEERU)

46	Woord en Daad / Building Change
47	Sikika
48	Global Financing Facility (GFF) World Bank
49	HURIC UGANDA
50	Malawi Health Equity Network
51	PMNCH
52	Health Worker for All Coalition
53	Human Rights Research Documentation Centre
54	World Health Organisation (WHO)
55	Medicus Mundi (MMI)
56	Cordaid
57	Vice Versa
58	Netherlands Ministry of Foreign Affairs
59	Netherlands Ministry of Foreign Affairs
60	Rutger
61	ShareNet
62	Netherlands Ministry of Foreign Affairs

Annex 9. The detailed information of outcomes mentioned on Page 16

Below is the list of 4 outcomes that not analysed and so they were deleted from the evaluation because the outcomes not verified by the substantiators, or the credibility of the outcomes was doubtful, and could not be sufficiently assessed by the evaluators, or core elements of either the outcome and/or the contribution was not confirmed and/or required adaptation:

1. Kenya: November, 2019, the Narok county government fully implemented the Adolescent Sexual Reproductive Health Policy on the side-lines of a teen summit. (32896)
2. Malawi: July 2018, the Ministry of Health (MoH) developed the Human Resources for Health (HRH) strategy 2018-2022 launched in Lilongwe, and incorporated HRH coalition written input. (32852)
3. Malawi: January 2019, the MoH, local government for District hospitals and Christian Health Association of Malawi (CHAM) recruited 520 health workers to work in tertiary hospitals following an HSAP Malawi Case Study presentation on the health worker funding crisis. (33722)
4. Malawi: April 2019, for the first time in a decade, the MoH increased overtime (locum) payments to nurses in a letter written by the Secretary for Health as a result of the National Organization of Nurses and Midwives of Malawi (NONM), and the Human Resources for Health (HRH) Coalition member's advocacy efforts. (32855)

The list of 7 outcomes that substantiated, but one or more minor details were recommended for adaption but evaluation team assessed these outcomes as sufficiently credible.

1. Malawi: After June 2019, civil society organizations (CSOs) became more active and better coordinated for engaging in discussions with local stakeholders concerning the Malawian Investment Case of the Global Financing Facility (GFF). (28436)
2. Malawi: During a White Ribbon Alliance meeting held at the Chitipa district council offices on July 25, 2019, the Chitipa district council formed a task force to champion family planning financing in the District. (32733)
3. Malawi: In November 2019, the MoH appointed an ambassador for community health who began on December 12, 2019. (32762)
4. African regional context: The East African Legislative Assembly (EALA) discussed a regional sexual reproductive health rights (SRHR) bill after advocacy and input from the Ugandan Youth and Adolescent Forum (a coalition of youth-led organizations). However, EALA did not pass the bill. (32911)
5. Global context: On May 1, 2019, the Dutch Ministry of Foreign Affairs (MoFA) published the "Sustainable Development Goals progress report". Within the "Civil Society" section, Partos included Wemos/AMAMI work on fiscal space for HW in Malawi as the first inspiring example. (28428)
6. Global context: On December 4, 2019, at the invitation of Management Sciences for Health (MSH), Wemos delivered a webinar for MSH grantees in Malawi, Uganda and Kenya on the country-briefing papers they had developed about the Global Financing Facility (GFF) in the countries. This was the first time MSH invited Wemos to hold such a webinar. (28440)
7. Global context: In May 2018, in Geneva, during a side event at the World Health Assembly, and on an explicit request from a wide variety of CSOs, ACHEST, Wemos and the Medicus Mundi International (MMI) established and launched the Health Workers for All Coalition (HW4A Coalition). (28570)

Annex 10. List of outcomes and description

The list of the complete outcomes w

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Outcome Harvesting quality check

In Outcome Harvesting, there are five criteria for verifiable outcome statements:

Specific: Each outcome statement is formulated in sufficient detail so that a reader without specialized subject or contextual knowledge will be able to understand and appreciate what is described. The outcome description should contain:

- When – day, month and year that the change happened
- Full name of who changed
- What did he, she, or they do concretely that is significantly different?
- Where – located on a map

Measurable: The descriptions provide objective, verifiable quantitative or qualitative information, independent of who wrote the outcome statement. How much? How many?

Achieved: There is a plausible relationship, a logical link between the outcome and what the intervention did that contributed to it. Who did what that wholly, but probably partially, indirectly or intentionally or unexpectedly, contributed to the change described in the outcome?

Relevant: The outcome represents a significant step towards the effect that the intervention seeks.

Timely: The outcome occurred within the time period being monitored or evaluated although the intervention's contribution may have been months or even years before.

Based on the SMART criteria, the following lists can be used for a quality check:

An outcome statement…

☐	…names the social actor (individual or group) as the subject of the sentence
☐	…explains what the social actor is doing differently or for the first time
☐	…specifies the timeframe for the change
☐	…specifies where the change took place
☐	…describes the change in specific terms (how much? how many?)
☐	…does not contain abbreviation, but spells them out at all times

A contribution description…

☐	…describes what you did to support the change
☐	…gives precise details - how much, where and when
☐	…includes both your direct and indirect contributions, as relevant
☐	…explains your role as part of the Health Systems Advocacy Partnership
☐	…describes the change in specific terms (how much? how many?)
☐	…does not contain abbreviation, but spells them out at all times

Finally, the following do's and don'ts can be considered:

DON'TS	DO'S
Don't describe a project activity as an outcome, such as, "We organized a conference or prepared tool X."	Describe not what you did, but what the social actor did because of the influence of your activities. A social actor may be an individual leader, elected official, government team, coalition, or civil society organization network.
Don't force yourself to find direct relationships between all activities and an outcome.	Realize that some changes may not be directly linked to an activity. Also, an activity might have been completed last year but the outcome may only have become visible this year. And finally, some things carried out may not lead to the expected or desired or unintended outcomes.
Don't report only positive outcomes or intended outcomes.	Report outcomes that are negative, unintended or unexpected. Report expected outcomes that did not occur as planned. These can be identified as pivot points and provide opportunities for learning to help explain why a process of change took a new direction.
Don't give vague descriptions of the change that happened.	Describe the outcome information in simple language and in sufficient detail so third parties are able to understand the change and verify it. Quantify the change to the degree possible.
Don't describe your contribution in vague terms, such as 'training and awareness raising'	Quantify the program's contribution as much as possible, such as 5 weekly training sessions of 4 hours each, 25 participants, 4 meetings, 3 policy documents, etc. As with the outcome, the formulation of the program's contribution must be specific enough to be verifiable.
Don't report only major outcomes.	List both small and big changes observed in each social actor to capture milestones in the change process.

Annex 12. Original and new Actor and ToC categories

The ToC outcome categories 'MT-Increased evidence-based lobby and advocacy capacity of multi-stakeholder networks and platforms, at local, national, regional and global level' and 'MT-Increased evidence-based lobby and advocacy capacity of civil society organisations at local, national, regional and global level' were merged.

The ToC outcome category 'MT-Increased involvement of the HSA partnership and CSOs in policy making processes by stakeholders on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH), commodities, health financing and governance' was deleted, as it didn't occur much and had a large overlap with multi-stakeholder processes.

Also, the ToC outcome category 'MT-Empowered communities are increasingly able to demand their rights' was deleted as it was found to be too narrow. Outcome that fall under this category can be found under 'Policy implementation'. Only a few outcomes were about actions taken by community members which undoubtedly showed how they 'demanded their rights', but more often community actors DID something, which falls under policy implementation.

On the other hand, the category 'LT-Increased social accountability by government related to Health Systems Strengthening (HSS) and advocacy topics' was found to be too general, and more overarching.

The category 'MT-Increased media, government, and private sector attention for Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance' was expanded to include other actors, so for example a global institution can also give sign of increased attention.

Below is the original and new categories

9. Who is the actor of your outcome?	**Reformulated for the ETE**
CSO (not part of HSA partnership)	CSO *(note: excluding contracted partners)*
Global institution or organisation	Global institution or organisation
Local or sub-national government	Local government
Media	Media
National government	National government
Regional institution/organisation (supra-national)	Regional institution or organization
Research/knowledge institute	Research/knowledge institute
	new: Community actors (individuals, professionals, committees or facilities)
	new: Network, alliance or platform
	new: National institution or organisation

11. Which OVERALL ToC outcome areas does this outcome best relate to?	Reformulated for the ETE	Potential related Actors
MT-Increased evidence based lobby and advocacy capacity of multi-stakeholder networks and platforms, at local, national, regional and global level	Increased lobbying and advocacy capacity or actions	• CSO • Network, alliance or platform • National institution or organisation • Research/knowledge institute
MT-Increased evidence-based lobby and advocacy capacity of civil society organisations at local, national, regional and global level	*merged with above*	
MT-Increased involvement of the HSA partnership and CSOs in policy making processes by stakeholders on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH), commodities, health financing and governance	*There were little outcomes here and often difficult to choose between this one and multi-stakeholder, so I put most under 'multi-stakeholder'*	
MT-Empowered communities are increasingly able to demand their rights	*can be found under:* Policy implementation *Note: only a few outcomes were about actions taken by community members where they really 'demanded their rights', but more often community actors DID something, so it more policy implementation, (which, for our analysis, can be a sign of 'communities being able to demand their rights').*	• Local government • Community actors
MT-Increased media, government, and private sector attention for Human Resources for Health (HRH), Sexual and Reproductive Health (SRH)	Increased attention of stakeholders (short-term)	ALL (except network)

commodities, health financing and governance		
MT-Increased multi-stakeholder engagement with regard to Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance	Increased engagement of multiple stakeholders	• CSO • local • national • network
LT-Improved support of policy makers for advocacy topics on Human Resources for Health (HRH), Sexual and Reproductive Health (SRH) commodities, health financing and governance	Improved support of policy makers	• Local government • National government • Regional institution or organization • Global institution or organisation • National institution or organisation
LT-Increased social accountability by government related to Health Systems Strengthening (HSS) and advocacy topics	*This is overarching, not a specific category*	–
Improved policies and/or budgets that strengthen health systems	Improved policies and/or budgets adopted by policy makers	• Local government • National government • Global institution or organisation
Effective policy implementation	Policy implementation	• Local government • National government

Annex 13. List of storytellers

No	Name
1	Siaya County Youth Forum
2	ACK Development services -Nyanza
3	BONDO YOUTH FRIENDLY CENTRE GROUP
4	Tembea Youth Centre for Sustainable Development
5	Imani Community Development Programs-IUCDEP
6	Ugunja Disability Network-Siaya County
7	Ucaha (United Champions Advancing Humanitarian Actions) Empowerment Centre
8	Ugunja Development Initiative
9	Talanta Youth Empowerment Centre
10	Malaika Foundation
11	Youth Alive! Kenya - Meta Kenya Lake Region Network For SRH
12	She Deserves To Soa, A Member Of The Meta Kenya Csos Alliance For SRHR
13	Heart To Heart Smile Organization
14	Coalition for Substance Abuse Prevention, A Member Of The Meta-Kenya Lake Region Csos Alliance
15	Lake Region Meta Kenya Csos Alliance For Srh -Citizen Voice of Action Initiatives (Cvai)
16	Inuka Success Organization Member of Meta Kenya Cso Coalition for Sexual Reproductive Health Alliance
17	Meta Kenya Vijana Na Kazi
18	Community Support Initiative
19	Girl 2 Girl Club A Member of The Meta KENYA Csos Alliance For Health
20	Meta Kenya network (Women Volunteers for Peace)
21	TINADA Youth Organization -TiYo, a member of MeTA Kenya Lake Region CSOs Alliance for SRHR. (TINADA is the lead organization of the alliance)
22	Siaya Muungano Network- Member of Youth Parliament- Convener- Alego Usonga Youth Parliament
23	"Youth Resource Centre Kenya"
24	Radio Lake Victoria
25	"Standard Group. Also, member of Amref Media Network Kisumu Chapter"
26	The Standard Group
27	Onesmus Baraka member of Cape Media
28	AMNH kisumu
29	Peace fm - Member of AMNH Kisumu Chapter
30	Lead Initiative Kenya
31	Anglican Development Services (Ads) Nyanza
32	Viagenco Community Development & Support Organization
33	Tropical Institute of Community Health and Development (Tich)
34	Kisumu Medical and Education Trust
35	Mbita Youth Parliament Mfangano Chapter
36	Africa Media Network on Health
37	Standard Group Limited-KTN News
38	K24 Television
39	Chitipa Wenya HCMC And Score Card Committee
40	Global Forum for Development
41	Pentecostal Assemblies of God-Soroti

42	Building-community Initiatives for Development and Self-reliance (BIDS) Foundation
43	Uganda Radio Network
44	Uganda National Health Users'/Consumers' Organisation (UNHCO)
45	"the Independent Publications Limited"
46	White Ribbon Alliance Uganda (2 epople)
47	Naguru Teenage Information and Health Center
48	Peer To Peer Uganda (PEERU)
49	New Vision newspapers
50	Diocese of Muhabura
51	Kabale Women in Development (KWID) (4 people)
52	Bukedde Newspaper
53	Daily Monitor
54	Global Forum for Development-GLOFORD Uganda
55	AFYARIKA
56	Young African Leaders Initiative (YALI)
57	Silan Foundation
58	Girl Redefined
59	Pentecostal Assemblies of God-Soroti
60	Linda Arts Organization
61	ADS-SR NIDP (Anglican development service-South Rift) Narok Integrated Development Program
62	Counter violence extreme (CVE)
63	Power dada
64	Mfangano youth parliament
65	Tropical Institute of Community Health and development (TICH)
66	Omega Foundation
67	Mbita Youth Parliament
68	Ugunja Youth Parliament (7 people)
69	AGAPE AIDS CONTROL PROGRAM (AACP)
70	Wenya Health centre (3 people)
71	Rafiki Social Development Organization
72	Community Support Initiative Tanzania (COSITA)
73	Tanzania Youth and Adolescent Reproductive Health Coalition
74	Morden Education and Culture Group (MECEG)
75	Thubutu Africa Initiative
76	Paralegal Aid Centre Shinyanga
77	"Service, Health, and Development for People living with HIV/AIDS. (SHIDEPHA)"
78	The Voice of Marginalized Communities (TVMC)
79	Access Facility Tanzania
80	Kishapu Paralegal Organisation (KIPAO)
81	Jitolee Group
82	Rural and Urban Development Initiative Agency (RUDIA)
83	Mpango Wa Kutokomeza Ukoma Na Kifua Kikuu Tanzania (MUKIKUTE)
84	Good Neighbours Tanzania - Shinyanga Area
85	Tanzania Healthcare and Career Awareness Program (TAHECAP)
86	Futurepreneur Zambia
87	Zambia Association for Child and Youth Care Workers
88	Daily Nation
89	African Health Accountability Platform (AHAP)

90	Children in Distress (CINDI)
91	Restless Development
92	Treatment Advocacy Campaign
93	Young Women Christian Association
94	Marie Stoppes
95	Mens Network
96	Zambia 24
97	Center for Reproductive Health and Education
98	Media H Zambia
99	Generation Alive Zambia
100	Adolescent Reproductive Health Advocacy (ARHA)
101	Africa Directions
102	North Star Alliance
103	Copperbelt Health Workers Association
104	Planned Parenthood Association of Zambia
105	Kansonga Health Centre
106	Foundation for Communication Support Services (FOCUS)
107	Rights Advice Centre (RAC)
108	Reigners of Life
109	Bwacha Clinic
110	National HIV/AIDS Council
111	Zambia Youth Forum
112	ChildFund Luangwa
113	Africa Media Network on Health