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# EVIDENCE FOR FAMILY PLANNING ADVOCACY

## *An Assessment of Decisionmakers' and Advocates' Needs and Strategies in East Africa*

This publication was prepared by Ellen Smith, Ramona Godbole, Ruth Musila, Violet Murunga, and Eliya Zulu for the Health Policy Project.

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# EXECUTIVE SUMMARY

Family planning (FP) advocacy plays a key role in policy development. Despite a significant body of evidence-based advocacy promoting family planning, there are few systematic studies on decisionmakers' opinions of such advocacy; how advocacy and evidence are used by decisionmakers; what types of evidence and advocacy are persuasive from the perspective of decisionmakers themselves; and how and why decisionmakers support FP policies. This study was designed to address these issues. The findings draw from structured interviews in three countries: Ethiopia, Kenya, and Malawi.

The findings highlight that decisionmakers from all three countries understood the value of family planning and support efforts to further elevate its profile. The findings also confirm that FP advocacy has played a major role in shifting the attitudes of decisionmakers toward embracing family planning as a critical health issue. However, to be effective, advocacy must follow well-defined steps. FP advocates need to map out their audiences and tailor the messaging, formats, and forums to the audience (parliamentarians, government officials, religious leaders, or subnational leaders).

A myriad of factors were found to influence decision making. Public opinion is of great importance in the three countries, and respondents noted that elected leaders base their actions and decisions about family planning on their constituents' views. It also emerged that some elected officials may not want to promote family planning for fear that doing so would decrease the size of their voting bloc and the influence their ethnic group has in national affairs. Nevertheless, the decisionmakers and advocates interviewed for this study believe that the influence of competing priorities—including economic (limited resources), sociocultural, religious, and political factors—can be incrementally reduced or removed through sustained and strategic FP advocacy. They also believe that individuals who currently oppose family planning could be transformed into FP supporters. This perspective is instructive for FP advocates, who need to tailor messages that consider and address the identified barriers in each country.

The following recommendations for those supporting FP advocacy effort emerged from this study:

1. Design communication strategies sensitive to the economic, sociocultural, religious, environmental, health, and political factors that influence decision making about family planning. For instance, in a context of limited resources, FP advocacy may seek to demonstrate the role of family planning in making savings in other sectors, such as health, education, transportation, water, and agriculture, which will contribute to national economic growth. Many decisionmakers are eager for evidence that demonstrates this link and will help them meet the national development goals for which they are accountable. Such multisectoral evidence may also broaden some decisionmakers' views of family planning, changing their perception of it from a narrow health or women's issue to a development issue.
2. Develop an array of FP advocacy materials: document the short- and long-term benefits of family planning; use a combination of personal stories and data to communicate these benefits; and create materials in different formats based on the type of decisionmaker, the decisionmakers' evidence needs, and the forum in which the materials will be presented.
3. Promote the scale-up of information, education, and communication (IEC) programs at the community level to increase community members' support for family planning. This may increase community acceptance of family planning, thereby decreasing the hesitation of elected leaders to support and promote it.
4. Continue collaborating with key decisionmakers who are FP champions by ensuring they remain engaged and well-informed about FP issues. Make sure champions have resources and information readily available so they can advocate for family planning with their peers.

5. Sustain efforts to engage with national and subnational leaders, parliamentarians, and religious leaders to increase and sustain support for family planning. Advocacy is not a one-event activity—efforts should be sustained but flexible enough to respond to shifting political, cultural, and programmatic changes. For instance, advocacy in a country at an early stage of the contraceptive increase (like Ethiopia) requires messages focused on the sustainability of contraceptive uptake.
6. Enhance the technical skills and capacities of local advocacy practitioners to generate and package evidence to promote family planning among a range of decisionmakers (government officials from other public sectors, parliamentarians, subnational leaders, religious leaders, institutional leaders, etc.). National and international advocacy actors are viewed as credible, and their complementary roles are valued by decisionmakers. However, international actors who previously have undertaken evidence generation and packaging should develop programs that build the capacity of national actors, because decisionmakers may be more comfortable getting messages on sensitive issues from local practitioners.

# ABBREVIATIONS

| | |
|---|---|
| AFIDEP | African Institute for Development Policy |
| CPR | contraceptive prevalence rate |
| CS | contraceptive security |
| CSO | civil society organization |
| DHS | Demographic and Health Survey |
| FMOH | Federal Ministry of Health |
| FP | family planning |
| GTP | Growth and Transformation Plan (Ethiopia) |
| HEW | health extension worker |
| HIV | human immunodeficiency virus |
| HPP | Health Policy Project |
| HRH | human resources for health |
| HSDP | Health Sector Development Plan (Ethiopia) |
| ICPD | International Conference on Population and Development |
| IEC | information, education, and communication |
| LAPM | long-acting and permanent methods |
| MCH | maternal and child health |
| MDG | Millennium Development Goal |
| MGDS | Malawi Growth and Development Strategy |
| MOF | Ministry of Finance |
| MOFED | Ministry of Finance and Economic Development |
| MOH | Ministry of Health |
| MP | member of Parliament |
| NCPD | National Council for Population and Development |
| NGO | nongovernmental organization |
| PS | Permanent Secretary |
| RH | reproductive health |
| RHU | Reproductive Health Unit (Malawi) |
| SRH | sexual and reproductive health |
| USAID | U.S. Agency for International Development |

# INTRODUCTION

Family planning (FP) advocacy plays a key role in support of policy development. Despite a significant body of evidence-based advocacy promoting family planning in recent decades, there are few systematic studies of decisionmakers' opinions of such advocacy; how advocacy and evidence are used by decisionmakers; what types of evidence and advocacy are persuasive from the perspective of policymakers themselves; and how and why policymakers support FP policies and programs (Trostle et al., 1999).

Despite global and national efforts to promote consultation between policymakers and researchers (Lavis et al., 2004) and invite an array of stakeholders to be part of research processes, little empirical research has been done on the influence of evidence from research findings on the knowledge, attitudes, and actions of policymakers, especially in developing countries (Hyder et al., 2007). Studies looking at the role of public health evidence in policy-level decision making indicate that, while evidence can be influential, many evidence-based advocacy approaches do not adequately take into consideration the political context and policy processes, which often have an important impact on the decisions made by policymakers, or fail to adequately "package" advocacy messages (Trostle et al., 1999; Hyder et al., 2010; Hennick and Stephenson, 2005; Aaserud et al., 2005; Albert et al., 2007; Hunsmann, 2012; Petticrew et al., 2004). In particular, policymakers and advocates in low-income countries often face additional challenges in using research evidence, including the weakness of their health systems, a lack of professional regulation, and poor access to evidence (Haines et al., 2004).

## Purpose

To better understand FP/reproductive health (RH) advocacy, the Health Policy Project (HPP), funded by and in collaboration with the U.S. Agency for International Development (USAID), in partnership with the African Institute for Development Policy (AFIDEP), conducted qualitative research to better understand what works in FP advocacy and characterize the evidence needs for policy decision making in three sub-Saharan African countries: Ethiopia, Kenya, and Malawi. The study was conducted from May to September 2012. It was designed to better understand how decisionmakers make decisions related to family planning; what types of evidence they find compelling; what advocacy approaches are most effective; and advocates' needs to implement evidence-based FP advocacy.

Specifically, the study was designed to answer the following questions:

- Which individuals, groups, or institutions have the strongest influence over FP policy and funding in the country?
- With what FP advocacy efforts are decisionmakers familiar? With what evidence about the benefits of family planning are they already familiar? In what context did they see this evidence presented, and how was it presented (in what format)? Did they find this advocacy and evidence convincing? Why or why not?
- Who is and is not seen as a credible advocate for family planning?
- What factors do decisionmakers take into account when making policy decisions?
- What might make decisionmakers change their minds about an issue in their professional or public life?
- Would decisionmakers be more inclined to support family planning, or strengthen their support for it, if its benefits could be shown in the near term (fewer than five years) as opposed to the long term?

- What types of evidence do decisionmakers find most convincing in increasing their support of family planning (for example: maternal/infant/child health, economic growth, women's rights and empowerment, savings to the health sector, savings to other sectors, other demographic factors, etc.)?
- What is the preferred format in which to present this evidence (for example: graphs, tables/numbers, videos, policy briefs, longer reports, PowerPoint, narrative stories of individual women, regional comparisons, etc.)?

We hope these findings help global and national FP/RH advocates understand what kinds of health or economic evidence decisionmakers would like to receive, and in what ways this evidence should be presented to achieve the greatest impact. The results also will help to deepen the understanding of the characteristics—interests, needs, and behaviors—of decisionmakers that influence their decisions, and thereby support the efforts of researchers and advocates to develop more effective advocacy strategies, platforms, and evidence tailored to the needs of their audiences.

## Context

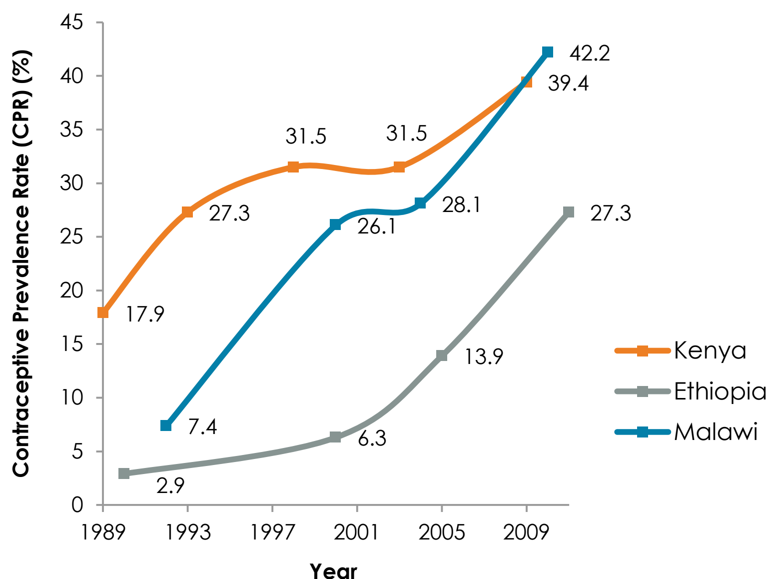
Ethiopia, Kenya, and Malawi were selected for this study because of their demonstrated commitment to strengthening their FP programs, both short and long term. Because of this commitment, they provide a rich environment for determining and documenting evidence needs for reducing unmet FP need and increasing uptake. The study findings are expected to have broad application, both in Africa and other developing regions, in stimulating family planning and related policies and programs beyond these three countries.

Ethiopia's modern married contraceptive use more than doubled, from 2.9 percent in 1990 to 6.3 percent in 2000, although remaining notably low, and fertility declined from 6.4 to 5.9 children per woman. However, in the following decade, the contraceptive prevalence rate (CPR) rose rapidly, to 27.3 percent in 2011, translating to a four-fold increase. Concurrently, fertility dropped by 1.1, from 5.9 in 2000 to 4.8 in 2011.

Malawi's modern married CPR increased phenomenally, from 7.4 percent in 1992 to 26.1 percent in 2000, and further to 42.2 percent in 2010. Fertility, however, declined only marginally, from 6.7 in 1992 to 5.7 in 2010.

Kenya's modern married contraceptive use increased to 31.5 percent in 1998. However, contraceptive use stalled until 2003, followed by an increase to 42.2 percent in 2008–09. Kenya is referred to as the pioneer of demographic transition in the region due to a decline in fertility to 6.7 in 1989, which represents a 41 percent decrease since 1978. Fertility has since declined further, to 4.7 in 1998, and remained nearly unchanged (total fertility rate of 4.6) in the most recent Demographic and Health Survey (DHS) (2008–09)

**Figure 1: Trends in modern married contraceptive use in Ethiopia, Kenya, and Malawi 1989–2011**




## Methodology

This study included two steps. The first was a literature scan related to decisionmakers' needs for evidence-based advocacy. Based on that review, the research team developed, piloted, and refined an interview instrument to explore a range of questions related to evidence-based FP advocacy. This interview instrument then was used to guide 68 interviews with decisionmakers and FP advocates in Ethiopia, Kenya, and Malawi. We coded and analyzed interview transcripts according to the themes identified by the research team based on the literature scan and those identified during assessment of the transcripts.

## Literature Scan

The research team conducted the literature scan through PubMed and Google Scholar to identify peer-reviewed journal articles from 1999–2012 related to decisionmakers' needs and experiences with health advocacy and evidence. Key search terms included policy, policymaker, decisionmaker, advocacy, research, data, evidence, health, and family planning. We reviewed articles if they included collection of data from high-level decisionmakers related to their opinions, experience, and recommendations regarding the role of health advocacy, research, and/or data in decision making. We reviewed 14 articles.

The literature scan highlighted several key points, which the research team used to develop the interview guide:

- Perceived quality and the trustworthiness of those who present evidence are often cited as factors important to its uptake (Trostle et al., 1999; Hennick and Stephenson, 2000; Innvaer et al., 2002; Albert et al., 2007; ODI, 2009).
- Research quality was often deemed less important than more pragmatic considerations, such as cost and experience. Policymakers reported making decisions without evidence because of the need for immediate action (Trostle et al., 1999; Petticrew et al., 2004).

- Timeliness, relevance, format, and clarity of evidence are important and need to be supported by timely dissemination (Innvaer et al., 2002; Pettigrew et al., 2004; Whitehead et al., 2004; Hennick and Stephenson, 2005; Aaserud et al., 2005; Albert et al., 2007; ODI, 2009; Hyder et al., 2010).
- While research and evidence facilitate the advocacy process, policymaking in reality is not strictly an evidence-driven process (Hunsmann, 2012). Political interests, social consensus, budget and resources constraints, mass media, and foreign donors all influence the policymaking process (Trostle et al., 1999; Innvaer et al., 2002; Aaserud et al., 2005; Hyder et al., 2010; Hunsmann, 2012). Advocacy messages thus must be tailored to any given political and social context (Aaserud et al., 2005; Hyder et al., 2010) and must be appropriately targeted and packaged to effectively meet the needs of different policy audiences (Hennick and Stephenson, 2005).
- Lack of communication and understanding between researchers and policymakers can serve as a barrier to evidence-based decision making (Innvaer et al., 2002; Hyder et al., 2010). Use of research is often viewed by policymakers as a time-consuming, complex, and difficult process (Hennick and Stephenson, 2005; Albert et al., 2007; Hunsmann, 2012). In turn, researchers and advocates must also understand the complexities of the policy process (Pettigrew et al., 2004).
- Policymakers may have a relatively low capacity to formulate policies on technical matters in health; this is a barrier to the use of evidence in the policy process (Hyder et al., 2010). Several studies have found that increased interaction between researchers and policymakers can facilitate understanding and uptake of research (Innvaer et al., 2002; Aaserud et al., 2005).

## Development of the Interview Guide

Building on the findings of the literature scan and guided by a Technical Advisor Group of experts in the field, HPP, USAID, and AFIDEP developed two interview guides, one for decisionmakers and one for advocates. The research team piloted versions of the interview guides in Kenya in May 2012 with five interviews. Based on observations from these pilot interviews, we modified the interview guides so they would take less time, be less repetitive, and clarify some questions. After the Malawi interviews (May 2012), we made additional improvements to the guides. Thus, the interview guides used in Malawi varied slightly from those used in Kenya and Ethiopia.

The decisionmaker and advocate interview guides consisted of 22 identical questions; five questions that appear only in the decisionmakers' guide; and 16 questions that appear only in the advocates' guide. Those questions exclusively for decisionmakers focused on decision-making processes, whereas the questions exclusively for advocates focused on experience in working with evidence and evidence-based advocacy. The interview guides employed mixed methods—including open-ended questions, yes/no questions, Likert scale questions, and hierarchal card sorting. (See Annex B and C)

## Interviews

HPP and AFIDEP identified initial interviewees based on offices held in government and nongovernmental organizations (NGOs)/civil society organizations (CSOs), and identified further interviewees through snowball sampling.

Three AFIDEP staff members conducted most interviews, with four other staff members filling in as needed. One or two of the interviewers generally conducted each interview. An illustrative list of types of interviewees in both the "decisionmakers" and the "advocates" groups follows:

- Decisionmakers:
  - Parliamentarians, such as heads of relevant parliamentary committees;
  - Senior government officials – ministers, deputy ministers, permanent secretaries (PS), departmental directors, and heads of secretariats or directorates. Relevant government agencies included the Ministry of Health (MOH), Ministry of Finance, Ministry of Planning/Development, Ministry of Education, Ministry of Youth, Ministry of Gender; Population Secretariats; and the National AIDS Commission.
  - Senior technocrats who advise senior government officials (such as technical officers, budget officers, etc.); and
  - Recognized FP champions in government.
- FP advocates:
  - Heads of local and international NGOs and parastatals whose work is relevant to FP advocacy;
  - Heads of CSOs that advocate for family planning;
  - Heads of training institutions for medical/allied health workers;
  - Nongovernmental FP champions; and
  - Representatives from donor partner organizations.

The staff members interviewed a total of 68 decisionmakers and advocates across the three countries. Table 1 shows the number of interviews by country as well as the category and sex of the respondents. A total of 57 of the interviewees agreed to be recorded; the interviewer took detailed notes for the remaining 11 interviews. The team fully transcribed all recordings and analyzed interviewer notes as transcripts for those who did not agree to be recorded. Each interview lasted approximately one hour.

**Table 1: Number of interviews by country, type, and sex of respondent**

| | Decisionmaker | | Advocate | | Agreed to be recorded |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| **Ethiopia** | 11 | 5 | 3 | 2 | 16 |
| **Kenya** | 8 | 5 | 3 | 4 | 14 |
| **Malawi** | 12 | 8 | 4 | 3 | 27 |
| **Total** | 31 | 18 | 10 | 9 | 57 |

The Malawi interviews were conducted in May 2012, during and just following Malawi's National Leaders' Conference on Family Planning, Population and Development. They conducted Interviews in Kenya between May and October 2012, and the majority of interviews in Ethiopia in August 2012.

## Ethics

The research team submitted the study protocol to the Futures Group Internal Research Review Committee, which determined that the research was exempt from the provisions of the Protection of Human Research Subjects regulations (45 CFR 46). AFIDEP staff conducted the interviews; AFIDEP holds a Federalwide Assurance (FWA) for the Protection of Human Subjects. As part of their training, interviewers successfully completed the online Collaborative Institutional Training Initiative (CITI) Human Research Curriculum (Social and Behavioral Research Group).

The team obtained informed consent from all interviewees. As mentioned previously, they were asked to consent to having their interviews recorded; interviewers took notes for the 11 interviewees who did not wish to be recorded. The team anonymized interview transcripts and made reasonable efforts to protect interviewees' identities in this report.

## Analysis

The research team developed an initial codebook based on the study questions. We then added themes and sub-themes as they reviewed transcripts. To assess inter-coder reliability and standardize the codebook and coding scheme, we used a staged double-coding approach on a sample of 10 percent of the transcripts (seven out of 68). At the beginning, the four authors independently coded three transcripts and met to discuss challenges and interpretations of the codebook. We revised the codebook, and then independently coded two additional transcripts and discussed any issues, resulting in minor additional revisions to the codebook. Finally, we independently coded two final transcripts to validate the codebook. We used Atlas.ti software for the coding.

The four authors then divided up and coded the remaining 61 transcripts, generating code reports for each code and reviewing for additional themes/sub-themes. In some cases, we applied a second layer of coding to the quotations from a specific code to organize themes that emerged around a specific topic. For example, an Atlas.ti report of quotations about the "government shifts" code was itself coded with a second layer of codes. In this example, the second layer of sub-codes was used to organize the "government shifts" quotes into two different categories: (1) the key shifts observed; and (2) the major reasons cited for these shifts. These sub-codes allowed for a systematic analysis of responses surrounding a topic.

We categorized all transcripts by the following variables: country and category of interviewee (decisionmaker or advocate). We further analyzed transcripts to look for patterns and comparisons of themes across these categories.

## Challenges and Limitations

A limitation of this study is that the line between decisionmakers and advocates blurred; some decisionmakers are also FP champions, particularly those leading government agencies in charge of FP policy and program implementation. Thus, the interviews might not have captured the advocacy efforts of those decisionmakers who also are champions of family planning. Further, their responses about their individual levels of support for family planning, the most compelling evidence regarding it, and the factors that influence their decisions about it may differ in comparison to other decisionmakers.

We also acknowledge that the small total sample sizes in each country (21 in Ethiopia, 20 in Kenya, and 27 in Malawi), which were separated further into the categories of decisionmaker or advocate for the quantitative analysis, will limit the statistical power of the study.

It is also worth noting that respondents were aware that the funder of the study (USAID) is the top funder for family planning in Africa, which may have led in some instances to a "Hawthorne effect," when study participants give what they think is the "correct response."

After completing the Malawi interviews, the research team modified the interview instruments. We found that the Likert format did not help in prioritizing potential advocacy approaches. A switch to hierarchal card sorting in Kenya and Ethiopia forced respondents to prioritize their answers. This change in format meant that the answers to a few of the quantitative questions from the Malawi interviews were not comparable to those from the Kenya and Ethiopia interviews; for this reason, we did not include Malawi results in a few of the quantitative results.

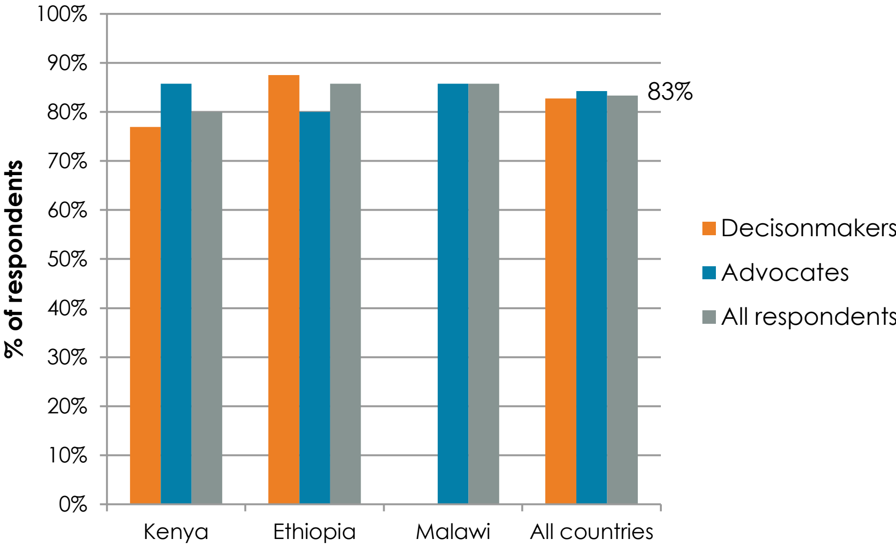
# RESULTS

Analysis of the results yielded significant findings regarding the topics of recent shifts in government support of family planning; context, format, and content of FP advocacy; salient factors in FP decision making; development of advocacy strategies; and creation of evidence for FP advocacy.

## Observed Shifts in Government Support

We first explored recent changes in government support for family planning to provide a background for the analysis of advocacy efforts and decision-making processes. Most respondents (83%) noted shifts in support in recent years (Figure 2 shows a breakdown by country and respondent type). Interviewees noted multiple recent changes in government support of family planning as well as some reasons for these changes.

**Figure 2: Percentage of respondents who observed a shift in government support of family planning in recent years[1]**




Interviewees identified several types of changes in government support in recent years. In approximate order of frequency, they cited the following observed shifts in support of family planning.

*Resources, budgets, and commodities*: Although all three countries are heavily dependent on external sources for FP funding, many respondents in Ethiopia and Kenya noted that their governments had recently increased the budget allocations for family planning. Common themes included increases in overall health budgets, creation of budget line items for family planning, allocation of regional funds to FP/contraceptive security (CS), funding of community health workers, and government provision of subsidized or free FP commodities. One Kenyan advocate noted that RH funding increased once the

[1] Interviewers did not ask decisionmakers in Malawi this question, so they did not include those decisionmakers' answers in Figure 2. After the Malawi interviews, the team made additional improvements to the interview guides, producing a slightly different interview guide for the Kenya and Ethiopia interviews.

treasury was included in the high-level FP advocacy group. An RH official in Kenya stated that he had observed "a shift towards planning for RH in the last few years" in the establishment of a caucus to track FP commodities.

In Malawi, most respondents noted a lack of budget and resources allocated to family planning, and stated that they had not observed funding changes in recent years. One Malawian advocate noted that "the real commitment from government would be to say 'this is a priority and this is how much money we are going to give it.'" A ministry official explained that "…because we don't take family planning as an emergency, sometimes [resources] can be shifted to other [more urgent] issues like drugs and the like."

*Conceptual or political support:* Many respondents noted that key political figures, decisionmakers, and institutions have become supportive of the idea of family planning in general, and specifically of government support. Ethiopian respondents were especially consistent on this topic, noting a shift toward strong support of family planning at various levels of government. An Ethiopian ministry official commented that the commitment to family planning reaches to the highest levels of government, as demonstrated by the late Prime Minister's Zenawi's article outlining its importance, published in The Lancet in 2012 (Habumuremyi and Zenawi, 2012). The level of commitment in Malawi recently has shifted with the election of a new president who is personally committed to FP/RH.

> *"Even if government resources are meager, they [government officials] would still prioritize and include family planning because it goes together with the rest of the reproductive health issues of women. The fact that we have a president who is a woman is a big, big plus and there will never be any better opportunity than this time for women."*
>
> *− Advocate, Malawi*

The comments on levels of conceptual or political support for family planning in Kenya were more mixed, with Kenyans noting past dips in support for family planning and that conceptual support for it is not accompanied by a commitment of resources.

*Policies, laws, and strategies:* Some respondents noted that they had observed shifts in government support of FP policies, laws, and strategies. Ethiopians frequently mentioned the elimination of the FP commodities importation tax in 2007, as well as the lifting of restrictions on FP advertising. Kenyan respondents cited national documents, such as national reproductive health policies, the national population policy, and policies that allow over-the-counter sales of some contraceptive methods, as evidence of change. One Malawian decisionmaker mentioned the development of a national plan of action for scaling up sexual and reproductive health interventions among young people.

*Human resources for health (HRH):* Interviewees in Ethiopia and Malawi cited HRH as another way that governments have committed to family planning in recent years; Kenyans did not mention HRH. The interviewees were focused on taking services to the community through community-based distribution and task shifting in lower-level health facilities. For example, Ethiopians emphasized the new Health Extension Worker (HEW) program, which has brought FP services to rural areas.

> *"Our government is committed to improve the health of the community and RH services through access, health facilities, and HEW (around 38,000 deployed in every district). There is a huge commitment from the government. We have seen FP coverage was doubled in a few years (CPR 14% in 2005 to 29% in 2010) because of the commitment of the government, who deployed more HEWs."*
>
> *– Government Official, Ethiopia*

Malawians emphasized task shifting to lower cadres of HRH as an improvement in HRH service provision, with one Malawian member of Parliament (MP) noting that the shift to government support for FP task shifting to lower-level cadres required thoughtful advocacy:

> *"It was tough to actually take it to the senior management [because] other people had their own views, thinking that it was too much task shifting into the cadre called health assistants. Others were afraid of complications and side effects, but we were able to convince senior management, so that in the end the reproductive health unit was accepted to actually do the provision of injectables [by health assistants] on a trial basis."*
>
> *– Government Official, Malawi*

*LAPM (long-acting and permanent methods) focus*: Ethiopians and Malawians also mentioned a focus on LAPMs as another recent shift in government support of family planning. One Ethiopian advocate explained:

> *"There is a big shift in terms of ... coming up with different community-based interventions, of which the implants scale-up initiative is one. Now we have started the [intrauterine device] IUD initiative and currently we are starting the permanent methods. This is a big shift for giving due emphasis in terms of family planning programs."*
>
> *− Advocate, Ethiopia*

After reviewing the major shifts in government support of family planning observed by the interviewees, we next looked at what caused these shifts. The responses below again are presented in the order of frequency with which they were cited. We asked interviewees specifically about the role of advocacy, but they introduced other topics, such as the role of advocacy; donor influence and HIV; population growth, youth population, and pressure on resources; dedication to national and international development policy frameworks; maternal mortality; and family planning as a "women's issue" or "health issue" vs. a "development issue." These topics are discussed in detail below.

*Role of advocacy*: When prompted, many respondents in all three countries felt that advocacy had played a key role in recent government support of family planning. They viewed advocacy as a way to raise the visibility of family planning as an important development issue, keep it on decisionmakers' radar screens, and provide important information to them. As one ministry official in Ethiopia put it, "Advocacy may be one thing to increase the political will and the commitment of the government." Similarly, an advocate from Malawi noted that having various ministries, district councils (i.e., local governments), and donors all simultaneously advocating for family planning had caused a shift in support for it.

Interviewees cited two specific advocacy approaches as especially effective: (1) field visits for decisionmakers to observe FP service provision sites and (2) involvement of female MPs. A ministry official from Ethiopia recalled a site visit during which MPs observed stockouts of FP supplies at first hand and were told that these shortages were due to the import tax on FP commodities. When they returned to Addis Ababa, these MPs—especially the women—advocated for the repeal of the import tax.

Another specific advocacy approach that respondents cited as shifting government support in favor of family planning was the availability of an agile mechanism to respond quickly to MPs' needs for FP-related information. A Kenyan advocate mentioned a parastatal that had a full-time staff member to respond to parliamentarians' needs for information, materials, and talking points related to RH issues. The parastatal "shares what's available so they [parliamentarians] can go and discuss [it] knowledgably."

Advocates also noted the utility of taking MPs to international conferences so as to better appreciate issues surrounding family planning. One advocate noted:

> *"That engagement and that exposure of parliamentarians and senior civil servants have helped them think about and contextualize family planning as a development issue."*
>
> *– Advocate, Kenya*

Finally, some decisionmakers gave examples of their own advocacy in support of family planning to other decisionmakers.

*Donor influence and human immunodeficiency virus (HIV):* Respondents from all three countries noted that donor support was one reason for an increase in the overall support of family planning in their country. Malawian respondents stressed the importance of donor influence and noted the government's lack of resources invested in family planning. One said that:

> *"Whatever changes are happening in a country towards family planning are very much driven by donors, and also non-governmental organizations, which are donor dependent. But the real commitment from government to say 'this is a priority and this is how much money we are going to give it,' I haven't seen in the past years I have been around."*

Interviewees also felt that attention and funds—especially from donors —had shifted toward HIV in recent decades at the expense of family planning, although some refocusing on it has occurred in recent years.

> *"The problem was that when HIV came, all the money went to HIV, so family planning was forgotten; it was no longer a darling to donors as it used to be. It was all about HIV; all the resources, people, training, and everything were about HIV, so we had to reposition family planning."*
>
> *– Government Official, Malawi*

> *"The [Ethiopian government's] budget allocated to RH was not enough ... In recent years, there have been policy shifts, it became the number one agenda for the government and for development partners ... The U.S. government were working only to finance HIV/AIDS, malaria and so on, but currently the U.S. development [funding] finances maternal and child health activities,so this shows there is a policy shift."*
>
> *– Government Official, Ethiopia*

*Population growth, youth population, and/or pressure on resources*: Interviewees noted that decisionmakers now see that previous neglect of FP—or even the promotion of high fertility, in some cases—has led to high population growth, which in many cases outstrips the resources available to the population. One Kenyan ministry official noted that, after funding for family planning had decreased, "The government realized that the population was growing at an alarming rate, so now there is actually a lot of attention on issues of family planning." Another Kenyan official outlined the shift in government support of family planning as politicians' thinking evolved from a "high population growth equals more votes" mentality to one that appreciates the demands that a high population growth rate puts on resources:

> *"In Kenya, it was very true for a long time that we had political leadership that was advocating 'get outside there and give birth to children so that you can have many people who will vote for me when I want to be a member of Parliament.' I think it was misguided because the population growth in this country is still too high at 2.4 percent. This actually outstrips our ability as an economy to be able to create jobs … With 46 percent of people living below poverty line, I think we need to cut down on our population growth by having very effective family planning—a menu of family planning options."*
>
> – *Government Official, Kenya*

There was an emphasis on both the special RH needs of the youth population and this population's key role in determining future population growth, especially in Kenya and Malawi.

> *"The youth bulge and the increase in population of young people to the population of the country [is high] … People have come to realize that if we don't target this youth group, we might have challenges in [the] future, because most of the issues are emanating from this age group. So if we are not planning—if we are not engaging family planning—then you should be prepared to have a very big increase in population over the next few years, and that is the issue."*
>
> − *Government Official, Malawi*

*Dedication to national and international development policy frameworks*: The commitments made by governments at the 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) have laid the foundation for poverty alleviation in sub-Saharan African countries. Family planning has been recognized as a development tool and is included in MDG 5b. Interviewees noted that some support for family planning stems from government dedication to national and international RH goals and policies. Ethiopian respondents in particular noted a strong commitment to achieving such goals. Dedication to achieving the MDGs was singled out by several respondents as providing a strong rationale for government support of family planning. Development assistance linked to measurable progress toward MDGs may also provide an incentive to support family planning.

> *"The other thing that has helped [generate support for family planning] is that the MDGs are now being used as a yardstick for development assistance. Because the Kenya government has to meet its MDG target, it has recognized that unless it addresses properly the population and family planning issues, it will not meet a lot of those MDGs."*
>
> – *Advocate, Kenya*

*Maternal mortality*: High maternal mortality was noted as one of the principal rationales for justifying government support of family planning. One MP explained how high maternal mortality has motivated increased support of family planning in his community: "there are a lot of deaths [of] the women and we wanted that to stop." An advocate in Ethiopia noted that the government also viewed family planning as "one of the key components to reduce maternal mortality."

*Family planning as a "women's issue" or "health issue" vs. a "development issue"*: Respondents in Kenya and Malawi noted that, in the past, decisionmakers were less supportive of family planning when they viewed it as either a "women's issue" or a "health issue." However, decisionmakers became more supportive when they began to view family planning as more of a "development" or multisectoral issue.

> *"Family planning for a long, long time was considered a female domain. When I started doing family planning advocacy … I wanted to invite other members of Parliament for a meeting. My letters would be referred to as 'the letters of women' and they would not be taken seriously. But today, I can tell you that if you go to a family planning forum where we are involving parliamentarians, you will get more men than women."*
>
> *− Female Advocate, Kenya*

> *"We had [presented family planning] as more of just a health issue, and that meant that the various other sectors were not integrating family planning into their development programs or sectoral plans. Family planning and development were being treated in isolation, and the whole idea of repositioning was to look at family planning as part and parcel of achieving development for the country."*
>
> *− Advocate, Malawi*

## Context of FP Advocacy

FP advocacy takes place within country-specific contexts. This section reviews some of the most salient contextual factors, as well as self-reported exposure of decisionmakers to FP advocacy.

### *Country contextual factors influencing FP advocacy*

The government of Ethiopia restricts FP advocacy to state actors. While non-state actors are allowed to support only the implementation of FP activities, such as educational campaigns and service delivery, they often work alongside the government, providing technical support and funding:

> *"Groups like CORHA [Consortium of Reproductive Health Associations] and others are not allowed to work on advocacy issues. They have to focus on service delivery."*
>
> *− Government Official, Ethiopia*

Family planning is included in Ethiopia's Growth and Transformation Plan (GTP) as a priority with set targets. Thus, policymakers speak with one voice and are held accountable to ensure that the targets are achieved, irrespective of individual views.

In contrast, in Kenya and Malawi, FP advocacy is embraced as a collaboration between government and non-state actors. In Kenya, the government leads agenda setting for population and FP advocacy and implementation, while providing guidance to development partners on technical support and financing needs. In Malawi, development partners play a more significant role in agenda setting for and implementation of population and FP advocacy.

### *Decentralization and FP advocacy*

While the focus of this study was on FP advocacy at the national level, respondents from the three countries highlighted the importance of FP advocacy at national and subnational levels (regional and local). The three countries have decentralized health systems—and in the cases of Ethiopia and Kenya, devolved governments—and planning and budget allocation is determined at the subnational level.

One advocate in Ethiopia explained how national and regional parliaments set their respective budgets, but "the *Woreda* Council decides on prioritizing the real actions [and] real activities at the *woreda* level. [Thus] At the regional level, a budget may be allocated to family planning programs, but at the *woreda* level, the Council may prioritize other services."

In addition to speaking with District Commissioners, MPs, ministers, and PSs, an advocate in Kenya explained how they also spoke with chiefs, "trying to get them to embrace family planning and influence the attitudes of the community."

In Malawi, FP advocates use the already existing structure of the district assembly, which includes district commissioners (DCs) and chiefs, to promote prioritization of family planning.

### *Delivery of FP advocacy messages*

All of the decisionmakers interviewed in Ethiopia and Kenya, and almost all of those in Malawi (90%), reported having received information on family planning. To better understand how decisionmakers receive FP advocacy messages, we looked at the main forums used to deliver such messages and the key institutions or people who deliver them.

Respondents from all three countries cited a wide range of approaches used to deliver FP messages and engage decisionmakers. These included the following:

- One-on-one meetings;
- Small, medium, and large meetings, including government-coordinated health, planning, and finance technical working groups or consultative meetings;
- National and subnational workshops, seminars, or conferences;
- Regional and international meetings or conferences;
- Electronic media (email and internet); and
- Print media (regularly circulated bulletins and brochures distributed at meetings).

International Conferences on Family Planning, held in Kampala in 2009 and Dakar in 2011, were cited multiple times by both FP advocates and decisionmakers as key settings where parliamentarians were "exposed to messages on the benefits of family planning." The National Council for Population and Development (NCPD) and USAID sponsored more than 60 parliamentarians to participate in the 2009 and 2011 conferences.

In Malawi, the landmark National Population and Family Planning Conference, held in Lilongwe in May 2012 shortly before we conducted the key informant interviews, was commonly cited as an example of a forum where FP messages were delivered.

Respondents from all three countries noted the importance of engaging representatives from various sectors in FP meetings to promote its broader development benefits. A Kenyan decisionmaker recommended that "to have an impact, there is a need to involve people in the agriculture, water, and environment sectors to help them understand the relevance of family planning." Similarly, respondents in Malawi noted that the National Population and Family Planning Conference hosted stakeholders from various levels and sectors of government.

Interviewees mentioned additional forums at which stakeholders present or receive FP messages in Ethiopia and Kenya. For example, Kenya's NCPD houses an FP resource center at which parliamentarians and other interested parties can access information.

In Ethiopia, field tours were commonly cited as effective in raising the awareness about family planning among parliamentarians and stimulating action by them. One high-level government official explained that "When they [parliamentarians] went out for a field visit they learned that there was shortage of contraceptive methods because of [the] import tax on contraceptives. When they returned, they held a meeting with the MOFED [Ministry of Finance and Economic Development] to address this concern." Ultimately, action by parliamentarians led to the removal of the import tax on contraceptives, thus increasing their flow within the country.

### *Choice of Presenter*

The majority (91%) of respondents from the three countries agreed that there is space for multiple players to advocate for family planning, as long as they are recognized as credible experts with experience in this field. Collaboration among key actors is a common approach for conducting advocacy activities in the three countries. Although the Ethiopian Government does not allow non-state actors to conduct "FP advocacy," one Ethiopian decisionmaker explained how "with leadership from the Ministry of Health, everyone working in this area has important role to play, including government organizations, private sectors, civil societies, and all players in the health sector."

Many respondents agreed that both national and international actors have a role to play in FP advocacy. However, nearly all respondents emphasized that national actors must take the lead in advocacy efforts because, as one noted, "national experts understand the issues, the context in which things are done, and they are able to articulate the issues in a manner that will move the policymakers to take actions." One respondent reflected the comments of many others as to the importance of involving national actors to obtain their buy-in and consequent support for family planning "because they need to own it and implement it."

Respondents from the three countries mentioned a range of institutions and individuals as relevant presenters of advocacy messages, including the following:

- Government, which has the mandate to promote family planning, coordinate FP activities, and provide FP services (especially ministries of health and planning);
- CSOs and NGOs, which have expertise and experience in the field of population and FP/RH;
- Academic and research institutions involved in teaching and doing research in the fields of population and FP/RH;
- Other sectoral institutions relevant to family planning, including ministries of gender, youth, and education;
- Women's groups;
- Political, religious, community, and traditional leaders; and
- Parliamentarians.

In all three countries, respondents said that engaging political, religious, community and traditional leaders is particularly important, given their influence at community level. For example, respondents from Malawi and Kenya noted that:

> *"The Imams in Malawi [helped] to dispel misconceptions about Islam and family planning."*
>
> *– Decisionmaker, Malawi*

> *"We need to start serious engagement with religious organizations because they have a large constituency. I don't think we have had a forum where people dialogue with Catholics about use of family planning."*
>
> *− Decisionmaker, Kenya*

Some respondents in Kenya mentioned engaging representatives from the environment, agriculture, and water sectors to promote family planning as a cross-cutting agenda. In Ethiopia, one respondent stated that, while national-level leaders are convinced about the benefits of family planning, there is a need for more efforts to convince regional leaders.

Respondents in Ethiopia cited the importance of engaging with professional associations to promote family planning—including professional associations of gynecologists, nurses, midwives, and public health practitioners; in Kenya and Malawi, such groups were either minimally or never mentioned.

### *Donors and development partners*

Respondents in Ethiopia and Kenya said that donors and development partners are not visibly at the forefront of FP advocacy; rather, they advocate indirectly by providing funding and technical support to the government advocacy agencies (NCPD in Kenya and the Population Affairs Directorate of the Ministry of Finance and Economic Development in Ethiopia). In contrast, in Malawi, donor agencies were reported to play a much more visible role and they were identified as key institutions for presenting advocacy messages. However, one Malawian decisionmaker explained how the government of Malawi has increasingly become more active in advocating for family planning, with "the Ministry of Planning and Economic Development … taking a lead on population issues and, alongside the Ministry of Health, advocating for family planning." This indicates the beginning of a shift in the way advocacy has been carried out in Malawi, where FP advocacy messages were traditionally delivered by "NGOs and development partners."

## Format of FP Advocacy

To understand how advocacy messages about family planning are delivered to decisionmakers, our analysis also looked at the formats used to present these messages.

### *Formats used*

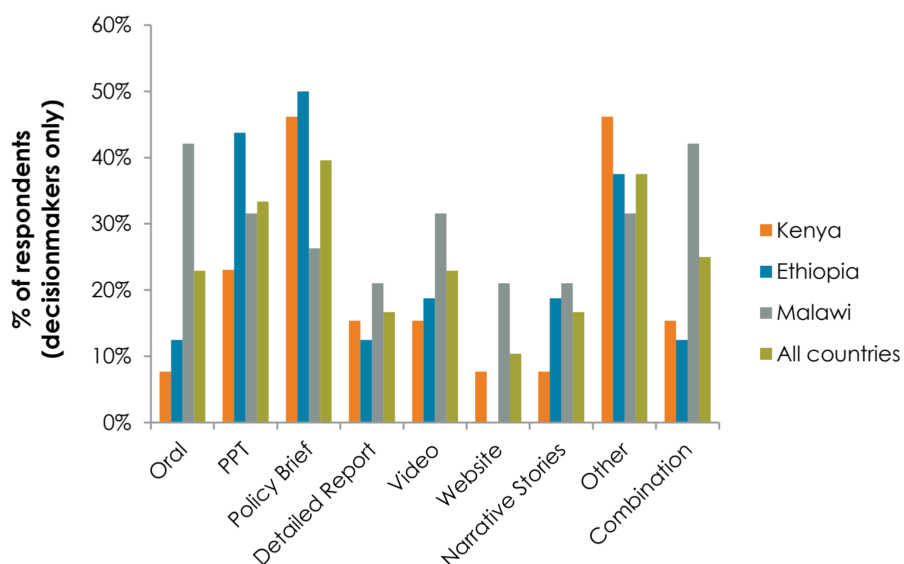
Decisionmakers from the three countries cited a range of formats used to provide them with information on family planning, including policy briefs, factsheets, leaflets, brochures, detailed reports, PowerPoint presentations, videos, multimedia presentations (RAPID and ENGAGE), oral presentations at meetings, flyers, posters, email, and websites.

Decisionmakers were more likely to have seen FP messages delivered through PowerPoint presentations than any other format. Fewer than half (47%) of decisionmakers from all three countries reported receiving information about family planning in the form of policy briefs, while nearly three-quarters (72%) of FP advocates cited policy briefs as one of the formats used to transmit FP information to decisionmakers. The discrepancy was particularly pronounced among Ethiopian decisionmakers and advocates (38% and 80%, respectively).

The RAPID and ENGAGE presentations were frequently described by both advocates and decisionmakers as the most engaging tools. One respondent from Kenya described ENGAGE as "a new state-of-the-art technology multimedia presentation that shows the magnitude and impact of rapid population growth since independence and calling to action decisionmakers to help slow population growth by investing in family planning." A respondent from Ethiopia described the RAPID model as "showing the relationship between population and development, the economy, health, education, and other important sectors." The video *Empty Handed*, featuring a Ugandan female parliamentarian, also was cited on several occasions in Ethiopia and Kenya as having an impact on generating action from parliamentarians.

When asked about which formats would be best for effective advocacy, decisionmakers had mixed views. In general, decisionmakers from the three countries considered policy briefs to be one of the best formats. Figure 3 shows the materials identified by decisionmakers as most effective for presenting FP advocacy.

**Figure 3: What do you think are the best formats for presenting FP messages?**



Malawian decisionmakers reported a preference for a combination of formats (42%, relative to 13% and 15% in Ethiopia and Kenya, respectively), while PowerPoint presentations were the most popular format among Ethiopian decisionmakers (44%, relative to 23% and 33% in Kenya and Malawi, respectively) (Figure 3). A few respondents mentioned that they preferred the information to be brief and clear. Many respondents viewed written materials, such as policy briefs and factsheets, as long lasting and transferable. Respondents who preferred a combination of all formats (print, oral, PowerPoint, video, and electronic) stated that the format used depended on the message being delivered—informative versus analytical.

> *"I think a combination is best. Visual formats leave an impact; the written is helpful for referring to; for those who have internet access, website[s] provide readily available material. The policy briefs also are good."*
>
> *– Decisionmaker, Malawi*

### *Personal stories vs. quantitative evidence*

Both advocates and decisionmakers had mixed views regarding the use of personal stories versus quantitative evidence in FP advocacy messages. Some respondents felt that decisionmakers, particularly parliamentarians, prefer facts and figures over narrative stories, while others felt that narrative stories are more appealing. Some felt that quantitative data can be confusing; others felt that narrative stories, which elicit emotions, would be more likely to translate into action by decisionmakers.

> *"If you are talking to policymakers at the higher level, the ministers, the permanent secretaries, treasury and central bank governor in [the] government, then you need [facts and figures with a short narrative]. If you are talking to community groups, local government authorities such as chiefs, [a narrative on the impact on a family or woman] works better for them."*
>
> *– Advocate, Kenya*

Others felt that a balance of the two is important and can complement one other to generate action:

> *"You can have a story of proven impact showing how a woman's life was transformed because of using family planning. Then accompany the human story with evidence showing, for instance, that there are a million such women in the country who can be transformed by investing so much in family planning."*
>
> *− Advocate, Kenya*

### *Comparisons with other countries or regions*

When asked to rate the use of comparative information about other countries in the region regarding FP advocacy messages, an average rating of 4.7 out of 5 (4.7 for decisionmakers and 4.6 for advocates) on the Likert scale emerged among respondents across the three countries. Many respondents felt that cross-country comparisons are useful, but a few said that caution must be used in making these kinds of comparisons. For instance, a respondent from Malawi noted that a comparative analysis showing variation between countries in the same region can help decisionmakers in a country reflect and spur debate so they can identify and learn from the actions taken by neighboring countries. A respondent from Kenya similarly cautioned that benchmarks used for comparisons must be chosen carefully; for example, by comparing Kenya with Rwanda, which is in the same region, rather than with South Africa. Other respondents felt that using success stories from Asia also would be useful.

### *Providing sustained information to decisionmakers over time*

Respondents from all three countries agreed that it is important to receive sustained FP messages (an average rating of 4.9 out of 5—4.9 for decisionmakers and 4.8 for advocates—on the Likert scale). Decisionmakers noted that, with so many competing priorities, sustained information is needed to ensure that family planning remains on the national agenda. However, one decisionmaker from Kenya also noted some of the challenges of keeping up with the need for sustained information on family planning:

> *"We come up with good messages and then release [them] and [they] bear some fruits in the short run, but we are not able to keep the tempo, so the gains may collapse."*
>
> *− Decisionmaker, Kenya*

## Content of FP Advocacy

To better understand the content of FP advocacy in the three countries, we assessed the framing of family planning, the policy tasks, and the relevance of FP messages to decisionmakers' goals and responsibilities.

### *Benefits of family planning*

Both decisionmakers and advocates reported that FP messages in the three countries mainly emphasized the impact of family planning on health, women's empowerment, and national economic growth. To a lesser extent, the messages also highlighted the environmental benefits of family planning. All (100%) decisionmakers in the three countries reported that they were convinced about the benefits of family planning. Most FP advocates also felt that decisionmakers were convinced about the benefits. When asked why they were convinced, most respondents mentioned the health and economic benefits of family planning and its role in empowering women.

Interviewers in Ethiopia and Kenya asked respondents to prioritize nine arguments typically used to promote family planning, in the order of which they were most convincing to decisionmakers. The decisionmakers and advocates agreed on three of the top four arguments they identified as most convincing, but diverged in their ordering (Table 2). Decisionmakers identified the benefits to the health of mothers, health of children, and family welfare as the top three most convincing arguments for family planning. Advocates agreed with decisionmakers that the most convincing argument was the benefits to the health of mothers. However, advocates believed that decisionmakers were more convinced by the contribution of family planning to national economic growth and the cost-effectiveness of implementing FP programs.

| Table 2. Ranking‡ of FP advocacy messages as convincing to decisionmakers, by type of respondent, for Ethiopia and Kenya* | | |
|---|---|---|
| **Message** | **Decisionmakers (n=29)** | **Advocates (n=12)** |
| FP improves maternal health | 1 | 1 |
| FP improves child health | 2 | 5 |
| FP improves family welfare | 3 | 4 |
| FP contributes to national growth | 4 | 2 |
| FP contributes to women's empowerment | 5 | 7 |
| FP contributes to slow population growth | 6 | 8 |
| FP is cost-effective | 7 | 3 |
| FP contributes to reduced stress on natural resources and alleviates climate change | 8 | 9 |
| FP saves money in other public sectors | 9 | 6 |

Question from interview guide: "In our advocacy efforts, we realize that we can't present all of the evidence that there is for family planning. Of these nine potential advocacy messages, please group them into what decisionmakers find "most convincing", "somewhat convincing", and "least convincing". (. – 3 in each category)"

‡1 = most convincing, 9 = least convincing. The ranking was calculated by averaging the responses by factor (1 = "most convincing," 2 = "somewhat convincing," 3 = "least convincing").

* For respondents who were advocates, this was their perception of the ranking of FP advocacy messages by decisionmakers.

** We excluded Malawi responses from this analysis because the questionnaire format used in Malawi framed this question differently, as noted in the Methodology section. We use the responses from Malawi to improve the framing of the question in Ethiopia and Kenya.

### *Specific recommendations, concrete actions, and relevance to decisionmakers*

All advocates said that advocacy messages for decisionmakers recommended specific and concrete actions. However, the percentage of decisionmakers who reported receiving specific and concrete recommendations was 100 percent in Kenya, 94 percent in Ethiopia, and only 78 percent in Malawi. These results point to some discrepancy in perception between decisionmakers and FP advocates in Ethiopia and Malawi.

When asked to elaborate on the specific and concrete actions advocated in FP messages, both decisionmakers and advocates cited increasing resource allocation for FP commodities. Increasing the health and reproductive health budgets and the government contribution relative to donor funding were also cited frequently by respondents. Other commonly cited specific and concrete actions in FP messages in all three countries were the following:

- Increasing access to FP services for under-served populations;
- Strengthening community-based distribution of FP information and services;
- Strengthening the supply chain management;
- Training more health workers; and
- Improving commodity security.

One FP decisionmaker from Ethiopia explained why advocates pushed for strengthening the logistics system in their FP messages, stating that “the logistics system was a big problem in the past because Ethiopia is a very big country.” In Malawi, establishment of a budget line for FP commodities was mentioned frequently as a specific and concrete action (the other two countries have already accomplished this goal). Raising the legal age of marriage, keeping girls in school longer, and including family planning in the national Growth and Development Strategy (MGDS) were also cited in Malawi.

Most decisionmakers in Kenya (82%) believed that the FP advocacy messages were relevant to their goals as policy formulators, legislators, and budget managers. In Ethiopia and Malawi, only about 60 percent believed this.

> *“Yes, the whole aim of our planning is to transform the quality of life of people in terms of economic growth, economic benefit, in terms of health, access to all in terms of education, access to all and to create competitive manpower. Family planning contributes to all these.”*
>
> − *Decisionmaker, Ethiopia*

Other decisionmakers felt that FP advocacy messages were not as relevant to their goals.

> *“They are not answering all my questions because in certain cases, when dealing with the specific issues that we are worried [about], messages need to be tailor made for different cultures.”*
>
> − *Decisionmaker, Malawi*

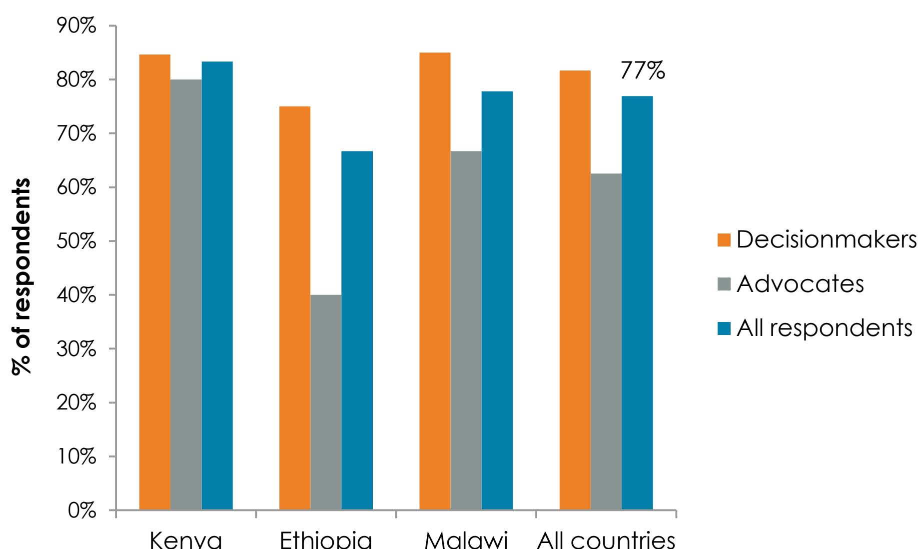
## Salient Factors in FP Decision Making

We asked key informants to discuss which factors influenced decisionmakers' decisions on family planning. In particular, the interviews focused on how the following topics impact family planning policies and budgets:

- Advocacy and evidence
- Personal, religious, cultural, and political factors
- Competing priorities and budget constraints
- Influence of outside individuals, institutions, or groups

Interviewers also asked why decisionmakers might not support family planning, even in cases where they have convincing evidence about its benefits, or why decisionmakers might change their opinions about family planning over time. When asked if they were "convinced" of the value of family planning, all respondents replied "Yes." Support for family planning appears to be changing, with 77 percent of the participants reporting that they had observed decisionmakers change their minds about family planning (see Figure 4). However, compared to decisionmakers, advocates in all countries were less likely to report observing a decisionmaker change his or her mind about family planning.

**Figure 4: Percentage of respondents who have observed decisionmakers change their minds about family planning**




Even with such high levels of support for family planning, key informants generally thought that there is a need for continued advocacy. Respondents ranked a number of factors that affect how decisions about family planning are made (Table 3). In Kenya and Ethiopia—where interviewers asked advocates and decisionmakers to rank a range of factors—both groups ranked evidence of the impact and cost-effectiveness of family planning highly (second highest). Advocates ranked "demonstrating short- or long-term impact" highest, a factor ranked only eighth by decisionmakers. In general, decisionmakers ranked factors related to the practical aspects of programs higher than did advocates. Other factors—including costs, political priorities, and cultural and religious factors—were also considered important.

| Table 3: Ranking‡ of factors affecting FP decision making, according to decisionmakers and advocates, for Ethiopia and Kenya* | | |
|---|---|---|
| **Factor** | **Decisionmakers (n=29)** | **Advocates (n=12)** |
| Evidence and data for impact of policy options | 1 | 4 |
| Cost of implementation | 2 | 2 |
| Value for money or cost-effectiveness | 3 | 5 |
| Political priority of other sectors | 4 | 3 |
| Cultural and religious factors | 5 | 6 |
| Concrete programmatic solutions | 6 | 10 |
| Public opinion on FP | 7 | 9 |
| Demonstrate short-term and long-term impact | 8 | 1 |
| Availability of human resources | 9 | 7 |
| Donor influence | 10 | 8 |
| Impact on re-election | 11 | 11 |
| Personal experience with FP | 12 | 12 |

Question from interview guide: "Budget or policy decisions about family planning are based on a number of factors. Please group these potential factors as "most important", "somewhat important", and "least important" to decisionmakers." (Have cards and pile sort – 4 in each category.)

‡1 = most important, 12 = least important. The ranking was calculated by averaging the responses by factor (1 = "most important," 2 = "somewhat important," 3 = "least important)
* For respondents who were advocates, this was their perception of the ranking of factors that decisionmakers take into account in FP decision making.

**Malawi responses were excluded from this analysis because the questionnaire format used in Malawi framed this question differently, as noted in the Methodology section. The responses from Malawi were used to improve the framing of the question in Ethiopia and Kenya.

Many of these topics also emerged during the open-ended interview questions portion of this study.

### *Advocacy, evidence, and information*

This study explored the degree to which decisionmakers use information and evidence (received through advocacy or other sources) to inform decisions regarding family planning. Given that the decisionmakers and countries selected for this analysis already were largely supportive of family planning and had pro-FP policies, our analysis also examined whether there was a need for further FP advocacy.

Overall, across all three countries, there was general agreement that evidence and data can be helpful for decisionmakers. Although there is general support for family planning at the national level in these countries, respondents generally confirmed the continuing importance and relevance of advocacy and evidence for family planning. Despite broad support, some barriers—individual, social, cultural, religious, political, etc.—remain. Thus, FP advocacy remains relevant and necessary to continue building support for family planning among individuals, as well as to maintain and build stronger commitment to it at the national and institutional levels. There was a general concern that the governments in each of the three countries needed to demonstrate their commitment to family planning by investing more national financial resources in FP programs and commodities, and that advocacy targeted at decisionmakers who actually allocate financial resources would play a key role in achieving this goal.

In Ethiopia, for example, one advocate explained that, even though the MOH and the government are strong champions of family planning, and there is support at all levels of government, more financial resources allocated for FP programs and commodities could achieve an even greater impact, and continued advocacy messaging would be crucial in realizing this goal.

Many Ethiopian decisionmakers also expressed a wish for more advocacy related to family planning. Even when the majority of people are in support of family planning at the national level, this support is not unanimous. One decisionmaker stressed that advocacy remains important in two ways. First, advocacy messages have the potential to convince individual policymakers of the importance of family planning; second, advocacy can reaffirm commitment from supporters who may, in turn, influence the opinions and behaviors of their non-supporting peers:

> *"Advocacy will have an impact for those who have negative attitudes towards family planning. We have to explain the benefits of family planning through advocacy so they will change their minds. And for those who are supporters, we can use them to ask others to change their minds."*
>
> *− Decisionmaker, Ethiopia*

Decisionmakers feel that having reliable, high-quality evidence on the health, social, environmental, and economic benefits of family planning can be an especially powerful advocacy tool. As one said:

> *"Everybody's mind can be affected by [having] reliable knowledge. Everyone's opinion will be changed by creating awareness. I don't think everyone's mind is already made up and cannot be changed. It depends on the advocacy."*
>
> *− Decisionmaker, Ethiopia*

Interviewees reported on the importance of how advocacy and evidence is presented. Information must be relevant to decisionmakers and be presented in a way that not only shows the benefits of action, but also the negative effects of inaction when it comes to family planning. Especially in situations where there is already high support for family planning, it may be necessary to tailor messages, and for messaging to go much deeper than merely pushing for general support. Messages should explain how and why FP family planning has and could potentially provide health, economic, or other benefits.

> *"[Advocates] must generate evidence of what has happened, but also what has not happened, why it has happened, why it has not happened, and associate all those factors …. I think it's not telling people the importance—they do understand the importance. Rather, it's important to bring evidence that will indicate what will happen if or if not, and then how to make it [happen]. That is important for decisionmakers."*
>
> *– Decisionmaker, Ethiopia*

These same themes were highlighted in Kenya. One decisionmaker described the role of FP advocacy in solidifying his support as an important investment for his country:

> *"I wouldn't say that my opinion has changed; in the back of my mind I knew that family planning [was important] … but my understanding has really improved, my appreciation of what family planning enhancement can do for the population, how it would assist other sectors … My level of appreciation has gone higher than it was initially … I used to look at it as how it will benefit me as an individual, but now it is broader."*
>
> *– Decisionmaker, Kenya*

One Kenyan decisionmaker explained how data and evidence produced by research institutions and advocacy organizations are crucial for making informed decisions that will have the greatest benefit to the country.

> *"We want civil societies that will do advocacy that will assist policymakers. [Data and research] will help the country move in the right direction. When we have no information, we make flawed decisions."*
>
> *– Decisionmaker, Kenya*

Participants in Malawi also recognized the importance of data and information in decision making. One decisionmaker said:

> *"Once you have presented the evidence, [the majority of decisionmakers] tend to agree that [family planning] is a very important area."*
>
> *– Decisionmaker, Malawi*

However, participants also mentioned the need to "repackage" advocacy messages so that they are more relevant to the needs and constraints of their audience, by showing concrete evidence in a concise manner.

> *"Evidence and data [are] very important, but policymakers can easily get bogged down. You need to prepare information that shows that 'this works' or 'this doesn't work.' You need to prepare that information in brief."*
>
> *− Advocate, Malawi*

Advocates in Malawi also mentioned the need to refocus or "reposition" FP advocacy messages to encompass more of a development perspective, rather than solely focusing on health benefits.

> *"I think the most important thing is that the time has come where we have to package our message and make sure that policymakers have to link all the developmental activities to family planning and population. [We need] to fully understand the long-term impacts of those things, because that is what's lacking."*
>
> *– Advocate, Malawi*

As in the other countries, decisionmakers in Malawi expressed a need for continued evidence in support of family planning, despite growing support. One decisionmaker noted that "advocacy messages will influence the ability to look at the issue differently." Echoing some of the same arguments we heard in other countries, this decisionmaker explained that thinking about family planning in a different light will not only have the potential to influence non-supporters, but will allow for those individuals who are already supportive of family planning to become more equipped to support their commitment with facts, while at the same time convincing those who may not support it.

Others emphasized additional needs and aspects of advocacy. Rather than focusing on advocating solely for more resources or commitment, some believed that it was also very important to focus on how to effectively implement FP policies that already exist.

> *"Honestly speaking, I think we have done enough advocacy in Malawi [to raise awareness]—now it's the question of implementing the policies. We have reached a stage where we are failing to meet the demand for family planning and now we have to provide the services."*
>
> *– Decisionmaker, Malawi*

### *National and government support of family planning*

In each of the three countries, when discussing how decisions were made regarding FP programs, policies, and financing, interviewees pointed to the importance of support and commitment to family planning at the national level. Simply put, when there is high-level commitment and prioritization of family planning on the national agenda, individual decisionmakers are more likely to prioritize and support family planning and make decisions accordingly.

The importance of a national agenda for family planning was most frequently cited in Ethiopia, where its prioritization is quite recent, with most of the progress in contraceptive uptake having occurred in the last decade. Several decisionmakers cited the inclusion of family planning in Ethiopia's strategic plan and economy development strategy as important factors, with one respondent explaining that "the fact that the government is paying attention to family planning has also made decisionmakers pay attention to the issue."

In Malawi, respondents also frequently cited the recent national family planning conference and the addition of population dynamics and family planning in the MGDS II (2011−2016) as key indicators of government commitment to family planning and key facilitating factors for decisionmakers to prioritize it in their work. In Kenya, there also was wide recognition of the government's recommitment to family planning, demonstrated by increased government spending for FP commodities since 2005 and inclusion of family planning in the Vision 2030 initiative. The extensive stakeholder and public engagement activities that NCPD and other stakeholders carried out during the development and dissemination of Kenya's 2012 population policy gave new impetus to decisionmakers in promoting family planning in their work.

### *Public opinion and political factors: Social, Cultural, and religious context*

Although the participants interviewed for this study were largely supportive of family planning, they noted that various religious, cultural, or social values regarding childbearing and family planning prevent some politicians and other decisionmakers from supporting it openly or in their work. As noted in the following excerpts from interviews with decisionmakers in Ethiopia, politicians from communities that value many children may need to tread carefully when talking about family planning to uphold their political support.

> *"We are politicians, so political concerns are important in every moment of our activities. Public opinion is associated with cultural and religious factors."*
>
> *– Decisionmaker, Ethiopia*

> *"As a multicultural country, there are different outlooks based on a religion or based on culture. If you go to pastoral areas, I expect some resistance about family planning because they believe that their culture will take care of their children."*
>
> *– Decisionmaker, Ethiopia*

Public opinion on a wide range of topics—such as pronatalism, gender, religion, and culture—can influence the degree to which decisionmakers politically prioritized family planning, as politicians desire to be popular and well-liked by their constituents:

> *"In an ethnic-based political context like most of the African countries, people don't want to talk about population because it is like you are reducing their voting bloc …. In societies where gender issues are a challenge, people don't want to talk about anything pertaining to the use of reproductive commodities. If the politician is not strong willed, he can easily think 'the people don't want to hear about this' and 'I don't want to [support family planning] because I want to remain popular.'"*
>
> *– Decisionmaker, Kenya*

One Kenyan advocate said politicians "tell [advocates] quietly 'We are with you,' but they may not necessarily publicly [support family planning when among] their constituencies."

In Malawi, some respondents noted that leaders may fear that open support for family planning will be perceived as an effort to erode culture or religious values.

> *"It's about pleasing the electorate…in an area where they don't believe in family planning because of culture or religious background, it will not work … Decisionmakers would like to please the people [and] they don't want to get a bad reputation."*
>
> *– Decisionmaker Malawi*

Respondents also discussed additional political factors that could influence a decisionmaker's support of family planning, including an unwillingness to bring up sensitive topics during election time, concerns that family planning would decrease the size of their electorate, and a desire to focus on other issues that would show greater short-term impact.

Several respondents explained a common view among politicians—that support for family planning is an unwise political move because its expansion would lead to decreased family sizes and potentially fewer voters, a view that one decisionmaker from Kenya labeled a major threat with the potential to "…reverse the gains of family planning."

Another advocate from Malawi noted that "timing is a very important key," and that, close to election time, decisionmakers "may deliberately say no [to FP] … because the minds of the masses may not be receptive."

Finally, one advocate in Malawi brought up yet another political issue—that politicians may more strongly focus on issues that may yield more of an impact in a short period of time, and this could influence their electability or political legacy:

> *"[Decisionmakers'] thinking is short term within the short period of their political stay in government. They think more of [the] short term than long term [and] with family planning, we are talking more about long-term gains."*
>
> *– Advocate, Malawi*

### *Donor influence*
The interviewees generally did not rank donor influence as having a large effect on decision making. Decisionmakers ranked donor influence as 10 out of 12 in the order of importance of those factors they take into account. Advocates ranked their perception of the importance of donor influence on decisionmakers as 8 out of 12 (see Table 3). However, a handful of interviewees in Kenya and one in Malawi cited challenges with regard to relationships with donors. One Kenyan decisionmaker explained that donor funding can come with strings attached and tied to various interests, rather than based on the needs and desires of the country:

> *"Donor influence: I think this one is terrible. [The] donor may come and say they would like to give a grant ... but the minute you sit down now to state what the components of this grant are, then you find that there are other interests in terms of supplies and equipment, who will be trained ... then you might be stuck there, that this is what you need to continue doing [for the donor]."*
>
> *– Decisionmaker, Kenya*

From the perspective of an advocate, however, this influence can be changed over time:

> *"The donor world, and especially for civil society organizations, influences FP programs a lot. However as implementers ... once donors have gained confidence in us, [we] can also present credible concepts to them."*
>
> *– Advocate, Kenya*

Donor funding can also affect which issues are prioritized and supported by national governments. One Kenyan decisionmaker explained that "if a donor is interested in a particular program, then you [as a government] don't want to put a lot of money there, because somebody else is helping" Thus, bilateral and multilateral donor funding may influence the government to focus on other issues, with the assumption that donor funds for family planning will continue.

Donor stipulations can also limit the uses of funding and inhibit integration of services.

> *"Donor conditions are attached to the money; if donors have given you money for HIV, you cannot take it for family planning, even when you know that integration will be useful here."*
>
> *– Advocate, Malawi*

### *Competing priorities*
"Resource shortages" and "competing priorities" were mentioned consistently across all three countries as extremely important factors in how decisions were made. Limited resources create competing priorities and make it necessary "to prioritize, to stress, or to emphasize some … to select the top priorities," according to an Ethiopian decisionmaker. A Kenyan decisionmaker added: "In policy decisions, there is a tendency to attend to where the concerns are immediate … since the impact of lack of family planning is not immediate, then we tend to postpone it for another day."

This can cause challenges in implementing or funding FP policies and programs, even in countries where there is a high level of support for family planning among decisionmakers. Despite strong and supportive evidence, effective advocacy, and commitment to family planning, sometimes "there are so many other competing priorities … so many other health problems … that politicians' hands are tied," as one Ethiopian decisionmaker noted.

One Kenyan advocate mentioned the need to prioritize health and development according to urgency, stressing that, in the end, decisionmakers may need to take action on more immediate and pressing health issues, rather than focus on the long-term benefits of family planning:

> *"So many sub-sectors require money. For you to divide those monies, it depends on how critical the issue is. With competing budget priorities for the government, you might realize that family planning is not critical. Would you get sick because you did not plan your family? That doesn't happen—you don't feel pain because you did not plan your family."*
>
> *– Advocate, Kenya*

Many decisionmakers thought that the implications of investing or not investing in family planning are not immediate, yet one of the key rationales they highlighted for investing in family planning was improvement of maternal and child health, whose effects can be felt in the short term. It appears that when they say the effects are not short term, they are comparing family planning to other health care issues, such as curative services for diseases, whose health impact can be observed immediately or is more evident to the general public.

## Developing Advocacy Strategies

When discussing how advocacy strategies were developed, most respondents focused on identifying who to target and what to say. Some focused on identifying the target audience—including understanding which individuals are strategically placed to influence topics relevant to family planning and which have proven supportive of it in the past—and understanding their needs and the types of messages that would resonate with them. Many interviewees also spoke of the importance of identifying problems and gaps in FP policies and service provision early in the advocacy process, so as to have a clear idea of *what* they were advocating. Many respondents also spoke of the prevalence, importance, and benefits of collaboration within the FP advocacy community.

### *Identifying and understanding the target audience*

#### *Identifying the target audience*

The first step that advocates delineated in developing advocacy strategies was to identify their target audience by analyzing which individuals have influence over topics relevant to family planning as well as which influential individuals have been supportive of it in the past. One advocate explained that she begins with a pool of all policymakers and then determines which individuals are strategically placed, such as a committee chairman. Another advocate from Malawi described the different types of influence an individual may have, such as influence over the budget or influence to negatively impact FP support; she stressed the importance of working with those who will be supportive of family planning and "making sure that those people who can influence positively have the information." An Ethiopian advocate noted that:

> *"One individual cannot do anything in the parliamentarian process. If you convince the standing committee, they will not do anything to support you. But if you convince a decisionmaker, for example … if you are able to convince the Minister of Education, then you can achieve a lot."*
>
> *− Advocate, Ethiopia*

Other advocates spoke specifically of the importance of maintaining good relationships with "patrons" who have a history of supporting family planning and are well placed to do so. One respondent from Malawi gave the example of her ongoing relationship with the chair of the Parliamentary Committee on Health; she continues to discuss FP issues with him so that "when they are discussing these issues in the Parliament, he could not leave that issue behind." Others spoke of the importance of "catching these

people" who are supportive of family planning and well placed to provide "patronship" to it, giving the examples of board chairmen, former first ladies, and former vice presidents. Another advocate from Malawi gave the example of a senior MP who has been a strong supporter of family planning for decades: "He has [family planning] at his heart for a long time. We saw that if we take this person to be our patron, we will not sweat to explain things; he is already in it. And he did a good job for us."

Respondents from all three countries strongly emphasized the importance of engaging parliamentarians as FP advocates, due to their roles in developing legislation, influencing budget allocation, and influencing their communities. In the recent past, significant efforts have focused on engaging parliamentarians, and parliamentarians from the three countries have been sponsored to attend various international meetings—for example, the annual meeting of the Southern and Eastern Africa Alliance for Parliamentary Committees for Health (SEAPCOH)—that underscore the role of family planning in development and build the capacity of parliamentarians to become stronger advocates for family planning.

Respondents from all three countries reported efforts to engage the Ministry of Finance to inform their budget decisions for family planning.

Respondents from the three countries felt that the support for family planning among leaders at the highest levels of government is critical for enhancing investments in family planning and the impact of FP programs. According to one Ethiopian decisionmaker, "If the Prime Minister speaks out about family planning, everybody will be motivated to discuss family planning. Likewise, if officials or politicians are FP advocates, it would be easier to dialogue with the community about family planning." This was reiterated by a Kenyan decisionmaker: "In Kenya, when President Moi was very vocal about family planning and led the campaign 'Let's Plan our Families' (translated from Swahili, 'Tupange Uzazi'), there was actually a lot of gains made in increasing the use of family planning." In Malawi, current President Joyce Banda coordinated the national Safe Motherhood campaign when she was Vice President and remains a strong advocate for maternal and child health. President Banda has provided an opportunity for FP advocates to nurture top leadership support for family planning. Respondents also mentioned Rwanda and Madagascar as success stories regarding top-level support for family planning and the resulting gains in contraceptive use.

One advocate from Kenya recommended training health workers on issues surrounding family planning so that they can become advocates themselves.

> *"We want health workers to know that at least 15 percent of [the] budget is supposed to go to health, and also we tell them that what the government is giving maybe around 6 percent. That is also advocacy, so that when they have an opportunity to talk to somebody in the government, they can know what to present to them."*
>
> *– Advocate, Kenya*

### *Understanding what resonates with your target audience*

Several advocates spoke of the importance of a baseline assessment of the target audience to better understand its perspectives and needs. One advocate from Malawi recounted that "You have to know what type of audience, what materials they need, and what is the best way of conveying the message to this target group." Another said: "Ask them what they need. And then provide information and say, 'If this is what you need, what do you think we should be doing?' They will come up with answers and then you can go and develop the advocacy messages. It will tally."

After conducting a needs assessment, respondents emphasized the need to tailor the style and content of a presentation to the audience at hand.

> *"If we are dealing with chiefs, we don't bring up too many figures and we don't bring in too much foreign language; we put it in local language and use more stories than figures and percentages. But if you are dealing with intellectuals, the [main] thing is they want quantitative figures. It depends on the type of audience that you are dealing with."*
>
> *– Advocate, Malawi*

Finally, several people mentioned the importance of examining which past advocacy approaches worked and which failed, so as to apply lessons learned to future advocacy.

### *Identifying gaps in policies and service provision*

Several advocates explained a process of reviewing both policy documents and practices among service providers to identify gaps; addressing these gaps then informs the "ask" of the advocacy messages. One advocate explained that her project identifies barriers to FP access and uptake among key populations in different parts of the country, using baseline surveys, interviews, and site visits. These analyses illuminate gaps between RH policies and their implementation on the ground, and provide the basis for her advocacy work. "We documented the gaps in FP services and policies and we used that document to influence changes in the national population policy." Another advocate conducts "in-depth analyses of the DHS to disaggregate the needs, gaps, and challenges. We then come up with realistic strategies to address the FP needs of the different segments of society." One interviewee uses her analyses of gaps between national policies and actual service provision to advocate for influencing future RH policies.

### *Linking family planning to existing goals and competing priorities*

Several advocates spoke of developing advocacy strategies around national and international goals. They felt that linking family planning to these existing commitments could bolster government support by illustrating how it contributes to achieving these goals. One Kenyan advocate explained how they use "policy briefs to tell [government decisionmakers] that family planning is the missing link in achieving the MDGs and Vision 2030" to get buy-in and support for family planning.

A few advocates cited the need to identify why decisionmakers should prioritize family planning. One advocate from Kenya noted:

> *"When we are heading to [the] election period, no one wants to talk about family planning. It is on us to really position ourselves and to see how we can engage them during this election period for the support to be an ongoing process. Otherwise we might lose out on the gains we have started … what they think about is votes and numbers."*
>
> *– Advocate, Kenya*

### *Collaboration among FP advocates*

Many of the advocates we interviewed spoke of the importance of collaborating with other FP advocates and professional and technical networks—including technical working groups, donor groups, government representatives, NGOs, and other stakeholders—when developing their advocacy strategies. Many stressed the importance of these groups in offering environments for presenting recent work and sharing experiences and challenges; building coalitions, networks, and consortiums; sharing information about stakeholders; coordinating national and international agendas (such as ICPD); bringing together best practices; and planning together. According to one respondent, "This [FP advocacy] is not a one-man show or one-organization show: we work closely with other stakeholders."

### *Influence of donors on FP advocacy*

Responses were mixed on the influence of donors in FP advocacy work. Some advocates felt that donors do not influence their work; some felt that they have a large influence; some felt that they have influence in certain ways but not others; and some felt that it depended on the donor. Overall, 41 percent of advocates thought that funders influenced their advocacy approach, with very different responses from the three countries: 83 percent in Kenya, 20 percent in Ethiopia, and only 17 percent in Malawi.

One advocate from Ethiopia stated that donors do not influence the work "because of shared vision and goals." Another from Malawi said that "they have never imposed their ideas on us, and we work with them very well … They have always been in the background." One advocate from Malawi stressed that his organization focuses on the human rights approach to family planning, and "as far as the people's rights are concerned we cannot be pushed to move this direction or the other so they [donors] don't really [affect our approach]. They play by our mandate."

On the other hand, some advocates felt that donors have a strong influence on FP advocacy work. One respondent from Kenya mentioned that "they are very specific when they are funding you to do ABCD. At times the donor will require us to change the approach." Another simply stated that "Donors decide on availability of funding and what to focus on."

Some respondents felt that donors influence certain aspects of their work more than others. One advocate from Ethiopia gave the example of donors influencing formatting and presentation style but leaving the content of the messages up to local advocates.

> *"The presentation mode was…designed and selected by our donors. They came to Ethiopia and we supported them in collecting evidence, but their major presentation [was created] in the U.S. They came to Addis and trained the presenters, so everything but the message is decided between partners. The evidence, the design, the framework, the presentation: everything is done by [the donor partner]."*
>
> *-Advocate, Ethiopia*

Private foundations were cited as giving more freedom for the work carried out with their funds than other donors. Advocates noted that with certain donors, "we are free to design the message, the target audience, and to select the appropriate presenters and channels that we feel are important." In contrast, one advocate from Kenya noted that the greater restrictions on the use of USAID funding, compared to private funds, limit the topics on which her organization can work.

> *"Where we have USAID funding, we are unable to provide certain services because of donor restrictions, so we try to leverage that support with funding from other sources."*
>
> *– Advocate, Kenya*

### *Requests for information*

A final theme that emerged in discussion of advocacy strategies was specific requests for information from decisionmakers. Respondents mentioned various examples of requests they have received, such as to conduct literature searches; provide presentations; and supply information on specific topics, such as postpartum IUDs. As one advocate put it, "In order for us to maximize the resources we are getting from the Ministry of Health, we have to make sure that we are responsive to their requests."

## Advocates' Experience and Recommendations about Generating FP Evidence

### *Who generates the evidence?*

Most advocates explained that their organization was responsible for synthesizing evidence from many different sources: 81 percent (and the majority in each country) reported that the evidence used in their advocacy materials is generated both by their own organization and other institutions. The sources most commonly named were DHS; national statistical agencies; evidence created by various FP models and tools; peer-reviewed journal articles; evidence generated at the headquarters of international organizations; various national ministries; international donor projects; academic institutions; NGOs; and national documents, policies, and reports. Many advocates cited the importance of technical working groups and collaboration among FP advocates in reviewing and synthesizing available evidence. Very few advocates reported conducting their own primary data collection or secondary data analysis on their own, without support from other institutions.

### *Training on advocacy tools and data use*

Most advocates (71%) responded that they had received some training on advocacy tools, mostly through on-the-job training; few had received pre-job training. Some had not received training specific to family planning, but had received training on related topics, such as RH or gender issues. The two most commonly cited FP tools on which advocates had received training were RAPID and ENGAGE. One advocate from Malawi explained the following:

> *"The training that we have is really at the level to help us appreciate how these things work. But it is not really for us to sit and start doing ENGAGE and RAPID in our offices … [If] we are asked 'How is this one working?' at least you are able to explain [it] to the audience."*
>
> *– Advocate, Malawi*

Most had been trained on advocacy and communications, including training to give presentations that had been created with evidence generated by others using FP tools. Very few interviewees reported having been trained on generating evidence or manipulation of specific advocacy tools.

One advocate from Ethiopia felt that "there is a lot of secrecy around these tools; they don't want to show how to enter the information."

#### How evidence and tools have been helpful

Advocates cited several ways in which the evidence generated from tools has been useful in FP advocacy. Several noted that evidence-based presentations, including those with projections into the future, help decisionmakers consider possible future scenarios in a way they might not have otherwise; such evidence can stimulate discussion and convince decisionmakers. Some interviewees praised the high quality of DHS reports, and also appreciated the comparability of this data source across different countries. Others noted that the captivating presentation style of some tools is very helpful, and another said that his presentation style had improved through using the graphics suggested by these tools. Finally, one advocate noted the usefulness of the tools in contextualizing or interpreting DHS findings for people who would not otherwise grasp their implications.

### *Evidence needs and obstacles regarding tools and data use*

While a few respondents said there were no obstacles to finding the data they needed, most cited a topic about which they would like to have more evidence or an obstacle they had encountered when using FP tools. Several advocates mentioned either the general lack of reliable and easily available data—including a lack of consensus about data sources and figures—or the lack of data between DHS surveys and the infrequency of reliable surveys.

One advocate said that advocacy tools are not always readily available. He pointed out that some tools are licensed and cannot be adapted or easily manipulated, which limits their usefulness in the country.

Technical and language issues also affected availability. One interviewee mentioned that slow internet speed can impede the use of such online tools as StatCompiler. Another respondent from Malawi noted the difficulties he faces with the level of language used in the tools, saying that he struggles with how to use the information "without losing its original intention—sometimes it is difficult. It really requires somebody who is really trained to master this, and it is not easy."

Advocates would like to have more evidence about best practices and successes from other countries, as well as better integration of qualitative and quantitative evidence. While some interviewees mentioned a need for further research, others said that there are already too many tools for analyzing family planning, or that family planning already is over-studied in their countries. One advocate from Kenya said, "I get anything I want. In Kenya, we have been studied to death and published to death!"

Finally, advocates wanted more evidence on various topics, especially related to the side effects of contraceptive methods, such as effects of long-term use of contraceptives, incorrect use of methods, and side effects in general. Other topics mentioned included women's issues/empowerment, poverty, budget tracking, data for smaller geographic or political areas, and climate change.

### *Advice on evidence-generating tools*

Advice on the important characteristics of evidence-generating tools varied significantly. Several advocates focused on either the user-friendliness of the tool or simple, concise advocacy messaging that should "have very focused themes," as one advocate from Ethiopia noted. Another interviewee from Ethiopia cited the need for simple advocacy materials: "make it simple, visually pleasant, figures not so much." Another advocate from Kenya advised using easily understood language in the tools.

> *"An advocacy tool is so simple: simple enough that … anybody can use it in your absence. Don't make it too technical that people have to refer [to other things] and it's looking like a PhD. Make it a simple thing like ENGAGE: presentations that you can just click a button and it goes. If you bring some documents and you manage it, that's not an advocacy tool. That's laboratory equipment, which an advocate cannot work with. An advocate needs something which they can run with, like a one-minute message and go!"*
>
> *– Advocate, Kenya*

Tools should be readily available, and local advocates should know how to manipulate the tools, according to an advocate from Malawi:

> *"Should be user-friendly and without barriers … like a license … People should utilize it because you want this message to go far; [you don't] want to limit who knows how to use it."*
>
> *– Advocate, Malawi*

Several respondents highlighted the importance of focusing on special populations and issues, such as women's empowerment, male engagement, and youth populations.

Interviewees mentioned several ways in which FP advocacy could be more locally relevant: incorporating a better understanding of cultural and religious beliefs; taking into account regional heterogeneity within a country; and alignment with government figures, policies, and priorities. One advocate stated: "Give priority to the government. Let the government decide, not [donors and implementing partners], no one!" Still others emphasized maintaining momentum for both government and donors, and ensuring that FP tools were used as part of a sustained process, rather than a one-time application. Finally, a few advocates recommended closer examination of existing tools to determine the necessity of creating new ones.

> *"They don't have to reinvent the wheel. Look at all existing advocacy tools that we are using and also see how we use them and how effective they are … then focus on how you can improve on the gaps."*
>
> *– Advocate, Kenya*

> *"What is already there? They should find out that and build on those. What messages are the most critical at that time? People also create tools just for the sake of creating tools because there is money. Can we create tools that respond to country needs?"*
>
> *– Advocate, Kenya*

To support the design of effective advocacy strategies, it is imperative to understand the contextual systems and decision-making mechanisms in each country. All of the study countries have parliamentary systems; however, their decentralized decision-making structures vary. Ethiopia is a federal state, with nine regional states. Kenya is only just now implementing its new constitution, which devolves significant authority to 47 county governments that will work closely with the central government. Malawi is the exception, with decentralized decision making entrenched within the health system, as opposed to the political structure.

## Country-specific Decision-making Contexts

### *Ethiopia*

When asked about salient factors in high-level or national decision making on policies and budgets related to family planning, respondents in Ethiopia highlighted three key factors: (1) alignment of the government's RH and FP policies with global health goals; (2) decision- making structures; (3) advocacy structures. These factors are elaborated upon below.

#### *Alignment of national RH and FP policies with the global health agenda*

Ethiopian respondents reported that the government's national development targets, and consequently its policy and budget decisions, are well aligned with the MDGs. In the health sector, these include the MDGs related to safe motherhood (MDG5), child health (MDG4), and the reduction of HIV/AIDS (MDG6), all of which concern access to sexual and reproductive health (SRH) services, including family planning. These MDGs are reflected in national policies, including the *Health Sector Development Plan* (HSDP), the MOH's main strategy document. The HSDP forms the health chapter of Ethiopia's development blueprint, '*A Plan for Accelerated and Sustained Development to End Poverty*' (PASDEP) (2005/06−2009/10); the GTP (2010/11−2014/15) and all three policies are aligned to the MDGs and incorporate FP targets. The HSDP III (2005/06−2009/10) and the HSDP IV (2010/11−2014/15), which are the third and final phases of the health sector plan, respectively, aim to increase the CPR from 25 percent to 60 percent and 32 percent to 66 percent, respectively. Further, HSDP IV aims to decrease unmet need for family planning from 34 percent to 10 percent by 2015.

In particular, respondents universally referred to Ethiopia's development blueprint, the GTP. Given that maternal and child health (MCH) and family planning are priorities of the GTP, respondents highlighted that family planning has been incorporated into the 2010/11−2014/15 HSDP IV. One advocate said "the government is very much committed into realizing the MDGs," and that advocacy messages should be aligned to the HSDP IV, which informs advocates of government priorities and development targets. Decisionmakers recognized that family planning is not exclusively a health issue, but also a development issue. One decisionmaker said

> *"We are aiming to be a middle-income country by 2025. To be a middle-income country, we should have a productive society, a productive age group. We are focusing on effective interventions—family planning, where each family would have to choose how many children they should have."*
>
> *− Ministry of Health official, Ethiopia*

Another decisionmaker related family planning to other development goals, such as education.

> *"If you prioritize or give emphasis to education, then education will be as a solution for family planning problems … Find some money for education and pave the way for girls' education first—when these girls or women are well educated, they will be capable of planning their family size and other resources also."*
>
> *− Parliamentarian, Ethiopia*

### *Decision-making structures (including resource allocation)*

In addition to linking advocacy issues to government priorities, advocates noted that they need to be able to effectively identify various levels of decisionmakers with appropriately targeted messages. Respondents outlined multiple pathways in decision making that would help identify effective points of entry.

Although the interviews did not specifically ask about it, during the course of the study, many interviewees noted that decision making in Ethiopia is decentralized. Every year, the Federal Parliamentary Assembly passes a national budget and allocates funds to each of the line ministries. The MOH has FP commodities as a line item in its health budget to address commodity security. Once the Federal Parliamentary Assembly has passed a national budget, decisions about how to allocate resources (specifically human, financial, and material resources) to the regional level are based on regional population distributions and sizes. A health sector review meeting takes place at the federal, regional, and *woreda* (district) levels, which results in differing prioritization levels of resource allocation to FP services under these specified jurisdictions. One Federal Ministry of Health (FMOH) official noted that "We [Federal Ministry of Health] support the Regional Health Bureau and the *Woreda* health offices to develop annual plans in their contexts. We give the Ministry's vision." Funds are allocated to regional governments and *Woreda* (district) councils, respectively, which then make budget decisions based on local priorities. The regional health bureaus derive funds from regional parliaments based on their own budgets for providing services at this level. Thus, despite allocation of funds to FP programs at the regional level, other services may be prioritized at the *woreda* level.

Given this structure, one advocate noted that advocacy messages on FP resource allocation are best targeted to the decision-making authorities in the federal parliament, regional parliament, and line ministries, but to influence policies, the appropriate line ministry should be targeted, as the overall health strategy (HSDP) is made at the central level.

In Parliament, one respondent highlighted two committees as being crucial for influencing budget-making decisions.

> *"There is a committee that deals with family planning, particularly with budget allocation. The budget standing committee follows the budget distribution and allocation. There is also another standing committee that deals with the activities of oversight, controlling and monitoring activities with regard to family planning, particularly the activities of the Ministry of Health."*
>
> *− Parliamentarian, Ethiopia*

### *Advocacy structures*

Two ministries—the Population Department in the MOFED and FMOH—as well as the Federal Parliament Assembly, are the key advocates for FP in Ethiopia. One Parliamentarian explained how MPs are working with MOFED to address family planning in relation to population growth.

> *"We are checking whether they [MOFED] have a plan to deal with these population issues of the country and whether they have a plan of activities to be done in a specific budget year and whether those activities will be budgeted to convert it [the plan] to some outputs—this is what we are checking and questioning—by this we can make some influence on this sector."*
>
> *− Parliamentarian, Ethiopia*

One respondent mapped the decision-making processes to help identify points of intervention/advocacy. In Ethiopia, the budget comprises both domestic revenue and external support from development partners. External support is coordinated through various forums, including a biannual high-level forum with development partners, chaired by the Minister of Finance and Economic Development and co-chaired by

development partners, during which progress and concerns on macro- level development issues are addressed. There is also a multi-stakeholder annual GTP progress review forum that engages a wide range of actors, including development partners, CSOs, religious institutions, NGOs, youth associations, women's associations, and private sector organizations; one respondent saw the annual GTP progress review forum as an ideal forum to discuss family planning. There is also a Joint Development Partners committee, which meets biweekly to identify and mitigate implementation budgetary challenges.

In Ethiopia, the government has clearly defined structures for advocacy and decision making on policies and budget allocation, which are aligned with the global and national development agenda. Advocates target their strategies based on these structures. The importance of issue champions (i.e., supportive individuals in influential positions) in spearheading a neglected policy issue is recognized as a worthy advocacy strategy. In Ethiopia, parliamentarians are seen as "the main actors to push family planning ahead or to bring it back—they are the main actors for family planning in the country." One respondent explained how female parliamentarians can be influential advocates for family planning and highlighted the work of two FP champions in Parliament who have medical training and have held senior positions in the FMOH. Female parliamentarians, who constitute about one-third of the Federal Parliamentary Assembly, have had an impact on parliamentary budget decisions and are particularly strong advocates because they can relate to the need for access to family planning and thus influence their parliamentary colleagues. Advocacy on FP issues is carried out by government colleagues in the MOFED and MOH and the relevant parliamentary committees.

### *Kenya*

When asked about salient factors in high-level or national decision making on policies and budgets related to family planning, respondents in Kenya highlighted two key contextual themes: (1) alignment of RH or FP policies with global health goals, and (2) decision-making structures.

#### *Alignment of national RH and FP policies with the global health agenda*

In Kenya, health and development are well integrated within the government's priorities and allocation processes. The *Kenya Health Policy Framework* (KHPF) 2012−2030 recognizes the contribution of citizens' health to development. Family planning in Kenya is aligned with the global and national development agenda. Parliament now has a say in the funds allocated to the MOH, in that parliamentarians debate the allocation of government funds rather than just "rubber stamping" the budget. The MOH's policies and priorities are aligned with the global development framework MDGs and Kenya's development blueprint, Vision 2030. MCH and HIV are the principal focus areas of MOH, and both integrate FP issues. Kenya was renowned for its successful FP program in the 1980s and 1990s, which subsequently stalled between 1998 and 2003, perhaps due to a funding shift to the HIV/AIDS epidemic. The repositioning of RH and family planning is attributed to the MDGs and the urgency of addressing factors that impinge on development, such as rapid population growth. The *Sessional Paper No. 3 of 2012 on Population Policy for National Development* (launched in October 2012), which aligns with Vision 2030, lists RH as one of the seven thematic areas for Kenya's socioeconomic development. In May 2013, the policy was awarded the Aspen Institute's Global Leaders Council for Reproductive Health "Resolve Award" in recognition of its role in expanding access to RH services. The goal of Kenya's FP program is to attain a CPR of 56 percent by 2015/2016. *The Family Planning Costed Implementation Plan* (2012−2016) seeks to support this effort. Since the establishment of the budget line for FP commodities, funding contributions for contraceptives from the government have trended upward—from KSh 200 million (US$2.62 million) in financial year 2005/06 to about KSh 500 million (US$6 million) per year in 2010/11 and 2011/12—estimated at 60 percent of the total budget for contraceptives. Despite this alignment and prioritization, budget allocations are not sufficient to meet the goals set by these policies.

### *Decision-making structures (including resource allocation)*

At the time of the writing of this report, Kenya had recently inaugurated its first government under its new system of governance, in which the country's decision making has devolved to 47 county governments. The focus of the central government (MOH) is policy formulation, resource allocation to counties, and oversight to maintain the quality of service delivery, while that of county governments is resource allocation and implementation of policies or service delivery. Once the Ministry of Finance (MOF) approves funds, relevant ministries allocate specific program funds based on their priorities. Nevertheless, Kenya still falls short of the Abuja Declaration, which stipulates that 15 percent of the national budget should be allocated to health.

A number of parliamentarians pointed out that, while they were previously simply required to rubber stamp budget decisions, the new Kenyan Constitution promulgated in 2011 has empowered legislators to have more influence on budget allocation decisions by the MOF, as they are presented to parliamentary committees prior to cabinet approval.

> *"We [parliamentarians] have a role in [budget] decisions because when you come up with a motion in parliament, the motion directs the ministry concerned to implement them. That is why it's very important to come up with motions and bills that can provide guidelines on how the country can achieve an appropriate and manageable population."*
>
> *− Parliamentarian, Kenya*

Moving forward, it will be interesting to observe the implications of devolution and local priority setting on health and access to and uptake of family planning.

### ***Malawi***

When asked about salient factors in high-level or national decision making on policies and budgets related to family planning, respondents in Malawi highlighted three key contextual themes: (1) the national development agenda; (2) decision-making structures; and (3) advocacy structures.

### *Alignment of advocacy messaging with national development issues*

Family planning in Malawi is aligned with the national development agenda. It was apparent that advocates and decisionmakers understood pertinent population and development issues, although advocates felt that decisionmakers needed to demonstrate more commitment to family planning, by increasing resources allocated to it, for example.

Malawi's development blueprint, the Malawi Growth and Development Strategy (MGDS) provides a framework to address the country's development targets. One advocate said that advocacy messages are purposely constructed to alarm policymakers, and pointed to the stagnation of the country's development as a consequence of a large population and inadequate human capital development. Such messages have played a role in convincing policymakers about the link between population and development. Several respondents also stressed the importance of linking FP advocacy to issues of population.

> *"In our own analysis, we saw that it was important to include issues of population [in the MGDS 2011−2016]. My boss, the PS, said if we are not going to address these issues, there is no way that Malawi is going to move forward."*
>
> *– Ministry of Economic Planning and Development official, Malawi*

This observation fits well with Malawi's focus on the link between population and development and, as such, is addressing rapid population growth through improved access to and utilization of family planning.

One respondent noted that it was critical that FP advocates effectively convey the link between Malawi's high population growth rate and the consequent high dependency ratio.[2] A high dependency ratio would force the government to be reliant on external/donor funds to provide basic social services. Decisionmakers in this study appeared to have an appreciation for the issues raised by FP advocates.

> *"I see the negative effects of large families and the population boom. I have seen the effects—I don't need more evidence. I think it's necessary that we do something about high fertility issues."*
>
> *– Ministry of Health official, Malawi*

*Decision-making structures (including resource allocation)*

The role of development partners in Malawi is to provide technical and financial assistance to the country's program of work. This implies that country plans guide external support.

> *"The health sector has governance structures under the sector-wide approach. There is a family planning task subcommittee that's under the sexual and reproductive health technical working group. Issues are first discussed at the family planning subcommittee level, and then they are recommended to the Sexual and Reproductive Health Technical Working Group (SRH TWG), which has the powers to endorse and move forward to the ministry endorsement."*
>
> *– Development partner official, Malawi*

Two respondents noted that positive policy shifts did not coincide with increased resources to support policy implementation, particularly regarding Malawi's FP program; rather, there is a reliance on development partners, including USAID, the largest contributor. The issue of reliance on development partners was worrisome to one advocate.

> *"Who is going to pay [donor funds] back in [future] years …? Are they [policymakers] connecting that with the future generation we are putting in trouble? Those are the things I am calling lack of connectivity to what's happening now and in the future, in view of population growth."*
>
> *– FP Advocate, Malawi*

The Reproductive Health Unit (RHU) of the MOH in Malawi runs the national FP program, but respondents felt that it was not well resourced and it did not have much influence, as it is not at a directorate level. The RHU is under the Directorate of Clinical Services within the MOH, and the head of RHU is a deputy director who does not sit at the Ministry's directors' meetings, where key policy and strategic decisions are made.

One MOH respondent illustrated the challenge of the lack of RHU's decision-making authority, talking about the government's policy change to allow health surveillance assistants (HSAs)—the lowest cadre of health workers—to distribute injectables at the community level. The respondent noted that, although the issue had been recommended by a subcommittee of the SRH TWG, "it was tough to actually take it to the senior management" at the ministry. Once this had been done, however, despite some resistance, the RHU was authorized to conduct a pilot study, which formed the basis for national roll-out.

However, following the 2012 National Family Planning Conference, which included intensive lobbying, the Government of Malawi committed to "strengthen the institutional arrangements to deliver effective policy leadership for population and family planning" by upgrading the Population Department in the

[2] A measure of the portion of a population composed of dependents (people who are too young or too old to work).

Ministry of Economic Planning and Development and the RHU into full directorates. The government also pledged to create a budget line for family planning. These commitments were announced at the London FP2020 summit in July 2012 as part of the government's strategy to meet Malawi's CPR target of 60 percent by 2020.

### *Advocacy focus*

One respondent highlighted that parliamentarians in the Parliamentary Committee for Health are receptive of information and advocacy on RH issues, which they relate to their constituents. Respondents also noted that there is a window of opportunity in Malawi due to the political will of President Banda, who introduced the Initiative on Safe Motherhood and has publicly promoted maternal health, including family planning. It was also noted that the president wants to transfer this political will to engage local leadership, including chiefs. As one respondent noted, the traditional chiefs in Malawi are key gatekeepers of culture, and thus their buy-in to family planning would have a significant impact in Malawi.

# DISCUSSION AND CONCLUSIONS

## Discussion

This study was designed to characterize the interests, needs, and behaviors of the decisionmakers that influence decisions and actions for family planning in sub-Saharan African countries. The findings draw from three case study countries—Ethiopia, Kenya, and Malawi—that reveal many similarities in how often decisionmakers were exposed to FP advocacy and evidence; effective channels, formats, and forums for delivery of advocacy messages; types of evidence that decisionmakers find most compelling; the salient factors that affect how FP decisions are made; and how advocacy strategies directed toward high-level policymakers are developed.

### *Decisionmakers' support for Family Planning*

Overall, decisionmakers from all three countries understood the value of family planning and support efforts to further elevate its profile. The study findings confirm that FP advocacy has played a major role in shifting the attitudes of decisionmakers toward embracing family planning as a critical health and development intervention. Indeed, the findings show that decisionmakers generally are convinced by evidence demonstrating the benefits of family planning on maternal health, child health, and family welfare, and now increasingly are becoming convinced by the evidence demonstrating its broader development benefits.

Given the policy frameworks that support family planning as part of strategies to meet the MDGs, matched with notable improvements in FP uptake in these three countries in the recent past, these findings were not surprising (http://www.countdown2015mnch.org/).

### *Effective FP advocacy strategies*

Effective advocacy strategies follow well-defined steps. FP advocates need to map out the nature of the audiences and tailor the messaging, formats, and forums for message delivery appropriately to the particular audience (parliamentarians, government officials, religious leaders, or subnational leaders). Indeed, a qualitative study in four developing countries, including two African countries—Malawi and Tanzania—identified poor packaging of evidence that fails to consider the needs of different policy audiences as a barrier to research uptake (Hennick and Stephenson, 2005).

### *Competing factors in FP policy, program, and budget decisions*

The acknowledged widespread national support for Countdown to 2015 in these three countries is not sufficient to effect changes in FP policy, program, and budget decisions. We found that a myriad of interwoven factors influences decision-making processes. Public opinion is of great importance in the three countries, and respondents noted that elected leaders base their actions and decisions on family planning on their constituents' views of it. Also, some elected officials may not want to promote family planning, fearing that they will diminish the future size of their voting bloc and the influence of their ethnic group in national affairs. This finding is supported by many studies that have cited political interests as barriers to the uptake of research by decisionmakers in developing countries (Hunsmann, 2012; Hyder et al., 2010; Aaserud et al., 2005). In fact, studies that look at the role of public health evidence in decision making reveal that such factors have greater impact than research evidence on the decisions made by policymakers, yet often are not considered adequately when developing advocacy strategies (Orton et al., 2011).

Nevertheless, decisionmakers and advocates in our study believed that the influence of competing priorities that constantly face them—including economic (limited resources), sociocultural, religious, and political factors—can be reduced incrementally or removed through sustained and strategic FP advocacy,

and that even those who currently oppose family planning can be transformed into supporters. This perspective is instructive in helping FP advocates in these countries to tailor messages that consider and address these barriers.

### *Factors that positively influence FP advocacy*

Advocacy messages need to clearly address the factors that decisionmakers take into account about the benefits of family planning. It is equally important, however, to recognize that information education, and communication (IEC), behavior change communication (BCC), and mass media campaigns—which are often considered as separate from policy advocacy—may also influence national or regional decision-making processes. We know that top-down support of family planning (from top national leadership) is important, but in these three democracies, bottom-up support also is important.

Respondents also emphasized the need for advocacy targeted to both central and subnational decisionmakers because the sampled countries have decentralized and/or devolved government structures that make policy, program, and budget decisions. Political will in the central government for creating an FP-enabling policy environment remains critical in those countries with decentralized systems. Ethiopian key informants emphasized how top-down leadership support for family planning can increase nationwide (including regional) support. Since family planning is a priority within Ethiopia's development blueprint (the GTP), and the cascading of GTP goals has been effective, decisionmakers in Ethiopia must ensure achievement of GTP goals related to family planning, irrespective of their personal views. Likewise, in Malawi and Kenya, central-level political will and commitment has resulted in an enabling policy environment that supports growth in contraceptive prevalence.

### *Factors that affect FP policy, program, and budget decisions*

Among the salient factors that influence decisions about family planning, the top three that emerged among the decisionmakers we sampled were (1) evidence and data on the impact of family planning as a policy option, (2) cost of implementing FP programs, and (3) value for money accrued as a result of implementing FP programs. However, competing funding priorities can override even the strongest FP data in how many resources are allocated to FP programs. FP advocates perceived the top three resource allocation arguments for decisionmakers to be (1) the short- and long-term benefits of family planning, (2) the cost of implementing FP programs, and (3) the political priorities of other sectors. This demonstrates that advocates understand the importance of data, including costing information, for decision making. The advocates' high ranking of the political priorities of other sectors shows that they acknowledge the political realities that decisionmakers face.

### *Effective FP advocacy messages, formats, and forums*

The FP advocacy messages, formats, and forums used to date have been relatively effective; the decisionmakers included in the sample had ample exposure to information on family planning and were able to articulate the pertinent arguments for investing in it. Decisionmakers reported that their FP messages have recommended specific and concrete actions, some of which have been implemented, including:

- the establishment of FP commodity budget lines (Ethiopia, Malawi, and Kenya);
- increases in budget allocations for family planning (Ethiopia and Kenya);
- strengthening RH and population coordinating agencies (Malawi); and
- various health systems improvements that have increased access to FP services.

Key health systems improvements identified by respondents include:

- task shifting and bringing services to rural communities (Ethiopia's Health Extension Workers and Malawi's Health Surveillance Assistants);
- strengthening contraceptive supply chain management (Ethiopia); and
- removal of the import tax on contraceptives (Ethiopia).

However, as advocates in all three countries noted, more advocacy work is needed to ensure that governments match the increased support for family planning with increased resource allocation.

Respondents believe that FP advocacy efforts should be led by national advocates (including relevant government agencies and key CSOs), with technical support and financing from international advocates (development partners). However, donors' influence has clearly been significant. Respondents noted that donor influence has led to government shifts in support of family planning in the three countries. For example, in Kenya, the funding shift from family planning to HIV/AIDS in the 1990s contributed to the stall in FP uptake between 1998 and 2003 (AFIDEP, 2013), which then resulted in greater direct government investment in FP commodities. Development partners also guide or influence the development of advocacy strategies. This level of support is more pronounced in Malawi because it has relatively weak technical capacity in evidence-based advocacy and technical assistance.

### *Effective FP advocacy tools*

Respondents stressed the importance of national actors in advocacy efforts; they are familiar with contextual nuances and understand the best advocacy approaches for different audiences. However, due to relatively low technical expertise and skills in generating and translating research and related evidence, FP advocates in the three countries tend to use evidence and tools generated and developed by international actors. To sustain advocacy efforts, there thus is a need to enhance the technical capacity of local advocacy actors. Moreover, FP advocates feel that some of the available tools are difficult to manipulate, and their expertise is often limited to learning how to present results from the tool, as opposed to how to modify or adapt the analyses. FP advocates also experience challenges in obtaining up-to-date evidence in the years between Demographic and Health Surveys, which are conducted approximately every five years.

The findings show that decisionmakers are best reached with concise and brief messages using policy briefs, PowerPoint presentations, and one-on-one meetings. Respondents viewed cross-national comparisons as acceptable as long as the countries selected for comparison are perceived as contextually similar; for example, Kenya versus Rwanda rather than Kenya versus South Africa. Furthermore, the information should be presented using a mix of statistics and compelling stories—particularly stories that demonstrate the benefit to a woman or a family when family planning is adopted. These findings add to the knowledge in this area supporting the notion that there is no blanket advocacy strategy, and that effective advocacy requires a good mix of evidence, content, format, and forum, tailored to the specific target audience.

## Conclusions

The findings of this study support and add to existing knowledge in the broader areas of research about FP policy and advocacy. Specifically, the study contributes a wealth of information relevant to the context of sub-Saharan African countries—where few studies in this area (and none in family planning) have been conducted. "It presents the ideas and opinions of advocates and decisionmakers in their own words, drawing on the knowledge and experience of individuals who are strategically positioned to comment on these topics." This allows exploration of the topics at hand in the words of the people, often with decades of first-hand experience, who are immersed in this work day in and day out. The study revealed that decisionmakers in sub-Saharan Africa understand the value of family planning but that competing priorities and constituents' sociocultural and religious barriers hinder its increased prioritization, particularly in resource allocation and decisionmakers' public support of family planning. Nevertheless, the study demonstrated that, with targeted advocacy, decisionmakers can change their minds on supporting family planning.

Our findings also revealed that FP advocates are doing a relatively good job in engaging decisionmakers, but still need training to improve their technical capacity in evidence generation, presentation of advocacy materials, and the reach of their advocacy efforts.

Finally, we did not find many generalizable conclusions about the ideal FP advocacy strategy but rather an "it depends" strategy, whereby the evidence, content, format, and forum used is tailored to the specific target audience.

# RECOMMENDATIONS

The following recommendations emerged from this study:

- Design communication strategies that are sensitive to the economic, sociocultural, religious, environmental, health, and political factors that influence decision making about family planning. For instance, given a context of limited resources, FP advocacy may seek to demonstrate the role of family planning in making savings toward investments in other key public sectors—such as health, education, transportation, water, and agriculture—that will contribute to national economic growth. In a densely populated country like Malawi, decisionmakers may be more open to messages about effects of population growth on land and natural resources than in a country less densely populated, such as Ethiopia. Many decisionmakers are eager for evidence that can demonstrate this link and help them meet national development goals, for which they are accountable. Also, this evidence may broaden views about family planning among some decisionmakers, from a perception of it as a narrow health or women's issue to a development issue.
- Develop an array of advocacy materials that document evidence on the short- and long-term benefits of family planning, presented using either personal stories or data, or a combination of the two, and available in different formats based on the type of decisionmaker, decisionmaker evidence needs, and forum.
- Promote scale-up of IEC programs at the community level to increase community members' support for family planning, which may incrementally increase its community acceptance and ease the fears of elected leaders as to supporting and promoting it. This study points to the importance of bottom-up support of family planning, since constituents' public opinion of it influences top-level decision making.
- Continue collaboration with key decisionmakers who are FP champions—such as female politicians or strategically placed influential individuals—by making sure they remain engaged in and well informed about FP issues. Advocates should make sure that decisionmakers have resources and information readily available to advocate for family planning with their peers.
- Sustain efforts to engage with national and subnational leaders, parliamentarians, and religious leaders toward increasing and sustaining support for family planning. Advocacy is not a one-event activity—it requires sustained efforts, which should also evolve as the program context evolves. For instance, advocacy in a country in an early stage of contraceptive increase (like Ethiopia) requires messages focused on the sustainability of contraceptive uptake.
- Enhance the technical skills and capacities of local advocacy practitioners to generate and package the evidence to promote family planning among a range of decisionmakers (government officials from other public sectors, parliamentarians, subnational leaders, religious leaders, institutional leaders, and others). National and international advocacy actors are seen as credible, and their complementary roles are valued by decisionmakers. International actors who previously have undertaken the technical roles of evidence generation and packaging should develop programs that build the capacity of national actors so they may carry out their own analyses on the topics they see as important and relevant to their audiences.

# ANNEX A: REPRESENTATION OF KEY INFORMANTS IN STUDY COUNTRIES

| | Ethiopia – Advocates | Kenya – Advocates | Malawi – Advocates |
|---|---|---|---|
| 1 | Family Guidance Association of Ethiopia (FGAE) | USAID | University of Malawi |
| 2 | United Nations Population Fund (UNFPA) | Pathfinder International | Malawi Interfaith AIDS Association |
| 3 | Pathfinder International | Reproductive Health and Rights Alliance (RHRA) | Family Planning Association of Malawi (FPAM) |
| 4 | Consortium of Reproductive Health Associations (CORHA) | Family Health Options Kenya (FHOK) | Family Planning Association of Malawi (FPAM) |
| 5 | United States Agency for International Development (USAID) | Innovations for Poverty Action (IPA) | Safe Motherhood Initiative |
| 6 | | University of Nairobi | United Nations Population Fund (UNFPA) |
| 7 | | UNFPA | UNFPA |
| | **Ethiopia – Decisionmakers** | **Kenya – Decisionmakers** | **Malawi – Decisionmakers** |
| 1 | Ministry of Finance & Economic Development | Ministry of Youth Affairs and Sports | Consultant, Formerly Ministry of Health |
| 2 | Ministry of Finance & Economic Development | National AIDS Control Commission (NACC) | Ministry of Health |
| 3 | Ministry of Health | Ministry of Public Health and Sanitation | Ministry of Health |
| 4 | Ministry of Health | Ministry of Public Health and Sanitation | Ministry of Health |
| 5 | Ministry of Health | Ministry of Finance | Ministry of Health |
| 6 | Ministry of Women's, Children and Youth Affairs | National Gender and Equality Commission | Ministry of Health |
| 7 | Ministry of Women's, Children and Youth Affairs | Ministry of Planning, National Development and Vision 2030 | Ministry of Finance |
| 8 | Ministry of Education | Ministry of Planning, National Development and Vision 2030 | Ministry of Economic Planning and Development |
| 9 | Federal Parliamentary Assembly | Kenya National Assembly | Ministry of Economic Planning and Development |
| 10 | Federal Parliamentary Assembly | Kenya National Assembly | Ministry of Economic Planning and Development |
| 11 | Federal Parliamentary Assembly | Kenya National Assembly | Ministry of Youth and Sports |

| | | | |
|---|---|---|---|
| **12** | Federal Parliamentary Assembly | Kenya National Assembly | Ministry of Youth and Sports |
| **13** | Federal Parliamentary Assembly | Kenya National Assembly | Ministry of Gender, Child and Community Development |
| **14** | Federal Parliamentary Assembly | - | National Assembly |
| **15** | Federal HIV/AIDS Prevention and Control Office (HAPCO) | - | National Assembly |
| **16** | - | - | National Assembly |
| **17** | - | - | National Assembly |
| **18** | - | - | National Assembly |
| **19** | - | - | National AIDS Commission |
| **20** | - | - | USAID |

# ANNEX B: INTERVIEW GUIDES

## *Annex B.1 Interview Guide for Decisionmakers Used in Kenya and Ethiopia*

***Study conducted by the HPP and AFIDEP Kenya and Ethiopia, 2012***

*Assessment of Decisionmakers' Needs for Evidence to Facilitate Family Planning Advocacy*

*Informed Consent*

**Date of interview:**

**Start time:**

**Name of interviewee:**

**Name of organization:**

Hello. My name is ______________________________ and I work for the African Institute for Development Policy. Our institute is working with the Health Policy Project, which is funded by USAID. We work on issues of reproductive health policy. One topic we focus on is creating evidence about the costs, benefits, and impacts of family planning and other reproductive health interventions, especially for use in advocacy.

We are conducting a survey about how decisionmakers and other stakeholders view such evidence, and would appreciate your participation. *We will use this information to focus on the types of materials and evidence that are most important to key decisionmakers such as you*. The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.

Participation in this survey is voluntary and you can choose not to answer any individual question, or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey, since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____________________________________ Date: _____________________

**RESPONDENT AGREES TO BE INTERVIEWED**

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us to produce a detailed transcript of our conversation, since it is not possible for me to write down everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview.

IF NO – Try to explain again the purpose and, if the answer is still NO, then continue with the interview, recording as much detail as possible, and type up the full transcript of the interview within 24 hours.

Signature of interviewee: ____________________________________ Date: ____________________

**RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED**

0 No

1 Yes

*Section 1: Background*

1.1. [Interviewer, please note sex of respondent]

0 Male

1 Female

1.2 [Interviewer, please estimate age or ask of respondent] (circle one):

0 20−35

1 35−50

2 Over 50

1.3 What is the name of your organization/ministry and your position?

Organization/Ministry name ____________________________________________________________

Position _______________________________________________________________________________

1.4. How many years have you been working in your current position?

_________ Years (*if less than 1, put< 1*)

1.5. How many years have you worked in this organization? Or other similar organizations/positions?

_________ Years (*if less than 1, put< 1*)

*Section 2: Role in Family Planning Policy, Programming, and Resource Allocation*

2.1. Could you briefly describe your role in the position of ________________ [or in a past position, if applicable], particularly with regard to family planning? (Probe: Has your role in family planning been focused on meeting the country's health goals, development goals, or economic growth goals?)

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

D.1. What does "increasing support of FP" mean in the context of your job?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.3. Could you please describe your decision-making authority or role in your current [*or "former," if applicable*] position regarding:

a. Family planning policies, such as population policies, reproductive health policies, family planning policies, etc.

______________________________________________________________________
______________________________________________________________________
______________________________________________________

b. Family planning programs

______________________________________________________________________
______________________________________________________________________
______________________________________________________

c. Resources for family planning programming (probe: includes budgets, commodities, human resources)

______________________________________________________________________
______________________________________________________________________
______________________________________________________

[**FILTER**] IF THE RESPONDENT HAS NOTHING TO DO WITH FAMILY PLANNING, END THE INTERVIEW AND THANK HIM OR HER FOR THEIR TIME.

2.4. In your role as a decisionmaker regarding FP policies, programs, or resources [*MODIFY, DEPENDING ON RESPONSES TO* 2.3], could you describe for me how you interact[ed] with others in the decision-making process? What I mean by that is interaction with [other] decisionmakers, civil society advocates, or donors. *(Probe: What was the approach taken toward family planning—was it to meet the country's health goals, development goals, or economic growth goals?)*

_______________________________________________________________________________
_______________________________________________________________________________
____________________________________________________________

2.5. In your role as __________, have you observed any shifts in policies, programs, or budgets concerning family planning and reproductive health in the last few years?

0 No

1 Yes

Do you think family planning advocacy played a role in this? Please explain with examples, if possible.

_______________________________________________________________________________
_______________________________________________________________________________
____________________________________________________________

### *Section 3: Advocacy Regarding Family Planning*

I would like to ask you some questions about advocacy related to family planning.

**Sub-Section: Context**

D.2. Have you received written materials or seen presentations or messages that advocate for or against family planning?

0 No *(If no, please skip to 3.5)*

1 Yes

3.1. If yes, what was the context where you saw these advocacy messages?(*Examples: a large meeting or conference, a small meeting, a meeting with you in your office, or in some other venue*)

*Skip question if interviewee has not been exposed to family planning advocacy.*

_____________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

3.2. Who presented the advocacy about family planning? (Skip question if interviewee has not been exposed to family planning advocacy.)

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

3.3.a. Are some people, groups, or institutions more credible or more appropriate than others in advocating for family planning in [note country]? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

0 No

1 Yes

Please explain.

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

3.3.b. Is it important to have national actors involved? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

*Probe: Examples of national actors include parliamentarians, colleagues, local organizations, academic/research institutions, voters, heads of a political party; examples of international institutions include international organizations, donors, academic/research institutions*

0 No

1 Yes

Please explain.

____________________________________________________________________________
____________________________________________________________________________
________________________________________________________

**Sub-Section: Format**

3.4. In what format were the advocacy materials that you have seen/been presented? *[Circle all that are mentioned.]*

Skip question if interviewee has not been exposed to family planning advocacy.

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other __________________________________________________________

Combination of the above (specify): ________________________________________

Don’t know

No response

D.3. What do you think is the best format for presenting these messages? *[Circle all that are mentioned.]*

*Skip question if interviewee has not been exposed to family planning advocacy.*

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other ___________________________________________________________________

Combination of the above (specify): __________________________________________

Don't know

No response

3.5. In our advocacy efforts, we often take one of two approaches:

(1) A presentation with a lot of facts and graphics about the benefits of FP, and one or two brief vignettes or stories to put a human face to the numbers; or

(2) A presentation that focuses on how family planning has impacted one woman or one family, with a few facts and graphics.

Which would have the greater impact on *your* support and actions for family planning? Please explain.

_____________________________________________________________________________
_____________________________________________________________________________
____________________________________________________________

On a scale of 1 to 5, with 1 being *"strongly disagree"* and 5 being *"strongly agree,"* please respond to the following statements:

| | **Strongly disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly agree** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|---|
| 3.5.d. It is important to provide sustained information over time to decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.e. Decisionmakers find it helpful to receive comparative information about other countries in the region (*for example: indicators, policies, financing*). | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

**Sub-Section: Content**

3.6. What specific benefits of family planning did the advocacy messages you've seen mention? *(For example: Did the advocacy focus on health benefits, economic benefits, environmental benefits, women's rights/empowerment, or something else?)*

If applicable:

What evidence opposing family planning did these messages mention? *(For example: Did the advocacy focus on economic growth and population, family planning as a Western agenda, religion or traditional values, or something else?)*

*Skip question if interviewee has not been exposed to family planning advocacy.*

___________________________________________________________________________
___________________________________________________________________________
_______________________________________________________

3.7. Are you convinced by the evidence on the benefits of family planning that has been presented to you? Why or why not? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

*Probe: Was the evidence about the role of family planning in meeting the country's health goals, development goals, or economic growth goals?*

0 No

1 Yes

___________________________________________________________________________
___________________________________________________________________________
_______________________________________________________

3.8.a. Beyond general support for family planning, did the advocacy recommend specific actions?

0 No

1 Yes

If yes, please give examples.

___________________________________________________________________________
___________________________________________________________________________
_______________________________________________________

3.8.b. Were these recommendations relevant to your job?

0 No

1 Yes

Please explain.

___________________________________________________________________________
___________________________________________________________________________
_______________________________________________________

D.4. Have the advocacy messages you have heard been relevant to your professional concerns and goals? Please explain. *(Probe: Did the messages demonstrate the benefits of family planning in meeting the country's health goals, development goals, or economic growth goals?)*

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

3.9. In our advocacy efforts, we realize that we can't present all of the evidence for family planning. Of these nine potential advocacy messages, please group them into what decisionmakers find "most convincing," "somewhat convincing," and "least convincing." *(Have cards and pile sort—three in each category.)*

| 3.9.a. FP improves maternal health. |
|---|
| 3.9.b. FP improves child health. |
| 3.9.c. FP improves family welfare. |
| 3.9.d. FP contributes to national economic growth. |
| 3.9.e. FP is cost-effective. |
| 3.9.f. FP saves money in other public sectors. |
| 3.9.g. FP contributes to women's empowerment. |
| 3.9.h. FP contributes to slowing population growth. |
| 3.9.i. FP contributes to a reduction in stress on natural resources or alleviates effects of climate change. |

3.10. Other than those I listed above, are there any other arguments about the benefits of family planning that are important to you?

0 No

1 Yes

Please explain.

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

## *Section 4: Decision Making in Family Planning Policies and Budgets*

I would like to ask you some questions about what factors decisionmakers take into consideration when making policy choices about family planning.

4.7. Are there reasons that prevent decisionmakers from prioritizing family planning, even in cases where its benefits have been well demonstrated? Please explain, with examples, if possible.

______________________________________________________________________________
______________________________________________________________________________
________________________________________________________

4.1. Budget or policy decisions about family planning are based on a number of factors. Please group these potential factors as "most important," "somewhat important," and "least important" to decisionmakers. *(Have cards and pile sort—four in each category.)*

As you do so, please explain to me your thought processes.

| |
|---|
| 4.1.a. Evidence and data that estimate the possible impacts of policy options |
| 4.1.b. Public opinion about family planning |
| 4.1.c. Availability of human resources |
| 4.1.d. Costs of implementation |
| 4.1.e. Cost-effectiveness or value for money |
| 4.1.f. Concrete, programmatic solutions or options are proposed |
| 4.1.g. Demonstration of the impact of FP investment within 2−5 years |
| 4.1.h. Donor influence |
| 4.1.i. Personal experience with FP (of decisionmakers and people close to them) |
| 4.1.j.Potential impact on re-election |
| 4.1.k. Political priority of other members/sections of the government |
| 4.1.l. Cultural and religious factors |

4.2. Are there any other factors that influence decision making regarding family planning policies, programs, or resource allocation? If so, please describe these factors and why they are important to decisionmakers.

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________

D.5. We realize that there are competing priorities across health and other sectors, due to limited resources. How are resource allocation decisions made? (*Probe: Where does family planning fit in all of this? How are strategic plans decided upon?*)

4.4. What sources of information do decisionmakers use when making policy decisions about family planning issues?

4.5. Has your opinion about family planning changed in the course of your professional life? Have you observed other decisionmakers change their minds? If so, why?

0 No

1 Yes

4.6. Do you think that some decisionmakers' minds are already made up and advocacy messages don't affect their decisions about policy for family planning? Please explain.

4.8. What are specific reasons why decisionmakers may privately support family planning but choose not to do so in public?

Is there anything else you would like to add about what we have been talking about today?

Thank you for your time. Your responses are very useful. We will send you a copy of the report when it is complete.

## *Annex B.2 Interview Guide for Advocates used in Kenya and Ethiopia*

### *Study conducted by the HPP and AFIDEP Kenya and Ethiopia, 2012*

*Assessment of Advocates' Needs for Evidence to Support Family Planning*

*Informed Consent*

**Date of interview:**

**Start time:**

**Name of interviewee:**

**Name of organization:**

Hello. My name is ______________________________ and I work for the African Institute for Development Policy. Our institute is working with the Health Policy Project, which is funded by USAID. We work on issues of reproductive health policy. One topic we focus on is creating evidence about the costs, benefits, and impacts of family planning and other reproductive health interventions, especially for use in advocacy.

We are conducting a survey about how decisionmakers and other stakeholders view such evidence, and would appreciate your participation. *We will use this information to focus on the types of materials and evidence that are most important to key decisionmakers such as you.* The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.

Participation in this survey is voluntary and you can choose not to answer any individual question, or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey, since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____________________________________ Date:_____________________

**RESPONDENT AGREES TO BE INTERVIEWED**

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us to produce a detailed transcript of our conversation, since it is not possible for me to write down everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview, and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose and, if the answer is still NO, then continue with the interview, recording as much detail as possible, and type up the full transcript of the interview within 24 hours.

Signature of interviewee: ____________________________________ Date: _____________________

**RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED**

0 No

1 Yes

### *Section 1: Background*

1.1. [Interviewer, please note sex of respondent]

0 Male

1 Female

1.2 [Interviewer, please estimate age or ask respondent] *(circle one)*:

0 20−35

1 35−50

2 Over 50

1.3 What is the name of your organization and your position?

Organization name ____________________________________________________________

Position______________________________________________________________________

1.4. How many years have you been working in your current position?

_________ Years (*if less than 1, put< 1*)

1.5. How many years have you worked in this organization? Or other similar organizations/positions?

_________ Years (*if less than 1, put< 1*)

*Interviewer:* Throughout the interview, use these definitions to steer discussions, and if necessary explain what we mean by these terms.

*Decisionmakers* – High-level political and technical leaders with authority in decision making (PS, Ministers, MPs)

*Advocacy* − Targeted messages to decisionmakers with a view to inform their decisions. (Sometimes these messages are accompanied with specific demands or 'policy asks.')

That is, make a distinction between messages targeted to members of the public, rural communities, etc.

### *Section 2: Role in Family Planning Policy, Programming and Resource Allocation*

2.1. Could you briefly describe your role in the position of ________________ [or in a past position, if applicable], particularly with regard to family planning? *(Probe: Has your role in family planning been focused on meeting the country's health goals, development goals, or economic growth goals?)*

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.3. Could you please describe what you do to influence decision making in your current (*or former, if applicable*) position regarding:

2.3.a. Family planning policies, such as population policies, reproductive health policies, family planning policies, etc.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.3.b. Family planning programs

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.3.c. Resources for family planning programming *(Probe: includes budgets, commodities, human resources)*

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

[**FILTER**] IF THE RESPONDENT HAS NOTHING TO DO WITH FAMILY PLANNING, END THE INTERVIEW AND THANK HIM OR HER FOR THEIR TIME.

2.4. In your role as an advocate for FP policies, programs, or resources [*Modify, depending on responses to 2.3*], could you describe for me how you interact[ed] with others in the decision-making process? What I mean by that is interaction with [other] decisionmakers, civil society advocates, or donors. *(Probe: What was the approach taken toward family planning—was it to meet the country's health goals, development goals, or economic growth goals?)*

________________________________________________________________________

________________________________________________________________________

________________________________________________________

2.5. In your role as __________, have you observed any shifts in government support in the last few years for family planning and reproductive health?

0 No

1 Yes

Do you think family planning advocacy played a role in this? Please explain with examples, if possible.

________________________________________________________________________

________________________________________________________________________

________________________________________________________

## *Section 3: Advocacy Regarding Family Planning*

I would like to ask you some questions about advocacy related to family planning.

A.1. What kind of training have you received on advocacy (including on-the-job training)?

________________________________________________________________________

________________________________________________________________________

________________________________________________________

A.2. Has a decisionmaker ever requested information from you or your organization to support a family planning policy or program decision?

0 No

1 Yes

### Sub-Section: Context

A.3. Which government positions or officers or individual decisionmakers do you target in your family planning advocacy activities? How do you decide who your target audience is?

________________________________________________________________________

________________________________________________________________________

________________________________________________________

3.1. In what contexts does your organization typically present advocacy messages? *(Examples: a large meeting or conference, a small meeting, a meeting in decisionmakers' offices, or in some other venue)*

______________________________________________________________________
______________________________________________________________________
____________________________________________________

3.2. Who presented the advocacy messages about family planning? How and why was it decided that this person [people] should be the presenter or messenger?

______________________________________________________________________
______________________________________________________________________
____________________________________________________

3.3.a. Are some people, groups, or institutions more credible or more appropriate than others in advocating for family planning in [note country]?

0 No

1 Yes

Please explain.

______________________________________________________________________
______________________________________________________________________
____________________________________________________

3.3.b. Is it important to have national actors involved?

*Probe: Examples of national actors include parliamentarians, colleagues, local organizations, academic/research institutions, voters, heads of a political party; examples of international institutions include international organizations, donors, academic/research institutions*

0 No

1 Yes

Please explain.

______________________________________________________________________
______________________________________________________________________
____________________________________________________

A.4. Do you think the funders of your advocacy work affect your approach? If so, how?

0 No

1 Yes

______________________________________________________________________
______________________________________________________________________
____________________________________________________

**Sub-Section: Format**

3.4. In what format[s] do you present advocacy materials? *[Circle all that are mentioned.]*

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other ____________________________________________________________

Combination of the above (specify): ______________________________________

88 Don't know

99 No response

A.5. Why do you present materials in this [these] format[s]?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.5. There are often one of two approaches to advocacy efforts:

(1) A presentation with a lot of facts and graphics about the benefits of FP, and one or two brief vignettes or stories to put a human face to the numbers; or

2) A presentation that focuses on how family planning has impacted one woman or one family, with a few facts and graphics.

According to your experience, which do you think has the greater impact on decisionmakers' support and actions for family planning? Please explain.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

On a scale of 1 to 5, with 1 being "*strongly disagree*" and 5 being "*strongly agree*," please respond to the following statements:

| | **Strongly disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly agree** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|---|
| 3.5.d. It is important to provide sustained information over time to decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.e. Decisionmakers find it helpful to receive comparative information about other countries in the region (*for example: indicators, policies, financing*). | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

**Sub-Section: Content**

3.6. What specific benefits of family planning do your advocacy messages mention? *(For example: Does your advocacy focus on health benefits, economic benefits, environmental benefits, women's rights/empowerment, or something else?)*

A.6. Who generates the evidence used in your advocacy materials?

0 My own organization

1 We use evidence produced by others. → If so, who? *(For example: local universities, international organizations, online sources, etc.)*

2 Both

3.7. How convinced are decisionmakers by the evidence on the benefits of family planning that you present? How does this vary depending on the audience?

*Probe: Was the evidence you presented about the role of family planning in meeting the country's health goals, development goals, or economic growth goals?*

3.8. Do your family planning messages advocate for specific and concrete actions? *(For example: "increase the reproductive health budget by 10%" or "expand reproductive health programs to remote areas" or "include family planning goals in national health plan" or "create/modify a national population policy" or "include family planning in the national health insurance schema" or "make more contraceptive methods available.")*

0 No

1 Yes

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

A.7. How do you ensure that your advocacy messages are relevant to your target audience? (If necessary, explain: By "relevant," I mean two characteristics: (1) that the messages address topics relevant to that person's or institution's professional concerns, and (2) that the messages correspond to the decision-making power that person or institution has.)

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.9. In our advocacy efforts, we realize that we can't present all of the evidence for family planning. Of these nine potential advocacy messages, please group them into what decisionmakers find "*most convincing*," "*somewhat convincing*," and "*least convincing*." (*Have cards and pile sort—three in each category.*)

| |
|---|
| 3.9.a. FP improves maternal health. |
| 3.9.b. FP improves child health. |
| 3.9.c. FP improves family welfare. |
| 3.9.d. FP contributes to national economic growth. |
| 3.9.e. FP is cost-effective. |
| 3.9.f. FP saves money in other public sectors. |
| 3.9.g. FP contributes to women's empowerment. |
| 3.9.h. FP contributes to slowing population growth. |
| 3.9.i. FP contributes to a reduction in stress on natural resources or alleviates effects of climate change. |

3.10. Other than those I listed above, are there any other arguments about the benefits of family planning that are important to decisionmakers? Why?

**Sub-section: Creating Evidence for FP Advocacy**

A.9. What evidence would you like to have that is not available today? How would you use it and with whom?

A.10. What obstacles do you encounter in finding the evidence about family planning that you would like to have?

A.11. Have you received any training on how to synthesize or use existing evidence? Please describe.

A.12. What models or tools have you used to present evidence on family planning benefits? *(For example: Reality Check, Spectrum/FamPlan, DHS StatCompiler, RAPID, ENGAGE, GAP, Adding it Up, etc.)*

A.13. Have you received any training on these tools?

0 No

1 Yes

If so, which one[s]? How useful did you find the trainings?

A.14. What do you find most helpful about these tools?

A.15. What obstacles have you encountered in using these tools or interpreting their outputs?

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________

A.16. What advice would you give to someone creating a new tool designed to generate support for family planning by decisionmakers?

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________

### *Section 4: Decision Making in Family Planning Policies and Budgets*

I would like to ask you some questions about what factors decisionmakers take into consideration when making policy choices about family planning.

4.7. Are there reasons that prevent decisionmakers from prioritizing family planning, even in cases where its benefits have been well demonstrated? Please explain with examples, if possible.

________________________________________________________________________________
________________________________________________________________________________
____________________________________________________________

4.1. Budget or policy decisions about family planning are based on a number of factors. Please group these potential factors as "*most important*," "*somewhat important*," and "least important" to decisionmakers. (*Have cards and pile sort—four in each category.)*

As you do so, please explain to me your thought processes.

| |
|---|
| 4.1.a. Evidence and data that estimate the possible impacts of policy options |
| 4.1.b. Public opinion about family planning |
| 4.1.c. Availability of human resources |
| 4.1.d. Costs of implementation |
| 4.1.e. Cost-effectiveness or value for money |
| 4.1.f. Concrete, programmatic solutions or options are proposed |
| 4.1.g. Demonstration of the impact of FP investment within 2−5 years |
| 4.1.h. Donor influence |
| 4.1.i. Personal experience with FP (of decisionmakers and people close to them) |
| 4.1.j. Potential impact on re-election |
| 4.1.k. Political priority of other members/sections of the government |
| 4.1.l. Cultural and religious factors |

4.2. Are there any other factors that influence decision making regarding family planning policies, programs, or resource allocation? If so, please describe these factors and why they are important to decisionmakers.

________________________________________________________________________________
________________________________________________________________________________
______________________________________________________________

4.4. What sources of information do decisionmakers use to make policy decisions about family planning?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.5. Have you ever observed decisionmakers change their minds about family planning in the course of their professional lives? If so, what happened?

0 No

1 Yes

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.6. Do you think that some decisionmakers' minds are already made up and advocacy messages don't affect their decisions about policy for family planning? Please explain.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.8. What are specific reasons why decisionmakers may privately support family planning but choose not to do so in public?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

Is there anything else you would like to add about what we have been talking about today?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

Thank you for your time. Your responses are very useful. We will send you a copy of the report when it is complete.

## *Annex B.3 Interview Guide for Decisionmakers Used in Malawi*

### *Study conducted by the HPP and AFIDEP Malawi, 2012*

*Assessment of Decisionmakers' Needs for Evidence to Facilitate Family Planning Advocacy*

### *Informed Consent*

**Date of interview:**

**Start time:**

**Name of interviewee:**

**Name of organization:**

Hello. My name is ______________________________ and I work for the African Institute for Development Policy. Our institute is working with the Health Policy Project, which is funded by USAID. We work on issues of reproductive health policy. One topic we focus on is creating evidence about the costs, benefits, and impacts of family planning and other reproductive health interventions, especially for use in advocacy.

We are conducting a survey about how decisionmakers and other stakeholders view such evidence, and would appreciate your participation. We will use this information to focus on the types of materials and evidence that are most important to key decisionmakers such as you. The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.

Participation in this survey is voluntary, and you can choose not to answer any individual question, or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey, since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____________________________________ Date: _____________________

**RESPONDENT AGREES TO BE INTERVIEWED**

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us to produce a detailed transcript of our conversation, since it is not possible for me to write down everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview, and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose, and if the answer is still NO, then continue with the interview, recording as much detail as possible, and type up the full transcript of the interview within 24 hours.

Signature of interviewee: ___________________________________ Date:____________________

**RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED**

0 No

1 Yes

### *Section 1: Background*

1.1. [Interviewer, please note sex of respondent]

0 Male

1 Female

1.2 [Interviewer, please estimate age or ask of respondent] *(circle one)*:

0 20−35

1 35−50

2 Over 50

1.3 What is the name of your organization/ministry and your position?

Organization/ministry name ____________________________________________________________

Position_______________________________________________________________________________

1.4. How many years have you been working in your current position?

__________ Years *(if less than 1, put< 1)*

1.5. How many years have you worked in this organization? Or other similar organizations/positions?

__________ Years *(if less than 1, put< 1)*

### *Section 2: Role in Family Planning Policy, Programming, and Resource Allocation*

2.1. Could you briefly describe your role in the position of ________________ [*or in a past position, if applicable*], particularly with regard to family planning?

______________________________________________________________________
______________________________________________________________________
____________________________________________________

2.2. What is your opinion about the role of family planning in meeting the country's health goals, development goals, and economic growth goals?

______________________________________________________________________
______________________________________________________________________
____________________________________________________

D.1. What does "increasing support of FP" mean in the context of your job?

______________________________________________________________________
______________________________________________________________________
____________________________________________________

2.3. Could you please describe your decision-making authority or role in your current [*or "former," if applicable*] position regarding:

2.3.a. Family planning policies, such as population policies, reproductive health policies, family planning policies, etc.

______________________________________________________________________
______________________________________________________________________
____________________________________________________

2.3.b. Family planning programs

______________________________________________________________________
______________________________________________________________________
____________________________________________________

2.3.c. Resources for family planning programming (probe: includes budgets, commodities, human resources)

______________________________________________________________________
______________________________________________________________________
____________________________________________________

[**FILTER**] IF THE RESPONDENT HAS NOTHING TO DO WITH FAMILY PLANNING, END THE INTERVIEW AND THANK HIM OR HER FOR THEIR TIME.

2.4. In your role as decisionmaker regarding FP policies, programs, or resources [*Modify, depending on responses to 2.3*], could you describe for me how you interact[ed] with others in the decision-making process? What I mean by that is interaction with [other] decisionmakers, civil society advocates, or donors.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.5. In your role as __________, have you supported changes in the last few years to promote family planning and reproductive health?

0 No

1 Yes

If so, what were they, what do you think caused them, and who played what role to achieve them? *(Examples: specific changes in FP or population policies; FP program design; role of civil society, including the media; etc.)*

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

## *Section 3: Advocacy Regarding Family Planning*

I would like to ask you some questions about advocacy related to family planning.

**Sub-Section: Context**

D.2. Have you received written materials or seen presentations or messages that advocate for or against family planning?

0 No *(If no, please skip to 3.5)*

1 Yes

3.1. If yes, what was the context where you saw these advocacy messages?*(Examples: a large meeting or conference, a small meeting, a meeting with you in your office, or in some other venue)*

*Skip question if interviewee has not been exposed to family planning advocacy.*

____________________________________________________________________________

____________________________________________________________________________

______________________________________________________________

3.2. Who presented the advocacy about family planning? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

____________________________________________________________________________

____________________________________________________________________________

_____________________________________________________________

3.3.a. Are some people, groups, or institutions more credible or more appropriate than others in advocating for family planning in [note country]? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

0 No

1 Yes

Please explain.

____________________________________________________________________________

____________________________________________________________________________

_________________________________________________________

3.3.b. Is it important to have national experts involved? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

*Probe: Examples of national actors include parliamentarians, colleagues, local organizations, academic/research institutions, voters, heads a of political party; examples of international institutions include international organizations, donors, academic/research institutions*

0 No

1 Yes

Please explain.

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________

**Sub-Section: Format**

3.4. In what format were the advocacy materials that you have seen/been presented? *[Circle all that are mentioned.]*

*Skip question if interviewee has not been exposed to family planning advocacy.*

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other ____________________________________________________________

Combination of the above (specify): ______________________________________

Don’t know

No response

D.3. What do you think is the best format for presenting these messages? *[Circle all that are mentioned.]*

*Skip question if interviewee has not been exposed to family planning advocacy.*

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other ________________________________________________________________

Combination of the above (specify): ________________________________________

Don't know

No response

3.5. On a scale of 1 to 5, with 1 being "strongly disagree" and 5 being "strongly agree", please respond to the following statements.

| | **Strongly disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly agree** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|---|
| 3.5.a. Numerical (quantitative) evidence is best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.b. Narrative or personal stories are best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.c. A combination of numerical (quantitative) and narrative or personal stories is best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.d. It is important to provide sustained information over time to decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.e. Decisionmakers find it helpful to receive comparative information about other countries in the region (*for example: indicators, policies, financing*). | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

**Sub-Section: Content**

3.6. What specific benefits of family planning did the advocacy messages you've seen mention? *(For example: Did the advocacy focus on health benefits, economic benefits, environmental benefits, women's rights/empowerment, or something else?)*

If applicable:

What evidence opposed to family planning did these messages mention? *(For example: Did the advocacy focus on economic growth and population, family planning as a Western agenda, religion or traditional values, or something else?)*

*Skip question if interviewee has not been exposed to family planning advocacy.*

__________________________________________________________________________

3.7. Are you convinced by the evidence on the benefits of family planning that has been presented to you? Why or why not? *(Skip question if interviewee has not been exposed to family planning advocacy.)*

0 No

1 Yes

__________________________________________________________________________

3.8. Did the family planning messages you have seen advocate for specific and concrete actions? *(For example: "increase the reproductive health budget by 10%" or "expand reproductive health programs to remote areas" or "include family planning goals in national health plan" or "create/modify a national population policy" or "include family planning in the national health insurance schema" or "make more contraceptive methods available.")*

0 No

1 Yes

__________________________________________________________________________

D.4. Have the advocacy messages you have heard been relevant to your professional concerns and goals? Please explain.

__________________________________________________________________________

3.9. How important is evidence about the following arguments to decisionmakers when they make policy or budget decisions?

| Argument | Not at all important | Not very important | Neutral | Somewhat important | Very important | Don't know | No response |
|---|---|---|---|---|---|---|---|
| 3.9.a. FP improves maternal health. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.b. FP improves child health. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.c. FP improves family welfare. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.d. FP contributes to national economic growth. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.e. FP is cost-effective. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.f. FP saves money in other public sectors. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.g. FP contributes to women's empowerment. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.h. FP contributes to slowing population growth. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.i. FP contributes to a reduction in stress on natural resources. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.9.j. FP helps to alleviate the effects of climate change. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

3.10. Other than those I listed above, are there any other arguments about the benefits of family planning that are important to you?

0 No

1 Yes

Please explain.

______________________________________________________________________________

______________________________________________________________________________

____________________________________________________________

### *Section 4: Decision Making in Family Planning Policies and Budgets*

I would like to ask you some questions about what factors decisionmakers take into consideration when making policy choices about family planning.

4.1. On a scale of 1 to 5, with 1 being "*not at all important*" and 5 being "*very important*," please tell me how important the following factors are to decisionmakers when thinking about family planning policies and budgets:

| | Not at all important | Not very important | Neutral | Somewhat important | Very important | Don't know | No response |
|---|---|---|---|---|---|---|---|
| 4.1.a. Evidence and data that estimate the possible impacts of policy options | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.b. Public opinion about family planning | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.c. Availability of human resources | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.d. Cost of implementation | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.e. Value for money or cost-effectiveness | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.f. Concrete, programmatic solutions or options are proposed | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.g. The ability to demonstrate the impact of FP investment within a short timeframe (2–5 years), in addition to longer term | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.h. Donor influence | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.i. Personal experience with FP (of decisionmakers and people close to them) | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.j. Potential impact on re-election | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.k. Political priority of other members/sections of the government | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

4.2. Are there any other factors that influence decision making regarding family planning policies, programs, or resource allocation? If so, please describe these factors and why they are important to decisionmakers.

__________________________________________________________________________________________

__________________________________________________________________________________________

____________________________________________________________________

4.3. How quickly do decisionmakers like to demonstrate the impacts of family planning on the following topics?

| | **Less than 1 year** | **1–5 years** | **6–10 years** | **More than 10 years** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|
| 4.3.a. The social and economic development of country | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.3.b. Improvement in maternal health indicators | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.c. Improvement in child health indicators | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.d. Fertility change | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.e. Population growth | 1 | 2 | 3 | 4 | 88 | 99 |

4.4. What sources of information do decisionmakers use when making policy decisions about family planning
issues?__________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________

4.5. Has your opinion about family planning changed in the course of your professional life? Have you observed other decisionmakers change their minds? If so, why?

0 No

1 Yes

__________________________________________________________________________________________

__________________________________________________________________________________________

____________________________________________________________________

4.6. Do you think that some decisionmakers' minds are already made up and advocacy messages don't affect their decisions about policy for family planning? Please explain.

__________________________________________________________________________________________

__________________________________________________________________________________________

____________________________________________________________________

4.7. Are there reasons that prevent decisionmakers from prioritizing family planning, even in cases where its benefits are well demonstrated? Please explain with examples, if possible.

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________

4.8. What are specific reasons why decisionmakers may privately support family planning but choose not to do so in public?

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________

Is there anything else you would like to add about what we have been talking about today?

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________

Thank you for your time. Your responses are very useful. We will send you a copy of the report when it is complete.

## *Annex B.4 Interview Guide Used for Advocates in Malawi*

### *Study conducted by the HPP and AFIDEP Malawi, 2012*

*Assessment of Advocates' Needs for Evidence to Support Family Planning*

*Informed Consent*

**Date of interview:**

**Start time:**

**Name of interviewee:**

**Name of organization:**

Hello. My name is ______________________________ and I work for the African Institute for Development Policy. Our institute is working with the Health Policy Project, which is funded by USAID. We work on issues of reproductive health policy. One topic we focus on is creating evidence about the costs, benefits, and impacts of family planning and other reproductive health interventions, especially for use in advocacy.

We are conducting a survey about how decisionmakers and other stakeholders view such evidence, and would appreciate your participation. We will use this information to focus on the types of materials and evidence that are most important to key decisionmakers such as you. The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.

Participation in this survey is voluntary and you can choose not to answer any individual question, or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey, since your views are important.

Will you participate in this survey?

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____________________________________ Date:_____________________

**RESPONDENT AGREES TO BE INTERVIEWED**

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us to produce a detailed transcript of our conversation, since it is not possible for me to write down everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose, and if the answer is still NO, then continue with the interview, recording as much detail as possible, and type up the full transcript of the interview within 24 hours.

Signature of interviewee: ____________________________________ Date: _____________________

**RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED**

0 No

1 Yes

*Section 1: Background*

1.1. [Interviewer, please note sex of respondent]

0 Male

1 Female

1.2 [Interviewer, please estimate age or ask respondent] *(circle one)*:

0 20−35

1 35−50

2 Over 50

1.3 What is the name of your organization and your position?

Organization name ____________________________________________________________

Position______________________________________________________________________

1.4. How many years have you been working in your current position?

_________ Years *(if less than 1, put < 1)*

1.5. How many years have you worked in this organization? Or other similar organizations/positions?

_________ Years *(if less than 1, put < 1)*

### *Section 2: Role in Family Planning Policy, Programming, and Resource Allocation*

2.1. Could you briefly describe your role in the position of ________________ [*or in a past position, if applicable*], particularly with regard to family planning?

______________________________________________________________________
______________________________________________________________________
__________________________________________________

2.2. In your opinion, do decisionmakers in this country regard family planning as contributing to the country's health goals, development goals, or economic growth goals? Please explain.

______________________________________________________________________
______________________________________________________________________
__________________________________________________

2.3. Could you please describe what you do to influence decision making in your current (*or former, if applicable*) position regarding:

2.3.a. Family planning policies, such as population policies, reproductive health policies, family planning policies, etc.

______________________________________________________________________
______________________________________________________________________
__________________________________________________

2.3.b. Family planning programs

______________________________________________________________________
______________________________________________________________________
__________________________________________________

2.3.c. Resources for family planning programming (probe: includes budgets, commodities, human resources)

______________________________________________________________________
______________________________________________________________________
__________________________________________________

[**FILTER**] IF THE RESPONDENT HAS NOTHING TO DO WITH FAMILY PLANNING, END THE INTERVIEW AND THANK HIM OR HER FOR THEIR TIME.

2.4. In your role as an advocate for FP policies, programs, or resources [*Modify, depending on responses to 2.3*], could you describe for me how you interact[ed] with others in the decision-making process? What I mean by that is interaction with [other] decisionmakers, civil society advocates, or donors.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

2.5. In your role as __________, have you observed any shifts in government support in the last few years for family planning and reproductive health?

0 No

1 Yes

If so, what were they, what do you think caused them, and who played what role to achieve them? *(Examples: specific changes in FP or population policies; FP program design; role of civil society, including the media; etc.)*

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

*Section 3: Advocacy Regarding Family Planning*

I would like to ask you some questions about advocacy related to family planning.

A.1. What kind of training have you received on advocacy (including on-the-job training)?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

A.2. Has a decisionmaker ever requested information from you or your organization to support a family planning policy or program decision?

0 No

1 Yes

**Sub-Section: Context**

A.3. Which government positions or officers or individual decisionmakers do you target in your family planning advocacy activities? How do you decide who your target audience is?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.1. In what contexts does your organization typically present advocacy messages? *(Examples: a large meeting or conference, a small meeting, a meeting in decisionmakers' offices, or in some other venue)*

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.2. Who presented the advocacy messages about family planning? How and why was it decided that this person [people] should be the presenter or messenger?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.3.a. Are some people, groups, or institutions more credible or more appropriate than others in advocating for family planning in [note country]?

0 No

1 Yes

Please explain.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

3.3.b. Is it important to have national experts involved?

*Probe: Examples of national actors include parliamentarians, colleagues, local organizations, academic/research institutions, voters, heads of a political party; examples of international institutions include international organizations, donors, academic/research institutions*

0 No

1 Yes

Please explain.

______________________________________________________________________
______________________________________________________________________
_____________________________________________________

A.4. Do you think the funders of your advocacy work affect your approach? If so, how?

0 No

1 Yes

______________________________________________________________________
______________________________________________________________________
_____________________________________________________

**Sub-Section: Format**

3.4. In what format[s] do you present advocacy materials? *[Circle all that are mentioned.]*

Orally, without written materials

PowerPoint presentation

Written policy brief

Detailed report

Video

Website

Narrative story of individual women or families, or personal testimony

Other _______________________________________________________

Combination of the above (specify): _________________________________

Don’t know

No response

A.5. Why do you present materials in this [these] format[s]?

______________________________________________________________________
______________________________________________________________________
_____________________________________________________

3.5. On a scale of 1 to 5, with 1 being "*strongly disagree*" and 5 being "*strongly agree*," please respond to the following statements:

| | **Strongly disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly agree** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|---|
| 3.5.a. Numerical (quantitative) evidence is best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.b. Narrative or personal stories are best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.c. A combination of numerical (quantitative) and narrative or personal stories is best for persuading decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.d. It is important to provide sustained information over time to decisionmakers. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.5.e. Decisionmakers find it helpful to receive comparative information about other countries in the region (*for example: indicators, policies, financing*). | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

**Sub-Section: Content**

3.6. What specific benefits of family planning do your advocacy messages mention? *(For example: Does your advocacy focus on health benefits, economic benefits, environmental benefits, women's rights/empowerment, or something else?)*

______________________________________________________________________
______________________________________________________________________
____________________________________________________

A.6. Who generates the evidence used in your advocacy materials?

0 My own organization

1 We use evidence produced by others. → if so, who? *(For example: local universities, international organizations, online sources, etc.)*

2 Both

______________________________________________________________________
______________________________________________________________________
____________________________________________________

3.7. How convinced are decisionmakers by the evidence on the benefits of family planning that you present? How does it vary depending on the audience?

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________

3.8. Do your family planning messages advocate for specific and concrete actions? *(For example: "increase the reproductive health budget by 10%" or "expand reproductive health programs to remote areas" or "include family planning goals in national health plan" or "create/modify a national population policy" or "include family planning in the national health insurance schema" or "make more contraceptive methods available.")*

0 No

1 Yes

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________

A.7. How do you ensure that your advocacy messages are relevant to your target audience? (If necessary, you can explain: By "relevant," I mean two characteristics: (1) that the messages address topics relevant to that person's or institution's professional concerns, and (2) that the messages correspond to the decision-making power that person or institution has.)

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________

3.9. How important is evidence about the following arguments to decisionmakers when they make policy or budget decisions?

| Argument | Not at all important | Not very important | Neutral | Somewhat important | Very important | Don't know | No response |
|---|---|---|---|---|---|---|---|
| 3.13.a. FP improves maternal health. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.b. FP improves child health. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.c. FP improves family welfare. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.d. FP contributes to national economic growth. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.e.FP is cost-effective. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.f. FP saves money in other public sectors. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.g. FP contributes to women's empowerment. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.h. FP contributes to slowing population growth. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.i. FP contributes to a reduction in stress on natural resources. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 3.13.j. FP helps to alleviate the effects of climate change. | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

3.10. Other than those I listed above, are there any other arguments about the benefits of family planning that are important to decisionmakers? Why?

______________________________________________________________________
______________________________________________________________________
________________________________________________________

**Sub-section: Creating Evidence for FP Advocacy**

A.9. What evidence would you like to have that is not available today? How would you use it, and with whom?

______________________________________________________________________
______________________________________________________________________
________________________________________________________

A.10. What obstacles do you encounter in finding evidence about family planning that you would like to have?

A.11. Have you received any training on how to synthesize or use existing evidence? Please describe.

A.12. What models or tools have you used to present evidence on family planning benefits? *(For example: Reality Check, Spectrum/FamPlan, DHS StatCompiler, RAPID, ENGAGE, GAP, Adding it Up, etc.)*

A.13. Have you received any training on these tools?

0 No

1 Yes

If so, which one[s]? How useful did you find the trainings?

A.14. What do you find most helpful about these tools?

A.15. What obstacles have you encountered in using these tools or interpreting their outputs?

A.16. What advice would you give to someone who is creating a new tool designed to generate support for family planning by decisionmakers?

## *Section 4: Decision Making in Family Planning Policies and Budgets*

I would like to ask you some questions about what factors decisionmakers take into consideration when making policy choices about family planning.

4.1. On a scale of 1 to 5, with 1 being "*not at all important*" and 5 being "*very important*," please tell me how important the following factors are to decisionmakers when thinking about family planning policies and budgets:

| | **Not at all important** | **Not very important** | **Neutral** | **Somewhat important** | **Very important** | **Don't know** | **No response** |
|---|---|---|---|---|---|---|---|
| 4.1.a. Evidence and data that estimate the possible impacts of policy options | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.b. Public opinion about family planning | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.c. Availability of human resources | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.d. Cost of implementation | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.e. Value for money or cost effectiveness | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.f. Concrete, programmatic solutions or options are proposed | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.g. The ability to demonstrate the impact of FP investment within a short timeframe (2–5 years), in addition to longer term | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.h. Donor influence | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.i. Personal experience with FP (of decisionmakers and people close to them) | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.j. Potential impact on re-election | 1 | 2 | 3 | 4 | 5 | 88 | 99 |
| 4.1.k. Political priority of other members/sections of the government | 1 | 2 | 3 | 4 | 5 | 88 | 99 |

4.2. Are there any other factors that influence decision making regarding family planning policies, programs, or resource allocation? If so, please describe these factors and why they are important to decisionmakers.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.3. How quickly do decisionmakers like to demonstrate the impacts of family planning on the following topics?

| | Less than 1 year | 1–5 years | 6–10 years | More than10 years | Don't know | No response |
|---|---|---|---|---|---|---|
| 4.3.a. The social and economic development of this country | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.3.b. Improvement in maternal health indicators | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.c. Improvement in child health indicators | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.d. Fertility change | 1 | 2 | 3 | 4 | 88 | 99 |
| 4.4.e. Population growth | 1 | 2 | 3 | 4 | 88 | 99 |

4.4. What sources of information do decisionmakers use to make policy decisions about family planning?

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.5. Have you ever observed decisionmakers change their minds about family planning in the course of their professional lives? If so, what happened?

0 No

1 Yes

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.6. Do you think that some decisionmakers' minds are already made up and advocacy messages don't affect their decisions about policy for family planning? Please explain.

______________________________________________________________________________
______________________________________________________________________________
____________________________________________________________

4.7. Are there reasons that prevent decisionmakers from prioritizing family planning, even in cases where its benefits are well demonstrated? Please explain with examples, if possible.

______________________________________________________________________________
______________________________________________________________________________
________________________________________________________

4.8. What are specific reasons why decisionmakers may privately support family planning but choose not to do so in public?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________

Is there anything else you would like to add about what we have been talking about today?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________

Thank you for your time. Your responses are very useful. We will send you a copy of the report when it is complete.

# ANNEX C: CARD-SORTING QUESTIONS

### *Description of process*

Two questions required key informants to hierarchically rank their responses.

Question 3.1 required respondents to group nine advocacy messages into three groups at the level at which they perceived decisionmakers to find these messages convincing. Cards with advocacy messages were arranged into a 3x3 matrix response sheet under the headings: "most convincing," "somewhat convincing," and "least convincing." Respondents were encouraged to talk through the rationale as they undertook the exercise. The advocacy messages and response sheet are presented below.

*Response sheet*

| | **Most Convincing** | **Somewhat Convincing** | **Least Convincing** |
|---|---|---|---|
| **FP improves maternal health.** | | | |
| **FP improves child health.** | | | |
| **FP improves family welfare.** | | | |
| **FP contributes to national economic growth.** | | | |
| **FP is cost-effective.** | | | |
| **FP saves money in other public sectors.** | | | |
| **FP contributes to women's empowerment.** | | | |
| **FP contributes to slowing population growth.** | | | |
| **FP contributes to a reduction in stress on natural resources or alleviates effects of climate change.** | | | |

# REFERENCES

African Institute for Development Policy (AFIDEP). 2013. *Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa: Case Studies from Eastern and Southern Africa*. Nairobi, Kenya: AFIDEP.

Aaserud M., S. Lewin, S. Innvaer, E. Paulsen, A. Dahlgren, M. Trommald, L. Duley, M. Zwarenstein, and A. Oxman. 2005. "Translating Research into Policy and Practice in Developing Countries: A Case Study of Magnesium Sulphate for Pre-eclampsia." *BMC Health Services Research* 5(68).

Albert M., A. Fretheim, and D. Maiga. 2007. "Factors Influencing the Utilization of Research Findings by Health Policy-makers in a Developing Country: The Selection of Mali's Essential Medicines." *BMC Health Research Policy and Systems* 5(2).

Bowen, S., and A.B. Zwi. 2005."Pathways to 'Evidence-Informed' Policy and Practice: A Framework for Action." *PLoS Medicine* 2(7): 600−605.

Habumuremyi, P., and M. Zenawi. 2012. "Making Family Planning a National Development Priority." *The Lancet* 380(9837): 78−80.

Haines A., S. Kuruvilla, and M. Borchert. 2004. "Bridging the Implementation Gap between Knowledge and Action for Health." *Bulletin of the World Health Organization* 82: 724−31.

Hennik, M. and R. Stephenson. 2005. "Using Research to Inform Health Policy: Barriers and Strategies in Developing Countries." *Journal of Health Communication* 10: 163−180

Hunsmann, M. 2012. "Limits to Evidence-Based Health Policymaking: Policy Hurdles to Structural HIV Prevention in Tanzania." *Social Science and Medicine* 74(10): 1477−85

Hyder A., G. Bloom, M. Leach, S. Syed, D. Peters, and Future Health Systems: Innovations for Equity. 2007. "Exploring Health Systems Research and Its Influence on Policy Processes in Low Income Countries." *BMC Public Health* 7(309).

Hyder, A., A. Corluka, P. Winch, A. El-Shinnawy, H. Ghassany, H. Malekafzali, M. Lin, J. Mfutso-Bengo, E. Segura, and A. Ghaffar. 2010. "National Policy-makers Speak Out: Are Researchers Giving Them What They Need?" *Health Policy and Planning* 26: 73−82.

Innvaer, S., G. Vist, M. Trommald, and A. Oxman. 2002. "Health Policy-makers' Perceptions of their Own Use of Evidence: A Systematic Review." *Journal of Health Services Research & Policy* 7(4): 239−244.

Lavis, J., F. Becerra Posada, A. Haines, and E. Osei. 2004. "Use of Research to Inform Public Policymaking." *The Lancet* 364: 1615−21.

Orton, L., F. Lloyd-Williams, D. Taylor-Robinson, M. O'Flaherty, S. Capewell. 2011. "The Use of Research Evidence in Public Health Decision Making Processes: Systematic Review." *PLoS ONE* 6(7): e21704.

Overseas Development Institute. 2009. "Key issues surrounding EBP." Pp. 2−3 in *A Toolkit for Progressive Policymakers in Developing Countries*. Retrieved December 17, 2013 from: http://www.odi.org.uk/rapid/projects/PPA0117/issues.html.

Petticrew, M., M. Whitehead, S. Macintyre, H. Graham, and M. Egan. 2004. “Evidence for Public Health Policy on Inequalities: 1: The Reality According to Policymakers.” *Journal of Epidemiology and Community Health* 58: 811−816.

Trostle J., M. Bronfman, and A. Langer. 1999. “How Do Researchers Influence Decision-makers? Case Studies of Mexican Policies.” *Health Policy and Planning* 14: 103−14

Whitehead, M., M. Petticrew, H. Graham, S. Macintyre, C. Bambra, and M. Egan. 2004. “Evidence for Public Health Policy on Inequalities: 2: Assembling the Evidence Jigsaw.” *Journal of Epidemiology and Community Health* 58: 817−821.

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