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Health Budget Advocacy

A Guide for Civil Society in Malawi

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Cover photo courtesy of SSDI-Communication Project.

Contents

Abbreviations

AIDS	acquired immunodeficiency syndrome
BCC	behaviour change communication
CSO	civil society organisation
DHC	District Health Committee
DHMT	District Health Management Team
DHO	district health officer
DIP	District Implementation Plan
DNHA	Department of HIV/AIDS and Nutrition
FP	family planning
FPAM	Family Planning Association of Malawi
GRB	gender-responsive budgeting
HIV	human immunodeficiency virus
HPP	Health Policy Project
HREP	Health and Rights Education Programme
HSSP	Health Sector Strategic Plan
IFMIS	Integrated Financial Management Information System
IMF	International Monetary Fund
M&E	monitoring and evaluation
MGDS	Malawi Growth and Development Strategy
MHEN	Malawi Health Equity Network
MoFEPD	Ministry of Finance, Economic Planning and Development
MOH	Ministry of Health
MP	member of parliament
MTEF	mid-term expenditure framework
MTR	mid-term review
NGO	nongovernmental organisation
NLGFC	National Local Government Finance Committee
OBB	Output-Based Budget
OPC	Office of President and Cabinet
ORT	other recurrent transactions
PETS	public expenditure tracking survey
PPD-ARO	Population and Development Africa Regional Office
SDSS	Service Delivery Satisfaction Survey
SWAp	Sector-Wide Approach
UN	United Nations
UNICEF	United Nations International Emergency Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organisation

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The Health Policy Project and its civil society partners welcome the spirit of openness and collaboration demonstrated by government partners during the drafting process. We hope this will serve as the foundation for ongoing collaboration between the government and civil society organisations engaged in health budget advocacy.

1. Bujari, P. and E. McGinn. 2013. *Influencing Government Health Budgets in Tanzania: A Guide for Civil Society*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 5.

1 Introduction

This guide is intended to inform civil society organisations (CSOs) in Malawi on health budget advocacy, serving as an introduction and easy reference guide. The guide describes how health budgets are developed in Malawi at both the national and district levels, and suggests entry points through which advocates can seek to influence government health budgets.

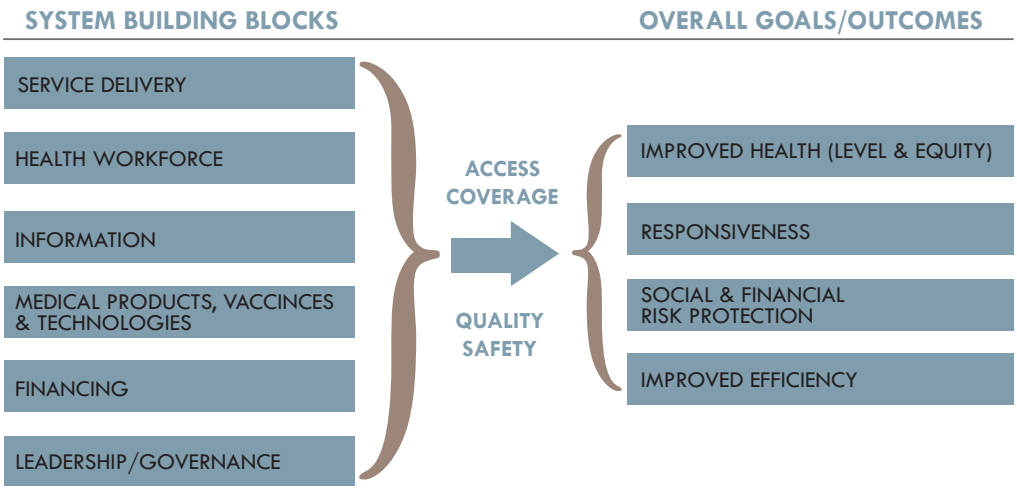
Before we discuss influencing government health budgets, it's important to position this conversation within the broader picture of health and development, health systems, and health financing.

1.1 Health Systems and Government Health Budgets

Strong health systems are essential to achieving health and development goals. The health system "consists of all organisations, people and actions whose *primary intent* is to promote, restore, or maintain health."[2] The primary goal of a health system is to improve health—both overall health and health *equity*[3] —and to do so "in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources." [4]

Health systems are composed of six "building blocks": (1) service delivery; (2) health workforce; (3) information; (4) medical products, vaccines, and technologies; (5) financing; and (6) leadership/ governance.[5] These components interact to impact the health system's overall goals and outcomes.

Figure 1. Building Blocks Framework



As seen in the building blocks framework, health financing is an important factor affecting the strength of health systems. Unfortunately, global resources are limited, so we must make the best use of available resources even as we continue to generate additional resources for health.

This booklet will focus on *government health budgets*, which are a crucial piece of the health financing system, reflecting the government's commitment to safeguarding health and affecting the strength and sustainability of the health system. In 2001, the heads of 89 countries (including Malawi) signed the

Abuja Declaration, pledging to allocate at least 15 per cent of their governments' annual budgets to improving health. [6]

Increasing government funding for health and ensuring that these funds are allocated and used effectively, equitably, and efficiently is key to reaching Malawi's health and development goals. Civil society organisations (CSOs) can help achieve this objective by engaging in *health budget advocacy*.

1.2 Why is Health Budget Advocacy Needed?

Every human being has the right to health,[7] and governments have the responsibility of ensuring access to those things that safeguard health, such as clean water, basic sanitation, essential medicines, and health services. In Malawi, government commitments to safeguard and improve the health of citizens are laid out in the Republican Constitution, Vision 2020, and the Malawi Health Sector Strategic Plan (2011–2016). The Health Sector Strategic Plan (HSSP) is aligned to the Malawi Growth and Development Strategy (2011–2016) (MGDS). Malawi has also committed to international declarations and agreements on health, such as the Abuja Declaration, the Alma Ata Declaration (1978), Health for All in the 21st Century (1998), the Kampala Declaration on Fair and Sustainable Health Financing (2005),[8] and the Rio Political Declaration on Social Determinants of Health (2012).[9]

Total health expenditures

In Malawi, overall health spending remains insufficient to meet existing needs. Total per capita spending on health in the country increased significantly between 2006 and 2009 (from US$28 to US$38.5). Still, in 2012, Malawi's total health expenditure per capita (US$39) remained lower than all but one country in the SADC region (Mozambique) and well below the regional average of US$147.[10]

Resource gap

In Malawi, the gap between resources needed to meet health needs and actual health expenditures is already substantial—US$307 million in 2012–2013. Moreover, without change, this gap is projected to grow significantly, reaching US$458 million in 2015–2016.[11]

Health expenditures as a share of government budget

Governments show their commitment to health largely by allocating public funds to health-related activities and initiatives. While Malawi did reach its Abuja goal in FY2008/09, devoting 15.9 per cent of the budget to health, the proportion of the budget dedicated to health has fallen steadily since then (see Figure 2). The steepest drop came in the 2014/15 budget, when the health budget fell to 8.8 per cent of the total, down from 11.9 per cent in the previous year.[12]

Government contributions as share of total health spending

Also of concern is the significant fall in the government's share of total health expenditures over the past decade, with Malawi's health sector becoming increasingly dependent on donors (see Figure 3). In 2001, donor contributions accounted for 36 per cent of total health expenditures. By 2012, donors' share of overall health spending had risen to 65 per cent,[14] and donors provided an even greater share (as much as 85%) of expenditures for the public sector healthcare services that serve the majority of Malawians.[15]

Figure 2. Health Spending as a Percentage of Total Government Budget (2008–2015)[13]

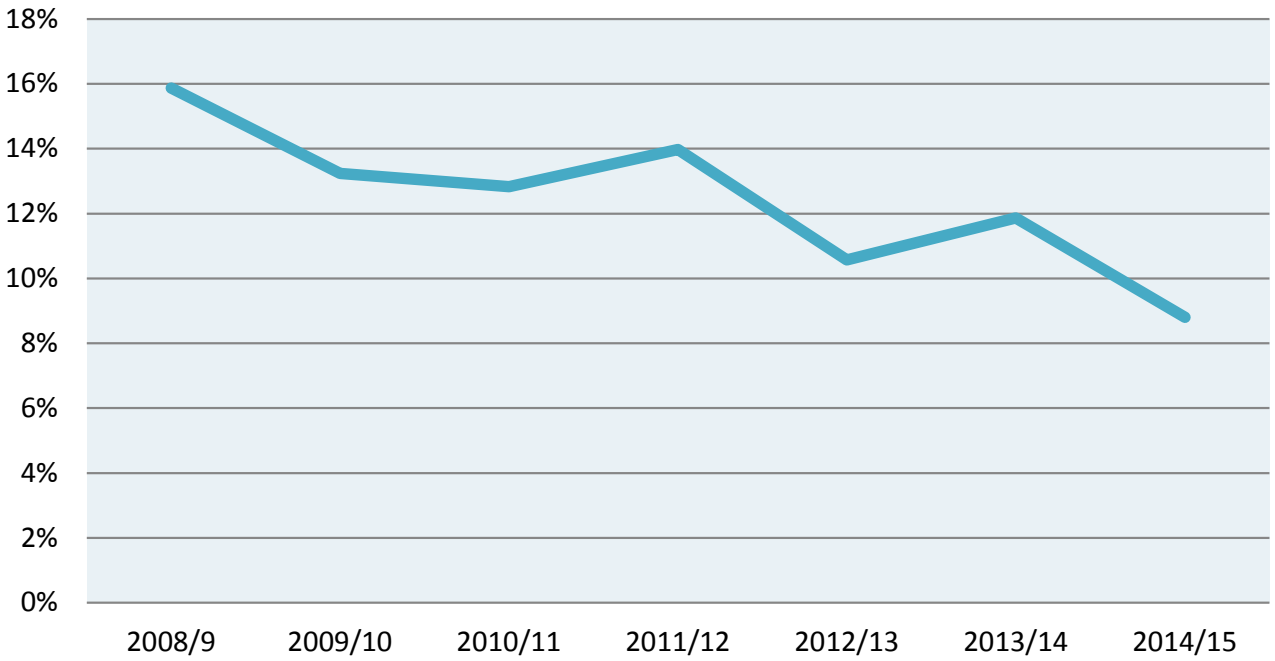
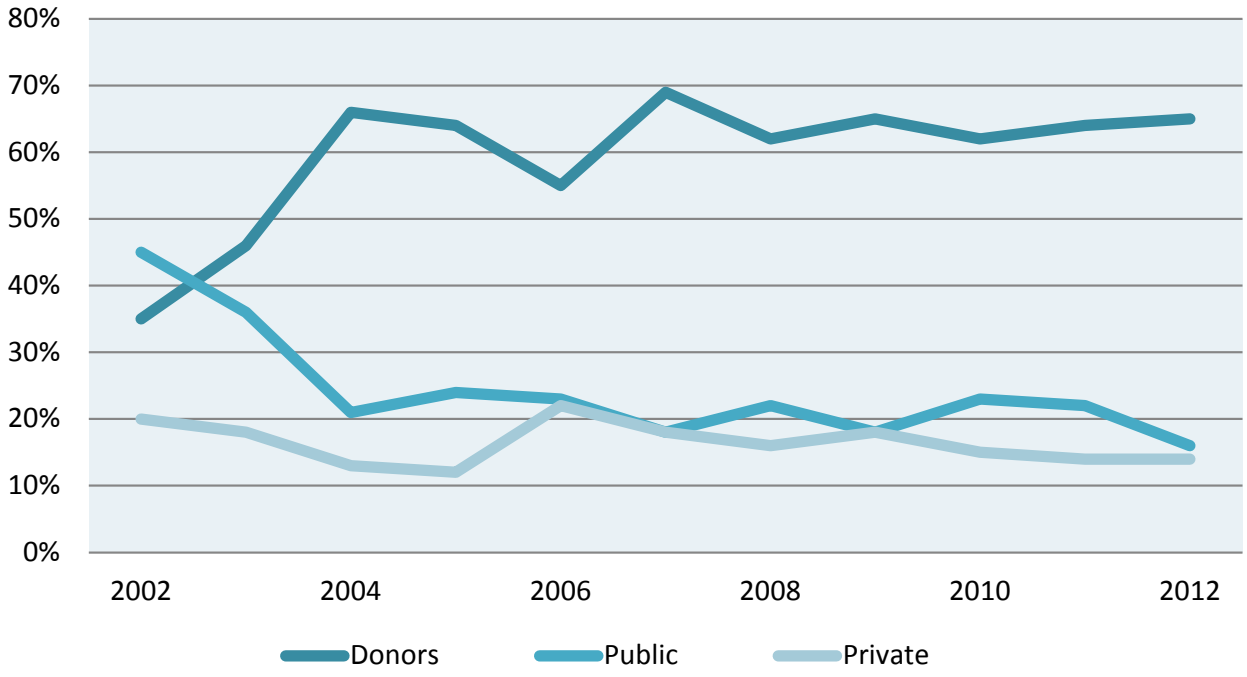


Figure 3. Donor Financing as a Share of Total Health Spending (2001–2012) [16]



In Figure 3, "private" refers to out-of-pocket health expenditures by individuals, as well as medical insurance schemes.

SOURCE: Dr. Dominic Nkhoma and Dr. Henry Ndindi, "Malawi's Experiences/Initiatives for Improving Access and Coverage in the Context of UHC." (PPT presented at ECSA Health Community Meeting, Kampala, Uganda, January 14, 2015). Ministry of Health, Government of Malawi.

Because health is central to sustainable development, inadequate funding for health impacts not just health, but other aspects of social and economic development as well.

Health challenges

The overall health status of Malawians has improved in some areas. Life expectancy rose from 39 years (1990s) to 55 years (2000s), largely as a result of improvements in combatting the HIV epidemic. Childhood mortality has also declined over the last two decades.[17] Nevertheless, Malawi continues to face significant health challenges, magnified by inadequate health spending.

For example, Malawi continues to struggle with inadequate availability of health services, including shortages of essential drugs (see Case Study 3). These shortages contribute to poor health outcomes, including preventable deaths. Additionally, Malawi's maternal mortality rate remains among the highest in the world (510 per 100,000 live births).[18] Finally, the HIV epidemic continues to take a toll. Around one in ten adults (10.6%) ages 15–49 are HIV positive, and HIV prevalence rates are higher among women (12.2%) than men (8.1%). There is a significant regional disparity in HIV prevalence, with adult prevalence in the Southern region reaching 14.5 per cent—twice as high as in the Northern and Central regions.[19]

Governments have an obligation to govern in the best interests of their citizens, and civil society plays an important role in making sure this obligation is met. The government of Malawi must devote more resources to health and use them more efficiently. By engaging in health budget advocacy, CSOs can help make sure this happens.

Goals of health budget advocacy

Health budget advocacy is designed to influence the size and distribution of government health budgets. CSO engagement in health budget advocacy can have one of several impacts:

(1) Increase the share of the overall health budget relative to other government spending

(2) Change allocations within the health budget, increasing funding for a specific issue

(3) Increase both the level of the overall health budget and allocations to specific budget lines

In addition to influencing the size and distribution of health budgets, civil society plays an increasingly important role in monitoring governmental commitments and holding public officials accountable for resource allocations and utilisation, making sure that funds are disbursed and used as planned.

Box 1. Voices of the Poor and Marginalised

The poorest and most vulnerable people in society are often most dependent on the public health system. These groups are deeply affected by public resource allocation decisions, but they often lack any say in those decisions.

Even if the government allocates funds to support disadvantaged groups, this lack of political "voice"—along with weak financial management—can prevent health resources from reaching those who are most in need.

Health budget advocacy can help poor and marginalised groups gain a voice in the health budget process. It can also help civil society find out when resources are not being spent as intended, or are not reaching disadvantaged groups.

Box 2. Relationship Between CSOs and Government

When undertaking advocacy for the first time, it is important that CSOs reflect on their relationships with government. The roles of government and civil society are different, but both exist to serve and build a better future for individuals and communities in Malawi. This vision should drive both government and CSOs, and both sectors must understand that their roles are complementary—neither can take the place of the other. In some cases, the relationship can become strained or adversarial, because advocacy can sometimes be seen as criticism of government. However, CSOs should aim to both help the government do its job and remind it of where improvements can be made. At all times, CSOs should offer solutions as part of advocacy campaigns, try to turn negatives into positives, and where possible, build bridges and common ground between civil society and government.

However, budget advocacy is often difficult for CSOs, due to a limited understanding of the budget cycle and limited government transparency in budget preparation and execution. Public guidelines on the government budget cycle (and where to intervene for maximum impact) are often lacking.

The purpose of this booklet is to describe as simply as possible how the government health budget is developed in Malawi, and to suggest entry points where advocates can seek to influence change.

1.3 The Role of Civil Society

Over the past decade, CSOs have more actively intervened in the budget process, along with monitoring and reporting on public expenditures in countries all over the world—these efforts can be successful. For example, a 2012 study of CSO budget advocacy in Uganda, Bangladesh, and the Philippines concluded that CSO involvement in budget advocacy positively influenced budget allocations for sexual and reproductive health.[20]

The monitoring and oversight role played by civil society is particularly important where—as in Malawi—national governments have delegated budgetary authority to local-level authorities.

CSOs can act as a bridge between communities and governments. They can help community members gain a greater voice in the budgeting process, bringing needs and issues to the attention of policymakers. CSOs can also help policymakers understand the impacts of budget decisions and point out when change is needed. For example, CSOs can help assess "value for money" by generating and analysing data on the impact (or lack thereof) of certain types of spending. Such information is useful to policymakers and advocates alike.

Civil society roles in the budget process (formal and informal)

In Malawi, CSOs can potentially play an important role in overseeing health expenditures at the district level, monitoring what is spent by district governments or local health facilities and using these findings to call for changes in how government funds are allocated and spent. Yet formal recognition of civil society's role in the health budgeting process is limited. A public consultation stage is included in the budget process

(see Section 3.2.1), but the role of CSOs per se is not made explicit. Beyond these consultations, the officially recognised role of civil society is largely limited to community sensitisation and mobilisation to support budget implementation. Recently, the International Monetary Fund (IMF) pushed for the involvement of CSOs in its consultations with the government of Malawi regarding the national budget. [21]

Informal roles for civil society include analysing public budgets, producing simplified and popular versions of the budget and related documents, playing a watchdog role, tracking expenditures at both local and national levels, and advocating for improvements to specific requests and overall transparency and accountability. Civil society's informal roles are arguably more effective, particularly when combined with strategic use of media and citizen engagement.

Table 1. Civil Society's Role in the Budget Process

Formal Role	Informal Role
Participate in in public consultations	Analyse public budgets
Provide input during IMF country visits	Produce simplified versions of the budget to increase public understanding
	Track expenditures
	Implement advocacy campaigns

Endnotes

2. World Health Organization (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva, Switzerland: WHO.
3. Health inequities exist when certain groups or people are markedly healthier than others. Addressing such inequities is an important goal of any health system.
4. World Health Organization (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* Geneva, Switzerland: WHO.
5. Ibid
6. The Abuja Declaration also urged donor countries to fulfill the still-unmet target of dedicating 0.7 per cent of their GNP as Official Development Assistance (ODA) to developing countries.
7. Article 12 of International Covenant on Economic and Social Rights.
8. The Kampala Declaration states that health is a fundamental human right that must be supported by fair and sustainable health financing systems. In line with World Health Assembly (WHA) resolutions 58.31 and 58.33, it affirms that out-of-pocket spending should be minimised and prepayments expanded with a view to avoiding impoverishment of households and moving towards universal coverage.
9. WHA resolution 65.8: Member states expressed their political will to improve public health and reduce health inequities through action on the social determinants of health.
10. Ministry of Health. 2014. Malawi National Heath Accounts with subaccounts for HIV/AIDS, malaria, reproductive health, and child health for fiscal years 2009/10, 2010/11, and 2011/12. Lilongwe, Malawi: Ministry of Health, Department of Planning and Policy Development.
11. Nkhoma, D. and H. Ndindi. 2015. "Malawi's Experiences/Initiatives for Improving Access and Coverage in the Context of UHC." PowerPoint presented at ECSA Health Community Meeting, Kampala, Uganda, January 14, 2015. Lilongwe, Malawi: Ministry of Health.
12. Malawi Health Equity Network (MHEN) 2014-15 Health Sector Budget Analysis.
13. Budget Statements delivered in Parliament by the minister of finance, economic planning and development for the various fiscal years.

14. Ministry of Health. 2014. Malawi National Heath Accounts with subaccounts for HIV/AIDS, malaria, reproductive health, and child health for fiscal years 2009/10, 2010/11, and 2011/12. Lilongwe, Malawi: Ministry of Health, Department of Planning and Policy Development.
15. USAID. 2015. "Malawi Health Systems Strengthening Fact Sheet." Available at http://www.usaid.gov/malawi/fact-sheets/usaid-malawi-health-systems-strengthening-fact-sheet-2012-13.
16. Nkhoma, D. and H. Ndindi. 2015. "Malawi's Experiences/Initiatives for Improving Access and Coverage in the Context of UHC." PowerPoint presented at ECSA Health Community Meeting, Kampala, Uganda, January 14, 2015. Lilongwe, Malawi: Ministry of Health.
17. Ministry of Health (MOH) [Malawi] and ICF International. 2014. *Malawi Service Provision Assessment* (MSPA) 2013-14. Lilongwe, Malawi, and Rockville, Maryland, USA: MoH and ICF International.
18. WHO. 2013. "Global Health Observatory Data Repository." Available at http://apps.who.int/gho/data/node.main.15. Maternal mortality estimates included in the MDG Endline Survey (2014) for Malawi are even higher—574 per 100,000 live births.
19. National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi and Calverton, MD: NSO and ICF Macro.
20. Dickinson, C., T. Collins, R. Loewenson, and S. Ghosh. 2012. "Civil Society's Contribution to Budget Advocacy for Sexual and Reproductive Health: Findings and Lessons Learned from Three Country Studies in Bangladesh, the Philippines, and Uganda." *Global Health Governance* VI(1).
21. Scholte, J. 2009. IMF *Interactions with Member Countries: The Civil Society Dimension*. Washington, DC: Independent Evaluation Office of the International Monetary Fund, IEO Background Paper.

2 Health Budget Advocacy: Planning and Implementation

2.1 What is "Advocacy"?

Advocacy is a *systematic* succession of actions designed to *persuade* those in power to bring a *change* to a specified issue of public concern. Advocacy is a deliberate process to deliver particular messages to decisionmakers who develop laws or policies, or distribute resources that affect people's lives.

This definition can be broken down into a few key concepts, evoked by the following key words:

- ***Systematic***—Advocacy is carefully planned to achieve clearly defined goals, following specific steps in planning and execution.
- ***Goals***—Advocacy seeks to achieve a clearly defined change related to laws, policies, regulations, programs, or funding. Health budget advocacy seeks to change the size, distribution, monitoring, and/or use of health funding.
- ***Process***—Advocacy is a deliberate process carried out over time, not a one-time intervention Successful advocacy requires persistence and sustained engagement.
- ***Targets***—Advocacy aims to influence the actions of key decisionmakers (politicians, government officials).
- ***Persuasion***—Advocates use evidence to craft convincing messages and strategies to convince target audience(s) to make the change(s) desired.

Box 3. Who Is an Advocate?

An advocate is someone who speaks up (or writes) publically about how things are and how they should be. Advocates promote change, and in many cases, are fighting for a better situation for the disadvantaged. You can **advocate for** a group (on their behalf), **or with** a group (building their capacity, or as a member of that group). Anyone can be an advocate—young or old, rich or poor, educated or illiterate.

Advocacy is sometimes confused with other concepts, such as behaviour change communication (BCC), fundraising, awareness-raising, or community and social mobilisation.[22] To differentiate between these concepts, it can be helpful to consider the targets, objectives, and outcomes of each approach. Although raising awareness or mobilising specific communities can be tactics or steps in an advocacy campaign, the ultimate targets of advocacy are key decisionmakers (politicians, government officials) and the ultimate goals are changes to laws, policies, and/or budgets.

2.2 Steps in the Advocacy Process

This section provides a brief overview of the steps in advocacy planning, highlighting some tips and lessons learned to help advocates influence government health budgets in Malawi.

Step 1: Selecting an issue or problem to address

Much of the hard work in planning a successful advocacy campaign occurs in the initial stages of the process—identifying a problem and coming up with a proposed solution (advocacy goal and objectives). As described in section one, health budget advocacy generally seeks to achieve impacts related to the size, allocation, or distribution of health budgets. Within this broad frame, health budget advocates will need to select a specific problem to address.

What problem are you seeking to address? First and foremost, advocates must clearly identify the problem or issue they are trying to address. These issues should

(1) Be related to public interest

(2) Require a policy-related change by decisionmakers (for example, a change in the content, development, or execution of government health budgets).

To clearly identify the advocacy problem, the issue must be studied and quantified.

- Who is affected?
- To what extent are they affected?
- What is the impact if this situation continues?

Helpful Tip: Consulting Affected Communities and Groups

When identifying advocacy issues and coming up with advocacy goals, it is vital to consult the communities affected by the issue you plan to address. Participatory methods of issue identification and goal setting can be useful and important because

- Affected groups are able to provide the most accurate information about their situation and what change is needed.
- Those affected by policies have a right to a voice in the policy process.
- Community support can help increase the perceived legitimacy of advocacy campaigns and help them be more successful.

Answering these questions will provide the basis for developing effective advocacy goals and objectives. It will also give CSOs a head start in gathering the evidence necessary to make a convincing case during advocacy campaigns.

Strategic thinking: When selecting advocacy issues to address, it is important to think strategically. CSOs should take on issues that will have a meaningful impact on public health and human rights. It is also important for CSOs to pick issues they are in a position to influence, whether on their own or in partnership with others. CSOs should also consider their organisation's interests, strengths, and capabilities (see Step 3: Assessing the External and Internal Context). Once the advocacy problem has been identified, further internal scanning can help organisations pick the right goals and objectives, and plan successful advocacy campaigns. However, it is important to take time at this stage to make sure the identified problem is aligned with the organisation's overall mission and goals. Advocacy requires passion and commitment. When an organisation takes on an advocacy issue that is aligned with its purpose, as well as the interests of its members and staff, the chances for success increase.

Step 1: Identifying the Problem

Example 1—Lack of access to family planning services
Malawi is one of the fastest-growing countries in sub-Saharan Africa. Its population has tripled over the past 40 years, and is expected to triple again by 2040, a result of high fertility rates combined with a lack of access to family planning (FP) services. Despite this, the government budget did not include any allocation for family planning until 2013. Instead, Malawi relied exclusively on donors to provide FP commodities and services. (Case Study 2 describes how advocates helped address this problem).

Example 2—Lack of access to information on resource allocation and use
Ensuring that information about resource allocation and use is readily available to the public and CSOs is vital to strengthening health systems. Access to information enables the public to hold government accountable for meeting their health needs, and helps CSOs identify challenges and propose effective solutions. However, Malawi does not have a government policy guaranteeing public access to information. Although legislation to address this was raised in Parliament in 2014, the measure had not yet been passed as of June 2015.

This is particularly important for CSOs new to health budget advocacy. It is important for organisations to clearly understand how this advocacy problem relates to their overall mission. Organisation leadership, staff, and volunteers should be able to clearly articulate this connection and explain how taking on the issue will benefit both the organisation and the community.

Step 2: Developing a goal and objectives

Along with identifying a health problem, advocates must also define a solution—the change they want decisionmakers to bring about. This change is the goal of the advocacy effort. Once the goal has been defined, then intermediate achievements towards the main goal (objectives) are set. Advocates can then focus on coming up with activities and strategies to achieve those objectives. Advocacy objectives should be very specific (you should know what you are advocating for, and when you have achieved it), and the proposed solution should have a public health impact and promote human rights.

The importance of specific advocacy objectives is illustrated by Case Study 3 on page 46. In this case, advocates had two objectives: (1) increase government allocations for the health sector, and (2) increase the government drug budget. Advocates were successful in increasing the drug budget, in part because the specificity of the goal allowed them to present convincing evidence. Advocates also took advantage of the moment of opportunity created by publication of the Comprehensive National Drug Quantification Study, which gave them the evidence necessary to persuade the Ministry of Health (MOH) and the Ministry of Finance, Economic Planning and Development (MoFEPD)[23] to increase the drug budget. Unfortunately, significant shortfalls in health budgets continued. This case also illustrates the importance of incremental progress (gaining and celebrating short-term wins) when seeking to achieve larger goals, such as government health budgets that meet the Abuja commitment (see Box 7).

Once the decision is made to embark on an advocacy campaign, the next step is to develop an advocacy strategy informed by the steps outlined below. However, CSOs should note that advocacy is not a linear

Step 2: Identifying Goals & Objectives

Example 1—Improving district-level health services (Case Study 1)
Goal: Improve the quality and availability of health services at district level.

Objectives: (1) Ensure that all district-level disbursements from MoFEPD to the health sector during the upcoming fiscal year are (a) on time, and (b) consistent with district budget allocations and cash flows.

(2) Strengthen the budget monitoring and advocacy capacity of the district health team.

(3) Improve disbursement and use of health resources once funds have arrived at the district level.

Rationale: Delays and inconsistencies in the disbursement of funds from MoFEPD contribute to weaknesses in health service delivery at the district and community levels.

Example 2—Advocating for the FP budget line item (Case Study 2)
Goal: Increase government allocation to FP commodities and services.

Objectives: (1) Create a budget line item for FP within the MOH budget.

(2) Secure funding for the FP budget line item.

(3) Increase funding for the FP budget line item.

Rationale: A budget line item provides advocates with a way to easily track the allocation and use of government resources. Advocates viewed creation of a line item for family planning within the MOH budget as a vital first step in securing increased government investment in FP goods and services.

process, and although these steps are listed in a sequence, their order and importance will depend on the situation and context. For example, one might find during implementation (Step 7) that it is best to gather more data or analyse external context more thoroughly (Step 3) because some interventions are not working as expected.

Step 3: Assessing the external and internal context

Advocacy campaign planning requires the CSO to assess the internal and external context in which it will operate. This will help CSOs identify appropriate advocacy targets and craft effective messages and interventions to influence those audiences.

Conducting an external scan: CSOs seeking to influence how a government budget addresses a particular issue must have a clear reading on the environment or landscape in which they are working. External scans can help:

- Identify appropriate advocacy targets
- Identify appropriate messages and interventions with which to reach those targets
- Identify potential allies (supporters) and opponents (detractors)
- Determine whom else to work with (or avoid)
- Identify potential champions, insiders, and influencers (see Step 6)

- Brainstorm potential challenges and ways to overcome them
- Identify opportunities on which the campaign can capitalise (for example, World AIDS Day events)

External scans accomplish this by considering a variety of factors.

Budget process. Advocates must understand the budget process, know which government institutions are responsible for shaping budget policy, and be aware of the entry points through which they can influence the budget. Section 1.3 outlines some of the formal and informal opportunities for CSOs to engage in budget advocacy. Section 3 provides an overview of the budget process and highlights some key entry points.

Key players. What institutions are involved in shaping budget policy? This group can include government officials, interest groups, the media, and others. CSOs must account for all of these actors when developing budget advocacy strategies.

Political and power dynamics. In addition to understanding the formal budget process, CSOs need to understand how political and power dynamics can shape the budget process. What power relationships and political dynamics exist among the individuals and institutions described above? How might these affect which individuals and institutions wield influence, and how?

Political and power dynamics affect how budget processes play out "in the real world," which may look different from budget processes on paper. Learning to understand and navigate these dynamics is an important skill that advocates can improve over time. In the beginning, more experienced advocates and friendly insiders can help CSOs find their way.

Stakeholder analysis / mapping. Stakeholders are all those who have an interest in the policy you are working to change. Some stakeholders may benefit from the change, while others may have an interest in keeping the status quo. There are a variety of tools and methods available to conduct stakeholder analysis or "mapping"—identifying relevant stakeholders, their positions on the issue at hand, and their level of influence (power). This information will help CSOs craft more effective advocacy campaigns.

Access to information. Understanding what information is available, when, and how to access it can help advocates be more effective. Advocates may need to analyse available budget data to produce useful information to support their arguments. See Annex 1 for more detail.

Broader context. It is important to keep in mind the broader social and political context in which budget advocacy takes place. To what extent is there awareness of your advocacy issue among your target audience(s)? How about within the media? To what extent does support and/or opposition exist? What beliefs could help or hinder your advocacy efforts?

Conducting an internal scan. To design effective advocacy approaches, organisations (or coalitions/teams) must also analyse their own strengths and weaknesses. For instance, do they have adequate financial resources to implement an essential media campaign? Do they have a spokesperson who holds credibility with the target audience? Are there enough data to suggest that the proposed advocacy

solution will work? Are there other programmatic activities that will affect the proper implementation and monitoring of the advocacy campaign?

Internal scans should include such factors as

Relevance: How does this advocacy issue fit with the organisation's overall mission and vision? Is the organisation known for working on this issue, or will it need to persuade others of its credibility?

Knowledge / capacity: Does the organisation have experience working on this issue? What knowledge or capacity gaps need to be addressed to make advocacy efforts successful?

Resources: What resources can the organisation dedicate to this advocacy effort? Think about the time and skills of staff and volunteers, as well as available funds. If funds are not currently available, how could resources be mobilised?

Positioning: How well placed is the organisation to influence the issue?

Partnerships: What partnerships does the organisation have? Could any partnerships be built to help the advocacy efforts succeed?

While this guide emphasises the importance of conducting contextual scans early in the planning process, advocates should continue to remain aware of context. By remaining alert for relevant changes and events, advocates will be ready to respond to potential challenges or take advantage of emerging opportunities as they arise.

Box 4 The Private Sector

While government officials are the main targets of health budget advocacy campaigns, the private sector can also play an important role. Private sector actors may be cultivated as allies or champions (see Step 6), helping advocates change government health budgets or enhance accountability for health spending. At the same time, private sector actors may be appropriate targets of health budget advocacy, as increased investment of private sector resources may strengthen and improve the sustainability of Malawi's health system.

Step 4: Identifying your target audiences

A combination of external scanning (see Step 3) and understanding of the budget process (see Section 3) can help identify target audience(s). Key questions include

- Who has the power to make the decision or take the action you are seeking?
- How can these decisionmakers be reached and/or influenced?
- At what level are these decisionmakers operating? (e.g., national, regional, district, community)
- Are decisionmakers supportive of your advocacy goal? Neutral? Opposed?

Step 5: Crafting your advocacy message(s)

Once you have identified your target audience(s), it is essential to assess the audience's receptiveness to your issue and identify how best to frame the issue in keeping with their interests. Some issues are popular and non-controversial, while others can be contentious or simply gain little traction in the

minds of decisionmakers. It is important for advocates to keep these issues in mind when crafting their advocacy messages.

It is highly recommended that CSOs develop key messages and talking points **prior** to embarking on their advocacy campaign, particularly if working with several spokespeople and/or in a coalition. Advocacy messages and the political "ask" must be consistent throughout the campaign, and it is helpful to have a shared document among all advocates to keep everyone on point. It is also good practice for advocates to brainstorm about possible difficult questions, and develop strong answers in advance that support the advocacy objectives.

Advocacy arguments should hinge on the government's own commitments, and advocates should show the value of taking action (how advocacy objectives will benefit decisionmakers and their constituents).

Box 5 Examples of Advocacy Tactics and Tools:

Lobbying
Petition
Media campaigns
Public events / rallies / sit-ins
Public lectures/discussions
Discussion papers
Policy briefs
Position papers
Videos/multi-media
Testimonials
Social media

Evidence is crucial to successful advocacy. When conducting budget advocacy, CSOs can present information on budgeting trends (e.g., How have allocations for health changed over time? How do allocations in the current budget compare to previous budgets?). Advocates can also focus on gaps between existing needs and available resources. For example, the government of Malawi estimates that US$1 billion will be needed to implement the HSSP in 2014/15 but, so far, only a little over half that amount ($563 million) has been generated, leaving a funding gap of $444 million.[24] Presenting convincing evidence may require analysiing existing information (see Annex 1) or generating new information.

Because policymakers are often interested in Malawi's progress over time or comparing the country's situation to that of its neighbours, advocates should be prepared to present data that show these contrasts. At the district level, advocates may want to focus on comparing health indicators and budget allocations with those of other districts.

The presentation of evidence can dramatically affect the impact of messages. For example, on their own, percentages and ratios are rarely convincing. It is important to present a human face for your message. Statements such as "maternal mortality is high at 510 per 100,000"[25] create no memorable feeling among decisionmakers. Consider repackaging the data to allow for a greater understanding and an emotional response. For example, "Every year, an estimated 3,450 women die from pregnancy-related causes in Malawi; this translates to 288 mothers dying each month or nine women dying every day." [26]

Helpful Tip: Persuasive advocacy messages

Choosing the right messenger is also important. Some decisionmakers will respond best to academic or medical authorities (e.g., head of a research institution or head of a medical association). Others might be moved by business, religious, or cultural leaders.

Often, advocacy has to use a mix to ***appeal to both the head and the heart.*** Often a decision-maker can hear data, but chooses to act based on personal experience or a moving personal account from others. The messenger must also understand the context in which he or she is delivering the message.

Step 6: Creating an action plan

As described above, internal and external scans can help advocates design interventions to achieve objectives. Once you have sketched out objectives and broad approaches, it is time to put together a detailed action plan. The key to a successful action plan will be choosing the most effective advocacy approaches for a particular context, and using these approaches at the right time—taking the timing of the budget process into account (see Figure 5). Action planning includes assigning clear roles and responsibilities. This is particularly important when working in partnership with other organisations.

Working with insiders: Insiders are people within the government who may be supportive of your cause and in a position to make decisions or influence others. Often, by virtue of their position or responsibilities, insiders cannot be public or outspoken advocates for issues that affect the public. However, they can be useful sources of important information, as well as a link between advocates and target audiences. On the other hand, if they are taken for granted or treated inappropriately, insiders can be hindrances to advocacy initiatives. Therefore, advocates need to identify insiders and relate to them in ways that make them feel respected and appreciated. They can be consulted for pertinent information without quoting them on such issues, an action that can threaten them or their positions. An exception might be made when insiders are formally engaged as consultants due to their knowledge and skills. Additionally, insiders must be assured of the benefits of advocacy activities and made aware of how such activities or initiatives support their own objectives and goals.

For example, when advocating for an increased budget to support youth-friendly services at the district level, you will need support from the youth friendly health services coordinator. This officer can provide local information on teenage pregnancy, youth-friendly services currently provided, gaps to be addressed, funds currently allocated, etc.

Working with influencers: Influencers are people who work closely with decisionmakers (or have relationships with them, such as a high-profile relative or business person). Influencers, therefore, not only know about the systems, but also about individual decisionmakers. They can provide the most useful information for targeting audiences and can be helpful in knowing audiences' schedules and interests, and the best ways to reach them. Influencers can also, if properly informed and in agreement with your advocacy issues, provide audiences with the background information necessary to prepare them to support these issues.

For that reason, influencers must be carefully identified and selected, and properly informed to lay the groundwork for decisionmakers' potential support. Influencers are key players in the success of advocacy issues and, like insiders, they should not be quoted without their permission.

Working with allies and champions: Advocacy initiatives need unified voices. Allies and champions provide an avenue for strengthening and unifying diverse constituents into one voice. While allies are usually peers and stakeholders from organisations with similar objectives, champions are usually high-profile individuals who are supportive of the issue and respected in society for various reasons. Champions can also be those on the "front line" of the issue, such as a healthcare provider, a young person advocating for sex education in schools, or a person living with HIV.

The selection of allies and champions should be carried out carefully so that the support needed from them will be obtained. It is important to ensure that allies and champions clearly understand the issue, are supportive of your objectives, and are willing to commit their time and skills in moving the agenda forward as needed.

Although many advocacy efforts find support among other CSOs, don't forget to look for potential allies in the business sector, and among faith-based organisations and issue-driven politicians.

Working with coalitions and networks: Often, it can be helpful for CSOs to join in support of each other's advocacy efforts. However, advocates should keep in mind that working in coalitions and networks poses both opportunities and challenges.

Opportunities

- Strength in numbers/unified voices—this can counteract other powerful lobbies like business
- Common agenda/consensus solution—debates within the CSO community can be resolved behind closed doors
- Shared resources, such as finances and skilled people; some tactics—like mass media campaigns—are only affordable when costs are shared
- More innovation—different experiences, connections, or strategies are brought to the table

Challenges

- Managing a coalition takes time, human resources, and a lot of internal communications
- Consensus takes time and compromise—CSOs may need to give up or alter the nature of their "ask" to accommodate everyone in the coalition
- Group decision making can slow down responses to new opportunities
- Egos and self-promotion can get in the way (instead, share credit and put the advocacy issue first in the news, before the names of individuals or organisations; consider naming the coalition and agreeing to dissemination of that name over the names of individuals/organisations)

Working with the media: The role of the media in supporting and advancing advocacy cannot be overstated. The media has the potential to initiate and strengthen dialogue on an issue, quickly spread the agenda, and channel public support. In working with the media, advocates must ensure that journalists and other media personnel clearly understand the issues at hand for effective communication. Several organisations provide trainings for journalists, which may consist of an intensive orientation to the issue (several days), followed by periodic orientations/refreshers. The key is to cultivate an ongoing relationship with the media, to sensitise and inform them of relevant issues, and encourage them to think of you as a reliable and trustworthy source of information on the subject.

In Malawi, the profile level and accuracy of news stories are highly dependent on the editor's understanding. If an editor is less informed on a subject (as may be the case with many health topics), news items related to the subject may be omitted or diluted. Working with editors to ensure their understanding of the subject at hand is an effective way to work with the media in Malawi. Editors and journalists have a different type of access to decisionmakers. They can call government officials and get them "on the record" (a statement or

Helpful Tips: Working with Parliamentarians

Etiquette. In Malawi, to address members of Parliament sitting in a committee, you must be SMARTLY dressed with no visible political identity (pins, colours), and you must address the committtee Chair. You must also use the term "honourable"—forgetting to do so may lead to rejection of your agenda. Finally, you must speak and have your handouts (briefs, position papers, reference documents) written in clear and concise English.

Choose the right MPs. Not all MPs have the same positions and level of influence. Choose MPs who are in key positions, such as members of the budget and health committees. Consider engaging MPs who are already supportive of the issue and/or may be open to learning about it. A landscape analysis is crucial in choosing which parliamentarians to engage.

Engage individual MPs when conducting advocacy related to their constituency.

Follow protocols and work through the Parliamentary Secretariat when seeking to achieve national-level policy change.

There are numerous protocols involved when working with Parliament. It is important to observe these protocols and engage through the Secretariat. This may encourage MPs to take issues more seriously and ensure that they follow through on their commitments.

Parliamentary staff can advise you on the proper protocols and can help you find out MPs' committee memberships, as well as when committees meet. The clerk of Parliament can identify the staff members assigned to work with various MPs and committees.

Engage with MPs while they are in Lilongwe. MPs spend most of their time in their constituencies and usually come to Lilongwe three times per year when Parliament is sitting, for about 4–6 weeks per sitting, depending on the issues to be discussed. Trying to work with MPs outside of these times can be expensive; it is costly to travel to their constituencies and even more so to invite them to meetings in Lilongwe (transportation and per diems). This is one reason it is important to establish close relationships with parliamentary staff. If they are supportive, they can alert you when MPs will be in town and help you get on MPs' calendars.

response to an assertion made in a news article). The media can be perceived as "neutral" which invites decisionmakers to offer "their side of the story." However, while budget increases or reallocations are not generally controversial, a news article on government spending can become political.

It is important to invest in training editors so that they understand technical issues like budget advocacy. It cannot be assumed that editors know everything; often, most CSOs have overlooked editors in their work. Therefore, engage editors as crucial allies in all advocacy work. Because most media houses in Malawi have a weak resource base, it is essential to build the capacity of reporters. Also consider developing media handbooks on reporting budget issues and packaging them in a user-friendly format such as PDF, Microsoft Word, or even PowerPoint.

Helpful Tip

Try to monitor what decisionmakers say, both in and outside of Malawi, and use public statements to support your advocacy objectives. If a decisionmaker states that he/she will address a problem, advocates should (1) write a letter to thank him/her for that commitment and/or (2) hold a press conference thanking him/her for such an action and elaborating on how it will benefit citizens.

When dealing with new or controversial issues, advocates must be resilient and consistent until the media takes an interest. Keep media contacts informed and updated on your issues; you may need to frame the topic in line with current story trends for it to be considered newsworthy. During interviews with the media, stick to your talking points and focus on the issues important to you. The interviewer can easily divert the path of discussion, which can dilute or undermine your messages.

Box 6 Dealing with Opposition and Detractors

Dealing with opposition requires knowledge of who is likely to oppose the change you are suggesting, and on what grounds. What are opponents' positions, and what arguments are they likely to use? This knowledge can help you gather information and develop messages that respond to or neutralise opposition arguments.

For example, if your proposal is likely to be challenged due to a lack of resources, can you demonstrate that it is actually a good investment?

Step 7: Implementing the activities

Successful advocacy hinges on steps 1–5: careful planning and analysis. However, implementing activities is where a CSO will spend most of its time and human and financial resources, as well as gauge progress and undertake course corrections. As such, it is equally important to implement activities in line with strong project management principles and ensure that they are guided by a carefully conceived work plan.

Implementation involves all of the interim steps needed to accomplish major activities. For example, before meeting a group of decisionmakers, you must develop fact sheets or policy briefs for their easy reference (see Annex 2: Writing Policy Briefs). These will be based on data you gathered and will outline your proposed solutions.

Monitoring commitments: The work does not end after conducting an advocacy campaign/meeting and securing commitments. Decisionmakers are often occupied with many demands and face multiple issues in need of their attention. As such, securing a commitment doesn't guarantee follow-through. Decisionmakers usually leave the responsibility of implementing their commitments to technocrats, who can themselves be overloaded with competing priorities or unable to relate to a particular issue. This can result in technocrats forgetting or resisting implementation of something agreed to by someone else. Advocates need to set aside time and resources for monitoring commitments until they are fully implemented, or develop strategies for further advocacy if implementation does not take occur. Case Study 2 illustrates the importance of monitoring commitments.

Step 8: Measuring success

Measuring success is as important in advocacy as it is in service delivery, behaviour change communication, or other programs. It is particularly important to recognise the "quick wins," which are incremental achievements that can shed light on the advocacy campaign's progress towards attaining the overall goal (see Box 7). For instance, after each advocacy event, the advocacy team should meet and review its performance, how its messages were received, what questions were raised, and what commitments were made (see also Step 7). This will help identify improvements for the next meeting and perhaps even add activities to the work plan, such as a specific follow-up activity.

Box 7 Quick Wins and Incremental Change

Advocates tackling big issues may find themselves discouraged if they don't see progress. Remember that the road to a big change is often paved with lots of small changes. When planning campaigns, include some smaller short-term goals to allow you to see your progress towards the larger goal. Along with taking time to celebrate quick wins, this can boost morale and help advocates endure for the long haul.

Be prepared for disappointment, but don't be prepared to give up.

Periodic review meetings are recommended after a major activity to debrief and assess the activity, whether it contributed to reaching the goal, and whether it remains on track. It is also helpful to determine whether a change of course or new activities are necessary. As mentioned in Step 3, advocacy campaigns must be responsive to changing circumstances and "serendipity."

For example, if a high-profile leader or celebrity gives birth, a maternal or child health campaign could issue a congratulatory press release, but then use the opportunity to point out the health issues faced by most pregnant mothers or newborns in Malawi. Malawian CSOs can also capitalise on events outside the country—such as a major UN conference on HIV or a statement from the leader of another country—to write a commentary in the newspaper or hold a meeting with key groups to discuss domestic perspectives on the issue. These opportunities may not have been foreseen when the advocacy strategy was developed, but they can often help advance the advocacy agenda. Likewise, advocates are advised not to despair when one intervention doesn't succeed. Critical review on what might have gone wrong is required, and the team can brainstorm on adjusting the advocacy plan accordingly.

Helpful Tip

Given the opportunity to meet a group of decisionmakers to discuss your advocacy issue, a compelling presentation is essential. It should feature a memorable and appealing title and should begin with your proposed solution (advocacy goal or objective). Your presentation should acknowledge and appreciate existing government policy commitments, and recognise any current programs, budget allocations, and disbursements making positive contributions to your issue. The presentation should also link current programs and funding trends to major national development agendas, such as the Malawi Growth and Development Strategy or the Vision 2020, and highlight implications for these broader goals if your issue is not addressed. Finish by demonstrating your trust and confidence in the decisionmakers, and reiterate the solutions that you proposed at the beginning of your presentation. The advocacy team is advised to be resourceful and prepared to respond to questions and requests for clarifications. If you are unsure of the answer to a certain question, DO NOT LIE or make up an answer; instead, promise to look for the facts and come back to the questioner with more information.

Endnotes

22. POLICY Project, 1999. *"Networking for Policy Change: An Advocacy Training Manual."* Washington, DC: Futures Group, The POLICY Project. Volume IX. Retrieved from http://www.policyproject.com/pubs/AdvocacyManual.cfm.
23. In FY2014/15, the Ministry of Finance and the Ministry of Economic Planning and Development were combined into a single ministry—MOFEPD.
24. Nkhoma, D. and H. Ndindi. 2015. "Malawi's Experiences/Initiatives for Improving Access and Coverage in the Context of UHC." PowerPoint presented at ECSA Health Community Meeting, Kampala, Uganda, January 14, 2015. Lilongwe, Malawi: Ministry of Health.
25. WHO. 2013. "Global Health Observatory Data Repository." Available at http://apps.who.int/gho/data/node.main.15.
26. Vlassoff, M. and M. Tsoka. 2014. "Benefits of Meeting the Contraceptive Needs of Malawian Women." *In Brief*, 2014 Series, No.2. New York: Guttmacher Institute.

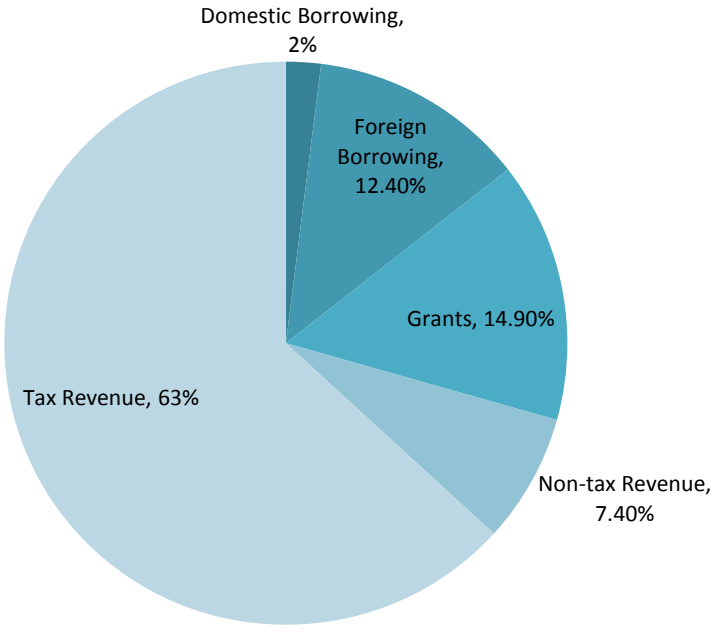
3 The Budget Process—How it Works and How to Engage

This section lays out the current budget development process in Malawi at both the national and local levels, and suggests key entry points and "targets" for advocacy. Section 3.1 describes where the funds for national and local health budgets come from. Section 3.2 provides an overview of national and district-level budget processes, describes how these processes fit together, and identifies key entry points for advocacy.

3.1 Where Does the Money Come From?

Government funds for health come from domestic revenue (e.g., taxes and non-tax revenues), borrowing from domestic markets, and grants or loans from development partners. Some of these funds are allocated for national-level health spending, such as the MOH budget. The national government also uses domestic and donor funds to allocate funds to district governments—either for general use (unconditional grants) or for use in a particular sector, such as health (conditional grants). Central government transfers to districts are based on a specific formula, developed by the National Local Government Finance Committee (NLGFC) (see Box 8) in collaboration with the MoFEPD and relevant ministries (e.g., the MOH for health). This formula accounts for total population and population density, as well as key indicators that demonstrate the need for, availability of, and utilisation of health services.[27] Therefore, total funding for the health sector can be found by analysing the national budget, which includes allocations to the MOH, National AIDS Commission, and the Department of HIV/AIDS and Nutrition (DNHA) at the central level, as well as allocations to district health offices.

Figure 4. Sources of Funding in the Government Budget FY2014/15



Source: FY2014/15 Budget Statement

Donor funds

Donor funding to the health sector comes through multiple channels. To adhere to the principles of the Paris Declaration, the MoFEPD in Malawi has worked with donors to increase the proportion of aid administered through the budget. However, significant donor funding remains "off budget" (provided outside the government budget) at both national and district levels. In the health sector, donor support is provided within the framework of the Sector-Wide Approach (SWAp), which includes both budget and "off budget" support. Donor support is governed by a memorandum of understanding signed by the government of Malawi and development partners, which establishes a program of work for implementation of the SWAp.

District level

At the district level, health sector funding comes from four sources: (1) budget allocations from the central government to the district government; (2) MOH resources (allocated at the national level) spent at the district level; (3) funds generated at the local level through administrative fees (such as market permits or fees for using land and other natural resources); and (4) donor funding provided directly to nongovernmental organisations (NGOs) and CSOs operating at the district level on health activities.

Box 8. About the National Local Government Finance Committee (NLGFC)

The NLGFC plays a key role in Malawi's budget process, acting as a bridge between local authorities and the central government. As described above, the NLGFC works in partnership with the MoFEPD and line ministries to determine the formula for central government transfers. Along with the relevant ministry, the NLGFC also makes recommendations regarding resource allocation among programs within devolved sectors (such as health). The NLGFC coordinates the development of local authorities' budgets within the timelines established by the national budget guidelines.

Every February, the NLGFC, in collaboration with the MoFEPD, conducts budget briefings and distributes budget guidelines to local authorities. In March and April, the NLGFC reviews local authorities' draft budgets and prepares a consolidated budget after consultation with the MoFEPD. This budget is submitted to Parliament as part of the Budget Speech. Throughout the year, the NLGFC also monitors implementation of local authorities' budgets.

3.2 How is the Health Budget Developed?

The national budget usually makes headlines in June, when the minister of finance gives the Budget Speech before Parliament. The Budget Speech is only the most visible piece of a much larger budget process, which is ongoing throughout the year at both district and national levels. The budget cycle of the government of Malawi runs from July 1–June 30 every year. The budget process is managed by the MoFEPD and has three main stages:

(1) Formulation

(2) Review and approval

(3) Execution, monitoring, and oversight

Figure 5. Annual Budget Cycle

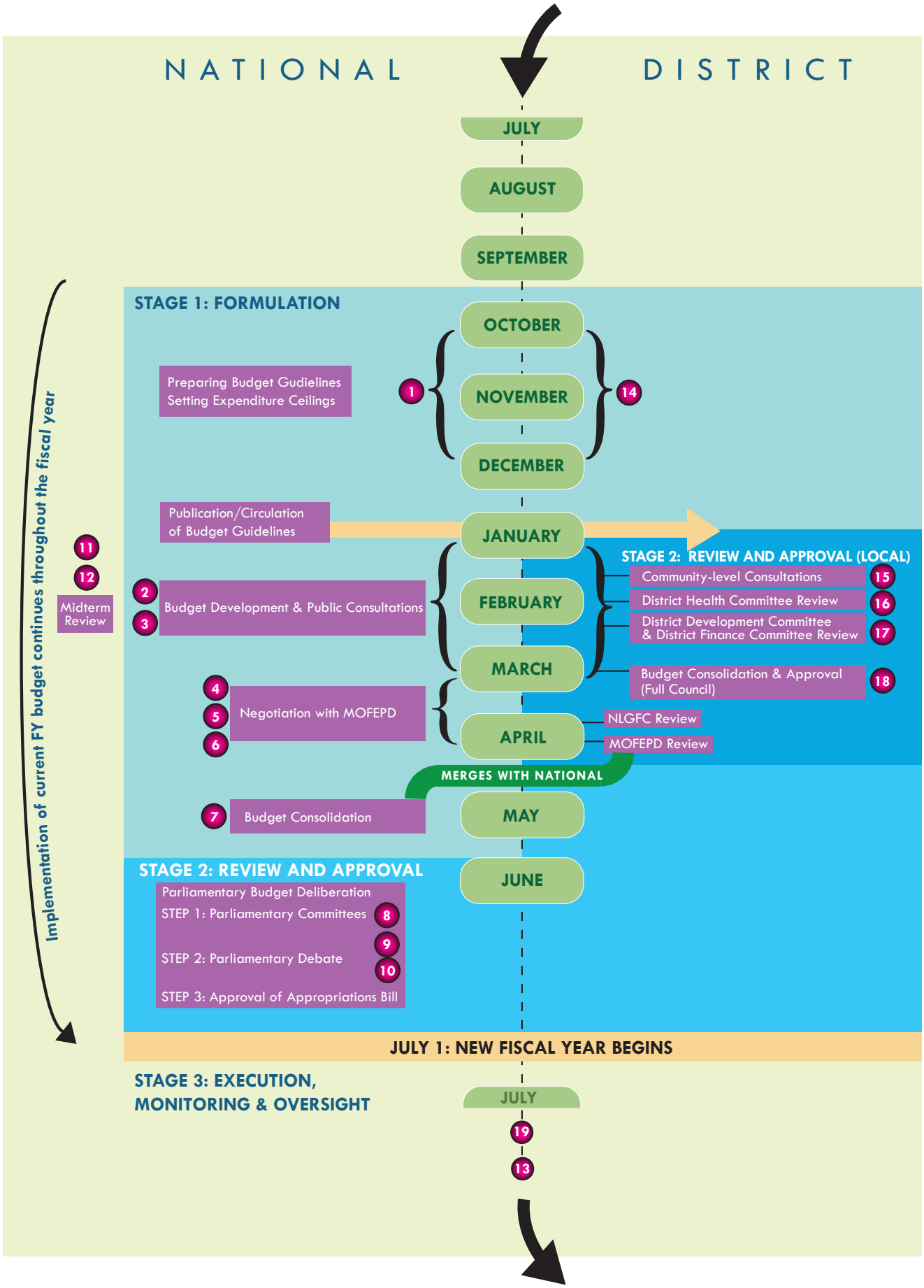


Figure 5 illustrates how these stages play out at the national and district levels.

Civil society plays an important role in the budget process—advocating for health funding to meet the needs of the community, fostering greater transparency, and holding decisionmakers accountable for resource allocation and use. At each stage of the budget process, there are different opportunities for CSOs to provide input and influence budget outcomes. Timing is a vital component of successful health budget advocacy (see "Helpful Tip" below). Understanding how the budget cycle works can help advocates engage the right players, in the right way and at the right time, to achieve their goals.

Helpful Tip: Timing is Key to Successful Health Budget Advocacy

Advocates need to choose the right moment to engage and think ahead—influencing a step in the budget process often requires starting before the actual stage begins.

For example, budget consultations between the MoFEPD and MOH typically take place in March. However, if advocates want to influence these consultations (or make sure they happen), they must start meeting with target audiences in January or February. Case Study 1 describes how advocates achieved the introduction of a budget line item for family planning into the MOH budget. To gain the support of key parliamentary committees during budget debates, advocates began engaging committee members long before the budget was formally presented to Parliament (see Case Study 1).

3.2.1 National Budget Process

Stage 1: Budget formulation

While the fiscal year begins July 1, starting with budget formulation can make it easier to understand the budget process. In Malawi, budget formulation generally happens between October and June.

October—December: Preparing budget guidelines / setting expenditure ceilings

Between October and December, the MoFEPD begins preparing for the next fiscal year's budget. This includes reviewing the previous year's expenditures and forecasting available resources for the coming year (the "resource envelope"). Based on this analysis, the MoFEPD Budget Directorate develops budget guidelines for the coming fiscal year.

ENTRY POINT #1—This stage is a key point for CSO engagement. Prior to publication of the budget guidelines, CSOs may be able to influence overall government spending levels for health in the upcoming year, how those resources are allocated geographically, and the introduction of specific health issues (such as HIV, maternal health, or health systems strengthening).

January: Publication of budget guidelines

In January, the MoFEPD distributes the budget guidelines to each ministry's Department of Policy and Planning and to the NLGFC, which distributes the guidelines to district councils.

The guidelines

- Outline government priorities/policy objectives for the fiscal year
- Include core principles of planning public expenditures and preparing budgets
- Provide detailed instructions for government institutions in preparing the national budget, including dates for submission of budgets to MoFEPD by line ministries
- Establish expenditure ceilings for ministries, departments, and local government authorities

Once the budget guidelines have been released, CSOs still have an opportunity to influence the health budget (including changing expenditure ceilings) through the "entry points" outlined below.

January–March: Budget development and public consultations

Release of the budget guidelines marks the beginning of internal budget deliberations within ministries, departments, and districts. These entities prepare mid-term expenditure frameworks (MTEFs)[28] and annual budgets based on the budget guidelines, which must be submitted to the MoFEPD by the end of March.

ENTRY POINT #2—At this stage, CSOs can influence allocations within the health budget (e.g., more funds for maternal health or family planning) by targeting the MOH director of planning.

Distribution of the budget guidelines also marks the start of a public consultation period, during which the MoFEPD solicits input from various stakeholders and interest groups. For example, the MoFEPD holds regional consultations, allowing members of the public to comment on the budget. These meetings often include representatives from the business sector and other prominent leaders.

ENTRY POINT #3— CSOs may use these public consultation meetings to highlight gaps and priority issues for the MoFEPD to consider when consolidating the budget in March. Although the public consultations provide a space for CSO participation, this space has not yet been used effectively.

Helpful Tip: Health Budget Advocacy is a Year-Round Activity!

No matter the season, some part of the budget cycle is happening. Effectively influencing health budgets requires sustained engagement throughout the year (see Figure 5).

March–April: Negotiations with MoFEPD

After receiving draft budgets, the MoFEPD holds consultations with each ministry. Ministries may use these meetings to argue for increases in overall expenditure ceilings, make the case for individual line items within their budgets, and/or negotiate regarding budget cuts proposed by the MoFEPD.

During this period, the MOH negotiates with the MoFEPD regarding its budget proposal, answering questions and providing justifications for its funding requests.

ENTRY POINT #4—During this period, targeting the MoFEPD budget director could result in an increase in the overall health budget, a reallocation within the health sector to a specific issue, or both. MoFEPD officials may not be familiar with the details of public health needs or understand why the MOH is requesting a particular level of health funding. Advocacy targeting the budget director can help avoid cuts to the MOH draft budget during the MoFEPD's budget consolidation process.

ENTRY POINT #5—CSOs can also help by supplying MOH officials with policy briefs (see Annex 2) and evidence to support them in their budget negotiations.

ENTRY POINT #6—Finally, CSOs may be able to facilitate increased face-to-face dialogue between the MOH and MoFEPD regarding the health budget.

May: Budget consolidation

In May, the MoFEPD consolidates the national budget based on its consultations and prepares the budget documents (see Box 10) for submission to Parliament. In June, the minister of finance presents the budget documents to Parliament through Budget Document Number 1: The Budget Statement—commonly referred to as the "Budget Speech" (see Box 10). The Budget Speech summarises the contents of the budget and includes a brief snapshot of the global, regional, and national economic outlook. The minister of finance's discussion of the health sector in the Budget Speech can influence parliamentary budget debate. Through the Budget Speech, the minister can highlight the importance of general health and/or specific health issues—for example, by discussing the economic impact of HIV and malaria or the potential economic benefits of investing in family planning. Likewise, if the Budget Speech includes little focus on health, this may imply that health is not considered important or worthy of investment.

ENTRY POINT #7—CSOs can engage with the MoFEPD during the budget consolidation process to affect final budget allocations for health. They can also lobby the minister of finance to influence the contents of the Budget Speech, helping to ensure that priority health issues are highlighted. Given the importance of the Budget Speech in setting the stage for parliamentary budget debates, this can be a potentially powerful entry point.

Box 9. Where Can the Health Budget Be Found?

The MOH budget does not constitute the entire health budget—money allocated to health is found in different places in the national budget. When analysing the health sector budget, advocates should look at the MOH budget, but also to the National AIDS Commission. Similarly, it is important to account for the substantial resources that are allocated to district councils for the health sector. To assess and calculate the total amount of money government allocates to health, one must look at a variety of line items.

Stage 2: Review and approval

June: Parliamentary budget deliberations

(Step 1): Review by parliamentary committees
The Budget Speech marks the beginning of the review and approval stage of the budget process. Following the speech, Parliament debates the draft budget. In FY2014/15, review of the draft budget by parliamentary committees was incorporated into Parliament's budget deliberations. In addition to the Budget and Finance Committee, which reviews the whole national budget, committees review the sections of the budget that fall within their purview.

Two committees are involved in jointly reviewing the health budget: the Parliamentary Health Committee and the Parliamentary Committee on HIV/AIDS and Nutrition. When these committees meet to review the draft budget, they have three options: (1) approve the budget with no changes, (2) request an increase in the overall health budget, or (3) request an increase or reallocation of funds within the health budget for a specific issue (such as HIV, maternal health, or health systems strengthening).

ENTRY POINT #8—At this stage, budget advocacy efforts should target allies within these parliamentary committees. Advocates can also target the Budget and Finance Committee, which is mandated to bring its budget recommendations to Parliament before passing it into law, accounting for any public submissions on preliminary budget assumptions (see Case Study 2).

(Step 2) Parliamentary debate
Following committee review, parliamentary budget debates begin. Parliament is required to vote on the budget by the end of June (before the end of the fiscal year).

ENTRY POINT #9—During this phase, vocal and influential members of Parliament (MPs) can be encouraged to speak out for more funding for health, either generally or for particular issues (e.g., maternal health). Mobilising like-minded MPs is crucial at this stage. This public debate can influence Parliament to direct more money for health or demand an increase for a specific program area.

ENTRY POINT #10—Engaging the media is also crucial at this stage, as media attention can encourage members of Parliament to focus on particular issues.

(Step 3):Approval of appropriations bill (gives government authority to begin expenditures)

Stage 3: Execution, monitoring, and oversight (July—June)

July: New fiscal year / budget execution begins

Once the budget is passed in July, disbursement of funds begins. Budget execution, monitoring, and oversight continue throughout the year.

Budget execution

- Ministries provide a breakdown of monthly cash flow requirements in line with their budget submissions.
- MoFEPD loads this budget data in the Integrated Financial Management Information System (IFMIS) for expenditure management.
- The data forms the basis for actual disbursements; MoFEPD provides funding to line ministries on a quarterly basis and to the accountant general on a monthly basis.
- Actual monthly funding is based on actual receipts from revenue and grants.
- Shifting resources committed to one budget line to another (called virements) may be permitted, and can be used to provide funding for unanticipated issues/needs.
- In emergencies, where no budget allocation exists, the "Unforeseen Expenditures" budget line is utilised.
- Funds that are allocated in the budget and not spent within the fiscal year remain with the MoFEPD.

February: Mid-term review (MTR)

After the first two quarters of budget implementation, the MoFEPD develops a revised budget based on the Economic and Fiscal Update report, which is shared with the Cabinet. The revised budget (based on the report) is then shared with parliamentarians, after which Parliament debates and approves the revised budget.

ENTRY POINT #11—The mid-term review is an excellent opportunity for CSOs to engage in advocacy to increase or change the health budget. This advocacy should target the MoFEPD Budget Directorate and parliamentarians.

ENTRY POINT #12—Budget advocates may be able to use virements to secure additional allocations for a specific priority, particularly if the priority arises due to an urgent and unforeseen circumstance. For example, virements in FY2014/15 were used to make some Global Fund resources originally allocated for HIV programs available for responding to Ebola, in case the epidemic reached Malawi.

Multiple bodies are responsible for budget monitoring and oversight:

- The Office of President and Cabinet (OPC) performs high-level monitoring/oversight of the national budget and publishes quarterly reports on recurrent and development expenditures (divided according to budget vote)
- MoFEPD—mainly through the Monitoring and Evaluation (M&E) Division—monitors implementation of the entire national budget (including implementation of ministerial and decentralised budgets).

Box 10. The Budget Documents

The national budget is composed of five key documents.

Budget Document No. 1: The Budget Statement (The "Budget Speech")—Delivered to Parliament by the minister of finance in May.

Budget Document No. 2: The Economic Report—Provides a detailed overview of the global, regional, and national economic outlook. The report places Malawi's economic performance in the context of the global economy and describes the performance of different sectors. The Economic Report can be an important source of information for CSOs, as it can provide evidence to support arguments for investing in health.

Budget Document No. 3: The Financial Statement—Provides a summary of the budget's performance for the financial year just ending, as well as details on resources required to finance government expenditures in the coming year. The statement includes approved and revised estimates of revenues and expenditures for the financial year just ending and similar estimates for the coming year. It outlines some expectations of what government will deliver during the coming budget year. For comparative purposes and based on the MTEF, figures for the years prior to current fiscal year are also presented in the statement. The Financial Statement also briefly discusses the relationship between the approved budget and the overarching national development agenda (like MGDS II). Document No. 3 provides an opportunity for CSOs to understand the working assumptions within the MTEF, as well as government's key priorities for the coming financial year.

Budget Document No. 4: The Output-Based Budget (OBB)*—Presents the budget based on activities to be implemented and outputs to be generated by each ministry. It is called an "output-based budget" because amounts are presented based on what each ministry plans to produce or achieve with each line item.

Outputs and activities within the OBB are presented as "votes." For example, the MOH budget is vote 310. Each vote is divided into three sections:

- **Introduction**—The ministry's mission, objectives, and strategies.
- **Budget summary**—Summarises the current and proposed budgets, broken down by line item.
- **Outputs and activities**—Divided into two subsections: the first summarises performance in the current fiscal year; the second describes anticipated activities and outputs for the upcoming fiscal year (the year being budgeted for). Each subsection includes two tables, one for other recurrent transactions (ORT) and one for development.

The **ORT budget** is for regular and ongoing expenses needed to maintain operations (e.g., salaries and other human resource costs, general maintenance of buildings, and supplies). The ***development budget*** includes new services or programs, significant scale-up of existing activities, or other investments, such as building a new health facility. Outputs and activities included in the OBB are based on national strategies. For the health sector, these are based on the current HSSP. This plan, in turn, is based on the MGDS. It is important for advocates to understand the connection between these documents, as budget "asks" presented in alignment with the priorities stated in these documents are more likely to gain support from decisionmakers.

* In the future, Malawi may transition to program-based budgeting, which focuses on higher-level results of expenditures (beyond outputs). For example, this could include improving the provider to patient ratio instead of counting the number of nurses trained.

Budget Document No. 5: **Detailed Budget Estimates**—Breaks down the activities and outputs presented in the OBB into specific expenditures, such as fuel, salaries, rents, and pharmaceuticals. The document is mainly used for accounting purposes, to enable the government to disburse funds. Together with Document No. 4, CSOs can use this document to conduct budget tracking (e.g., Public Expenditure Tracking Surveys).

- MoFEPD M&E desk officers are the point persons for monitoring expenditures, and submit monthly reports to the head of M&E Division.
- Parliamentary committees are responsible for monitoring budget implementation within their respective purviews, including providing oversight of ministerial budgets in collaboration with the MoFEPD.
    - Budget and Finance Committee (national budget)
    - Issue-specific committees (e.g., the Parliamentary Health Committee and the Parliamentary Committee on HIV/AIDS and Nutrition)
- Ministries, including the MOH, supervise implementation of their respective budgets at both the national and district levels.
- NLGFC monitors implementation of district-level budgets (decentralised budgets).
- District councils monitor implementation of their own district budgets.
- The district health officer (DHO) and District Health Committee monitor implementation of district-level health budgets.

ENTRY POINT #13—Civil society plays a key role in monitoring government spending. CSOs can target or work with MOH staff within their units of interest (e.g., Reproductive Health Unit, HIV Unit, Expanded Programme of Immunisation) to increase transparency on government spending on specific health areas. MoFEPD desk officers and the head of the M&E unit are key targets for advocacy related to budget monitoring. MoFEPD quarterly expenditure reports are a valuable source of information that can be used to conduct budget analysis and support advocacy (see Annex 1).

3.2.2 District-level budget process

As a result of decentralisation reforms, district governments in Malawi play an increasingly important role in the delivery of health and social services. Beginning in 2005, Malawi began devolving budgetary responsibility for certain sectors (including health) to district councils.

The District Council is composed of locally elected councillors, the district commissioner, traditional leaders, the heads of devolved sectors, and civil society representatives. The latter are selected through district civil society networks, which are established by CSOs to coordinate their activities. Each year, the District Council elects a chairperson from among the councillors. The heads of the devolved sectors,

Box 11. Participatory Budget Monitoring

Community involvement in budget monitoring is becoming increasingly important as countries pursue decentralisation reforms. CSOs play an important role in facilitating community participation in budget monitoring. Case Study 1 describes the use of one such mechanism: public expenditure tracking surveys.

including the district health officer (DHO), play a key role in developing budgets under the leadership of the district commissioner and his/her management team. This process also involves the District Health Management Team (DHMT) (composed of the DHO and a district nursing officer, administrator, accountant, human resource officer, health promotion officer, district medical officer, and district environmental health officer). The DHMT is the main structure for managing district health services. The DHO is responsible for developing and managing the health budget under the supervision of the District Council, including facilitating consultations at all levels and providing technical advice to councillors as they review the health budget.

Helpful Tip: District Council's Budget Authority

CSOs engaging in budget advocacy at the district level should be aware of what changes are within the control of the District Council and those that need to be made at the national level. The national budget guidelines leave district councils with relatively little power to reallocate resources among or within different sectors. Therefore, achieving change at the district level may require a combination of district- and national-level advocacy.

Role of civil society: district level

Decentralisation reforms in Malawi have created valuable new opportunities for community members and civil society to engage with the budget process and influence health service delivery. Civil society plays several key roles in relation to district-level health budgets. First, CSOs and other civil society stakeholders can participate in the creation of the budget by providing input into the district-level budget process. Second, civil society representatives serving on the District Council are involved in the review of draft budgets, which gives them additional opportunities to influence health budgets. CSOs not serving on the council can influence their civil society representatives through the district civil society network. Finally, they can advocate at the national level (through the NLGFC and the MoFEPD) to influence the expenditure ceilings for health in their districts. Civil society can play a role in influencing the budget development process at the local level, and can also contribute to government transparency and accountability at all levels by monitoring how these funds are subsequently spent.

For example, civil society can help ensure a transparent budget processes. In theory, each district uses the process outlined below to develop health budgets, but few, if any, districts do so in practice. In some, community participation has been dampened by the lack of responsiveness. If community members share their priorities and needs during budget consultations on a yearly basis, but see little change, they may be less likely to participate in future consultations. In other districts, resource constraints have reduced opportunities for public consultation.

Stage 1: Budget formulation

October–December: Preparing budget guidelines/setting expenditure ceilings

As described in Section 3.2.1, the MoFEPD prepares for the upcoming year's budget process between October and December.

ENTRY POINT #14—CSOs operating at the district level can advocate nationally to influence expenditure ceilings for health in their districts. At the national level, engaging the MoFEPD and the MOH may be the

most effective, as the MoFEPD establishes the budget ceilings that determine district-level health budgets, and the MOH decides how national budget resources for health are deployed at district and local levels.

January: Publication of budget guidelines

In January, the NLGFC communicates the MoFEPD budget guidelines and district expenditure ceilings to district councils.

January–March: Community-level consultations

Ideally, health budget formulation begins at the community level, through the Village Development Committee and the Area Development Committee**.** These committees provide public input into the health budget process in the form of "wish lists" of key health sector priorities and needs. Remember that district-level budgeting is still subject to the guidelines established by the MoFEPD.

ENTRY POINT #15—CSOs can influence local health budgets by making sure that the process for developing district and local health budgets includes public consultation, and by participating in these consultations. Gathering and presenting evidence in support of key arguments and positions will be critical for success. It may be helpful to involve the local member of Parliament in budget consultations. If the MP is interested in health issues, he/she can be an advocate for increasing the health budget. The MP can also be helpful later, during parliamentary review.

Stage 2: Review and approval

January–March: District Health Committee review

The Village Development Committee and the Area Development Committee submit their "wish lists" to the District Health Committee (DHC). In contrast to the DHMT, which operates at the district level and is composed of heads of health units, the DHC operates at both the community and district levels and involves district councillors, as well as community representatives. The DHC, led by the DHO, develops a draft health budget based on the "wish lists" provided by the village and area development committees, together with other information. Health facilities provide crucial inputs to the budget process, as they are able to provide information about utilisation and availability of health commodities, services, and infrastructure. Each health facility has a Health Advisory Committee, which submits its budget needs and recommendations to the DHO.

ENTRY POINT #16—CSOs can engage the DHO, the DHC, and the DHMT to influence the overall size and allocation of health budgets.

January–March: District Development Committee and Finance Committee review

The Health Committee submits the draft budget to the District Development Committee and the District Finance Committee. The Development Committee reviews the budget from a technical perspective, while the Finance Committee considers its resource implications.

ENTRY POINT #17—CSOs can engage the District Development Committee and the District Finance Committee (and committee members) to influence the size and distribution of allocations for health within the district budget.

March:District-level budget consolidation and approval

The full District Council reviews all devolved sector budgets (including the health budget) and consolidates these into the district budget. The council approves the budget and submits it to the NLGFC by the end of March (when ministries are also submitting draft budgets to the MoFEPD).

ENTRY POINT #18—CSOs can engage the District Council during this consolidation process to influence district and local health budgets. The Council Secretariat—specifically, the office of the director of planning and development—can provide CSOs with the draft budget to enable them to prepare for the council meeting. As described above, CSOs can also engage at the national level (through the MoFEPD and the MOH and, to some extent, the NLGFC) to influence budget allocations for health in their districts.

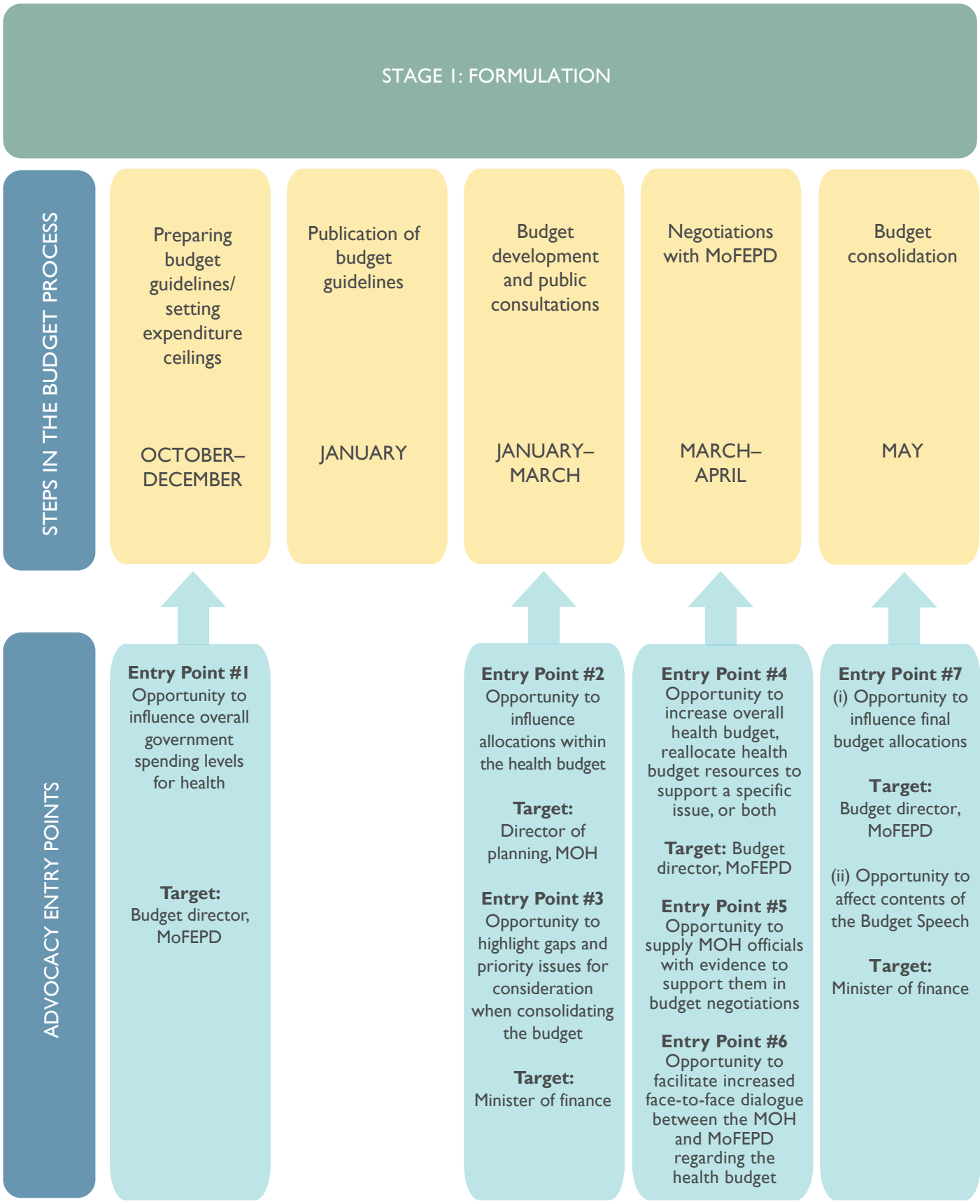
April–June: National-level review (NLGFC, MoFEPD, Parliament)

The NLGFC reviews district budgets and submits them to the MOFEPD for final approval. At this point, the district-level budget process merges with the national budget process. When the national budget is presented to Parliament in June, it includes budgets for each district, including allocations for specific sectors, including health. As described above, MPs can serve as advocates for the district health budget, as part of the parliamentary review of the national budget, provided that they have been engaged on health budget issues.

Stage 3: Execution, monitoring, and oversight (July—June)

ENTRY POINT #19—CSOs play an important role in budget monitoring and oversight. Accurate information is crucial to enabling CSOs to play this role. The NLGFC, which monitors implementation of district budgets, can be a valuable source of information for advocates.

Figure 6: The Budget Development Process at the National Level



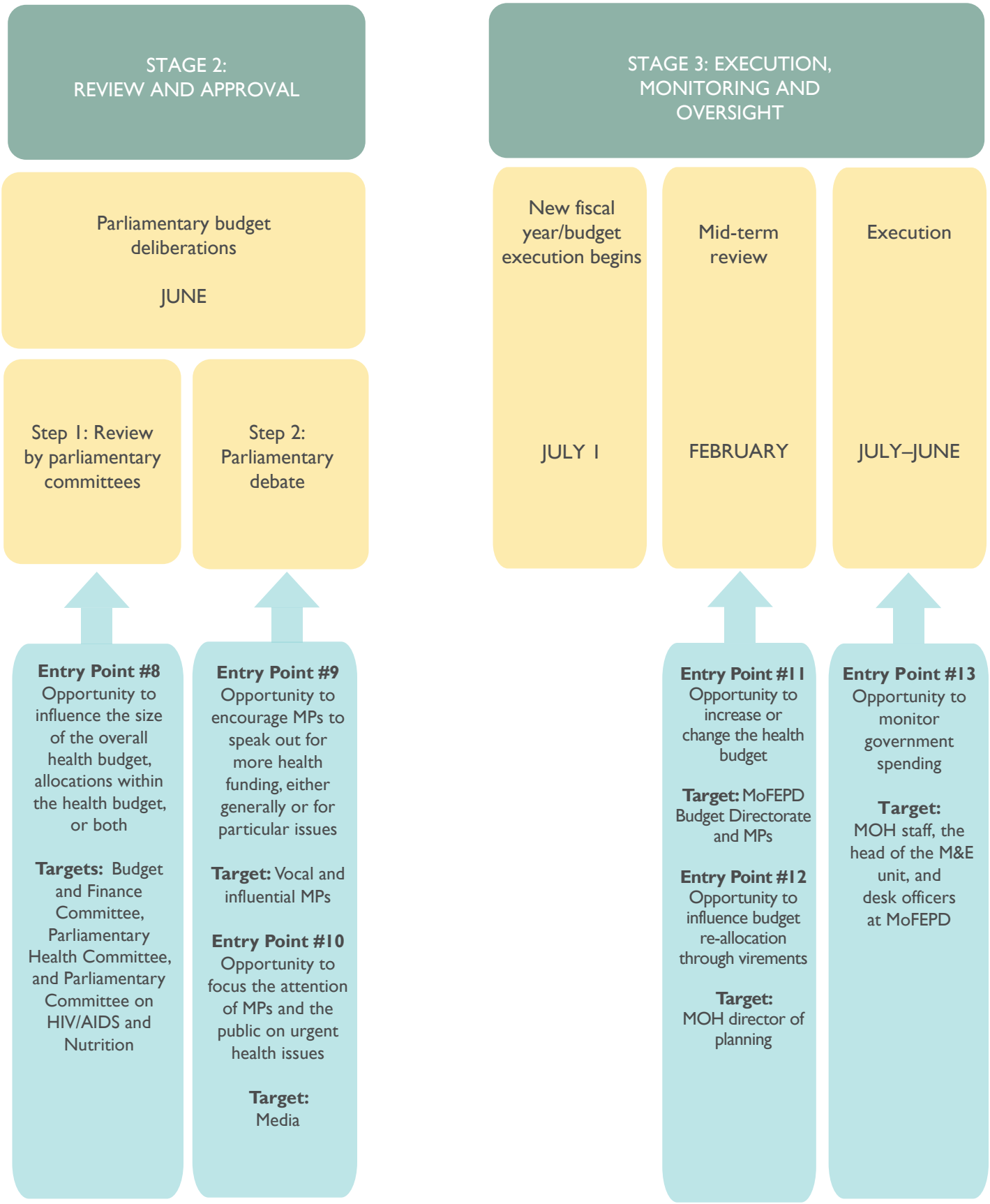
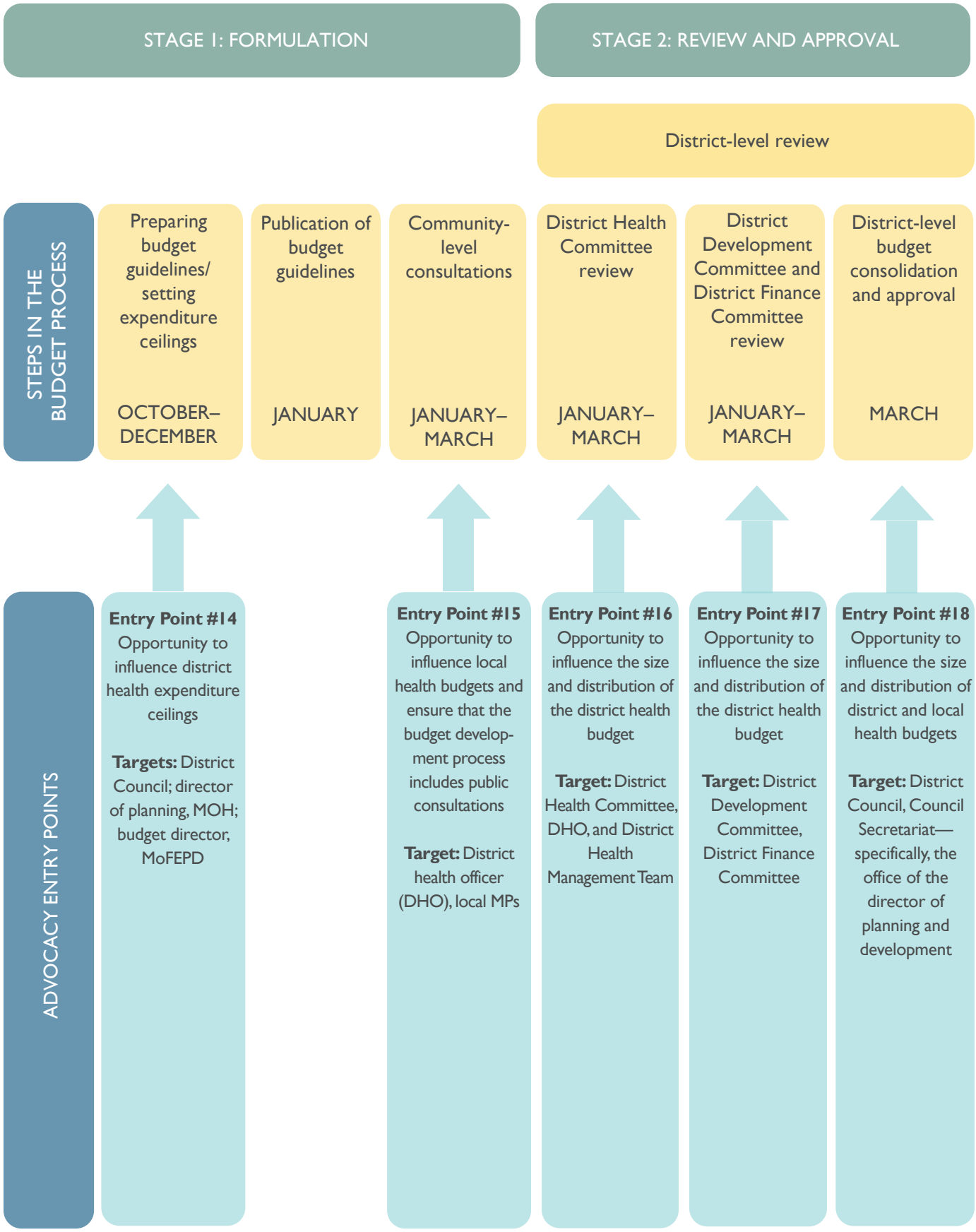
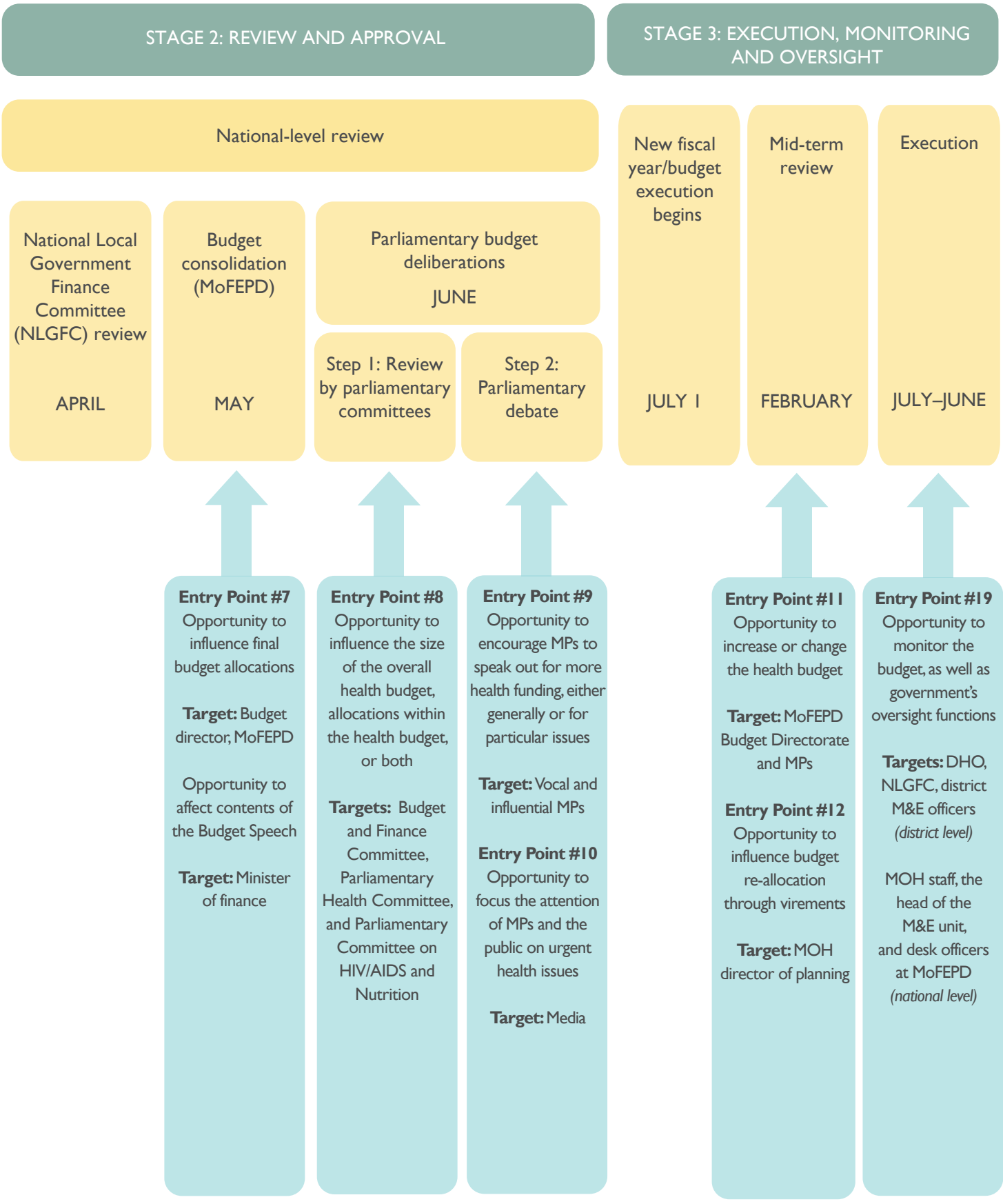

STAGE 2:
REVIEW AND APPROVAL
STAGE 3: EXECUTION, MONITORING AND OVERSIGHT
Parliamentary budget deliberations
JUNE
Step 1: Review by parliamentary committees
Step 2: Parliamentary debate
New fiscal year/budget execution begins
JULY 1
Mid-term review
FEBRUARY
Execution
JULY–JUNE
Entry Point #8 Opportunity to influence the size of the overall health budget, allocations within the health budget, or both
Targets: Budget and Finance Committee, Parliamentary Health Committee, and Parliamentary Committee on HIV/AIDS and Nutrition
Entry Point #9 Opportunity to encourage MPs to speak out for more health funding, either generally or for particular issues
Target: Vocal and influential MPs
Entry Point #10 Opportunity to focus the attention of MPs and the public on urgent health issues
Target: Media
Entry Point #11 Opportunity to increase or change the health budget
Target: MoFEPD Budget Directorate and MPs
Entry Point #12 Opportunity to influence budget re-allocation through virements
Target: MOH director of planning
Entry Point #13 Opportunity to monitor government spending
Target: MOH staff, the head of the M&E unit, and desk officers at MoFEPD

Figure 7: The Budget Development Process at the District Level




STAGE 2: REVIEW AND APPROVAL
STAGE 3: EXECUTION, MONITORING AND OVERSIGHT
National-level review
National Local Government Finance Committee (NLGFC) review
APRIL
Budget consolidation (MoFEPD)
MAY
Parliamentary budget deliberations
JUNE
Step 1: Review by parliamentary committees
Step 2: Parliamentary debate
New fiscal year/budget execution begins
JULY 1
Mid-term review
FEBRUARY
Execution
JULY–JUNE
Entry Point #7 Opportunity to influence final budget allocations
Target: Budget director, MoFEPD
Opportunity to affect contents of the Budget Speech
Target: Minister of finance
Entry Point #8 Opportunity to influence the size of the overall health budget, allocations within the health budget, or both
Targets: Budget and Finance Committee, Parliamentary Health Committee, and Parliamentary Committee on HIV/AIDS and Nutrition
Entry Point #9 Opportunity to encourage MPs to speak out for more health funding, either generally or for particular issues
Target: Vocal and influential MPs
Entry Point #10 Opportunity to focus the attention of MPs and the public on urgent health issues
Target: Media
Entry Point #11 Opportunity to increase or change the health budget
Target: MoFEPD Budget Directorate and MPs
Entry Point #12 Opportunity to influence budget re-allocation through virements
Target: MOH director of planning
Entry Point #19 Opportunity to monitor the budget, as well as government's oversight functions
Targets: DHO, NLGFC, district M&E officers (district level)
MOH staff, the head of the M&E unit, and desk officers at MoFEPD (national level)

Endnotes

27. Factors taken into consideration include outpatient department utilisation rates, stunting, bed capacity, infant mortality, fertility and death rates, water sources, incidence of extreme poverty, food security, HIV prevalence, and youth population. Although this formula does not change on an annual basis, it is important for advocates to be aware of it, as changes can have significant impacts on the allocation of resources to health programs and services at the district and community levels.
28. MTEFs project government spending anticipated over the coming three years, while annual budgets detail proposed expenditures for the upcoming fiscal year.

4 Successful Case Studies in Health Budget Advocacy

Case Study 1—District-Level Advocacy to Monitor Disbursement and Use of Resources for Health

Lloyd Mtalimanja, program manager, Malawi Health Equity Network (MHEN)

In Malawi, the share of government budgets dedicated to health is insufficient to meet existing need (see Section 1.2). At the district level, where the majority of health services are delivered, this shortage is compounded by deficiencies and inconsistencies in the disbursement and use of funds.

At the beginning of the fiscal year, districts submit their budgets to the MoFEPD (see Section 3.2.2). Their packet of budget documents includes an output-based budget (OBB), a detailed budget, a workplan, and a "cashflow," or monthly funds necessary to carry out planned activities. These district budgets are part of the larger District Implementation Plan (DIP), which outlines all activities to be carried out during the year by both government and nongovernmental partners at the district level.

Disbursements of health funds from the national level (MoFEPD) to districts are often delayed, or not aligned with districts' plans. Moreover, when disbursements arrive in districts, funds are often diverted from critical intervention areas to areas of low priority. Overall, these challenges compromise service delivery in terms of timeliness, availability, and quality, which contributes to poor health outcomes. In 2011, the Malawi Health Equity Network (MHEN) conducted an analysis of health sector funding for Mchinji and Dedza districts to clarify the extent of these disbursement issues. Of the scarce resources allocated for health at the national level, MHEN found that even fewer resources reached the district level.

Advocacy problem

(1) Disbursements of health funding from the MoFEPD to district councils did not happen as planned in the budget (late and/or insufficient), leading to cash shortages that undermined the quality and quantity of health services at the district level. As a result, some districts ended up with a net loss by the end of the year.

(2) A lack of effective independent budget monitoring, lobbying, and advocacy contributed to weaknesses in the disbursement and use of health resources at the district level.

Advocacy objectives

Improve implementation of DIPs and district health budgets by

(1) Ensuring that health-related disbursements from the MoFEPD to the district level are timely and consistent with allocations and projected cash flows

(2) Building the budget monitoring and advocacy capacity of the district team (representatives from the Mchinji District Council Secretariat, the DHO, and CSOs active in the district)

(3) Addressing weaknesses in the disbursement and use of health resources once funds have arrived at the district level

Key players

Of the two districts studied, MHEN chose Mchinji as a focus district. With support from TROCAIRE, MHEN worked with district-level CSOs and officials in Mchinji to develop and implement an advocacy strategy that identified and targeted the MoFEPD, the MOH, and parliamentarians as key decisionmakers in addressing the problem.

What advocacy methods and processes were used?

MHEN has conducted annual nationwide Service Delivery Satisfaction Surveys (SDSSs) since 2006. These surveys assess health services from the perspectives of health workers and those accessing the services. The SDSS revealed weaknesses, including shortages of crucial medicines and supplies, along with poor resource tracking and accountability. In response, MHEN undertook a participatory budget tracking exercise in two districts, Mchinji and Dedza, to determine potential causes of these weaknesses and to identify possible solutions. MHEN used a public expenditure tracking survey (PETS) methodology to analyse disbursements from MoFEPD to district councils in the two districts. They found that disbursements were often delayed and not in line with the approved budget. MHEN's analysis identified delays and inadequacies in disbursements from the MoFEPD to district councils as one factor negatively affecting the quality and availability of government health services in two districts. MHEN used these findings to engage parliamentarians during mid-term review of the 2011/12 national budget.

One key to MHEN's success was its use of a participatory methodology. By involving key government stakeholders in the research and analysis process, MHEN was able to ensure their validation of the findings and foster greater commitment to addressing identified shortcomings.

(1) MHEN trained the Mchinji district team in the use of PETS to monitor public spending in targeted districts and regions to influence greater budget accountability.[29]

(2) MHEN then partnered with Mchinji's district team to use PETS to assess the implementation of the DIP and district budget, comparing the district's cash flow against actual disbursements from the MoFEPD between July and December 2011.

(3) The report's findings were discussed and validated by district officials and CSO representatives. It found that out of 159 planned activities/key interventions outlined in the DIP, only 57 were actually implemented—largely because of funding shortages. Funding disruptions affected the DHO's ability to pay for utilities (such as water and electricity) at health facilities or supply fuel for generators, as well as its ability to procure drugs and other services. This affected the quality and availability of health services.

(4) Representatives from the MHEN Secretariat, the MoFEPD, and the MOH presented the report at a meeting of MPs from the Health Committee during the midterm review of the 2011/12 national budget.

What were the main advocacy messages?

The meeting delivered two key messages to decisionmakers:

- The national government's failure to disburse funds to districts in a timely manner and in line with projected cash flows is reducing the quality and availability of district-level health services.
- The inability of the district health office to provide services due to funding disruptions is affecting health outcomes and contributing to otherwise preventable deaths.

What challenges were encountered?

The main challenge was the availability and capacity of CSOs in Mchinji District. Few CSOs were already engaged in monitoring and advocacy related to the district budget, so it was difficult for MHEN to identify enough CSOs to develop effective partnerships to achieve the project's objectives. Those CSOs that were available had very limited advocacy capacity and experience.

What were the results of advocacy?

Following the advocacy activities, a number of positive outcomes were realised:

- The district received MK10 million in payment in arrears from the MoFEPD. Without MHEN's advocacy efforts, these funds would likely never have been disbursed. The payment was used to offer critical life-saving services and interventions, including referral services, procurement of fuel for the generator, procurement of essential drugs, settlement of utility bills (e.g., water and electricity), and debt settlement to suppliers of various goods and services. This resulted in improved quality of life for patients/clients and prevention of avoidable deaths.
- The DHO has entrenched the practice of quarterly DIP reviews, involving a variety of stakeholders in the process.
- Transparency has been enhanced. Financial reports that detail the budget, cash flow, actual disbursement, and funding gaps are produced, routinely summarised, and publicised on notice boards at the council secretariat.

Mchinji district can be used as a model for other districts on effectively conducting budget tracking, engaging in budget advocacy, promoting community participation, and entrenching transparency.

Lessons learned

- Inclusive approaches to budget advocacy are pivotal to success. Part of MHEN's success was due to involving relevant officials (such as the district environmental health officer and the director of finance) in the entire advocacy process, from analysis through results. Their involvement helped these officials appreciate the potential benefits of budget advocacy initiatives.
- Success in budget advocacy also hinges on effective presentation of facts and evidence, and utilization of available, opportune moments in time, such as budget reviews.

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Case Study 2—Advocating for a Family Planning Budget Line Item

Health Policy Project (HPP)

Malawi is one of the fastest-growing countries in sub-Saharan Africa. The population has tripled over the past 40 years, and is expected to triple again by 2040. The average couple has five to six children, yet both men and women express a desired family size of four children.[30] Over one-quarter of married women of reproductive age in Malawi have an unmet need for family planning (FP) services that could help them better time and space their pregnancies. High rates of unplanned and mistimed pregnancies, caused in part by a lack of access to FP services, create serious health and development challenges for the country. Yet, until 2013, the government budget did not include any allocation for family planning. Instead, Malawi relied exclusively on donors to provide FP commodities and services.

What was the advocacy problem?

Expanded access to FP services is vital if Malawi is to achieve its health and development goals. Until FY2013/14, the government budget did not include any allocation for FP commodities, leaving Malawi completely reliant on donor resources.

What was the advocacy goal?

To increase domestic funding for family planning to (ultimately) expand access to FP services.

What were the advocacy objectives?

(1) Establish a line item for family planning within the MOH budget.

(2) Secure funding for the FP line item.

(3) Continue advocacy for increased funding for the FP line item until it corresponds with existing need.

Creating a budget line item is an important starting point in efforts to expand access to FP services, and provides a mechanism for allocating government funds specifically to family planning. It also helps advocates hold the government accountable because it allows them to track exactly how much money is being allocated and spent on FP commodities.

Who were the advocates? What partnerships were formed?

The advocacy effort was led by MPs, especially women parliamentarians (members of the Women's Caucus), with support from the USAID-funded Health Policy Project (HPP) and its partners, including the Family Planning Association of Malawi (FPAM) and Partners in Population and Development Africa Regional Office (PPD-ARO).

Who were the decision-makers?

Targeted decisionmakers included the former vice president and minister of health (Right Honorable Khumbo Kachali) the budget director of the MoFEPD, the minister of health, the MOH director of planning, the Parliamentary Committee on Health, and the Parliamentary Budget Committee.

What advocacy methods and process were used?

Advocacy efforts began in February 2012, when FPAM, with assistance from HPP, presented on the social and economic effects of high fertility to Malawi's Parliamentary Committee on Health. Representatives from the MOH Reproductive Health Unit and the Ministry of Economic Planning and Development also attended. The presentation used an interactive software modelling tool—RAPID (Resources for the Awareness of Population Impacts on Development), provided by HPP—to present data for different scenarios. Following the presentation, committee members agreed to lobby for the creation of an FP line item within the national budget.

In August 2012, HPP partnered with PPD-ARO to conduct a regional advocacy training in Uganda, targeting women parliamentarians from four countries to strengthen their skills as champions for investing in family planning within their governments. During the workshop, women MPs from Malawi reiterated their commitment to establishing a budget line item for family planning. Following the meeting, HPP organised country monitoring meetings, and women MPs engaged their fellow parliamentarians and built coalitions with chairpersons of various national committees, thereby establishing a strong voice for family planning in Parliament.

In April 2013, a new FP line item was created in the 2013/14 national budget; however, no funding was allocated. Led by the delegates who had participated in the advocacy trainings, a large group of MPs declared they would not pass the budget unless the FP line item was funded. Media coverage of this event helped build momentum in support of funding the line item.

Several weeks later, the MPs held a follow-up meeting opened by the chair of the Public Appointments Committee, who spoke boldly about investing in health and family planning. This was the first meeting of its kind in Malawi, with chairpersons of parliamentary committees meeting directly with senior MOH and MOFEPD officials to discuss the budgetary allocation for health. As a result, the MOFEPD allocated 26 million MKW to the newly-created budget line for FP commodities for FY 2013/14.

The story continues…

What happened next illustrates the importance of sustained engagement. Recognising that the allocation of resources was only the beginning, advocates followed up to determine how the MOH was spending the FP funds. In the third quarter of the 2013–2014 budget year, they held a roundtable meeting with MoFEPD and MOH representatives and discovered that, nine months after the allocation for FP commodities, the MOH had not spent any of the funds. Pressure and scrutiny from parliamentarians brought the problem to the attention of the minister of health. As a result, the MOH spent all the funds within the final quarter of the fiscal year. Without follow-up, the resources would likely have remained unspent, making the case for future FP allocations more difficult.

In 2014, the parliamentarians successfully lobbied for an increase in funding for the FP line item, and 60 million MKW was allocated in the FY2014/15 budget. Advocates continue to engage and push for additional increases in the FY2015–2016 budget; which is projected to be 70 million MKW.[31]

What were the main advocacy messages?

The main advocacy messages were

- Invest in family planning to save the lives of mothers and children.
- Invest in family planning to reduce poverty and support development.
- Invest in family planning to slow population growth and reduce the social, environmental, and economic impacts of population growth.
- Invest in family planning to save money on social services such as education and health.

What challenges were encountered during the advocacy process?

It was challenging to schedule meetings with parliamentarians. The high cost of bringing MPs from their constituencies to Lilongwe meant that meetings had to take place when MPs were already in the capital on parliamentary business.

Results of the advocacy

- Creation of an FP budget line item (April 2013)
- Allocation of 26 million MKW to the FP line item in FY2013/14 budget
- Increased annual allocations to 60 million MKW in FY2014/15, and 70 million MKW in FY2015/16 budgets[32]

Lessons learned

- There is a need to closely monitor commitments made by the MOH and MoFEPD.
- Evidence was vital to advocacy success; data enabled MPs to confidently articulate issues, ask relevant questions, and make a strong case for investing in family planning.
- Timing is also critical. For example, advocates engaged fellow parliamentarians, the MOH, and the MoFEPD long before parliamentary budget debates. When parliamentarians "made noise" during parliamentary debates, the key players at the MOH and MoFEPD were already aware of the FP budget line item issue, and ready to take action. Had parliamentarians not been engaged, this could have created confusion and/or delays.
- Budget advocacy does not stop at securing allocations; advocates must also monitor disbursements.

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Case Study 3—Advocating for an Increase in the Malawi National Drug Budget (FY2014/15)

Maziko Matemba, Executive Director, Health and Rights Education Programme (HREP)

Malawi's health sector faces daunting challenges that affect every level of service delivery. These challenges are mainly the result of years of underinvestment in the health sector. In FY2014/15, this underinvestment was particularly pronounced as a result of the zero deficit budget (a budget that relies exclusively on domestic resources with no donor funding), adopted by the government of Malawi after donors withdrew budget support upon the discovery of public financial mismanagement—a situation popularly known as "Cashgate".

When the minister of finance presented the FY2014/15 national budget before Parliament, he announced an allocation of MK52 billion for the health sector, less than half the amount proposed by the MOH (MK135 billion). When the minister made this budget statement, there was an immediate outcry from CSOs, which initiated an advocacy process to increase the health allocation.

CSOs were particularly adamant about increased funding for the drug budget. They based their argument on the findings of the Comprehensive National Drug Quantification Study—the first of its kind in Malawi—conducted by the MOH in collaboration with the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). The study determined the requirements for essential medicines and medical supplies in each health facility, and revealed a significant funding shortfall. In FY2013/14, the study estimated that Malawi needed MK27 billion for essential medicines and medical supplies, but the national budget allocated less than one-quarter of this amount (MK6.0 billion), resulting in a shortfall of MK21 billion.

The study projected that Malawi would require MK31 billion for essential medicines in 2014/15, but only MK9.1 billion was allocated in the year's budget presented to Parliament—a shortfall of MK21.9 billion (70.6% of estimated need). The study strongly recommended addressing these shortfalls, pointing out that this is the most sustainable way to deal with persistent drug shortages.

What was the advocacy problem?

Malawi suffers from persistent drug shortages, largely due to massive discrepancies between essential medicines requirements and budget allocations.

What was the advocacy goal?

Increase domestic funding for health, addressing chronic drug shortages and poor availability and quality of public health services.

What were the advocacy objectives?

(1) Increase the allocation for the health sector in the 2014/15 national budget.

(2) Increase allocations for essential medicines and supplies (the "drugs budget") in the FY2014/15 national budget.

Who were the advocates? What partnerships were formed?

Several CSOs advocated for increased budget allocations for health in the FY2014/15 budget, with HREP and MHEN among the most active. HREP concentrated its advocacy efforts on the MOH and the MoFEPD, focusing specifically on increasing the drug budget. MHEN engaged Parliament (mainly the Parliamentary Committee on Health) and the media, focusing on increases to the overall health budget. In the process, HREP and MHEN established strategic alliances with journalists and senior health officials. This case study focuses on HREP's efforts to increase the drugs budget.

Who were the decisionmakers?

- Ministry of Health (Office of Planning)
- Ministry of Finance
- Members of Parliament
- Parliamentary Committee on Health

What advocacy methods and process were used?

This advocacy campaign was ad hoc, designed to take advantage of an opportunity created by the publication of the Drug Quantification Study around the time that budget debates began in Parliament. HREP and other CSOs lobbied MOFEPD and MOH officials, as well as key parliamentarians, to increase the allocation for essential medicines in the FY2014/15 budget. HREP used findings from the Drug Quantification Study as evidence to support its advocacy efforts.

What were the main advocacy messages?

- Chronic shortages of essential drugs harm the health of Malawians.
- Until budget allocations for essential drugs match anticipated need, these shortages will continue.
- The government should increase FY2014/15 drugs budget to MK31 billion, the amount needed to meet projected need for essential drugs.

What challenges were encountered during the advocacy process?

- There is no consistent, coordinated advocacy approach among various CSOs engaging in advocacy on the FY2014/15 health budget.
- There was insufficient collaboration among different advocates and some relevant interest groups were not approached to add their voices to the campaign.
- The lack of strong evidence (demonstrating specific health needs other than essential drugs) and unified messages made it more difficult to advocate effectively for an overall increase in the health budget.

Results of the advocacy

The FY2014/15 drugs budget was increased by MK8 billion, to MK17 billion. Although still less than the required MK 31 billion, the increased amount was sizeable in comparison with previous allocations.

Lessons learned

- *Evidence was key to success.* The availability of credible evidence—specifically, the National Drug Quantification Study—was crucial in convincing the minister of finance of the urgent need to increase the allocation for essential medicines. Budget allocations for other equally important aspects of health delivery were not increased, in part due to the lack of evidence to support advocacy arguments.

- *Lack of communication and coordination.* CSOs' advocacy efforts on behalf of the FY2014/15 health budget were largely uncoordinated, which likely reduced their effectiveness.

- *Lack of capacity.* This advocacy effort demonstrated that advocates lacked sufficient advocacy skills, which could have helped them unite to form a stronger, more credible voice.

Endnotes

29. World Bank. 2010. *Using Public Expenditure Tracking Surveys to Monitor Projects and Small-Scale Programs: A Guidebook*. Washington: DC: World Bank. Available at http://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1239047988859/5995659-1282763460298/PETS_FINAL_TEXT.pdf.
30. National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey* 2010. Zomba, Malawi and Calverton, MD: NSO and ICF Macro.
31. At the time of publication, the budget was still under consideration by Parliament.
32. Estimate, as Parliamentary review of the FY2015/15 budget was ongoing at the time of publication.
33. Sharma, B. 2012. *Tools for Gender-Responsive Budgeting*. Presented at a workshop on promoting women's empowerment through gender-responsive budgeting and planning in public sector management. Malaysia, November 8–9, 2012

Annex 1. Conducting Budget Analysis

Budget analysis enables CSOs to understand the intent and potential impact of governments' plans for raising and spending public resources. Public budgets can be analysed from various perspectives:

- Looking at budget trends over time
- Comparing the share of resources allocated to one sector, such as health, as a proportion of the overall budget or in relation to another sector
- Assessing how a budget addresses the needs of a particular group (such as women, children, adolescents/young people, or the poorest households), or how it affects the overall economy.

A good budget analysis provides evidence to support advocacy, strengthening the ability of CSOs and the public to influence decisions on the generation (e.g., tax policies) and allocation of resources. Although the budget receives the most attention when the Budget Statement is made in parliament, CSOs should engage in budget analysis and advocacy throughout the budget cycle.

Connecting budget analysis with advocacy

Budget analysis is most valuable when used to create change. CSOs can use the results of budget analysis to influence budget debates, propose alternative policies, inform the public, build constituencies, and hold the government accountable.

CSOs should be aware that public budgeting is about trade-offs among competing interests; increases in spending on one program or service almost always require a decision to either increase revenues or cut spending on other programs. CSOs can improve their chances of success by integrating these potential trade-offs into their analyses and advocacy objectives.

Budget analysis tools

CSOs can use a variety of tools to conduct budget analysis. Costing (estimating the direct, indirect, and shared costs of a given activity in relation to its anticipated results—e.g., cost per unsafe abortion case prevented) can be used to inform decisions on expenditure levels and activities. Budget monitoring tools, such as PETS, can be used to gauge whether the funds allocated for local-level health service provision are being used efficiently and effectively, and whether they are achieving the desired results. By identifying leakages as money is transferred to the district level, CSOs can play a key oversight role, helping to strengthen the health system and address inequalities in access to care.

Similarly, analysing how budgets impact vulnerable populations (either directly or indirectly) can help identify whether policies and programs are working, detect gaps in spending, and suggest alternatives.

Accessing information for budget analysis

Budget analysis requires access to comprehensive, timely, and useful information. Different types of analysis have different information needs. For example, useful information for a gender analysis would include data disaggregated by sex, as well as data relating to key gender issues, such as maternal mortality

and violence against women. Most likely, this information is available at the responsible line ministry (the MOH, for example, or the MoFEPD). It may include previous expenditure trends and budget analysis reports, program/project reports, and details on the assumptions underlying the proposed budget estimates (such as the anticipated resource envelop). To conduct budget analysis, CSOs may first need to campaign for public access to government information. Currently, Malawi has no law or policy regarding this type of access, but there are efforts underway to introduce such a policy. This is vital, not just to help CSOs engage in advocacy (either in general, or budget advocacy in particular), but also to increase the overall transparency and accountability of government.

Annex 2. Writing a Policy Brief

Policy briefs are important advocacy tools, presenting decisionmakers with a written description of an advocacy issue and your desired action from them. They should be prepared in advance of meetings with decisionmakers and can be used during discussions; copies of policy briefs should be left with decisionmakers at the end of the meeting. Policy briefs can also be shared with allies and influencers, helping them stay "on message" as they support your advocacy efforts.

Policy briefs should include

- ***A concise and memorable title***—for example, "Saving Lives, Saving Money: The Case for Investing in Family Planning"
- ***Date***
- ***Author***—usually the author is an organisation rather than an individual
- ***Summary***—a brief paragraph (no more than a half page in length)
    - Introduce the issue, clearly informing the reader of the topic of the brief.
    - Provide minimal background information necessary to understand the "ask."
    - Introduce your "ask" or policy recommendation(s)—what are you asking the policymaker to do?
    - Introduce key messages and/or evidence points (that you will expand upon in the body of the brief).
- ***Body of the brief***— policy recommendations
    - Policy briefs are generally organised by policy recommendation. Each recommendation should be clear, feasible, and backed by evidence.
    - Generally, a policy brief should include no more than five policy recommendations. Any more will risk weakening your message and reducing the likelihood that the reader will remember all of your "asks".
- ***Conclusion and "take-away" messages***
    - Conclude with a final paragraph that restates your policy "ask" and its potential impact importance. Also restate one or two of your most important points (your "take-away messages").

After reading the brief, your reader should understand

- The issue you are discussing (e.g., disbursements of national health funding by MoFEPD to district councils)
- Why the issue matters (Who will be affected, how will they be affected, and why is it important?)
- What action policymakers are being asked to take (policy recommendations)
- What are the anticipated results/impact(s) of this action?

Anticipating opposition / questions—Advocates should consider taking the opportunity to anticipate and respond to opposition arguments or questions. For example, if you are likely to encounter resistance on the grounds of limited resources, be prepared with evidence showing that your desired action is worthy of investment and/or could actually result in savings.

Presentation—Avoid large blocks of text. Instead, use bulleted lists and visuals to make your points. Readers should be able to get your message by "scanning" the brief.

Length—Policy briefs should be *brief*—preferably no more than two pages (four pages maximum). Remember your audience. Policymakers are often busy, and have many different priorities competing for their time. They are unlikely to read a policy brief longer than two pages.

Language—Use simple and straightforward language—avoid technical language and jargon. Policymakers may be unfamiliar with these terms. Additionally, technical language and jargon tends to make your messages less "punchy" and memorable.

Annex 3. Writing a Discussion Paper

A discussion paper is another tool that advocates can use to communicate important policy issues to policymakers and decisionmakers.

What is the difference between a policy brief and a discussion paper?

A policy brief is short—its purpose is to briefly introduce the issue and present policy recommendations or "asks," together with supporting evidence. A discussion paper is a longer document, designed to present a thorough overview of a particular issue. Discussion papers may be up to 15 pages long, and provide more comprehensive and nuanced information and evidence related to the issue at hand. These papers are often presented to committees or other policy-making bodies as they deliberate on a specific issue. Discussion papers tend to be more neutral than policy briefs, including a thorough overview of relevant pros and cons and summarising available quantitative and qualitative evidence. Discussion papers may also present areas where more data/research is needed.

Title—A concise, clear, and memorable title is beneficial.

Executive summary—Presents an overview of the topic at hand, as well as the key points and evidence that will be presented in the paper (no more than 1–2 pages).

Description of the issue/problem—What problem are you trying to solve? Why does it matter?

Causes of the issue/problem—A discussion paper provides room to delve more deeply into the factors behind the problem you are trying to address. The evidence you present regarding causes will create the foundation/basis for your conclusions/recommendations.

Current policy context—This section should clearly describe the policy context. What policies have been used already to address the problem at hand? Have these policies had the intended effect? What are the strengths and weaknesses of current policies (supported by as much evidence as possible)? Where does the problem lie? Is it in the policy itself, or in its implementation?

Policy solutions—Present possible policy positions/solutions, including the strengths and weaknesses of each. This discussion builds your argument, leading ultimately to your conclusions/policy recommendations.

Conclusions / recommendations—Present your conclusions based on the preceding sections.

Given the more scientific and detailed nature of discussion papers, you may need to bring in additional experts to help you draft or review the document.

Annex 4. Gender-Responsive Budgeting

The national budget is one of the most important policy tools available to a government and ultimately reflects its socioeconomic priorities. Although the figures compiled in budget documents might seem gender-neutral, empirical findings show that expenditure patterns and the way that government raises revenue have a different impact on women and girls compared to men and boys, often to the detriment of the former. This is due to the societal roles played by women and men, the gendered division of labour, varying responsibilities and capabilities, and the different constraints that women and men face. Women are typically left in an unequal position relative to men in their communities, with less economic, social, and political power.

One key element that CSOs should look for in a budget is its responsiveness to the different needs and priorities of all gender groups. A budget that reflects and addresses these different needs and priorities is considered gender-sensitive. A gender-sensitive national budget recognises the underlying inequalities between women and men and redresses them through the allocation of public resources. It also views women not as "a vulnerable group who are the beneficiaries of government assistance but rather as rights holders, whose governments are under obligation to empower and protect."[33] The process of developing such a budget is called gender-responsive budgeting (GRB), referring to actual government expenditures on women and girls compared to men and boys, as well as the impacts of spending on these groups. Gender-responsive budgets are not separate budgets for women, and engendering the budget is not about favouring women, but about striving for equity in resource mobilisation, resource allocation, and the sharing of benefits. Gendered budgets are planned, approved, executed, monitored, and audited in a gender-sensitive way. Undertaking GRB initiatives leads to a more equitable use of resources. The table below summarises GRB.

Important to Note

Gender analyses of the health budget are crucial for improved targeting of advocacy messages. CSOs should be able to conduct a ***sex-disaggregated public expenditure incidence analysis,*** which involves analysing public expenditures in the health sector to see how such expenditures benefit women, men, girls, and boys to differing degrees. They should also be able to perform a ***gender-aware policy evaluation of public expenditure.*** This ensures an understanding of the policy assumptions underlying budgetary appropriations and identifies their likely impact on current patterns and degrees of gender differences.

GRB is…	GRB is not…
Allocating money for activities that eliminate gender barriers	Creating a separate women's budget
Mainstreaming a gender equality perspective into public finance and economic policy	Spending an equal amount on women and men; rather, it is about determining whether spending equitably addresses women's and men's needs
Analysing the impact of any form of public expenditure, or method of raising revenues, on women and girls compared to men and boys	Merely having additional resources to cater for gender needs; rather, it is also about ensuring that available resources are used to meet differing needs and priorities of sub-groups of females and males
Reprioritising expenditures and revenues to suit gender needs and priorities	Merely generating gender-responsive budgets; rather, it also involves tracking the implementation and impact of various budgetary allocations meant to address the different needs of women and men

Analysis for Gender-Responsive Budgeting

To make an informed stand about the gender-responsiveness of the health budget, CSOs need to conduct proper gender analyses. These analyses support actions and policies that will shift existing gender relations to bring about greater equality between women and men; identify strategic gender needs; use social and economic indicators to measure gender impact; and sometimes involve gender-specific strategic policies.

Studying findings from such an exercise is crucial for improved targeting, and will help government understand how it may need to adjust priorities and reallocate resources to live up to its commitments and achieve desired, inclusive results. When analysing the budget, CSOs should remember that gender-responsive budgeting focuses on more than just the number of times women are mentioned, or on measures that only affect women. Gender analyses lift the veil on what governments are doing, and for whom. More support on conducting a gender-responsive budgeting analysis can be obtained from the ministry responsible for gender (as of June 2015, the Ministry of Gender, Children, Disability, and Social Welfare).

Key Resources

This guide has introduced the concept of gender-responsive budgeting. However, implementation requires additional information and skills. These key resources provide more in-depth guidance.

Budlender, D. and G. Hewitt. 2003. *Engendering Budgets: A Practitioners' Guide to Understanding and Implementing Gender-Responsive Budgets, 2003 Commonwealth Secretariat.* New York: UN Women. http://www.aic.ca/gender/pdf/Commonwealth_Budgets.pdf

Budlender, D., Elson, D., Hewitt, G. and T. Mukhopadhyay. 2002. *Gender Budgets Make Cents: Understanding Gender Responsive Budgets, Commonwealth Secretariat* http://openbudgetsblog.org/wp-content/uploads/2011/01/GBMC.pdf

Government of Malawi. 2012. *District Training Manual on Gender Mainstreaming in Strategic Planning, Budgeting, Monitoring and Evaluation*. Lilongwe, Malawi: Government of Malawi.

Government of Malawi. 2012. *Gender Responsive Budgeting Training Manual* (Draft). Lilongwe, Malawi: Government of Malawi.

United Nations Population Fund (UNFPA) and United Nations Development Fund for Women (UNIFEM). 2006. *Gender Responsive Budgeting in Practice: A Training Manual.* New York: UNFPA. Available at http://www.unfpa.org/sites/default/files/pub-pdf/gender_manual_eng.pdf.

UNIFEM. n.d. Web Portal on Gender-Responsive Budgeting. Available at http://gender-financing.unwomen.org/en

Annex 5. Key Resources*

Advocacy

Advocacy Partnership. 2011. TB/MDR-TB *Advocacy Tool Kit.* Leamington Spa, UK: Advocacy Partnership. Available at http://www.stoptb.org/assets/documents/global/awards/cfcs/TB_MDR%20Advocacy%20Tool%20Kit.pdf.

Description: While originally developed for tuberculosis advocates, this toolkit offers advocacy-oriented CSOs a set of tools and guidance that can be easily adapted to any issue area. The toolkit provides direction on effectively setting goals and objectives; creating an advocacy strategy and plan; working with the media and government; building coalitions and alliances; developing key messages; monitoring advocacy; and mobilising resources and funding.

Arroniz Pérez, R. 2010. *Handbook for Political Analysis and Mapping.* New York: International Planned Parenthood Federation, Western Hemisphere Region. Available at https://www.ippfwhr.org/sites/default/files/Political%2520Analysis%2520and%2520Mapping%2520web%2520version.pdf.

Description: This handbook provides three modules to help organisations demand greater transparency and accountability from their governments. The modules assist with (1) identifying entry points to the political system, (2) understanding the political context, and (3) identifying key actors.

Sprechmann, S. and E. Pelton. 2001. A*dvocacy Tools and Guidelines: Promoting Policy Change.* Atlanta: CARE. Available at http://www.careclimatechange.org/files/toolkit/CARE_Advocacy_Guidelines.pdf.

Description: CARE's toolkit outlines essential advocacy skills such as forming strategic relationships, monitoring and evaluating advocacy initiatives, communicating effectively, using the media, developing an advocacy strategy and plan, and analysing policy. The series is primarily designed for CSOs looking to build their capacity to engage in advocacy.

International HIV/AIDS Alliance. 2002. *Advocacy in Action: A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS.* Brighton: International HIV/AIDS Alliance. Available at http://www.comminit.com/node/312161.

Description: This toolkit offers activities for groups looking to engage in advocacy and develop skills. Activity examples include identification of targets, allies, and resources; creating an action plan; writing a press release; conducting a media interview; and working from inside the system.

Pact. 2004. The Advocacy Expert Series.
Available at http://www.pactworld.org/cs/featured_publications#advocacy.

Description: Pact's series covers managing advocacy campaigns, building relationships with government, working with the media, and building and maintaining coalitions. This collection is appropriate for both experienced advocates and the newly initiated.

POLICY Project. 1999. *Networking for Policy Change: An Advocacy Training Manual.* Washington, DC: Futures Group, POLICY Project. Available at http://www.policyproject.com/pubs/AdvocacyManual.cfm.

Description: This training manual outlines the three building blocks of advocacy—formation of networks, identification of political opportunities, and organisation of campaigns—and provides tools for building skills in these areas. The manual is best suited for CSOs looking to increase staff capacity and/or launch advocacy initiatives.

POLICY Project and Maternal & Neonatal Health Program. 2003. *Networking for Policy Change: An Advocacy Training Manual, Maternal Health Supplement*. Washington, DC: Futures Group, POLICY Project. Available at http://www.policyproject.com/pubs/manuals/MH_FULL.pdf.

Description: In this training manual, maternal health advocates and CSOs can gain information on identifying target audiences, forming and implementing an advocacy plan, developing key messages, and implementing M&E.

Shannon, A. 1998. *Advocating for Adolescent Reproductive Health in Sub-Saharan Africa.* Washington, DC: Advocates for Youth. Available at http://www.advocatesforyouth.org/publications/378?task=view.

Description: Advocates for Youth's guide provides an overview of adolescent reproductive health advocacy, including setting goals and objectives, building networks, gaining support from gatekeepers, and M&E. While intended for CSOs in sub-Saharan Africa involved in adolescent reproductive health, the guide provides useful tips for any CSO operating in a low-resource setting.

Budget Analysis and Monitoring

Malajovich, L. 2010. *Handbook for Budget Analysis and Tracking in Advocacy Projects*. New York: International Planned Parenthood Federation, Western Hemisphere Region. Available at https://www.ippfwhr.org/sites/default/files/advocacy-budget-eng-final.pdf.

Description: The International Planned Parenthood Federation's budget analysis and tracking handbook is structured as a workshop, providing activities on conducting a budget analysis and tracking financial expenditures.

Schnell, A. and E. Coetzee. 2007. *Monitoring Government Policies: A Toolkit for Civil Society Organisations in Africa.* London: Catholic Agency for Overseas Development (CAFOD), Christian Aid, and Trócaire.

Available at http://commdev.org/files/1818_file_monitoringgovernmentpolicies.pdf.

Description: Specifically designed for CSOs, this toolkit provides in-depth, practical guidance and exercises on a range of relevant topics, from building relationships and establishing networks to analysing policy budgets and monitoring government policies.

World Health Organization (WHO). 2008. *Health Systems Governance: Toolkit on Monitoring Health Systems Strengthening.* Geneva, Switzerland: WHO. Available at http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Governance.pdf.

Description: WHO's toolkit provides insight into health financing, tracking financial commitments, and relevant sources of information around health systems governance.

Coalitions and Networks

People's Voice Project and International Centre for Policy Studies. 2002. *Citizen Participation Handbook.* Kyiv: World Bank, Canadian Bureau for International Education, and Canadian International Development Agency. Available at http://siteresources.worldbank.org/INTBELARUS/Resources/eng.pdf.

Description: Best suited for CSOs looking to launch new coalitions, this handbook contains details on coalition building, including practical steps to building a coalition, illustrative case studies, and common obstacles. It also provides guidance on public outreach and materials development.

Centre for Development and Population Activities (CEDPA). 2000. *Social Mobilization for Reproductive Health: A Trainer's Manual*. Washington, DC: CEDPA. Available at http://www.cedpa.org/files/747_file_socialmob_english_all.pdf.

Description: Best suited for new CSOs, coalitions, or networks, this manual provides exercises for finding a common purpose and developing a collective plan of action, key messages, and an M&E plan.

Media Engagement

The Health Communication Unit at the Centre for Health Promotion, University of Toronto. 2000. *Media Advocacy Workbook.* Toronto: The Banting Institute, University of Toronto. Available at http://www.ywca.org/atf/cf/%7B075DF925-0921-4061-B9A5-7032F1EA255C%7D/media%20advocacy%20workbook.pdf

Description: This workbook provides useful tips on developing a media advocacy campaign, identifying an audience, drafting key messages, and using messages to effectively communicate with an audience. The workbook will prove most useful for CSOs with limited communication resources.

Work Group for Community Health and Development, University of Kansas. n.d. *Community Tool Box.* Lawrence, Kansas: University of Kansas. Available at http://ctb.ku.edu/en/tablecontents/index.aspx.

Description: This online toolbox provides a wealth of information for both CSOs and individual advocates working in any topic area. Sections include implementing advocacy; getting an issue on the public agenda; developing a strategic plan, organisational structures, and training systems; using tools for effective leadership and facilitation; conducting media advocacy; obtaining grants and managing resources; and planning for long-term institutionalisation.

Stakeholder Analysis

Nash, R., A. Hudson, and C. Luttrell. 2006. *Mapping Political Context: A Toolkit for Civil Society Organisations.* London: Research and Policy in Development Programme; Overseas Development Institute. Available at http://www.odi.org.uk/resources/docs/186.pdf.

Description: *Mapping Political Context: A Toolkit for Civil Society Organisations* provides practical advice to CSOs looking to conduct a stakeholder analysis.

De Toma, C. n.d. *Advocacy Toolkit: Guidance on How to Advocate for a More Enabling Environment for Civil Society in Your Context.* Brussels: Open Forum for CSO Development Effectiveness. Available at http://cso-effectiveness.org/IMG/pdf/120110-of-advocacy_toolkit-en-web-2.pdf.

Description: This toolkit provides a range of tools, including those for conducting a stakeholder analysis, building alliances, developing key messages, and forming SMART advocacy objectives. It also provides templates for developing an M&E framework, selecting advocacy indicators, identifying advocacy targets, and drafting an advocacy plan.

* Resources are excerpts from two Health Policy Project briefs: West Slevin, K., and C. Green. 2013. "Networking and Coalition Building for Health Advocacy: Advancing Country Ownership." Washington, DC: Health Policy Project, Futures Group; and West Slevin, K., and C. Green. 2013. "Accountability and Transparency for Public Health Policy: Advancing Country Ownership." Washington, DC: Health Policy Project, Futures Group.

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