

End-Term Evaluation of Health System Advocacy Partnership Programme

Final Report

Submitted by ResultsinHealth

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List of Abbreviations

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

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Code and terminology references used in this report

Codes for Outcomes and Stories collected

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

Terminology

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

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

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

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

INTRODUCTION

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

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

EVALUATION OBJECTIVE, FRAMEWORK AND METHODOLOGY

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

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

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

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

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

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

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

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

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

FINDINGS: OUTCOME HARVESTING AND STORIES OF CHANGE

Outcome Harvesting

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

Stories of Change

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

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

FINDINGS: CONTENT

Capacity-strengthening strategies and results

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

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

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

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

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

Achievement of HSAP's TOC

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

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

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

Effectiveness of advocacy approaches

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

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

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

Relevance toward HSS and SRHR

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

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

Lessons Learned

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

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

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

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

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

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

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

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

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

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

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

Sustainability of the HSAP Programme

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

EVALUATION LIMITATIONS

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

CONCLUSION

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

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

RECOMMENDATIONS

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

1.1 The Health Systems Advocacy Partnership Programme

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

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

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

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

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

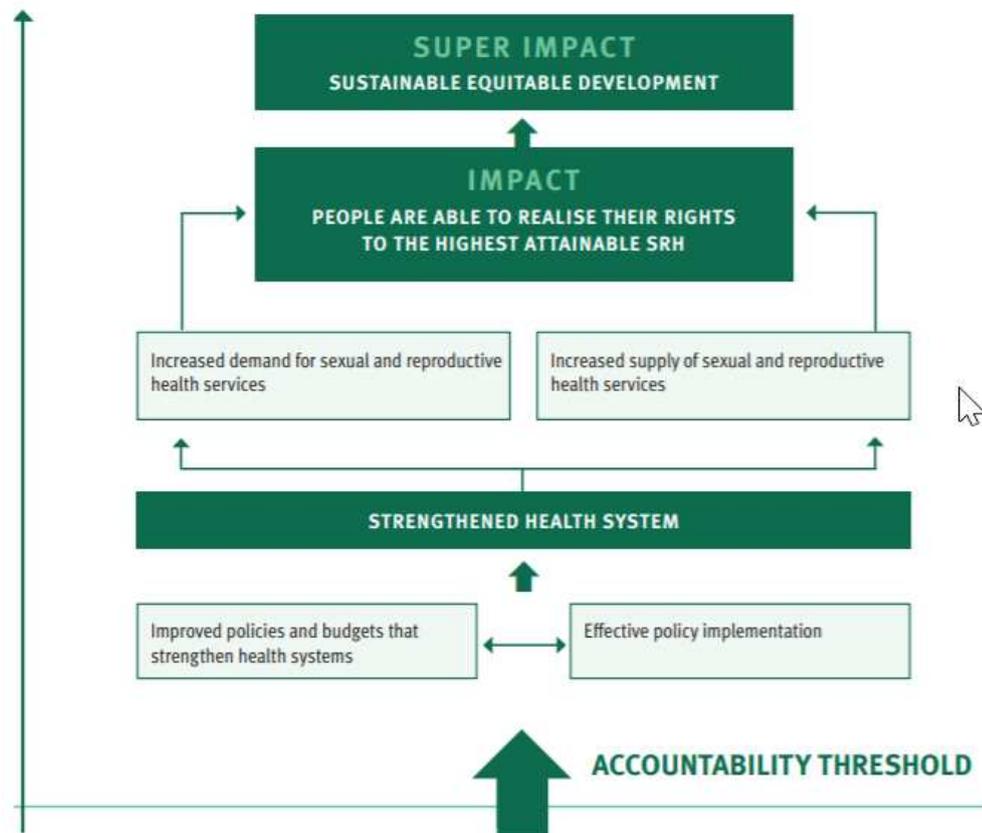
1.2 Theory of Change

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

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

The HSAP interventions by thematic area include: human resources for health (HRH), SRHC, HF and governance.² Below is the overall TOC of HSAP programme³:

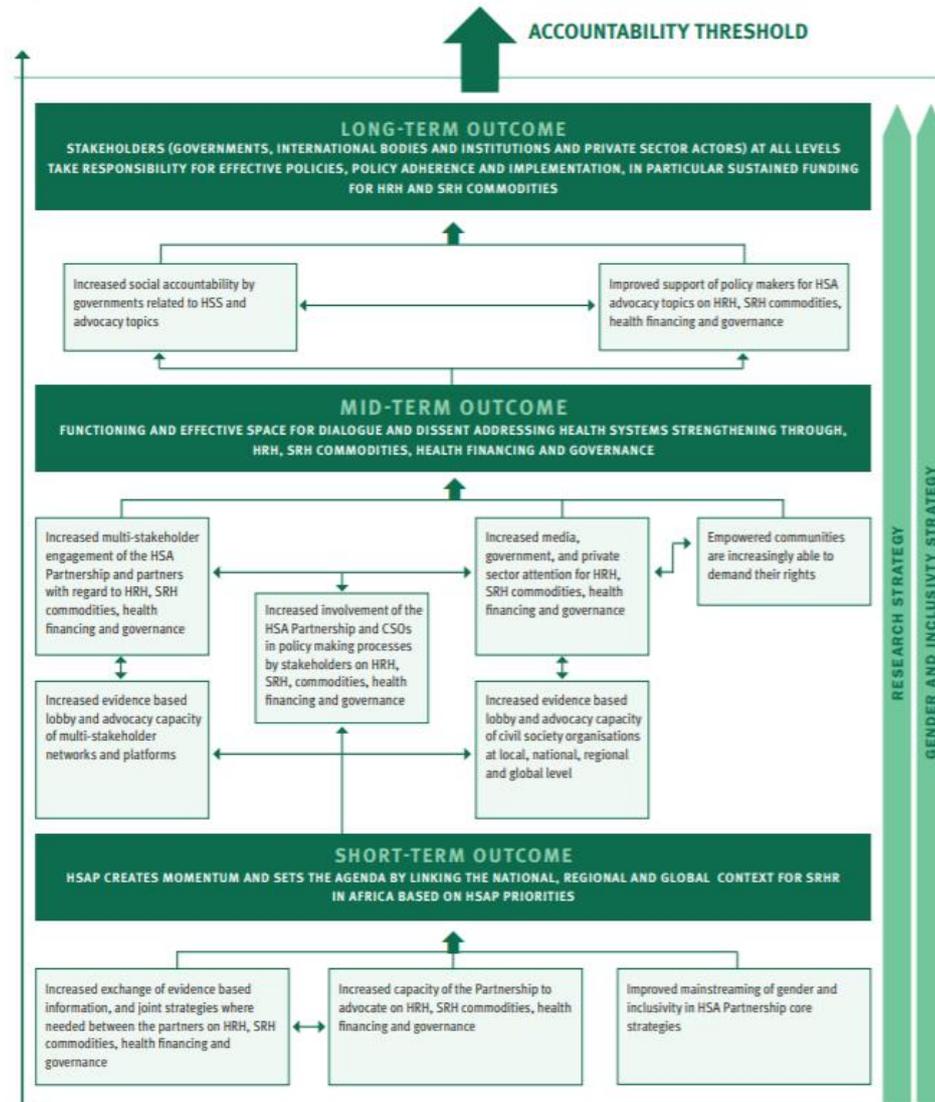
Figure 1; Visualisation of the Theory of Change above the accountability threshold



² ToR End evaluation of the HSAP

³ Taken from TOC "Pushing the SRHR agenda forward by strengthening health systems: Overall Theory of Change HAS Partnership"

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



1.3 HSAP End-Evaluation Objective and Scope of Work

1.3.1 Evaluation objective

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

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

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

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

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

1.3.2 Scope of work

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

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

2 Evaluation Framework

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

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

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

2.1 Evaluation Questions

1. How relevant was partner capacity strengthening by HSAP Consortium and Contracted Partners for HSAP's contribution to HSS and SRHR?
 - a. To what extent have efforts to strengthen the partners' capacities:
 - i. led to changes in their advocacy skills and capacities?
 - ii. led to advocacy-related outcomes (intended or unintended)?What were the contributing and/or hampering factors for partner capacity building?
 - b. To what extent did the Contracted Partners' efforts to strengthen CSO and community-based organisation (CBO) capacity to strengthen community capacity lead to:
 - i. changes in the communities' empowerment to demand their rights?
 - ii. intended or unintended outcomes of 'empowered communities increasingly able to demand their rights'?What were the contributing and/or hampering factors for capacity strengthening at a community level?
 - c. To what extent have the Contracting Partners' efforts to strengthen CSO (as partners) capacities affected the legitimacy of the CSOs to be locally owned and embedded in communities/society, local norms and values (perceived as meaningful and trustworthy, and accepted in society)? What were the changes over time and the implications of the changes toward their legitimacy? What were the contributing and hampering factors for ensuring and/or strengthening CSO partner legitimacy?

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

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

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

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

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

2.2 Target Audience and Use of Findings

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

2.3 Geographical coverage

Countries visited and not visited for the End Evaluation

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

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

Table 2: Location visited during data collection

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

3 Evaluation Methodology

3.1 Evaluation Approach

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

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

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

3.2 Evaluation Phases

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

3.3 Data Collection Process

3.3.1 Data collection process per context

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

Table 3; Data collection process by context

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

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

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

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

3.3.2 Data collection tools

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

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

5. A facilitation guide on how to map and rank the (selected) outcomes during the Annual Reflection
The final data collection tools can be found in (Annex 5).

3.4 Evaluation Respondent

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

1. Internal substantiators harvested outcomes (harvester).
2. External substantiators, validated and deepened our understanding of existing outcomes (e.g., national and international policymakers/advocacy targets such as government staff [both policymakers and practitioners], parliamentarians, representatives from regional or international institutions, and community representatives). The external substantiators were identified by the harvester. To substantiate more outcomes and obtain a comprehensive picture of overall HSAP programmes, and in consideration of the limited evaluation resources, only one external substantiator was assigned to each outcome.
3. Capacity-strengthening receivers (partners and network partners) or storytellers, shared stories on how the capacity-strengthening activities led to advocacy-related outcomes (CSOs, CSO networks or platforms, and media).
4. (Key) informants (two groups):
 - Internal resource persons/individuals, HSAP Consortium and Contracted Partners, and MoFA⁴ shared experiences about the partnership and other evaluation questions.
 - External resource persons/individuals, knowledgeable about the capacity-strengthening and or advocacy activities of the HSAP programme and well informed about the debate, evidence and practices related to HSS and SRHR, provided outcomes not listed as outcomes, highlighted issues from the external environment influencing the outcome of activities and/or were able to share perceptions about the importance of the programme.

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

Table 4; Respondents per context

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

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

⁴ The MoFA was only interviewed during the inception report

3.5 Sampling Strategy

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

Table 5: Result sampling strategy

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

3.6 Online Training and Piloting

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

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

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

3.7 Data Collection Timeframe

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

3.8 Quality Assurance

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

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

3.9 Data Management

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

3.10 Outcome Harvesting and Story Collection Process

3.10.1 Substantiation process

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

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

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

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

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

Substantiation process

In substantiating the outcomes, each substantiator was asked assess the accuracy of the outcome and provide feedback on the outcome assigned to him/her using the Sprockler tool (outcome verification, see Annex 11). The evaluation team decided to substantiate one outcome with one substantiator, with some exceptions of several outcomes in the global, Dutch, and Malawi contexts. The decision was made by prioritizing how the resources had been used during the evaluation to substantiate more outcomes for a complete picture of the overall programmes. Thus, in total, 68 substantiators provided feedback on 69 outcomes. For Kenya, 8 outcomes were substantiated by recently published research conducted in Kajiado⁶, "Watershed Partnership and The Health Systems Advocacy Partnership in Kajiado", as a reliable source for substantiation. Visiting the location wasn't necessary for verification, and the HSAP team and the evaluation team agreed to avoid the possibility of overloading the intended substantiators, since they were to be approached again for data collection.

Challenges experienced in the substantiation process

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

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

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

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

3.10.2 Story collection process

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

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

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

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

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

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

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

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

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

3.11 Data Analysis

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

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

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

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

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

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

3.12 Ethical Consideration

General consideration

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

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

Informed consent was obtained from all the respondents.

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

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

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

3.13 Limitations of the Evaluation

- The evaluation did not include a systematic review of all implemented activities and outputs; but instead focused on outcomes and determined how implemented activities and outputs contributed.
- The research was largely based on the HSAP programme's documentation and interviews with people involved in the programme. This may have created positive bias. To mitigate bias, data was triangulated across methods and interview groups. In particular, information from respondents not linked to a specific outcome and information about a specific outcome by more than one respondent were compared for outcome credibility. In addition, data about weak and strong aspects, missed opportunities and lessons learned across respondent groups are examined to ensure that not only positive outcomes were harvested and substantiated.
- The evaluation findings were based on data limited to early 2020. This may have led to important outcomes that emerged later in 2020 being missed, and risked that the evaluation did not do justice to the full programme implementation. Unexpected outcomes were not well identified. Only a few hampering factors were identified to indicate that the situation could have been worse if not for the HSAP programme.
- To harvest unexpected and negative outcomes, in each context harvesters were asked to think about or identify any outcomes that could have been missed. In the Sprockler inquiry, all substantiators and harvesters were asked to identify if the outcome was intended or unintended. Few to no negative outcomes⁷ were harvested by the HSAP programme (further information on efforts by the evaluation team to harvest negative outcomes and identify missed opportunities can be seen in section 4).
- Impact of COVID-19 pandemic on the evaluation:

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

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

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

4.1 Outcome Harvesting: Findings on Outcomes Harvested and Substantiated

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

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

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

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

The list of substantiators can be found in annex 8.

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

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

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

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

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

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

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

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

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

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

Process of analysis and interpretation

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

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

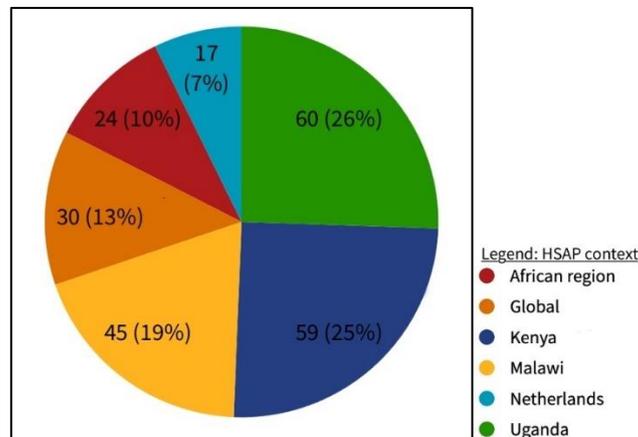
The locations and dates for these activities were missing. Most importantly, there was no description of a change—before and after.

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

4.1.1 Overall outcome harvesting findings

The extensive OH findings can be found in the OH Visualizer Report¹⁰. In this report, the evaluation team presents the main highlights of the OH findings. This evaluation considered 240 reported outcomes by the HSAP between 2018-2019 in: Malawi, Uganda, Kenya, The Netherlands, and global and regional contexts (see figure 3 below).

Figure 3; Outcomes per context



The following chart shows the kind of outcomes harvested by the HSAP¹¹. The categories are similar to the TOC outcome categories. The HSAP TOC distinguished levels of outcomes: short-term, mid-term, and long-term outcomes, and one level above the accountability ceiling—outcomes close to impact. The following categories were used for outcome categorisation and analysis in this report:

Mid-term level:

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

Long-term level: Improved support of policymakers

Level close to impact (above accountability ceiling):

- Improved policies and/or budgets adopted by policymakers

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

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

- Policy implementation

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

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

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

Legend: outcome category

- Lobbying and advocacy capacity
- Attention of stakeholders
- Engagement of multiple stakeh.
- Support of policy makers
- Policies and/or budgets adopted
- Policy implementation

Figure 4; Outcome category for entire HSAP

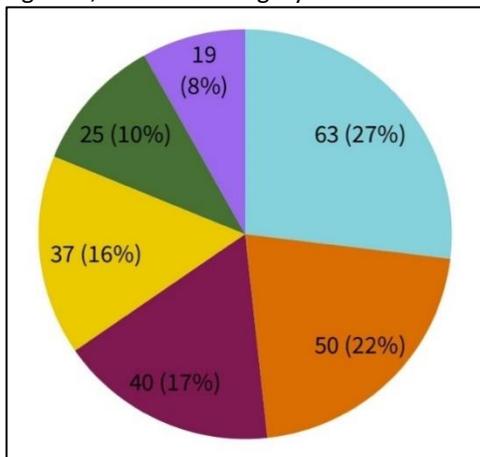


Figure 5; Outcome category per context

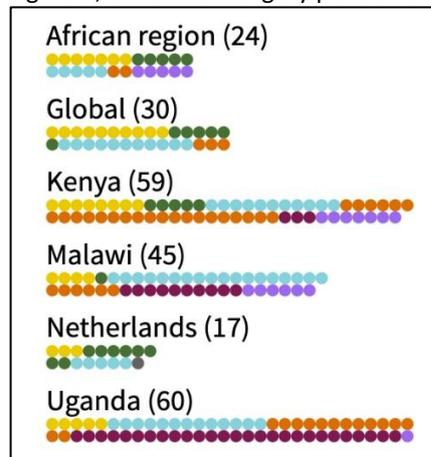
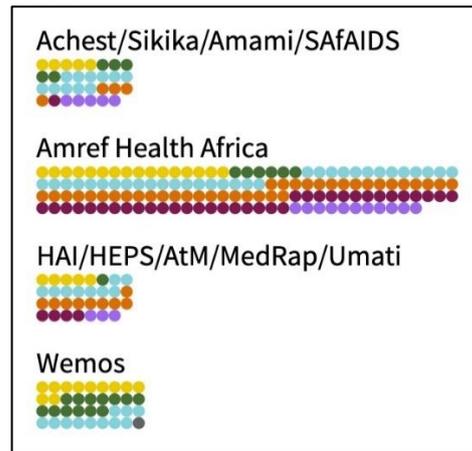


Figure 6; Outcome category per actor for entire HSAP



Figure 7; Outcome category main Consortium Partner



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

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

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

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

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

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

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

4.1.2 Reflection on the TOC and its usefulness for analysis

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

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

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

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

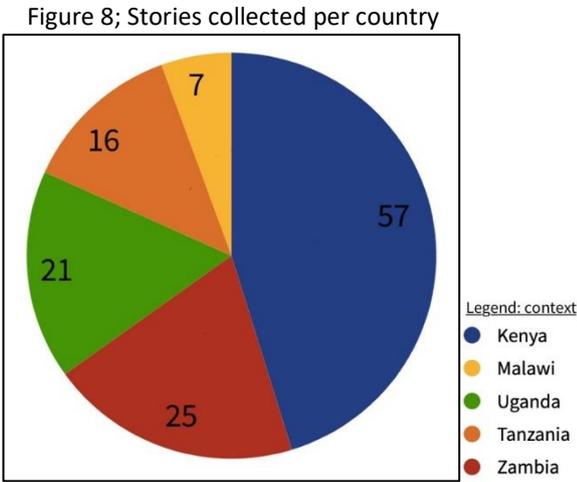
4.2 Sprockler Stories Report

In total, 126 stories were collected in Kenya, Uganda, Malawi, Tanzania and Zambia during the evaluation. This document includes an overview of the key trends and patterns observed in the responses to the story inquiries per country. Each full story can be read in the Story Report Visualizer¹².

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

4.2.1 Overall collected story findings

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



4.2.2 Thematic areas of collected stories

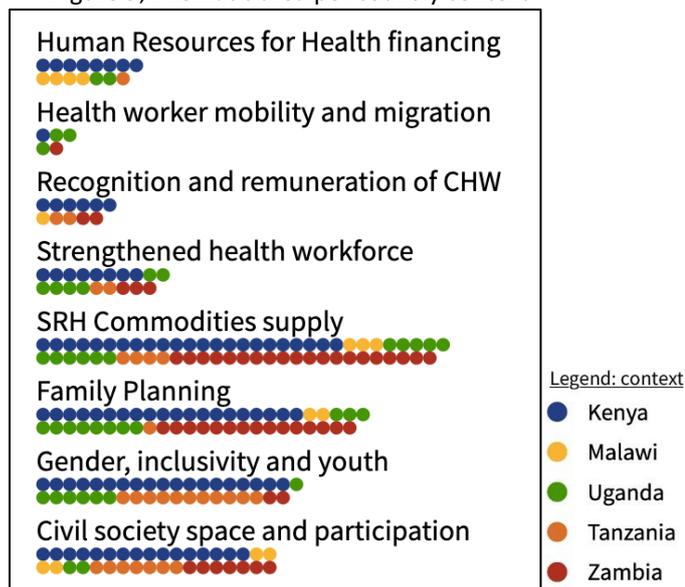
Storytellers indicated which thematic area their story belonged to. They could choose multiple answers (see Figure 9 below). Most stories were about SRHC supplies (including FP). However, since many stories focused only on FP (and not other SRHC supplies), the evaluation team decided to single out FP-related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

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

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

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

Figure 9; Thematic area per country context



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

1. HRH Financing

Story from Uganda (33007)

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

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

Story from Kenya (32640)

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

Story from Tanzania (33573)

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

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

Stories from Kenya (32685)

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

Kenya (32690)

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

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

3. SRHC supplies including FP

Stories from Zambia

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

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

4. Gender, inclusivity, and youth

Story from Kenya (32636)

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

Kenya (32629)

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

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

Kenya (32655)

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

5. Civil society space and participation

Tanzania (3353)

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

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

Malawi (32958)

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

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

Malawi (33634)

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

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

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

4.2.3 Similarity between stories and outcomes

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

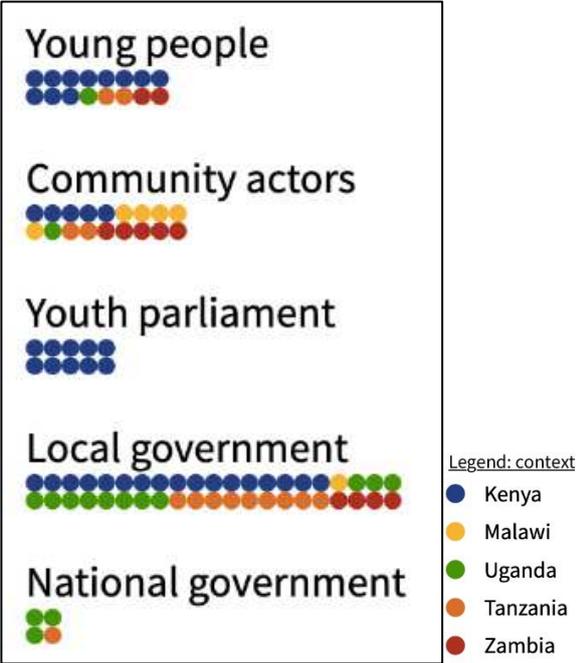
In Kenya, for one media outcome, there were 7 journalists (radio, TV, print, and online) from the AMNH Lower Eastern Chapter who confirmed this outcome through their stories. In Uganda, one media outcome was also confirmed by storytellers. In addition, several policy implementation outcomes were confirmed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

4.2.4 Type of Actors

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

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

Figure 10; Actor new per context



4.2.5 Link between stories and TOC

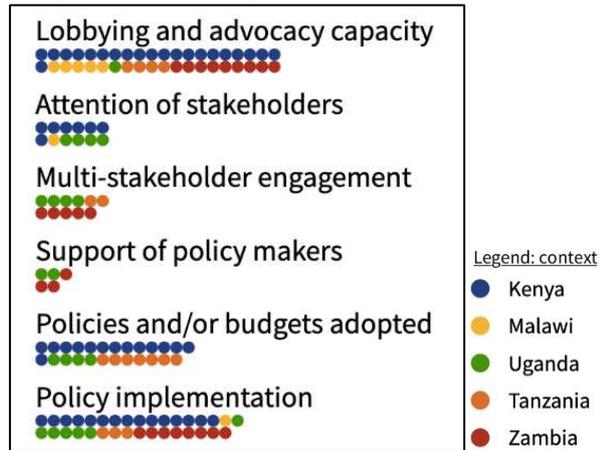
The following figure shows the extent to which HSAP has been able to realise their TOC objectives, as represented in the collected stories from 5 country contexts. It should be noted that some stories described outcomes that had already been mentioned, and were therefore used for triangulation (see section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

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

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

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

Figure 11; TOC category per context



5.1 Effectiveness of Capacity-Strengthening Efforts

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

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

- a. To what extent have efforts to strengthen the partners' capacities:
 - i. led to changes in their advocacy skills and capacities?
 - ii. led to advocacy-related outcomes (intended or unintended)?What were the contributing and/or hampering factors for partner capacity building?
- b. To what extent did the Contracted Partners' efforts to strengthen CSO and CBO capacity to strengthen community capacity lead to:
 - i. changes in the communities' empowerment to demand their rights?
 - ii. intended or unintended outcomes of 'empowered communities increasingly able to demand their rights'?

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

HSAP capacity-strengthening focus

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

- a. Amref: CSO capacity building and lobbying and advocacy (CHWs, health worker migration (HWM)¹³ and retention, and financing for FP).
- b. ACHEST: lobbying and advocacy (HRH and governance) and CSO capacity building at a global, regional, national and district levels, e.g., training for consumer score cards for social accountability and the Global Health Diplomacy Training.
- c. HAI/MeTA: increasing CSO capacity to conduct evidence-based lobby and advocacy, including building an evidence base on SRHC by improving the research expertise of Contracted and Network Partners on access to SRHC in Uganda, Kenya, Tanzania and Zambia.
- d. Wemos: increasing the evidence base for and developing advocacy strategies and materials to influence national and global positions on financing for health and HRH, and increasing CSO engagement in policy processes such as influencing the Global Financing Facility (GFF) and universal health coverage (UHC). Wemos capacity strengthening at a country level included assistance to countries to develop evidence-based papers and lobbying and advocacy strategies to increase CSO capacity to claim greater engagement in policy processes¹⁴.

HSAP capacity-strengthening strategy and advocacy results

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

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

¹⁴ Progress reports July-Dec 2018

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

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

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

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

At a global and regional level, HSAP Consortium Partners provided opportunities for CSOs to participate in global/regional forums. They supported CSOs when participating in national- and county-level technical working groups and when CSO coordination groups reviewed and strategized on policies. HSAP Consortium Partners also assisted participating countries in developing evidence-based papers and lobbying and advocacy strategies, and created space for CSOs to influence districts/counties and national and global policies¹⁵.

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

Results of the capacity-strengthening strategy

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

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

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

¹⁵ Source: Desk review inception report from each context

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

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

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

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

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

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

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

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

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

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

One of the HSAP-strengthened networks was the Youth Parliaments¹⁶ to address SRHR issues in Kenya, Uganda, Tanzania, and Zambia. Examples include the Ugunja Youth Parliament¹⁷ in Siaya County (Kenya) and in Kabale, Lira, Dokolo and at the national level (Uganda), Bukombe (Tanzania), and Mufulira (Zambia). Youth voices were strengthened either through organising intergenerational dialogues at a community level, capacitating youth chairpersons, engaging adolescents in developing adolescent health messages, or supporting them when participating in regional meetings/conferences.

Results of the building (existing) platforms and networks strategy

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

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

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

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

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

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

3. Engaging with media

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

Results of engaging with media strategy

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

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

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

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

Results of amplifying community voices strategy.

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

Examples of successfully amplifying community voices:

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

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

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

5.1.2 Strengths and weaknesses of the HSAP capacity strengthening efforts

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

Strengths: common and unique strategies that worked well

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

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

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

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

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

Weaknesses: What did not work well

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

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

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

5.1.3 Supporting and hampering factors of capacity strengthening

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

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

5.2 The Effectiveness of the Advocacy Approaches

5.2.1 Effectiveness of Advocacy approaches

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

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

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

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

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

Specific HSAP approaches to advocacy included the following.

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

Evidence-based advocacy approaches included:

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

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

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

a. *Engaging communities in dialogue and dissent*

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

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

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

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

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

The pre-eclampsia campaign in Uganda

The pre-eclampsia campaign in Uganda was a good example of involving media, Parliament, government and health facilities, by sensitizing them with evidence. This had an amplifying effect and more pregnant mothers were checked in the health facilities and this avoided unnecessary maternal deaths. HSAP supported journalist visits to health facilities to note the toll of pre-eclampsia. Media started writing about this topic, which generated interest from parliamentarians and policymakers. HSAP facilitated policymaker visits to a hospital to see stock outs of essential medicines first-hand (e.g., magnesium sulphate) and the lack equipment such as oxygen cylinders and incubators, all of which are essential for preventing pre-eclampsia. Parliament requested that the government look into this situation and this pressure resulted in funding for magnesium sulphate. In Lira, Amach Health Centre IV was provided with manometers. The campaign also sensitized communities about the dangers of pre-eclampsia resulting in an increase of pregnant women going for a check-up. The sensitization campaign was continued by the various stakeholders, including the MoH-appointed a Pre-eclampsia Ambassador¹⁸.

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

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

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

Positive examples were as follows.

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

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

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

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

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

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

1. Human Resources for Health (HRH)

HSAP aimed for increased political commitment to systematically improve HRH, including addressing inequitable access to health workers for vulnerable groups and people living in rural areas, the workforce's ability to treat everyone with dignity and create trust, and enable or promote these groups' demand for services. At a global level, HSAP aimed to link with civil society (networks) that push for implementation of Member State commitments that contribute to creating and maintaining sustainable health workforces¹⁹.

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

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

¹⁹ HSAP ToC 2019 page 9-10

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

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

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

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

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

2. SRHC

HSAP aimed to collaborate with in-country expertise, including civil society, to collect data to fill knowledge gaps and inform evidence-based interventions to increase access to SRHC. In addition, HSAP aimed to engage in multi-stakeholder platforms specifically created and resourced for medicines policy dialogue and dissent²¹.

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

- In 4 countries²², MeTA served as a successful platform for One Ugandan external MoH expert who praised MeTA's work, "*MeTA has been very useful in identifying the gaps and bringing them to [a] policy level. They have a sharp eye to identify; they make noise. We need that kind of partnering; they interact with the people. MeTA has really helped in bridging the gap between policy and people.*"
- At a national level in various districts, HSAP conducted research about the availability and stock outs of SRHC, including FP commodities, in all countries, except Malawi. In Malawi, HSAP used consumer score cards as a social accountability method for this data. Key findings were severe stock outs and access limitations. In Malawi, a Task Force for FP was set up in the Chitipa district and in Zambia, TWGs on FP were established in the districts. In Zambia, after HSAP and others'

²¹ HSAP ToC 2019 page 10.

²² Kenya, Uganda, Tanzania and Zambia.

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

3. Health Financing

HSAP aimed to develop advocacy messages and train local CSOs in lobbying and advocacy aimed at encouraging governments and other stakeholders to make the necessary financial investments for health and allocate this funding in an effective and efficient way. Furthermore, HSAP set out to analyse the effectiveness of Global Health Initiatives (GHIs), and the way these programmes interact with and have an impact on health systems in regions or countries²³.

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

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

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

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

4. Governance

HSAP aimed to strengthen the capacities of local CSOs to enable them to hold governments and decision makers to account for their function and performance, including maintaining the strategic direction of policy development and implementation, regulating the behaviour of a wide range of actors, and establishing transparent and effective accountability mechanisms²⁴.

²³ HSAP ToC 2019 page 11.

²⁴ HSAP ToC 2019, page 12.

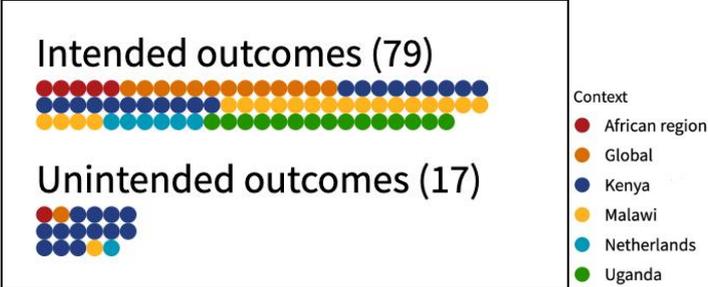
This evaluation found numerous CSO achievements holding governments to account for their function and performance in delivering on SRHR and HSS, especially at subnational levels. Accountability mechanisms have been established at a CSO level, such as AHAP and national-level multi-stakeholder and CSO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

5.2.2 Negative outcomes and unintended outcomes

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

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

Figure 12; Intended and unintended outcomes



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

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

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

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

Table 8; Factors and Actors Contributing to HSAP Outcomes

Factors and Actors	Enabling
Receptiveness of governments and communities	<p><i>Country context:</i></p> <ul style="list-style-type: none"> • All government respondents stated HSAP added value by providing <ul style="list-style-type: none"> ○ evidence for policy change ○ information sharing ○ technical expertise and funding ○ community links ○ community needs and demands • Spirit was collaboration, not competition • Enabling factor - engaging with sub-national governments <ul style="list-style-type: none"> ○ more receptive to advocacy/change than national-level governments <p><i>Sub-national level-communities:</i> Receptive to active engagement in HSAP’s participatory advocacy</p>
Availability of funds	<p><i>Overall context - HSAP’s funding:</i> Conducive for research, meetings with multiple stakeholders, involving media and sustaining advocacy</p>
Existing legal and policy frameworks	<p><i>Country context:</i> Contracted Partners and substantiators acknowledged the conducive nature of having legal and policy frameworks in place that enabled HSAP to advocate for domestication and implementation. For example, the 2018 WHO Guidelines on CHWs sparked advocacy for CHW recognition at regional and national levels. In Siaya county, in Kenya, HSAP could advocate for the FP Costed Implementation plan because Siaya had a Health Bill to which this plan could be anchored.</p>
Sophisticated global health infrastructure	<p><i>Global context:</i> HSAP became embedded in and worked with other influential organisations and programmes promoting global health (e.g., MMI, Geneva Global Health Hub (G2H2), The Partnership for Maternal, New-born and Child Health (PMNCH) as the organiser of the GFF Civil Society Coordinating Group (CSCG), and Share-Net International), which amplified HSAP’s advocacy. The environment for global advocacy for HSS was both enabling and disabling in transparency and CSO participation. For example, GFF was open to CSO involvement and invited them to participate.</p>

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

Table 9; Factors and Actors Hampering HSAP Outcomes

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

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

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

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

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

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

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

5.2.4 Strengths and Weakness of HSAP's advocacy

Strengths of HSAP's advocacy

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

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

Weaknesses of HSAP advocacy

Attribution/contribution:

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

Lack of joint advocacy strategies and mechanisms:

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

Follow up of advocacy achievements:

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

Addressing SRHR comprehensively:

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

Lack of systemic changes in HSS and accountability:

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

Visibility:

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

5.3 Relevance towards HSS and SRHR

The relevance of the programme towards HSS and SRHR was part of the TOR²⁵ and a request that emerged during the inception period. The partners within HSAP had a varied focus on either HSS, SRHR or both. The overall TOC stipulated an assumption of the programme's relevance towards HSS and SRHR. Thus, in this evaluation, to proof this assumption, three forms of evidence were triangulated: outcomes substantiation, collected stories and key informant interview (KII) findings. In describing the relevance, we categorised the relevance of HSAP's outcomes and stories collected for HSS and SRHR, HSS alone, and SRHR alone. Examples of similarities and differences between contexts for the relevance of the programme for HSS and SRHR are described.

5.3.1 Relevance towards HSS and SRHR (combined)

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

5.3.2 Relevance towards HSS

Focus for influencing HSS in country

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

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

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

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

Focus for influencing HSS at regional and/or global level

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

5.3.3 Relevance towards SRHR

Focus for influencing SRHR in country

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

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

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

STORY FROM TANZANIA [33571]:

Target Group: - Kahama DC and Shinyanga DC/TC

Organization: The Voice of Marginalized Communities (TVMC)

Changes achieved: Ending teenage pregnancy by creating bylaws at the Ward level restricting boda-boda riders from picking up female students.

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

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

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

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

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

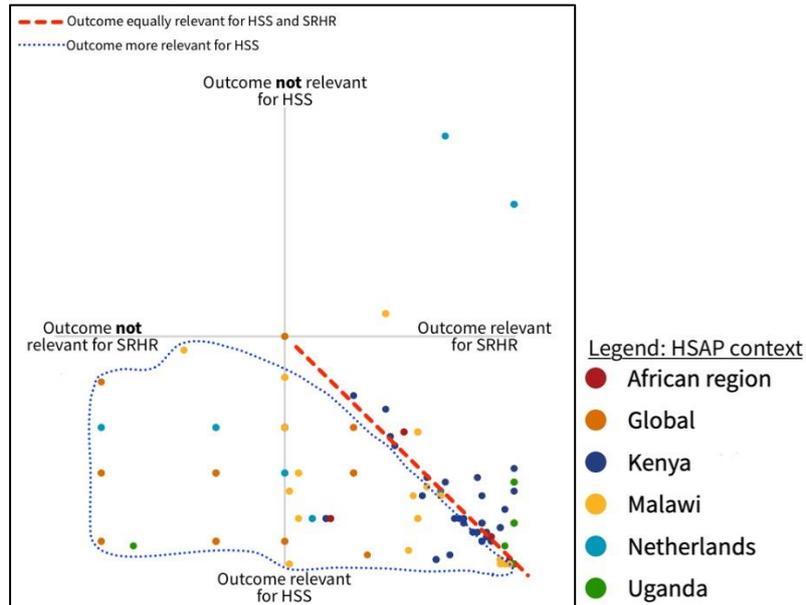
Relevance of outcomes for the SRHR at regional, global and/or the Dutch context

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

5.3.4 Linkages between HSS and SRHR

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

Figure 13; Outcome relevance of HSS and SRHR



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

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

The relevance of HSS for SRHR was not debated. However, a stronger link could have been made between the HSS interventions and their effect on SRHR by monitoring this more clearly²⁶. HSAP could have made the link between SRHR and HSS more explicit by planning and following up improvements in SRHR through HSS advocacy strategies. In some cases, they actually did so, e.g., conducting surveys to increase SRHC. The relevance of increasing social accountability by using consumer score cards at a district level for SRHR was illustrated in Malawi where there was a change in the approach to improving access to contraceptives for youth as a result of feedback from consumer score cards.

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

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

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

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

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

5.4.1 Gender and inclusivity

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

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

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

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

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

Relevance women/girls:

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

Relevance to PwD, other marginalised groups and LGBTI:

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

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

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

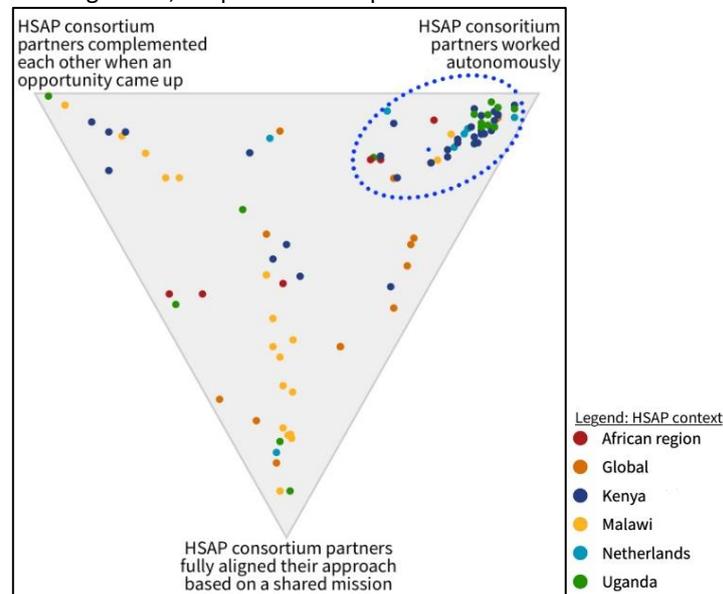
5.4.2 Collaboration and governance

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

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

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

Figure 14; Respondents’ responses about collaboration



Collaboration

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

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

Governance

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

5.4.3 Linkage levels

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

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

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

Complementarity

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

Autonomy / Southern leadership

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

5.4.4 Visibility/legitimacy

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

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

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

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

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

Chapter 5.3 demonstrates that HSAP's advocacy was relevant for HSS and SRHR to a certain extent. However, this evaluation team did not find examples of HSAP building the evidence for their TOC claim HSS is a precondition to improved SRHR and that advocacy for SRHR influences the strengthening of health systems. The evaluation team learnt that during HSAP capacity building sessions, each partner researched this precondition. The research findings were published in May 2020²⁷, which came after the date the HSAP evaluation had ended (February 2020). Therefore, the evaluation team did not include this result in their analysis. Eventually, the research results could provide data for a richer analysis of the relevance of HSAP's advocacy for HSS and SRHR, since the two fields—HSS and SRHR—generally operate in isolation, but were uniquely joined by the HSAP.

5.5 Sustainability of the HSAP Programme

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

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

²⁷ (Source: feedback from HSAP Partnership Desk)

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

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

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

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

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

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

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

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

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

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

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

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

The Uganda Youth Parliament (UYP) functioned inconsistently during its first five years. Since 2017, Amref supported the revival of the UYP, and since then, four more parliaments have been established in the Lake Basin region. HSAP (Amref) provided training in skills, e.g., parliamentary procedures, budget advocacy, and strategies, to enhance social accountability. The parliaments have thus become self-functioning advocacy networks. Throughout the HSAP, Amref supported Youth Parliaments with small grants and mentorship, e.g., community forums.

Youth Parliaments consist of volunteers, who often work for local CSOs. They are regarded as youth champions, and are trusted by the communities because they are independent and have good contacts with county officials. These CSOs often receive funding from other stakeholders to conduct their work. The Youth Parliaments have sessions in which they decide on advocacy topics the youth champions take back to their CSOs, who implement the related activities, e.g. school visits and awareness sessions in the communities.

In addition, Youth Parliaments have advocated for district funding, specifically for youth activities. This has now been agreed and adopted (mid 2020), and is anchored in law. The Youth Parliaments and other parties can now send concept notes to apply for district funding.

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

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

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

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

5.5.2 Governance mechanisms to sustain advocacy efforts

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

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

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

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

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

6.1 Discussion

6.1.1 Achievement of HSAP's TOC

HSAP contributed significantly in realizing their overall programme TOC objectives. This evaluation shows that HSAP advocacy strategies contributed to notable outcomes related to HRH, governance, HF and SRHC across the eight contexts in which HSAP operates: Kenya, Malawi, Tanzania, Uganda, Zambia, The Netherlands, African region and global. HSAP contributed to better recognition of CHWs, and addressing HWM and deployment in health facilities. For SRHC, HSAP's efforts contributed to fewer stock-outs and better supplies and availability of FP methods and other commodities. HSAP was the significant contributor to the inclusion of CSOs in GFF processes at a national level. HSAP advocated for HF, especially in relation to FP funding. At a sub-national level, HSAP partners effectively advocated for functional facilities at health centres including youth corners where youth can receive information and services related to their SRH. HSAP's approaches to CSO and other stakeholder capacity strengthening and lobbying and advocacy have yielded fruit. The evaluation team has shown how HSAP's approaches presented in the TOC pathways have substantially contributed to good advocacy results: consistently investing in generating and using evidence for advocacy; creating and showing leadership and facilitating multi-stakeholder platforms; engaging with media, parliamentarians, CSOs, networks and governments and building their capacity; empowering communities to claim their rights; using valuable entry points with decision makers at all levels; and sharing knowledge of HSS and SRHR and political and policymaking processes. The evaluation team found that these approaches complemented and reinforced each other and that HSAP's TOC pathways were valid. The literature confirms the effectiveness of strategies such as generating credible evidence²⁸, effective leadership and networking²⁹ and positioning the network well in politics³⁰. In particular, the evaluation team found that HSAP was unique in their approach of engaging with communities, and empowering them to claim their rights and demand services from authorities. This was a bottom-up approach to ensuring accountability and a sustainable and effective approach to facilitate dialogue and dissent, where it matters, close to people's lives and realities.

6.1.2 Effectiveness

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

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

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

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

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

For many outcomes substantiated in this evaluation, external respondents (substantiators) indicated that in the national, global and Dutch contexts, HSAP contributed significantly, although discerning attribution in advocacy projects remained difficult. At a sub-national level, HSAP directly influenced local governments and communities. At national, regional and global levels, HSAP's influence was more often indirect and HSAP was one of many stakeholders advocating for change. Advocacy for HSS and SRHR was ongoing and did not start with the HSAP programme. Wemos is a recognized global advocate for HSS and AMREF for improving health services and advocacy in countries. HAI is a strong player in strengthening SRHC supplies and ACHEST is recognized as a strong African voice on HRH and governance. The strength of each partner's activities continued during the HSAP programme. Furthermore, other stakeholders may have advocated for a certain policy change long before HSAP joined the endeavour. In HSAP's outcome harvesting, these nuances were rarely taken into account. This is not exclusive to HSAP; it is widely recognised that attribution of results is particularly difficult in advocacy programmes and it is difficult to find robust counterfactuals when no programmatic interventions take place³¹. Furthermore, in advocacy programmes, no single organization can claim successes related to their contributions. Many stakeholders and dynamics influence a particular advocacy outcome, and advocacy targets (mostly policymakers) may not be willing to acknowledge contributions of non-governmental players to the changes they made³².

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

Visibility/legitimacy

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

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

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

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

Community empowerment to claim their rights and demand services

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

Linkages between global and national advocacy

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

Complementarity

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

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

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

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

6.1.3 Relevance

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

6.1.4 Lessons learned

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

6.1.5 Sustainability

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

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

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

6.2 Conclusion

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

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

6.3 Recommendations for Future Programmes

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

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

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

Recommendations for future OH use:

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

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