HEALTH SYSTEMS ADVOCACY PARTNERSHIP

Health Systems Advocacy Partnership

End Term Evaluation Response

ACHEST

amref health africa

HAI HEALTH ACTION INTERNATIONAL

wemos HEALTH UNLIMITED

Ministry of Foreign Affairs of the Netherlands

HSAP Management Response Letter

Introduction

In this letter, the Health Systems Advocacy Partnership (HSAP) presents an integrated reflection on the End-Term Evaluation (ETE) which was conducted in 2020 by Results in Health (RiH). The objective of this evaluation was to determine HSA Partnership programme progress toward achieving its objectives. We are pleased to share the findings of the ETE, as the evaluation confirms the results that we achieved and the validity of the HSAP Theory of Change.

The HSA Partnership envisaged the realisation of equitable access to the highest attainable quality of SRH by creating a strong health workforce, access to sexual and reproductive health commodities, and investment in sustainable structures for health financing and governance. The HSA Partnership implemented four core strategies: capacity strengthening of civil society organisations, research, public awareness raising, and lobby and advocacy. The ETE has been a helpful tool to understand to what extent the HSA Partnership has realised its ambitions, as well as for internal critical review and learning by the HSA partners.

Taking the findings and conclusions from the ETE as a starting point, this letter establishes how HSA partners appraise and understand the ETE findings and capture lessons learned, which we will take on into future partnerships. Instead of providing a comprehensive response on every individual ETE finding, we have instead chosen to reflect on a selection of key findings. Our responses are accommodated under the themes of Civil Society Strengthening, Inclusivity, Advocacy Approaches, Governance and Collaboration, Health System Strengthening (HSS) and Sexual and Reproductive Health and Rights (SRHR), Outcome Harvesting and Sustainability. All partners had the opportunity to provide input and feedback to this letter.

Civil Society Strengthening

The HSA Partnership was extremely happy to see within the ETE that civil society (CS) strengthening, one of the core objectives of our programme, was evidently successful. We were glad to learn that each of the four strategies we adopted for capacity strengthening: Civil Society Organisation (CSO) capacity-strengthening, capacity-strengthening of (existing) platforms and networks, media engagement and amplification of community voices, has been effective. The ETE found that these strategies resulted in CSOs having increased SRHR/HSS knowledge, lobby and advocacy skills and engagement within policy-making processes at local, national, regional and global levels (including in multi-stakeholder platforms). Finally, it resulted in increased HSS and SRHR knowledge among community members, who increasingly held their leaders accountable and demanded their

rights. HSA partner expertise and evidence-based advocacy was highly recognised by governments, media, CSOs and other stakeholders.
According to the evaluation conducted by RiH, the HSA Partnership has proven that a significant and meaningful strengthening of civil society is possible within a five-year programme. Since it is one of the main reasons why our programme was designed, and a core aim of the Ministry of Foreign Affairs' (MoFAs) Dialogue and Dissent Grant Programme, we are highly appreciative of its success.

Inclusivity

HSA partners agree with the ETE that "gender mainstreaming and inclusivity or engagement strategies were not evident in the HSAP programming at the start". Although 'gender and inclusivity' was a crosscutting strategy in the HSAP Theory of Change from the beginning, we acknowledge that in the programme development phase not enough attention was given to the operationalisation of this strategy at the consortium level. As a result, activities focused on gender and inclusion of women did happen in several contexts, but an overarching framework was lacking.

However, after the midterm review, we undertook several steps to integrate gender more thoroughly. This included steps at an organisational level, as well as partner level, e.g.:

1. Commissioned a gender specialist to perform a gender analysis and develop recommendations.
2. Explicitly addressed gender in work plans and within our outcome harvesting systems.
3. Provided several training sessions on gender mainstreaming to the country teams.

These steps improved the gender-responsiveness of our programme, for example through gendered policy analysis and increased collaboration with women-led CSOs. However, it can be concluded that our gender mainstreaming did not reach the level of being "gender-transformative"[1]. As such, one of the lessons learned is that if 'gender' is not fully operationalised from the start of a programme, in the conception and design phase, it is challenging to modify the programme at a later stage, since the key themes, target groups and objectives are by then readily defined. Therefore, for a future programme we would accommodate gender transformation from the very start and develop elaborate gender transformation strategies in collaboration with experts.
Furthermore, the ETE stated that programme planning was not inclusive of target groups and that the programme did not specifically target marginalised groups such as people living with disabilities or LGBTQIA+. In the early stages of programme development, we made the conscious decision to take a broad health systems strengthening approach, with women, girls and youth as the key specific target groups. These groups have, in several instances, been involved in or have led the programme's development. Specific marginalised groups, like people living with disabilities and people living with HIV, were also part of the platforms that we strengthened in some countries. Yet, we do recognise this applied more so for activity development in the countries than for overarching management or operational structure. The partnership did not provide systematic guidance at alliance level, and the extent of target group involvement was therefore country dependent.

[1] https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

Advocacy Approaches

In addition to the high level of effectiveness of our capacity-building interventions, the evaluators commended us on our advocacy outcomes. Some of which they found to be "impressive for the short implementation period". Of all the outcomes achieved, 66% were linked to advocacy interventions with government stakeholders leading to policy and budgetary changes. The ETE report further demonstrates that our approach of amplifying the voices of rights-holders was highly effective in holding duty-bearers to account. They noted that "[t]his was a sustainable and effective approach to facilitating dialogue and dissent where it mattered—close to people's lives and realities".

The evaluators further found to be our multi-stakeholder approach to be a best practice. The HSAP used these platforms to share information and evidence, which were complemented by other partners. The HSAP convened meetings and established structures in which these stakeholders could gather and work together. Members had access 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. The external evaluation found these to be effective channels for influencing decision makers and increasing accountability.

Governance and Collaboration

The governance structure of the HSAP enabled the partnership to function and reach results over a period of five years. However, there were also shortcomings. The ETE discussed several governance/collaboration related shortcomings and points of improvement, for example, on the definition of roles, strategic planning, funding of coordination activities, alignment and amplification between partners, national/ regional/ global connections, and Northern versus Southern leadership. For most of these issues, we had made an effort to get the right structures in place, but unfortunately our assumptions on the practical realities (e.g. mandate, budgets, authorisation, and power dynamics) that would determine their operationalisation and success did not always hold true. This led to sub-optimal governance and collaboration in several domains. We will briefly reflect on these points:

Alliance level governance – The HSA Partnership worked with an external consultancy (Berenschot) in the development of an alliance governance plan. This governance plan enabled structured collaboration between the four partners at the alliance level, through the MG and the PG. However, we agree that governance, especially in the first term of the programme, also had several shortcomings and that the roles of the different partners could have been clearer from the start. A lesson learned is to adequately budget for shared activities amongst different implementing and consortium partners.

National/regional/global connections – At a global level the HSA Partnership organised planning sessions, but because advocacy goals and themes sometimes differed at the three levels, it became challenging to connect those and thus find synergy and amplification. However, there were examples where the connection and synergy between national and global was strong, for example the collaboration between ACHEST and Wemos on Health Workforce Financing in Uganda, in which research was conducted jointly, focusing both on presenting the status of health workforce financing at a national level and the global influence on it. ACHEST led national advocacy activities (Parliament, MoH) and Wemos led global level activities (global conferences, webinars). Another example is of HAI connecting Medicines Transparency Alliances (MeTAs) from different countries working on SRHC via annual conferences for South-South learning.

Alignment and amplification in country – At the start of the programme, each HSA country context team developed a contextualised ToC, that the team reflected on annually. The partnership opted to use the geographic contexts as the focal point of our collaborations, rather than to take a thematic approach. Unfortunately, our assumption that these shared contextualised ToCs would lead to strong collaboration (including a shared advocacy agenda), proved unfounded. Context partners came together yearly to discuss their ToC and align their work, but each partner worked on their own advocacy objectives and messages. Therefore, a lesson learned is that thematic ToCs and a joint advocacy strategy should be explored to see whether this is more effective in promoting complementarity.
Furthermore, we have invested in the development of a management structure with roles per context. But as the ETE observes, this did not function as anticipated in all contexts, because these structures lacked a mandate and a budget. However, in countries such as Zambia and Uganda the Country Management Teams worked really well. We suspect power dynamics to have played a substantial role in this. One of our lessons learned for a future programme is to be more mindful of the impact of power dynamics and conduct a complete power analysis before the start of the programme. We would furthermore promote a co-creation process at the country level (including a budget), which would counter working in silos.

Northern versus Southern Leadership – In the design of the programme, southern partners were closely involved, and the decision to have the management and governance structures located in the Netherlands was made collaboratively. However, we found that having the management group, programme group and coordination desk located in the Netherlands indeed created largely Northern-driven programme management processes. This was despite the fact that there were several processes in which Southern partners were heavily involved, such as PMEAL.

Health Systems Strengthening and Sexual and Reproductive Health

In the Executive Summary of the ETE it is stated that "Promotion of HSS as a precondition for SRHR and advocacy for SRHR influencing HSS was a missed opportunity", and that the evaluation team did not find examples of HSAP building the evidence for the ToC claim that HSS is a precondition to improved SRHR and that advocacy for SRHR influences the strengthening of health systems. The partners do not agree with the ETE that the interlinkage between SRHR and HSS was "a missed opportunity", as each HSA partner worked consciously to connect their work on SRHR and HSS (and vice versa) and there are many results that demonstrate this. Most importantly, this was the focal point of our Learning Agenda, the results of which were published in a Digizine[2]. The research within the Digizine sets out the conceptual relation between SRHR and HSS, (published after the ETE, acknowledged in the ETE) and was discussed with MoFA via a webinar.
Furthermore, throughout the programme, this linkage was created in many ways, as is shown by the large number of harvested outcomes that tackle both HSS and SRH.

Outcome Harvesting

In the Executive Summary of the ETE it is stated that The ETE shows few negative or unintended outcomes. This combined with several of the RiH substantiators being closely involved in the programme are listed as indicators of possible bias in the results. However, the ETE team has triangulated the data with

[2] https://www.wemos.nl/wp-content/uploads/2020/05/HSAP-E-zine_What-we-have-learnt.pdf

interviews to counteract this possible positive bias. Through this triangulation process, they found a high validity of our outcomes (93%, a standard much higher than is usually found within advocacy programmes). Furthermore, RiH also used different evaluation techniques, such as key informant interviews and focus group discussions, as well as collected 126 stories, which corroborated the harvested outcomes. So, while we echo the IOB concerns in relation to the usage of outcome harvesting within evaluations, we believe that by using mixed methods and triangulation, RiH was able to significantly decrease the positive bias outcome harvesting can lead to.

Sustainability

The ETE sets out several ways in which the HSA Partnership aims to ensure the sustainability of the programme, but states that some of the mechanisms put in place still depend heavily on HSA funding and capacity provision, and that it is thus questionable whether or not these efforts can, or will, continue after the HSA Partnership ends. We acknowledge that some mechanisms for sustainability depend on HSA funding. Unfortunately, it is a lasting struggle to get lobby and advocacy activities funded. Therefore, safeguarding funding for these activities beyond the programme lifetime, is and will remain a challenge. That said, the ETE also acknowledges that a significant amount of our work will most likely be sustainable, such as the adaptation and implementation of new policies, sustained increased capacity of CSOs (due to organisational development), and sustained multi-stakeholder engagement (due to integration of various platforms within the Ministries of Health).

Looking back, we are pleased we had the ETE carried out in a timely manner, early in 2020. This allowed RiH to collect most of the data smoothly, before the impact of the COVID-19 pandemic. It facilitated a suitable evaluation and a thorough report. A drawback of this early evaluation, as also acknowledged in the ETE, is that activities conducted throughout 2020, many of which were focused on exit-strategies and sustainability, could not be taken into account. The ETE, for example, recommends developing exit strategies for each context, which have been developed and implemented by the HSA Partnership over the course of this year. Our 2020 work will, however, be laid out in our final report to be submitted in 2021.

Conclusion

This letter presented our own reflections as the HSA Partnership on the End-Term Evaluation conducted by Results in Health. The recommendations of the consultants have been useful for internal critical review and to extract lessons learned.

The HSA partners were pleased to learn that an external evaluation team confirmed that our strategies of: (1) using evidence for advocacy; (2) creating and facilitating multi-stakeholder platforms; (3) engaging with and building the capacity of media, parliamentarians, CSOs, networks and governments; and (4) empowering communities to claim their rights and using valuable entry points with decision makers at all levels, were valid, complementary and mutually reinforcing.
Also, we were proud to learn that RiH confirmed our successes in multi-stakeholder platforms, capacity strengthening of individual CSOs, CSO networks, communities, and media. Moreover, that we achieved notable advocacy results relating to policy adoption, budgets, and policy implementation.
The programme weaknesses that RiH identified provide useful insights, which the partners will consider in future partnerships, so that we will be able to work towards our valuable missions, ever more effectively.

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