RAF's Approach to Advocacy

Guidance for Applicants & Grantees

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LIST OF ABBREVIATIONS

AusAID	Australian Agency for International Development
BC	British Council
CMW	Community Midwives
DFID	Department for International Development
DHQ	Donor History Questionnaire
EDO	Executive District Officer
EmONC	Emergency Obstetric and Neonatal Care
GDP	Gross Domestic Product
GoP	Government of Pakistan
GSEP	Gender, Social Exclusion and Poverty
I-SAPS	The Institute of Social and Policy Services Pakistan
INGO	International Non-Governmental Organisation
LHV	Lady Health Visitor
PAP	Population Association of Pakistan
PMA	Pakistan Medical Academy
PMU	Policy Management Unit
POC	Programme Oversight Committee
PST	Programme Strategy Team
MDG	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NGO	Non-Governmental Organisation
RAF	Research and Advocacy Fund
TOR	Terms of Reference
TRF	Technical Resource Facility
WRA-P	White Ribbon Alliance Pakistan
WHO	World Health Organisation

Authors: Sally Golding, Sarah Hall, Fatimah Shah with thanks to Seema Khan and Dr. Donya Aziz.
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Background

The Maternal and Newborn Health Research and Advocacy Fund (RAF) is a five year national programme funded by DFID and AusAID - which aims to support research and advocacy initiatives to influence pro-poor policy and practice reform related to MNH in Pakistan.

The purpose of RAF is to improve MNH practices and supporting policies related to Millennium Development Goals (MDGs) 4 and 5. To do this, RAF supports quality non-clinical research and effective advocacy. RAF has already undertaken three rounds of proposals, and is in the process of announcing the fourth round. To date, most proposals received and funded by RAF have been research-oriented, often with weak links to policy or practice change as it affects MNH.

This document comes from the recognition that opportunities exist to more quickly and collectively bring about change in MNH outcomes for poor and marginalised women and children. With this in mind, RAF recognises the need to place advocacy firmly at the centre of its programme.

RAF's Approach to Advocacy

Advocacy is the most critical component of RAF's mandate. It is vitally important that stakeholders build upon and use existing evidence on MNH in Pakistan and elsewhere in the region, as well as evidence generated from RAF's portfolio, to push for policy and practice changes which will improve MNH outcomes especially for the poor and the marginalised. With this in mind, RAF supports policy-oriented research and civil society advocacy initiatives by encouraging and supporting innovative communications, networking and advocacy projects to get key messages out to target audiences with the aim of promoting policy and practice reforms.

The concept of accountability - that is, the ability of citizens to hold government officials and bureaucrats to account - is at the core of RAF's approach to advocacy. Building citizen's capacity to exercise their voice, and to demand greater transparency and accountability, has great potential to influence government policies or processes, and leverage change.[1] RAF recognises that poor women and socially excluded groups are often unable to influence decision-making in Pakistan and that differences in power often determine whose voice is heard. RAF will therefore engage with a variety of partners and will actively seek to fund organisations with strong links at the grassroots level and the ability to reach marginalised groups.

RAF sees advocacy as a process of active engagement – which involves the use of key tools and techniques to influence and facilitate change. It targets specific change, and specific actors, and goes beyond simply raising awareness. Advocacy is the pursuit of influencing outcomes, - including public policy and resource allocation decisions - within political, economic, and social systems and institutions that directly affect people's lives[2]. This can be at an institutional, district, provincial or national level.

We recognise that effective advocacy in Pakistan faces a number of challenges. There is a general lack of understanding within civil society on how to use advocacy and communications tools effectively in pursuit of policy change. Even where advocacy successes have occurred, few lessons have been documented. Moreover, there is often a disconnection between research and civil society advocacy. Few organisations working on MNH are directly involved in policy-oriented advocacy. The media is largely disengaged with these issues, and there is not a strong tradition of working with them. In addition, while political will and momentum is critical for improvements in maternal health, relatively little is known about how to catalyse political leaders into providing sustained support for maternal health over a time span long enough to make a difference.

RAF funded advocacy should build upon existing robust evidence to push for scaling up of proven, cost effective interventions which focus on improving MNH services and access for the poor and marginalised. In addition, political commitment and greater financial resources are critical in order to accelerate progress. RAF has an important role to play in supporting civil society advocacy to hold government and policy-makers accountable for service delivery. Policy change is not enough to improve health outcomes; policy needs to be implemented accountably through interventions that target those most in need. RAF also has a key role to play in bringing stakeholders together, sharing lessons on advocacy, supporting effective approaches and encouraging organisations to speak with one voice to influence policy and practice.

[1] Sharma, Bhavna, 2008. Voice, Accountability and Civil Engagement, A Conceptual Overview. UNDP.
[2] Cohen, 2001

1. APPROACHES TO SUPPORTING ADVOCACY

RAF is a grant-making fund, therefore its mandate does not allow it to act as an advocacy actor itself – rather its role is to support and facilitate grantee advocacy through the following approaches:

- Supporting evidence based research for policy influencing.
- Supporting targeted advocacy initiatives.
- Enhancing linkages between districts, provincial and national actors encouraging information sharing, networking and collaboration.
- Supporting advocacy capacity development of its grantees.

1.1.1 SUPPORTING EVIDENCE BASED RESEARCH FOR POLICY INFLUENCING

There is considerable evidence that shows that the quality of research has a direct impact on its policy uptake. The key to effective advocacy is a strong and credible research base that is translated into clear, achievable policy recommendations. Policy influence is also affected by the relevance of the issue to policy-makers and by the operational usefulness of the research findings to them[3]. Better use of research-based evidence in this way can help to save the lives of women and newborns in Pakistan.

RAF has already provided grants for research through three open calls. Proposals have been selected for funding on the basis of the extent to which they demonstrate rigorous and inclusive research methodologies and innovative dissemination ideas. So far, funded projects have focused on RAF's five priority areas (more equitable access to services, improved quality of service provision, institutional context, the role of research and advocacy in health policy reform and the role of innovation in improving MNH services), addressing various issues within them, that include:

- Functioning, acceptability, management and scale up of Community Midwife services;
- Public private partnership models for family planning services;
- Beliefs and perceptions on MNH in Balochistan;
- Testing integrated neonatal care packages;
- Post-partum care;
- Post abortion care; and
- Basic Maternal and Newborn Health needs in crisis and post-crisis situations.
- Advocacy on post abortion care.

RAF will support current research projects to use their findings to influence policy and practice reform where appropriate, for this purpose communications and dissemination is an integral part of all RAF research projects. RAF provides guidance to its grantees to undertake strategic research dissemination and communication at the end of the project, to inform stakeholders who can utilise their findings most effectively. RAF will also assume a more active role in assisting future grantees to develop research ideas, which address gaps and have the potential to leverage change; and then supporting them to generate credible, convincing research that is relevant to policy-makers and provides clear solutions and recommendations. RAF will encourage all research and advocacy activities to be based on a systematic analysis of existing evidence and the changing policy context. In addition, RAF will increase its support for secondary research that draws together existing evidence and learning for advocacy.

1.2 SUPPORTING TARGETED ADVOCACY INITIATIVES

Before grantees start planning and implementing specific advocacy activities they should develop a clear advocacy strategy. Developing such a strategy will require political analysis, stakeholder analysis, a mapping of opportunities for change, and potential threats or obstacles to achieving it.

[3] ODI, Research and Policy in Development Programme Briefing Paper No 1, October 2004

Grantees should also consider: the political forces at work; vested interests; partners to influence; possible opposition; and ways of neutralising that opposition.

This document seeks to provide guidance and parameters in terms of the advocacy activities RAF will fund. For example, the document provides analysis of the MNH policy context in Pakistan, highlights the policy issues the fund has chosen to prioritise, and identifies some of the drivers for change.

1.3 ENHANCING LINKAGES BETWEEN DISTRICT, PROVINCIAL AND NATIONAL ACTORS ENCOURAGING INFORMATION EXCHANGE, NETWORKING AND COLLABORATION

RAF aims to maximise linkages and synergies between different actors and activities, and will work at national, provincial and district levels to support information sharing, networking and collaboration, through encouraging grantee partnerships and networking.

Identifying relevant CSOs or networks who are working in particular provinces and actively encouraging them to collaborate and share information, for example through forums and RAF's website, will help facilitate cross-regional linkages between organisations. There will be a strong emphasis on collaboration through RAF's grant process, in order to avoid duplication of efforts and to ensure that organisations speak with one voice. RAF forums will encourage and support groups to communicate at district, provincial and national levels to share lessons learnt, research findings, advocacy plans and experiences. Through such communications activities, these voices will be leveraged to influence district, provincial and national decision-makers.

1.4 SUPPORTING ADVOCACY CAPACITY DEVELOPMENT OF GRANTEES

The capacity needs and implementation challenges of Pakistani CSOs are far from uniform, given the enormous range of actors, from community-based organisations operated by volunteers to well established research institutions and Non-Governmental Organisations (NGOs) with a national and provincial presence. RAF will look at opportunities to support its grantees through sharing information and encouraging linkages.

Collaboration between grantees could help to build a partnership approach to apply for grants, whereby potential grantees match skills with other organisations to bid together. For example, one partner might have strong community based links, another effective track record of lobbying provincial governments and a third strong media and communication skills – by working together they bring their different but complementary skills to bear on a particular advocacy issue. RAF will encourage organisations with complementary skills to share experiences and look at opportunities to work in partnership where appropriate.

Advice and support could include sharing learning on best practice in all areas of communications, advocacy, and monitoring and evaluation. This will ensure plans are innovative yet realistic and achievable, with measurable results. RAF will encourage the use of existing communication toolkits, advocacy materials and policy analysis.

Guidance for Applicants & Grantees

Through this document RAF highlights broad MNH themes and potential opportunities. In doing so RAF has provided parameters for grantees on the priority issues that RAF will consider for advocacy funding. The remainder of the document is designed to guide grantees and potential grantees on key components of successful advocacy; identifying stakeholders and targets for advocacy and tailoring messages and activities for these targets, within the context of the following priority themes.

1. PRIORITY THEMES FOR MNH ADVOCACY

RAF has drawn on commissioned papers, stakeholder meetings and internal expertise to prioritise broad themes for future advocacy funding, matching the importance of the issues against opportunities for change and RAF's particular niche. These themes provide an overarching framework for grantees, and will be used as the basis for further analysis and prioritisation of the key issues that RAF will consider for funding.

RAF recognises that these themes are closely interlinked and intends to play a role in exploring the linkages, lessons learnt and opportunities for further analysis. It should be noted that RAF has already funded grantee research on some of the themes and opportunities highlighted. As such it will encourage grantees to capitalise on that research, where opportunities for advocacy exist around a particular theme.

1.1. THE 18TH AMENDMENT:

Ensuring Commitment, Accountability and Effective Implementation on MNH

The 18th amendment has significant implications for RAF. The current situation is complex and unclear. The global trend of decentralising government and decision-making to the local level has provided opportunities for a whole new set of actors to engage in decision-making. In theory, bringing government to the local level brings it closer to citizens and should increase opportunities for people's participation in decisions that affect their lives. However, citizens do not all have the same capacity, time and resources to participate, and there is a risk that it will be the elites who engage, with poor and socially excluded groups becoming further marginalised.[4]

Previously, policy on MNH was developed and implemented at a Federal level. Post June of this year, Provincial governments will be responsible for setting policy, targets, and budgets for health. There are therefore real opportunities for RAF to utilise its mandate for advocacy to support grantees to promote opportunities for poor and socially excluded groups to exercise their rights and voice, to push for commitments and to hold Provincial governments and decision-makers accountable for the delivery of MNH services. RAF recognises its need to focus a much greater proportion of its funding for grantee advocacy at a provincial level going forward. Opportunities therefore exist to influence how decisions are taken, for instance, on which services to finance, and how to support providers to deliver appropriate services for poor and marginalised women and children.

Aims:

- National MNH commitments are reflected in new Provincial structures, systems and processes post 18th Constitutional amendment.
- Prioritisation of social sector spending and enhanced budget allocations for frontline MNH services. This includes support to proven family planning interventions, community health

[4] Sharma, Bhavna, 2008. *Voice, Accountability and Civil Engagement, A Conceptual Overview*. UNDP.

workers and midwives, the provision of comprehensive obstetric facilities, financing of basic drugs and training medical staff to deal with maternal health problems.
- Bolstering commitment of members of provincial assemblies, through increased understanding of how to improve the MNH issues within their constituencies and engaging communities including socially excluded groups.
- Local health systems respond to the needs of the populations they serve by supporting participation and transparency at the local level.
- Inclusion of robust targets on maternal, newborn and child health in local health strategies, with regular reporting on progress in implementing commitments, including measurable results/impacts.

Examples of Potential Opportunities:
- As programmes are devolved to the Provinces there is a need to understand the translation of national commitments and the capacity to deliver MNH services at the Provincial level. RAF can support grantees to undertake research, analysis and prepare advocacy materials which are province-specific and target key MNH stakeholders. This could focus on monitoring the effective implementation of programmes such as MNCH, or the effective integration of vertical programmes.
- Supporting grantees to generate and communicate province-specific maternal and newborn health indicators as a way of gaining support. Providing disaggregated data by geographical location, income group, age, ethnic group, etc.
- Supporting MPs to draft and pass legislation similar to Reproductive Health Bill presently pending in the National Assembly.
- Advocacy to ensure minimum budget allocations by the provinces to the social sector will be critical. The National Assembly could be lobbied, for instance, to consider passing a 20th Constitutional Amendment requiring the Provinces to allocate a minimum amount of their budgets for social sector spending.
- Given their new lead role, Members of Provincial Assemblies should be a primary focus for advocacy efforts. Support could be given to Members of the Provincial Assemblies (MPAs) to propose changes to their 'Rules of Business' in Provincial Assemblies which would allow Standing Committees to prioritise particular issues. Instead of being dependent on the Speaker's consent, this could enable Assembly Committee members to take the initiative around the health related issues they wish to focus on.

1.2 IMPROVED QUALITY OF SERVICES

As an overarching concept, quality of care refers to the reliability, reach, responsiveness and effectiveness of the healthcare system. Improving the quality of care and services includes clinical factors, such as safe procedures, accurate information and reliable products, as well as healthcare providers' awareness and sensitivity to their patients' cultural values, social concerns and individual needs. Factors that patients consider important in determining quality of care include: acceptable waiting times; convenient opening hours; confidential relationships; availability of gender-sensitive services; continuity of services; and being treated with dignity and respect.[5]

The further extension and consolidation of health services and infrastructure in Pakistan must be accompanied by a continuous improvement in the quality of those services and systems. The improved quality of MNH service provision, especially EmONC and family planning, should contribute to a significant reduction in maternal and newborn mortality and morbidity rates. A clear advocacy

[5] Sathar et al (2005) cited in Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF

agenda exists in scaling up of evidence based minimum packages of care and enhancing capacity of existing human resources for health.

1.2.1 CONTINUUM OF CARE

The quality of care that a mother receives during pregnancy, that mother and newborn receive at delivery and in the early postnatal period constitutes the continuum of care that determines the survival and health of both the mother and child [6]. The World Health Report 2005[7] refers to the 'continuum of care' as the core underlying principle for MNCH programmes. The report defines it as a continuum not only through the lifecycle i.e. adolescence, pregnancy, childbirth and childhood but also refers to the need to ensure that quality care is provided within the home, community, health centres and hospitals. Opportunities exist for RAF to fund advocacy to scale up evidence based minimum package of care with specific focus on the immediate postnatal period and role of human resources.

1.2.2 EMERGENCY OBSTETRIC AND NEONATAL CARE

The provision of accessible and effective emergency obstetric and neonatal care (EmONC) is critical to ensuring better MNH outcomes. EmONC refers to the care of women and newborns during pregnancy, delivery and the time after delivery. Basic EmONC can be provided in health centres, however, comprehensive EmONC should be provided at the hospital[8]. If local health centres lack the capacity to carry out emergency operations, there should be an effective referral system in place to ensure women can be transferred to facilities where they can obtain the necessary care.

1. 2.3 TECHNOLOGIES AND DRUGS

Scaling up access to appropriate technologies and drugs has the potential to dramatically reduce maternal and newborn mortality and morbidity. Post-partum Haemorrhage (PPH), for example, accounts for 35% of maternal deaths in Pakistan[9]. A recent positive development has been the MoH's registration of Misoprostol for the management of PPH. The use of Misoprostol by midwives, skilled (and sometimes unskilled) birth attendants has been proven to reduce maternal mortality in countries such as Indonesia and Tanzania[10]. There is a lack of clarity and agreement on how this should be distributed and by whom. Opportunities exist to clarify recommendations on this to potentially promote the use of Misoprostil by service providers and to inform women of its availability. This could make a significant contribution to decreasing maternal mortality.

Similarly, eclampsia and pre-eclampsia account for 10% of maternal deaths in Pakistan[11]. There is ample evidence to suggest that Magnesium Sulfate is the drug of choice for the treatment and prevention of eclampsia and severe pre-eclampsia. Although it is registered for use in Pakistan, there are currently no guidelines on the roll-out of its use. Opportunities exist to advocate for guidelines and increased supply in Provinces.

1.2.4 HUMAN RESOURCES FOR HEALTH (HRH)

A key barrier to the delivery of quality care is the capacity of HRH in Pakistan. Strengthening the capacity of HRH, that is the number, skills and competencies of health care professionals,

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[6] Filippi, V. et al (2006) *Maternal health in poor countries: the broader context and a call for action,* Lancet (368) ; Tinker, A. et al, (2005) *A Continuum of Care to Save Newborn Lives*, The Lancet Neonatal Survival Series, No. 3

[7] WHO (2005) *World Health Report 2005: Make every mother and child count*, World Health Organization, Geneva

[8] Raise Fact Sheet: Emergency Obstetric Care, www.raiseinitiative.org

[9] WHO 2010

[10] Sanghi H. G. et al (2004) *Prevention of postpartum hemorrhage study, West Java, Indonesia,* Popline, Vol. 39; Prata N et al. (2005), *Controlling postpartum hemorrhage after home births in Tanzania: A technology managed effectively by traditional birth attendants*, International Journal of Obstetric Gynaecology

[11] UNFPA

administrators and other local MNH stakeholders, is critical to improving MNH outcomes. Evidence from numerous studies has shown reductions in maternal and perinatal mortality and morbidity outcomes when women have a skilled attendant, who is a qualified health care provider with midwifery or obstetric skills, present at every birth[12].

In Pakistan, much of the focus on HRH for MNCH looks at the effectiveness of primary healthcare workers such as CMWs, LHWs and TBAs. It is also important to ensure that skilled attendants work within a supportive health system that provides reliable supplies of medicines and medical equipment, and a referral system with doctors providing high quality obstetric care.

There is also evidence that many women do not access health services for fear of being treated disrespectfully. Clinic staff and community workers are not trained to recognise and respond to patients' circumstances, to expand discussion beyond patients' immediate needs to their wider health concerns, and to engage them in discussion and negotiation regarding reproductive healthcare solutions.[13] Improving quality of care also requires that patients' perspectives and levels of satisfaction are taken into account when evaluating services, and are incorporated into policy decisions.

***Aims*:**

- Improved quality of care through scale up of evidence based minimum packages of care during antenatal, delivery and postpartum stages.
- The continuum of care is at the centre of systemic approaches to improving overall care.
- Greater efficiency of referral and feedback systems to prevent delays in accessing essential obstetric services, through better training of birth attendants (skilled and unskilled), increasing community participation and better transport networks; coupled with a strategy focussing on women at higher risk. *See section 3 on Equitable Access to Services also*.
- Improved access to Emergency Care and greater investment in upgrading of essential obstetric care in district hospitals.
- Scaling up of affordable and appropriate technologies and drugs to prevent and manage common obstetric complications.
- Better training, performance, retention, integration and coordination of HRH.

Examples of Potential Opportunities

- Modular Training for Primary Health Care Providers – there is a real opportunity to formulate a policy which allows for and encourages a dynamic career structure for healthcare workers. For instance, the MNCH PC-1 outlines a mechanism by which existing LHWs can be taken into the CMW training course to build upon their knowledge. This kind of modular training should be institutionalised so there is a continuous growth in knowledge, opportunity and career for HRH.
- There is a strong advocacy and communications agenda on the deployment of the CMWs which has stalled in some provinces. Simple messaging along the lines of 'Save lives, get CMWs out!' could have a significant impact alongside lobbying of provincial governments.
- RAF grantees are undertaking research on addressing the retention of LHWs and CMWs. The outcomes of the research can potentially be used to inform an advocacy agenda.
- Integration of client perspectives on health worker performance in health policy and stronger accountability mechanisms at all levels, including staff performance, management and supervision, financial management, etc.).

[12] Bhutta, Z. et al (2010), *Systematic review on Human Resources for Health Interventions to Improve Maternal Health outcomes: Evidence from Developing Countries*, Aga Khan University
[13] Sathar et al (2005), cited in Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF

- Use of existing evidence to advocate towards provincial governments on scaling up minimum packages of care.

1.3 MORE EQUITTABLE ACCESS TO SERVICES

A large number of maternal and newborn deaths could be avoided if women had access to timely, appropriate, affordable and adequate care in Pakistan. Access to, and utilisation of, health care services is determined by factors such as physical access to services, economic access or affordability of services and social and cultural barriers which limit access to or acceptability of services. A 2010 DFID study highlights the 'futility' of strengthening the supply side of a health system without addressing the major demand side barriers that currently prevent many of the poorest women from accessing health services.[14]

1.3.1 FINANCIAL BARRIERS

In Pakistan, there are few insurance or pre-payment schemes, and so out-of-pocket costs of healthcare can include consultation fees, the cost of medicines, as well as travel fares. Poor households can thus incur out of pocket expenditure[15] as high as 76 per cent of the total amount spent on healthcare per annum.[16] Costs for MNH care can exclude the poorest women accessing critical health services, leaving them to rely on self treatment, traditional healers, and delivery at home without skilled birth attendance. As women may have less access to funds than men and less negotiating power, choice in services for ANC and safe delivery can also be restricted.[17]

1.3.2 WOMEN'S STATUS, EMPOWERMENT AND EDUCATION

Pakistani women face a number of different barriers in accessing and utilising maternal health services. These include poor levels of education (explored in the section on 'Women and education' below), lack of decision-making power, lack of financial resources, fear of violence and constraints to mobility.[18] Moreover, the size and diversity of Pakistan means that there are also significant differences between and within provinces, and between and within communities.

Women's status affects not only their nutritional and educational outcomes, but also the importance that is given to female health. When women are not valued as citizens and community members, neither they nor their family members are likely to consider them as entitled to maternal care.[19] Women's lack of status also contributes to increased violence against them, which can cause serious problems in pregnancy. Nearly a quarter of the postpartum women interviewed in a 2004 study[20] in Pakistan reported that they had experienced some form of physical abuse during their pregnancies. Studies from India, Egypt and Uganda[21] have found a link between limited use of antenatal care and increased obstetric complications in women who experience domestic violence. Research from India also indicates that violence during pregnancy is associated with adverse birth outcomes and higher infant mortality.[22]

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[14] Hulton et al (2010), *The Evidence toward MDG 5: A Working Paper*, Paper commissioned by DFID and NORAD, Options, p.98

[15] WHO (2000)

[16] Ibid.

[17] Russell, S. and Abdella, K. (2002) *Too poor to be sick: Coping with the cost of illness in East Hararghe*, Ethiopia, Save the Children, London

[18] Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF

[19] Women and Children First (2010) *Submission to International Development Committee's Inquiry into DFID's programme in India*

[20] Fikree et al., (2004)

[21] Ahmed et al, (2006); Diop-Sidibe et al (2006), Kaye et al. (2006)

[22] Ahmed et al, (2006), see fn. above.

1.3.3 TRANSPORT BARRIERS

In rural areas of Pakistan, distances to the nearest health facility are a particular problem. Many households do not have reliable, suitable and affordable transport services that are essential for access to care. Long-distance travel to healthcare facilities is a major barrier to accessing healthcare services, particularly for women who may have restrictions placed on their mobility or who may not be able to afford the transportation costs or the time needed for travel. This is particularly true when accessing antenatal care services, and during emergencies when accessing services quickly may be necessary. In many provinces hospitals do not have functional ambulances. In response to this, the Punjab government is, for example, planning to roll out a public private partnership model to help address this shortfall.

***Aims**:*

- Reduced barriers to poor and vulnerable women accessing services, including cost, transportation, discrimination and cultural beliefs.
- Greater empowerment of women to increase their use of health services; and make governments more accountable to their needs.
- Health services free at the point of use, and/or availability of alternative health financing approaches to user fees.
- Poor women's access to social protection and cash transfer programmes which enable them to cover the costs of accessing reproductive health care.
- Improved transport networks and the development of community-based transport systems.

***Examples of Potential Opportunities**:*

- There is scope to further understand different health insurance and social protection measures and their role in improving access to MNH. The Ministry of Health are currently looking at health insurance plans, this provides potential opportunities for research and advocacy however there is a risk that research could lag behind the policy agenda.
- RAF could support research and advocacy on lessons from the Benazir Income Support Programme (BISP), unconditional cash transfers and any potential linkages with maternal health, community health insurance or voucher schemes. Such research could seek to learn lessons with a view to what might replace BISP should a change of government move in that direction.
- As transport infrastructure, such as poor roads, can clearly act as a barrier to accessing essential health care, there may be opportunities for advocacy on reducing barriers. This should be based on a review of the type of transport measures which have improved access and reduced delays in reaching care in other parts of the world.
- RAF could support work to understand the perspectives of men and families in order to understand household barriers to facilitating access to healthcare for women.
- There is relatively little empirical research focusing explicitly on the relationship between social exclusion and health inequalities in Pakistan. There is a need for greater knowledge about the difficulties that excluded groups face in accessing MNH services, and the discrimination they may experience within the health system.

1.4 FAMILY PLANNING

Promotion of family planning in Pakistan has the potential to significantly reduce maternal and child mortality, to contribute to the empowerment of women and contribute to poverty reduction. In 2000, approximately 90% of global abortion-related and 20% of obstetric-related mortality and

morbidity could have been averted by the use of effective contraception by women wishing to postpone or cease further childbearing.[23]

Significant evidence exists to show that meeting women's unmet need for family planning through promoting and increasing the use of contraception has important implications for reproductive and maternal health. Unintended pregnancies may result in unsafe abortions, and the lack of availability of contraception may lead to multiple pregnancies, which can have a detrimental effect on the health of mothers[24].

1.4.1 CONTRACEPTION

Poor women's inability to exercise control over their own bodies and reproductive activity due to patriarchal cultural norms also affects the uptake of contraceptive methods. In Pakistan, the main barriers to using contraception are women's concerns about their husbands' or in-laws' views about family planning; the perceived social and cultural unacceptability of contraception; and the belief that family planning decisions were made by the husband and fertility was determined by God's will.[25]

1.4.2 BIRTH SPACING

Family planning is one of the most cost effective ways of reducing infant and child mortality[26]. By enabling longer intervals between births, it substantially decreases the risk of infant and child mortality. Children born between 18-35 months of a sibling are 0.4 times as likely to die in infancy as children born within under 18 months. Data from the 2006-7 PDHS shows that the average birth interval in Pakistan is 29 months but one-third of babies are born less than two years after the previous birth.[27]

1.4.3 ABORTION

Unplanned pregnancies are the main reason that women seek induced abortions. A 2007 Population Council study estimated that approximately 900,000 abortions occur per annum in Pakistan. Unsafe abortions remain a major cause of both maternal mortality and morbidity. A 2004 study[28] estimates that 23% of all Pakistani women who have an abortion are hospitalised for ensuing complications.

Promotion of family planning is therefore a priority focus area for RAF. High level political commitment is needed alongside a broad coalition of support from elite groups and religious leaders, adequate funding, the use of mass media and access to contraceptives through medical facilities, social marketing, and outreach services29. RAF has an important opportunity to support grantee advocacy which looks to promote political commitment and effective implementation of family planning at a Provincial level.

Aims:

- Increased prevalence and use of contraception
- Longer birth intervals are more widespread
- Post abortion care institutionalised within the health sector

[23] Collumbien et al 2004
[24] Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF
[25] Hussain and Khan (2008); Agha (2010) cited in 'Briefing Paper: Gender Inequality, Social Exclusion and Maternal and Newborn Health' (Seema Khan, Oct 2010)
[26] Cleveland, J. et al,(2006) , *Family planning: the unfinished agenda*, The Lancet
[27] Agha (2000) cited in Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF
[28] Population Council (2004)
[29] Cleveland, J. et al. (2006), *Family planning: the unfinished agenda*, The Lancet

Examples of Potential Opportunities:

- The Ministry of Population Welfare developed the 2010 National Population Policy. The policy was never formally adopted by GoP due to the devolution of the Ministry of Population Welfare to the provinces. An advocacy agenda therefore exists to ensure the provinces either adopt components of the proposed 2010 Policy or develop their own policies.
- Research gaps remain on linking supply side issues, e.g. ensuring access to and information about contraception, to demand side issues, e.g. attitudes and understanding the barriers to access and use of contraception. Opportunities for advocacy exist in ensuring that potential learning from this is used to advocate towards Provincial Governments to develop appropriate information and education campaigns to increase access.
- A clear advocacy agenda exists to push for adequate commitments on family planning at a Provincial level on proven interventions. This could advocate for, for instance, 10-20% of total family planning budgets on information and education on contraception and birth spacing.
- In an attempt to reduce the stigma associated with contraception use, advocacy could focus on religious leaders, explaining the potential impact of family planning on saving lives of mothers and newborns, and developing champions amongst them.

1.5 NUTRITION

Despite recognition of malnutrition as a problem in Pakistan, high levels of malnutrition continue to exist, with little progress made over the last 20 years. Lack of political commitment, combined with minimal investments in nutrition interventions and the lack of a clear strategy have hindered progress. Currently there is no national nutrition policy or national strategic plan for addressing malnutrition in Pakistan[30].

Under-nutrition, i.e. insufficient access to nutritious food and essential micronutrients, can lead to pregnancy complications and low immunity in mothers and newborns, heightening the incidence of maternal and newborn mortality. Poor maternal nutritional status is often the result of repeated pregnancies, inadequate food intake due to limited access to food within the households, and poor dietary habits.[31]

Low literacy levels, especially amongst adolescent girls and women, their lack of involvement in decision making, early marriage, lack of birth spacing and poor access to healthcare are all factors determining child and maternal nutrition in Pakistan[32]. Undernourished girls often grow up to become undernourished women who give birth to a new generation of undernourished children.[33] Focusing on improving nutrition for adolescent girls in the pre-conception period is an important priority.

Child malnutrition continues to be a problem due to maternal malnutrition, inappropriate infant and child feeding and caring practices, frequent episodes of diarrhoea, infectious diseases and lack of safe drinking water and household sanitation, particularly in rural areas. According to a 2009 UNICEF report 42% of children under the age of five are stunted (have low height for their age), 31% are underweight and 14% are wasted[34].

[30] http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1171488994713/3455847-1232124140958/5748939-1234285802791/PakistanNutrition.pdf

[31] Siddiqi, S. et al *Pakistan's maternal and child health policy: analysis, lessons and the way forward*

[32] http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1171488994713/3455847-1232124140958/5748939-1234285802791/PakistanNutrition.pdf

[33] Submission to the International Development Select Committee

[34] UNICEF (2009) *State of the World's Children*

Key challenges remain in addressing under-nutrition; building commitment, building capacity and scaling up proven interventions that focus on those most in need. RAF has a potentially important role to play in assessing and monitoring evidence generated from current programmes and commitments on under-nutrition in Pakistan and supporting advocacy efforts based on this evidence.

Aim:
Scale up and integration of proven interventions on Nutrition to impact on MNH outcomes for the poor and marginalised.

Examples of a Potential Opportunity:
- Opportunities exist to better understand the experience and evidence coming out of programmes and the commitments to nutrition in Pakistan; to enable greater levels of coordination and to advocate for the scale up of proven interventions to achieve equitable, sustainable coverage.
- Using existing evidence to generate advocacy messages and activities which focus on improving nutrition for adolescent girls.

1.6 WOMEN'S EDUCATION

There is broad consensus and evidence about the influence of education on maternal health outcomes. Education gives women the knowledge to understand their health needs, and to demand and seek health care. Education therefore has the double effect of improving access to information as well as empowering women to make choices.

A low level of education is also an important factor in determining whether a woman bears children at a young age, which may result in unfavourable health outcomes for both maternal and child health, particularly if the girl is young and physically and psychologically underdeveloped. In Pakistan, women with more than secondary education get married at a median age of 24.5 years, nearly six years later than women with no education (18.2 years)[35]. Levels of women's education are also positively associated with low rates of use of contraceptives and antenatal care.[36] Infant and child mortality rates are also lower among children whose parents are more highly educated. A maternal death has long-term implications for a child's education, care and health. The implications for the girl child tend to be even greater as it leads to a continued cycle of poverty and poor health[37].

Gender inequality in access to education and health is a strong determinant of maternal and infant mortality rates. Improved access of education for women is therefore critical to the success of medicinal and development interventions targeted at reducing maternal and infant mortality.[38]

A long term and effective strategy to improve the MNH indicators in Pakistan could involve strategic commitments and investments to improve education. However, while women are the prime beneficiaries of such an intervention, it is important to convey the significance of MNH to the male members of the society through education at a younger age. Potential therefore exists in impacting MNH through increasing general understanding amongst men, women, boys and girls about basic health concepts and key MNH issues e.g. timely access to skilled birth attendants.

[35] PDHS 2006-7
[36] Mumtaz (2002)
[37] Global Maternal Mortality Fact Sheet, White Ribbon Alliance, 2010.
[38] Female Education and Maternal Mortality: A Worldwide Survey C McAlister, T F. Baskett, Faculty of Medicine, Dalhousie University, Halifax NS, Department of Obstetrics and Gynaecology, Dalhousie University, Halifax NS. November 2006

Aim:
Whilst improving female education and literacy is a crucial long term goal for GoP, in the short to medium term, RAF seeks to ensure that MNH is integrated into secondary education and adult literacy programmes.

Examples of Potential Opportunities

- Promoting key messages about MNH in adult literacy programmes. For example, the National Commission for Human Development (NCHD) has developed a curriculum for adult literacy that includes messages on MNH. Grantees may choose to use RAF funding to advocate for provincial level commitment and funding for implementation of the curriculum or other literacy programmes.
- Integrating basic messages about maternal and newborn Health in secondary education curricula: Potential opportunities also exist to advocate to the national textbook board and provincial textbook boards for the integration of basic messages on MNH into secondary education textbooks.

2. MNH ADVOCACY - STAKEHOLDERS AND TARGETS

Doing a stakeholder and power analysis is an important part of developing an advocacy strategy. A power analysis aims to identify those actors/institutions with the power to bring about the desired change and those who have influence over these decision makers. This helps in identifying where and which institutions or individuals should be the advocacy targets. Targets can be broken down into:

- Primary targets (those with the most direct influence)
- Secondary targets (those with influence over the primary targets or those with some influence on the issue but not as much as the primary targets). These secondary targets are sometimes referred to as 'influentials'. Influentials can be found in a variety of places, and can include the media, members of parliament, donors, faith leaders, other government departments and trade unions.

2.1 WOMEN AND COMMUNITIES

Women, their families and the communities in which they live are the most important beneficiaries of and potential actors for any advocacy undertaken on MNH.

Engaging with communities is therefore critical. If they are not included there is little or no chance that poor people's preferences, opinions and views will be reflected in government priorities and resulting policies[39]. Promoting women's voice by raising awareness of their rights and empowering them to engage in collective action and demand change should be an important part of RAF supported advocacy efforts. Without sufficient knowledge and interest, communities cannot build dialogue with the state.

Civil society organisations have often proven successful in empowering communities and strengthening the voice of socially excluded groups. However, the voices of poor communities are rarely homogenous. Different civil society organisations are driven by different interests and often have varying levels of capacity to ensure the representation of marginalised and excluded groups[40]. CSOs, NGOs, networks and alliances taking on a representative role must ensure that their MNH advocacy is based on the identified needs of the communities in general and poor and excluded groups in particular. This is also important for ensuring that rather than advancing a 'one size fits all'

[39] Sharma, Bhavna, 2008. *Voice, Accountability and Civil Engagement, A Conceptual Overview*. UNDP.
[40] Ibid.

approach, advocacy is tailored to the specific geographic, cultural and traditional needs of communities.

2.2 POLITICIANS AND POLICY MAKERS

In order to tackle poor MNH outcomes in Pakistan, it is essential to engage in dialogue with politicians to build political commitment. Increasing citizens' capacity to demand change will have little impact if the state is not responsive to the needs and interests of the people it represents[41].

A bipartisan approach that includes politicians at the national, provincial, and local levels should be an important element of any advocacy initiative. The 18th Amendment implies that in future advocacy focused on MNH should prioritise engagement with provincial assembly members in particular. For example:

- Standing Committees on Health and/or other related Standing Committees including Finance, Women's Development, Population Welfare
- Public Accounts Committees
- Social sector and Finance Ministers
- Women's Caucus

There is evidence to show that reform-minded individuals from within government have been instrumental in movements that have successfully brought about change.[42] Advocacy efforts should also aim to cultivate political champions who are credible and well-respected.

There is a tendency amongst researchers to provide overly complex and detailed information on MNH to politicians. Advocates must keep briefings short and use accessible language. Briefings that include district level information and statistics are often particularly valued by politicians as they are relevant to their constituencies.

The implications of the 18th Amendment also hold true for the civil service who play an important role in both developing and implementing policy. As a result the relevant provincial Director Generals, for example of Health and Finance, and their advisors are important potential targets for MNH advocacy, as are those officials who are responsible for managing the MNCH Programme in the provinces.

2.3 LOCAL GOVERNMENT

Local government elections were held in 2001 and 2005 under an Ordinance which allowed for the federal government to set the framework for local governments until 2009 after which this authority was to be devolved to the Provinces. Although announcements regarding local government elections are made from time to time, it is unclear if and when these will next be held.

The restructured local government system consisted of multi-tiered governance structures at the District level with reserved representation for women, peasants, workers and religious minorities in each tier. This enabled the representation and participation of marginalised communities in district level governance processes, including policy implementation and oversight at the grassroots level.

Presently the Provinces have the mandate to legislate on, and to subsequently hold local government elections which have been pending since 2009. The previous local government system had created a tier of powerful District based representatives who were able to meet the needs of and provide political patronage to voters at the grass roots level, thus diminishing the influence of politicians in

[41] Sharma, Bhavna, 2008. *Voice, Accountability and Civil Engagement, A Conceptual Overview*. UNDP.
[42] Gaventa and Barrett (2009) Citizenship DRC

the Provincial and Federal legislatures. Needless to say in today's tense political environment in the run up to a General Election, it is not in the interest of provincial politicians to hold local government elections. As and when elections are held local government representatives, such as Nazims (District Mayors), are potential targets for MNH advocacy.

Until the next local government elections are held, the administrative affairs of the Districts are in the control of the Chief Ministers through Commissioners and District Coordination Officers (DCOs). These officers are instrumental in ensuring the effective implementation and monitoring of all programs at the District level. As such they are important targets for MNH advocacy.

2.4 SERVICE PROVIDERS

Those at the service delivery end - doctors, gynaecologists, LHWs, CMWs etc - form the backbone of the MNH services structure. They play an essential role in delivering services to poor and marginalised communities and are invariably the first 'expert' point of contact in a woman's pregnancy. As such they are key to the quality of care received by women and newborns, the effective implementation of MNH policy and to the achievement of positive MNH outcomes. They are both stakeholders and potential targets for advocacy on MNH.

2.5 MEDIA

The media is a key tool for promoting people's voice by airing community's views. The Pakistani media has emerged as a powerful actor capable of influencing public opinion and political strategies and providing an element of accountability.

If engaged with effectively, the media can provide opportunities to inform and influence public opinion, the private sector, and policy makers and groups involved in political processes. The main benefits of using the media are[43]:

- The ability to deliver messages to a large number of people, potentially attracting public interest and supporters to a cause
- Getting an issue onto policymakers' agenda
- Increasing profile and credibility with policymakers, therefore improving access to them
- Contributing to a change in behaviour of target audiences by informing them of best practice

There is great potential to harness the influence of Pakistan's media to influence pro-poor policy and practice reform related to MNH. RAF will encourage grantees to use media, alongside policy analysis and lobbying, as a tool for influencing decision-makers and communities as appropriate.
The media is a target as well as a tool. Training and sensitisation of the media professionals is a cost effective way of facilitating their ability and commitment to get key information and messages out to audiences. Thus, media owners, producers, and reporters need to be sensitised on the importance of promoting good MNH practices and highlighting the need for improved services by providing them with a constant flow of convincing stories, data and briefings.

2.6 RELIGIOUS LEADERS

In much of Pakistan's rural areas local religious leaders are influential in promoting acceptability for, and utilisation of MNH and other health services. As such grantees should consider engaging with local religious leaders as part of their advocacy strategy.

There are numerous examples of effective engagement with religious leaders. In 2004 the Ministry of Population Welfare convened an International Conference on Islam, Family Planning and

[43] Golding, S et al 'Tax Justice Advocacy: A Toolkit for Civil Society'

Reproductive Health. Religious leaders from 23 Muslim countries were brought together with local leaders to discuss the importance of Reproductive Health in Islam. The Conference resulted in the Islamabad Declaration and a follow up conference in 2005. On the basis of the Islamabad Declaration the Ministry of Population Welfare began training courses for local religious leaders.

Esteemed Islamic Scholars and Institutions such as the Al-Azhar University in Cairo have also produced studies and declarations on Islam and Reproductive Health. However there is little awareness of these initiatives and resources among local religious leaders, politicians, and the media. This presents an advocacy opportunity to be further explored.

2.7 EDUCATIONAL INSTITUTIONS

Educational institutions play an important role in training professional medical staff, developing generalist academic curricula and educating young people and adults. They are therefore potentially important actors in promoting a better understanding of MNH amongst both beneficiaries and practitioners.

In terms of advocacy potential asks could be:

- Inclusion of demographics and strengthening of MNH in medical college curriculums
- Addition of gender relevant reproductive health into secondary school and adult literacy curriculums
- Innovative approaches to place health workers in rural areas, e.g. rural placements as a mandatory part of training curriculums

3. KEY MESSAGES

This section aims to provide RAF grantees with general guidance on developing key messages and includes some examples for illustration purposes.

A message is a concise and persuasive statement about an advocacy issue that captures[44]:

- What you want to achieve, the change you want to see
- Why you want to achieve it – positive or negative consequences of no action
- How you propose to achieve it
- What action you want taken by the audience

There are many different ways to communicate a given advocacy message. It is firstly critical to tailor the message according to the audience - choosing the right words for the relevant audience and directing them at the targets in a way that they will understand, and hopefully respond positively to. The kind of messages depends very much on who is being targeted. It's sometimes easiest to think of a 'primary' or 'core' message and then have 'supporting messages'. The tone, length and style of these will depend on the audience. In the context of a geographically and culturally diverse country like Pakistan it is also important to ensure that key messages are adapted to reflect local circumstances. They also need to be cognizant of the disparities and inequalities that exist to ensure they reflect the needs of poor and marginalised communities and groups.

Grantees should ensure that messages are memorable. They should stick in the mind of the target long after the meeting has ended or the article has been read or the radio has been turned off. An effective message uses simple and unambiguous language that can be easily understood – grantees should try to avoid technical language unless you are addressing a MNH expert.

[44] Golding, S et al 'Tax Justice Advocacy: A Toolkit for Civil Society'

The core message can be easily captured in a popular, simple slogan. A slogan is particularly useful for public mobilisation and use in the media. Since they are designed to mobilise the general public, and are therefore very targeted at the public, messages should be emotive, passionate, eye-catching to get people determined to take action.

Grantees should think about:

- What is the most persuasive way to present a core message to the target audience?
- What way of presenting the message will most resonate with the target and encourage them to listen and take the message on board? Understanding the audience's perspective is key to being effective in this regard.
- What information does the target need, and what don't they need?
- What key action do you wish the target, in particular, to take?

Key messages may change over time to reflect changed attitudes or circumstances. For example, as public understanding develops so the complexity of the message to the public can reflect this change.

Table 2: Examples of Potential Messages on MNH, Who they could be aimed at and Why[45]

THEME	Target Audience	Role of Target Audience	Why Target	Potential Messages	How to target
Provincial commitment, accountability and delivery on MNH *- the example used here is the need to ensure MNH policy and practice is devolved effectively post 18th Amendment*	Provincial health policy makers e.g. Health Ministers, DG Health	Responsible for developing MNH policy at provincial level	Increased responsibility re MNH policy & implementation in light of 18th Amendment	Decentralisation gives you greater responsibility to improve the health of women and babies; we need MNH policies and practice to save lives; Ensure that appropriate language and commitments on MNH are reflected in PC 1s.	Lobbying; media campaign
	Provincial assembly members e.g. Health Committee, Speaker, Women's Caucus	To scrutinise policy and implementation and represent views of communities	The speaker can change the rules so Health Committee can scrutinise health policy and practice more effectively; Committee members can lobby for that change	Devolution for government should mean devolution for assembly members - you should be given the power to hold provincial government to account on health policy, just as national assembly members were.	Face to face lobbying; 2-sided briefing papers; presentation to Committee
	Non-health policy makers Women's Caucus in Provincial Assembly; Women in Development Ministry	Complementary support to health policy; potential allies	Women's caucus can provide vocal support for addressing gaps in MNH policy in Assembly; Women's Ministry can be insider voice in government supporting MNH policy	Help us end the unnecessary deaths of so many women and babies. You are these women's voice in the corridors of power. Tell your fellow Ministers/Assembly members this province needs to act now to fill the gap and ensure we have MNH policy and practice that works in the interests of families.	Face to face lobbying; 2-sided briefing papers; Ask representatives to meet with women in local communities
	Provincial Finance Ministers, DG Finance	Responsible for finances	To persuade them to release adequate budget for MNH in provinces	Investment in MNH has been shown to pay large economic dividends. The benefits of investing in MNH include long term savings to the health system and to the economic development of communities and provinces. Ensure 'X' percentage of the provinces budget is spent on MNH.	Lobbying International fora

45 Golding, S et al 'Tax Justice Advocacy: A Toolkit for Civil Society'

THEME	Target Audience	Role of Target Audience	Why Target	Potential Messages	How to target
Family Planning (contraception)	Health policy makers, national and provincial e.g. Provincial Health Secretary DG Health Provincial Health Committee	Form/implement health policy	i) role in ensuring strong commitments to family planning, in particular, contraception and birth spacing ii) role in policy implementation	Access to appropriate contraception is critical to improving maternal mortality	Press; media campaigns; lobbying;
	Non health policy makers (eg education)	Complementary support to health policy	Possibility of including relevant topics in education syllabus	Education has an important role to play in improving health outcomes for women and girls. Girls and boys should plan families responsibly and together. Ensure they are supported to do so by educating them in best practice.	Press; lobbying; international fora;
	Local health providers	Local level interface with citizens	Strengthen capacity to advise on and promote use of contraception	Smaller families, stronger families; better women's health	Health provider trainers; district health authorities; local media
	Men	Control decisions on access to contraception	Change behaviour to discuss with wives, accept contraception helps women's health	Smaller families, stronger families	Local CBOs, NGOs; men's fora, local media, theatre groups
	Religious leaders	Control messages on Islamic views on use of contraception	Reach agreement that contraceptive use is not un-Islamic	Islam values women's health and stronger families	Religious authorities; liberal imams, international Islamic seminars, religious media etc

4. ACTIVITIES

While RAF provides grantees with guidance on how to develop their advocacy projects, it recognises that each advocacy project is unique and requires specific activities targeted towards achieving specified outcomes on a particular issue. The outcome of an advocacy activity can be a tangible result or initiation of a documentable process of change. It is important for grantees to clearly specify the envisioned outcomes and develop a strategy towards achieving these.

In order to optimise advocacy outcomes these activities should be part of a coherent advocacy *strategy* – with clear goals, objectives, key messages, target audiences and timelines. The advocacy activities must be mutually reinforcing and appropriate to the identified target audiences.

Table 3: Examples of the types of advocacy activities that RAF would support

Method	Details	Common Use	Examples
Networking	Building alliances with as many people and organisations as possible. Creating a movement for change. Networking is integral to effective advocacy as it helps in complementing individual skill sets and organisational capacities, and joining forces towards a common goal.	To make long-term advocacy sustainable. When additional strength in numbers and skills are needed.	Pakistan Reproductive Health Network (PRHN), Pakistan Alliance on Post-Abortion Care (PAPAC), Alliance Against Sexual Harassment (AASHA).
Raising awareness *It is essential to remember that awareness raising is a means to an end, not an end in itself.*	Informing people of the situation so that they are aware of the issues. Often the first step in an advocacy process, so that people engage in the issue/campaign and help take action. Advocacy must build from the process of awareness raising, interact with the communities to understand their needs in light and communicate their voice to the policy/decision makers towards a desired change.	When information is hidden. When issues are complex. To build confidence of those partners you hope will take action in the future.	Training Posters leaflets Community meetings Road Shows drama,
Lobbying	Speaking directly to the target audiences, explaining the details of the problem and the proposed solution. Influencing decisions made by legislators and officials in the government through individual or group effort often by using intermediary ‘influentials’.	When the target audience is willing to listen to facts and open towards discussion or a careful argument	Policy briefs, Community and district meetings with Provincial government or assembly members, Phone calls Public meetings/forums, Inviting minister/District Officers to make presentations and chair sessions at events, e.g. Politicians can be invited to tour MNCH services in their districts with media members
Media	Strategic use of media is an effective way to raise public awareness, encourage debate and discussion and spread campaign messages.	When it is not possible to get direct access to policy makers	Press releases Sensitising local media representatives e.g. briefing

		To raise awareness To raise the profile of MNH issues To generate external pressure on decision-makers	a journalist, editors, reporters etc. Writing opinion editorials Involving main stream media in a subtle manner e.g. Popular discussion programmes on radio or TV to discuss on MNH issues (in general or specific to a particular area with strategic mention of decision makers/responsible authorities)
Mobilising / Popular campaigning	Closely connected with awareness raising and media and involves harnessing public pressure so that a maximum number of people can engage in the campaign and contact decision makers to call for change	When policy-makers can be swayed by public opinion and/or by their constituents. To show strength of feeling To use strength in numbers and organisation	Petitions SMSs Letter writing,

5. CONCLUSION

This document highlights the importance of advocacy for RAF; it articulates how RAF defines and approaches advocacy and aims to ensure that advocacy is at the heart of RAF support to grantees. It outlines overarching policy priorities for RAF, lays the parameters for grantee strategies and provides guidance for their design and implementation. It therefore seeks to strengthen the advocacy component of the MNH RAF programme as a whole.

This document aims to influence RAF's operational plan as it moves forward in order to ensure advocacy is more strongly and systematically reflected in RAF's portfolio and that effective advocacy on MNH is conducted by grantees. Grantee programmes will need to reflect the priority themes identified, the aims outlined within them, the stakeholders and targets that will need to be engaged with and the suite of potential advocacy activities to enable effective engagement. In particular the process will need to take on board the implications of the 18th Constitutional Amendment, and the renewed focus on MNH in the provinces as the power to influence policy and implementation shifts in that direction.

The document encourages a broad understanding of the root causes of Pakistan's high maternal and newborn mortality and of the influences on MNH policy and implementation. As such it sees as core an integrated understanding and approach to poverty, gender and social exclusion. It also emphasises the importance of engaging with stakeholders and targets beyond the MNH and medical community if we are to see a step change in the health and well being of women and newborns. So for example the role of finance ministries, educational establishments, religious leaders and the media are highlighted.

Key to effective advocacy is effective communication with target audiences. The document therefore provides guidance on developing key messages, including examples, tailoring them to the target audience and potential advocacy activities that will highlight and generate pressure for the changes that MNH advocates wish to see. It emphasises the importance of avoiding a 'one size fits all' approach and instead encourages grantees to adapt their advocacy messages and activities to specific provinces and districts and individuals, communities, or organisations within them.

It is hoped that this document will provide an overarching guide for RAF, grantees and other stakeholders to contribute towards achieving positive change in the lives of the most important stakeholders; women, families and communities whose experience of inadequate MNH policy and practice has informed the document and who stand to benefit from its success.

Please refer to RAF's Maternal and Newborn Health – The Policy Context in Pakistan for an overview of MNH, National Programmes, Policies and Acts related to MNH in Pakistan.

ANNEX I THEMES, TARGETS AND TOOLS

Below is an indicative table of potential targets matched to the MNH themes and issues identified in the 'RAF Priority Themes for MNH advocacy' section(P.8) . It includes ideas for tools and activities to influence the targets. For more ideas on activities see pg24:

THEME	SPECIFIC ISSUES	DECISIONMAKERS (primary)	INFLUENCERS (secondary)	TOOLS FOR INFLUENCE (examples only)
Provincial commitment, accountability and delivery on MNH	▪ Financing: financial commitments for MNH e.g. percentage of revenue allocation ▪ Ensuring MNH representation in Integrated vertical programme i.e. in PC1s ▪ Adapting national policies/legislations to provincial level ▪ Monitoring policy commitments and evaluating implementation (process) ▪ Role of health/gender committees (process) ▪ Change in rules of business of standing committees (process) e.g. increased powers for Health committee to select a health issue and take action (currently only speaker can assign an issue) ▪ Lobbying for an MNH legislation similar to Reproductive Rights Health Bill ▪ Formation of provincial assembly committees MNH	Provincial and National (where applicable) Ministers (Health, Education, Finance, Women Development etc.) Provincial Assembly Speakers and Members (especially Health Committee) Planning Commission	▪ Media ▪ Civil Society ▪ Provincial Planning Dept ▪ Provincial Health Secretary ▪ DG Health ▪ Provincial Health Committee ▪ Provincial Finance Committee ▪ Provincial Finance Secretary ▪ DG Finance ▪ Advisors	▪ Media – opinion editorials, ▪ Direct lobbying, ▪ Briefing documents, ▪ Community and district meetings with Provincial government or assembly members, ▪ Public meetings/fora, ▪ Invite Ministers to make presentations and chair sessions at key events
Quality of care	▪ Scaling up effective minimum packages of care, specific focus on neonatal period Enabling effectiveness of primary health care workers e.g Community Midwives, LHWs, TBAs etc o Integration & coordination o Modular training, curriculum (all) o Addressing retention (geographic/financial) ▪ Evaluation of impact	Provincial Health Ministers MNCH Programme: Provincial Programme Managers & Deputy Programme Managers	Service deliverers ▪ Provincial Planning Dept ▪ Provincial Health Secretary ▪ DG Health ▪ Provincial Health Committee ▪ CMWs, LHWs ▪ Nursing Council ▪ Advisors	**Decision-maker focused:** ▪ Politicians can be invited to tour MNCH services in their areas with media members and/or share their findings with DSOs & Assembly members ▪ Lobby meetings with short briefings ▪ Phone calls ▪ Seminars of experts to engage decision-makers ▪ Public meetings/fora ▪ Politicians invited to tour MNCH services in their areas, maybe with members of media

				▪ Writing opinion editorials
Access barriers	Women's Status and Empowerment Financial barriers e.g. insurance, learning from BISP Transport barriers	Ministry of Health: Minister & DG Ministers of Finance Social Sector Ministers Women's Parliamentary Caucus	▪ Provincial Health Secretary ▪ DG Health ▪ Provincial Health Committee ▪ Womens Caucus ▪ Standing Committee on Womens Development ▪ Other donors ▪ UNWomen ▪ UNFPA ▪ Communities	▪ Engaging with decision-makers re research results, ▪ share community experiences through radio phone-in or shows ▪ Briefing journalists ▪ Invite Ministers to make presentations and chair sessions at key events
Family planning	▪ Contraception (lack of availability/socio cultural factors) ▪ Birth spacing ▪ Post Abortion Care	Ministry of Health Service deliverers e.g. Doctors, Gynaecologists, LHWs	Secondary targets: ▪ communities ▪ UNFPA ▪ Religious councils and leaders Primary Targets: ▪ Provincial Health Secretary ▪ DG Health ▪ Provincial Health Committee	Community focused: ▪ Posters and leaflets ▪ Community/local radio bulletins, dramas etc ▪ Community meetings Decision maker focused: ▪ Lobbying ▪ Briefing documents etc. Service deliverers: ▪ Training ▪ Sharing research results etc.
Nutrition	Use of evidence on what works in Pakistan and elsewhere to advocate for scaled up interventions Improve nutrition for adolescent girls at pre-conception stage			Community focused: ▪ Posters and leaflets ▪ Community/local radio bulletins, dramas etc ▪ Community meetings
Women's education	Integrating MNH in to secondary education Roll out of MNH curriculum in adult literacy	Ministry of Education National text book board Education board	▪ NCHD (National Commission for Human Development)	▪ Lobbying meetings with short briefings

		Provincial text book boards	▪ Education Task Force ▪ Provincial education programmes ▪ Other donors ▪ Youth Councils ▪ UNFPA ▪ Pakistan Coaltion for Education	