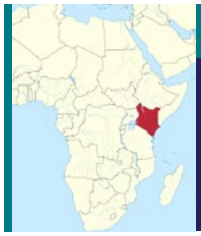
ABOUT MACS

Globally, millions of women, newborns, and children die every year from preventable causes. National governments are responsible for ensuring that all people – especially the poor and vulnerable – have access to the high-quality health services that can prevent these needless deaths.
But many governments have not kept their promises to improve women's and children's health.

A knowledgeable and empowered civil society—concerned citizens, health professionals, religious leaders, community organizations and advocates—can hold governments accountable for fulfilling their commitments. Through civil society alliances, citizens can speak with a united and coherent voice on the needs and priorities of their communities, and can partner with government to drive meaningful action.

In 2012, Family Care International (FCI) launched the *Mobilizing Advocates from Civil Society (MACS)* project in Burkina Faso and Kenya to bring together civil society organizations working in reproductive, maternal, newborn, and child health (RMNCH) and to strengthen their capacity to advocate powerfully and effectively for health policies and programs that meet the needs of women and children.

MACS
Mobilizing Advocates from Civil Society



KENYA

Women's and children's health in a devolved state: Advocates tackle crippling health worker shortages through budget advocacy

Context

Kenya is an East African country of 43 million people, situated on the Indian Ocean. Kenya ranks 147th out of 186 countries[1] according to the UN's Human Development Index, with a poverty rate of 48%. Despite this, its economy remains the largest in East Africa and continues to grow at a 5% annual rate[2]. While Kenya has seen some improvement in reproductive, maternal, newborn, and child health (RMNCH) indicators over the past decade, Kenya's maternal mortality ratio is still very high at 400 deaths per 100,000 live births.[3] Women and children living in poverty, or in certain geographic areas, continue to have poorer health outcomes due to dramatic inequities in access to quality health care. Nowhere is this more evident than in the North Eastern region bordering Somalia, where the rate of skilled birth attendance is 32%, compared to a national average of 62% and 89% in the Central Region and Nairobi.

Photo: Mark Tuschman

DEVOLUTION

In 2010, Kenya's new Constitution introduced a devolved (i.e. decentralized) system of government, transferring many governing functions and responsibilities—including budgeting and spending—from the national government to 47 new county governments. County governments now had the power to set their own priorities and focus on issues relevant to their citizens. While the national government would make policies, county governments were now responsible for implementing them. In particular, health policy implementation became almost exclusively the responsibility of county governments, though most had no prior experience fulfilling this important role.

Elections in March 2013 marked the official launch of devolution. CSOs working at the county level now had closer access to public officials and decision-makers, but everyone had to learn how these new political and governance structures would work, as new decision-makers grappled with their new responsibility for managing the health system.

To address these and other gaps, Kenya has made numerous global, regional and national commitments to RMNCH.[4] In its commitment to the 2010 Global Strategy for Women's and Children's Health[5], Kenya pledged to recruit and deploy an additional 20,000 primary health care workers, in order to provide maternal and child health services to an additional 1.5 million women and 1.5 million children. Kenya has only 11.8 health workers per 10,000 people, more than 40% below the World Health Organization's minimum recommendation of 22.8 health workers per 10,000.

The policy and accountability landscape changed drastically after the implementation of devolution *(see box, above)*. While the national government made many commitments, the

county governments were now responsible for putting them into action. County governments generally felt little ownership over promises made prior to devolution, so advocates had to learn how to work within the newly devolved political system in order to ensure that commitments to women and newborns would be fulfilled.

Building an alliance of advocates

Kenya has a vibrant civil society, but civil society organizations (CSOs) and advocates often work alone rather than in coordination. When the MACS project began, FCI identified a range of CSOs that worked on RMNCH issues and were interested or experienced in advocacy. FCI brought them together to form an Alliance[6] reflecting the broader continuum of care addressed by the global commitments rather than individual RMNCH issues. Some CSOs within the Alliance operated at the national level, others at the county level, and some had experience working internationally. Their areas of expertise ranged from technical assistance to applied research.

During initial MACS Alliance meetings, members shared their advocacy agendas, strategies, target audiences and needs for additional training. Alliance members articulated a common need to strengthen their advocacy skills and capacities and to recognize the strategic differences between successful policy advocacy directed at government decision-makers and behavior change communication (BCC) or information, education and communication (IEC) activities, which are designed to change individual health behaviors and raise awareness of public health issues.[6]

In line with Kenya's Global Strategy commitments, the Alliance identified a context-specific, cross-cutting strategic focus: budget advocacy to increase funding for human resources for health (HRH), at the county and national levels, in order to address Kenya's serious shortage of health workers.

Developing and executing an advocacy strategy

After devolution, Alliance members were unsure how county governments would develop budgets and allocate funds, and how these decisions would impact public policy implementation. FCI commissioned a policy brief, *Reproductive, Maternal, Newborn, and Child Health in a Devolved State: The Kenya Context,* to explain how the health sector would operate under the devolved system, to identify the key decision-makers, and to describe how policies would be implemented and resources distributed. Through a training organized by FCI, Alliance members learned about developing evidence-based advocacy strategies with SMART[7] objectives, identifying formal and informal decision-makers and influential people, adapting messages to target audiences, and making a concrete policy "ask," a process that was further complicated by the new political environment.

To enhance their understanding of budget processes, Alliance members participated in a workshop on budget analysis and advocacy, and developed budget advocacy

STEPS FOR BUILDING THE MACS ALLIANCE IN KENYA

strategies that made sense within the newly devolved context. With input from Alliance members, FCI created a poster-sized budget calendar for Alliance members and advocacy partners to clearly identify key dates within the annual budget cycle at both the national and county levels. The budget calendar also highlights opportunities for CSOs to participate in priority setting and accountability. These posters were shared with Alliance members and advocacy partners who continue to use them for advocacy and to train other CSOs and county decision-makers.

After developing a common advocacy objective, identifying key policy audiences, and building the knowledge and skills to influence them, the Alliance members went to work across many of Kenya's counties. Rather than embarking on a single work plan, the Alliance operated as an information-sharing platform; FCI held in-person quarterly meetings to exchange updates and strategies and hosted an online list-serv that enabled partners to share questions, concerns and opportunities on a more regular basis. Through the MACS project, FCI also provided funds to three member CSOs to conduct tailored budget advocacy to improve HRH in their respective counties.

Achievements and impact

An external evaluation of the MACS project identified several key outcomes:

SKILL-BUILDING AND CAPACITY DEVELOPMENT: Alliance members shared skills and knowledge they gained from trainings and their experience in the MACS project with organizational colleagues and external partners, including other community-based organizations and even local and county-level government officials.

ADVOCACY SUCCESSES: Alliance members used their new advocacy capacities to influence the decisions and actions of key government decision-makers, directly contributing to the following results:

- **A county government included RMNCH in its fiscal strategy,** the critically important priority-setting stage of the budget cycle.
- **County governments allocated resources to important RMNCH programs,** including recruitment of more nurses, the purchase of health equipment, and programs focused on reducing female genital mutilation.
- **County government decision-makers increasingly accepted member organizations as experts and included them as valuable partners in advancing RMNCH.** In some counties, officials signed a Memorandum of Understanding with CSOs, formally endorsing their work, and one Alliance member facilitated a first-time conversation between county parliamentarians and the county Ministry of Health to address the implementation of public health policies.
- **County government officials gained a better understanding of the national and county budget processes.** Alliance members shared their knowledge of the budget cycle with county government officials, who were also navigating budget processes under the newly devolved system. FCI's budget calendar enabled advocates and government officials to keep track of key decision-making moments.

SUSTAINABLE ADVOCACY SKILLS: MACS Alliance members feel that their combined voice has been strengthened and their policy influence has increased. With support from FCI and fellow Alliance members, they can continue to build their knowledge and advocacy skills and to pursue common advocacy objectives.


Photo: Mark Tuschman

Lessons learned

CONTEXT MATTERS. In countries where the political environment is volatile or unstable, access to information is limited, or spaces for civil society participation are few, advocates must establish objectives and develop strategies based on a deep and realistic assessment of the context.

ADVOCATES MUST BE ADAPTABLE. When the political or social context changes, advocates need to creatively adapt and evolve, as the MACS Alliance adapted to Kenya's newly devolved governance structure.

FOLLOW THE MONEY. Budgets reflect a country's real priorities: political commitments, and even formal changes in policy, mean little unless they are accompanied by the funding necessary to provide essential health services for women, newborns and children. Advocates should call for access to accurate, timely budget information, engage with government during key decision-making moments in the budget cycle, and use budget information to argue for increased funding for RMNCH services.

By taking the time to understand the context, building the skills necessary to address changing circumstances, and developing advocacy strategies tailored to new decision-making structures, FCI and the advocates in the Kenya MACS Alliance were able to use the information and lessons learned to further their successful advocacy efforts at the county level, with real national impact.

[1] United Nations Development Programme. *http://hdr.undp.org/en/countries/profiles/KEN*

[2] World Bank. *http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG*

[3] Countdown to 2015. *http://www.countdown2015mnch.org/documents/2015Report/Kenya_2015.pdf*

[4] At the regional level, Kenya committed to the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights; The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol); and the Campaign on the Accelerated Reduction of Maternal Mortality in Africa (CARMMA). Kenya also enacted a number of supportive national policies that were included in its new 2010 Constitution, the *Vision 2030* long-term development agenda, the Poverty Reduction Strategy, the national health policy for 2012 to 2030, and the National Health Sector Strategic Plan.

[5] World Health Organization. *http://www.who.int/pmnch/knowledge/publications/fulldocument_globalstrategy/en/*

[6] The RMNCH Alliance included: Family Care International (FCI), Africa Women Communication and Development Network (FEMNET), AMREF Health Africa (formerly AMREF), Health Rights Advocacy Forum (HERAF), Kenya Female Advisory Organization (KEFEADO), Kenya AIDS NGO's Consortium (KANCO), GROOTS, Center for the Study of Adolescence (CSA), Masculinity Institute (MAIN), Wem Integrated Health Services (WEMIHS) and Save the Children.

[7] SMART objectives are: Specific, Measurable, Achievable, Realistic and Time-bound

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