HEALTH SYSTEMS ADVOCACY PARTNERSHIP

Health Systems Advocacy Partnership

Mid Term Review Response

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Ministry of Foreign Affairs of the Netherlands

HEALTH SYSTEMS ADVOCACY PARTNERSHIP

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Introduction

In this report, the Health Systems Advocacy (HSA) Partnership presents an integrated reflection on the Mid-Term Review (MTR) that was conducted between July and November 2018 by an external review team from consultancy company IOD PARC. Taking the conclusions and recommendations from the MTR as a starting point, this report shows how HSA partners value and understand the MTR findings and how we intend to follow up on the recommendations in the remaining two years of the partnership.

The main objective of the MTR was to assess the mid-term indicators related to our Theory of Change (ToC). Based on the outcomes, the partnership planned to use the MTR to sharpen our PME framework. Secondary objectives included learning and concrete recommendations regarding which strategies should be maintained, improved, or stopped. Finally, the MTR aimedat informing the development of the follow-up policy framework for Dialogue and Dissent. The final MTR report as submitted by the consultants late November provides a snapshot of our program. However, the data and analysis presented by the consultants are not comprehensive enough to provide an extensive overview of our progress so far as a stand-alone document. Although relevant for future planning, reflections on specific elements of our HSA programme such as southern ownership, civic space, working with a ToC, and working in a partnership were not covered in the report. Despite these issues, the MTR has been helpful to initiate internal critical review by the HSA partners. To ensure the MTR is most useful for learning and planning, we have decided to present our reflections on the MTR conclusions and recommendations integrated within this report.

Input into this management response was gathered from participants from all partners who represented our focus countries and international contexts. Findings and recommendations of the MTR were discussed in the recently concluded HSA Joint Action Planning (JAP) meeting held in Tanzania (27-29 November 2018). Directly after the JAP meeting, a writing team with representatives from HSA partners developed this report. In this report, green text boxes are presented with sections directly copied from the executive summary, conclusions and recommendations of the MTR report which was submitted by IOD PARC, followed by our reflections and intended actions. Additional reflections by the HSA Partnership on topics outside the scope of the MTR are presented in grey text boxes.

Introduction (by IOD PARC)

The objectives of this review were to assess the extent to which the Health Systems Advocacy Partnership, (HSAP) has achieved its six midterm indicators, (MTI) as set out in its Theory of Change (ToC), and to generate learning in the contexts of: Kenya, Uganda, Zambia, the Netherlands, the Africa Region, and Globally. The overarching research question for this review was:

Is there a functioning and effective space for dialogue and dissent by CSOs including HSAP partners addressing health systems strengthening through advocating for improved HRH, SRH commodities, health financing and governance?

The review specifically examined whether progress has been achieved against the six midterm indicators, and if so, how.. A workable set of recommendations to improve the progress on the six midterm indicators for the remainder of the program implementation period was a requirement of the review.

Methodology (by IOD PARC)
Taking a case study approach to advocacy interventions, a theory-based review design was utilised and employed both secondary and primary data collection. The qualitative methods used were semi-structured interviews and focus group discussions, and secondary data encompassing a light touch document review. Purposive sampling was used. The interview and focus group discussion guides were agreed during the inception phase with the HSA Partnership. The review team sought to include the perspectives of all stakeholder groups as well as those of the HSA Partnership. The data collection was predominantly based on field visits to Kenya, Uganda and Zambia, with remote interviews being conducted with stakeholders across the other contexts: the Netherlands, Global and African region.2 The evidence is largely based on perceptions and reported experiences and was triangulated where feasible.

IOD PARC was selected by the HSA partners based on the five proposals received and subsequent interviews with the top candidates that scored best in relation to the TOR for the assignment. After a first kick off meeting in August 2018, the consultants developed an inception report in which they highlighted the methodology. Although the inception report promised a document review to understand the background of the program, the final report states that IOD PARC conducted a 'light touch' review. HSA Partners believe that the minimal review of project documents has limited the opportunity for triangulation by the consultants. The document review was followed by interviews and focus group discussions which took place during field visits in Kenya, Uganda, and Zambia and at a distance with the other context teams (Netherlands, Global, African region). The data collection focused on the following six midterm indicators:

- **MTI 1:** Increased lobby and advocacy capacity and thematic knowledge of multi-stakeholder networks and platforms, at local, national, regional and global level.
- **MTI 2:** Increased lobby, research, thematic, and advocacy capacity of civil society organisations, at local, national, regional and global level.
- **MTI 3:** Extent and quality of HSA Partnership and CSO partners in creating/using/maintaining space for CSO demands and positions related to advocacy topic.
- **MTI 4:** Quality and quantity of engagement of the HSA Partnership and its partners with decision-makers on formulation and/or implementation related to HRH, SRH commodities, health finance and governance.
- **MTI 5:** Level of credibility of knowledge products and need for/use of knowledge products by communities, health workers, policy makers and CSOs, produced by HSA Partnership.
- **MTI 6:** Level and quality of support for the advocacy topic among decision-makers.

In the following sections the MTR conclusions on these indicators are presented followed by the recommendations from the consultants.

MTR Conclusions

The following section provides an integrated review on the MTR conclusions.[1] The green boxes show the MTR conclusions as presented by IOD PARC on the six core indicators and the overall research question, followed by a partnership reflection to what extent the HSA Partnership recognises the conclusion.

MTI 1: Increased lobby and advocacy capacity and thematic knowledge of multi-stakeholder networks and platforms, at local, national, regional and global level. (by IOD PARC)	
Strengths	*Weaknesses*
1.1 All networks and platforms that are involved in this project, whether policy makers, media and or CSOs (both district/county and national) believe that the capacity building support that they receive is very useful and has enabled them to advocate for change in the areas specific to this project. 1.2 CSOs indicated that the training cascade model that is being used is very effective. This model allows more people to benefit from the HSA Partnership capacity training that is provided and helps ensure that there is not a loss in institutional memory. 1.3 The coalitions that have been enhanced, and/or developed are seen as a vital component of the project as they give a stronger voice to all advocates regardless of their position in the advocacy 'cascade'. 1.4 Advocacy capacity development of the media has been very effective, and well received by journalists. Collaboration between the Partnership and the media has increased media coverage of relevant stories to keep issues in the public eye, and has impact on decision-makers.	1.5 Although the capacity building support that is offered is seen as being very effective, there is a strong sense that more is and wanted during the remainder of the project. This is the case for CSOs, media and some decision-makers. 1.6 There is potential to strengthen the training cascade by undertaking a mapping and assessment of needs across levels of the advocacy cascade to identify gaps and areas to increase sustainability and impact. 1.7 There is potential to develop a multi-stakeholder and multi-level platform for sharing knowledge and good practice.

Partnership reflection on conclusion MTI 1

The MTR report acknowledges that the HSA programme has contributed to increased lobby and advocacy capacity of all networks and platforms that are involved in this project, both at the

[1] MTR Conclusions, Page 52 - 56

district/county, national and at the global level. These networks and platforms are most often multi-stakeholder engagements platforms, including policy makers, the private sector, CSOs and the media. Examples are the Ugandan Reproductive, Maternal, Neonatal and Child Health (RMNCH) CSO Coalition, the Medicine Transparency Alliance (MeTA) platforms, the Health Workers for All (HW4All) Coalition, the Geneva Global Health Hun (G2H2) and the African Media Network on Health (AMNH). Concerning the media network, the MTR report concluded that the capacity building support enhanced the capacities of journalists, "not only as professionals who are able to advocate for change, but to facilitate them to see the gaps within health systems strengthening that require addressing".

The conclusion confirms the Partnership's own reflections and we also recognise the fact that more capacity strengthening can be done. In the last two years of the programme, the Partnership will continue investments in capacity strengthening of multi-stakeholder platforms and networks. Activities will go beyond training as the partnership increases its focus on mentorship and cross-learning across contexts and thematic areas. Further details about the partners capacity strengthening plans are provided under recommendation six ' strengthening approaches to capacity development'.

MTI 2: Increased lobby, research, thematic, and advocacy capacity of civil society organisations, at local, national, regional and global level. (by IOD PARC)	
Strengths	*Weaknesses*
2.1 There has been an increase in the capacity of CSOs at all levels within the country contexts to advocate and lobby decision-makers. 2.2 HSA Partnership has conducted various capacity building and training workshops for CSOs and other stakeholders which has been considered useful. 2.3 The HSA Partnership has strengthened the effectiveness of existing local groups such as KWID in Uganda and the youth parliament in Kenya. These provide models of good practice in targeting and tailoring capacity building which can be shared and built on elsewhere.	2.4 The space for CSOs to advocate has been created and/or is more effectively utilised. However, there is a perception by some CSOs at country level, that unless there is continued training/capacity building there is a possibility that the space that has been created/is being inhabited may be lost. 2.5 Robust evidence on increased capacities at the various levels is limited, and there is a need for more effective monitoring mechanisms. 2.6 There is a lack of systematic sharing of good practice on models that work well across contexts. 2.7 There are gaps in CSO understanding e.g. that SHR commodities are more than family planning.

Partnership reflection on conclusion MTI 2

Whereas MTI 1 is focussed on the capacity of networks and coalitions, this indicator focuses on the capacity of individual CSOs. Similar to MTI 1 the report concludes that there has been an increase in lobby, research, thematic and advocacy capacities of CSOs at all levels within the country contexts. Although this is a positive conclusion, we had hoped to receive more specific conclusions and recommendations to strengthen our capacity building activities. In line with our reflection on MTI 1, the Partnership will continue to provide contextualized capacity building for CSO's, with a specific emphasis on mentorship and cross-learning as described in further details under our reflection of recommendation six.

We agree with the conclusion that there is a need for more effective mechanisms to monitor CSO capacities. At the moment, the capacity of CSOs (at an organisational level) is assessed annually via a modified 5C survey, which assesses the capacities of both CSOs we train, as well as the core partners and our sub-grantees. In addition to the self-assessment tool, partners use pre-/post-questionnaires, for example when providing workshops and trainings. However, this needs a more structured approach. From 2019 onwards and retro-actively for 2018, partners will strengthen the mapping of CSOs with whom the programme engages. Lastly, through Outcome Harvesting (which will also kick off in January 2019) we will begin measuring the level of involvement and contributions of CSOs towards the realisation of the contextualised ToCs.

MTI3: Extent and quality of HSAP and CSO partners in creating/using/maintaining space for CSO demands and positions related to advocacy topic (by IOD PARC)	
Strengths	*Weaknesses*
3.1 Capacity training has helped CSOs to make demands of policy makers and have a more united voice that is heard by policy makers. 3.2 Where there is already space, the Partnership has helped to maintain and exploit it. 3.3 CSOs have used the media effectively to use and maintain advocacy space; media workers' capacity for advocacy on SRH has been strengthened.	3.4 Local CSOs have in some contexts experienced a disconnect between local and national levels, limiting their communication of local issues to national CSOs. 3.5 There is a need for continuing financial resources to sustain the space.

Partnership reflection on conclusion MTI 3

Based on the findings within the MTR report for each context, which is summarized in the above table, it can be concluded that in many cases civic space required for lobby and advocacy was already existing prior to the HSA programme. The added value of the HSA Partnership lies in its support to CSOs to maintain and make active use of the space for bringing forward our advocacy

topics. The Kenya chapter of the MTR report states that the HSA Partnership has been able to enhance the space and facilitate local CSOs to strengthen their occupation within the space. Furthermore, in Uganda, the consultants concluded that the HSA Partnership has played an important role in supporting CSOs and CBOs to build networks and create platforms to enable a common voice on critical issues at the country level. Within the Netherlands and Global contexts, the HSA Partnership has also contributed to broadening civic space by facilitating voices from our focus countries in the debate to ensure that African perspectives are being heard regarding the importance of HSS for improved SRHR outcomes. Examples include the series of Global Health Cafés in the Netherlands, mentoring for CSOs during the WHO Executive Board Meeting and World Health Assembly, side-events on HRH during the Alma Ata conference in Astana, and the Annual People's Health Movement meeting in Dhaka.

In addition, MTI 3 is closely linked to the overarching question of the MTR "*Is there a functioning and effective space for dialogue and dissent by CSOs including HSAP partners addressing health systems strengthening through advocating for improved HRH, SRH commodities, health financing and governance?"* It was concluded by the evaluators that there is clear evidence HSA Partnership has positively contributed to effective space for dialogue and dissent for CSOs - especially at the country level. Besides the analysis in this report, our Annual Plans and Annual Reflection reports also show examples from each of the HSA contexts that support this conclusion.

MTI 4: Quality and quantity of engagement of the HSAP and its partners with decision makers on formulation and/ or implementation related to HRH, SRH commodities, health finance and governance (by IOD PARC)	
Strengths	*Weaknesses*
4.1 The HSA Partnership, including those who are involved in the advocacy initiatives, engages effectively with decision-makers in most cases. The HSA partners are well positioned in the country contexts and are highly strategic in how they approach decision-makers. The training that they offer to CSOs to increase coverage is very effective and enables CSOs to do SMART advocacy. 4.2 Champions at all levels in the country contexts are evident. This is a clear strength of this project and its use of the double pressure advocacy model. 4.3 HSA partners seem to be well respected and credible in their country contexts.	4.5 The attitudes of policy makers who are targeted by the HSA Partnership project at all levels within the country contexts are positive. However, though policy makers may hear and be receptive to the advocacy initiatives, policy makers themselves are faced with numerous challenges. Firstly, even if a policy maker has been 'reached' what they can do is limited. Though this is an external factor, the HSA Partnership should be more realistic about what this project can achieve in resource constraint environments. 4.6 Issues relating to resource constraints were noted by all decision makers who were interviewed in the country contexts.

4.4 Policy makers/government stakeholders in all contexts see the value of CSOs and partners in filling gaps and helping society as a whole within the broad SRH and HSS arena.	

Partnership reflection on conclusion MTI 4

The HSA Partners are pleased to read that its multi-levelled advocacy approach has been evaluated as effective and that policy makers in all contexts see the value of CSOs partaking in SRHR dialogue and dissent spaces.

The indicator measures the quality of engagement on the formulation and implementation of the four health systems building blocks, which has been noted to be high. The evaluators also measured the barriers that duty-bearers come across, as described in the challenges. We acknowledge that duty-bearers (although willing to initiate change) are sometimes hampered by resources to implement policies that strengthen SRHR, especially in low- and middle-income countries (LMICs). This is why within the partnership we also lobby for alternative ways for (local) governments to increase its services without extra costs involved to improve cost-effectiveness. For example, when SRH commodities expire in one region, while they face shortages in another region. Simply by redistributing these commodities, access and availability may be improved without any additional costs. Furthermore, in Kenya, we successfully lobbied to get the SRH budget ring-fenced at county level. This has meant that budget allocated to SRH must be spent in this field.

By employing these strategies, we keep in mind the resource constraints LMIC have and offer alternative approaches. While focussing on cost-effectiveness, we also continue to push for increased health financing by advocating towards national and international policy makers to stick to their financial commitments (such as the Abuja declaration and Maputo plan of Action) and by presenting evidence about the economic benefit of investing in SRHR. The partnerships reflection on the concern raised by the consultant about realistic expectation about the outcome of our partnership are further elaborated under recommendation 3 & 5, which are recommendations related to this concern.

Box 1. Working with a Theory of Change

In general, all partners in the HSA Partnership find a ToC model a useful framework for (strategic) planning, monitoring progress and reflection. Lobby and advocacy exists within continuously changing contexts and environments. Working with a ToC (which consists of a visual and a narrative) provides the opportunity to continuously reflect on and adjust the pathways to achieve a strengthened health system for improved SRHR outcomes. At the same time, the ToC model also provides enough structure to ensure revisions to pathways remain in line with expected outcomes at short, medium and long term. While the benefits of the TOC model are appreciated, it is also recognized across the partnership that we do not optimally put them into practice. Specific challenges have been noted regarding documentation of change processes: how to monitor if

change is occurring and how to define the HSAP contribution to this change. Another challenge has been that the original ToCs were quite broad and not thematically structured, as they needed to cover all outcomes of all the partners on different themes, which did not always enhance focused advocacy programming.

To date there has been one moment of revision in early 2018 focusing on the original five ToCs (Global, Netherlands, Kenya, Zambia and Uganda). There was a general feeling that the original TOCs did not clearly illustrate the HSA strategy and thus not facilitating the work planning process. During this reflection exercise partners refined expected outcomes and adjusted pathways, to make them more aligned with the changing realities on the ground. Moving forward, HSAP will take a more active approach with the ToC framework. Starting with the annual reflection for 2018, the Outcome Harvesting methodology is being introduced to guide this process. An important step in this exercise will be to reflect on the outcomes harvested and how they fit within our current ToCs, which could potentially result in additional revisions made to change or sharpen pathways and/or work plans for 2019.

In summary, the HSA Partnership is in favour of continuing to use the TOC framework. It allows us to frequently review the ToC, sharpen and adjust it where needed based on achieved results. This flexibility is essential for an advocacy program, where opportunities or (political) setbacks can suddenly arise. As working with a ToC is new to most of the partners it has been a learning by doing process where we see clear benefits, as well as room for improvement.

MTI5: Level of credibility of knowledge products and need for/use of knowledge products by communities, health workers, policy makers and CSOs, produced by the HSA Partnership (by IOD PARC)	
Strengths	*Weaknesses*
5.1 The Partnership has a strong and clear focus on the importance of research to support evidence-based advocacy. 5.2 In the country contexts the HSA Partnership has been able to ensure that there is demand for the research that they produce. This enables the research to be used as evidence to advocate for space, and also to ensure that there is a space for CSOs within the complex HSS arena. This evidence is used by members of the media as well as policy/decision makers. 5.3 Demand for knowledge products is high; decision and policy makers would like to see more evidence produced so that they themselves are in a stronger position to	5.5 CSOs did not widely use the Partnership's knowledge products, and were not aware of products. 5.6 It is not possible to be conclusive with regards to whether the products match the needs of the communities. Although a baseline for some indicators was completed by the HSA Partners, there was little interaction with the communities where this work is being undertaken, and no needs assessment had been undertaken. 5.7 How HSA Partnership knowledge products are used varies between the CSO platforms in the respective countries.

advocate for change 5.4 Demand for knowledge products is high from the media to inform their reporting.	5.8 There is a major gap in cross country/context learning and exchange. Many research participants said they had not seen or had access to knowledge products produced by other contexts.

Partnership reflection on conclusion MTI 5

The MTR report acknowledges the relevance of the analysis and operational research conducted by the HSA Partnership. Moreover, the MTR report also supports our conviction that there is a good understanding among our CSO partners regarding the importance of building a strong evidence base for health systems advocacy. Furthermore, it was found that evidence generated by the HSA Partnership is being used by policy makers and media. One example illustrating the high demand for our evidence was the request from the Zambian Ministry of Health to scale up our annual research on SRH commodities nation-wide. Another example at global level is the high demand for the package of knowledge products on HRH and health financing topics provided both in hard copy and electronically through a knowledge platform.[2]

Partners note that the strengths in relation to this indicator refers to the relevance of our research activities, but not necessarily to how we disseminate our findings in the knowledge products we produce. According to the MTR the HSA Partnership can still improve on how to communicate research findings in a way that better fits the needs of our different target audiences, such as policy makers, media and communities. For example, more insight regarding the knowledge needs of communities and health workers is required to better ensure that our knowledge products match these needs. Beyond the MTR conclusions about usefulness of our research for communities, we think it would also be interesting to gain more understanding in the data analysis needs of policy makers. Through increased understanding of what data policy makers would like to have and how it should be presented we can ensure they can use our products to create leverage in current debates. A good example we can learn from, are the GFF case studies which we conducted in Kenya, Tanzania and Uganda. These case studies sparked a series of discussions with development partners, civil society and the GFF. In 2019, we like to increase our learning about the effectiveness of our research products in advocacy activities. One of the case studies of our learning agenda focuses on the relevance of our SRH commodities research for policy makers.

Although we acknowledge that we can improve on matching the needs of target audiences, we do not agree with the MTR finding that our activities related to research and the development of knowledge products involve “minimal interaction with the communities”. For example, in Uganda, evidence to inform the citizen hearings is collected in health facilities by “community champions”, who live and work in the same communities. Furthermore, the HSA Partnership organised meetings for health facility staff in Kenya, Uganda and Zambia to present and discuss the findings of the SRH

[2] see: http://www.wemosresources.org/

commodities research. Although the partnership acknowledges the need to ensure that research findings are reflecting the challenges and needs of the communities, the target audience for our research and lobby and advocacy (as opposed to direct interventions) are predominantly decision-makers at the different levels (from local to global), using evidence gathered from stakeholders in country, including civil society and community representatives.

The HSA Partners recognise the gap in learning and exchange across contexts. Although all the partner organisations facilitate exchange and learning regularly, an HSA partner working in one context may not always be informed about the knowledge products produced by another partner in another context. Given that an inventory of knowledge products is being made on a biannual basis at partnership level as part of outcome reporting, it should be feasible to create a knowledge database that is accessible for all HSA colleagues to access research data relevant for each partners work. The knowledge platform launched by Wemos could be a model for this. Other models such as the portal from the Advocacy Accelerator[3] could be very useful to make our products more widely available for CSOs.

MTI 6: Level and quality of support for the advocacy topic among decision-makers (by IOD PARC)	
Strengths	*Weaknesses*
6.1 There is support from decision-makers for advocacy for SHRH. 6.2 Decision-makers are aware that the HSA Partnership produces knowledge products, since these are used to provide evidence for the need to advocate 6.3 At the country level the HSA Partnership is well positioned due to the reputations of the organizations involved in the partnership. 6.4 Research that is undertaken by the partners is seen as being very helpful, although decision-makers are not generally in a position to undertake such research due to budget constraints. The research produced helps promote evidence-based decision-making.	6.5 There was little evidence provided of interaction with the private sector other than that which is being undertaken within MeTA.35 6.6 Several networks and contacts with influential people are specifically linked to certain individuals within the various organizations. If these individuals were to leave these relationships/networks could be lost. 6.7 There is the potential for overlap with other CSOs and multilaterals, one of which is UNICEF, as well as other organisations who have offered decision makers advocacy training. This was noted by several decision-makers who indicated that they had received advocacy training from HSA Partnership as well as other NGOs.

[3] See: https://advocacyaccelerator.org/

Partnership reflection on conclusion MTI 6

The partnerships Annual Plan and Annual Reflection reports show various examples that support the conclusion by the consultants that there is support for our advocacy topics by decision makers. Partners are convinced that the strategy to focus on health system strengthening to improve SRHR works. Where direct advocacy for SRHR is often sensitive (as shown by recent statements by the Tanzanian president, rejection of the regional SRHR education bill in East Africa, and the influence of the Mexico City Policy), advocacy focused on health systems seems to be less sensitive and therefore more acceptable across different stakeholders. For the HSA Partnership this opens up opportunities to bring SRHR under attention of decision makers from a less sensitive angle, which may increase their support. As lobby and advocacy often depends on personal relations, we acknowledge that these also contribute to our partnership results. Clear documentation of advocacy actions and plans by the partners helps to ensure continuity in case of staff turnover.

We acknowledge that engagement with private sector has been limited so far. Our main engagement at this moment is indeed within the MeTA platforms. For example within MeTA, commodity value chain challenges are discussed in which private actors play an important role. Our SRH commodities research also involves both public, private and mission (not-for-profit) health facilities. That said, the public sector remains the primary focus of our advocacy work, given that national governments set the regulations to ensure SRH rights can be attained. For instance, in our lobby work concerning National Health Insurance we focus on ensuring that SRH services and commodities are covered by the national package, which will oblige private insurance providers to do the same.

Finally, concerning the potential for overlap with other CSOs and multilaterals the consultants might have misunderstood our work, the partnership does not intend to provide general advocacy capacity building training to decision makers. Activities such as, field visits for parliamentarians and sharing of knowledge products might have been considered as capacity building by decision makers or framed like that by partners for strategic reasons. Although these activities build the capacity of decision makers their core objective is focussed on policy influencing. Through our work in coalitions and networks (MTI 1) we sometimes include multilateral organizations like UNICEF or UNFPA in order to create a common voice towards decision makers. In addition, the partners activities do not replace other existing efforts but rather they synergize and complement existing efforts to create a critical mass of advocates.

Overall Conclusion (By IOD PARC)

There are clear strengths to the project, including the partnership's ability to strengthen the capacities of CSOs, decision-makers and media, and that gains have been made in the advocacy arena. There are also areas that require strengthening during the remainder of the project's life cycle.

With specific relation to the overarching research question**, is there a functioning and effective space for dialogue and dissent by CSOs including HSA partners addressing health systems strengthening through advocating for improved HRH, SRH commodities, health financing and governance?** There is clear evidence to indicate that the HSA Partnership has been able to contribute to enabling a functioning and effective space for dialogue and dissent for CSOs concerned with addressing health systems advocacy at all levels of the advocacy cascade. There are strong examples of where there have been gains in ensuring that the issues relevant to the HSA Partnership advocacy agenda are being taken seriously and that gains are being made. This is especially the case at the local level of the country contexts.

A key point made in a country context is that the HSA Partnership needs to be realistic about what it can expect to achieve given that in the countries where it works there are major constraints on resources and on the political will to engage in health.

Partnership reflection overall conclusion

Based on the different outcomes presented in the annual plans and reflections partners recognise the conclusion and the fact that most of our advocacy results are achieved at country and local level. The MTR consultants acknowledge that they have not been able to gather sufficient data on our international work to present a grounded conclusion of our work in the contexts of Global, African Region and The Netherlands. Our analysis of the D&D indicators in 2017 shows that in relation to the indicator "Improved and adopted policies", 85% of the policy changes influenced by the HSA Partnership were achieved at local and country level while 15% was achieved through our engagements in the Netherlands, Globally and in the African region. In relation to the partnerships budget allocation and the complexities of international policy influencing, partners are positive about the international results. Firstly, complexities related to international policy influencing include that policy decision making processes often take multiple years and therefore take more time to influence. Secondly, much of our work in the international context is aimed at creating a breakthrough at national level, for example by tracking commitments that national governments make in international fora. Thirdly, the types of policies that the Partnership is influencing are very different, varying from by-laws in a local government to international agreements, which weigh differently in terms of influence and impact. Finally, in the international or regional policy arena there are many actors involved around policies, compared to the national and especially local policy level. As we only track policies to which we have made a contribution, we also are transparent on the 'size' of our contribution to the policies and we acknowledge the multitude of stakeholders that contribute to these results.

MTR Recommendations

The following section provides an integrated review on the MTR Recommendations.[4] The green boxes below show the eight recommendations provided by the consultants, followed by a partnership reflection on these conclusions and how we plan to integrate the recommendations in our future work.

1) Continue to use the double pressure advocacy module (by IOD PARC)

The advocacy module that is being used in this project is what is commonly known as the double pressure advocacy model. This model builds a double pressure on decision-makers so that they hear advocacy messages from CSOs at different levels using a bottom up and top down approach. Use of a double pressure advocacy model will help ensure continuation and sustainability of the gains/progress made since it builds system-wide advocacy. Specific recommendations are:

- The double pressure advocacy model could be referred to and more explicitly used when discussing advocacy initiatives with the various stakeholders and champions of this project.
- It can be used to map activities to ensure a balanced approach to assessing capacity to inform priority levels and organisations to invest in.

Origin: Conclusions 4.1 - 4.4

Partnership reflection recommendation 1:

Our approach as HSA partnership in the country contexts of Kenya, Uganda, Zambia, Tanzania and Malawi is to influence duty bearers through a combination of high-level advocacy by CSOs at (inter)national fora and bottom-up advocacy by community groups, to which we offer capacity building to empower their voices. There are numerous examples to find, for instance in Uganda, where grassroots community groups, national CSOs and media actors have worked together to increase HRH and family planning budgets, or in Zambia where the HSA partnership engages with public and private sector at the national level and community leaders at the local level to address SRH commodity issues.

From the MTR report, partners understand that this approach is labelled as 'double pressure advocacy' approach and is considered effective. The Partnership will continue to use this approach to ensure progress. In the first half of the programme there has been huge investment in capacity strengthening of CSOs and community groups at all levels within the country contexts and the MTR concludes that their capacities have indeed improved. In the second half of the programme the Partnership will specifically invest in sustainability, to build more momentum around our agenda with strong national and global CSOs and communities that can continue to drive this agenda on health systems strengthening, even after the programme has ended.

[4] MTR recommendations, Page 57 - 60

2) Build on and share good practice for working with youth in other contexts (by IOD PARC)
The model that is being used in Siaya in Kenya with the formation of the youth parliament works effectively and is a model that can be replicated and introduced in other areas of Kenya and in other country contexts. The model enables the HSA Partnership to strengthen an effective space for dialogue and dissent for youth-focused CSOs advocating for improved HRH, SRH commodities, health finance and governance. Once other youth parliaments are established, the HSA Partnership should:

- Ensure that they are able to engage in cross learning, not only with other youth parliament groups but also with other CSOs within the various layers of the advocacy cascade
- Consider ways in which cross-learning between the project sites can be enhanced, either through additional exchange visits, documented or videoed learning, or through virtual communication.

Origin: Conclusion 2.6

Partnership reflection recommendation 2:

SRHR is an important topic for the youth as they are often denied the right to SRH services and commodities and lack access to comprehensive sexuality education. Therefore, HSA partners agree with the MTR recommendation that we need to engage with the youth within our programme. The work of the youth parliament in Kenya is a successful example on how we already engage with youth, and in 2019 this approach will be scaled up to 3 more counties. Moreover, youth-led CSOs are among the CSO networks we work with. For instance, in Uganda the RMNCAH CSO Coalition includes over 10 youth focused and led organizations.

HSA Partners acknowledge the importance to work with youth and the need to increase youth engagement. However, the youth parliament in Kenya is not the only model to ensure youth engagement. One of the core contributing success factors of the parliament is the Kenyan devolution governance model in which many political functions are devolved to county level which improves local opportunities to actively participate in decision making. In countries with more centrally led governments and in international spaces the model might be less effective. In order to ensure youth voices are amplified, additional analyses is needed to increase our understanding regarding strategies for youth engagement that have the largest impact in each of our focus contexts. For instance, in many cases rural less educated youth are excluded by the often better educated, urban youth-led CSOs. Lessons learned from other projects as by working with rural youth clubs, saving associations, youth community health workers as role models and community radio may also help to amplify the most disadvantaged youth to demand for SRH services and commodities. One of the partnership strategies already initiated for 2019 is strengthening meaningful youth participation in advocacy in the 6 districts in Uganda, through organizing intergenerational dialogues. In case we engage with youth-led CSOs capacity strengthening is important to ensure that these CSOs have the

resources and technical advocacy capacity to be most effective in spaces for dialogue and dissent. Our work with youth may also move beyond working with CSOs by stimulating a more informal youth movement through (social) media.

In conclusion, HSA partners acknowledge the importance of youth engagement to ensure increased demand for the right to inclusive SRH services and commodities. In 2019, Partners will document best practices in working with youth with the ambition to scale up youth engagement models that are most effective in each of our target contexts.

3) Engage with communities by building on learning from the Ugandan model (by IOD PARC)
Community voice is vital to this project, since communities are a fundamental part of the advocacy cascade, both from a bottom up and top down perspective. There is a need to engage more systematically with communities. The community engagement model that is being used in Uganda, specifically by KWID in Kabale which builds on community needs and priorities provides a strong model for other contexts to strengthen communities' voices, and the effectiveness and relevance of HSA Partnership support. Specific recommendations are:

- Undertake an assessment and mapping with communities of the issues that communities themselves see as being of relevance in their specific context rather than 'sensitising' them to the issues that the HSA Partnership considers of importance in the advocacy agenda.
- Tailor community level capacity building to the specific needs and priorities of local communities with their engagement.
- Address issues of community demand as well as supply. This requires grass roots education about SHR to support informed demand.

Origin: Conclusions 2.3, 2.6

Partnership reflection recommendation 3:

One of the sub outcomes within the ToC of our HSA partnership is that 'empowered communities are increasingly able to demand their rights'. There have been different approaches in the different countries and contexts on how to operationalize this. One approach, which has been used mainly in Uganda, is to organize engagements at community level between citizens and policy makers, like citizen hearings, public meetings and intergenerational dialogues. In the months prior to these meetings, community champions monitor the availability of health services through score cards and their findings are used as evidence in the discussions with local policy makers. This is facilitated by local, sub-contracted community-based organisations, who are gatekeepers to the community and engage in follow-up to hold local leaders accountable to their commitments.

HSA Partners agree with the MTR recommendation that this is a best practice model, as it really gives community members a voice, and elements of this model will be scaled up to Malawi and Kenya, where partners will increase the investment in social accountability at community level in

2019 and 2020. However, the partnership recognizes that this is not the only model to engage communities and increase community voices. Another approach that partners have used in many contexts, is to support people who represent a certain community, like the leaders of women's rights groups, youth groups, doctor unions, nurses associations, Community Health Worker groups and associations of People Living with HIV/AIDS through capacity building, mentoring and networking, to stand up for their rights and the rights of their community members to quality healthcare and good working conditions. Also with this approach partners have seen good results, for example in Kenya, where those trained community representatives engaged in public participation forums organized by county governments, and were successfully able to advocate for increased FP budgets, as described in the annual reflection 2017.

Lastly, the MTR recommends to undertake an assessment with communities of the issues that they themselves see as being relevant in their specific context, rather than 'sensitising' them to the advocacy issues of the HSA partnership. Partners recognize the importance of this, and the value of strengthening community members to address their priority issues, whatever those are. But this is also a dilemma for the partnership because we have also experienced that this often means every community addresses different issues, and there is a risk of fragmentation. To implement a 'double pressure' model and effectively link local, national and international advocacy, there is an added value of focusing on a few topics, instead of many. Additionally, as the ultimate objective of this programme is to strengthen SRHR outcomes, especially when it comes to sensitive topics, like family planning, sometimes sensitization is necessary for community member to take this up in their dialogues with local governments. Furthermore, communities can only raise issues if they are aware of them, which is often not the case. For example, communities are not aware of new funding opportunities for SRHR interventions from GFF, so for communities to play an active role in decision-making and monitoring they need to be introduced to the topic. There needs to be a balance between demand-driven and supply driven discussions.

In general, HSA partners conclude that the MTR shows us that we need to keep challenging ourselves and keep learning what approaches towards community engagement work best. Communities are a vital element of the advocacy cascade. Therefore, in the coming years, the partnership will invest in more cross-contextual learning and exchange regarding community engagement approaches.

Box 2. Southern Ownership

Recommendation four from the MTR highlights the challenges related to ownership of the partnerships advocacy agenda which also feeds into the debate how to ensure 'southern' organisations have a say and own the development and implementation of the D&D interventions.

The HSA partnership is a unique partnership in the sense that African organisations were embedded in the program from the start. The partnership consists of two African organisations and two Dutch organizations, who complement each other's expertise. When the HSA Partnership developed its

programme, it was valuable to have two African-based organisations as core partners who have been involved from the beginning in programme development and have decision making power. Although Amref Flying Doctors in the Netherlands is the penholder, there is a strong collaboration with Amref Health Africa Head Quarters in Nairobi, who are in the lead when it comes to developing advocacy strategies and campaigns. It is important to recognise the value of Amref Health Africa Head Quarters and ACHEST in setting the agenda of the partnership, as they ensure an African voice is embedded in all levels of our partnership and are able to directly connect partnership activities to realities of African governments, platforms and networks.

Despite the fact that 'southern' ownership has been ensured from the inception of our partnership we still recognize the need to find a balance between setting common overarching advocacy goals and ensuring ownership at different levels. A common goal is to ensure coherence and pressure at different policy development levels, and at the same time HSA partners should also offer enough space for country offices and national and local CSO's to contextualize the HSA advocacy agenda or to set their own agenda to address local needs. In 2019, partners will further deepen their understanding which modalities work best to ensure advocacy agenda's reflect different local needs, and are owned by stakeholders from international to local level.

4) Continue and build partnerships with decision-makers (by IOD PARC)

The HSA Partnership already has productive relationships with the MoH in the country contexts where they work; these are critical and need to be built on and sustained. There is some overlap with advocacy provided by other development partners which may lead to duplication. Specific recommendations are:

- Strengthen relationships with MoH by continuing to identify and target people who are in a position to influence change, and systematically building relationships.
- As well as the MoH, engage with decision makers who are part of the Ministries of Finance, to influence the Ministries of Finance budget allocations for health issues.
- Harmonise advocacy to decision makers with other development partners to avoid duplication or competition.

Origins: Conclusion 6.1 - 6.4, 6.6, 6.7

5) Continue to build partnerships with the media and private sector (by IOD PARC)

Relationships with the media are already strong and there is evidence that health issues are now appearing in the media in a more frequent basis with health now being seen as 'news', and that these have impact on decision-makers. To capitalize on these gains the media champions who are working with the HSA Partnership could be encouraged to advocate more to their editors to increase health coverage. Evidence on private sector engagement was limited, indicting low levels of partnership. Specific recommendations are:

- Continue to work in partnership with the media to develop their advocacy capacity and to collaborate on providing news items relevant to the HSA Partnership scope of work.
- Engage with the private health sector to develop more effective partnership working to influence private sector health provision to support the Partnership's aims.

Origins: Conclusions 1.4, 3.3, 6.5

Partnership reflection recommendations 4 and 5:

As recommendation 4 and 5 both concern partnership building with actors, we have combined our response to both recommendations.

In line with our ToC, HSA partners acknowledge that developing relationships and partnership-building with stakeholders is vital to the success and sustainability of our work. As partners, we perceive relationship building as a continuous process where we analyse which stakeholders to focus on, to be most effective in reaching our objectives. The partners acknowledge that working with different stakeholders, such as the ministry of finance and education, media and private sector can be strategic. As part of our learning agenda, we will study intersectoral collaboration for SRHR which will help to learn how to advance how we work with different ministries at national and local level in order to break the silos between these sectors but also galvanize current efforts to ensure that collaborative frameworks between sectors are functional. As indicated in our analysis of the conclusion of MTI 6, we acknowledge that our engagement with the private sector has been limited so far and can be strengthened were strategic in ensuring improved access to SRH services and commodities for all. Although we acknowledge the need to work with a variety of stakeholders, engagement with Ministries of Health (MoH) will often remain the first entry point. By creating buy-in from the MoH there is a stronger basis to engage with other ministries and private sector actors.

Concerning the recommendations about our work with the media, we are already successfully working with editors. Inviting journalists and editors for training, inviting media for field visits and a 'one stop shop' embedded in the Africa Media Network on Health in which journalists can get all the information they need on different health subjects or specific diseases may further enhance health reporting. At global level, our work is also being picked up, for example in a recent editorial by the Lancet quoting a study of the health workforce in Malawi.[5] In conclusion, HSA partners will continue networking and partnership-building based on our continued learning which stakeholders should be reached to be most effective in our various advocacy efforts.

6) Strengthening approaches to capacity development and sustaining capacity (by IOD PARC)

Many examples of capacity building and training activities were found, however value will be added by strengthening these to make them more relevant and useful to different stakeholders. In

[5] See: 'Health-care system staffing: a universal shortfall' (EDITORIAL| VOLUME 392, ISSUE 10161, P2238, NOVEMBER 24, 2018).

addition, there should be a recognition that the value of ad-hoc capacity building is limited, and a scheduled plan of ongoing interventions will provide better value. Training need to be tailored to need. It is also important to monitor and report on capacity development interventions to assess effectiveness and sustainability of capacity building. There was a widely expressed demand for more capacity development.

- Continue using the capacity building/training cascade model that is currently being used. This model has the potential to ensure that more than one individual within an organization will benefit from the training that is provided by the HSA Partnership which will help with institutional learning and sustainability.
- Undertake capacity assessments at regular intervals throughout the project and ensure that these are accompanied by detailed advocacy capacity development plans, with regular follow-up, and that these are reported against in partner reporting to allow for necessary adjustments and to measure progress. Ask CSOs for their own assessment of their needs. Adapt the capacity assessment tools as necessary to ensure that the relevant areas for capacity support are included in assessments.
- Undertake capacity assessments of the CSOs who have received training on advocacy from the HSA Partnership, but that are not direct beneficiaries of funding. Monitor their advocacy initiatives so as to ascertain if they are able to create lasting change. This will enable the HSA Partnership to learn if their capacity training is of benefit and whether the CSO platforms are effective.
- Develop with country partners a forward plan for training and learning experiences to meet demand.
- Develop training to meet gaps, e.g. gaps in understanding of SHR commodities. Run workshops to explain that SHR commodities are more than family planning.

Origins: Conclusions 1.5, 1.6, 2.4, 2.5, 2.7

Partnership reflection recommendation 6:

In order to understand the MTR report statement that our capacity building is “ad hoc” the HSA partners followed up with the consultants for further explanation. The consultants elaborated that they recognised that we have multi-annual capacity building plans for CSOs, but that CSOs themselves are often not aware of these plans. HSA core partners and sub-grantees train local CSOs (at least two representatives per organisation) often repeatedly in various forms of advocacy and/or in undertaking research. Annually, dozens of CSOs that we train and work with are assessed via a modified 5C survey that measures their organisational capacity to conduct lobby and advocacy (developed in 2017 and modified in 2018).

Partners agree that detailed advocacy capacity development plans for CSOs outside the partnership can be strengthened. To ensure the training meets the need partners, we can use the aggregated data of the 5C scan conducted with CSO’s. The analysis will help to identify capacity gaps which can

be addressed in training. At the moment post-questionnaires, reflection sessions and day-to-day experiences are also used by partners to develop follow-up capacity building interventions for CSOs. The partnership aims to strengthen these follow-up and planning interventions, which are (and will remain) tailor-made and exist of hand-holding when individual CSOs are advocating with decision-makers for the first time. Furthermore, interventions also include facilitating cross-exchange between CSOs by bringing them together at various platforms. Partners will improve on the streamlining capacity building initiatives between HSA partners to ensure there is no overlap of content. A tool is currently under development (to be reported on in the first quarter of 2019), which tracks what capacity building interventions individual CSOs have received in a particular context, and how we are collaborating with them. The reviewers remarked that we should track advocacy initiatives of CSOs. As we work with hundreds of CSOs we track those that work on the same pre-conditions formulated within our ToCs to ensure that the monitoring within this programme remains manageable. We believe that by using a sampling approach we can still evaluate the effectiveness of our capacity building interventions.

Box 3. Working in Partnership

Reflecting on the first 2,5 years of collaboration, HSA partners acknowledge both added values and challenges concerning working in partnership.

The main added value of working in partnership is that we bring different expertise and networks together through which we can have a joint impact to improve SRHR. The five core partners each have their own strengths which complement each other in reaching the HSA objectives. Amref as lead organisation and largest African health organisation has a rich track record in improving health of African communities. The organisation's services delivery work creates the opportunity to work at grassroots level and creates high levels of legitimacy for the partnership in advocacy at local, national and international level. ACHEST is an organisation founded by highly experienced African health leaders with experience in government and unilateral organisations, their networks and experience are of added value especially at national, regional and international level. Health Action International focuses on advancing access to medicines and brings in crucial expertise on research, commodity supply chains and a tested multi stakeholder engagement approach; the Medicines Transparency Alliances (MeTA). Finally, Wemos is well experienced in international global health spaces for dialogue and dissent and ensuring that local issues are heard at those levels. The different thematic expertise and networks make it possible to leverage on each other's strengths and link local to international advocacy. Finally partners appreciate the checks and balances from working in partnership which contributes to learning.

The Ministry of Foreign Affairs (MoFA) plays multiples roles as donor and strategic partner, while they are also an advocacy target for the other partners. HSA partners appreciate that the strategic partnership role has contributed to a more supportive and equal relationship. The partnership also provides the opportunity to link our work to the Ministry's interests at both international and country level. The recent discussions and exchange of information between MoFA and the other partners on the Global Financing Facility is a good example of the opportunities this partnership brings. Acknowledging this opportunity, we have observed that in many cases the partnership with MoFA and the embassies has not moved beyond information sharing. For the remaining

years and in a future framework we would recommend to clarify MoFA's partnership ambitions and identify concrete areas for collaboration with MoFA and the embassies which are regularly evaluated.

Besides the added value of working in a partnership, it also comes with challenges. One main challenge is the tension between individual organisational priorities and our joint objectives as formulated in the TOC. A lesson learned is that partnership collaboration needs attention and high investment in coordination. Also, we learned that a continuous reference to the joint vision and a TOC in which roles of partners are clearly distinguished, contributes to a more coherent partnership. Documenting, sharing and celebrating (steps to) success also enhance partnership spirit. To enhance impact of our work the HSA partners aim to deepen our understanding of successful partnership collaboration models in 2019.

7) Improve learning, knowledge sharing and documentation of learning (by IOD PARC)

There were some good examples of routine reflection and documentation mechanisms in addition to some, limited, examples of high-quality knowledge products which are used by the media and decision makers as advocacy-based research. However, learning and documentation and knowledge sharing platforms could be greatly improved to enable all organisations involved in the project to access and to use products effectively. There is also a need to increase and share examples of good practice. This is particularly relevant to CSOs, as in general the CSOs are not widely using the HSA Partnership knowledge products.

- The HSA Partnership should continue to produce high quality research and advocacy-based evidence that is accessible to all audiences, and importantly, to decision makers.
- Undertake a needs assessment for knowledge products to address identified gaps n content and access, particularly for national and local CSOs.
- Improve the documentation of qualitative aspects of the project at impact level, including stories of change to promote project learning. Put in place a dissemination strategy for this and seek platforms to share good practice accessible to all actors within the advocacy cascade including the media.
- Provide a platform for national and local CSO to come together to share their experiences, link all of the networks and platforms together. The media should also be included and other advocacy actors/platforms. This will give this project a more united voice.
- Develop mechanisms for documenting institutional knowledge to mitigate the risks of key personnel within contexts controlling knowledge, with corresponding risks of institutional memory loss issues if these people leave.

Origins: Conclusions 1.7, 2.6, 5.1- 5.8

Partnership reflection recommendation 7:

Recommendation 7 does to a large extent overlap with the conclusion on MTI 5. Although we agree with the review committee that access to and exchange of knowledge products could be improved,

the HSA Partnership itself has a broader understanding of the concepts of learning and documentation. During the recent JAP meeting we set four priorities for learning:

1. Learning research to test the key assumption underlying our ToC: "The HSA Partnership's approaches for health systems strengthening contribute to better SRHR outcomes";
2. Better mainstreaming of gender and inclusivity (including youth engagement);
3. More regular exchanges and learning visits between context teams;
4. Sharing lessons learned and best practices with external audiences.

In the Annual Plan 2019, we shared our learning research agenda, consisting of four organisational case studies that will contribute to a better understanding of how our strategies for health systems strengthening lead to improved SRHR. Our reflections on gender and inclusivity are shared under recommendations 2 and 8. With regard to more regular exchanges and learning visits between context teams, we do take into account the recommendation by the MTR consultants that this might be equally interesting for national and local CSOs as well as for the media.

Through our capacity building activities, we also facilitate national and local CSO to come together to share their experiences and link up together. For example, after trainings to local community-based CSOs in Kisumu county, the organisations that participated in the training decided to start a joint platform to work on joint advocacy strategies and collaborate where possible. Learning takes place at all levels between all context. For instance, CSO's operating in the Netherlands learn a lot from national and local CSO's during exchange visits and workshops. A partnership learning tender which we expect to launch in January 2019 could contribute to stimulate learning initiatives within and between different levels of our work.

8) Gender

Gender was a sub-question within the MTIs. The MTR found no evidence in terms of how this project addresses the issue of gender. When research participants at different levels were asked about gender there was a strong consensus that the project to date has not focused on issues that relate to gender. It was not clear to them how gender may be related to this project, nor in fact what was actually meant by gender. The HSA Partnership therefore needs to consider the following questions:

- What is the significance and relevance of gender to the HSA Partnership activities and aims?
- How is gender defined for HSA Partnership?
- Is gender a priority for the HSA Partnership?
- To what extent is there a need to address gender within the scope of the project?

Once gender is more clearly defined and addressed in the Partnership's work the Partnership should:

- Specify the intended gender outcomes and related activities in the HSA Partnership TOC and results frameworks.
- Provide gender/female awareness training to all stakeholders as part of capacity development.
- Support CSOs to address gender and women's empowerment in their activities.

Partnership reflection recommendation 8:

At the core of the HSA Partnership is the assumption that through health systems strengthening it is possible to make sustainable and significant gains in SRHR outcomes in Africa. The HSA Partnership envisions that strong health systems are inclusive and provide equitable access to health care for all, including marginalised groups like women, adolescents, people living with disabilities, elderly, people living with HIV/AIDS etc. The inclusivity of health systems cannot be considered a given; it requires that equity measures are taken into account in the design of all initiatives aimed at health system strengthening.

Nevertheless, mainstreaming gender and inclusivity in the activities of the HSA Partnership has been a challenge from the start. As partners do not agree with the MTR consultants that it is preferred to take gender out of this project. Gender and inclusivity are cross-cutting in our ToC. After various trainings in 2018, organised by HSA partners as well as by the Partnership Desk during the Joint Action Planning meeting, it is now our objective to ensure gender and inclusivity come out clearly in the work plans of 2019. Moreover, the HSA Management Group decided to install a gender taskforce to support, track and document the integration of gender and inclusivity in the programme. Another plan is to develop a joint position paper about how to mainstream gender and inclusivity in health systems strengthening strategies.

Mainstreaming gender and inclusivity is more than engaging with female champions. The HSA Partnership has been working closely together with CSOs with a primary objective to facilitate women empowerment or enhance inclusivity of other marginalised voices in advocacy. We agree that it would be interesting to further explore how their expertise and their agendas can feed our work and how the HSA Partnership can contribute to their empowerment.

Box 4. Civic Space

At the core of the Dialogue and Dissent Policy Framework is the assumption that CSOs play a political role in influencing spaces for dialogue and dissent by contributing to and maintaining civic space. It is therefore unfortunate that the information provided on civic space by our MTR report is limited, given the lack of a contextual analysis of the enabling environment for our advocacy work. The HSA Partnership continuously monitors the civic spaces in which we are working to inform our strategic planning.

The work of the HSA Partnership takes place at the crossroads of two different spaces, which could generally be referred to as the "space for SRHR" and the "space for health systems

strengthening to achieve UHC". Since the start of the HSA programme, two dynamics can be recognised. On the one hand, with the launch of the Sustainable Development Goals (SDGs) agenda, the momentum for UHC has been growing at the global and national levels as one of the key health SDGs. UHC is meant to be a country-owned and country-driven agenda, aimed at the development of country-specific policies and programs for which domestic resources are mobilised. The target of UHC is twofold: 1) equitable access to quality health services and 2) financial risk protection. Currently, the financial protection aspect of UHC is at the centre of global and national policy dialogues, while attention for equitable access to quality health services is less prominently discussed under the umbrella of UHC. Here we see a clear role for CSOs in holding governments accountable for ensuring equitable access to high-quality health services.

At the same time, we see a second dynamic related to the space for SRHR. In the five HSA countries, financing of SRHR services and commodities - e.g. family planning - is strongly donor-dependent and heavily subsidized through out-of-pocket expenditures. Since the start of the HSA programme, the financing landscape for SRHR is uncertain. International donor funds are decreasing and many low-income countries are graduating to middle-income status, losing eligibility for donor funds. As a result, public funding through domestic resource mobilisation is necessary to ensure sustainability of sexual and reproductive health and rights (SRHR) investments. This requires that SRHR too becomes a country-owned and country-driven agenda.

The HSA Partnership sees a particular role in ensuring that high-quality SRHR services, as well as the underlying building blocks necessary to deliver these services are prioritised on the UHC agenda of the HSA countries, the African region and globally. The HSA Partnership is in the right position to take up this broker role between the two spaces for SRHR and UHC. Firstly, the HSA Partnership focuses on the bigger picture (sustainable financing for HRH; reliable supply chains for SRH commodities; strong governance) and simultaneously acts as a watchdog to keep sensitive and marginalised topic (e.g. financing for family planning and remuneration of community health workers) on the agenda. Secondly, the HSA Partnership has created direct linkages between global and regional debates and national political discussions and has shown to be able to mobilise and empower civil society voices from grassroots to global level. Together with communities and civil society voices we create and occupy civic space to speak out for the prioritisation of equitable access to SRHR service on the UHC agenda.

Conclusion

This report presents our own reflections as HSA partnership on the Mid Term Review conducted by IOD PARC. Although the quality of the report was not as high as we expected, the recommendations of the consultant have been useful to initiate internal critical review. Therefore, we presented the main recommendations of the consultant together with our reflections as HSA partnership.

The HSA partners are proud to learn that an external evaluation team has confirmed that we have been able to achieve out mid-term objectives. The consultant concludes that there is clear evidence that the HSA partnership has been able to contribute to enabling a functioning and effective space for dialogue and dissent for CSOs addressing health systems advocacy at all levels of the advocacy cascade, and this is in line with our own analysis. Also, there are examples that show that the partnership was able to strengthen civil society, build an evidence base and influence district and national advocacy agenda's.

Supported by the MTR recommendations the partnership will continue to use a multi-level advocacy approach, based on continuous relation building with decision makers, media and CSO's. To ensure our work meets the demands of communities, partners intend to scale up best practices to ensure inclusive involvement of communities and youth. Our learning agenda will be at the core of our approach to identify and scale up best practices. Based on the MTR recommendations, HSA partners have set the following actions to improve our work in 2019;

- A gender taskforce will be set up to ensure gender and inclusivity (with specific reference to youth) will become a more integral part of our work.
- Partners will conduct a mapping of community and youth engagement models within the partnership to identify and implement scalable best practices.
- Partners will improve mapping of CSO's involved in the partnership and ensure a more structured engagement with CSO's in development of advocacy capacity development plans.
- In order to stimulate learning beyond our research on the key assumptions, a partnership learning tender will be launched in January 2019 with the aim to stimulate learning initiatives within and between different levels of the partnership.
- Recognizing opportunities and challenges concerning ownership of the program, working with a TOC and in Partnership, partners intend to identify the best operational modalities based on our lessons learned.

Based on the review of the MTR during the HSA joint action planning, partners have been finalizing their 2019 workplans and integrating lessons learned. Within a joint meeting with the management and program staff of the program scheduled for February 2019, partners aim to further detail our priorities for improvement including operationalisation of core opportunities for collaboration across the different contexts. The HSA partnership is looking forward to a new year where we can start building on these reflections, and lessons learned, to ensure further impact of our health systems strengthening approach to ensure all people at all times can realize their right to sexual and reproductive health.

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