MAKING ADVOCACY EFFECTIVE IN A CONTEMPORARY SETTING

By Manoj Kurian, Programme Executive, Health & Healing, World Council of Churches

The field of the poor may yield much food, but it is swept away through injustice. Proverbs 13.23

“Blessed are those who hunger and thirst for righteousness, for they will be filled” Matthew 5:6

What is Advocacy?

Advocacy is an ongoing process aiming at changing attitudes, actions, policies and laws by influencing people and organizations with power, systems and structures at different levels, for the betterment of people affected by the issue concerned. On the basis of Christian values, we could describe advocacy as a process by which we speak out with one voice against injustice, to confront structures of power, practices and attitudes which deprive human beings of dignity and to offer alternative visions based on the Gospel.

Methodology

It is critical that we adopt a mixture of advocacy strategies, mobilization, dialogue and confrontation in driving the advocacy agenda.

Mobilization

Mobilization is the campaign component of advocacy, where awareness is built up among the community or the constituency being ‘spoken for’. This is in order to ratchet up the pressure for change on the “spoken to” target. In an ideal situation, there is a building up of a movement, which gathers momentum to apply sustained advocacy pressure on the issue concerned.

Dialogue

In the case of ‘dialogue’, it is critical to have partners to help deliver the message to the target audience. This could be a government, an organisation, the international community and it could even be our own community. When we direct advocacy to our own communities or constituency, it could be termed ‘internal advocacy’ when the target is external to our own communities or constituency- it could be termed ‘external advocacy’ or ‘out-reach’. There is also a need to create opportunities for dialogue and to establish ground rules that include mutual respect, dignity and fairness. It also pays to have these

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COUNTRY EXPERIENCES IN HUMAN RESOURCES FOR HEALTH

By Mike Mugweru, Africa Christian Health Association’s Platform Officer

ZIMBABWE

During the Africa Christian Health Associations Human Resource and Advocacy workshop held at the CHAK Guest House in March this year, the Zimbabwe Association of Church related Hospitals (ZACH) shared that professionals who qualified to practice in the field of health had to start practicing in the rural areas in Zimbabwe. After practising for two years, each professional was considered eligible for post-basic training. Young doctors tended to remain in rural areas because of the perks offered. It was said that since independence in 1980, mission hospitals in the rural areas had not been upgraded and hence could not cope with the increasing population. This had resulted in burnouts because few staff were handling an increased number of patients.

Upgrading of hospitals to include building of more wards, addition of more beds and recruitment of more staff would go a long way to alleviating the stresses caused by the current imbalance. In addition, introduction of programs to train health professionals working in rural areas, especially in relation to Primary Health Care would really be important.

Training programs to strengthen governance of the health institutions were also cited as requirements. It was normal for staff to find themselves with leadership and management responsibilities albeit as stop-gap measures, yet they did not have the requisite skills to manage those positions. It was mentioned that there were staff returning from the diaspora, and they needed accommodation within proximity of the institutions they would work for which is lacking.

The adoption of a multi-currency system of payment would act as an incentive in attracting professionals to come back into the country. This is because professionals have certain remuneration expectations which they want to be matched at home.

Lastly, the government through the Ministry of finance had standardized user fees for all health centres. Therefore quality of service delivery and range of services offered have become the determinants of where the public choses to get its health services from.

ZAMBIA

In Zambia, the Churches Health Association of Zambia (CHAZ) is a recognized partner by the government in matters of health. CHAZ provides 50% of health care services in rural areas.

All professional health workers in Zambia, except some classified cadres are paid by the government. In terms of HRH policies, CHAZ follows the Government’s strategic policy for health in HR. However, the CHAZ secretariat has its own HR policy.

The Ministry of Health provides leadership in HR matters which encompass sponsorship mechanisms and training.

The Global Funds round 8 grant took into account 30 nurses who will be bonded to CHAZ mission facilities. CHAZ has a retention programme started in 2003 for medical doctors working in its health facilities, it has been scaled to include other professional cadres such as clinical officers, nurses and other categories, it provides for payment of children’s education, rural basic allowance, communication facilities, and topups. The government’s requirement is that all graduating health professionals serve in a rural area before they are given full qualification. The challenges faced include dilapidated buildings for staff accommodation.

In terms of retention, the role of the Ministry of Health is to appoint the administrators to all hospitals yet the hospitals which they oversee do not meet their salaries. In some instances there are underqualified administrators posted to mission hospitals. There is no payment of user fees in rural health facilities in Zambia, hence member facilities suffer because they cannot depend on government support throughout. Top ups, are programme specific but come with unit costs hence disparities among payment of same cadres of workers.

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interactions well documented and visible to neutral observers. Lobbying and negotiations are also valuable actions that can be effective components of dialogue.

**Confrontation**

There are many forms of ‘Confrontation’, which include public debates, demonstrations or litigation. In case of demonstrations, it is important to ensure the legality of gatherings and to espouse non-violence and the safety of those involved. The ‘Confrontations’ will benefit greatly from meticulous planning, consultative processes, good grounding on the legal facets surrounding the issue. Successful communications and media strategies are fundamental to successful execution of advocacy efforts.

**Evaluation**

It is important to plan Advocacy work in a framework which can help assess the time and the quantum of resources that is invested in it. The efforts need to be evaluated for their relevance to the people concerned, the competence of those who have handled it, its visibility in media and public debate and the impact with regards to outcome.

**Moral and ethical imperative for advocacy**

Life in our communities can be compared to a journey in a vehicle on a very poorly maintained road. The tires of the vehicle get punctured frequently and we spend a lot of time patching and repairing the tires and changing them. Do we continue our painfully slow journey in this fashion? Will we not make efforts to mobilize and advocate for the larger task of repairing and maintaining the road?

Much of the health and healing work that we do can be seen as the ‘repairing and patching’ to get the vehicle running. But the fundamental and structural issues that lie at the root of the challenges our societies face is symbolized by the road that needs to be repaired. These need to be faced and dealt with. It calls for collaboration, networking, dialogue, mobilization and advocacy.

It is not conceivable to transform societies for a better future without sound advocacy. The Human resource crisis in the health service sector cannot be addressed without seriously considering the local, national and international drivers of the crisis. We have good examples of successful advocacy efforts bearing fruits in the field of human resource management. At the national level, the Memorandum of Understanding that the Christian health Association of Kenya (CHAK) has developed with the Ministry of Health in Kenya, is the fruit of sustained advocacy work by that particular Christian Association.

In the international arena, the development of the Global code of practice on international recruitment of health personnel has been made possible by the efforts of the World Health Organization along with a coalition of organizations called the Global Health Workforce Alliance, through a wide and thorough consultative process.

This too has happened because of the dedicated and consistent advocacy of a wide spectrum of partners across the world. We cannot rest on the laurels of modest achievements. The call for advocacy on many issues are loud and clear. We need to see much greater investment in health across the world.

We need our communities to benefit from universal health care and social security. The unfair trade and intellectual barriers that keep marginalized communities poor need to be dismantled. The power structures that sustains inequity and injustice and keep wealth concentrated amongst few at the cost of the majority need to be challenged effectively.

The world has enough resources to meet the needs of every human being, but it does not have enough resource to sustain human greed.”

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The world has enough resources to meet the needs of every human being, but it does not have enough resource to sustain human greed. The moral and ethical imperative for our engagement with critical issues and advocating for the welfare of the least and marginalized is clear.
ROLE OF CHURCH HEALTH SERVICES COORDINATING COMMITTEE IN ADVOCACY

By Dr. Samuel Mwenda; General Secretary, CHAK

The Church Health Services Coordinating Committee is a partnership structure of the Christian Health Association of Kenya (CHAK), the Kenya Episcopal Conference (KEC) and the Mission for Essential Drug Supplies (MEDS).

The role of the committee includes among other things to coordinate joint strategizing in engaging government on behalf of the three bodies, to strategize on joint engagements with donor partners of common interest e.g. AIDSRelief, PEPFAR & CDC and as a forum for sharing experiences, lessons and best practices between CHAK, KEC and MEDS.

Advocacy with donors

A good example of advocacy with donors included the work of the CHSCC in demonstrating the capacity of CHAK, KEC and MEDS in handling the sustainability of the AIDS relief project, which was transitioning to local indeginous organizations from a consortium of international donors.

The AIDS relief project oversees among other things, the care of 60,000 HIV patients, 40,000 of whom are actively on Anti-Retroviral Treatment.

Transition of AIDSRelief has meant strengthening of the capacity of CHAK-KEC-MEDS and transferring management of AIDSRelief to them in a phased approach guided by an agreed work plan.

This includes
• Site Management – sub-grantee contractual role with Treatment facilities mapped in geographical regions.
• Health systems strengthening.
• Support for integration of HIV care to the rest of hospital management.
• Advocacy for government to support health Facilities with staffing and commodities.
• National Hospital Insurance Fund – for better rebates to Church Hospitals.
• To Ministry of Health (MOH) for inclusion in various Health Sector policy and planning structures.
• To the Ministry of Health (MOH) for fair consideration in the roll out of the new Health Sector Service Fund (HSSF), which is a new direct funding mechanism for Health facilities in Kenya.
• With Capacity Kenya for HR advisor support.
• With UNICEF for Integrated Management of Children Illness capacity building and funding program.
• Oversee dissemination and implementation of MoU with GoK.

Lessons:
• There is strength and synergy in working together in advocacy.
• We have pooled our resources which enables us to tackle diverse issues.
• We are encouraged and empowered to face new challenges and to sustain our advocacy campaigns.
• We are able to mobilize the Church Leaders for effective joint advocacy.
• We shall reclaim the space that is being taken up by some NGO networks.
In 2008 one of the partners of the Uganda Protestant Medical Bureau (UPMB) organized a workshop in which UPMB would participate in implementing a Monitoring and Evaluation methodology in one of its Health Centres.

The Health Centre selected was Kyetume Health Centre under UPMB, which would pilot the Community Score Card (CSC) methodology used in monitoring and evaluating health interventions at the health facility and in the community. This model would be replicated in the rest of the facilities under the UPMB network.

The Community Score Card

The CSC is a process by which community members (service users) provide organized feedback to service providers (health workers) such as those working at Kyetume Health Centre. It facilitates a bottom up process of a community assessing the performance of its service providers. It also strengthens accountability and transparency in health care delivery through joint planning and national level advocacy. Overall, it is meant to point out which aspects of service are delivered well and which aspects of services require improving and what level of collaboration is needed to bring about these positive changes in the provision of services.

Why did UPMB adopt this approach?

It was in order to empower communities to offer direction and responsibility over their own health development. Previous models of development have worked on the premises that communities are passive recipients of aid and services. The new approach changes all that.

Benefits of the community score card approach

(a) For social accountability. To enable Faith Based institutions and civil society to express demand for the public services and exact accountability for local service providers to improve the quality of

Continued from page 2

Country experiences in HRH

In Lesotho, it was said that immigration to South Africa and to NGO’s dealing with HIV/AIDS, which stands at 22-28% in the country had contributed largely to the lack of medical personnel in faith based institutions. In the country, there is no training program for doctors.

Most doctors are immigrants from Zimbabwe and other countries. They get accreditation from Lesotho, there are nurses from Kenya, Botswana, DR Congo, and other countries. It was said that getting people to work in remote areas is difficult. Hence there is a high turnover of staff found in the rural areas.

The rural areas lack social amenities such as schools and markets. They have no water and no electricity, hence they do not attract any manpower. Immigrant doctors say that language, cultural differences pose a challenge to their continued stay. Many hospitals have deteriorated due to lack of financial and human ressources. There are very little resources to help member hospitals of the Christian Health Association of Lesotho (CHAL) attract more qualified human resource. The member hospitals of CHAL found in the rural areas are dependent on immigrants, since the rural areas have no electricity and transport network. People have to walk long distances. Health centres are situated in isolated and difficult to reach places.

IMPORTANT NOTICE:
Various policy documents from different CHA’s are available, upon registration on the ACHA website.
Visit: http://www.africachap.org/x5/. Click on policy documents
services.

(b) To facilitate information flow from the community to the national level and downward again.

(c) To provide a path for feeding useful feedback from grassroots to national level.

(d) To have a simple but scientific tool to monitor and evaluate government policies and economic programs.

(e) To give the poor and marginalized a voice to tell their story as they see and feel it.

**Expected outcomes of a CSC Process:**
1. An empowered community aware of their own rights to health care and with ability to demand for them, and service providers aware of community rights, responsibilities and needs.

2. Improved communication, dialogue and friendship between service users and service providers resulting in effective service delivery.

3. Greater access to government financing and budget information by communities and partners in the SRH and HIV sectors.

4. Appropriate policies in place to enhance better health provision and well being of communities.

5. Feedback provided on the sexual reproductive health indicators, strengths and gaps exposed and proposed way forward made.

**Lessons learnt**
(a) The CSC Methodology is very relevant, inspiring and able to generate the level of dialogue between the service users and service providers, ownership and policy actions.

(b) When planning the training of community facilitators, we need to include skills in communication, report writing, adult learning among others.

(c) Community meetings such as community assessment and multi-stakeholder require a neutral moderator to back up the presenters who are always the community facilitators. The moderator helps to stir the discussion, to neutralize those who want to dominate and to interest the rest of the audience to talk and to ensure that pledges and commitments are made.

**A snapshot of various indicators captured on the community score card**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Reasons for score</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of drugs</td>
<td>40%</td>
<td>(a) Drugs for treating Malaria and other common illnesses are available</td>
<td>(a) Quantity of drugs should be increased. (b) Investigations should be done to find out if any staff takes drugs from health facility. (c) There should be close monitoring of the flow of drugs in the health facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) Medicines for STIs treatment is inadequate. (c) Sometimes patients are advised to buy drugs from other places after prescriptions. (d) The available drugs are very expensive</td>
<td></td>
</tr>
<tr>
<td>Waiting Time</td>
<td>30%</td>
<td>(a) There is always a staff to attend to a patient - 24 hours. (b) Some health workers spend a lot of time conversing. (d) Some staff arrive late to work. (e) Most of the staff are absent especially on Saturdays</td>
<td>(a) Accommodation for staff should be constructed near the health facility. (b) Staff need to be encouraged to arrive early at work. (c) More staff should be available especially on Saturdays</td>
</tr>
<tr>
<td>Fairness in service</td>
<td>45%</td>
<td>(a) Health providers ignore young people in favor of older ones</td>
<td>(a) Cards should be given to patients in order of arrival to ensure first come first serve basis</td>
</tr>
<tr>
<td>provision</td>
<td></td>
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For more Information on the community scorecard, contact the ACHAP secretariat
AN INTRODUCTION INTO MONITORING AND EVALUATION

By: Samuel Muhula M&E Officer CHAK

**What is Monitoring and Evaluation?**

Commonly known as M & E, it is a process by which data is collected, analyzed in order to provide information to policy makers and others for use in program planning and project management.

**Monitoring** is a ‘process evaluation’ since it focuses on the implementation process of a project/program or any intervention while evaluation measures how well the program activities have been able to meet expected objectives.

**Monitoring and Evaluation plans include:**
(a) Anticipated relationship between activities, outputs and outcomes
(b) List of data sources
(c) Cost estimates for M&E activities
(d) Responsible parties
(e) Monitoring schedule
(f) Indicator definitions
(g) Dissemination and utilization plan of information gained.

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What do you do?</td>
<td>• Measures how well the program activities have met expected objectives?</td>
</tr>
<tr>
<td>• How much does implementation vary from site to site?</td>
<td>• Extent to which changes in outcome can be attributed to the program</td>
</tr>
<tr>
<td>• Did the program benefit the intended people?</td>
<td>• Focuses more on quality of program</td>
</tr>
<tr>
<td>• ongoing continuous process</td>
<td>• carried out at intervals</td>
</tr>
<tr>
<td>• collection of data at multiple points thr’ out program cycle</td>
<td>• data collected at intervals</td>
</tr>
<tr>
<td>• determine if activities need adjustments to improve desired outcomes</td>
<td>• control group needed- change in outcome attributed to program</td>
</tr>
</tbody>
</table>

**Indicators**
(a) Variable that measures an aspect of a program.
(b) Measures the value of change in meaningful units.
(c) Focuses on a single aspect of a program.
-Narrowly defined to capture the aspect as precisely as possible.
(d) Can be quantitative or qualitative
-Quantitative-numeric (Nos. or percentages)
-Qualitative-descriptive (can be used to supplement the Nos. & percentages).
(e) Qualitative indicators adds richness of information about the context in which the program has been operating.

**Challenges with M &E**
(a) Advance proper planning
-M&E and programs do not communicate
-Issues with budget
-Not able to meet targets
-Not able to evaluate program

(b) Different funders requiring different and ever changing monitoring & reporting requirements.

(c) Inadequate understanding of what M&E is all about
Poor reporting culture.


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