DRIVING POLICY CHANGE FOR IMPROVED HEALTH
A Technical Advocacy Approach
ABOUT PATH

PATH is a leader in global health innovation. An international nonprofit organization, we save lives and improve health, especially among women and children. We accelerate innovation across five platforms—vaccines, drugs, diagnostics, devices, and system and service innovations—that harness our entrepreneurial insight, scientific and public health expertise, and passion for health equity. By mobilizing partners around the world, we take innovation to scale, working alongside countries primarily in Africa and Asia to tackle their greatest health needs. Through our work in more than 70 countries, PATH and our partners empower people to achieve their full potential. Together, we deliver measurable results that disrupt the cycle of poor health. Every year, PATH reaches more than 150 million people with lifesaving technologies, tools, and approaches. Learn more at www.path.org.

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INTRODUCTION

Innovation in global health has improved the lives of millions of people around the world. To ensure innovative solutions reach those who can benefit from them the most, we need to create supportive global, national, and sub-national policy environments. Advocacy is a highly effective channel through which to cultivate the policies, structures, and processes that are required to bring innovations to scale and achieve lasting change.

Technical advocacy is one of the tools in PATH’s advocacy toolbox. It takes an evidence-based approach to advocacy that combines the latest health data and evidence with strategic efforts to inform and influence key decision-makers on technical issues. It happens at the intersection of advocacy and technical assistance.

Technical advocacy is used to increase access to health commodities, tools, and interventions by integrating them into policies, normative guidelines, and strategies. When lifesaving solutions are entrenched in policy, they often become more available and accessible. As a result, they are more readily used and, ultimately, more impactful.

This collection of stories from sub-Saharan Africa, Southeast Asia, and South America highlights PATH’s 10-part approach to technical advocacy. This 10-part approach is based on proven principles designed to deliver results for health policies that improve access to quality care; increase resources for more robust health programs; and ensure commitments to public health by leaders.

The 10-part technical advocacy approach set forth in this paper is not a set of stringent guidelines. The process of developing an advocacy strategy may not happen in a linear fashion and some parts of the approach might not apply to a particular context or issue. Rather, the 10 parts are intended to serve as a framework that can help global health implementers and advocates thoughtfully plan how best to achieve their policy goals. Although the following examples are specific to particular countries and health issues, the methods used to accomplish technical policy change can be applied in a variety of settings to address a myriad of issues.

ABOUT PATH ADVOCACY

At PATH, we combine expertise in advocacy with the development and delivery of new health innovations. PATH has advocacy and public policy presence in our Washington, DC office, as well as in other country offices around the world. For four decades, we have applied our technical expertise and leveraged our influential partnerships to inform and advocate for actions in response to the health priorities identified by the communities we serve.

Technical advocacy is one of many evidence-based approaches that PATH uses to drive change. We engage across the advocacy spectrum, which includes raising issue visibility and building political will; creating enabling environments through the development and adoption of policies, strategies, legislation, and guidelines; mobilizing resources for high-priority health issues; generating and translating data to inform decision-making and programmatic action; strengthening advocacy capacity; cultivating citizen demand to ignite action and accountability; and building coalitions.
PART 1 - IDENTIFY THE ADVOCACY ISSUE.

Identifying a very specific and evidence-based issue that can realistically be addressed through a policy change is the foundation of an effective technical advocacy strategy.

Examples of common technical advocacy issues include service delivery bottlenecks, gaps in policies and normative guidelines, a lack of training or human resources for a specific level or cadre of health care, and gaps in financial resources. The following are examples of specific issues that could be clearly addressed with technical advocacy approaches:

- Evidence reveals that community health workers in a country are highly capable of administering solutions for diarrheal disease. However, policy restrictions allow only doctors and nurses to administer the intervention, which creates a significant service delivery barrier.

- A country's high neonatal mortality rate is attributable in large part to newborn sepsis. Antibiotics exist to treat the condition, but the medication is not widely available.

- Too many women are dying during childbirth because of excessive bleeding. The country has clinics and hospitals with trained medical staff and treatments, but women don't visit facilities because services are too expensive.

Not all issues are well suited to technical advocacy approaches. Broad and cross-cutting challenges—such as a low level of public support for a health topic, limited funding for the overall health budget, or bottlenecks caused by corruption—may be better addressed with a different type of advocacy strategy.
In 2013, Kenya underwent a major devolution process that resulted in the creation of 47 county governments, each overseen by a county governor with the authority and mandate to raise revenue, craft policies, and allocate budget resources. During the same time, Kakamega County, like many other counties, faced a number of worrisome health care trends: rising maternal, newborn, and child mortality rates; low rates of skilled delivery; low antenatal care coverage; and continued unmet need for contraception.

In the hope of reversing these trends, the newly elected Kakamega County Governor—Wycliffe Oparanya—created the Imarisha Afya ya Mama na Mtoto cash transfer program in 2014, with technical support from UNICEF and other partners. Known locally as “Oparanya Care,” the program provides 2,000 shillings (about US$20) to a mother at specified intervals when she utilizes recommended services, such as completing her fourth antenatal care visit; delivering her baby in a health facility included in the program network; and bringing her child to a postnatal clinic for well-child visits. The program also pays stipends to community health volunteers who provide community education, referral, and home visits to families in the county.

By the end of 2016, Oparanya Care achieved stunning results. The program enrolled 39,221 mothers and disbursed $1.1 million.1 In three years, skilled deliveries in the county increased from 33 to 67 percent and attendance at the fourth ANC visit increased from 34 to 65 percent.2

However, PATH recognized that the sustainability of these results and the Oparanya Care program was in jeopardy, due to one major issue: program funding was not protected by any legally-binding policy. Instead, funding depended on political directives, leaving money extremely vulnerable to future changes in leadership or shifting priorities. Experiences with other initiatives in Kenya revealed that if programs are not anchored in policy—even if they make a difference in people’s lives—they can rapidly erode after a leadership change.

PATH advocates determined that to protect program funding, the government would need to formally ring-fence, or set aside, 4.5 percent of the county budget every year for the program. To do so, the Kakamega County government would need to establish a County Fund to house the money. At this point, the solution came into focus—the creation of a bill, known as the Kakamega County Maternal, Newborn, Child Health and Family Planning (FP) Bill, which would need to be signed into law by the governor to legally set up the County Fund.

After working in Kakamega County for multiple decades, implementing the USAID APHIAplus project, PATH had established a deep network of local partners, as well as relationships with decision-makers that could be leveraged to draft and negotiate language for the bill. The Kakamega County MNCH Alliance, a partnership of local civil society organizations that PATH helped to create in 2016, played a critical role in the creation and passage of the bill. Together, partners identified and subsequently mobilized two key groups of stakeholders: 1) experts in the county ministry of health with responsibility for developing the technical content of the policy, and 2) political leaders with control over the budget.

In May 2017, the County Assembly passed the MNCH/FP bill, and in July 2017, the Kakamega County Governor signed the bill into law; this permanently established a County fund that ring-fences 4.5 percent of the annual county budget to support Oparanya Care and the community health volunteers. The Kakamega County MNCH and Family Planning Act, 2017, and its associated fund, serve as a model for subnational resource mobilization for a specific technical intervention that can be replicated in other decentralized contexts.
PART 2 - DETERMINE THE ADVOCACY GOAL.

Once an advocacy issue has been identified, it is important to state the desired change as a specific, measurable advocacy goal. Most technical advocacy goals include two key components:

1. The specific technical solution, commodity, or intervention that needs to be made more available or accessible; and
2. The policy, guideline, strategy, or budget mechanism that needs to be updated or developed in order to achieve this scale-up.

Every goal should take into account the latest and best practices regarding the issue. The goal must also make sense within the local governance structure and policy frameworks. Practically, this often requires advocates to conduct a thorough review of the evidence, as well as a policy landscape analysis and/or consultation with multiple technical experts.

A technical advocacy goal might involve updating existing treatment guidelines to align with the latest evidence, developing entirely new normative guidance, or shaping policies that direct financial resources to the highest priority interventions.
In Guatemala, cervical cancer is the leading cause of cancer-related deaths among women 25 years and older and the most common cancer among all women. Although new, effective cervical cancer screening strategies and technologies were available, prior to 2015, Guatemala’s national cervical cancer guidelines did not reflect those advances. For example, previous guidelines in Guatemala left out recommendations for human papillomavirus (HPV) testing, a relatively new screening technology which is more effective than Pap tests or other previous screening methods in detecting pre-cancerous lesions of the cervix before cervical cancer develops.

When the World Health Organization (WHO) released updated guidelines on cervical cancer prevention and control in 2013, PATH and the Guatemalan Ministry of Public Health and Social Assistance (MSPAS) saw an opportunity to confront the country’s rising incidence of cervical cancer by updating MSPAS’ guidelines in accordance with the latest WHO evidence, technologies, and recommended approaches.

PATH and partners worked closely with the MSPAS to not only revise outdated guidelines but also to facilitate their approval and implementation. PATH knew its key strength in this initiative was the ability to bring partners together and compile the evidence to motivate policy change. Therefore, PATH sought the partnership of two nongovernmental partners, each with robust programmatic experience, expertise, and credibility: The Union for International Cancer Control (UICC) and Instancia por la Salud y el Desarrollo de las Mujeres (Instancia).

In order to ensure that their revised guidelines would reflect the latest global evidence on cervical cancer prevention and treatment, PATH helped gather technical recommendations from highly credible bodies, including the Pan American Health Organization (PAHO) and the WHO’s International Agency for Research on Cancer (IARC), and to identify local experts to re-write the actual content of the guidelines.

Once a near-final version of the revised draft guidelines was complete, PATH’s partner, Instancia, helped to integrate feedback from technical experts in MSPAS and ushered the guidelines through the approval processes. Critically, Instancia fostered high-level local policy champions—including advisors within MSPAS—to raise visibility and accelerate the approvals process.

In December 2014, MSPAS signed the guidelines, making Guatemala the first Central American country to update its cervical cancer screening guidelines to reflect WHO recommendations. In order ensure the guidelines were implemented and led to the anticipated impact, PATH partners collaborated with MSPAS to host a national launch event. Since then, Instancia has been continuing technical advocacy to ensure guideline implementation.

**Steps to identifying an advocacy goal**

Any change needs to be clear and specific, and it should directly link to the root cause of the advocacy issue (Step 1). If you don’t target your root causes, you might not be solving the policy problem. For example:

- **Main problem:** Too many women are dying of cervical cancer in Guatemala.
- **Root causes:** Even though up-to-date screening tools existed that could help prevent the vast majority of cervical cancer cases, policy did not allow physicians to procure or access the tools.
- **Advocacy goal:** Update the Guatemalan national cervical cancer prevention and treatment guidelines to include HPV testing and align with latest WHO evidence and recommendations.
Successful technical advocacy depends upon engaging and mobilizing support from individuals and/or groups with both the capacity and mandate to effect change. Decision-makers tend to be technical government officers who work “behind the scenes” in the chain of decision-making. They might work in the ministry of health or on a district health management team, and they have authority to make decisions about the scope of a health policy or technical guideline. These individuals have influence over more visible political leaders—like ministers of health, permanent secretaries, or chief administrative officers—who are often not the direct target audience of technical advocacy, but in some cases, are required to provide the final authority to enact policy change.

Technical advocacy influencers can include locally respected implementing organizations, coalitions, academics and universities, think tanks or research institutions, and health workers. While influencers may not have the authority to shape the content of a policy or sign it into law, their credibility allows them to educate and advocate to decision-makers who do hold those responsibilities. Influencers also often have special access to decision-makers and their opinions and suggestions are impactful.

People care more about an issue—and are consequently more motivated to act—when it aligns with their key interests. Therefore, taking time to understand what decision-makers and influencers care about is critical to selecting the most persuasive and compelling tactics and messages.
In 1981, Vietnam launched its National Expanded Program on Immunization (EPI), a landmark program which played a key role in substantially increasing national immunization coverage. Since then, the country has built on this progress, accelerating its vaccine program, and passing legislation to expand the use of and financing for vaccines.

Nevertheless, by 2015 Vietnam still faced substantial obstacles in safely and effectively implementing the EPI. In the summer of 2013, Vietnam experienced outbreaks of Japanese encephalitis and measles, which highlighted the problem of decreasing immunization coverage. There were also reports of vaccinations in unlicensed facilities, stock-outs, and unaffordable vaccine prices for families. Several children had adverse reactions to a pentavalent (5-in-1) vaccine, alarming the public and calling into question the safety of vaccines. Perhaps most significantly, in January 2015, Vietnam began transitioning out of eligibility for vaccine financing support from Gavi, the Vaccine Alliance, an international public-private partnership that co-finances vaccines with low-income countries. This meant that the government had to mobilize more domestic financing for vaccine procurement to fill the impending resource gap.

In light of these challenges, Vietnam’s Prime Minister tasked the country’s General Department for Preventive Medicine (GDPM) with developing an Immunization Decree. The GDPM called upon PATH’s Mekong Regional Program, based in Hanoi, to direct efforts around the development of the Decree.

PATH recognized that writing the Decree was only part of the endeavor. Its passage depended on generating support among decision-makers who would eventually sign it into law. Therefore, PATH undertook a mapping exercise to identify decision-makers, influencers, and their respective interests. The team determined that there were two groups of decision-makers at different levels who ultimately needed to pass the Immunization Decree: 1) Leaders in the Ministry of Health including the minister and his vice ministers and 2) the Prime Minister. PATH would have to engage these leaders indirectly by way of their key influencers, notably the technical experts working beneath them. These influencers included directors, vice directors, and technical officers in the Ministry of Health; health experts in the Office of the Prime Ministry; and financial experts in the Ministry of Finance and Ministry of Planning and Investment.

Efforts to mobilize technical influencers in the government paid off. In July 2016, Vietnam’s Prime Minister Mr. Nguyen Xuan Phuc signed the Immunization Decree into law. The Immunization Decree represents one of the most comprehensive immunization system reforms by any country in the last decade. By outlining specific roles, responsibilities, and protocols across the immunization system, the Vietnamese government is working to remove uncertainty felt by families and providers and ensure that all childhood immunizations are fully covered under the public health insurance program. With this framework in place, the government will be able to effectively mobilize resources for immunization—from both the public and private sectors—so that every family can safely access vaccines for their children.
If a community is facing a pressing health concern or challenge, there is a good chance that the solution involves overcoming at least one major policy-related obstacle. Prior to operationalizing technical advocacy approaches, it is important to understand any relevant obstacles or opposition and to develop a strategy for managing them.

Below are some examples of challenges that could stand in the way of accomplishing your technical advocacy goal:

- Lack of awareness or education: No one has taken the time to gather, translate, or disseminate evidence on the topic.
- Competing priorities: The solution creates a direct conflict with another priority for decision-makers and influencers.
- Procedural obstacles: A policy is not scheduled for revision.
- Misinformation and misconception: Either the issue or its solution is stigmatized.
- Opposed leaders or decision-makers: Key actors may resist or oppose your desired change.

While technical advocacy is well suited to overcome these obstacles, it is not an effective channel to address challenges such as low public awareness or widespread opposition among the public.

PART 5 - IDENTIFY POTENTIAL OPPOSITION OR OBSTACLES.
SAVING THE LIVES OF MOTHERS IN LABOR BY UPDATING KENYA’S NATIONAL ESSENTIAL MEDICINES LIST

Postpartum hemorrhage (PPH), or excessive blood loss after a mother gives birth, is one of the leading causes of maternal mortality in Kenya. By 2014, a strong body of evidence demonstrated that both oxytocin and misoprostol are highly effective, low-cost methods of preventing and managing PPH in low-resource settings. Unlike oxytocin, which requires constant refrigeration, misoprostol can be transported and stored at room temperature. This makes it an excellent alternative in situations or circumstances where oxytocin is not available or cannot be administered. However, prior to 2016, misoprostol was not listed for use for PPH management in Kenya’s national Essential Medicines List (EML). The EML guides national drug policy, details safe and cost-effective medicines that should be widely available, and helps the government prioritize funding and support for those commodities.

Although misoprostol was listed on Kenya’s national EML, it was only listed for induction of labor—not for preventing and treating PPH. Moreover, the EML only listed misoprostol for use by a specialist, such as an obstetrics and gynecology physician (OB/GYNs). OB/GYNs practice almost exclusively at the higher levels of the health system in Kenya, meaning women who could not access those facilities—often, poorer women in rural communities—were unable to receive misoprostol to control excessive bleeding in childbirth.

With support from PATH, the Ministry of Health (MOH) in Kenya convened a task force to 1) expand the use of misoprostol in the national EML to include PPH prevention and treatment and 2) expand accessibility of misoprostol for PPH by making it available in level 2 facilities. Stakeholders quickly identified that managing the misconceptions of misoprostol as a medicine used solely for terminating pregnancies would be a significant challenge. While misoprostol can be administered to end a pregnancy, abundant evidence exists to prove it is a safe and effective way to prevent and treat excessive bleeding during childbirth, saving the lives of both mothers and babies.

As a first step, the MOH, with support from PATH, worked quickly to form a task force intentionally named the “Misoprostol for Postpartum Hemorrhage Task Force” in order ensure clarity about the proposed policy change for use of misoprostol—for PPH prevention and management only. With support from PATH and other partners, the MOH took considerable care recruiting task force members who would be credible to all stakeholders, including representatives from faith-based organizations, professional associations, and service providers. This helped to tacitly build consensus and affirm the focus on misoprostol as a tool for PPH, especially in light of the advantages to deliver without requiring a cold chain.

Once PATH and partners, such as Family Care International (FCI), began compiling evidence and making specific language recommendations for the EML, another more procedural obstacle emerged: the Director of Medical Services was reappointed, putting a new leader in the decision-maker position. This ‘changing of the guard’ only further indicated to the Misoprostol for PPH Taskforce the importance of partnering with the maternal and newborn health technical officers in the MOH. Not only do technocrats have more stable positions than political appointees, but they are also the primary influencers in the passage of technical guidelines, such as EMLs. Fortunately, for years, PATH advocates and task force members in Kenya had developed a high degree of trust with these technical officers so that by the time the national EML was up for revision, these technical officers were ready to take up recommendations to expand the use of misoprostol.

Thanks to the advocacy by PATH and the Misoprostol for PPH Taskforce, in July 2016, the MOH updated Kenya’s EML to expand the use of misoprostol for the treatment and management of PPH. Importantly, this update also increased the accessibility of misoprostol at lower levels of the healthcare system by allowing nurses and community midwives, and not just OB/GYN specialists, to administer the drug without referrals. This policy change increased the number of tools available to stop PPH, and ultimately will help save the lives of thousands of Kenyan women and newborns by preventing deadly blood loss during childbirth.

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3 Family Care International (FCI) is now part of Management Sciences for Health (MSH).
PART 6 - TAKE STOCK OF YOUR ADVOCACY ASSETS AND GAPS.

Any organization carrying out technical advocacy work should evaluate its strengths and shortcomings with regard to the specific issue at hand.

To conduct effective technical advocacy, there are several core assets that organizations typically need. These include:

- Deep technical knowledge of the thematic issue;
- Expertise in skillsets such as policy analysis, policy research, and drafting legislation/guidelines;
- Access to evidence to support the solution;
- Awareness of the local context, including relevant policy and/or decision-making processes, systems, and structures; and,
- Relationships with decision-makers, influencers, and technical partners.

Take stock of your organizational capacity across these competencies. Where your organization lacks a certain asset, consider partners who can help fill the gap.
LIMITING RESTRICTIONS ON LIFESAVING THIOMERSAL-CONTAINING VACCINES IN THE UNITED NATIONS ENVIRONMENT PROGRAM MERCURY TREATY

During the United Nations Environment Program (UNEP) treaty negotiations on mercury, government delegates sought to restrict products that release mercury into the environment, thereby posing serious health risks. Some vaccines contain a preservative called thiomersal, which contains a small amount of ethylmercury. Although studies have demonstrated thimerosal’s safety in vaccines for children and adults, inaccurate scientific information led to discussions during treaty negotiations on restricting use of thimerosal-containing vaccines.

Limiting human exposure to mercury is generally important, but PATH advocates recognized that a mercury treaty with restrictions on thiomersal would undermine UNEP’s primary goal: to protect people’s health and the environment. PATH and partners knew the devastating implications of restricting access to thimerosal-containing vaccines. Vaccines helped save between 2 and 3 million lives annually; roughly half of those lives saved were due to vaccines containing thimerosal. Restricted access would endanger the immense health gains achieved during the last century.

In order to spearhead a strong evidence-informed advocacy strategy. In this context, PATH assessed its three primary assets as: 1) technical expertise; 2) convening power; and 3) an expert network of partners.

**Technical expertise.** PATH advocates had a deep understanding of global evidence on thiomersal and the implications for restricting its use. In 1999, a lack of substantial evidence led to the precautionary removal of thiomersal from vaccines in the United States. Although this decision was later reversed, it perpetuated misconceptions about the preservative. With technical knowledge on the issue, PATH and partners translated and publicized scientific evidence to affirm the safety of thiomersal and correct the inflammatory misconception.

**Convening power.** With decades of expertise, PATH had a reputation as a leader in global health vaccines and immunization. With this convening power, PATH coordinated a single consensus position—in the form of a statement letter—across a range of health stakeholders.

**Expert network of partners.** PATH’s partners in the space included including the International Pediatric Association, the Academy of Pediatrics, and Gavi, the Vaccine Alliance civil society working group, a group of more than 200 immunization-focused organizations from around the world. This delegation of organizations—and their networks of national advocates—drew upon technical and national-level evidence about vaccine supply chains and immunization costs to educate treaty delegates and decision-makers about the safety of thiomersal.

Due to PATH’s efforts, the final language in the treaty expressly protected the use of thimerosal in vaccines. In addition, country delegates gained a powerful understanding of the safety and value of vaccines. Most importantly, PATH and partners protected global access to lifesaving vaccines, ensuring that immunization—one of the world’s most powerful, effective, and efficient tools in the fight against disease—continues to protect millions of families and communities around the globe.

*Note: Thiomersal is also known as thimerosal in the United States.*
PART 7- IDENTIFY KEY PARTNERS.

It is virtually impossible to achieve policy change as a single organization or individual alone. Partnering adds resources, skills, and support, thereby improving the ability to reach and persuade a wider set of decision-makers and influencers.

The best technical advocacy partners are highly credible and bring unique resources or skills, particularly those that are gaps for your organization. For example, if there is a dearth of local data or information on a topic, engage a local or global research institution who either has access to evidence or can generate it.

Common technical advocacy partners include implementing organizations, coalitions, universities and researchers, and business leaders. Often, government officials are not only decision-makers but also important partners in achieving technical advocacy goals.

Different advocacy issues and objectives require different levels and models of partnership, ranging from loose and informal to very structured and formal. In the context of technical advocacy, common types of collaboration include information and data sharing; mutual consultation; joint planning and strategizing; and formal alliances.

To consider when identifying a partner: Do they bring technical expertise? Are they credible? Do they have connections with key decision-makers? Do they have experience translating technical content for the media? Do they have resources that help address gaps you've identified? Do they have a good reputation as a supportive partner? Ensure that you have a diverse range of partners (from different sectors and with different skillsets).
In the Indian state of Uttar Pradesh, where infant and maternal mortality rates are high, one of the major barriers faced by mothers and newborns is transportation to a hospital. Many women and children die at home or in transport before they can reach skilled care. In 2010, recognizing the urgency of this situation, the state of UP purchased 2,000 ambulances to be deployed for an emergency ambulance service that would serve poor women and newborns. Deployed carefully and effectively, in India’s most populous state, this commitment had the potential to save thousands of lives every year. Yet, without a policy or framework to help them apply it effectively and sustainably, progress stalled.

PATH, a long-time implementer of maternal and newborn health programs in UP, recognized the need for a strong policy framework that cut across the health and transportation sectors.

PATH began by convening international and local partners that had credibility with key Government of Uttar Pradesh health decision-makers. Some of these credible partners included the mission director of the National Rural Health Mission for the state of Uttar Pradesh and the general manager and the nodal officer for referral transport in the State Program Management Unit. Other partners included the National Health System Resource Centre, Population Foundation of India, Intrahealth’s MANTHAN Project, and UNICEF. This group first came together to advocate for the formation of an institutionalized task team or “seva” to offer expert, diverse policy recommendations. The Mission Director of the National Rural Health Mission served as chair of the seva, while PATH undertook a leadership role as Secretariat.

With programmatic experience in maternal and newborn health, both PATH and the MANTHAN Project realized the policy environment was creating a barrier to effective service provision. They partnered to compile evidence—specifically, a dossier of background papers—that would help to shape the policy framework for the medical transport program.

As the process progressed, having a wide range of national-and state-level champions from many sectors helped advocates to maintain momentum in the face of inevitable bureaucratic delays and changes in leadership. In addition, bringing together officials from various sectors helped to improve the quality of the framework that would ultimately guide the program.

In early 2014, the emergency medical transport policy framework was formally endorsed by the Government of Uttar Pradesh and preceded the formal launch of the emergency transport program. Today, any woman in UP can dial a toll-free number and expect an ambulance to arrive in 20-30 minutes. As a result, thousands of women and babies have better access to the high-quality care they need to start their new lives together.
PART 8 - SELECT THE APPROPRIATE ADVOCACY TACTICS.

Technical advocates can draw on a wide range of tactics to achieve their desired policy change. A highly focused, strategic advocacy effort that engages the appropriate people with the necessary technical skills, knowledge, and relationships is likely to be more successful than a large-scale, highly-visible campaign. As with any advocacy effort, technical advocacy activities should be targeted and prioritized to best advance the identified goals.

Depending on the advocacy goal, useful tactics might include one or more of the following approaches below:

- Using data: Generating, analyzing, synthesizing, packaging, and/or strategically disseminating data for decision-makers and influencers.
- Convening partners: Bridging the gap between technical experts and decision-makers.
- Accessing the appropriate formal and informal channels: Identifying and embedding advocates within decision-making channels and forums, such as government-convened technical working groups.
- Supporting the development of new or revised policies: Drafting suggested language for a piece bill or piece of legislation, or writing and submitting an application for review by a technical committee.
- Communicating with strategic messages: Clearly articulating a need (that is rooted in data and evidence) and crafting persuasive messages about how to achieve it.
SAVING MOTHERS’ LIVES IN GHANA BY PREVENTING POSTPARTUM HEMORRHAGE

Ghana Health Service declared maternal mortality a national emergency in 2008. High maternal death rates, especially in the northern part of the country, meant that too many lives were being lost. Ghana was failing to reach the Millennium Development Goal target 5, a 75 percent reduction in the level of maternal mortality by 2015, and needed to take immediate action.

Excessive bleeding after childbirth, or postpartum hemorrhage (PPH), was a major contributor to Ghana’s high maternal mortality rates. Global and local health organizations, including PATH, conducted research on the gaps and advances that could have a significant impact on PPH. They identified that Ghana lacked a health policy framework on PPH that could help policymakers, health professionals, and community health workers better prevent and treat the condition.

PATH employed several important tactics to both create a national policy framework for PPH and generate broad-based endorsement. The two most important tactics were (1) translating technical evidence and (2) convening partners.

Translating technical evidence. PATH helped to create a technical working group where stakeholders reviewed the latest evidence on PPH prevention and management. This evidence was translated into clear advocacy materials, including briefs and messaging that outlined the issue and proposed a policy solution. Eventually, the evidence and messages were incorporated into a draft strategy that was shared for broader comment, including for feedback from regional government officials and Queen Mothers, who serve as local decision-makers in Ghanaian communities.

Convening partners. PATH led a policy advocacy workshop—timed to align with a global women’s health conference, thereby ensuring maximum representation—that convened technical experts, advocates, and decision-makers. There, this group of partners and stakeholders agreed on an overall strategy to guide the creation of a health policy framework on PPH. During the next year, PATH convened other advocates to meet formally and informally with key government health officials to move initial recommendations forward.

By the end of the year, advocates had spent countless hours building a strong base of support for the strategy across the country. Working extensively with the government partners, they created the final draft PPH strategy and presented it to the Minister of Health, who approved it. In January 2014, the government launched the new PPH strategy, which provided evidence-based guidelines on the most effective tactics for preventing and treating the complication of PPH. Media covered the launch extensively, which helped to raise awareness for the issue of PPH and support uptake of the new guidelines. Health providers at all levels in Ghana can now do more to save the lives of mothers suffering from excessive bleeding during childbirth.
Strong technical advocacy messages are precise, directive, and solution-focused. These messages clearly describe the problem at hand, what specifically needs to be done, and the outcome or desired change. Moreover, they are geared towards a target audience and address that audience’s primary interests and motivators.

While inspirational messages are compelling components of other advocacy approaches—to activate citizens, communities, and high-level politicians—technical advocacy is most effective when messages are grounded in robust evidence and are highly practical and actionable.

Below are examples of both effective and ineffective messages for technical advocates:

- **Effective message:** “If oxygen were readily available, childhood deaths from pneumonia could be reduced by at least 35 percent.”

  This is effective because it outlines the problem (deaths from pneumonia), proposed solution (expanded use of oxygen), and outcome (fewer childhood deaths).

- **Ineffective message:** “Together we can achieve universal health coverage!”

  This is an ineffective message from a technical advocacy perspective because it only defines the desired outcome (universal health coverage), and that outcome is very broad. The message provides no information to the target audience about why this change is needed or how to achieve it.
INCREASING ACCESS TO OXYGEN AS A MEDICAL GAS TO REDUCE CHILD MORTALITY FROM PNEUMONIA

Oxygen is a medical gas frequently used for the management of hypoxemia, or dangerously low levels of oxygen in the blood. Without oxygen, it would be next to impossible to treat hypoxemia resulting from conditions such as pneumonia, which is the leading infectious cause of mortality in children under five.

Even though oxygen is an essential treatment for many conditions affecting newborns, children, and adults, it remains a scarce medical resource in low- and middle-income countries (LMICs). Each year, lack of access to oxygen supplies contributes to thousands of deaths, including an estimated 122,000 child deaths from pneumonia.

In response to these challenges, PATH spearheaded advocacy and communications efforts called the HO₂PE campaign. The HO₂PE campaign sought to expand access to oxygen therapy through awareness raising, policy change, and market strengthening. The campaign was rooted in a set of clear, direct, and evidence-based messaging framework.

One of the key messages is included below:

• Oxygen supplies are unavailable in one out of three health facilities in low resource settings.
• However, if oxygen were readily available, childhood deaths from pneumonia could be reduced by at least 35 percent.
• By adding oxygen to the local Essential Medicine List and dedicating more funding for oxygen supplies, we can save thousands of lives.

One of the HO₂PE campaign’s primary objectives was to drive global policy change by updating the WHO List of Essential Medicines (EML) and List of Essential Medicines for Children (EMLc) to include oxygen therapy as a treatment for hypoxemia. PATH sought to achieve this change by submitting a technical application to the WHO to update these policies. The HO₂PE campaign used a suite of assets—including a technical messaging framework, video, social media content, graphics, and infographics—to rally partner organizations and influencers in the global community around the technical application, encouraging them to advocate the WHO for its passage. The HO₂PE campaign’s action-oriented messages encouraged 11 partner organizations to write letters of support to the WHO for the passage of the application. In June 2017, WHO announced that it accepted PATH’s submission and updated both the EML and EMLc.

PATH continues to leverage the HO₂PE campaign to expand access to oxygen therapy, namely an effort to encourage countries to update their own national EMLs in accordance with the new global EML.
Technical advocacy, like any other rigorous discipline, should be evaluated for impact. The final outcomes that advocacy initiatives seek to achieve are often easily measured, for example, the passage of a law, increased financial resources allocated for a specific health issue, or changes to government regulations. However, achieving these desired changes can take time, so it is important to measure incremental gains in awareness, support, and commitment along the way.

Take time to identify the intended outcomes as well as the indicators that will demonstrate you are making adequate progress along the way. These should be concrete and measurable.

From time to time, reviewing progress against pre-identified indicators can help assess if you need to adapt or evolve your strategy to more effectively reach your advocacy goal. Sometimes, it may also be necessary to adjust indicators in order to achieve success.
In Zambia, many women living in rural and remote areas are not able to practice family planning because methods are unavailable or out of reach. In 2011–2012, a pilot study implemented by ChildFund Zambia and FHI360, with support from the Zambian government and the US Agency for International Development (USAID), demonstrated that community-based distribution (CBD) of injectable contraceptives was a feasible, safe, and effective way to meet the currently unmet demand for family planning. The pilot study generated strong evidence for the scale-up of CBD of injectable contraceptives.

PATH saw the potential to translate this evidence into impactful policy change that could increase family planning access. PATH worked closely with members of the national Family Planning Technical Working group to establish the Community-Based Distributors Task Force, which included the Ministry of Community Development Mother and Child Health, FHI360, ChildFund Zambia, Scaling Up Family Planning, and others. Together, the Task Force developed a plan for sustainable policy change with a clearly articulated outcome—a policy issued by the Zambian government to allow trained community-based health workers to administer injectable contraceptives to women.

In order to achieve this objective, PATH created an advocacy strategy and work plan, and identified a series of indicators with a corresponding timeline. The team identified the following key indicators to track progress:

- Number of supportive media statements given by decision-makers.
- Number of positive statements given by leaders of relevant professional bodies.
- Number of CBD task force meetings held.
- Number of policy directives issued.

This work culminated in a decision by the Government of Zambia allowing trained community-based health workers to administer injectable contraceptives to women. The decision marked the beginning of an important policy shift. And while the change in policy to allow CBD of injectable contraceptives was a key indicator of success, now advocates have adjusted their target, turning their focus to implementation, to ensure that women are truly able to access these services.

One way PATH and partners knew that progress would continue is that the Government of Zambia put into place a plan for scale-up of the program to all districts in the country. Additionally, there has been movement to assess how community-based programs might be put into place to ensure greater access to a range of other health technologies throughout Zambia, demonstrating the further impact of this program.