4. JAPAN

4.1 Levels of priority for MDGs 4 and 5

Health is located under the ‘human security’ pillar of Japan International Cooperation Agency (JICA)’s approach to development cooperation. Within health, JICA places particular emphasis on measures to fight infectious diseases such as HIV/AIDS, tuberculosis, and parasitic diseases, as well as on efforts to promote reproductive health, including maternal and child health and family planning31. The Ministry of Foreign Affairs is much more committed to infectious diseases, MDG 6, than MDGs 4 and 5.

JICA groups together its efforts to reduce child mortality (MDG 4) and to improve maternal health (MDG 5) under the title ‘maternal and child health’ in its report on contribution to achieving the MDGs32. JICA takes an integrated approach to improving the health outcomes of mothers and children, and links women’s health explicitly to a lifelong improvement in reproductive health33. This approach echoes the continuum of care approach manifest in the ‘MCH Handbook’ that is used in Japan, and is now being promoted in several developing countries. Whilst the health of newborns is not made explicit in JICA policy documents, it is implicit in its approach to MCH.

The Reproductive Health Team of JICA is in the process of developing a Reproductive Health document (to include maternal health) and a separate Child Health document (English versions due late 2007). The RH Document will set out JICA’s strategic direction and will place priority on countries with high RH needs, defined in terms of MMR, progress towards meeting ICPD objectives and progress towards meeting MDGs.

Japan’s expenditure on MCH in developing countries for 2001-200334 was:

- Ministry of Foreign Affairs’ Grant Aid: 8,045 million Yen (US$67 million)
- Ministry of Foreign Affairs’ Grant Aid for human security: 656 million Yen (US$5.5 million)
- JICA’s Technical Cooperation (excluding expenditure on training and dispatching Japanese volunteers in the field of MCH): 8,680 million Yen (US$72 million)

JICA is merging with the Japan Bank for International Cooperation (JBIC), to be completed in 2008-09. The ‘New JICA’ will be one of the world’s largest bilateral development cooperation agencies with financial resources of US$8.5 billion, and will allow the agency to provide both technical assistance and grant and loan assistance under one roof35. However, an overarching challenge is the decreasing overseas development assistance (ODA) budget in the face of Japanese economic recession and fiscal crisis. Making the case for ODA with the Japanese public, the Ministry of Foreign Affairs and the Ministry of Finance is a major challenge for JICA and for NGOs.

31 Ibid.
34 Figures provided by Mr Naoyuki Kobayashi, Reproductive Health Team Director, JICA
This challenge is all the greater because there is low awareness of development issues and the MDGs – not just MDGs 4 and 5 – among civil society, the media, government officials and parliamentarians. It is very difficult to campaign specifically on MDGs 4 and 5 when people are not familiar with the MDGs at all. The politically conservative government and Prime Minister also creates a difficult environment in which to advocate for sexual and reproductive health and rights, integral to the achievement of MDG 5; ‘we are in an ice age in Japan’. Forthcoming elections at end of July 2007 may or may not ease this situation.

The key advocacy challenges for Japan are therefore:

- How to raise awareness of MDGs, especially MDGs 4 and 5 with civil society and media.
- How to justify increasing expenditure on MDGs 4 and 5 in the context of declining ODA.
- How to generate increased political commitment to MDGs 4 and 5.

### 4.2 Mapping Advocacy

#### 4.2.1 Capacity, resources and entry points for advocacy

**a. Capacity and resources**

**Key NGOs**

- **JOICFP** – well-established and largest reproductive health NGO in Japan, it provides respected technical advice to Government, especially JICA. It is the focal point for several advocacy and policy dialogue initiatives (eg. White Ribbon Alliance, secretariat for GII/IDI network, IPPF liaison office; chairs JICA-NGO Dialogue and Ministry of Foreign Affairs-NGO Dialogue on ODA more broadly); it is experienced in advocating to parliamentarians. Focuses on MDG 5 and broad reproductive health and rights. Whilst it has strong capacity, it is working at full capacity.

- **Africa Japan Forum** - very involved in NGO health networks (see below).

- **Asian Population and Development Association (APDA)** – advocates to parliamentarians about reproductive health issues.

- **Aiiku Kai (love and raise child organisation)** – strong domestic advocate of MCH in Japan, established by Royal Emperor family. Has not had an international focus to date, but could be a strong partner.

- **Japan Centre for International Exchange (JCIE)** – need to get on board as an advocacy resource given their influential political connections. However, initially they are a target audience for advocacy (see below).

**Relevant Networks**

- **GII/IDI**[^36] Health NGO Network – Japanese health sector network of about 40+ NGOs, provides regular forum for NGO policy dialogue with Ministry of Foreign Affairs. Chaired by the influential Professor Hiroko Hara. Its Secretariat is at JOICFP. Recognises that MDGs 4 and 5 are important, although the network includes advocates on all the health-related MDGs and the majority of NGOs focus on HIV/AIDS and infectious diseases.

[^36]: Global Issues Initiative/Infectious Diseases Initiative
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- 2008 Japan G8 NGO Forum - network of 100+ NGOs in all sectors mobilising for G8 Summit to develop a Civil Society Manifesto in which the MDGs will be central. Its Secretariat is at Japan Centre of NGOs for International Cooperation. One ‘unit’ within the Forum focuses on Poverty and Development; within that, there is a Health Working Group with about 11 members, chaired by Mr Masaki Inaba of Africa Japan Forum.
- White Ribbon Alliance is in the early stages of developing a safe motherhood advocacy campaign and resource development in Japan; only has 7 or 8 members at the moment. To date, it has created networks with individuals, companies (e.g. Itoen, a leading beverage company, also Yakult – white ribbon vending machines), labour (trade) unions and other organisations – especially fundraising activities.
- Women and Health Network of feminist researchers and advocates, also chaired by Professor Hiroko Hara.
- Global Call for Action Against Poverty - will launch campaign on all 8 MDGs in July 2007 (T-shirts, slogans, celebrities).

Multilaterals
- UNICEF – MDG4 focus, very high profile and hugely respected in Japan (linked to legacy of UNICEF ‘standing by Japan’ after World War II). The Japan Committee for UNICEF has had enormous fundraising success. UNICEF is a very strong brand that could be used to mobilise support for MDGs 4 and 5.
- UNFPA – MDG5 focus. Has engaged with support to parliamentarians for reproductive health issues, with JOICFP.

Researchers
- The International Medical Center of Japan (IMCJ) – a government institution reporting to the Ministry of Health and Labour Welfare (MoHLW) but works very closely with JICA and to some extent with Ministry of Foreign Affairs. Provides respected technical expertise, and could be a useful broker to champion a continuum of care approach to MDGs 4 and 5 with both MoFA and MoHLW (note: difficult relationship between these two ministries).

b. Entry points/audiences to reach

Parliamentarians
- The Prime Minister is a key target (currently Shinzo Abe – though he may come under pressure to resign depending on results of House of Councillors (Upper House) elections on 22 July 2007).
- Japanese Parliamentarian Federation on Population (JPFP) was very active, although it is now in a time of transition with older politicians retiring. The Chair of JPFP is the son of the former Prime Minister. There is a need to educate younger parliamentarians on reproductive health issues, including maternal health, particularly after the forthcoming elections.
- Network of female parliamentarians and other potentially interested politicians: see Annex 5 for list provided by JOICFP.

Government officials
- Key - Prime Minister’s Office: key decision-makers for G8 Summit.
- Key - Ministry of Foreign Affairs: contact Dr Taro Yamamoto, Deputy Director, Global Issue Cooperation Division: taro.yamamoto@mofa.go.jp (important, though not the key decision-maker).

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- Key - Ministry of Health, Labour and Welfare: Division of International Affairs, and Division of Maternal and Child Health (domestic focus), works closely with WHO; tensions with Ministry of Foreign Affairs.
- Important to reach the economic circles through two Councils that are crucial committees regarding ODA in general (not MDGs 4 and 5 specifically): (a) Council of Economic and Fiscal Policy: very powerful, chaired by the Prime Minister, composed of 11 people including 4 ‘civilians’; (b) Overseas Economic Cooperation Council: composed of the Prime Minister, Chief Cabinet Secretary, Minister of Foreign Affairs, Minister of Finance and Minister of Economics, Trade and Industry (closed meetings).
- JICA/JBIC do not have a major role in influencing the G8 agenda, but might be able to influence TICAD agenda.

NGOs
- Japan Centre for International Exchange (JCIE): are the secretariat for the Friends of the Global Fund. JCIE is very influential with politicians and has close ties with political leaders and former Prime Minister. It is very powerful, and eager to promote human security and MDGs – although to date it has focused on TB, HIV&AIDS and malaria. Need to get them engaged on MNCH. Note: JCIE is part of the establishment and requires a very careful approach. They will be very careful about what campaigns they will or will not do.

Civil Society
- High schools and companies – to raise awareness of MDGs in general as well as MDGs 4 and 5. JOICFP’s network covers over 800 schools and 8,000 employees of companies to raise awareness of safe motherhood.
- Through the extensive reach of trade unions – the White Ribbon Alliance is having some success in engaging trade unions on international cooperation, with health and education as a central focus. JOICFP has set up a Safe Motherhood Group within the National Labor Union, which has extensive membership.
- Through media (see below)

Media
- Newspapers – have the biggest impact on opinion leaders and senior officials; huge copy circulation; no marked differences in political stance of different papers, therefore need to reach all the major papers.
- Internet news is more appropriate for reaching younger people.
- Television is more influential than the internet but less than the newspapers. NHK (national channel) – e.g. “Passion” programme introduces a Japanese person who works in developing countries; TV Tokyo and Fuji TV (private channels) feature comedians/artists who visit developing countries.
- JICA’s PR Section could provide list of Japanese media

Professional associations

To date, relatively few nurses and midwives are interested in international issues. Stakeholders perceived a need to bring them on board:

- Nursing Council
- Midwifery Council: Taeko Mori, Head of Midwifery Council (has worked in Myanmar)
- Public Health Nursing Council
• Universities and Medical, Midwifery and Nursing Colleges, e.g. Professor Shigeko
Horiuchi, Dean of St Luke’s Nursing Graduate School (well-connected politically, has worked in Brazil).

c. Potential champions

Stakeholders suggested a number of potential champions who might be able to lend weight to an advocacy campaign in Japan:

• Norika Fujiwara: famous female model and now comedian on TV, popular with younger generation, does talk shows, married and thinking about becoming pregnant, interested in reproductive health.
• Princess Kiko: recently gave birth, had partial placenta previa and had to have C-section, expressed her thanks to the health system for safe delivery and healthy son and future heir to throne.
• UNICEF Goodwill Ambassador: Ms Tetsuko Kuroyanagi: very famous celebrity who can influence older high-class women and influential politicians. UNICEF is very trusted by the public. http://www.unicef.org/people/people_tetsuko_kuroyanagi.html.
• UNFPA Goodwill Ambassador: Ms Yuko Arimori: famous marathon runner who represents the new generation of independent women and will be influential to younger women in Japan. http://www.unfpa.org/ambassadors/yuko.htm.
• Dr Arita: chairman of Board for Agency for Cooperation on International Health (ACIH) – ‘super-influential’, led smallpox eradication around world; recently advocating importance of poverty reduction for health outcomes – could try to engage him on MNCH and poverty linkages.
• Dr Yasuhide Nakamura, professor of Osaka University – leading influential researcher on MDGs 4 and 5 and a proponent of the ‘continuum of care’ concept. Contact: yastisch@aol.com. http://www.hus.osaka-u.ac.jp/english/faculty.html

Summary:

A limited number of committed Japanese NGOs are working on maternal health, more on child health. Active health networks exist, although their members have a bias towards infectious diseases rather than MDGs 4 and 5. Regular mechanisms for NGO-Government policy dialogue function, though not specific to health. The Japanese presidency of the G8 Summit is galvanising NGO networks to advocate around key issues, including health. JOICFP is very well plugged into reproductive health and maternal health networks, including with parliamentarians; UNICEF has a very high profile and would be an important ally for any advocacy campaign on MDGs 4 and 5. It would be strategic to engage a number of politically influential NGOs who have not to date engaged on theses issues, such as Japan Centre for International Exchange and Aiiku Kai.

The priority audiences are perceived to be Parliamentarians and government officials, particularly the Prime Minister, Ministers of Foreign Affairs and Health and Labour Welfare. The International Medical Center of Japan could be a useful broker to champion a continuum of care approach to MDGs 4 and 5 with both MoFA and MoHLW, and already works closely with JICA. Broad public campaigns on all MDGs are underway and are an important pre-cursor to targeting civil society and media on MDGs 4 and 5. A good number of potential champions were identified, from royalty and celebrities to eminent researchers.
4.3 Analysis of Advocacy Messages

4.3.1 Making the case – using the evidence

In this section the views from the three donor countries have been amalgamated due to the similarity of the views expressed.

In Japan, Norway and the UK, data on the scale of the problem and also on progress and success stories (‘child mortality has fallen by x%’) is essential for both political advocacy and public campaigning. Journalists demand statistics to give impact to their stories, just as politicians want to communicate clear results on what difference their donor funds have made. Contrasting the child, newborn and maternal mortality data of developing countries with domestic figures is seen to be a powerful way of highlighting the injustices of the situation. This is an advocacy tactic used by politicians, civil servants, NGOs, and the media alike. Lifetime risk indicators tend to be easier to understand than the maternal mortality ratio.

4.3.2 What does and does not work

Framing messages for politicians and policy-makers

There have been few political advocacy initiatives on MNCH, especially MDG 5. IPPF and JOICFP have organised successful visits to developing country programmes (e.g. Pakistan, Ethiopia – theme of FGM) for Japanese parliamentarians, UNFPA Goodwill Ambassador, and high level Japanese newspaper journalists. However, IPPF and other NGOs have received limited or no response to letters written to Parliament and the Ministry of Foreign Affairs.

The ‘Friends of the Global Fund’ has been very effective in its advocacy and resource mobilisation for HIV/AIDS, TB and malaria. Its success is largely due to its high-powered political membership, including the former Prime Minister and other very influential economic leaders. Similarly, the Japan Committee for UNICEF has been hugely successful in fundraising for UNICEF, using attractive messages that demonstrate how, ‘this donation saves the lives of x children’.

Economic arguments for MNCH are seen to be important to convince the Japanese government – particularly the Ministry of Foreign Affairs and parliamentarians - to mobilise more resources for MNCH. UNICEF Tokyo urged the Global Business Plan global leaders to make the case for, ‘donor investment in MDGs 4 and 5 now will save costs in the future’. This is a challenging message given the trend of declining ODA in Japan, so the Government will need to be convinced that, ‘it is cost-effective for donors to invest now and developing country governments can take over later’. Other stakeholders stressed the message that, ‘saving lives of mothers and newborn is not costly and that even a small contribution can make a difference; that saving mothers’ lives is cost-effective since it will have a big social and economic impact on the community’.

Given the centrality of the ‘human security’ principle of ODA, several stakeholders recommended making the links to the ‘protection of mothers and children’. Some stakeholders thought that there was a need for more persuasive storytelling among the policy community; for example, comparing maternal mortality figures to a plane crash every x minutes.
The Japanese leadership of G8 will focus on the environment and climate change, so several stakeholders identified the need to make the links between climate change and MNCH. One bridge is to use the discourse of population – which also appeals to more conservative parliamentarians – although great care must be taken not to undermine the principles of a broad reproductive health and rights approach.

Framing messages for civil society and media

In terms of public campaigning, lessons from the ‘Make Poverty History’ campaign show that it appealed to young people, who perceived the white wristbands as fashionable. Creating this kind of appeal will be a challenge for MDGs 4 and 5. Many stakeholders emphasised the importance of framing international MNCH issues in the light of domestic concerns in order to mobilise public interest. However, it is difficult for the public to relate to concerns of high fertility and lack of maternal care in developing countries when at-home concerns focus on low birth-rates, ageing population and over-medicalisation of deliveries.

JOICFP has found that ‘saving the lives of mothers’ message is simple and well-accepted by all ages and both sexes, whereas using the term ‘reproductive health’ is too lengthy in translation and too contentious a message. Stakeholders reported that civil society responds more to emotional stories than facts and figures. Contrasting the differences and creating solidarity between Japan and developing countries has an impact. It can also be effective to talk about saving women and children’s lives in the context of the relatively recent history and poverty in Japan. That is, not so long ago, Japanese women were dying in pregnancy and childbirth and newborns were not surviving: ‘Our Japanese DNA carries with it the age of poverty and mothers’ lives in danger…we know the tragedy in our families, now we can help other countries still living in poverty’.

Some stakeholders felt that it would be less effective to appeal to messages centred on ‘injustice’, since Japanese society is not rooted in social justice principles in the same way as, say, the UK.

For both civil society and media, simple, understandable messages are required, plus human interest stories to demonstrate how resources are saving lives of mothers and children. JICA is in the process of preparing such stories (videos and publications) to demonstrate the difference JICA’s resources are making on the ground.

4.3.3 Messages to resonate at different levels

See section 4.3.2 above.

4.4 Analysis of advocacy processes

4.4.1 Building and sustaining advocacy partnerships

- International partnerships – such as the Global Business Plan itself - are important to mobilise resources in Japan and to encourage the Japanese Government to act.
A consensus approach to advocacy is required with the Japanese Government, i.e. the global community’s and developing country recipients’ public recognition of Japan’s contribution to ODA and MDGs 4 and 5 (e.g. at TICAD or G8) is more likely to encourage the government to act. In other words, a starkly different approach is needed to bring Japan on board with the Global Business Plan; unlike ‘like-minded’ donor governments who are more likely to be convinced in terms of accelerating achievement of the MDGs.

The Japanese Presidency of the G8 Summit is galvanising NGO networks into concerted action around the MDGs. This presents a good opportunity to sustain joined-up action on MDGs 4 and 5 in future.

4.5 Advocacy opportunities over the next 1-3 years

4.5.1 Getting the message out

Opportunities for getting the message out to Japanese politicians and policy-makers

- 4th Tokyo International Conference on African Development (TICAD), May/June 2008 - organised by the Government of Japan, the Global Coalition for Africa, the UN Office of the Special Advisor on Africa, UNDP and the World Bank, to promote high-level policy dialogue between African leaders and their partners, and to mobilise support for African-owned development initiatives. Cynics describe TICAD as more of a showcase to justify Government opinions, and to compete with China rather than a forum for decision-making or vision-setting. However, others regard TICAD as an important forum which will inform the G8 Summit agenda on Africa. The 3 main themes of TICAD 2008 are (a) promote private investment for Africa (b) human security, including peace, education, health…, (c) environment and climate change. It is unlikely to be an opportunity to headline the MNCH agenda. However, it may be possible to make the case to include MDGs 4 and 5 under the headline issue of Human Security. Contact TICAD Secretariat at UNDP Tokyo. http://www.undp.org/ticad2/about.shtml

- Japanese Presidency of G8 Summit, June 2008 - Prime Minister Abe confirmed in Japanese Parliament on 13 June 2007 that Africa will be one of the main agendas. JICA is already increasing its resources for Africa – mainly for roads and border posts, agriculture, environment and climate change, and information and communications technology capacity. However, it is not yet clear whether any/much attention will be given to health in Africa. The big agendas are set through the Sherpa process. Japanese NGOs are looking to/urging the UK Prime Minister to get MDGs 4 and 5 on the table and into the G8 Communique. Note: JICA is not a key agenda-setter for G8.

- Annual meeting of WHO and Japanese Ministry of Health, Labor and Welfare’s Division of International Affairs - focuses on Japan’s voluntary contribution to WHO. At present, ‘not a Yen’ goes to MNCH, but could make a case for redirecting some of these funds. International Medical Center of Japan’s Bureau of International Cooperation are involved in these discussions. Contact Hitoshi Murakami at IMCJ: murakami@it.imcj.go.jp

Opportunities for getting message out to Japanese general public

- Global Call for Action Against Poverty - GCAAP will launch a campaign on all 8 MDGs in July 2007 (using T-shirts, slogans, celebrities).
- Mother’s Day events – used by JOICFP for domestic advocacy.
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- **JICA and UNFPA Tokyo Symposium on reproductive health, December 2007** - target audiences will be young people and the mass media – focus on unwanted pregnancy and reproductive health. Contact: Mr Naoyuki Kobayashi at JICA (Kobayashi.Naoyuki@jica.go.jp).

**4.5.2 Processes for developing communication strategies at country level (including using local PR/Communications companies)**

Please see 4.5.1 above. No one interviewed was able to suggest names of appropriate PR/communications companies.
5. NORWAY

5.1 Levels of priority for MDGs 4 and 5

Political leadership on MDGs 4 and 5 is extremely high in Norway. The GBP on MDGs 4 and 5 is itself a creation of Prime Minister Jens Stoltenberg. While Norway gives broad support to all 8 MDGs, priority is given to goals 4 and 5. The Norwegian MDG4 & 5 Initiative involves a number of different government bodies:

- The Prime Minister’s Office provides the overall vision and political leadership of the initiative. [http://www.regjeringen.no/en/ministries/smk.html?id=875](http://www.regjeringen.no/en/ministries/smk.html?id=875)
- The Norwegian Agency for Development Cooperation (Norad) facilitates the dialogue among the government stakeholders, provides technical input and embeds the strategy in the agency’s health and development work. [http://www.norad.no/default.asp?v_ITEM_ID=1139&v_LANG_ID=0](http://www.norad.no/default.asp?v_ITEM_ID=1139&v_LANG_ID=0)
- The Norwegian Directorate of Health and Social Affairs (SHDir) provides technical support and advice. [http://www.shdir.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english](http://www.shdir.no/portal/page?_pageid=134,112387&_dad=portal&_schema=PORTAL&language=english)

Norway has been very committed to MDG 4 in particular, and been a key supporter for the Global Alliance on Vaccines and Immunization (GAVI) from its inception in 2000. MDG 5 has been more recently added to the Norwegian priority agenda, and several stakeholders welcomed the more holistic approach of the GBP. The Norwegian government is establishing partnerships with India, Nigeria, Pakistan and Tanzania to facilitate their own plans to reach MDGs 4 and 5, recognising the inter-connection of the health of children, newborns and their mothers. The Prime Minister is actively building a network of global leaders at the highest level to join the GBP.

This high level of commitment has been achieved without bottom-up demand from the Norwegian public. A recent joint Nordic survey on public knowledge about the MDGs revealed that Norwegians do not know very much about the MDGs, however 9 out of 10 Norwegians are willing to do something to contribute to development.

The key advocacy challenges for Norway are therefore:

- How to sustain this level of political commitment to MDGs 4 and 5, especially if government changes at the next elections.
- How to mobilise civil society to a non-domestic issue
- How to mobilise the Norwegian public, NGOs and media in order to build up greater awareness and a broader constituency for these issues.
- How to ensure that the Norwegian Government monitors expenditure on MDGs 4 and 5 and delivers against their commitments.

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5.2 Mapping Advocacy

5.2.1 Capacity, resources and entry points for advocacy

a. Capacity and resources

Key NGOs

- Most stakeholders saw NGOs having an important role in ensuring that interest in MDGs 4 and 5 is sustained beyond the lifetime of particular political agendas, although it will be a challenge to make it an election issue.
- Stakeholders recommended international development NGOs such as CARE, Norwegian Red Cross, Norwegian Church Aid, Norwegian People’s Aid, MSF as strong advocates for development, including (but not specifically) MDGs 4 and 5. They also have broad membership which could be tapped. None of these NGOs were available during the mapping process, so it was not possible to gather further details of their political advocacy and public campaigning experience and capacity.
- Save the Children Norway was also mentioned by all stakeholders; however, they focus on education and children in conflict, and are very explicit that they do not prioritise MDGs 4 and 5. Given the strong reputation of Save the Children and their charismatic leader, it might be worth exploring whether they would get behind a campaign on MDGs 4 and 5 in future.
- Norsk forening for seksuell og reproduktiv helse og rettigheter (NSRR), a member association of the International Planned Parenthood Federation, is not so well-known, and has very limited capacity (one part-time staff). However, it has established an informal Parliamentary Network on Sexual and Reproductive Health and Rights – a small working group from 5 political parties, led by a Labour MP, Britte Hildeng. NSSR works as the Secretariat for the Network and organises seminars twice a year for parliamentarians and other institutions. After the September 2007 local elections, NSSR will start training the Youth Groups of the political parties. NSSR has run public campaigns on domestic issues (e.g. Chlamydia) but not on international issues.

Relevant Networks

- Many stakeholders noted the striking absence of NGO networks working on MDGs 4 and 5. There are not many players, and they are not well-coordinated. There is a divide between those advocating around children’s rights and those championing women’s rights (including sexual and reproductive health and rights and maternal health).
- The consultation process did not identify any networks or individual NGOs that are doing budget tracking work or putting pressure on government to monitor and publish expenditure on MDGs 4 and 5. Some stakeholders put this down to the fact that the Government is seen to be so committed to the issues that there is no perceived need for a ‘watchdog’ function in civil society. Rather, NGOs focus on their own activities and profile.
- There was an Education for All network but it was reported that this had not been very active and took up time with little valued output.
- The most relevant networks have broader mandates: Forum for Convention on the Rights of the Child; Network of Norwegian Aid Organisations – Bistandstorget. These might be avenues worth exploring to discuss the merits of a more joined-up approach to advocacy around MDGs 4 and 5.
Multilaterals

- UNICEF Norway has child survival as one of its three priorities, and recognises the close linkages with maternal health. UNICEF Norway is perceived more as an NGO than part of the UN system in many people’s eyes and has a high profile. UNICEF will be the focal organisation for the annual TV telethon campaign in 2007 (see Opportunities section). To date, UNICEF has not conducted media and public campaigns on child survival, but is open to doing so in future.
- The UN agencies are collaborating on the Millennium Campaign to promote all 8 MDGs. UNICEF plays a coordinating role in this, which raises the possibility of highlighting MDGs 4 and 5 at a later stage of this Campaign (see Opportunities section).

b. Entry points/audiences to reach

Parliamentarians

- Whilst the Labour Party holds a majority in Government at the moment, several stakeholders see the Global Business Plan as a real opportunity to forge a cross-party platform on MDGs 4 and 5 and to build a broad political alliance, to sustain political commitment in the longer term.
- Several politicians were suggested who might have an interest in the issues:
  - Anniken Huitfeldt - MP for Labour Party, mother, Head of Labour Party’s Women’s Network, member of the Board of Save the Children Norway. Contact: anniken.huitfeldt@stortinget.no
  - Sonja Irene Sjøli – MP for opposition party, on Standing Committee on Health and Care Services. Contact: sonja-irene.sjoli@stortinget.no
  - Britt Hildeng – MP for Oslo representing the Labour Party, chairs informal Parliamentary Network on Sexual and Reproductive Health and Rights. Contact: britt.hildeng@stortinget.no
  - Marianne Aasen-Agdestein – MP for Labour Party, on Financial Committee, was on Health Committee, interested in international issues. Contact: Marianne.agdestein@stortinget.no
  - Marianne Borgen – Socialist left party candidate to be the next Mayor of Oslo in September 2007 elections; Director of Norwegian Programmes at Save the Children; previously head of office at the Ombudsman for children in Norway. Contact: Marianne.borgen@reddbarna.no
  - Inga Torkildsen – Socialist left, on network of parliamentarians promoting the UN Convention on the Rights of the Child, often in media.
  - Women’s networks in all political parties.
  - Young politicians too – who are popular on television discussions, e.g. Vice President of Labour Party.
  - Leader of Coalition and opposition parties: Conservative Party, Progress Party (Siv Jensen – Progress party is usually against development aid, but came back from a trip to Africa convinced of the need to do something on MCH), Socialist Left Party (Heiki-Holmås).
- Political youth parties were identified as a key audience by several government and non-governmental stakeholders. The Labour Youth Party has already been engaged on GAVI; contact: Martin Henriksen. Other political parties should also be engaged.

Government officials

- Most stakeholders did not see the need to target policy-makers since they are already convinced of the importance of MDGs 4 and 5, particularly led by the Prime Minister and Minister of Foreign Affairs.
Other NGOs
- Some stakeholders suggested targeting Norwegian grassroots women’s networks to reach more women. For example, Norske Kvinner Sanitetsforening (NKS) that started maternal and child health in Norway, and FOKUS (umbrella organisation consisting of numerous women’s organisations, both political and not). However, there were mixed views on how relevant some of the women’s groups are nowadays, their willingness to engage on international issues, and the extent of their outreach – these points would need further exploration.
- Could explore bringing Norwegian organisations that promote breastfeeding on board with an international campaign.

Civil Society
- Many stakeholders recognised the need to engage civil society more actively in international issues, including MDGs 4 and 5.
- Stakeholders suggested a range of informal women’s networks that might be worth exploring to mobilise more Norwegians to engage on international issues. For example, mothers’ networks – tend to be informal groups meeting in cafes or internet societies; housewives’ associations (though their reach is uncertain).
- Several stakeholders suggested reaching the younger population through schools, churches and the Guides and Scouts movement. Also through the universities who often run humanitarian campaigns, for example one of the Medical Schools ran a fistula campaign in 2007. See also Youth Political Parties above. Experience shows that youth organisations prefer to get involved with visual demonstrations/stunts and have something concrete to do. The National Council for Child and Youth Organisations is an umbrella group for 73 organisations in Norway, reaching about 500,000 members, some with international interests; some of these groups may be mobilised on MNCH. Contact: Monica Sydgård monica.sydgard@lnu.no.
- Working with the diaspora was also suggested – especially the Indian and Pakistani communities living in Norway.

Media
- Most stakeholders recognised the media as an important advocacy partner through which to reach civil society. However international development issues are not high on the media’s agenda, and news coverage tends to be very inward-looking: ‘we are living on the top of the world in every sense – looking at our own belly button’.
- However, vaccination work has received quite a lot of attention, largely due to the Prime Minister’s visible involvement.
- Several stakeholders were sceptical about the extent to which the media would take up MDGs 4 and 5 as stories unless there was a Norwegian angle (see Messages).
- It is difficult for Norwegian journalists to get hold of ‘real voices’ and NGOs could play a role in facilitating journalists to visit programmes.
- Two journalists who are receptive to covering sexual and reproductive health issues are: Kaja Storvik with Dagsavisen newspaper; and Sissel Henriksen with Klassekampen (recently interviewed IPPF’s Secretary General, Dr Gill Greer). Aftenposten is the other key newspaper to target, though harder to engage with.
- With the internet revolution increasing the pace of news stories, it is increasingly difficult to get indepth stories on issues into the news headlines. The main TV and radio stations are scaling down on travel budgets.
- The Prime Minister’s Office and Norad Information Director recommended targeting the following media:
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- **Television**: NRK Dagsrevyen programme (800,000 viewers, up to 1 million on Saturdays); NRK Urix programme (foreign news, scope for longer features); TV2 News at 18.30 and 21.00 (500-70,000 viewers); TV2 God morgen, Norge (breakfast show) (150,000 viewers). Saturday evening shows on TV2 and NRK would reach a broad audience.
- **Radio**: NRK radio - Norgesglasset (mid-day programme) (800,000 listeners) and Ukeslutt (news show on Saturdays) (800,000 listeners).
  
  **Women’s magazines** are key: Elle, and KK read by half of Norwegian women aged 25-55 years (KK’s Editor-in-Chief is interested in politics); Henne, Norsk Ukeblad and Hjemmet, more traditional weekly magazines, but with a style that is open to the topics, given a Norwegian link and story.
- **Weekly magazine** is key and has good coverage - Dagbladet Magasinet (included in Dagbladet on Saturdays – news features)

**Professional associations**
- Some stakeholders suggested bringing the Norwegian Medical Association, Midwives Association and Nurses Association on board with a campaign. To date, they have not been actively engaged on international issues. However, the Medical Association has just established a group on health promotion to bridge domestic and international issues which may open up opportunities.

**Private sector**
- Norwegian companies are increasingly engaging in corporate social responsibility, so it might be worth exploring companies that would be interested in supporting MDGs 4 and 5. Contact: Norwegian corporation group, NHO – Mr Kaare Verpe, Director of Information.

**c. Potential champions**

Stakeholders suggested a number of potential champions who might be able to lend weight to an advocacy campaign in Norway, although several cautioned that a celebrity approach is quite short-lived unless the champion has real passion, and care must be taken to minimise cynicism by the public:

- Prime Minister Jens Stoltenberg is already a key champion, and important for attracting media coverage. He has been very visible on the international stage, and stakeholders urge him to make the issues more visible on the domestic agenda – so that the media and NGOs will follow.
- The Royal Family plays an important role in Norwegian society. Royal Crown Prince Haakon Magnus and Crown Princess Mette-Marit: both advocates on HIV & AIDS, the Princess is UNAIDS Goodwill Ambassador. They have their own Humanitarian Fund which supports health and education projects. The Crown Princess is also patron of FOKUS Forum for Women and Development Questions.
- Princess Martha-Louise: has been an Ambassador for UNICEF, although the current division of duties in the royal household does not allow her to continue this role.
- UNICEF Goodwill Ambassadors: Sissel Kyrkjebø, singer – might be willing; Ole Gunnar Solskjær, soccer player – but he will be very selective about which campaigns he backs.
- UNFPA Goodwill Ambassador: Kari Jaquesson, leading fitness personality and mother, very committed to sexual and reproductive health and rights including maternal health, is on Board of NSSR. [http://www.unfpa.org/ambassadors/kari.htm](http://www.unfpa.org/ambassadors/kari.htm)
Dr Sverre Lie: eminent paediatrician who has been active in international networks, close contact of Tore Godal.

Famous skiers: Kar Traa, Bjorn Daehlie, Kjetil Andreaamodt.

Actor: Lisa Fjeldstad.

Comedians: Shrabanna Rehman, Harald Eia.

Musician: Mira Craig – popular with young people.

Summary:

Limited number of major international NGOs with advocacy capacity but not specifically focused on MDGs 4 and 5; lack of coordination between child rights’ advocates and maternal/women’s health advocates; limited experience of joint campaigning; striking absence of NGO networks focusing on health or with ‘watchdog’ function; potential to piggy-back on parliamentary network on SRHR, Norwegian Aid Organisations network, and UN agencies’ Millennium Campaign on MDGs.

Priority audiences and entry points include parliamentarians across all political parties to sustain political commitment in the longer term; political youth parties; general public using domestic voluntary groups and the media to increase awareness of MDGs 4 and 5. A good number of potential high profile champions were identified from politics, royalty, music and sport.

5.3 Analysis of Advocacy Messages

5.3.1 Making the case – using the evidence

In this section the views from the three donor countries have been amalgamated due to the similarity of the views expressed.

In Japan, Norway and the UK, data on the scale of the problem and also on progress and success stories (‘child mortality has fallen by x%’) is essential for both political advocacy and public campaigning. Journalists demand statistics to give impact to their stories, just as politicians want to communicate clear results on what difference their donor funds have made. Contrasting the child, newborn and maternal health data of developing countries with domestic figures is seen to be a powerful way of highlighting the injustices of the situation. This is an advocacy tactic used by politicians, civil servants, NGOs, and the media alike. Lifetime risk indicators tend to be easier to understand than the maternal mortality ratio.

5.3.2 What does and does not work

Framing messages for politicians and policy-makers

Some stakeholders are concerned that the framing of messages around MDGs 4 and 5 over-emphasise motherhood rather than the health of all women, and play down important but contentious issues such as unsafe abortion. Some technical experts are also concerned that the ‘continuum of care’ message is too broad and open to misinterpretation about what the technical package really is.
Stakeholders recognise that whilst simple messages are preferable, the Global Business Plan demands more complex messages than for GAVI (e.g. it costs x to vaccinate one child). The message for MDGs 4 and 5 needs to capture that a series of low-cost, inter-linked initiatives in an integrated health system can make a difference; that delivering services locally and empowering communities to access them works; that governments must take responsibility for building public services for all.

Framing messages for civil society and media

Lessons from campaigning on domestic issues such as cot deaths in Norway highlight the importance of partnership – building alliances between healthcare professionals, researchers, government, NGOs and the people affected themselves (the mother who has lost a child, or the families who have been left behind by a mother dying).

Several stakeholders reiterated the need to enable those affected to articulate their own voices, to allow those affected to tell their own story. This is a much more powerful way of delivering the message. ‘Journalists want to speak to real people with real voices who have experienced it, not just statistics; ‘go to the heart rather than the head’. However, it is difficult for Norwegian journalists to get hold of real voices, especially when their travel budgets are being cut back. A mix of factual and emotional messages is effective, such as, ‘give a child a life; give a mother a chance to survive’.

Norway's incredibly strong social welfare system with generous maternity benefits, and the economic gains that Norway has enjoyed as a result, provides a strong platform of goodwill from which to advocate for taking care of women and children in other countries too. One can appeal to Norwegian pride too. Fostering a sense of solidarity between Norwegians and African and Asian families is seen to be important: ‘a child is a child – a precious gift to a family wherever they are in the world; ‘nine months are equally long, wherever a pregnancy occurs in the world; equal expectations; equally great loss’.

Some stakeholders suggested drawing the links between the situation in developing countries and the historical situation in Norway since many people have a grandmother who has experienced giving birth at a time when maternity and neonatal services were not so strong.

Stakeholders with experience of campaigning on domestic issues have learned that death is frightening, so a positive approach to campaigning is needed to engage the public. To show what can be done to make a difference. However, the media are less interested in ‘sunshine stories’ and will rarely cover positive stories unless a famous Norwegian public figure ‘is in the midst of the story’; ‘the situation is not enough – we need a committed Norwegian to tell the story’ e.g. the Prime Minister visiting polio campaign in India. Some stakeholders acknowledged the power of seeing Norwegians ‘representing us in far places’ whilst others (such as UNICEF) are trying to move away from this, ‘we think the heroes should be the local people themselves rather than Norwegians’.

Campaigners also stressed the need to be clear on what the public is being asked to do in response, such as write/email their MP, sign a petition, or join a street protest, or give money (eg. Rotary Groups finance malaria nets).
5.3.3 Messages to resonate at different levels

See section 5.3.2 above.

5.4 Analysis of advocacy processes

5.4.1 Building and sustaining advocacy partnerships

- There is a need to build broad alliances to create enthusiasm for GBP – across political lines and across NGOs.
- Strong government leadership on MDGs 4 and 5 is obscuring the perceived need for a vibrant civil society 'watchdog' function, and lessening the need to present a 'united front'.
- Further discussion is required to identify potential avenues for building civil society partnerships in this context. One starting point might be to form a consortium on MDGs 4 and 5 for the TV Telethon.

5.5 Advocacy opportunities over the next 1-3 years

5.5.1 Getting the message out

Opportunities for getting the message out to Norwegian politicians and policy-makers

- Launch of GBP in September 2007 will generate some news coverage for a few days
- UN Special Session for Children, December 2007, and launch of UNICEF report on State of Worlds’ Children, focus on children’s health.
- International Stillbirths Alliance conference, November 2008, to take place in Norway, co-hosted by Landsforeningen uventet barnedød (LUB)/Norwegian Sudden Infant Death Syndrome Society. One of the goals of the Alliance is to advocate on stillbirths in developing countries. Stillbirths are not included explicitly as MDG targets, although they are inextricably linked with MNCH. International researchers, WHO and others will come together to share information, advance research and inspire prevention campaigns. Contact: Mr Trond Mathiesen, Secretary General LUB: trond@lub.no

Opportunities for getting the message out to the Norwegian general public

- Prime Minister’s visit to Africa in October 2007, to be covered by NRK TV.
- Annual TV Telethon on NRK channel: nearly all stakeholders thought that this would be a great opportunity to focus on MDGs 4 and 5. It has very high visibility, most Norwegians watch it and it raises significant funds. Each year, the Telethon selects a focal theme and organisation that benefits from the funds raised. In autumn 2007, it will be UNICEF in collaboration with ‘Right to Play’ and the Athletic Union of Norway on the theme of ‘Together for Children’, focused on children living with and affected by HIV/AIDS. In 2008, Blue Cross, an alcohol awareness charity. In the past, UNICEF has applied with an MCH theme, however they were turned down. What is needed is for an NGO - or a consortium of NGOs - to apply with the MDGs 4 and 5 theme.
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- **Millennium Campaign**: all the UN agencies are cooperating well to create awareness for all 8 MDGs, e.g. organised recent media and public events to highlight progress at mid-point towards 2015. Limited funding from the Ministry of Foreign Affairs is available. UNICEF thinks that the coordinating group could discuss the feasibility of focusing on MDGs 4 and 5 next year. UNICEF could raise this with UNDP and others at the evaluation meeting in August 2007. Contact Kjersti Flogstad, UNICEF Norway Secretary General: kjersti.flogstad@unicef.no

5.5.2 Processes for developing communication strategies at country level
(including using local PR/Communications companies)

Please see 5.5.1. above. Few interviewees were able to suggest names of appropriate PR/communications companies.

- Dinamo – a PR company who have broad interests in profit and not-for-profit clients, worked with many NGOs on the annual TV Telethon.
- Burson and Marsteller – big PR company, focus on for-profit work, but may be worth exploring.
6. UK

6.1 Levels of priority for MDGs 4 and 5

Political commitment to MDGs 4 and 5 is high in the UK. The Department for International Development (DFID) has a well-deserved reputation for championing difficult issues such as sexual and reproductive health and rights, including unsafe abortion. Respect for DFID affords it a convening power in the areas of MNCH. In 2004, DFID developed the *Strategy on Reducing Maternal Deaths: evidence and action*, and reports annually on progress against its priorities. DFID bilateral expenditure (excluding poverty reduction budget support) on maternal and newborn health plus reproductive health was £32.3 million in 2005/06. However, it is difficult to ascertain whether spending is increasing year on year or not, due to changes in the way that DFID reports thematic expenditure.\(^{40}\)

DFID provides core support to WHO, UNFPA, UNICEF and the World Bank and supports agencies that focus on sexual and reproductive health, such as the International Planned Parenthood Federation and the PMNCH. DFID also has a number of Programme Partnership Agreements with major NGOs such as ActionAid, Christian Aid and Save the Children Fund, all of whom work on MDG4. The health of newborns is implicit in DFID policies and programmes. DFID promotes the integration of maternal, newborn and child health efforts in national development plans.\(^{41}\)

As former Chancellor of the Exchequer, Gordon Brown championed ‘education for all’ on the international stage. In his new role as Prime Minister, he recently launched the “International Health Partnership – A Global ‘Compact’ for Achieving the Health Millennium Development Goals”. This initiative seeks to make health systems work in line with the Paris aid effectiveness declaration principles of harmonisation and alignment, through ‘one country plan, one monitoring framework, one financing mechanism’. It will be crucial that the GBP complements, and works in tandem, with advocacy efforts for this new UK-driven initiative (which focuses on wider health issues including MDGs 4 and 5) in order to avoid undermining both initiatives in the eyes of developing country leaders and the UK electorate.

Whilst public awareness of the MDGs in general is high, largely thanks to the ‘Make Poverty History’ campaign, civil society is less engaged on MDGs 4 and 5 specifically. Indeed, the successes of HIV & AIDS campaigns overshadow those focusing on child health and maternal health. The results of a recent Eurobarometer survey of European public opinion on development issues found that only 13% of the UK respondents thought that reducing the number of women who die as a result of childbirth should be one of the top three priorities, and 27% thought that reducing child mortality should be one of the top three priorities.\(^{42}\)

\(^{41}\) Ibid.
With political will at the highest levels of power, the key inter-related advocacy challenges for the UK are:

- How to sustain this level of political attention on MDGs 4 and 5, especially if government changes at the next elections.
- How to increase awareness among civil society to the issues on MDGs 4 & 5.
- How to harmonise and coordinate UK-inspired global health initiatives with other global initiatives.
- How to ensure that the UK Government monitors expenditure on MDGs 4 and 5 and delivers against their commitments.
- How to communicate the returns on tax-payers’ investment in MDGs 4 and 5.

### 6.2 Mapping Advocacy

#### 6.2.1 Capacity, resources and entry points for advocacy

**a. Capacity and resources**

**Key NGOs**

- Several larger and smaller specialist NGOs are active advocates for MDG5 in the broader context of sexual and reproductive health and rights, including Marie Stopes International (MSI), Interact Worldwide, and International Planned Parenthood Federation (IPPF). Women and Children First is a very small NGO with limited capacity focusing on both MDGs 4 and 5, including newborn health. Save the Children Fund (SCF) UK is a major advocate for child health and health systems strengthening, and has promoted an active campaign on abolishment of user fees. It is increasingly promoting MDG4 together with MDG5, and is involved with the Countdown 2015 on MDGs 4 and 5. It benefits from dedicated parliamentary lobbying and media units.

- Amnesty International has expertise in championing human rights, and is planning to launch an advocacy campaign in 2008 with maternal mortality as one if its key themes (see Opportunities section 8.1.1).

- The UK-based UN Special Rapporteur on the Right to the highest attainable standard of health, Paul Hunt, is also planning to launch a global maternal mortality and rights initiative, in collaboration with others (see Opportunities section 8.1.1).

- Stakeholders reported a lack of coordination between NGOs, often the result of competition for scarce resources and brand-consciousness. Historically, there has been ‘friction between SRHR and HIV/AIDS advocacy communities’ and the need for better integration is now recognised – though that mechanism is not yet functioning.

- Several of the influential development NGOs, such as Christian Aid, Oxfam, ActionAid, World Vision, are not perceived as visible champions on MDGs 4 and 5, although some are engaged in broader promotion of health systems strengthening (e.g. ActionAid is secretariat for Action for Global Health network – see below). Many stakeholders see these organisations as having the ear of politicians, particularly those that have Programme Partnership Agreements with DFID.

- Many organisations’ advocacy functions are constrained by the lack of longer-term funds available for advocacy activities.
Relevant networks

- There are several NGO networks and initiatives relevant to MDGs 4 and 5. However, they have varying capacity and there is an urgent need for strong coordination and leadership – along the lines of the more effective UK NGO AIDS Consortium. Several of the initiatives NETWORKS below were not aware of each other.

- Lessons from the Countdown 2015 for Sexual and Reproductive Health Rights (SRHR) movement point to the importance of facilitation to bring advocates together to find common ground. This movement had an important convening role and, ‘brought together what had been an embattled group – an opportunity to connect and inspire each other at national, regional and global level; it re-energised people’

- The UK NGO Network on Sexual and Reproductive Health and Rights has been successful in pressing UK government to commit to SRHR and MDG 5, but has not played such an active monitoring role to hold them to account for its commitments. The Network is currently in a self-confessed phase of transition and needs resourcing and further professionalizing. A Working Group on MDG5 has been proposed recently, but it is not yet clear what its mandate will be. Mainstream development NGOs have been less active in this network to date.

- The new pan-European Action for Global Health (Gates-funded network in Brussels, France, Germany, Italy, Spain, UK) champions all health-related MDGs, including MDGs 4 and 5 – from a health systems and financing perspective. Although it is early days, the network has strong potential for political advocacy - particularly to use the UK’s role in the European Union to strengthen advocacy efforts with other European governments. Its current focus is on holding governments to account for health expenditure (see recent policy reports). Public campaigning will be a second phase activity, and might be able to work as the health dimension of the Global Campaign for Action Against Poverty’s broader Millennium Campaign.

- The White Ribbon Alliance (WRA) is embryonic in the UK, with active Board members, but not yet registered or with an institutional home. It is likely to have a fundraising focus for developing country WRA Secretariats rather than an explicit advocacy function in the UK.

- Women and Children First perceives a gap in the UK advocacy lobby on MNCH, and plans a meeting in September 2007 to bring together NGOs, researchers and others working on MDGs 4 and 5 to discuss the need for a dedicated MNCH network/alliance.

Researchers

- Some of the most eminent researchers in the field are UK-based (e.g. Institute of Child Health, London School of Hygiene and Tropical Medicine, IMMPACT programme at Aberdeen University).

- Several NGO stakeholders identified the need to join up more with researchers who can, ‘am them [advocates] with the meat of their messages,’ for example to use the recent Lancet series on related issues.

b. Entry points/audiences

Parliamentarians

- MDGs 4 and 5 have benefited from huge Ministerial support at DFID through Hilary Benn and Gareth Thomas. With the recent Cabinet reshuffle, the new DFID Minister (Douglas Alexander) and the new Under Secretaries of State are priority audiences. Also the Treasury now that Gordon Brown has become Prime Minister.
• Cross-party parliamentary support continues to be crucial, for example through the All Party Parliamentary Group on Population and Reproductive Health, All Party Parliamentary Group on Overseas Development, and the International Development Committee – with forthcoming inquiry on maternal health (see section 8.1.1 Opportunities).
• Cross-party groups in the Scottish Parliament are an emerging audience since the Scottish Executive has its own budget for international development.
• The Labour Women MPs network, chaired by Barbara Follett, is another potential avenue.
• See annex of parliamentarians interested in health (A Schmidt of SCF UK to send – N.B. not yet received).

**Government officials**
• Stakeholders within and outside DFID identified DFID top management as another key audience to be held to account for public expenditure on MNCH, and to build in MNCH as a key criterion for Programme Partnership Agreements with NGOs.
• Within DFID, there is also a perceived need to challenge country offices to do more to advocate with partner governments on MDGs 4 and 5. Several stakeholders noted that DFID’s status as a champion of MNCH comes from Palace Street rather than in the field. The Maputo Plan of Action on Sexual and Reproductive Health is a great opportunity for DFID country offices to get behind African governments.

**Other NGOs and networks**
• As noted above, politicians and NGOs alike identified the need for other major UK-based NGOs to give higher visibility to MDGs 4 and 5.
• The Gender and Development Network could be harnessed around MNCH.
• One NGO suggested advocating to other funding sources, such as the Lottery Fund, Children in Need, Comic Relief, to encourage them to direct money to MDGs 4 & 5.

**Civil Society**
• Stakeholders had diverse opinions on the potential effectiveness of targeting civil society through a large-scale public campaign.
• Many stakeholders thought the priority should be to focus advocacy efforts on holding policy-makers and politicians to account for their commitments, tracking expenditure and performance against strategy (see above).
• Some politicians expressed a desire to see another Make Poverty History-type movement of street protests and letter-writing, building on the high degree of public goodwill for international development. Such a campaign would need a well-resourced media strategy. However, several NGOs stressed the difficulties of public campaigns on access to SRHR, health systems etc. The challenge now is to convince the public that aid works, to see results.
• If public campaigns are thought to be worthwhile, then the challenge is to ‘stop preaching to the converted’. Rather, to reach out to new audiences such as faith-based organisations; students, especially medical schools and those doing development degrees, women’s sections of student unions; diaspora communities; trade unions, who helped with advocacy on HIV/AIDS.
• New mothers were identified as an audience to be reached more effectively. Most stakeholders agreed there was potential to build solidarity with mothers in the UK through networks such as the National Childbirth Trust, breastfeeding groups, even the Mothers’ Union and Women’s Institute.
Media

- The PR and media community is sophisticated in the UK. International development issues do not receive a high profile, although a good number of journalists are familiar with the issues.
- Several NGOs (e.g. SCF, IPPF, MSI, Interact) work closely with journalists in UK and developing countries. One journalist warned that the media, ‘gets sick and tired of being manipulated by NGOs – NGOs can help facilitate and point in the right direction – but must understand the journalists have to write the story, which may challenge the NGO’.
- IPPF is beginning to engage with the challenge of new media, such as E-media, bloggers, film producers, photo journalists.
- MSI and Interact Worldwide have had effective special inserts on SRHR and maternal health in newspapers. SCF has attracted strong media coverage on issues such as breastfeeding, most recently with the Breastfeeding Manifesto, a consortium of NGOs.
- Annex 6 provides a list of print and broadcasting journalists/editors who are interested in health issues.
  In addition, women’s magazines such as Marie Claire (Maria Riordan) and Grazia are very effective in increasing awareness and getting public committed and involved as part of a coordinated campaign, e.g. letter-writing campaigns to MPs.

Professional associations

- The Royal Colleges of Obstetricians and Gynaecologists, of Nursing and of Midwives are seen to give important credibility to campaigns on MNCH. Some of the colleges have got more involved in international issues in recent years. For example, the RCOG is working closely with the White Ribbon Alliance UK.
- The Royal College of Midwives has held joint events with the National Childbirth Trust on UK issues, and might be willing to explore international advocacy.

Private sector

- Only a few stakeholders suggested mobilising the private sector, e.g. Bounty Packs to women who have just delivered in hospital; financial companies promoting child saving trusts.

c. Potential champions

Engaging a public figure is key to getting national media coverage in the UK. However, all stakeholders found it very difficult to identify a credible public figure with personal stories, who would be willing to speak out. Many respondents were also sceptical about the effectiveness of this approach. Suggestions included:

- Sarah Brown, mother, wife of Prime Minister Gordon Brown and Chief Executive of PiggyBankKids, her charity set up after the loss of their newborn daughter. http://www.piggybankkids.org/?c=/pages/biographies.jsp
- Melinda Gates.
- Sophie, Countess of Wessex, married to Prince Edward, has experienced ectopic pregnancy and premature birth of daughter by C-Section.
- Gwyneth Paltrow, actor, has UK base, mother of young children, married to rock star.
Jeremy Vine, TV presenter & radio broadcaster, presented Panorama TV programme on poor state of maternity services in the UK, and wrote piece for Daily Mail on experience of his wife giving birth.
http://www.dailymail.co.uk/pages/live/femail/article.html?in_article_id=452056&in_page_id=1879

Richard Horton, editor of The Lancet.

Dr Gill Greer, Director General of International Planned Parenthood Federation.

Summary:

Many large and smaller international NGOs with sophisticated advocacy skills focused on MDGs 4 and/or 5, and broader sexual and reproductive health and rights. Some major development NGOs not focused on these MDGs. Several NGO networks active in lobbying politicians and policy-makers – have been successful in pushing for government commitments, but weaker on monitoring them. However, advocacy efforts are not well-coordinated. Lack of coherent, unified messages between child health, maternal health and sexual and reproductive health and right advocates. Friction with with HIV/AIDS advocates, yet positive lessons to be learned from AIDS consortium, campaigning and political advocacy. Relatively limited resources available for advocacy, although Gates-funded Action for Global Health pan-European network opens up new opportunities. Advocates could make greater use of UK’s strong research capacity.

Priority audiences and entry points include new DFID Ministers and senior DFID officials, and parliamentarians across all political parties. Opinion is mixed regarding the merits, or otherwise, of general media/public campaigns to increase awareness. More targeted awareness raising among voluntary groups with domestic MNCH interests is worth exploring (e.g. National Childbirth Trust). A limited number of potential high profile champions were identified, though many respondents were sceptical about the effectiveness of this approach.

6.3 Analysis of Advocacy Messages

6.3.1 Making the case – using the evidence

In this section the views from the three donor countries have been amalgamated due to the similarity of the views expressed.

In Japan, Norway and the UK, data on the scale of the problem and also on progress and success stories (‘child mortality has fallen by x%’) is essential for both political advocacy and public campaigning. Journalists demand statistics to give impact to their stories, just as politicians want to communicate clear results on what difference their donor funds have made. Contrasting the child, newborn and maternal health data of developing countries with domestic figures is seen to be a powerful way of highlighting the injustices of the situation. This is an advocacy tactic used by politicians, civil servants, NGOs, and the media alike. Lifetime risk indicators tend to be easier to understand than the maternal mortality ratio.

One caution from leading UK researchers asked to evaluate programmes, is that governments and civil society cannot expect to see a decrease in child and maternal mortality unless the programme inputs (e.g. trained skilled birth attendants, drugs) have been scaled up sufficiently. Whilst this is an obvious point, it is a useful
reminder of the importance of sequencing demand and supply efforts, if advocacy initiatives are to minimise public cynicism about aid and issue fatigue.

Donor countries have an important role to play in funding research - to produce evidence for the public good - and in providing research expertise to undertake independent studies in developing countries (in collaboration with developing country partners). In the UK, DFID already invests in several important research programme consortia that focus on MDGs 4 and 5. It will be important that the new DFID Research Strategy for 2008-2013 continues to invest in these priority areas, and encourages researchers to analyse the role of political will in achieving better maternal, newborn and child health outcomes.

6.3.2 What does and does not work

One of the key challenges for advocacy on MDGs 4 and 5 by UK-based advocates is the lack of a prioritised and unified message. Lessons learned from international HIV/AIDS campaigns and the Global Campaign for Education point to the importance of speaking with one voice. For example, a coherent, simple message around universal access, coordinated effectively through the well-resourced UK NGO AIDS Consortium is perceived to have been very successful. The Global Campaign for Education has made valuable use of the extensive UK school network to communicate its messages, resulting in high visibility with local MPs in their constituencies.

Framing messages for politicians and policy-makers

Many advocates and researchers emphasised the continued need to focus messages for UK policy-makers on investing in health systems strengthening as whole in order to achieve MDGs 4 and 5. This is seen to have been one of the (few) failures of the AIDS campaign – the message of strengthening health systems did not get through. This requires long-term, predictable financing, harmonised financing mechanisms, and alignment with country plans.

Advocates and researchers emphasised that the other key message for UK politicians and policy-makers (DFID, Treasury) is the need to track and account for UK Government's actual expenditure on MDGs 4 and 5; to monitor its performance against strategies; to monitor trends in spending – to turn positive political rhetoric into actual increased resources on the ground. Researchers have a role to play in filling gaps in the evidence base on financing, and feeding this information through to advocates.

Framing messages for civil society and media

Whilst women’s rights and empowerment are understood to be key to improving MNCH outcomes, stakeholders felt that these concepts cannot be used to sell messages to civil society and media. Similarly, health systems’ strengthening is a key part of the solution rather than the message that will grab the public’s attention and provoke them to engage and act.

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43 See http://www.research4development.info
Rather, several stakeholders expressed the need to capitalise on the emotive nature of MDGs 4 and 5 - ‘the marshmallow-ness of infants and children’. Related to this, many informants stated the need to convey the injustice of women and children dying needlessly.

Stakeholders varied in their opinions of how to communicate the more contentious aspects of MDG5, particularly sex and unsafe abortion. Many favoured a softer message around ‘saving the lives of women and children’. However, some parliamentarians and NGOs advised against watering down the message: ‘it’s only worth doing if it’s an honest campaign’.

As well as messages about the problems, many stakeholders emphasised the need to convey the solutions and success stories too, to state what it is possible to do – what it takes to save the lives of women and children. Several stakeholders (government and civil society) also cautioned against, ‘a relentless diet of NGOs critiquing DFID’ which easily leads to cynicism. Rather, to use messages that celebrate how aid money is making a difference and what the British public can be proud of.

Many stakeholders stressed the importance of using ‘authentic southern voices’ in advocacy for donor country audiences. ‘I think successful advocacy comes from the authenticity of the voices speaking – these may not be absolutely in tune with our views’. Organisations such as IPPF and PANOS are training southern journalists to cover these issues, and several NGOs (e.g. SCF, IPPF, MSI) have organised visits for northern journalists to developing countries. One of the Board Members of the White Ribbon Alliance UK is a film-maker who works with local communities in Africa and Asia to capture and communicate the voices of ‘real women’.

Personal, human interest stories combined with hard statistics are seen to be essential to engage the media. A key lesson learned in messaging is the effectiveness of linking international issues with the domestic agenda, and juxtaposing the lives of women and children in developing countries with those living in the UK or elsewhere in Europe. Interact Worldwide’s ‘Parallel Lives’ campaign used this approach very successfully on issues of young people’s sexual and reproductive health and rights. ‘Different Planets’ highlights extracts from an award-winning45 article in the Guardian newspaper that illustrates this powerful approach (Box 5). The journalist was supported by Save the Children Fund. Several stakeholders stressed the need for NGOs to work in a way that allows journalists to retain their independence and integrity.

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45 One World Media Awards 2007: http://www.owbt.org/
Box 5: Different planets

A recent report revealed that Sweden is the best place in the world to give birth, and Niger the worst. Joanna Moorhead visited both. She was shocked not only by the vast differences in the quality of care women and babies receive, but also by how easily things could be put right.

Tuesday October 3, 2006 The Guardian

It's 10am on a stiflingly hot Monday morning and I am in a delivery room with one of the unluckiest mothers on the planet. She is Dahara Laouali, and at the moment she is lying on a narrow, dusty hospital trolley pushing her baby into the world. Although the birth is imminent - Insa, the midwife, says that with the next contraction the head will be out - Dahara is making no noise at all. This is Niger, where the tradition is that mothers labour in silence. It is hard keeping quiet in the throes of childbirth: but almost everything is hard for mothers in Niger.

Dahara pushes, pain creasing her sweating face, and then pushes again - and suddenly between her legs there is a little boy with the walnut features of newborns everywhere, and a mop of damp, dark hair. Insa gives a delighted squeal, but Dahara is still silent: as her baby is wrapped in a cloth, she turns her face to the wall and sobs quietly. Maybe she is tired after the labour. Maybe she wants to be alone. Maybe she is not ready quite yet to welcome the baby into her heart. But maybe, too, she is remembering other births, and other babies. Because this boy is the fifth child Dahara has pushed into the world and of the others, only one is still alive.

This, then, is Dahara's misfortune: and it is not just a personal tragedy, but one she shares with every other mother in her country. Niger is officially the most dangerous place on earth to have a baby: in May, a Save the Children report found that, of the 125 nations it surveyed, Niger was where childbirth was most likely to end badly. Statistically, Dahara, who is 26, has a one-in-seven chance of dying during her reproductive years as a result of a pregnancy-related complication or infection, or childbirth injury. Her baby son, lying here on the table, has a 15% chance of not reaching his first birthday and a one-in-six chance of not making it to the age of five. And Dahara is fortunate to have had the skills of a midwife like the cheerful Insa: across the country, only 16% of deliveries are attended by anyone with any training at all……

…..Ten days later, I am in another maternity unit. This one is in the University Hospital at Uppsala, north of Stockholm. Bande is 3,200 miles away, although I feel as if I have travelled from the middle ages to the middle of the 21st century. In almost every way, giving birth in Sweden is light years away from giving birth in Niger. And yet, of course, it is all ultimately about the same thing: a mother and a baby.

The mother and baby I meet in Uppsala are Carmen Helwig and her new daughter. Carmen paints a strikingly different picture of new motherhood. She is older - 38 - but Tess is her first baby. She was born by caesarean section because of worries over a uterine scar, the result of previous surgery…. "Once I'm home, I'll be able to phone the hospital with any worries and the midwives will come out to see me every day if I need them," she says.

Carmen is Dahara's mirror-image, one of the luckiest mothers in the world. The Save the Children report found that, while risk can never be entirely removed from the business of becoming a parent, the dangers for Swedish women are minuscule in comparison with the risks for mothers in Niger. Carmen's chance of dying as a result of childbirth over her lifetime is one in 29,800 (Dahara's, remember, was just one in seven). The risk of Tess dying in her first year is one in 333. In Sweden, 100% of births are attended by a skilled, trained midwife. Overall, it is the safest place in the world to become a mother. .........

Source and full article:
http://society.guardian.co.uk/health/story/0,,1886340,00.html?gusrc=rss
6.3.3 Messages to resonate at different levels

See section 6.3.2 above.

6.4 Analysis of advocacy processes

6.4.1 Building and sustaining advocacy partnerships

- There is an urgent need for coordinated, joined up advocacy partnerships, to communicate priority messages on MDGs 4 and 5 with one voice.
- One possible way forward might be to use the Women and Children First workshop on MDGs 4 and 5 to map out the overlapping networks to identify their comparative advantages, gaps, and opportunities for partnership (e.g. SRHR Network MDG5 working group, White Ribbon Alliance, Action for Global Health).
- The Action for Global Health Network with its 15 members in 5 European countries could be a viable mechanism for a concerted campaign on MDGs 4 and 5.
- Civil society organisations and networks need to balance their role in holding policy-makers to account with the need to partner with DFID to keep civil society on board through positive stories about the effectiveness of aid.

6.5 Advocacy opportunities over the next 1-3 years

6.5.1 Getting the message out

Opportunities for agreeing a unified message among UK civil society advocates

- **Women and Children First’s planned workshop on MDGs 4 and 5, September 2007** - for UK-based NGOs, researchers, development cooperation agencies, private sector representatives. Aims to identify the way forward for a UK lobby on MNCH issues – to play a similar role to the UK NGO AIDS Consortium and UK Network on SRHR. Contact info@wcf-uk.org
- **UK Network on Sexual and Reproductive Health and Rights – a Working Group on MDG 5** was proposed in June 2007. The scope of such a group needs to be developed to ensure that it brings added value. [http://www.bond.org.uk/wgroups/sexualhealth/TOR.html](http://www.bond.org.uk/wgroups/sexualhealth/TOR.html)

Opportunities for getting the message out to UK politicians and policy-makers

- **International Development Committee Inquiry: Maternal Health** – to examine how development cooperation agencies, particularly DFID, can support progress towards MDG5. Written submissions due by 14 September 2007. This is an important opportunity for advocates/researchers to challenge the evidence on financial expenditure. [http://www.parliament.uk/parliamentary_committees/international_development/id0607pn34.cfm](http://www.parliament.uk/parliamentary_committees/international_development/id0607pn34.cfm)
- **UK political party conferences**: Action for Global Health is planning a series of fringe events at the UK political Party Conferences in 2007. They have already secured a meeting at the Liberal Democrat Conference in Brighton on 18
September 2007. The meeting’s theme will be, ‘Global Health and the MDGs: what next?’ They are looking for a speaker to represent and showcase the Global Business Plan. Contact Kate Hawkins: HawkinsK@interactworldwide.org

- Mother’s Day events: these have been popular with female and, to some extent, male parliamentarians, and gain more support than using International Women’s Day as a platform, since many MPs more readily identify with mothers and children rather than the edifice of women’s rights.

6.5.2 Processes for developing communication strategies at country level (including using local PR/Communications companies)

Please see 6.5.1. above. Few interviewees were able to suggest names of appropriate PR/communications companies.

- Cathy Bartley and Peter Robb – do PR and media work for UN agencies and others, e.g. launch of the UNFPA State of the World’s Population Report. Need to identify firms.
7. **PAKISTAN**

7.1 **Levels of priority for MDGs 4 and 5**

As a result of donor efforts the MDGs are prioritised by policy makers, programme implementers and NGOs. However, although MDGs 4 and 5 are institutionalised as a national concern through their inclusion in most policy documents including the PRSP, Gender Policy and the newly developed MNCH Policy, these MDGs are not mainstreamed into all development interventions across the health sector.

MNCH is perceived to be given greater priority at Federal Government level than at Provincial or District Government levels. Although health has been decentralised out to Provincial Government few interviewees mentioned any significant MNCH interventions at that level. The interventions which were most frequently described were district level pilot programmes run by UNICEF and Pakistan Initiative for Mothers and Newborns (PAIMAN). These District programmes reflect an increasing awareness of the importance of MNCH among health professionals. However, their level of impact is limited.

The lack of any large scale or high profile programmes is seen to reflect that absence of true political commitment by the Government, particularly in the Provinces and Districts, towards MDGs 4 and 5. This lack of political will is exacerbated by over-optimistic reports based on inaccurate data; the absence of any political champions for reproductive health issues; and the small percentage of the Government budget which is allocated to health, despite major financial inputs from the Asia Development Bank (ADB), Japan International Cooperation Agency (JICA) and the Department for International Development (DFID). The latter is currently the government’s lead donor on MNCH.

MDGs 4 and 5 are viewed as being high on the agenda of a number of the major development cooperation agencies, particularly JICA, NORAD, DFID and USAID, however due to lack of donor coordination there is often duplication of work. The ADB has also been active in allocating resources for MCH programmes.

The key advocacy challenges for Pakistan are:

- Mainstreaming MDGs 4 and 5 into policy documents
- Ensuring that Provincial and District governments prioritise maternal, newborn and child mortality
- Changing the cultural mindset in relation to women and their health
- Harmonising donor efforts to advocate for MDGs 4 and 5
7.2 Mapping Advocacy

7.2.1 Capacity, resources and entry points for advocacy

High maternal and child mortality rates from previous Demographic and Household Surveys (DHS) are used for advocacy and lobbying purposes by most stakeholders. The latest DHS data are due to be released and interviewees reported that they are waiting for these to inform future research and strategies for advocacy.

The major barrier to effective advocacy is the low status of women; the lack of reliable data at district level; the lack of coordination between stakeholders and the absence of any unifying messaging, network or forum. This results in a small number of individuals being seen to monopolise the sector without being able to achieve effective over-arching impact. Several interviewees suggested the need for a balanced and well-matched group of politicians, policy makers, civil society organizations, development cooperation agencies, civil servants and social activists to come together to form a consultative group with clearly defined roles and messaging.

There is a clear need for greater, and better organised, advocacy at multiple levels, through improved links and feedback between programmes, networks and alliances, and government Technical Advisory Groups and fora; and, on the demand side, for increased pressure to be put on national and local government by the media, religious leaders and civil society organisations.

a) Capacity and resources

Key NGOs

- PAIMAN, backed by a US consultancy and funded largely by USAID, works through a support group methodology focusing on newborn care and safe delivery issues in ten districts of Pakistan. The programme is working with government to train 12,000 community midwives in the next five years
- The White Ribbon Alliance is gathering together a group of professionals and experts to form a branch in Pakistan.
- Women’s Health Project

Relevant networks

- Women’s Political Schools (WPS), a project part-funded by the Norwegian government, based at the Ministry of Women’s Development and run by UNDP. The project has trained 12,000 Nazims (mayors) and 26,000 councillors in gender-sensitisation.
- Ministry of Health’s Lady Health Workers project of 10,000 women that are in close contact with communities at grass roots level.\(^{46}\)

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\(^{46}\) Initiated under the Ministry of Health, the Lady Health Worker Programme (LHWP) aimed at integrating family planning (FP) into the doorstep provision of primary health care. Lady Health Workers (LHWs), who have a minimum of 8 years of education and are residents of the community they serve, undergo 15 months of training. They then serve approximately 1000 individuals, delivering a range of services door-to-door related to maternal and child health, including immunisation promotion, growth monitoring, FP, and health education. They treat minor ailments and injuries, and are trained to identify and refer more serious cases. Their FP responsibilities include motivating women to practice FP, providing pills and condoms, and referring for injections, intrauterine device (IUD) insertion and care, and sterilisation.
The Norwegian Ambassador mentioned Pakistan’s Rural Support Programmes, led by Sheyep Sultan – ‘a vast network’ which he believed could play an important role. Religious networks are also important, and various interviewees stressed the need to involve Imams, Pirs, Sunni Islamic Scholars, and other influential community figures in any advocacy on PMNCH.

**Bilaterals**

- Asia Development Bank Reproductive Health project
- In the context of the present geopolitical and development situation in Pakistan international development agencies play an important role in bringing MNCH issues to the forefront of the political agenda. Official development assistance is a vital part of Pakistan’s development scenario and the government and civil society organizations are heavily dependent on development cooperation agencies’ priorities.

**Multilaterals**

- UNICEF (through its Khuzdar project)

*b) Entry points/audiences to reach*

**Parliamentarians**

- One interviewee considered that Pakistan’s parliamentarians are under-used for advocacy purposes. It was suggested that if Parliamentarians were properly equipped with briefings and messages on to which they could stamp their ‘brand’ then they would quickly become eager advocates on MNCH.

**Government officials**

- Technical Advisory Groups within the Government are key groups to target for any future advocacy work.
- The Parliamentary Secretary within the Ministry of Population and Welfare proposes to use the DHS district level data for dissemination to politicians to raise awareness of the situation in their districts and help them develop appropriate strategies.

**NGOs**

- Any NGOs working in MNCH

**General public**

- Interviewees felt that it was important to reach civil society via the groups described above, with a particular emphasis on involving men in the campaign.
- Religious leaders could also play an important role in bringing MNCH higher on the political agenda by influencing public opinion.

**Media**

The media, especially electronic media, was seen as potentially playing an important role in advocacy for MNCH by mobilizing policy makers and political leaders through increased public pressure.

c) Potential champions

The general consensus among interviewees was that potential champions for MNCH should be drawn from a range of people representing a wide range of interests. No individual names came through as clear leaders for a role as ‘figurehead’ or spokesperson for the campaign. Individuals who were suggested were:

- **Imran Khan** (ex cricket captain of Pakistan and politician, although he was also described as a controversial)
- **Kulsoom Saifullah** (socialite)
- **Kashmala Tariq** (politician)
- **Abdul Sattar Edhi** (national level social worker)
- **Pervaiz Musharraf** (President)
- **Dr. Shahed** (prominent TV anchorman)
- **Aitzaz Ahsan** (Interior Minister under Benazir Bhutto, is a member of the PPP and highly respected)
- **Najaad** (a top actress in a drama who plays a woman having her 7th child in as many years)
- **Shairo Khan** (a film star who is universally admired in both India and Pakistan. It was thought that ‘he would cause people to sit up and listen’.)
- Also clerics from Saudi Arabia and Al Azar University in Cairo
- **The Council of Islamic Ideology** (a constitutional body that helps government Islamise the law; ‘if the Chairman of the Council spoke out about this issue, that would have a great impact’)
- **The Chief Justice**
- **Begum Nawazish** (a male ‘character’ TV host who dresses as a woman, and does interviews. He asks shocking, personal questions on a late night show and is much loved by Pakistanis.)

Summary:

The overall view of interviewees was that advocacy for, and implementation of, MNCH remains weak and uncoordinated. Success stories such as UNICEF’s Khuzdar project and PAIMAN are not presented at the correct fora and awareness of their achievements is low. Other projects such as the Women’s Health Project and the Asia Development Bank Reproductive Health project have shown little evidence of impact. The main focus of NGOs is on MNCH rather than specifically on MDGs 4 and 5.

7.3 Analysis of Advocacy Messages

7.3.1 Making the case – using the evidence

The majority of interviewees, including media representatives, were aware of the official national statistics presented by major UN agencies, but they were viewed by the majority of professionals as failing to include rural and unreported mortality. For the first time the DHS includes MNCH data. Before leaving Pakistan we were given an early copy of the report, and it was clear that the MMR was lower than generally assumed throughout Pakistan. This is likely to convey the impression, contradicted by many we spoke to, that government measures are working. This is likely to reduce both advocacy efforts on MMR and also pressure on the government, and is
Evidence of the way in which inaccurate data (in this case earlier assumptions of a MMR of 500) can seriously impede effective advocacy.

It was widely agreed that the absolute necessity for successfully making the case for reducing maternal, newborn and child mortality and morbidity was obtaining accurate national level and district level data, and making this available to all. At present data sources are scattered and inaccessible to many. This problem should, in part, be resolved when the DHS results are made public as dissemination takes place at national level and the data are openly accessible. However, the concern still remained that the DHS data would under-report mortality, and not provide information on morbidity levels.

7.3.2 What does and does not work

Framing messages:

National leaders are seen to respond to external threats and public pressure by attempting to instil a mixture of fear and public health education within civil society, although it is doubtful that this would be an appropriate or sustainable way of presenting messages on maternal, newborn and child mortality. It was widely felt that messages should be targeted strongly at men, as the main household decision makers, if they are to result in attitudinal and behavioural change. Some interviewees reported that questioning male honour regarding the treatment of their wives should be a central focus of advocacy messages. Others focused on the need to change the attitudes of men, mothers-in-law, policy makers and health care providers through a combination of evidence- and ‘honour’-based messages.

Two interviewees stressed the importance of male prejudice and discrimination towards Pakistani women, particularly Muslim women. One noted that while Muslim women prefer to deal only with women doctors and stay in women-only wards, there exists a very low ratio of beds for females in hospitals and clinics; and there is a very low ratio of women paramedics. A private hospital in Islamabad (Shifferi) had an intake of 90% male nurses and only 10% female. This in-built discrimination implies that even where institutional delivery improves, Muslim women may be reluctant to attend.

Four interviewees stressed the importance of drawing on Koranic readings on the value to Muslims of the mother, and of support to the mother during pregnancy and childbirth. It was felt that Muslim scholars and community leaders had wrongly been identified as unhelpful, and we were reminded of the pivotal role played by Ayatollah Khomeini in Iran, in issuing a fatwa supporting family planning and MNCH. Although Pakistanis are predominantly of the Sunni faith, while Iran is Shi’ite, and fatwas are therefore entirely inappropriate – nevertheless it was felt that drawing on deeply held-religious beliefs, and perhaps highlighting the contradictions between those beliefs and reality on the ground – would stimulate debate and awareness in Pakistani Muslims.

It was also felt that Pakistan’s national pride could be harnessed by making comparisons with countries of similar population, size and geo-political importance and then stressing the contrast in the survival rates of mothers and children. Comparable countries include Iran (although it was felt that most Pakistanis do not feel empathy with Iranians); Malaysia, Indonesia; but also Bangladesh. Indeed the latter’s achievements in MNCH might provoke a strong, and hopefully positive
reaction from Pakistanis who, it was said, would be embarrassed by the success of their smaller and poorer neighbour.

There needs to be a national consensus among key stakeholders in order to ensure that coordinated messages are conveyed. Coordination of stakeholders is currently a key problem.

Previous campaigns which were viewed as having been particularly effective were UNICEF’s polio, iodized salt and expanded immunization programmes. A word of warning was given, however, by respondents who reported that highly successful campaigns can create such high levels of demand, as in the case of the polio programme, that demand outstrips supply, and that instead of complementing the expanded immunization programme, it drew attention away from it – thus reducing uptake. It appeared that uptake of the polio campaign occurred instead of, rather than as well as, uptake of the expanded immunization programme.

7.3.3 Messages to resonate at different levels

The following messages emerged from our interviews in Pakistan:

- Mothers and their babies should be considered together

- The status of health workers should be raised – by the institution of public and much-trumpeted awards and medals for good work/achievements in the field of MNCH

- Because of the power men exercise, and because the loss of a woman’s life appears to be treated lightly the following messaging was proposed: orphans, particularly male orphans (rich and poor, powerful and weak, young and old) should be invited to speak of the loss of their mother at a young age, and of the impact this had on them. Individual interviews, recorded on DVDs (similar to the Polio interviews circulated by UNICEF) could have a tremendous emotional impact, and once again emphasize that the loss of a mother causes lifelong loneliness, a sense of abandonment, and suffering to those she leaves behind.

- The importance of mothers to the future of societies should be underlined, and the status of mothers enhanced. This can be done by inviting e.g. Presidents and other high-profile figures to speak of their support for their wives at childbirth; and of their willingness e.g. to attend visits to doctors together with their wives.

- People should be reminded of Koranic and biblical readings on the respect due to the mother.

- A sense of crisis should be created: The same numbers of women die each year as all those that died in the earthquake.

- Pakistani men should be shamed into understanding that they are presiding over the unnecessary deaths of their wives.
The contrast between Islamic teachings of the value of the mother (the first, second, and third most important person in anyone’s life, according to the Koran, with the father only the fourth), and the reality on the ground, where women and children are effectively treated with contempt.

7.4 Analysis of advocacy processes

7.4.1 Building and sustaining advocacy partnerships

A number of our interviewees (including a high-level government official) complained of the inability of government officials in Pakistan to spend their allocated budgets; to manage and deliver services effectively. There was a general consensus that shortage of funds was not the issue; rather bottlenecks were caused by a lack of capacity by the Ministry of Health to manage the effective delivery of services. Some interviewees felt strongly that development cooperation agencies should be helping government build technical capacity, and should not provide further budget support. This reasoning led a number of interviewees to recommend that demand should not be built up as the supply of services could not respond to increased demand.

In order to support government with the delivery of services, there is now growing cohesion and harmonisation between UN partners in Pakistan, under the chair of a powerful MP. This is an encouraging development. However, there is less cohesion evident between development cooperation agencies, in particular between development cooperation agencies and USAID; and very little evidence of co-ordination between NGOs.

While UN organisations undertake some advocacy they are limited, as partners of government, in their ability to apply public pressure on government. NGOs could be much more effective in pressurising government departments to deliver, but their lack of cohesion and, in the case of a few, their lack of credibility with local communities makes that unlikely. The White Ribbon Alliance is establishing a branch in Pakistan, and could undertake effective public advocacy. However the Alliance also works on the ‘supply’ side, and is therefore not the single-minded advocacy organisation that could lead a public campaign in Pakistan. PAIMAN undertakes advocacy in the ten districts it works in, but keeps that advocacy localised, while its director does not believe in the need for an over-arching, nationwide campaign to reduce maternal and child mortality rates.

A more promising network is that of the Women’s Political Schools, based at UNDP and the Ministry for Women’s Welfare. This project could be an effective vehicle for educating and communicating with a wide range of local opinion-formers and decision-makers. The project already has experience of training local politicians in gender-sensitisation, and could easily adapt and undertake advocacy work on MNCH. However, while the project would no doubt fulfil the educational role successfully, it is unlikely to be able to undertake a sophisticated advocacy role, which may require applying pressure on government; rebutting government arguments, and challenging government officials.

The 100,000-strong Lady Health Workers network could no doubt be supported and encouraged to undertake similar educational tasks on MNCH.

Very little work has been done with religious organisations in Pakistan. These have extensive networks, undertake welfare work and communicate directly with very large
numbers of people. However they would need assistance with briefing material, with clear messaging, and with educational tools.

It is clear that what is missing is one lead organisation, committed in a single-minded way to advocacy on MNCH; able to operate independently of government, and to exercise leadership by uniting other NGOs and organisations working on the issue. Above all it should be able to develop strong, culturally appropriate messages and actions that can be adapted and adopted by a range of other organisations already working on this issue. These could be used to mobilise public opinion, and to raise the expectations of women and their families for high standards of hygienic, skilled care in accessible clinics; for more women paramedics and for more beds for women in clinics and hospitals.

7.5  Advocacy opportunities over the next 1-3 years

7.5.1  Getting the message out

- While opportunities for advocacy in Pakistan are not limited to elections, nevertheless the forthcoming presidential and parliamentary elections due to take place, at the latest, in October 2007 are extremely important. There is little time now for the MNCH community to organise to apply pressure on parties preparing their election manifestos, but missing such an opportunity would be regrettable. All the likely presidential candidates, including ex-President Benazir Bhutto, currently based in London, should be targets of effective advocacy on this issue.

- In addition an effective advocacy campaign would ensure that Parliamentary candidates include reference to MNCH in their political manifestos, and that data on MMR and IMR in parliamentary districts are disaggregated and brought to the attention both of candidates, but also the voting public. An advocacy campaign aimed at women voters, encouraging them to vote for candidates that prioritised the delivery of hygienic and skilled health care to their districts, would help focus the minds of would-be parliamentarians.

- The celebration of Pakistan’s 60th year of independence from Britain on the 28th July 2007 should provide an opportunity for advocates to point to the lack of progress made in protecting the health of women and children over this period.

- Pakistan’s finance minister presents the annual budget in June each year. The build-up to Budget Day, in 2008, and the quarterly review meetings held thereafter, provide opportunities to advocates concerned about health spending, as well as under-spending, to highlight the issue of resources for MNCH in Pakistan.

- In 2009 Pakistan will hold local elections across the four provinces, with direct elections for councils and indirect elections for tehsils/towns and districts. These elections provide another opportunity to raise demand amongst voters for high standards of MNCH.
7.5.2 Processes for developing communication strategies at country level (including using local PR/Communications companies)

Communicating effectively with Pakistan’s population of over 164 million requires clearance of major linguistic and other hurdles (Box 6). Philologists estimate there are over 300 dialects and languages spoken and each is distinctly different from the other. The literacy rate is just 26%. However Pakistanis are great communicators as the explosion in mobile phone use indicates.

Pakistan’s national TV, Pakistan Broadcasting Corporation (PBC), has falling audience numbers according to some sources, but reaches a wide rural audience. From the reports of PAIMAN and others, PBC is willing to broadcast innovative programming and documentaries that use human stories to illuminate the tragedy of Pakistan’s MMR and IMR. GEO is a private channel, with an audience over 10 million every day, that broadcasts human-interest programmes, including ones directed at women.

An important medium, which one of our interviewees claimed may have helped a drop in maternal and child mortality, is the mobile phone. It was suggested that traditional birth attendants (TBA) could now use the mobile phone to check whether skilled healthcare workers were present at a clinic before sending pregnant mothers there, thus avoiding delays in care and wasted journeys. Mobile subscribers exceeded 61.1 million by May 2007, according to Pakistan Telecommunications Authority (PTA), and 2.7 million new subscribers are added monthly. In January 2007, PTA also reported over 12 million internet users.

President Pervez Musharraf began his rule by increasing freedom for the press and liberalising broadcasting. However, media rules were tightened this year, and, because of growing opposition to the President, programmes were taken off the air during our visit to Islamabad.

Journalists we interviewed believed that the overwhelming majority of Pakistanis ‘did not consider this (MNCH) an issue…in the recent Budget debate not a single Opposition member raised this issue in the chamber. …Politicians are not sensitized to it as an issue…’. This may, in part be due to lack of specialist journalists. One of our interviewees explained that the Pakistan media lacks capacity and few journalists specialize. “Everyone is interested in politics!” and clearly MNCH is not considered political. Very few know and understand social issues, health, education etc. Our interviewee had trained 112 journalists on behalf of PAIMAN – 28 of them women from the Urdu, Pashdu and Sindhi provinces of Pakistan. They took the journalists on a retreat, gave them technical workshops, took them on field trips to Basic Health Units and also provided them with statistics (although all our media interviewees were irritated by the inconsistency of data on maternal mortality which ranged from 350 to 700 per 100,000 per year).

One gynaecologist attended this training and during her lecture on the physiology of MNCH seven journalists walked out saying they were embarrassed. Despite this, it

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**Box 6: Languages in Pakistan**

- **Urdu**: Urdu is the national language of Pakistan. It is a mixture of Persian, Arabic and various local languages. It is similar to Hindi but written in Arabic script.
- **English**: Official language
- **Punjabi**: Mainly spoken in the province of Punjab
- **Sindhi**: Mainly spoken in the province of Sind
- **Pashtu**: Mainly spoken in North-West Frontier Province (NWFP)
- **Balochi**: Mainly spoken in the province of Baluchistan.
was considered that ‘the course produced excellent results. At a PAIMAN project in Jalum, the Daily Jang (big circulation national daily) wrote a negative story about a mother and the lack of newborn care in the hospital. A hospital administrator complained to the local politician, who then put pressure on the editor to sack the journalist Fortunately the editor refused’.

We asked about successful media campaigns; and the following were immediately mentioned:

- The Polio campaign which had nationwide coverage and brought in show business celebrities and high profile politicians, for example Bhutto applying polio drops to her child). Some religious leaders complained that these drops contained contraceptives and tried to bar them but these problems were overcome.

- The iodized salt campaign of UNICEF which increased consumption of the salt from 0% to 50-60%

- The Expanded Programme for Immunisation (EPI) However, it was noted that the ‘overplayed’ Polio campaign eclipsed the EPI programme, which was a serious problem: ‘The entire health sector was dragged into the polio campaign…while children could die if not given EPI’.

- A campaign for Ariel soap powder, based on a TV series in which an anchor interviewed people from all walks of life about their mothers. During the interviews the anchor asked sensitive questions about attachment etc. These interviews were described as very moving and apparently had the nation in tears, and gripped to the television for weeks!

We asked whether newspapers ran sustained campaigns on issues. Our interviewees said no, but thought it a good idea as it would provide continuity in stories, and keep readers interested – therefore retaining committed readers. It was suggested that the editor of the Lahore based Daily Times (Najam Sethi) might be interested in this idea.

Midas – an advertising agency working for the National AIDS Control Programme’s BCC component.
8. ORISSA

8.1 Levels of priority for MDGs 4 and 5

An increased priority to getting MDGs 4 and 5 on track is reflected in the Federal Government’s National Rural Health Mission (NRHM) which has, since 2005, had a strong emphasis on maternal and child health. The NRHM seeks to provide effective healthcare to rural populations throughout India, with a special focus on 18 states (including Orissa) which have weak public health indicators and poor infrastructure.

Despite the efforts of the NRHM, and other initiatives including Janani Suraksha Yojana (JSY), Integrated Management of Neonatal and Child Illnesses (IMNCI) and Navajyoti which have a specific remit to reduce maternal and child mortality, political commitment at State level is far weaker. For example infant and maternal mortality was not mentioned in the manifesto of Biju Janata Dal (BJD) - the regional party of Orissa, and there was concern among interviewees about the lack of political will, although it was felt that there is increasing recognition of the importance of MNCH: ‘Five years ago no one would have talked about MMR. They (government) are at a transition stage – their mindset is changing’.

The Chairperson of the State Women’s Commission undertook an advocacy campaign on safe motherhood in all districts in Orissa. This compounded her understanding of the gravity of the situation and she has now made it a mandate of the Commission to continue to address MDGs 4 and 5. Despite this example, the general lack of political concern about MDGs 4 and 5 among State politicians and bureaucrats was described as, at least in part, explaining the gap that exists between policy and implementation: ‘Making priorities is one thing, and delivering them is another. All the schemes and programmes have a political will in the country but delivery is only possible if there is a proper bureaucratic will to do it’.

UNICEF in Pakistan is working to achieve increased international commitment to MDGs 4 and 5. MDG 4 is reflected in UNICEF’s Master Plan of Operations for 2004-2007, signed between UNICEF and the Government of India, and funded by bi- and multi-lateral development cooperation agencies including DFID. In contrast, budget support for the Orissa Sector Health Plan, and other donor budget support means that MDGs 4 and 5 are not highlighted for priority as spending is initiated by government rather than development cooperation agencies.

The key advocacy challenges for Orissa are:

- Translating national commitment to MDGs 4 and 5 into a similar level of commitment at State level
- Encouraging advocacy for MDGs 4 and 5 to be viewed as constructive, rather than as ‘blame’ mechanism
- Channelling money for health into interventions that will impact on maternal, newborn and child mortality
8.2 Mapping Advocacy

8.2.1 Capacity, resources and entry points for advocacy

a) Capacity and resources

The overall view of advocacy capacity in Orissa was that although MNCH issues are given higher priority than in other states, there is a need to build civil society’s capacity in effective advocacy, and that existing networks need to be more innovative and radical in their activities.

Advocacy efforts are also hindered by lack of accurate and reliable data. The Sample Registration System (SRS) and National Family Health Survey (NFHS) are used by advocacy groups but District maternal mortality rates are not available. A representative of one of the multilateral development cooperation agencies said that as an advocacy professional he does not use the official statistics, he feels more comfortable using small case study data on infant mortality. He then ties this in with the poor infrastructure and poverty levels in rural areas. He felt that the key success in his work was ‘when the media reported on malnutrition deaths in a remote hill village.. The images were powerful … all the media travelled there, politicians too. As there was no road they, the ‘big shots’, slipped in the mud as they walked towards it (the village) … the images played a powerful role’.

Key NGOs

- The State Commission for Women has, as a result of partnering with UNICEF, an increased understanding of the importance of safe motherhood and is using advocacy, social mobilisation and public hearings (Box 7) involving District administration, stakeholders and beneficiaries as a way of generating increased demand to reduce maternal and newborn mortality rates in Orissa.

Relevant networks

- An essential network are the women’s groups arising out of the micro-finance movement:’ There are now almost 208,000 Women’s Self-Help Groups set up since 2001. – if you estimate that each group has a membership of about 10, that is 2,080,000 women’. One such micro-finance organisation is Bharat Integrated Social Welfare Agency (BISWA). BISWA is a relatively new, fast growing micro-finance company that currently has approximately 5,000 self help groups in the State.

Multilaterals

- UNICEF in conjunction with WRA, Nehru Yuva Kendra Sangathan, State Commission for Women
- UNFPA
b) Entry points/audiences to reach

Parliamentarians

- The Chief Minister of Orissa is trying to raise the profile of MNCH on the political agenda.
- The Minister of Health (who is from Orissa’s tribal districts) is concerned, but his influence is limited due to a) a lack of equivalent concern within the powerful civil service b) the post of Health Minister does not entitle him to a seat in the Cabinet of the Chief Minister; and c) the Health Budget is under spent, and appears to have been cut in real terms. There were several references to lack of accountability within the Orissa State bureaucracy.

NGOs

- Dr. Saraswati Swain of NIAHARD NGO has conducted many advocacy and research studies on maternal, new born and child health.
- The White Ribbon Alliance (WRA) is present in 30 districts in Orissa and works with more than 300 NGOs and CSOs on issues relating to safe motherhood.
- The WRA has also organised public hearings based on the findings of verbal autopsies into maternal deaths as a way of increasing public awareness of their rights to health care (Box 8). A number of these public meetings have resulted in health service providers being publicly censured for negligence and, on one occasion, a doctor was publicly arrested for accepting bribes. The WRA has also, in partnership with UNICEF, focused on policy centred advocacy and submitted a report on maternal health services to state politicians: ‘The Minister of Women and Child Development declared that the Collector of the District and the Chief District Medical Officer would be responsible for every child’s death’.
- Nehru Yuva Kendra Sangathan is an autonomous civil society organisation supported by the Ministry of Youth Affairs and Sport. This is the largest grass roots level youth organisation in the state. It has 500 district offices, 18 zonal offices and 47 regional offices all over India. In Orissa more than 8000 Mahila Mandalas (women’s groups) have been established. The regional offices in Sambalpur and Berhampur have partnered with UNICEF to engage in a Maternal Mortality Rate advocacy campaign which aims to build an informed and responsive cadre of youth advocates on safe motherhood in 15 districts.
- ASHA (‘The Hope’) which works in Dhenkanal and Keonjhar Districts is involved in small to medium scale advocacy for MNCH issues.

Box 8: White Ribbon Alliance Advocacy

‘In one district there were three maternal deaths in a fortnight. We organised the media and organised a campaign. We did a verbal autopsy questionnaire and invited one doctor, one media person and the District Coordinator of the WRA. We visited the three houses. Two of the maternal deaths could have been avoided if there had been a blood bank in the local health centre. Also the medical chief of the hospital agreed that there had been a sense of carelessness on the part of a doctor who carried out a caesarean section. This was made as a public statement’. ‘We organised a public meeting. As a result of this the doctor was suspended; and money was sanctioned by government and the Red Cross was requested to put a blood bank in the district medical hospital’. ‘The Panchayati Raj Institution leaders will also be involved (in advocacy), slowly, slowly we are moving up a level but we can’t expand the public enquiry system as we don’t have funds to scale up this activity’.
Media

Media coverage tends to be focused on major MNCH events, although a number of editors and reporters are sufficiently committed to MNCH to provide regular coverage of issues relating to both Oryan and tribal groups in the State.

Newspapers:
Dharitri – is already engaged in advocating for MNCH
Sambad – is currently advocating to reduce maternal mortality

TV:
- Doordarshan
- Asian News International (a TV news agency associated with Reuters)

c) Potential champions

- The Centre for Youth and Social Development (CYSD). CYSD is one of the largest civil society networks in the state and has undertaken highly effective advocacy on primary education, participatory governance, social accountability, the right to information and rural livelihoods. They are currently involved in campaigning around the MDGs generally through the Wada na Todo (Don’t Break Your Promises) campaign.
- The Sambalpur Integrated Development Institute (SIDI) has taken a rights based approach to advocacy for MNCH. SIDI works in the west of Orissa with tribal groups and is less high profile than CYSD.

The overall consensus of opinion was that there is a need for increased and coordinated advocacy, rather than the current small-scale, isolated and ad hoc advocacy campaigns. It was also felt that media coverage should be regular and more high profile. One interviewee summed the situation up when he said: ‘We need to sustain this process of advocacy, whether by development agencies, civil society or the government. A continuous process of engagement is required with politicians and media with much higher intensity. Therefore a need of advocacy is consideration of lessons learnt, and developing a strategy with more intensity and sustainability’.

Summary:

A wide range of stakeholders including government, civil society networks, statutory bodies and the media are engaged in advocacy for MNCH, but efforts are not coordinated.

There were concerns that donor agencies who work closely with government and the civil service are not in a position to undertake public advocacy which challenges the State government.

8.3 Analysis of Advocacy Messages

8.3.1 Making the case – using the evidence

Maternal health services are a broad barometer of the functioning of the entire health system. While formal evidence from Janani Surakshya Yojana (the maternal benefit
incentive scheme) indicates that ‘in two years we find institutional delivery has increased by 33% in the first year’, the majority of interviewees painted a picture of childbirth as dangerous and resulting in many more deaths than are reported: women who lose their lives as a result of pregnancy and childbirth in India are often invisible. Existing data and surveillance systems were viewed as inadequate although data drawn from government resources are used for existing advocacy efforts. These government sources include the SRS which reports infant mortality rates as 58 per 1,000 live births for India as a whole, and 77 per 1,000 live births for Orissa (2006). Another source of evidence is the NFHS. This reports the infant mortality rate as 65 per 1,000 live births for Orissa (2006). All interviewees who were engaged in field based research suggested that in tribal and rural areas maternal mortality rates were likely to be as much as double the official MMR rates for India. As one interviewee said: ‘You have to follow the official statistics but on the ground it’s very different. If you look at institutional delivery rates then you can see that MMR must be higher… In one village last year there were seven deliveries, only one was institutional, the other six were at home’.

8.3.2 What does and does not work

Framing messages:

At present advocacy in Orissa is undertaken by organisations working in isolation and there is a need for an integrated approach towards advocacy for MDGs 4 and 5. Advocacy is also on the whole low-key, and because so many organisations working in the field are dependent on either development cooperation agencies or government for funds, they are anxious about stirring up public debate or controversy. This means there is limited pressure on government and the bureaucracy to improve delivery of services.

Organisations such as UNICEF, the WRA, Nehru Yuva Kendra Sangathan, and the State Commission for Women have undertaken localised people-centred, policy and media advocacy, but for a limited period of time. This lack of a sustained advocacy process was reported by media interviewees as being a fundamental problem.

In terms of messages that work, it was thought (although no evidence currently exists to support this) by the majority of interviewees that focusing on women’s productive contribution to the household, and thus to the community and district, would be a constructive and powerful way to advocate for MDGs 4 and 5. They felt it was important to do this, because of prevailing negative attitudes towards women’s worth e.g. it was said that in remote villages the birth of a calf, with its ability to quickly generate revenues, would be of greater value to a community than the birth of child.

As in Pakistan it was viewed as essential to focus a campaign on increasing men’s concern about MNCH: ‘The care women get is a process which should start nine months before the birth. Not just on the day of delivery. You need to convince the husband, or her brother, or her eldest son, or the male that surrounds her life’.

The key lessons that had been learnt from previous advocacy campaigns were that plenty of time is needed to provide advocacy organisations with a full understanding of the issues surrounding MDGs 4 and 5; that a continuous process of intensive engagement is needed with politicians, policy makers and the media; that civil society should be enabled to challenge district functionaries and that the functionaries in turn should be convinced that they have an obligation to listen to civil society. Another
key lesson is that advocacy efforts will be challenged by the lack of accurate data; and that sustainable coordinated advocacy efforts require the investment of more time, energy and money than are available to most organisations.

8.3.3 Messages to resonate at different levels

The overriding message given to us in Orissa was that

- Women and children in remote tribal areas, in the forests and mountains, were hidden, forgotten, never counted and therefore overlooked by the state and district organisations responsible for health care.

Other messages included:

- ‘This is our responsibility’.
- Maternal and child deaths equivalent to an ‘airbus crashing into the sea’ or 10 bus crashes with 60 people in each
- ‘The Mother is the Soul ‘Matira Maa’…like the earth, giving food, water…without mother you are nothing…”
- “We can do it”
- “Mother’s safety is your responsibility” – aimed at the male.
- ‘Mother is the entire world’
- ‘Your support counts a lot’ – every single person is responsible

8.4 Analysis of advocacy processes

8.4.1 Building and sustaining advocacy partnerships

Stakeholders engaged in advocacy efforts come together during focussed campaigns but there is no permanent partnership for advocacy. This is, in part, due to competition among NGOs and CSOs as each compete for limited funds. A few existing networks are already established. The ones with the highest profile are the White Ribbon Alliance (WRA), and the Centre for Youth and Social Development (CYSD). The WRA is part of an international alliance and has a specific mandate to address maternal health. In Orissa its network includes an alliance of individuals, CSOs and development agencies working from panchayat through to national level. The WRA has undertaken focussed, high impact advocacy work which challenges local government at district level, and was viewed by a number of interviewees as a natural leader for a national advocacy campaign, for example: ‘Make them a front runner – they need to know what to deliver and at what level …. (But) they are already recognised. They have gained recognition because of their maternal mortality advocacy. They are willing to challenge the State’.
The CYSD is an established, highly experienced advocacy organisation focusing on education (Wada na Todo – Do Not Break Your Promises). They have also run a high impact advocacy campaign on the MDGs (Nine is Mine).

There is some potential for the development of an advocacy partnership between these two organisations, although CYSD are concerned that engagement in MNCH would dilute the effectiveness of their current work. However, there is some interest on the part of CYSD in becoming involved, perhaps through provision of technical assistance on the development and design of advocacy campaigns.

General challenges for advocacy in Orissa were seen to be sensitization of politicians, policy makers and civil society; and building a sense of urgency over the need to reduce maternal, newborn and child mortality and morbidity. Bearing this in mind, an initial partnership or alliance between the WRA and CYSD could be an effective approach. However, there is also a need to bring in civil society organisations, particularly the many thousand of Women’s Self Help Groups that currently exist in the State. These currently focus on women’s economic empowerment but are a potential way of increasing civil society demand for improved services. However, they are already burdened with a range of responsibilities, and would need considerable capacity building and financial support. This could be provided by the development of an independent, formal advocacy partnership.

8.5 Advocacy opportunities over the next 1-3 years

8.5.1 Getting the message out

Few interviewees were able to provide information on specific forthcoming opportunities for advocacy on MDGs 4 and 5. Most felt that increasing political commitment should be the key priority and, as such, advocacy efforts should be focussed towards politicians who will be involved in the 2009 national election, and local elections.

8.5.2 Processes for developing communication strategies at country level (including using local PR/ Communications companies)

In order for successful advocacy and communication packages to be developed a number of key issues need to be addressed:

- Generating within Government the same sense of urgency which is already being expressed by NGOs and individual journalists on maternal, newborn and child mortality.
- A coherent and culturally and politically compelling ‘vision’ for an advocacy strategy
- Linking advocacy results to programme results
- Building advocacy capacity
- Engaging sustained media interest in maternal, newborn and child mortality, and in non-performance of government in these areas.

The Centre for Youth and Social Development (CYSD) is a leading advocacy organisation in Orissa. Box 9 describes the way in which they develop advocacy strategies. One example of the impact of a thoroughly researched and coherently
structured advocacy campaign is the development by an NGO group of an Assembly Legislators forum which continually debates the issue of education. As a result various standing committees of the Assembly are discussing education’s share and allocation of the budget.

**Box 9: Stages of the ‘9 is Mine’ education campaign**

Stages of the 9 is Mine Campaign:

1) Primary research on the 'big picture'.
2) Identify a key issue emerging from 1) above.
3) Call a round-table discussion to address the key issue.
4) Media sensitisation.
5) At community level they used the right to information to help civil society challenge government by assisting them to decide what questions to ask, and who to ask, e.g. how many teachers are really recruited in the Panchyatt, and how many single-teacher schools are there?
6) They also trained village education committees, parent teacher associations etc., to ensure demand for accountability

N.B. Media sensitisation was a key challenge. Few press base their facts or stories on research, therefore stories are over-simplified and full of stereotypes. CYSD counted inch by inch column coverage on primary education, and also looked at the depth (quality) of coverage in the press. Then they presented it to editors. It was a highly sensitive meeting. Editors initially refuted CYSD’s findings, but then reached an overall agreement. CYSD did not address issues of bias of coverage. Editors were then given information on a basket of social development interventions: ‘slowly some articles started to appear’. Feature writers then began to engage in discussions and CYSD took responsibility for providing them with information. Some papers commissioned training for their district respondents and sub-editors. One paper has taken education up as a major issue.

No interviewees were able to suggest appropriate PR/communications companies in Orissa.
9. TANZANIA

9.1 Levels of priority for MDGs 4 and 5

The progress that Tanzania has made in reducing child mortality is evidence of the Government’s commitment to MDG 4, however, in contrast, the maternal mortality rate is perceived to be rising. The development of the Road Map for maternal and child health, which is included within the Poverty Reduction Strategy Paper (PRSP) is a major indicator of Government’s commitment to address this challenge, as is the government’s involvement in gender budgeting. Despite this concerns were expressed about the way in which policy commitment is translated into the budget: ‘We are concerned that it is not an evidence based strategy and certain key issues have not been adequately budgeted for. Policy commitment is not translated into the budget. Therefore it is important for the 21 partners in the basket to do internal advocacy with government. But you need a new set of skills to influence finance and budgeting – the agencies don’t necessarily have these skills’.

One interviewee expressed concern that ‘The health budget is going down. Nominally it is going up, but in relative terms it is declining’ and another was concerned about the reality of translating the Road Map from policy to implementation: ‘There is the Road Map in Tanzania but it’s massive and it’s not realistic that it will all be funded. It’s not clear how the priorities were set and how they will be measured... there are no systems in place. Implementation is a problem of the Road Map’.

Coupled with budgeting and systems issues, and similarly to Pakistan and Orissa, most interviewees were concerned that national commitment to MDGs 4 and 5 is not reflected at district level: ‘Decision makers at district level are important. Not enough is done at this level, and many are not aware of policies such as the PRSP’. This lack of commitment to MDGs 4 and 5 at district level was seen, in part, to stem from the lack of knowledge of district levels of maternal, newborn and child mortality: ‘Unfortunately at district level commitment is not as high as at national level because research is not shared with people at district level, and their capacity to do research for themselves is limited’. Another interviewee who has, for many years, been concerned with data quality issues described her frustration over poor data collection and lack of understanding:

‘In 2001 I tracked data in one district down to community level. I looked at maternal and child data and found it wasn’t put in the Comprehensive District Council Health Plan. I was quite amazed. They said ‘we didn’t see any deaths’. I said ‘you can’t say that because you are talking about institutional deliveries – you aren’t talking about communities’. What made me so sad was that the work plan goes from the District to the Region, who scrutinize it and then take it to the Ministry of Health, but no one spotted that problem – that maternal and child health wasn’t included in the work plan’.

The key advocacy challenges for Tanzania are:

- Raising the awareness of local government to MDGs 4 and 5
- Ensuring that reducing maternal mortality is given similar priority to reductions in child mortality
- Translating policy commitment into sector budgets
9.2 Mapping Advocacy

9.2.1 Capacity, resources and entry points for advocacy

a) Capacity and resources

Capacity to undertake advocacy work is relatively low due to lack of funds and specialist skills. However, there appeared to be more organisations involved in advocacy for MNCH in Tanzania than in Pakistan and Orissa. However, as with the other countries, their work was viewed as fragmented, needing greater coordination (Box 10), and there was little direct evidence of the impact of these advocacy campaigns.

Organisations which were viewed as having the capacity and credibility to lead a campaign were the Health Equity Group, and the Gender Network Programme (the latter is part of the SWAp technical committee).

Key NGOs

- White Ribbon Alliance (although concerns were expressed that they only have one full time employee and would therefore need to take on additional staff)
- Aga Khan Foundation
- Save the Children Fund
- Care International
- EngenderHealth (Box 11)
- JHPEIGO
- Family Care International
- Women’s Dignity Project (seen as very capable but not popular with Government)

b) Entry points/audiences to reach

Parliamentarians

- Ministry of Health
- Ministry of Finance
Government officials

- District Medical Officers
- Planning officers
- District commissioners
- Pharmacists
- Lab technicians
- Zonal RCH Coordinators
- District Councils
- Council Health Management Teams
- District Executive Directors
- District Development Officers
- National Bureau of Statistics

These rather generic lists of parliamentarians and government officials reflect attempts to stop maternal mortality being seen as a health sector issue. Interviewees were unanimous that there is a need to improve coordinated planning and budgeting processes: ‘We have an outcome based PRSP as a way of trying to move away from sectors… The Joint Assistance Strategy for Tanzania calls for division of labour among government (most Ministries have very weak capacity), therefore the structure is in place for bringing Ministries together but it doesn’t happen in practice’.

Civil society

Civil society was viewed as an important entry point for advocacy, but interviewees focused on the potential role of the civil society organisations described above, rather than discussing broader opportunities for engaging with civil society.

Media

Organisations with the greatest experience in undertaking advocacy emphasised the importance of media involvement as ‘people are thirsty for information in Tanzania, for stimulating and provocative information at local level’.

- TAMWA were viewed very highly
- Private media channels (no names supplied) were also considered more effective than public channels: ‘It is easier to work with the private than the public owned media houses because the former are more pro-active and eager to deliver. They are more driven and work hard and are more competent than the latter in ensuring that you get the quality product you need’.
Professional associations

- Tanzania Women’s Media Association (TAMWA)
- Tanzania Women Lawyers Association (TWLA)
- Tanzania Women Doctors Association, which was reported as having been particularly successful in mobilising resources, providing services and getting the ear of government and the private sector.
- The Tanzania Chapter of Eastern, Central and Southern African Obstetricians and Gynaecologists Society (ECSAOGS)
- The Tanzania Chapter of Eastern, Central and Southern African College of Nursing (ECSACON)

c) Potential champions

Interviewees had conflicting opinions about the type of ‘champion’ who would be able to generate interest in and commitment to MDGs 4 and 5. Some felt that the person should be highly influential. Others that ‘ordinary’ women would be more compelling. In terms of engaging in advocacy at different levels – both have an important role to play:

- Gertrude Mongela: ‘She has strong personal experiences to share…For this kind of campaign it is important for the person to give his/her own personal example. This is more important than their status of the individual’.
- The wife of the Prime Minister: ‘You need a woman who people can look up to, as opposed to someone who people relate to. Perhaps the wife of the Prime Minister’.
- Women from urban and rural communities: ‘Use the First Lady and the Prime Minister’s wife as Patrons. But as champions – let’s get in the ordinary champions. Find a couple of women who can talk and pull in crowds’.
- The President: ‘The president is very popular… So if you could get the President to support this, with a clear and simple message it could be very powerful. If he puts his mind to it he can make sure that health workers are accountable’.
- The private sector: ‘There is money in the private sector (about $25m per year) but they don’t know what to do or what the priorities are’.
- The Tanzania Association of Midwives: ‘They would be an important advocacy organisation if they were given the skills and information’.
- Mary Kisimba (legal rights advocacy).
- Family Care International (FCI): ‘They have done good work on the skilled birth initiative. They are very well respected. They are an international organisation but you could use them to support a national level organisation’.
- The Social Investment Coalition: ‘They are trying to set up a campaign to reduce Maternal Mortality Rates’.

Summary:

The key messages were that there is an urgent need for advocacy capacity to be increased, that advocacy efforts need to be coordinated, and that the lead organisation should have credibility with the government and a permanent presence in the country. There is a role for champions drawn from all sectors of society but their efforts should be directed at engaging and influencing different audiences.
9.3 Analysis of Advocacy Messages

9.3.1 Making the case – using the evidence

As in Pakistan and Orissa serious concerns were expressed about the accuracy of the official statistics on maternal, newborn and child mortality. One interviewee said ‘We have a starting point in the initial analysis done for the MDGs which gives a MMR of 578. They give a picture but not the real picture. However, it points people in the direction that things are not good. In some places people are saying MMR is 1,400 but you have to use the best data that is available to you’. Another interviewee pointed out the existing gaps in both the system, and in the HMIS tool which is currently used to collect data: ‘The DHS is missing some important questions. You will never see data for the newborn. The Road Map focuses on newborn and maternal mortality – but we don't have that data’.

The main reasons for the inaccuracy of the data revolve around unrecorded maternal and neonatal deaths. One interviewee who had recently undertaken field based research described the situation: ‘Our big data problem is at health facility level. Most are manned by unskilled personnel. In Lindi maternal and child mortality is high. We asked to see the registers but the health worker told us ‘I am not registering anything’. This is because most untrained health workers don't think that data collection is important. In Lindi we found in charge someone who has never been trained (how does she do dosage?). The real MMR is probably nearer 1,000 because we are not getting any true data in rural areas where maternal death is considered ‘a normal thing’.

Work is underway with the National Bureau of Statistics to see if the 2012 census can be used to investigate maternal mortality and whether there are ways, other than through the DHS which is regarded as unreliable, to routinely collect data which could be disaggregated by district or by women’s age. WHO is also trying to develop a framework for tracking MDGs 4 & 5 but the Government is reported not to be receptive to a system which would replace the current HMIS. Overall, however, the majority of interviewees were less concerned about which data collection system was used so long as it was accurate, did not increase health workers’ work loads, could be disaggregated to show regional variations, and progress against agreed indicators.

9.3.2 What does and does not work

Framing messages:

Basing advocacy messages on international comparative data was not felt to be an effective basis for a campaign: ‘You have to bring the data to your own situation...People talk globally but we need to take the data down to the ground. To make it appropriate you have to talk about things that are specific to village level’. However, it was felt that international comparisons could be effective as ‘a variation of public shaming. Point out the disparities between rich and poor countries. We have a moral responsibility to do something’ but that any message must be linked to a ‘change that is doable and can be delivered. Messages must show what will be done, how it will be done, how it will be measured and then must report back. But don't promise too much’.
Interviewees felt that a more effective use of comparative data would be to draw comparisons between districts at national level: ‘Giving comparisons between Africa and Europe doesn’t really click… what would work better is comparing mortality rates between districts’.

One NGO representative also inserted a note of caution regarding global campaigns in the absence of accurate data, effective implementation systems, and measurable indicators (Box 12)

High level political engagement was felt to be essential: ‘In Africa until Presidents stood up to declare HIV a national disaster things had not happened. As soon as they did this things started to happen. But I have not heard an African president say ‘our women are dying, we must stop it’. However, if the Prime Minister of the UK could get President Kikwete and other African presidents to say ‘our women are dying – and we must to stop it’ this is quite an advocacy stance by itself and could move mountains!’.

Box 12: Concern about global advocacy initiatives

‘Regarding global leadership level, in the long run I’m a bit wary of what impact this will have a national and household level. The Jubilee 2000 campaign was remarkable in its impact but I would almost rather not have a global campaign if it’s about messaging rather than something that commits on the ground. Safe Motherhood hasn’t improved anything in 20 years. Jubilee 2000 was the exception in terms of the long term commitment it generated, and it resulted in something demonstrable and measurable - writing off of debt. I’m all for effective global, media and PR campaigns but only if it has concrete, tangible, measurables, and someone is held accountable. Globally if DFID and NORAD are pushing this then they should be obligated to put in place tracking measures at the highest level, perhaps this could be through an international ombudsman of women dying. BUT they must set out how the media hype will translate and be measured both upwards and downwards in terms of its impact. If the point is to create change on the ground, then national measures will also need to feed up and down into District and International tracking. What are we asking people to be concerned about? What change are we trying to generate? How can it be measured and who is accountable? These are essential questions for which there must be answers’.

Other interviewees, however, thought it more important to focus on initiating concern and action among men at community level: ‘Men know the problems they will have to face to raise the family without the mother. This is actually what touches them most. The shifting of the wife's responsibility to the man”.

It was also felt that a successful campaign should also focus on motivating health professionals, alongside practical improvements in their working conditions: ‘The working environment is a major problem. Health professionals need to be motivated in terms of money, and improved working conditions. They feel they are being discriminated against…If the media could highlight positive examples of good health care then this might also help encourage them’.

Theoretical and practical examples were given of small scale advocacy initiatives that had been, or could be, effective:

‘For me strong vertical initiatives can work, and the time has come for a stand alone initiative on MNCH. For such initiative to succeed, it needs to be propped on three major pillars: political will across the country; local and international resource support; and strong community mobilization’.

‘They say the Dead Mothers Don't Cry video is very powerful. The first time the MPs saw it they cried. One had just lost his wife. He was the one who stood up in parliament and spoke about it’.
Two NGOs described the need for a global advocacy campaign to address the issue of maternal morbidity as well as maternal mortality:

‘Morbidity is very important. You want to see the women as survivors not victims... Dead women can’t talk, therefore, you have to have the survivors’ stories’.

‘It is very important to include morbidity. If the campaign can do this, then that would be a major achievement’.

Despite the, albeit few, examples of successful campaigns, or models for advocacy, there was concern about the lack of evidence of their impact – with the exception of the campaigns organised by Haki Elimu (an NGO focussing on education issues). Haki Elimu was repeatedly suggested as an organisation which others could learn from. Their Director’s views on the key factors needed for a successful campaign against maternal, newborn and child mortality are set out in Box 13 below.
Box 13: Haki Elimu advocacy experience

‘Part of the challenge is not to lose focus on those two MDGs while also having to say something rather unsexy about public health. An important element is accountability and getting money to the right place. In education we have a rather unusual and elegant scheme which is the Capitation Grant. There hasn’t been anything like that in health and we need it. Health’s more problematic as it’s episodic, but we need it. You could do a ‘minimum health care package’. If we could agree on what that is then you could link both global attention to it, and national action. It should be about districts getting the package and delivering it. We need to give guarantees of quality of care to our population at all facility levels’.

Monitoring and evaluation: ‘People get away with very little. We have made progress in education as one could palpably talk about shortfalls and what needs to be done. Evaluations in health have allowed us to get off the hook. The Ministry of Health exert inordinate influence and there’s pressure on Development Corporation Agencies to look good. The evaluations should be truly independent and not have the name of the government on them. The campaign must break through the current false dichotomy of buildings and health care staff. When you go to a health centre you want credible care services from credible and competent health care providers, it’s not the building that’s important. If you can’t work on improving both buildings and human resources then it makes more sense to focus more on improving the quality of health workers’.

Campaigns: ‘Media is everything. I’m not a big fan for organising public marches. If you think of the amount of time needed to arrange them, one may need to re-consider because the transaction costs are far too high. An effective campaign under this initiative is likely to be more successful if it focuses on effective use of radio, TV, and to a lesser extent on newspapers. It is expensive but effective and at times it can be made cheap. Get a smart advertising company to give you pro bono time e.g. ScanAd - who have an office here. They are an affiliate of McCann Advertising Company in Nairobi which already has links with the Global Fund and various UN initiatives’.

‘The campaign could take advantage these (pro bono) ads with specifically designed 30 second radio and TV spots which could make a lot of difference. If the campaign is going to take the global or regional approach, then you could do what Celtel and Vodacom do. Have spots that can be dubbed in various languages and adopted to the different countries in much of southern Africa. Doing country specific spots could be quite expensive. Further, there are big TV news stations e.g. BBC, CNN, Sky and Al Jazeera which have lots of breaks between programmes where they don’t do adverts, but preview their own shows and services – fillers. One might take advantage of striking a deal with these stations to slot in some ads. CARE International and the UN Food Programme, for example, have done such deals with CNN, where they are provided with slots in this ‘filler’ time. The advantage of this kind of campaign is that you can also strike quite some good deals with national TV. This is where the clout of Gordon Brown and the Tanzanian Finance Minister comes in. You could persuade the TV stations that they won’t lose revenue and it’s a win-win situation for them. They don’t lose any money and they are seen to be part of the campaign. Piggy-back on existing programmes and talk shows. The very powerful ones are not those with talking heads, but those that show the reality of the situation (by clips of film or outside broadcasts) and then discuss it. Have a 3 way partnership between media, government and civil society. Santiawaku programme on Government TV is a good example. They go out to a village every week. In the morning the community discusses the issues it would like to ask Government officials, and then in the afternoon the questions are put to the Government. People are happy to keep appearing because the lure of publicity is so great for politicians, and also sometimes there are good reasons why something hasn’t been done – and they are able to explain this’.

Campaign materials: ‘It is essential that materials are interesting. Don’t involve development health type communications companies. Use creative agencies instead. The messages mustn’t be preachy or too over dramatic, which is what the development health type agencies tend to produce. They create concern but also paralyse their audience. It is good to use humour as well – we have found that you can get over very provocative messages in this way better than you could otherwise by using cartoons. The main thing to aim for is that even if you don’t give a damn about the issue, it’s so interesting that you’ll talk about it with your friends. You need to wake people up – and then go to what can be done, and make it doable.'
9.3.3 Messages to resonate at different levels

The messages emerging from Tanzania were similar to those suggested in Pakistan and Orissa. The only exception was that interviewees put greater emphasis on showing women as survivors, and linking messages to interventions that are clearly measurable and have clear lines of accountability:

- ‘Put the woman as the centre of the family – to portray the mother as the centre of attention. Children without a mother – it’s a major problem’.

- The campaign should focus on the deaths of mothers: ‘Most men may not as seriously be moved when an infant dies, as they would to a death of the mother. Men would, for example, say…if a child dies, I can get another one. But it is harder to get another wife’.

- ‘It (MMR) was 529 and is now 578 – our mothers, our sisters, our wives are dying. The increase in MMR makes them very angry – it makes them sit up and listen’.

- ‘We have to talk of the death of our aunties and our sisters. We have to talk of what happens to a family when a mother dies and the father has to look after the family – we must show the impact’.

- ‘Advocate for low cost, high impact interventions at the community level such as child survival services including keeping the baby warm, immediate breast feeding etc. Such simple, simple interventions. But also try to look at the continuum of care for the mother and child including post-partum services’.

- ‘Demanding for their rights, that would be a very strong thing – to say ‘look these things should not happen’’.

- ‘The key advocacy messages and anchors for an international advocacy campaign to hang its work on is the human resource crisis and EMOC availability’.

- ‘The campaign package should be that women and children have effective access to quality services to save their lives. The campaign should not go bigger than that’.

- ‘You need to synthesise and simplify information, for example by saying that one woman dies every minute, and then link it to the economic aspect. If a woman dies then she cannot do economic activities or raise her children, therefore you’ve destroyed the household, the village and the community’

- ‘These women have given birth to presidents, they’ve made us who we are. How much do cotton wool and gloves cost?’.

- ‘When you see a pregnant woman you don’t say ‘congratulations’. You say ‘pole’ (sorry)’.
9.4 Analysis of advocacy processes

9.4.1 Building and sustaining advocacy partnerships

As the venue for the Partners’ Forum on maternal, newborn and child health, Tanzania has a lead start over many countries in terms of opportunities to build and sustain advocacy partnerships. Existing networks such as the Health Equity Group and the Tanzania Gender Networking Programme are strong and active. The progress that Tanzania has made in reducing levels of child mortality means that it has been hailed as ‘the shining star of Africa’. All these factors amount to strong potential for undertaking influential and sustained advocacy on maternal and newborn mortality. The greatest challenge, however, appears to be building on the strong links between the existing networks to form a cohesive partnership advocating with one voice under a single coherent ‘banner’ message.

The lead advocacy organisation in Tanzania (Haki Elimu) described a way in which advocacy could be undertaken in order to more widely engage public opinion and exert pressure on policy makers and parliamentarians:

<table>
<thead>
<tr>
<th>1) Existing linear structure of advocacy:</th>
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</thead>
<tbody>
<tr>
<td>Data ➔ Reports ➔ Campaign ➔ Policy decisions</td>
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</table>

<table>
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<tr>
<th>2) Fluid structure of demand based advocacy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data + reports ➔ Campaign ➔ Policy decisions</td>
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<tr>
<td></td>
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<tr>
<td>Reaching the public through the media ➔ ‘Real’ debate i.e. debate which is self-generated among editors, commissioning features and the public writing letters to newspapers ➔ (public pressure)</td>
</tr>
</tbody>
</table>

For this to be achieved the existing networks need to engage more consistently with media networks such as TAMWA in the development of direct, hard-hitting and sustained campaigns which capture, and compel, both the public and parliamentarians to engage in reduction of maternal and newborn mortality.

9.5 Advocacy opportunities over the next 1-3 years

9.5.1 Getting the message out

- The Norwegian Prime Minister’s visit in autumn of 2007
- In September there will be a big Family planning event run by Engender. This will be high level advocacy opportunity for the initiative.
- International women’s day.
Global Business Plan for Millennium Development Goals 4 & 5
Advocacy Plan Phase I: Research and Mapping

- GBV day in October
- Day of the African Child (June)
- Annual gender festival (11\textsuperscript{th} – 14\textsuperscript{th} Sept) – there are national and international participants attending (in 2005 there were >10,000 people attending). The main workshop is on maternal mortality.

9.5.2 Processes for developing communication strategies at country level (including using local PR/Communications companies)

Communications companies who are developmentally oriented but also very creative, and known to be excellent:

ScanAd - who have an office in Dar es Salaam. They are an affiliate of McCann Advertising Company in Nairobi which already has links with the Global Fund and various UN initiatives.

Matatizo Multimedia Production Company
PO Box 38019, DSM
matatizo@raha.com
Tel 0754567110
(David Kyungu)

Compass Communication Company
mariast@compass-tz.com
(Maria Sarungy?)

Real 2 Reel Film Production
PO Box 105927, DSM
creat@real2reel.org
0784273283
(Phil Reader)

Real 2 Reel has done the most successful advertisement ever for Hakielimu. It is a series of parallel stories following a rich child and a poor child’s experiences of education.
10. ADDITIONAL OPPORTUNITIES FOR ADVOCACY OVER THE NEXT 1-3 YEARS

10.1 Europe

The UK’s position in Europe could be used to mobilise engagement of other European development cooperation agencies on MDGs 4 and 5, through European launches of the Global Business Plan. For example:

- **4th Session of the Council of Europe meeting:** first week of October 2007 - contact Christine McCafferty MP (Labour) who chairs the All Party Parliamentary Group on Sexual and Reproductive Health and Rights, and is also the UK delegate to the Council of Europe. mccaffertyc@parliament.uk
- **European Parliamentary Forum on Population and Development:** contact mccaffertyc@parliament.uk

10.2 Global

In addition to the launches of the Global Business Plan and the UK ‘International Health Partnership Initiative’ in September 2007, a number of other highly related global initiatives and campaigns are on the event horizon. It is crucial that any global advocacy campaign for the Global Business Plan dovetails with these initiatives – to avoid duplication of efforts and to speak with one voice.

- **‘Countdown to 2015’** launch of report, September 2007, New York - an accountability mechanism established in 2005 that grew out of *The Lancet Child Survival and Neonatal Survival Series*, originally just for the child survival goal. The 2007 conference will track progress for MDGs 4 and 5 together, since maternal and child deaths have similar underlying causes and connected solutions. Countdown will focus on tracking progress in the 60 countries with the highest levels of mortality.\(^{47}\) [http://www.childsurvivalcountdown.com](http://www.childsurvivalcountdown.com)
- **‘Women Deliver’ conference**, 18-20 October 2007, London – organised by a partnership of UN agencies, bilateral organisations and NGOs, to mark 20 years since the launch of the Safe Motherhood Initiative. [http://www.womendeliver.org](http://www.womendeliver.org)
- **Reducing maternal mortality as a human rights imperative**... initiative by the UN Special Rapporteur on the right to the highest attainable standard of health, together with Center for Reproductive Rights, Averting Maternal Death and Disability Program, Colombia University, Family Care International, CARE and Physicians for Human Rights, to be launched at ‘Women Deliver’ conference in October 2007.
- **Amnesty International’s Global Campaign for Human Dignity**, 2008 – to focus on poverty and human rights with a key theme to be the impact of the denial of human dignity on people’s health and home. Specifically, the campaign will focus on maternal mortality and on HIV/AIDS and human rights.

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\(^{47}\) *Countdown to 2015: will the Millennium Development Goal for child survival be met?* Joy E Lawn, Anthony Costello, Charles Mwansambo and David Osrin. Arch. Dis. Child. 2007; 92; 551-556. [http://adc.bmj.com/cgi/content/full/92/6/551](http://adc.bmj.com/cgi/content/full/92/6/551)
Global Business Plan for Millennium Development Goals 4 & 5  
Advocacy Plan Phase I: Research and Mapping


- *International Confederation of Midwives conference, 2008 in Glasgow* – to be hosted by the Royal College of Midwives. Would welcome closer cooperation with the Partnership on Maternal Newborn and Child Health to make the Partnership more real to members. Contact Frances Day-Stirk: frances.day-stirk@rcm.org.uk
11. CONCLUSION AND RECOMMENDATIONS

11.1 Conclusion:

Within a short timeframe, this assignment enabled the views of a small but wide ranging sample of opinion-formers and decision-makers in both developing and industrialised countries to be collected and analysed.

A recurring message from the majority of interviewees was that there is an urgent need for further action to reduce maternal, newborn and child deaths, and that powerful advocacy is an important key to achieving this. However, current advocacy efforts are not having the impact that they should due to the need for a leadership organisation; a ‘banner’ behind which to mobilise; focussed and clear framing of messaging; and carefully marshalled and often repeated arguments. These challenges are compounded by insufficient funding, low levels of capacity and lack of coordination at a local or national level. A constant theme present in the interviews was that ‘something needs to be done now!’; and that ‘it can’t be business as usual’.

A range of messages and ‘political opportunities’ are identified in the report, at both global and national level that provide valuable leads and hooks for advocacy in the future. The messages that the campaign uses in the future, however, will be influenced by who, or which organisation, will send the message. Messages from government often carry different weight from those delivered by, for example, NGOs or UN organisations. UN organisations, working closely with governments may be limited in the extent to which they can publicly hold governments to account in their messaging. Independent NGOs, however, may be in a position to be more challenging in their messaging.

In other words messaging will vary depending on which organisation is making the case for improved MNCH. The nature of the organisation will determine both the content and the impact of the message.

11.1.1 Framework for messaging

The need to reduce maternal, newborn and child mortality was universally accepted by all interviewees but, other than the often used phrase ‘save mothers and babies – now!’; all struggled to envisage or describe a potential overarching frame for messaging. This is linked to the complexity of the issues underlying maternal, newborn and child mortality (as described in Section 2 - Background). In this report we suggest three potential frames for advocacy: 1) the equity argument (i.e. it is inequitable that deaths are so heavily concentrated in developing countries; 2) the economic argument (i.e. the loss of human capital and potential; and 3) the continuum of care frame (i.e. as an approach to guide technical interventions). Our interviewees suggested that it is not an either/or situation and that each of these messages should be utilised within the campaign – but for different purposes, and with specific audiences in mind. Fig. 5 is a simplified schematic illustration of the ways in which the three messaging frameworks could work together. Examples of the ways in which previous campaigns have successfully used social mobilization, political advocacy and communication activities are provided in Boxes 14 and 15 in Section 11.1.2 ‘Lessons Learnt’).
11.1.2 Lessons learned on the MNCH advocacy process

One thing that is clear is that it is essential to awaken awareness to the scale of maternal, newborn and child deaths. Many of the messages that are currently used by MNCH advocates carry a tone of hopelessness. It is strongly suggested that the advocacy campaign should complement these with messages that give a sense of outrage; but also provide positive and uplifting information, showing that interventions can, and do, work.

Other lessons learnt are that small scale advocacy campaigns can be effective in raising awareness and initiating change at local levels, for example the work of the WRA in Orissa (Box 8, page 59). However, none of the MNCH advocacy work that we encountered could be described as having achieved long-term, sustainable change. This is not a criticism of the campaigns themselves but reflects the absence of national and international leadership, problems in funding, resource capacity (human and material), and multiple demands on staff time. If the GBP provides such leadership, then it will be timely and appropriate, especially if it takes a strong consultative and partnership approach with on-the-ground advocates and stakeholders.

Lessons learnt also include those from non-MNCH advocacy. For example, UNICEF’s polio campaign in Pakistan (Section 7.3.2, page 51) shows a potential down-side of highly successful campaigns – in that demand can outstrip supply and attention can be drawn away from, what should be, complementary programmes. A number of interviewees in all countries were concerned that if the GBP advocacy campaign is successful then it would also result in creating levels of demand that could not be met by the current level of health services. While this is a possibility it is not a justifiable reason for inaction. It does, however, highlight the need for the GBP to consider carefully a) what it campaigns for; b) what messages are targeted at which audiences; c) the need to for high level political advocacy to Governments to include recognition of the need for policies and resources aimed at strengthening health systems and increasing the numbers of health workers and midwives (and providing them with sufficient structural support to work in an enabling environment e.g. provision of housing, incentives etc); and d) working closely with country-based civil society organisations and stakeholders to amplify messages and optimise utilisation and efficiency of existing resources.
Two non-MNCH advocacy campaigns offer useful lessons for the GBP. These are the work undertaken by HakiElimu of Tanzania (Box 13 page 72) and CYSD in Orissa (Box 9, page 64). CYSD’s three year ‘9 is Mine’ campaign, in particular, demonstrates the use of social mobilisation, political advocacy, and communication approaches in order to achieve a clearly defined target - 9% of GDP to be spent on primary education and health at national level (Box 14). Their ‘Right to Information’ campaign shows in more detail the way in which a range of communication activities can be used successfully (Box 15).

<table>
<thead>
<tr>
<th>Box 14: The ‘9 is Mine’ Campaign (CYSD)</th>
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<tbody>
<tr>
<td><strong>Activities (in chronological order)</strong></td>
</tr>
<tr>
<td>Undertook primary research on education at national level</td>
</tr>
<tr>
<td>Discussions held with Prime Minister</td>
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<tr>
<td>Alliance formed with Teachers Union to build consensus and instil a sense of accountability</td>
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<tr>
<td>Worked with selected local NGOs to help them understand the bigger (national) picture</td>
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<tr>
<td>Set up ‘Education Watch’ (a citizen watchdog group). Round table discussions held on specific issues</td>
</tr>
<tr>
<td>Undertook primary research on past and existing media coverage of education (looked at column inches, and content and quality of coverage)</td>
</tr>
<tr>
<td>Presented the findings to newspaper editors</td>
</tr>
<tr>
<td>Provided newspaper editors with information on a basket of social development interventions including interventions: ‘slowly articles started to appear’.</td>
</tr>
<tr>
<td>Engaged feature writers in discussion and provided training to district respondents and sub-editors</td>
</tr>
<tr>
<td>NGO group built up an assembly legislators’ forum to engage in continuous discussion on education e.g. share and allocation of budget</td>
</tr>
<tr>
<td>Used the right to information to educate citizens at community level about what questions to ask, how to ask them, and who to ask e.g. how many teachers are really recruited in the Panchyatt? How many single-teacher schools are there?</td>
</tr>
<tr>
<td>Trained NGOs to provide this civic education at community level</td>
</tr>
<tr>
<td>Trained village education committees; parent teacher associations etc. to ensure community-based demands for accountability</td>
</tr>
</tbody>
</table>
In terms of resourcing advocacy, several UK-based advocates highlighted the lack of funding available for advocacy initiatives on MDGs 4 and 5. Advocacy requires dedicated resources and can be very cost-effective, yet this is not necessarily recognised by development cooperation agencies. DFID’s AIDS and Reproductive Health Team is developing a new central Advocacy Fund for advocacy on MNCH and SRHR. However, DFID acknowledges that this pot will be very limited (£250,000). DFID’s Civil Society Challenge Fund has supported project-based advocacy initiatives, and the new Governance and Transparency Fund presents a new, but untested, funding opportunity. One way that DFID could further institutionalise its support to advocacy for MDGs 4 and 5 would be to specify the contribution to achieving MDGs 4 and 5 as criteria for its Programme Partnership Agreements.

There is also an urgent need for more in-country resources to build advocacy capacity in developing countries. This requires a mix of aid instruments, to include financing mechanisms that channel donor funds direct to civil society groups – as a complement to budget support to government. For example, DFID’s country-level Programme Partnership Agreements supported Haki Elimu campaign in Tanzania.
Specialist support and strengthening of advocacy skills is needed within developing countries. This could be achieved by linking advocacy specialists (from global through to community based advocacy) with country-based organisations and individuals. These could be drawn from NGOs, the media, parliamentarians and professional organisations.

We found strong individuals working to reduce maternal, newborn and child mortality in the developing countries, however, there is a need for a strong guiding institution to take on the role of effective leadership and coalesce the network of concerned individuals.

There is also a need for a clear and strong externally resonating frame, in other words ‘a public positioning of the issue that inspires external audiences, especially political leaders who control resources, to act’.

11.2 Recommendations

Our recommendations arise directly from this research. They represent ideas generated when discussing prospects for advocacy with an extraordinary, if limited and selective, range of interviewees.

i) Generating a sense of urgency

The sense of urgency expressed by NGO, CSO donor and media interviewees, particularly in the developing countries reflects the need for the GBP’s global campaign to take the lead in advocacy on MDGs 4 and 5 in order to instil similar awareness of the need to reduce maternal, newborn and child mortality amongst wider national and international audiences.

ii) The presentation of data

The first of our recommendations relate to data. The tragedy of morbidity and death rates amongst women, newborns and children has for professional reasons been ‘sliced and diced’ to reflect various professional specialisms – in maternal, newborn and child health care. This has meant that numbers used in global and local advocacy have been scattered between these categories, when in reality morbidity and death rates of pregnant women, mothers, newborns and children are very closely linked – and amount to very significant numbers. In addition, as noted earlier in this report, stillborns, including those stillborn at term, are not included in mortality rates. Integrating these numbers, and repeating them consistently in a disciplined manner, will draw attention to the scale of the tragedy affecting mothers and their children; and might go some way to uniting the disparate groups working on these issues.

Interviewees encouraged us to ensure that both the mother and child are grouped together for advocacy purposes; that advocacy too is ‘integrated’.

We recommend therefore, that for effective advocacy purposes:

- professional divisions are downplayed, and the morbidity and mortality rates for women and their children, including stillborns, are grouped together, and used collectively and consistently. In other words, the ‘external resonating

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48 “Generating Global Political Priority For Maternal Mortality Reduction” Shiffman & Smith, 2007
frame’ called for by Jeremy Shiffman, should not reflect divisions specific and internal to professional organisations.

- There should be a particular emphasis on the very high morbidity rates (300 million women? WHO) who have survived the trauma of childbirth, but suffer mental and physical disabilities; and on the weak health outcomes of children that are deprived of adequate health care and nutrition in the early days, months and years of their lives.

These very large numbers can then be used to frame the debate in terms of the following:

- The injustice of the drastically reduced life chances of women and children in poor countries.
- The injustice of the increased lifetime risk facing mothers and children compared to the reduced risk in some other comparable poor countries (perhaps Bangladesh, for example); and to the almost non-existent risk facing women and children in rich countries. For example, the message could be: “in India one woman dies every seven minutes in childbirth. In Switzerland (for example) one woman dies every 5 (8?) years in childbirth.”
- The contrast between mortality and morbidity rates for this group - women, mothers and children – and that of other high-profile diseases.
- The acute personal loss and suffering endured by women, their orphans, children, husbands and parents - as a result of mortality and morbidity rates at or around childbirth. Viewed from the perspective of those left behind, the tragedy of maternal or child mortality is heightened.
- The economic wastage of lives damaged by a condition, childbirth, that need not be life-threatening. Healthy mothers (with access to contraception) and their educated children make significant and productive contributions to any economy and society.
- Society should be reminded that the future existence of humanity depends on the survival of mothers and babies at birth.

While these ideas emerged from the discussions with interviewees, we do not believe that they yet represent the strong ‘external resonating frame’ required to mobilise society and to apply pressure on governments for changes and improvements in policies.

iii) ‘A strong guiding institution’.

In the developing countries we visited, the absence of reliable, credible data on MNCH at district, national and regional level was a recurring concern. Such data is fundamental and underpins effective advocacy. In all three countries there was controversy over data – particularly data on maternal mortality, and data on MMR and IMR in remote, rural areas.50

As Jeremy Shiffman and others have noted, advocacy on MNCH is hindered by the absence of what Shiffman calls a ‘strong guiding institution’ at international level.51 It

49 “Generating global political priority for maternal mortality reduction.” Jeremy Shiffman and Stephanie Smith. The Maxwell School of Syracuse University, June, 2007
50 As described earlier in the report Our visit to Pakistan coincided with the publication of new, and more reliable data on maternal mortality, which implied that earlier data had been much exaggerated. The new numbers implied in turn that good progress is being made – something challenged by nearly all our interviewees. Because initial data wrongly overstated maternal mortality rates, campaigners and advocates in Pakistan are now hobbled in their efforts to apply further pressure on government to make meaningful progress on this MDG goal.
51 As above.
became clear to us that such an institution, to be effective, would have to be independent of governments in both developing and donor countries. Development cooperation agencies have of necessity to work closely with recipient governments; and the UN representatives we met were, for all the best reasons, closely tied to governments. However, if pressure is to be mounted on national and state governments to achieve the MDG goals, then, neither development cooperation agencies nor UN organisations are in a position to apply such public pressure.

We note that while there are a plethora of agencies gathering and disseminating data on children; and while there exist a range of prestigious institutes gathering population data, there is, to our knowledge, no international research institute that focuses exclusive attention on women in their role as mothers, and as carers of vulnerable infants and children. There is no ‘Research Institute for the Woman and her Child’. To draw global attention to the plight worldwide of pregnant women, mothers and their babies, we recommend the establishment of an international research institute – a Research Institute for the Woman and her Child for collecting MNCH data, with branches in countries with high MMR and IMR rates.

It may not of course be necessary to establish a ‘new’ institute. Instead development cooperation agencies might wish to consider establishing a well-funded, independent ‘Collaborative Forum for the Woman and her Child’. Vinod Paul has suggested that it may be a good idea to look at the ‘Countdown 2015’ Initiative and build on it. We would only stress that the naming of such a Forum or Institute and its work, should not be abstract, should not focus on the professionals within the institution, but on the mothers and children outside that are the focus of their work. There should be explicit reference in the name of the institution to the ‘woman and her child’.

The institute or forum’s mission should be to gather accurate, regional, national and district-level data, with a commitment to collecting data in remote areas. The institute should then ensure that the data is assembled, disseminated and deployed in such a way as to support and promote effective advocacy.

iv) Donor advocacy

Development cooperation agencies, including UN organisations, working closely with recipient governments (‘the supply side’), will need to undertake advocacy that is sophisticated, sensitive to local autonomy, low-key, and aimed at a range of constituencies within developing country governments. We suggest that target groups for advocacy must extend beyond the health ministry to include politicians and civil servants within the finance ministry; the education ministry; and ministries for population welfare. Encouraging greater co-ordination between these ministries to promote family planning and achieve reductions in maternal, newborn and child mortality, should be one goal of donor advocacy.

Greater co-ordination between development cooperation agencies in these countries would also strengthen advocacy for MDGs 4 and 5.

v) Developing country advocacy

Advocacy should not be driven by development cooperation agencies alone. It also needs to be led from within developing countries and so local, independent champions of MNCH must be given support. These will include local opinion-formers
like faith groups, prominent journalists, NGO representatives but also elected politicians. We particularly recommend that development cooperation agencies engage directly with parliamentarians as these can, and almost certainly will, undertake advocacy on the issues they perceive important for their local constituency. They are also able to apply pressure on government ministers and civil servants. (The perception of interviewees was that development cooperation agencies often by-pass parliamentarians and deal directly with civil servants.)

vi) Children as advocates: school curricula

Children are both an important target group for advocacy in developing countries and also potential advocates. These are the potential ‘politically empowered victims’. We heard a number of stories of the positive role that young, literate and informed boys and girls played in supporting their families and communities and protecting them from threats posed by pregnancy and childbirth. Furthermore, these boys and girls are the mothers and fathers of tomorrow.

We recommend that development cooperation agencies/governments engage in advocacy directed at young people (and give consideration to including culturally appropriate courses on MNCH within school curricula. The purpose of these would be educate both teachers and children in the facts of childbirth, the threat that childbirth represents to mothers, babies and their communities; and the measures that should be taken to protect women, mothers and babies in and around childbirth).

vii) Targeting advocacy at Medical colleges and universities

Medical students, principals/faculty, professional councils and universities in developing countries are another important constituency to target. If mothers are to be treated with dignity through pregnancy and birth; if their status during this period is to be raised; if fathers are to be encouraged to be more involved in MNCH, then it will be important to develop curricula to ensure specialist education in MNCH for trainee doctors and other paramedics in low-income countries.

Medical students in Pakistan, Orissa and Tanzania do not appear to be trained in the social and communication skills needed to involve and prepare both parents for the experience of childbirth. We recommend that development cooperation agencies and governments include professional councils, universities, principals and faculty as both targets of advocacy and as champions of advocacy as a way of strengthening curricula, deepening awareness amongst medical students of the need to involve both parents in the birth and care of the child; and to enhance respect for, and the treatment of women and babies during pregnancy and childbirth.

viii) Targeting hard-hitting messages at faith groups

Advocacy campaigns have to compete with whichever are the current and dominant issues capturing media and public attention. For advocacy to be effective, and to attract the attention of audiences in the north already captured by climate change, the war in Iraq and HIV/AIDS advocates, or audiences in the south preoccupied by poverty and deprivation, we recommend that communication on maternal, newborn and child mortality be more direct and hard-hitting than in the past.

One example would be to target faith groups and faith leaders and challenge the contrast between on the one hand, ‘worshiping’ the ‘mother and child’; elevating the mother to the first, second, third most important person in any one’s life (as Islam does) – while also tolerating high rates of mortality and morbidity in child-bearing
women. Advocacy should not hesitate to challenge and debate this, as it could help revive and re-invigorate already deeply-embedded values. Such advocacy could be targeted at Christian and other faith groups in western countries, and at Hindu and Islamic groups in developing countries.

We heard encouraging reports of Muslim leaders in developing countries responding positively to advocacy on MNCH. The most notable example is that of Iran, and the fatwas on MNCH issued by Ayatollah Khomeini. While there were conflicting accounts of the influence Muslim scholars and leaders exercise in, for example, Pakistan, nevertheless these potential advocates have platforms from which they regularly communicate with large numbers of people in their communities.

ix) Targeting advocacy at men: stories of loss of love and care.

In societies in which the status of women and mothers is very low, and where the loss of the mother is treated as ‘natural’ or ‘inevitable’, it may help communication with men at all levels, to get men whose mothers died in childbirth to tell their stories.

These stories should be told by men that are presidents and prime ministers, celebrities, civil servants, sports stars; but also ordinary men; young as well as old. The perspective of a motherless man would both attract the attention of other men; and highlight the fact that without a mother, children never regain the same intensity of care, love and attention. Such advocacy would invest the issue with the emotional power that is often drained from reports of high numbers of deaths amongst women and babies, reports that cause audiences to ‘switch off’ as the absence of the mother and child give them no-one with whom to identify. They can however identify with living orphans.

Allowing individuals to tell their story of loss in individual, repeated episodes on TV, radio or film, could be powerful.

Fathers and sons involved in the care of mothers and children should be ‘showcased’ and celebrated. This can probably best be done by showing fathers from a range of backgrounds – ranging from the president to a rural labourer – playing a positive role in supporting their wife during pregnancy and childbirth, and caring for the young child.

x) Advocacy on health worker shortages in remote areas

Any advocacy campaign on MNCH in developing and donor countries will invariably need to raise the issue of the shortage of skilled health workers, and on the need for policies and incentives to reverse the outflow of health workers from poorer to richer countries. While this is a policy issue, and policy change is an endpoint of advocacy, the human resource crisis being experienced in many developing countries cannot be ignored by the advocacy campaign.

Interviewees, and in particular the Minister for Health in Orissa, drew our attention to the severity of the shortage of health workers in rural, remote areas, and suggested that one of the barriers to appropriate care is dependence on doctors and skilled health workers from outside those communities. These paramedics have little commitment to the community, and suffer because of the poor infrastructure and lack of amenities for their own families. An advocacy campaign on MDGs 4 and 5 could promote policies that would provide financial and skilled training to individuals from these remote communities willing to return to, and work within their own communities.
Funding and maintaining training facilities built and maintained close to remote, rural communities, would greatly facilitate such participation.

xi) Demand-led advocacy and a stand-alone campaign

To generate demand for more resources; for the retention of health workers; for higher standards of hygiene and care, and for greater respect for women and their babies, we recommend that generalised demand-led advocacy on MNCH is most appropriately undertaken by independent NGOs at international, national and local level.

Awareness of MDGs 4 and 5 is spreading. However awareness tends to be restricted to a minority within the development community. The public at large remains at best ignorant, and at worst cynical about these goals. At the same time, NGOs tend to specialise in one or other goal. The GBP’s advocacy campaign will have to compete with HIV/AIDS, trade, climate change, poverty reduction etc. for attention. For these reasons we recommend the establishment of a stand-alone international campaign on MDGs 4 and 5.

xii) Advocacy leadership

For such a campaign to succeed leadership is necessary. In other words there have to be strong individuals in a leadership role; but also a lead organisation/partnership/coalition that develops a singular, positive brand, and ensures widespread recognition of the brand and associated messaging. Involving communicators who have credibility but do not have a stake in the specialist debates that take place within the MNCH profession would help to ensure that advocacy is based on overarching messages which encompass mothers, children and newborns.

In our view, where this organisation is based (i.e. north or south) is less important than its independence from government, its inclusiveness, its intellectual effectiveness, its relevance and its compelling advocacy.

xiii) Recruiting allies

One of the first tasks of any lead organisation would be to direct advocacy at those most likely to be allies - friendly organisations that must be persuaded to join an army of vocal advocacy: e.g. faith groups, political parties, other NGOs working on health, development, poverty reduction, women’s and children’s rights.

The lead organisation/partnership/coalition will have to develop branding/messaging and other advocacy tools appropriate for adoption and adaptation by any organisation based north or south and working on MNCH. The lead organisation could in particular channel authoritative data to national and local campaigns on MDGs 4 and 5 in their region/country/districts. Above all the lead organisation should help those with less capacity to marshal arguments in support of these MDGs; rebut arguments against them; and, using carefully prepared (and culturally sensitive) messaging, help less well equipped organisations communicate effectively with their own networks and communities.

From there advocacy should fan out (at local, national and international level) towards a) the media b) the private sector and c) influential opinion-formers and decision-makers.
A concerted effort should be made to train and educate journalists in countries with high rates of maternal and child mortality.

Because journalists in developing countries work within the editorial framework set by their editors, the latter should be taken aside and intensely briefed on the issue. They should be encouraged to mount sustained campaigns on MDGs 4 and 5, something we were led to believe is unusual practice for print and broadcasting media in developing countries. In other words, editors should be encouraged to print stories with a follow-up – to keep readers’ attention.

For such a newspaper or broadcasting campaign to succeed, the lead advocacy organisation in that country should use their contacts and networks to provide a constant stream of compelling stories, data and briefings to journalists. Such proactive approaches are far preferable to the passive issuance of press releases, and dependence on busy (often unpaid) journalists to think up or investigate new stories.
12. MOVING ON FROM PHASE I (MAPPING) TO PHASE II (CAMPAIGN DESIGN)

This chapter is included in the report since, although it goes beyond the original scope of work, we think it important to recognise that while Phase I is a discrete piece of work, its aim is to provide information which informs the design of a global advocacy campaign. As such we have tried to highlight below some key issues which we feel need to be considered during the design of the campaign. The views expressed below are drawn from what interviewees said but also, and equally importantly, from what they did not say.

During Phase I we elicited answers to a wide range of questions during interviews in six countries. Naturally, a range of opinions were expressed in response to many of these questions. While this was to be expected, many of the responses directly and indirectly demonstrated that advocacy leadership is needed.

Something that advocacy leadership, and the campaign design, will need to address is that there are questions which will be raised during the course of the campaign, and which will need to be addressed, for example:

1. What should be the banner headline/rallying call? A banner or rallying call does not have to include the whole story: e.g. continuum of care, comprehensive healthcare systems, hygienic clinics, trained health workers for all mothers and their children. It is important, however, to provide the full story to creatives in an advertising company, but with the purpose of enabling them to come up with a single, unifying banner headline.

2. Arguments will be made against the campaign – both its banner headline, and its more specific messages. How will this resistance be rebutted?

3. What would a continuum of care look like in Pakistan, Orissa and Tanzania, and how can it be achieved?

The mapping phase and existing literature on MNCH indicate that there are key messages which can be drawn on for design of the campaign. The following are a list of suggestions, although there are doubtless others which will also need to be considered:

- Women and children serve the very existence and continuity of humanity. This entitles them to respect and to certain rights – above all the right to survive the trauma of reproducing humanity for the future.
- It is profoundly unethical to allow 300 million women to suffer mental and physical ill health resulting from childbirth, when the means to protect women from the risks of childbirth are well known and well understood in all societies.
- Society cannot afford the economic costs of supporting 300 million women – their children and their families - when these women are mentally and physically impaired by the trauma of childbirth.
- It is profoundly unethical to tolerate the deaths of 14 million babies and their mothers each year, when the means to ensure that families are planned; and that mothers and babies survive the trauma of childbirth exist, and are well known to all.
• It is also profoundly unethical, and unjust to ignore the deaths and suffering of 14 million babies and their mothers each year largely because women and babies are powerless.
• The emotional loss and suffering of those left behind by the deaths of mothers and babies is unbearable, and is an experience that has touched the lives of most people in poor countries, and even those living in rich countries. Looking at maternal, newborn and child mortality rates through the lens of such loss would generate emotional power.

The climate/landscape in which this campaign will be undertaken is tough. Inserting concern about MNCH into debates about climate change, which threatens the lives and livelihoods of far larger numbers; or into political spaces in which debates about nuclear weapons and further potential wars and terror are conducted, will require enormous advocacy power, which in turn must draw not on statistics and data, but on human emotions.

The report has identified key opinion-formers/decision-makers in six countries, in some cases at district level, in most cases at national and international level. We have also tried to identify what they think/do, and more importantly what they don’t think and do. The advocacy strategy will have to carefully target such opinion-formers and decision-makers. Messaging aimed at these people will have to be tailored and adapted to ensure they are appropriate and compelling.

It may appear obvious to many already involved in MNCH why saving the lives of mothers, newborns and children should be prioritised. However this is not necessarily the case outside the MNCH community where, because the issue is absent from public debate, attention is focussed on many other issues. In other words, the PMNCH needs to develop internally and externally resonating frames that would oblige the public and policy makers to:

a) acknowledge the scale of deaths, near misses and morbidities, and
b) address the crisis with appropriate and effective solutions.

These arguments need to be marshalled in such a way as to ring true with experts and practitioners, the wider community of opinion-formers and decision-makers, and activists.

This will require addressing issues that are of extreme sensitivity in some countries and organisations. Issues relating to:

• Social and institutional restriction and, sometimes, denial of women’s and children’s rights
• The resistance of the women’s movement in some countries to actively support issues related to mothers and children
• Fears of over-population and the accompanying implicit perception of maternal, newborn and child deaths as a way of limiting population growth
• The need for access to family planning services
• Safe abortion – and the numbers of women that die as a result of having to resort to unsafe and often illegal abortions
• Economic policies that impede the development of equitable health policies which could provide a continuum of care easily accessible to poor and marginalised women.
• Divisions within different departments of donor organisations; differences between development cooperation agencies; and lack of coordination
between multilateral agencies. These, often powerful players in poor countries, need to give greater prioritisation to this issue.

Campaigns on maternal and child health have often carefully avoided touching on some or all of these issues, for fear of alienating influential political audiences. However such caution has helped to obscure the issue from public debate. While it may not be appropriate to address these issues head-on, if the PMNCH is to lead on the GBP advocacy campaign it will need to consider these obstacles privately, or publicly. Facing and integrating these issues into the advocacy campaign’s design and preparation, will increase the likelihood of assembling an effective campaign and undertaking effective advocacy.

Analysis, goals and messaging.

The analysis developed above will provide PMNCH with the building blocks on which the MNCH community can build its campaign. It will then be necessary to address the following questions:

1. What would success look like?
2. Given the above analysis, what is our banner/rallying call?
3. What are the campaign’s key messages?
4. What is the climate/landscape in which advocacy will take place? And how does that affect the timing and nature of the messaging?
5. How should messages i.e. the rallying call, be pitched to diverse audiences?
6. What arguments will work against the key messages of the campaign? Answering this point may not change the banner/rallying call, but will help campaigners prepare rebuttals to opposition. This is vital advance preparation.

Once these questions have been fully addressed, the campaign will then have to a) target key decision-makers/opinion-formers and b) use the answers to the above to answer a further set of questions which relate to target audiences:

7. Who are the decision-makers? At an international level? At national and district level?
8. Who are the key opinion-formers – in academic institutions/NGOs/multilateral institutions/government departments/the media?
9. What do they currently think and do?
10. Why do they think/do that?
11. What does the campaign want them to think/do?
12. What might stop them?
13. What needs to be done to mobilise their support behind the campaign banner?

In conclusion, the basic elements of an effective inside track advocacy campaign for MDGs 4 and 5 exist already, with some gaps identified above. Filling the leadership gap, refining the messaging, and tailoring advocacy targeted at powerful individuals and institutions are key tasks for the next phase. It will also be important to help generate support for demand side advocacy campaigns, particularly in poor countries.