

# An Assessment of Family Planning Decision Makers' And Advocates' Needs and Strategies In Three East African Countries

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**CONTEXT:** Despite decades of evidence-based advocacy for family planning in developing countries, research on how decision makers perceive and respond to such efforts is lacking.

**METHODS:** A literature review yielded 10 peer-reviewed journal articles published between 1999 and 2012 on decision makers' needs for and experiences with health advocacy and evidence. Two sets of questions about family planning research and advocacy—one for decision makers and another for advocates—were developed from emerging themes and used in structured interviews with 68 key informants in Ethiopia, Kenya and Malawi.

**RESULTS:** Decision makers reported understanding family planning's value and confirmed that advocacy had helped to spur recent favorable shifts in government support of family planning. Key informants stressed that advocacy messages and formats must be tailored to the needs and interests of particular audiences to be effective. Messages must also consider barriers to decision makers' support for family planning: constituents' negative attitudes; fear that increased adherence to family planning will shrink the size and influence of specific voting blocs and ethnic groups; and competing economic, social, cultural, religious and political priorities. Decision makers reported valuing the contributions of international family planning organizations and donors, but were more comfortable receiving advocacy messages from local sources.

**CONCLUSIONS:** According to decision makers, sustained and strategic family planning advocacy developed and delivered by culturally attuned national actors, with support from international actors, can diminish barriers to government support for family planning.

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Despite global and national efforts to promote consultation between decision makers and public health researchers,<sup>1</sup> and to include stakeholders in research processes, empirical studies on the influence of health research findings on the knowledge, attitudes and actions of decision makers—especially in developing countries—are scant.<sup>2</sup> Likewise, few systematic studies have been conducted to examine how decision makers view advocacy, how they use public health research findings and advocacy, what types of research and advocacy they consider persuasive, and how and why they choose to support policies indicated by research.<sup>3</sup> Findings from those studies suggest that many advocates who strive to help decision makers use research findings to inform health policy fail to adequately consider political realities or to present advocacy messages in a persuasive package.<sup>2–8</sup> In low-income countries, decision makers are further hampered in connecting health research to policy by weak health systems, lack of professional regulation and poor access to evidence.<sup>9</sup>

To our knowledge, no studies have specifically investigated decision makers' views on and use of family planning research and advocacy. Thus, under the Health Policy Project funded by the U.S. Agency for International Development (USAID), we conducted a qualitative study of how parliamentarians, government officials and their technical

advisors in three East African countries—Ethiopia, Kenya and Malawi—make decisions related to family planning, what types of evidence they find compelling, what other factors compete with research evidence to influence their decision making and what advocacy approaches are most effective. We chose the three countries because of the progress their governments have made in strengthening family planning programs: Modern contraceptive use has risen substantially among married women in each in recent decades (Ethiopia, from 6% in 2000 to 29% in 2011;<sup>10,11</sup> Malawi, from 7% in 1992 to 42% in 2010;<sup>12,13</sup> and Kenya, from 18% in 1989 to 39% in 2008–2009<sup>14,15</sup>). In addition, the countries were selected because both the African Institute for Development Policy and Health Policy Project/Futures Group had conducted or were currently conducting work on family planning and reproductive health there and, thus, had access to contacts. Research findings from these countries may provide valuable lessons for evidence-informed family planning advocacy elsewhere.

## METHODS

### Literature Review

We began by searching PubMed and Google Scholar to identify peer-reviewed journal articles from 1999–2012 related to decision makers' needs and experiences with

**TABLE 1. Key informants' affiliations in study countries**

Informant type		
<b>ETHIOPIA</b>	<b>KENYA</b>	<b>MALAWI</b>
<b>Decision makers</b>	<b>Decision makers</b>	<b>Decision makers</b>
Ministry of Finance and Economic Development (2)	Ministry of Finance (1)	Ministry of Finance (1)
Ministry of Health (3)	Ministry of Public Health and Sanitation (2)	Ministry of Economic Planning and Development (3)
Ministry of Women's, Children and Youth Affairs (2)	Ministry of Youth Affairs and Sports (1)	Ministry of Health (5)
Ministry of Education (1)	National Gender and Equality Commission (1)	Consultant, Formerly Ministry of Health (1)
Federal HIV/AIDS Prevention and Control Office (1)	Ministry of Planning, National Development and Vision 2030 (2)	Ministry of Youth and Sports (2)
Federal Parliamentary Assembly (7)	National AIDS Control Commission (1)	Ministry of Gender, Child and Community Development (1)
	Kenya National Assembly (5)	National Assembly (5)
		National AIDS Commission (1)
		USAID (1)
<b>Advocates</b>	<b>Advocates</b>	<b>Advocates</b>
Family Guidance Association of Ethiopia (1)	Family Health Options Kenya (1)	Family Planning Association of Malawi (2)
UNFPA (1)	UNFPA (1)	UNFPA (2)
Pathfinder International (1)	Pathfinder International (1)	Safe Motherhood Initiative (1)
USAID (1)	USAID (1)	University of Malawi (1)
Consortium of Reproductive Health Associations (7)	Reproductive Health and Rights Alliance (1)	Malawi Interfaith AIDS Association (1)
	University of Nairobi (1)	
	Innovations for Poverty Action (1)	

Notes: UNFPA=United Nations Population Fund. USAID=U.S. Agency for International Development. Figures in parentheses designate number of informants of that affiliation.

health advocacy and evidence. We used the following search terms: “policy,” “policymaker,” “decision maker,” “advocacy,” “research,” “data,” “evidence,” “health” and “family planning.” Articles were selected if they reported high-level decision makers’ opinions, experience and recommendations regarding health advocacy, research or the use of data in decision making. These filters yielded 10 articles for review, of which eight included some developing countries; none focused on family planning.

Six themes emerged. First, the trustworthiness of those who present research findings and the perceived quality of those findings are important to their uptake.<sup>3,4,6,16,17</sup> Second, decision makers are less influenced by research quality than by such pragmatic issues as the cost of implementation.<sup>3,8</sup> Third, timeliness, relevance, format and clarity of evidence matter.<sup>2,4-6,8,16,18</sup> Fourth, political interests, social consensus, constraints on budgets and other resources, mass media and foreign donors strongly influence policy-making;<sup>2,3,5,7,16</sup> advocacy messages must take these influences into account,<sup>2,5</sup> and must articulate and package them to speak to the specific needs of distinct audiences.<sup>4</sup> Fifth, gaps in communication and understanding between researchers or advocates and decision makers are barriers to evidence-informed decisions;<sup>2,16</sup> decision makers may resist using research because they fear that doing so will be time-consuming, complex and difficult,<sup>4,6,7</sup> while researchers and advocates may fail to grasp the complexities of the policy process.<sup>8</sup> Finally, because decision makers may be ill-equipped to formulate policies on technical health matters,<sup>2</sup> increased interaction with researchers can build their capacity to understand and use research evidence.<sup>5,16</sup>

### Interviews with Key Informants

To build on the themes gleaned from the literature review, we sought to interview individuals holding high offices in government or in nongovernmental organizations (NGOs)

and working in the fields of family planning or reproductive health in Ethiopia, Kenya and Malawi. We first created a list of decision makers and advocates by conducting a stakeholder analysis, and then used snowball sampling to find other key informants. Decision makers included parliamentarians, senior government officials, senior technocrats and recognized family planning champions in government (Table 1). Advocates included heads of local and international NGOs and parastatals, heads of civil society organizations, heads of training institutions for health workers, nongovernmental family planning champions and donors; donors were included in the advocate category because they can play an important role in family planning advocacy, and because some respondents currently affiliated with donors have previously served as family planning advocates with a variety of in-country institutions.

In consultation with experts in the field from the Futures Group, USAID and the African Institute for Development Policy (AFIDEP), we developed one interview guide for decision makers and one for advocates. Five pilot interviews were conducted in Kenya in May 2012, and we used the resulting feedback to improve the clarity of the interview guides and to reduce repetition and administration time; additional minor revisions to two questions were made following a preliminary analysis of findings shortly after the study’s launch in Malawi later the same month. We administered these versions in Ethiopia in August 2012 and in Kenya from June to October 2012.

Ultimately, the two interview guides overlapped on 22 questions; the guide for decision makers had five additional questions focusing on decision-making processes, while the guide for advocates had 16 additional questions focusing on experience working with evidence and evidence-informed advocacy. Both guides used a combination of question types: open-ended, yes-or-no, ranking and card sorting. Ranking questions asked respondents their level

of agreement or disagreement with statements on a five-point Likert scale. Card-sorting questions, depending on topic, had nine or 12 possible responses printed on cards, which respondents were asked to arrange into groups of three or four cards each, representing how important or convincing the respondent found each factor to be. Results from all questions were comparable across all countries, except for those from card-sorting questions, which were comparable only for Ethiopia and Kenya.

The Futures Group internal research review committee reviewed the study protocol and determined that the research was exempt from the provisions of the Protection of Human Research Subjects regulations.

Overall, 49 decision makers and 19 advocates participated in an hour-long interview (Table 2); all participants gave informed consent before being interviewed. None of the key informants we approached refused to be interviewed, although eight declined to be recorded. Recorded interviews were transcribed by the research team for analysis; for unrecorded sessions, interviewers took detailed notes, which then served as transcripts for analysis.

### Analysis

Prior to the interviews, we developed an Atlas.ti codebook based on the interview guides to conduct a content analysis and capture patterns of responses; we added themes and subthemes to the codebook as transcripts were reviewed. To assess intercoder reliability and standardize the codebook and coding scheme, we used a staged double-coding approach on seven (10%) of the transcripts. First, each of the coauthors independently coded the same three transcripts, and then met to discuss challenges and interpretations of the codebook. Next, we revised the codebook, independently coded another two transcripts and made minor additional revisions. Finally, we independently coded two more transcripts to validate the codebook.

We divided and coded the remaining transcripts, generated reports for each code and reviewed for additional themes and subthemes. We categorized all transcripts by country and type of interviewee (decision maker or advocate), and further analyzed transcripts to look for thematic patterns and compare them within and across the two categories. During analysis, the research team identified transcripts by code, rather than by name, and made reasonable efforts to conceal participants' identity.

## RESULTS

### Country-Specific Contexts

Country context and the need to advocate at different levels of government came up in interviews in each of the three countries. Ethiopia has a federal parliamentary system of government with regional semiautonomous states; until recently, only those within the country's government could participate in policy advocacy, while entities receiving substantial foreign funding could provide technical support and service delivery. At the time of the study,

**TABLE 2. Number of interviews by country, according to informant type and gender, and whether they agreed to be recorded**

Country	Decision maker		Advocate		Agreed to be recorded
	Male	Female	Male	Female	
Ethiopia	11	5	3	2	16
Kenya	8	5	3	4	14
Malawi	12	8	4	3	27
Total	31	18	10	9	57

Kenya and Malawi had identical presidential parliamentary systems; government and development partners (i.e., foreign government funding agencies and nongovernment organizations) worked collaboratively on family planning advocacy. Respondents from the three countries highlighted the importance of family planning advocacy at the national and subnational levels. In all three countries, advocacy at the national level was considered important, because that is where family planning policies and agendas are set. But because the health systems in these countries are decentralized, planning and budgeting are also subnational functions, so respondents deemed regional- and local-level advocacy to be important as well.

When asked about salient factors in high-level or national decisions about policies and budgets related to family planning, respondents in Ethiopia and Malawi commonly stressed that family planning advocacy messages need to be aligned with national development plans. Respondents in Ethiopia and Kenya took this a step further by reporting that decision makers are also influenced by the need to align their governments' reproductive health and family planning policies with the global health targets set forth in the United Nations Millennium Development Goals (MDGs). For example, one Kenyan decision maker said "Because the Kenya government has to meet its MDG target, it has recognized that unless it addresses properly the population and family planning issues, it will not meet a lot of those MDGs."

In all three countries, respondents said that advocates must understand their government and target efforts toward individuals with decision-making authority, particularly with regard to resource allocation. Ethiopian respondents emphasized the requirement that family planning champions come from within government—chiefly, the ministries of health and finance and economic development, as well as relevant parliamentary committees; Kenya and Malawi have no such restrictions.

### Government Support for Family Planning

Respondents in each country mentioned new policies, laws and strategies friendly to family planning in recent years. For example, in Ethiopia, import taxes on family planning commodities and restrictions on advertising have been eliminated; in Kenya, national reproductive health and national population policies have been revised to assign higher priority to family planning and allow the

sale of emergency contraceptives and combined oral contraceptives over the counter; and in Malawi, a national plan has been implemented to scale up access to sexual and reproductive health care among young people.

However, small variations existed between countries. Although respondents in all three countries said that, in principle, family planning had gained support at high levels of government, in only Ethiopia and Kenya has this support been backed up by increases in national spending. In Malawi, respondents noted that other health issues perceived as more urgent received funding priority. One Malawian decision maker said “Because we don’t take family planning as an emergency, sometimes [resources] can be shifted to other [more urgent] issues, like [pharmaceutical] drugs.” In addition, respondents in Ethiopia and Malawi—but not Kenya—mentioned the expansion of family planning services and a new emphasis on the supply of long-acting and permanent methods (such as IUDs) in public health facilities as evidence of increased government support for family planning.

When asked what had caused the increased government support for family planning, respondents in each country replied that advocacy had played a key role, particularly through the involvement of female parliamentarians and decision makers’ field visits to family planning sites. They ranked advocacy first among ways to raise the visibility of family planning as a development tool, to keep it on decision makers’ radar screens and to channel information about it to decision makers. One Ethiopian decision maker remarked “Advocacy may be one thing to increase the political will and the commitment of the government.”

In addition to advocacy, respondents cited other sources of influence on governments’ increasing support for family planning. Most frequently, respondents mentioned donors’ renewed attention to family planning after years of concentrating funds on HIV.

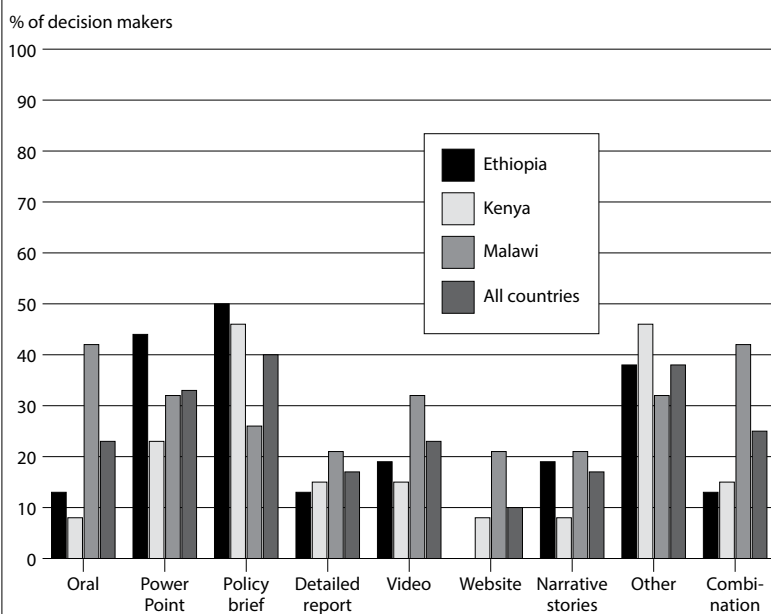
“The U.S. government were working only to finance HIV/AIDS, malaria and so on. But, currently, the U.S. development [funding] finances maternal and child health activities, so this shows there is a policy shift.”—*Ethiopian decision maker*

Respondents also mentioned decision makers’ recognition that high population growth stresses a country’s resources; the government’s commitment to the MDGs and the acknowledged link between family planning and socioeconomic development; concern about high maternal mortality; and advocates’ reframing family planning as an engine of development, rather than as a women’s issue or a health issue.

“We had political leadership that was advocating ‘give birth to children, so that you can have many people who will vote for me when I want to be a Member of Parliament.’ I think it was misguided, because the population growth in this country is still too high.”—*Kenyan decision maker*

“Because the Kenya government has to meet its MDG target, it has recognized that unless it addresses properly

**FIGURE 1. Percentage of decision makers who considered selected family planning messaging methods as best for effective advocacy, by method and country**



the population and family planning issues, it will not meet a lot of those MDGs.”—*Kenyan decision maker*

“There are a lot of deaths [of] the women and we wanted that to stop.”—*Malawian decision maker*

“When I started doing family planning advocacy...I wanted to invite other members of Parliament for a meeting. My letters would be referred to as ‘the letters of women’ and they would not be taken seriously. But today...if you go to a family planning forum where we are involving parliamentarians, you will get more men than women.”—*Kenyan advocate*

### Settings, Format and Content of Family Planning Advocacy

All of the decision makers from Ethiopia and Kenya, and almost all of those from Malawi, reported having received information on family planning in the usual ways: office visits; regional, national and international meetings; and electronic and print media. In Ethiopia, field visits were commonly cited as an effective way to convey the benefits of family planning to parliamentarians. In one instance, such a visit led to the removal of an import tax that had limited access to contraceptives. Decision makers had mixed views on which formats are best for effective family planning advocacy (Figure 1), but generally favored printed policy briefs, because they are longer lasting and more easily shared than verbal messages. Those who preferred a combination of methods said that the format used should serve the message being delivered.

In regard to content, all of the decision makers said they were convinced of the benefits of family planning. According to our card-sorting results, decision makers in Ethiopia and Kenya ranked family planning’s benefits to the health of mothers, the health of children and the welfare of families as the three most convincing arguments for its support

**TABLE 3. Ranking (and average score) of how convincing decision makers consider family planning advocacy messages, by type of respondent, Ethiopia and Kenya**

Message	Decision makers (N=29)	Advocates (N=12)
Improves maternal health	1 (1.29)	1 (1.45)
Improves child health	2 (1.32)	5 (1.91)
Improves family welfare	3 (1.61)	4 (1.82)
Contributes to national growth	4 (1.68)	2 (1.55)
Contributes to women's empowerment	5 (1.89)	7 (2.09)
Contributes to slow population growth	6 (1.96)	8 (2.18)
Is cost-effective	7 (2.18)	3 (1.73)
Alleviates stress on natural resources and effects of climate change	8 (2.57)	9 (2.45)
Saves money in other public sectors	9 (2.57)	6 (1.91)

Notes: Ranked from 1 (most convincing) to 9 (least convincing) on the basis of average score. Decision makers sorted nine potential advocacy messages by dividing them into three equal groups by how convincing they were (most, somewhat and least convincing); advocates sorted by how they thought decision makers would sort messages. Rankings were calculated by averaging the responses by factor (most convincing=1, somewhat convincing=2 and least convincing=3), and ordering from low to high average score. Responses from Malawian key informants were excluded, because the questionnaire used in Malawi framed this question in a way different from that used in Ethiopia and Kenya.

(Table 3). Advocates correctly perceived that decision makers would rank maternal health benefits as the most convincing reason to support family planning; however, they believed that decision makers' second and third most convincing reasons would be family planning's contribution to national economic growth (ranked fourth by decision makers) and the cost-effectiveness of implementing family planning programs (ranked seventh by decision makers).

Asked what specific actions family planning advocacy messages directed them to take (not shown), decision makers and advocates both cited increasing resources for commodities. In addition, respondents frequently cited increasing health and reproductive health budgets, and bringing the government's contribution closer to the amount of donor funding. Other specific and concrete actions of family planning messages commonly cited by respondents in all three countries were increasing access to family planning services for underserved populations,

**TABLE 4. Ranking (and average score) of how important decision makers consider factors affecting family planning decision making, by type of respondent, Ethiopia and Kenya**

Factor	Decision makers (N=29)	Advocates (N=12)
Evidence and data for impact of policy options	1 (1.34)	4 (1.73)
Cost of implementation	2 (1.62)	2 (1.55)
Value for money or cost-effectiveness	3 (1.69)	5 (1.73)
Cultural and religious factors	5 (1.76)	6 (1.73)
Concrete programmatic solutions	6 (1.83)	10 (2.09)
Public opinion on family planning	7 (1.86)	9 (2.09)
Demonstrate short-term and long-term impact	8 (1.86)	1 (1.36)
Availability of human resources	9 (2.10)	7 (2.00)
Donor influence	10 (2.38)	8 (2.00)
Impact on reelection	11 (2.45)	11 (2.45)
Personal experience with family planning	12 (2.66)	12 (2.55)

Notes: Ranked from 1 (most important) to 12 (least important) on the basis of average importance score. Decision makers sorted 12 potential advocacy messages by dividing them into three groups with four messages each, according to level of importance (most, somewhat and least); advocates sorted by how they thought decision makers would sort messages. Rankings were calculated by averaging the responses by factor (most important=1, somewhat important=2 and least important=3), and ordering from low to high average score. Responses from Malawian key informants were excluded, because the questionnaire used in Malawi framed this question differently than that used in Ethiopia and Kenya.

strengthening community-based distribution of family planning information and services, strengthening supply chain management, training more health workers and improving commodity security.

Most decision makers in Kenya (82%) believed that the family planning advocacy messages they had received were relevant to their goals as policy formulators, legislators and budget managers; however, in Ethiopia and Malawi, only about 60% of decision makers believed this.

### Family Planning Advocacy Audiences and Messengers

When asked what audiences advocates should address, respondents in all three countries noted the importance of bringing representatives of multiple government sectors together to promote family planning's broad development benefits. One Kenyan decision maker said "There is a need to involve people in the agriculture, water and environment sectors to help them understand the relevance of family planning." In addition, respondents in all three countries emphasized engaging religious and traditional leaders because of their influence on communities. To this point, a decision maker in Malawi said "The imams in Malawi [helped] to dispel misconceptions about Islam and family planning."

Although many respondents agreed that both national and international actors have a role to play in family planning advocacy, nearly all said that national stakeholders must take the lead. One Kenyan advocate explained "National experts understand the issues, the context in which things are done, and they are able to articulate the issues in a manner that will move the policymakers to take actions."

### Factors in Family Planning Decision Making

According to our card-sorting results, decision makers in Ethiopia and Kenya generally ranked factors related to the practicality of a family planning program highest in terms of importance to decision making (Table 4): first, evidence and data showing the impact of policy options, followed by cost of implementation, cost-effectiveness and competing political priorities of other government sectors. Advocates perceived that a program's short- and long-term impact would be most important to decision makers—a factor that decision makers ranked eighth; they underestimated decision makers' top priority, evidence and data, by ranking it fourth. Advocates and decision makers ranked only three factors the same: cost of implementation (second), impact on reelection (11th) and personal experience with family planning (12th).

The factors ranked by decision makers framed open-ended questions in our interviews centering on how the following topics influence family planning policies and budgets.

- *Personal, religious, cultural and political factors.* Although the participants interviewed for this study generally supported family planning, they noted that religious, cultural or social values regarding childbearing and family planning prevent some politicians and other decision makers

from supporting it openly or in their work.

“[In] a multicultural country, there are different outlooks based on a religion or based on culture. If you go to pastoral areas, I expect some resistance about family planning, because they believe that their culture will take care of their children.”—*Ethiopian decision maker*

“In societies where gender issues are a challenge, people don’t want to talk about anything pertaining to the use of reproductive commodities. If the politician is not strong-willed, he can easily think ‘the people don’t want to hear about this’ and ‘I don’t want to [support family planning], because I want to remain popular.’”—*Kenyan decision maker*

“It’s about pleasing the electorate....In an area where they don’t believe in family planning because of culture or religious background, it will not work....Decision makers would like to please the people [and] they don’t want to get a bad reputation.”—*Malawian decision maker*

One political constraint, according to several respondents, is a commonly held fear that family planning will actually shrink the population and, in turn, the size of voting blocs—a view that one Kenyan decision maker said is a major threat with the potential to “reverse the gains of family planning.” According to an advocate in Malawi, decision makers resist sensitive topics when they are close to an election. And another said that decision makers focus on initiatives that will pay off in the short-term, while they are in office, and that “with family planning, we are talking more about long-term gains.”

•**Advocacy and evidence.** Respondents in all three countries agreed that advocacy is needed to overcome barriers to support of family planning. According to one Ethiopian decision maker, such advocacy is important to convince opponents that family planning is beneficial, and to reaffirm the commitment of family planning supporters so that they can be more effective advocates. Decision makers reported feeling that reliable, high-quality evidence on the many benefits of family planning can be an especially powerful advocacy tool. An Ethiopian decision maker said: “Everybody’s mind can be affected by reliable knowledge.”

Development partners guide or influence the development of advocacy strategies in the three countries. The level of support from such partners was apparently more pronounced in Malawi than it was in the other two countries, because it has a relatively weak technical capacity in evidence-based advocacy and technical assistance.

Informants discussed the importance of how advocacy and evidence are presented. They stressed that information must be relevant to decision makers and offered in a way that not only shows the benefits of action, but also the negative effects of inaction. Especially where support for family planning is already high, it may be necessary to tailor messages, and for messaging to go much deeper to explain how and why family planning has provided and could potentially provide health, economic or other benefits.

Respondents emphasized the importance of communicating evidence to decision makers concisely.

“Evidence and data [are] very important, but policymak-

ers can easily get bogged down. You need to prepare information that shows that “this works” or “this doesn’t work.” You need to prepare that information in brief.”—*Malawian advocate*

Some respondents said advocacy should not only push for more resources, but also encourage decision makers to implement existing family planning policies.

“Now it’s the question of implementing the policies. We have reached a stage where we are failing to meet the demand for family planning and now we have to provide the services.”—*Malawian decision maker*

Information, education, communication, behavior change communication and mass media campaigns—often considered to be separate from advocacy—may also influence national or regional decision making. Top-down support of family planning is important, but in these democracies, bottom-up or grassroots support is also important. One Kenyan advocate recommended training health workers on the politics of family planning, so they will know what to say when they have an opportunity to talk to someone in government.

•**Obstacles to finding and presenting reliable evidence.** Advocates praised the high quality and cross-country comparability of Demographic and Health Survey data, but lamented the lack of information during the five-year interval between surveys. Several advocates reported being hampered by a lack of reliable and easily accessible data, and also by a lack of consensus about data sources and figures. For example, there are United Nations Population Division data; however, these are not usually comparable to the DHS data.

There are many tools for generating and presenting family planning data<sup>19</sup>—some of which can be used to estimate the costs, benefits and impacts of family planning use. Few advocates, however, reported collecting their own primary data or analyzing secondary data without help from other institutions. This is not surprising, given that few advocates reported having training in using family planning advocacy tools to generate evidence. Instead, most advocates had been trained to communicate what others had compiled; the two most commonly cited family planning tools on which advocates had received training were RAPID and ENGAGE. Furthermore, some advocates perceived a lack of transparency regarding their access to and use of analytic tools. For example, one Ethiopian advocate said “There is a lot of secrecy around these tools; [the developers of these tools] don’t want to show how to enter the information.”

Some advocates noted the captivating graphics of some tools for presenting family planning evidence. One mentioned the advantages of these tools in contextualizing or interpreting data for people who would not otherwise grasp their implications. However, legal, technical and language issues limit tools’ usefulness. One advocate pointed out that some are licensed and cannot be adapted or easily manipulated to meet his needs. In addition, online tools are compromised by slow Internet speeds in many regions.

An advocate in Malawi said that the language used in family planning advocacy tools can be too technical for him to explain clearly to others.

• **Competing priorities and budget constraints.** Respondents in all three countries cited “resource shortages” and “competing priorities” as extremely important factors in decision making. One Ethiopian decision maker observed that sometimes even when evidence is strong, advocacy is effective and a government’s commitment to family planning is secure, “there are so many other competing priorities... so many other health problems...that politicians’ hands are tied.”

Although many decision makers thought that the impact of investing or not investing in family planning is not immediate, one of the top reasons they cited for investing in family planning was improvement of maternal and child health—the effects of which can in fact be seen in the short-term. One advocate suggested that when decision makers say that family planning’s benefits are not evident in the short-term, they are comparing family planning to other types of health care, such as curative services for diseases, which have an immediate, observable impact.

“With competing budget priorities for the government, you might realize that family planning is not critical. Would you get sick because you did not plan your family? That doesn’t happen. You don’t feel pain because you did not plan your family.”—*Kenyan advocate*

• **Donors.** Decision makers and advocates in Ethiopia and Malawi generally considered donors of low importance in terms of influence on family planning advocacy and decisions. According to an Ethiopian advocate, advocates and donors have “shared vision and goals.” In Malawi, an advocate said that donors “play by our mandate.” Kenyan respondents, however, were less sanguine about the relationship. One advocate said, “Donors decide on availability of funding and what to focus on.” According to disaggregated card-sorting data, Kenyan decision makers ranked donor influence higher than their Ethiopian counterparts (7th vs. 11th—not shown).

Some respondents in Kenya and one in Malawi saw challenges in their countries’ relationships with donors. A Kenyan decision maker acknowledged that donor funds can have requirements that conflict with a country’s needs. A Malawian advocate mentioned money for HIV interventions as an example: “You cannot take it for family planning, even when you know that integration will be useful here.” And another Kenyan decision maker pointed out that the funding choices of donors can lead a government to assign different priorities in its family planning budget than it otherwise might: “If a donor is interested in a particular program, then you [as a government] don’t want to put a lot of money there.”

## DISCUSSION

Our findings show that decision makers generally are convinced by evidence demonstrating the benefits of family planning for maternal and child health and family welfare.

Increasingly, they are becoming convinced by evidence demonstrating family planning’s broader development benefits. Given the policy frameworks that support family planning as part of strategies to meet the MDGs,<sup>20</sup> and the significant improvements in family planning uptake in the three study countries, these results are not surprising.

However, the widespread support acknowledged for the MDGs—and specifically those aimed at reducing child mortality and improving maternal health—is not sufficient in and of itself to change family planning policy, program and budget decisions. We found that many interwoven factors influence decision-making processes: notably, the opinions of constituents; fear that successful family planning initiatives will diminish the size of voting blocs and the influence of ethnic groups; and competing economic, social, cultural, religious and political priorities. Future advocacy efforts will have to build on the widespread support of development goals and take the next step of addressing the other factors that can hold much sway over family planning policy decisions.

Even so, decision makers and advocates in our study believed that barriers to family planning can be reduced or removed through sustained and strategic advocacy, and that even opponents of family planning can be converted to supporters; this perspective can help family planning advocates in the three countries tailor messages that consider and address these barriers. Respondents emphasized that advocacy aimed at both central and subnational decision makers is needed because of decentralized or devolved government structures for policy, program and budget decisions. Political will in the central governments is critical in these countries, however, for creating a policy environment favorable to family planning.

In general, decision makers and advocates believed that donors had little influence on decision making. Respondents did say that donor influence has led to government shifts in support of family planning in the three countries. Development partners also guide or influence advocacy strategies—most actively in Malawi, to compensate for that country’s relatively weak technical capacity.

The family planning advocacy messages, formats and forums used to date have been effective; the decision makers surveyed had ample exposure to information on family planning and were able to articulate the pertinent arguments for investing in it. Decision makers reported that the family planning messages they received had proposed specific and concrete actions, some of which they have implemented.

## Recommendations

This study’s findings point to the following recommendations for effective family planning advocacy.

• **Design context-specific communication strategies.** Communication strategies should be sensitive to the various levels of factors that influence decision making. For instance, decision makers in a densely populated country like Malawi may be more open to messages about the effects of popu-

lation growth on land and natural resources than those in a country less densely populated, such as Ethiopia. Many decision makers are eager for evidence that can help them meet national development goals, for which they are accountable. Also, this evidence may help decision makers see family planning not only as a health or women's issue, but also as a development issue.

- **Highlight short- and long-term benefits.** Advocates should develop materials that provide evidence of the short- and long-term benefits of family planning. These should be presented using personal stories or data, or a combination of the two, and be made available in formats appropriate for the forum and the type and needs of individual decision makers.

- **Increase community support.** Information, education and communication programs should be scaled up to increase local community members' support for family planning. This will also make it easier to gain support from elected leaders.

- **Maintain champions.** Advocates should make sure that decision makers who are family planning champions remain engaged and well informed, so that they continue to advocate for family planning to their peers.

- **Be persistent.** Advocacy is not a one-event activity and should evolve in step with family planning programs. For instance, advocacy in a country in which contraceptive use is just beginning to increase (such as Ethiopia) requires messages focused on the sustainability of contraceptive uptake.

- **Enhance the technical capacity of local advocates.** It is important that local advocates learn to generate and package evidence themselves on the topics they see as important and relevant to their audiences. In addition, local advocates should take the lead in presenting results.

We expect that advocates in other countries can apply these lessons using context-specific evidence to support decision making for family planning policies and resource allocation decisions.

## LIMITATIONS

We recognize that this study has limitations. First, our selection of countries—specifically, three countries with strong political commitment to and policies and programs on family planning—may limit the study's generalizability; however, the long professional histories of some respondents covers contexts with less support of family planning, and we hope that their lessons learned—as expressed in these interviews—are applicable to a wider range of circumstances. Some decision makers, especially those leading government agencies in charge of family planning policy and programs, are also champions of family planning. Because our intention was to capture the disaggregated views of decision makers and advocates, our interviews with these decision makers may not have captured their advocacy efforts. Moreover, these decision makers may differ from the others we interviewed in their responses to questions about their support for family planning, the re-

search evidence they find most compelling and the factors that influence their decisions. Although decision makers at subnational levels of government and local religious and cultural leaders were mentioned in the interviews, their inclusion was beyond this study's scope; a study comparing these groups with their national counterparts would be useful. Six of the 19 advocates were representatives of international donors, and some of the remaining 13 advocates may have received funding from these donors. Donors may differ from nondonor advocates, and nondonor advocates' thinking or answers could be influenced by their funding sources. Small sample sizes in each country and category limit the statistical power of the study's quantitative analysis; however, robust qualitative data allowed us to make reliable inferences. Because respondents were aware that USAID, the top funder of family planning in Africa, also funded this study, they may have answered in ways they thought USAID would approve—a bias known as the “courtesy bias.” Finally, two questions in the Malawi interviews that sought to determine preferences for various advocacy approaches were changed from using the Likert scale format to hierarchical card sorting; results from these questions were not included in our analyses, because they would not be directly comparable to results from Ethiopia and Kenya.

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## RESUMEN

**Contexto:** A pesar de décadas de trabajo de incidencia política basada en la evidencia relativa a la planificación familiar en países en desarrollo, no hay suficiente trabajo de investigación acerca de cómo los tomadores de decisiones perciben y responden a tales esfuerzos.

**Métodos:** Una revisión bibliográfica dio como resultado 10 artículos de revistas con arbitraje publicados entre 1999 y 2012, sobre las necesidades y experiencias de los tomadores de decisiones en relación al trabajo de incidencia política y la evidencia en materia de salud. A partir de temas emergentes se desarrollaron dos conjuntos de preguntas sobre investigación e incidencia política en planificación familiar—uno para tomadores de decisiones y otro para defensores del tema— que se utilizaron como parte de entrevistas estructuradas con 68 informantes clave en Etiopía, Kenia y Malawi.

**Resultados:** Los tomadores de decisiones reportaron haber comprendido el valor de la planificación familiar y confirmaron que el trabajo de incidencia política había ayudado a incentivar cambios favorables recientes en el apoyo gubernamental a la planificación familiar. Los informantes clave pusieron énfasis en que, para que sean efectivos, los mensajes y formatos de incidencia política deben ajustarse a las necesidades e intereses de las audiencias específicas. Los mensajes también deben considerar las barreras al apoyo en materia de planificación familiar que enfrentan los tomadores de decisiones: actitudes negativas de sus electores; temor de que una mayor adherencia a la planificación familiar vaya a reducir el tamaño e influencia de bloques específicos de votantes y grupos étnicos; y otras prioridades en materia económica, social, cultural, religiosa y política que compiten en importancia. Los tomadores de decisiones reportaron que valoran las contribu-

ciones de las organizaciones internacionales de planificación familiar y de los donantes, pero que se sentían más cómodos recibiendo los mensajes de incidencia política a partir de fuentes locales.

**Conclusiones:** Según los tomadores de decisiones, un trabajo sostenido y estratégico de incidencia política en materia de planificación familiar, desarrollado y presentado por actores nacionales en sintonía con la cultura local, y con el apoyo de actores internacionales, puede disminuir las barreras al apoyo del gobierno a la planificación familiar.

## RÉSUMÉ

**Contexte:** En dépit de décennies de plaidoyer basé sur des preuves pour la planification familiale dans les pays en développement, la recherche sur la manière dont les décideurs perçoivent ces efforts et y répondent est insuffisante.

**Méthodes:** Une analyse documentaire a produit 10 articles publiés dans la presse validée par les pairs entre 1999 et 2012 concernant les besoins des décideurs et leur expérience en matière de plaidoyer et de données probantes sur la santé. Deux ensembles de questions sur la recherche et le plaidoyer relatifs à la planification familiale—un à l'intention des décideurs et l'autre à celle de ses défenseurs—ont été développés sur la base de thèmes émergents et ont servi dans le cadre d'entretiens structurés avec 68 informateurs clés en Éthiopie, au Kenya et au Malawi.

**Résultats:** Les décideurs ont déclaré comprendre la valeur de la planification familiale, confirmant par ailleurs la contribution du plaidoyer à la récente évolution favorable du soutien gouvernemental à son égard. Les informateurs clés soulignent que, pour être efficaces, les messages et approches du plaidoyer doivent être adaptés aux besoins et aux intérêts d'audiences particulières. Les messages doivent aussi tenir compte des obstacles opposés au soutien de la planification familiale par les décideurs: les attitudes négatives des groupes concernés; la crainte qu'un recours grandissant à la planification ne réduise la taille et l'influence de certains blocs d'électeurs et groupes ethniques; et les priorités économiques, sociales, culturelles, religieuses et politiques concurrentes. Les décideurs déclarent valoriser les contributions des organisations internationales de planification familiale et des donateurs, mais ils préfèrent les messages de plaidoyer issus de sources locales.

**Conclusions:** Selon les décideurs, un plaidoyer pour la planification familiale soutenu et stratégique, développé et délivré par des acteurs nationaux sensibles à la culture, avec l'appui d'intervenants internationaux, peut amoindrir les obstacles au soutien gouvernemental de la planification.

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