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 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 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.