MEASURING ADVOCACY FOR POLICY CHANGE

the case for respectful maternity care

21-22 October 2013 • Boston, Massachusetts

Final Meeting Report

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Executive Summary

On October 21-22, 2013, the Maternal Health Task Force (MHTF) and USAID|TRAction brought together nearly fifty people in Boston, Massachusetts to participate in a meeting entitled, *Measuring Advocacy for Policy Change: The case for respectful maternity care.* The goals of the meeting were threefold: to identify lessons learned from past global health policy advocacy campaigns; to identify key measurement issues and strategies for policy advocacy; and to begin to plan for how policy advocacy for respectful maternity care can be informed by these lessons learned, and how this success can be measured.

Meeting participants included representatives from the maternal health field working in research, program implementation, and advocacy; advocacy experts from a variety of fields; those concerned with measuring advocacy for policy change; and experts in human rights policies and laws. Participants traveled to the meeting from five different continents—North America, South America, Europe, Asia, and Africa—emphasizing the reality that disrespect and abuse is a global issue.

Over the course of the meeting, ten prominent themes emerged:

1. Key lessons-learned from other advocacy work suggest that there has to be an "information environment" for cultural shifts to happen. For the anti-tobacco campaign, for example, this shift was evident in everything from changing social environments (no smoking in key places to designated "smoking areas") to changes in how often we see smoking in movies to regulation of sales of cigarettes and increased taxes. Smokers were bombarded with information over a sustained period of time and we were all part of a shifting cultural landscape over time. No single, short-term campaign likely explains the overall perception and behavior changes we have witnessed.
2. Timing is critical. For policymakers, one "big moment" (a campaign, event, or something that happens or changes suddenly) can yield significant progress, and it is crucial that an advocacy campaign be pre-positioned to take advantage of these moments when they occur. This is in contrast to behavior change advocacy, which relies on continual communication strategies to make small, incremental steps.
3. Consensus on definitions is key. Those working in the field of respectful maternity care need to determine whether "disrespect and abuse" or "respectful maternity care" is more compelling and that will form the foundation for building an advocacy campaign.
4. Simplicity is critical for advocacy campaigns. This includes simple numbers, simple asks, and simple stories. One speaker noted that the challenge of making advocacy evidence-based lies in how to keep it from getting too complex. This may be a challenge for the field of respectful maternity care, which is still coalescing around definitions and measurement strategies.
5. The trifecta for policy change success is <u>advocacy</u> (building constituency, changing policy, garnering resources); <u>activism</u> (elevating the issue, calling the question); and <u>social marketing</u> (on the ground, or "the ground game").

6. One critical question raised is whether a top-down or bottom up approach is more effective. What are ways to implement and measure each? One speaker noted that 50% of the world is women (a "built in" constituency), yet women have not been engaged effectively on this issue. It is not yet clear what bottom-up advocacy looks like in maternal health, but this might be the angle that will shed the most light.
7. A sense of success as a way to start the "ask" of the policy community is important. Speakers from the AIDS and child health advocacy fields noted that getting momentum going in a way that is positive makes it easy for the movement to grow. In the AIDS movement, campaigns that told simple stories of success such as "In the previous month XX people had access to treatment who did not previously…." made important inroads for everyone to feel that HIV could be managed.
8. Outcome mapping is a first step in planning for advocacy in order to keep the community grounded throughout the process.
9. Measurement is the foundation of successful advocacy, and it is particularly important to measure what you can in the "muddy middle." This involves choosing interim outcomes that tell a story and are not just indicators. Interim measures can include strength of alliances, organizational capacity, and level of engagement from a base of support. Additionally, creating a theory of change is an important way to start even if it is not entirely clear from the beginning how to measure these dimensions. (Having said this, you do not have to measure everything in your theory of change, which is a ground-breaking idea for public health professionals.)
10. Working with allies who feel similarly from the outset will help drive coalition building, but it is important to leave the door open for potential allies to join later. A compelling example shared was Senator Jesse Helms, initially an opponent to the AIDS movement when it was associated with the gay community, who later became an enormous ally for HIV-infected children.

An overarching theme that emerged throughout the meeting was how difficult it is to set advocacy targets and priorities for a set of phenomena—disrespect and abuse and respectful maternity care—that are not yet fully defined. As a result, the areas for future development emerging from this meeting involve the following: (1) supporting ongoing work to develop definitions, (2) supporting generation of prevalence estimates, (3) setting advocacy priorities and strategies, (4) developing advocacy metrics, and (5) determining an implementation research agenda for RMC. It was acknowledged that doing so will require the involvement of a variety of stakeholders and actors, and meeting participants and partners who actively engage in a *community of practice*.

List of Acronyms

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CHANGE	Center for Health and Gender Equity
D & A	disrespect and abuse
FCI	Family Care International
MCHIP	Maternal Child Health Integrated Program (part of Jhpiego)
MHTF	Maternal Health Task Force
MMR	maternal mortality ratio
RMC	respectful maternity care
RTI	Research Triangle Institute
SSA	sub-Saharan Africa
TOC	theory of change
TRAction	Translating Research into Action
UNICEF	United Nation's Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

Although there have been marked advances in the delivery of maternal health services in many parts of the world, the number of women with "skilled attendance at birth," especially in developing countries, suggests that there is a long way to go. Many women in low-resource settings seek antenatal care (ANC); far fewer seek to deliver within facilities. The question of why this is so has perplexed many in the maternal health field, especially as conditional cash transfers and other forms of incentives take hold. One hypothesis for why women do not give birth in facilities is that the amount of disrespect and abuse that women endure in such facilities, while giving birth, is well known. Additionally, disrespect and abuse during childbirth may explain why unexpectedly poor maternal health outcomes continue to be documented in some regions with high facility-based delivery rates.

Lack of Respectful Maternity Care

In 2010, Bowser and Hill conducted a landscape analysis of disrespect and abuse during childbirth.[1] Their work found that disrespect and abuse is a common phenomenon in countries all over the world—both wealthy and poor—and classified disrespectful and abusive behaviors into seven categories: physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care and detention in facilities. This landscape analysis showed that much work needs to be done in order to understand why women are being treated so poorly and, even more importantly, how to change these conditions.

Advocating for respectful and dignified maternity care, and figuring out how to measure advocacy for this change, was the focus of a meeting held by the Maternal Health Task Force (MHTF) and USAID|TRAction in Boston, October 21-22, 2013. *Measuring Advocacy for Policy Change: The case for respectful maternity care* brought together close to fifty participants (please see Appendix B for a complete list of participants) who represented the maternal health field from a research, program implementation, or advocacy perspective; advocacy experts from a variety of fields; those concerned with measuring advocacy for policy change; and experts in human rights policy and law. The wide geographic representation of meeting participants reflected the reality that disrespect and abuse occur in all corners of the globe.

Role of Policy Advocacy

Policy advocacy is a complex, strategic effort to influence policy makers to distribute resources, create policies, reform policies, and manage implementation of policies that support a specific cause or agenda.[2] Strategies to advocate for policy change fall across the global, national, and/or local level and can be done through a number of channels: communicating directly through policy makers (campaigning or lobbying); communicating through the media; implementing a campaign for change; or building policy advocacy capacity of community based organizations.[3] This engagement is done across a continuum of policymakers and involves complex interactions between a myriad of players including grant makers, grassroots organizations, grantees, and

[1] Bowser D. and Hill K. (2010) *Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis.* USAID|TRAction Project.

[2] CARE Website. Promoting Policy Change: http://www.care.org/getinvolved/advocacy/tools.asp

service delivery workers.[4] Further, policy advocacy works in the dynamic, unpredictable policy environment – one of changing contexts and shifting strategies in which success is dependent on the current public policy landscape, rather than advocacy efforts[5].

Evaluating policy advocacy helps determine which strategies are most effective in creating the desired policy change and informs advocacy planning efforts.[6] Ideally, the evaluation approach is part of an on-going process that is adjusted as context, policy, and strategy change. Due to the complex nature of policy advocacy, evaluators find it challenging to apply traditional program evaluation methods to policy advocacy evaluation.

This report summarizes the dialogue between meeting participants of the fields of respectful maternity care (RMC) and policy advocacy as they wrestled with and discussed ideas to bring approaches from policy advocacy to the field of respectful maternity care, and how successes in doing so might be measured.

In addition to this meeting, and as part of USAID|TRAction's and the MHTF's recent work to foster dialogue between these two communities, the MHTF also launched a blog series with posts from experts working to address the issue of disrespect and abuse around the world. Authors addressed topics such as achieving respectful care though education and awareness, investing in health systems and providers, fostering community partnerships, and addressing HIV-related stigma as an important part of respectful maternity care, among other issues.

The USAID|TRAction and MHTF team used a number of online tools to share the meeting proceedings with the broader global health community in real-time and at the end of each day. The MHTF engaged colleagues around the world on Twitter (#RMCadv), posted daily updates from the meeting on the MHTF Blog, captured and shared videos and speaker presentations, and used Storify to publish daily summaries (Day 1 and Day 2) of the meeting discussions.

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[4] The Evaluation Exchange, Harvard Family Research Project, Spring 2007.

[5] Guthrie, K., Louie J., David T., and Foster C. *The Challenge of Assessing Policy and Advocacy Activities: Strategies for a Prospective Evaluation Approach*. Blueprint Research & Design and The California Endowment, 2005.

[6] Reisman, J., Gienapp, A., and Stachowiak, S. *A Guide to Measuring Advocacy and Policy*. Organizational Research Services and Annie E. Casey Foundation, 2007.

Meeting Goal and Objectives

The overarching **meeting goal** was to identify existing and potential strategies to measure advocacy for policy change to advance respectful maternity care.

The **meeting objectives** were the following:

1. To identify lessons (both positive and negative) from advocacy efforts that have attempted to make far-reaching change in the policy arena in other areas of global health;
2. To identify and describe measurement of key outcomes and intermediate milestones for respectful care policy and advocacy; and
3. To determine next steps to strengthen and build synergies within the respectful care community on measurement for policy and advocacy.

The **long-term meeting goal** was to develop a community of practice around measurement and metrics for respectful care policy advocacy.

Meeting Sessions

Day 1

The first day of the meeting included an overview of respectful maternity care and the history of this field. Next, several speakers presented on past examples of advocacy for policy change from important allied fields in public health such as HIV and AIDS, tobacco, and child health. An analysis of successful work in each field resulted in some of the major themes highlighted in the section below. After discussing the paths taken by policy advocacy campaigns in these fields, participants had the opportunity to engage with experts in measurement issues on what we know about policy advocacy evaluation including lessons learned from advocacy for policy change on reproductive health and rights; the power of interim measures on the way to change; and effective strategies for measurement. The role of governing bodies in policy change and human rights and maternal health policy were also discussed.

Importantly, the day started with the recognition that the issue of respectful maternity care has two major challenges that will need to be addressed by any advocacy campaign: 1) not everyone will be galvanized on the issue feeling that it is "less than essential" in the face of an array of hardships in low resource settings; and 2) there will be resistance from those who feel that by addressing poor interpersonal care women experience, health care providers are singled out unfairly.

Additionally, the role of numbers was one that warranted much discussion in recognition of the fact that the numbers of "cases" of women who experience disrespectful and abusive care may not be as great as, say, the numbers of women living with HIV or at risk for malaria. At this point, while the research community tries to get a grasp of the prevalence of women being mistreated during labor and delivery, it was recognized that even with data considered less than reliable, there may be numbers that will work for advocates and activists. Advocacy campaigns need simple numbers, and these need not have the same level of specificity that public health professionals often seek.

Discussions around measurement consistently noted both how complex measuring policy advocacy is, and the necessity of doing so. As several of the speakers noted, focusing on what is easily measurable often does not yield sufficient information on how advocacy is contributing to bigger picture gains. Advocacy is, by nature, highly adaptive and fluid and the monitoring and evaluation frameworks we choose to measure advocacy must be similarly flexible. Developing a theory of change—a type of outcome map—was proposed as a methodology to keep advocacy efforts focused and the evaluation grounded. A theory of change should clearly articulate the linkages between strategy and outcomes, but should also be a living document that accommodates the dynamic reality of advocacy.

The "muddy middle" of a theory of change was highlighted as a particularly important place for measurement—though complex, this stage of advocacy represents an opportunity to celebrate first successes and build momentum. Choosing the right indicators for this measurement is critical in order to say that a strategy contributed to any policy change, and qualitative measurement is often what is needed.

Other important considerations that measurement speakers highlighted include the need to consider realistically what measurement is possible within a given timeframe and to be wary that attention is often given only to what is measured. This perspective highlights the need to have programs inform advocacy and measurement—rather than the other way around—and the necessity of developing meaningful indicators, particularly in the "muddy middle."

Finally, speakers discussed two current perspectives on maternal health advocacy, noting that the "how" and "who" of policy decision-making varies tremendously. While the research community tends to discuss "evidence-based policy making", in reality what often happens is "policy-based evidence making." The political calculations behind the latter may be influenced by communities, champions (or celebrities), the media, and networks of invested stakeholders; flexibility and political savvy are essential when sorting out these key influencers.

There was also recognition of the fact that there is a tension between a human rights framework (e.g. women have the right to high quality care) and an economic framework (e.g. investing in women pays off for communities and societies). While each theory has merit, the challenge is in finding the right balance in these two frameworks that will be the most compelling for a given audience.

The question was posed whether respectful maternity care is a social justice issue and, if so, how we could possibly tease apart the complexity of the system in which it resides. Given that health systems are both technical and political, there are a number of key questions to ask:

- How do we organize and with whom?
- What data count?
- What framework is at play or should be used?
- Does it matter who experiences disrespect and abuse?
- Whose voice matters? Whose should drive work in advocacy?
- What is the message?

Given the complexity of the system to be addressed and the dynamics of power, advocacy for respectful maternity care will not likely be linear and it may be important to have women at the front line, serving as the voice of this experience and making demand for change. Importantly, it will be critical to identify what a successful "end point" would be in the short, intermediate, and long term, and how these outcomes could be measured.

Day 2

Day two of the meeting began with a description of what some RMC advocacy currently looks like, with speakers focusing on the country level, citizen participation and accountability, and providers as change agents towards women-centered care. These presentations and discussions shared lessons from key geographic locations and grounded the conversation in important ways.

From the perspective of RMC at a country level, there was discussion about desired outcomes including changes in national policies and guidelines to include rights-based language, a respectful maternity care curriculum worked into disciplines such as medical, nursing, midwifery, and public health school, and some social norm change so that women are aware of their rights and can expect

and demand that their rights be respected. Examples from Nepal, Nigeria, and Malawi demonstrated that these kinds of policy changes are possible and may look different depending on the setting. Importantly, there were also questions raised about whether the promotion of respectful maternity care in its current form contributes to improving quality of care and improved health outcomes, issues that are lynchpins for galvanizing interest and resources.

The next speaker highlighted a number of ways that citizen participation can be mobilized to address respectful maternity care. At a high level, citizens can be engaged to demand change in places where international commitments that are not honored, laws and policies that are not respected, and institutions not recognized. Closer to the ground, there are managers not treated well; poor quality and performance standards, and weak local management, coupled with discrimination. By starting with a plan to listen to women, there may be ways to address issues that span health systems, management, human resources, and quality. Without starting with women's narrative, however, we will not be able to set important metrics for change.

Drawing on women's experience is also critical for instilling a sense of rights (in the words of the third speaker, a demand for "one woman one bed!") From a health care providers' perspective, however, it is also important to recognize that the staff shortage is extreme in many places; the knowledge base is often extremely limited; and that low pay and poor working conditions form a toxic dyad that results in a disrespected and disempowered workforce. In order to change this scenario, investment in providers including training and upgrading of infrastructure may help to create lasting change.

In the late morning of day 2, Mary Beth Hastings led a large group exercise to brainstorm the outcomes we would want to see if policy advocacy for respectful maternity care was successful. Following this large group discussion, meeting participants broke into small groups and were tasked with selecting one of the brainstormed outcomes and developing an advocacy strategy to achieve it from one of five perspectives: global, national, regional, community, professional association-targeted advocacy. The outcomes and strategies chosen by each group are summarized in the table below.

Advocacy Level	What is the targeted outcome?	Who must be influenced?	What are interim outcomes?
Global	Include RMC in all policies	– Professional associations – World Bank – WHO – UN agencies – Foundations – Countries – Women's groups	Global South included at all levels RMC included in: – Universal health coverage – Mother-baby friendly hospital initiative – Quality of Care – Sustainable Development Goals
National	Increased investments in reproductive health facility infrastructure which support RMC	– Increase community demand – Providers – Professional associations – Civil Society Organizations – Human rights bodies – someone who can "make the noise" – Ministries of Finance and Health – Donors – Health Facility governing bodies	– Mapping of existing policies, laws, legislation – Mapping of potential allies, opposition, influencers – Increased visibility of the issue – Infusion of issue into infrastructure improvement initiatives – Increased capacity of facilities – Staffing norms set
Regional	RMC is incorporated in health facility assessments and used to inform planning and budgeting	– District planners and implementers	– RMC incorporated into subnational indicators – Using media to help advertise and call for greater improvements – Working with research community to define indicators to incorporate
Community	Patient/ provider charter at facilities (includes RMC)	– Community leaders who demand accountability – Community members – need to change expectations – Service providers and health managers – Key members of the Ministry of Health	– Meetings with providers to raise awareness/acceptability – MOH approval at district level – Community-level coalition formed
Professional Organizations (eg. FIGO, ICM, COINN, INA)	Infuse RMC into professional association ethical standards	International- and national-level professional associations	– Meetings with international and national professional associations – Acceptable standards are harmonized and endorsed – Joint statement about "whole site" approach – RMC and mutuality of respect integrated into all professional association advocacy – Stronger space for local professionals' voice created by international associations, which will help raise issues like shortages and conditions and reduce professional isolation and fragmentation – Media training for spokespeople to lobby for professionals' voice

Major Themes

Over the course of the meeting, ten prominent themes emerged:

1. Key lessons-learned from other advocacy work suggest that there has to be an "information environment" for cultural shifts to happen. For the anti-tobacco campaign, for example, this shift was evident in everything from changing social environments (no smoking in key places to designated "smoking areas") to changes in how often we see smoking in movies to regulation of sales of cigarettes and increased taxes. Smokers were bombarded with information over a sustained period of time and we were all part of a shifting cultural landscape over time. No single, short-term campaign likely explains the overall perception and behavior changes we have witnessed.
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4. Simplicity is critical for advocacy campaigns. This includes simple numbers, simple asks, and simple stories. One speaker noted that the challenge of making advocacy evidence-based lies in how to keep it from getting too complex. This may be a challenge for the field of respectful maternity care, which is still coalescing around definitions and measurement strategies.
5. The trifecta for policy change success is <u>advocacy</u> (building constituency, changing policy, garnering resources); <u>activism</u> (elevating the issue, calling the question); and <u>social marketing</u> (on the ground, or "the ground game").
6. One critical question raised is whether a top-down or bottom up approach is more effective. What are ways to implement and measure each? One speaker noted that 50% of the world is women (a "built in" constituency), yet women have not been engaged effectively on this issue. It is not yet clear what bottom-up advocacy looks like in maternal health, but this might be the angle that will shed the most light.
7. A sense of success as a way to start the "ask" of the policy community is important. Speakers from the AIDS and child health advocacy fields noted that getting momentum going in a way that is positive makes it easy for the movement to grow. In the AIDS movement, campaigns that told simple stories of success such as "In the previous month XX people had access to treatment who did not previously…." made important inroads for everyone to feel that HIV could be managed.
8. Outcome mapping is a first step in planning for advocacy in order to keep the community grounded throughout the process.
9. Measurement is the foundation of successful advocacy, and it is particularly important to measure what you can in the "muddy middle." This involves choosing interim outcomes that tell a story and are not just indicators. Interim measures can include strength of alliances, organizational capacity, and level of engagement from a base of support. Additionally, creating a theory of change is an important way to start even if it is not entirely clear from

the beginning how to measure these dimensions. (Having said this, you do not have to measure everything in your theory of change, which is a ground-breaking idea for public health professionals.)

10. Working with allies who feel similarly from the outset will help drive coalition building, but it is important to leave the door open for potential allies to join later. A compelling example shared was Senator Jesse Helms, initially an opponent to the AIDS movement when it was associated with the gay community, who later became an enormous ally for HIV-infected children.

Conclusions and Areas for Further Development

There was a common acknowledgement among meeting participants that the field of respectful maternity care is rapidly evolving and expanding in a variety of arenas, and that this growth and activity needs to be supported. However, there is an inherent tension that comes from multiple actors simultaneously developing definitions, measurement techniques, advocacy metrics, and policy targets for respectful maternity care. Each of these endeavours is dependent on all the others, and it will be critical for actors involved in each to work in concert to achieve the common goal of reducing disrespect and abuse.

To this end, several areas for further development were identified by meeting participants:

1. Global research community to finalize definitions of disrespect and abuse and respectful maternity care and generate estimates of global prevalence of disrespect and abuse.
2. Leading advocacy groups must create a coordinating mechanism for RMC advocacy to articulate priorities and strategies.
3. Establish a Theory of Change and advocacy metrics to measure progress towards RMC advocacy targets.
4. Develop and research interventions to promote RMC.
5. Foster foundational partnerships at the donor level.

In each of the activities, there is much that the RMC community can learn from other health fields, and a broad set of partners, stakeholders, and champions should be engaged. The meeting concluded with participants committing to sharing their work—whether research, programs, or advocacy—broadly to support the formation of a community of practice.

Appendix A: Steering Committee Members

1. Mickey Chopra, UNICEF
2. Mary Beth Hastings, CHANGE
3. Ana Langer, MHTF
4. Mande Limbu, White Ribbon Alliance
5. Purnima Mane, Pathfinder
6. Jim Sherry, USAID|TRAction
7. Ann Starrs, Family Care International
8. Ali Yamin, François-Xavier Bagnoud Center for Health and Human Rights, Harvard University

Appendix B: Participant List

1. Kaosar Afsana: BRAC Health Program
2. Halida Akhter: Pathfinder International, Bangladesh
3. Erin Anastasi: UNFPA
4. Eva Bazant: Jhpiego/MCHIP
5. Diana Bowser: Brandeis University
6. Neal Brandes: USAID
7. Mickey Chopra: UNICEF
8. Jessica Christian: MHTF
9. Brenda D'mello: CCBRT
10. Louise Dunn: Women Deliver
11. Lynn Freedman: AMDD
12. Ariel Frisancho: CARE Peru/ Foro Salud
13. Andrea Goetschius: MHTF
14. Karen Grepin: New York University
15. Mary Beth Hastings: CHANGE
16. Tamil Kendall: MHTF
17. Marge Koblinsky: USAID
18. Margaret Kruk: Columbia Mailman School of Public Health
19. Ana Langer: MHTF
20. Carlisle Levine: BLE Solutions
21. Mande Limbu: White Ribbon Alliance
22. Kathleen McDonald: MHTF
23. Kate Mitchell: MHTF
24. Martha Murdock: FCI
25. Emily Peca: TRAction
26. Hannah Ratcliffe: MHTF
27. Laura Reichenbach: TRAction
28. Veronica Reis: Jhpiego/ MCHIP
29. Paula Rowland: Organizational Research Service
30. Jonathan Rucks: Pathfinder International
31. Kristin Savard: White Ribbon Alliance
32. Rhonda Schlangen: Independent Evaluation Consultant
33. Jim Sherry: TRAction
34. Brian Southwell: RTI
35. Mary Ellen Stanton: USAID
36. Ann Starrs: FCI
37. Tim Thomas: MHTF/ TimothyThomas.net
38. Erin Thornton: Every Mother Counts
39. Sandy Thurman: Emory University
40. John Townsend: Population Council
41. Lara Vaz: Saving Newborn Lives
42. Tisna Veldhuijzen Van Zanten: TRAction
43. Josh Vogel: WHO
44. Katie Vogelheim: Hansen
45. Charlotte Warren: Population Council
46. Mary Nell Wegner: MHTF

Appendix C: Meeting Agenda

MEASURING ADVOCACY FOR POLICY CHANGE

the case for respectful maternity care

Day 1 • October 21, 2013

MORNING SESSION (PLENARY) *Note: Breakfast and Registration will open at 8:00am*		*FACILITATOR: Tim Thomas*
9:00-9:30	**OPENING/WELCOME** Introductions, goal and objectives of the meeting	*Maternal Health Task Force* *USAID TRAction*
9:30-9:45	**Overview of respectful maternity care** Video: *Break the Silence: Respectful Maternity Care (Courtesy of White Ribbon Alliance)*	*Mary Ellen Stanton, USAID*
	Learning from past successes in advocacy for policy change	
9:45-10:15	HIV and AIDS: Domestic and global efforts and scale up	*Sandy Thurman, Emory University*
10:15-10:45	Q and A and Discussion	*Jim Sherry, USAID TRAction* *Ana Langer, MHTF*
10:45-11:15	**COFFEE/ TEA BREAK**	
	Learning from allied fields	
11:15-11:30	The case of tobacco	*Brian Southwell, RTI*
11:30-11:45	The case of child health	*Mickey Chopra, UNICEF*
11:45-12:30	Q & A and Discussion	
12:30-1:30	**LUNCH**	
AFTERNOON SESSION (PLENARY)		*FACILITATOR: Tim Thomas*
1:30-1:50	Watermelons and Seeds: Lessons from Evaluating Advocacy for Reproductive Health/ Rights	*Rhonda Schlangen , Independent Evaluation Consultant (video conference)*
1:50-2:10	The power of interim measures on the way to big scale change	*Paula Rowland, Organizational Research Service/ IMPACT*
2:10-2:30	Use of measurement: Effective strategies	*Carlisle Levine, BLE Solutions(video conference*
2:30-3:00	Q & A and Discussion	
3:00-3:30	**COFFEE BREAK**	
3:30-5:00	**Maternal health advocacy: Reflections from two perspectives**	
	Who decides and how? Influencing global policy on maternal health	*Ann Starrs, Family Care International*
	Human rights and maternal health policy	*Lynn Freedman, Adverting Maternal Death and Disability/ Columbia University*
	Q and A and Discussion	
	CLOSE OF DAY 1	
5:00-6:00	Reception at Simmons	

MEASURING ADVOCACY FOR POLICY CHANGE

the case for respectful maternity care

Day 2 • October 22, 2013

MORNING SESSION (PLENARY) *Note: Breakfast will be available at 8:00am*		*FACILITATOR: Tim Thomas*
9:00-9:15	**Recap of Day 1**	*USAID*
9:15-10:30	**What does RMC advocacy currently look like? Achievements and limitations**	
	Framing country-level national policy objectives	*Mande Limbu, White Ribbon Alliance*
	Citizen participation, accountability and respectful maternal care: Challenges & opportunities	*Ariel Frisancho Arroyo, CARE Peru*
	Women-centered care: Providers as change agents	*Brenda D'mello, CCBRT*
	Q and A and Discussion	
10:30-11:00	**COFFEE BREAK**	
LATE MORNING SESSION (LARGE & SMALL GROUP WORK)		*FACILITATOR: Mary Beth Hastings*
11:00-11:30	**Defining Policy Advocacy** Large group discussion	
11:30-12:00	**Brainstorm to identify international, donor, and national policy priorities and targets** Large group discussion	
12:00-12:30	**What would we like to see changed, and how will we measure it?** Small work groups on specific policy priorities	
12:30-1:30	**WORKING LUNCH**	
AFTERNOON SESSION		*FACILITATOR: Tim Thomas*
1:30-2:00	**What would we like to see changed, and how will we measure it?** Small work groups continued	
2:00-3:00	Report out to large group	
3:00-3:20	**COFFEE BREAK**	
3:20-5:00	**Next Steps, Partnership, Engagement** Large group discussion	
	CLOSE OF DAY 2	