ADVOCACY EVALUATION

SHAKING THE TREE:

Evaluating Programs that Combine Services and Advocacy

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Abstract

Reproductive health service delivery organizations in developing countries are increasingly engaging in advocacy for social change. This paper examines the trend and lays out the related monitoring and evaluation (M&E) challenges and opportunities to consider. It argues that M&E strategies that integrate both services and advocacy measurement are needed. These strategies can effectively demonstrate accountability and deliver results to stakeholders—both upwards to donors and downwards to the individuals reproductive health providers serve. Building on strengths of existing services and advocacy M&E practices enables providers and advocates to shake the M&E tree and harvest fruit that is already grown.

Introduction

Imagine you are a nurse at a small health center in a remote and mountainous area of Peru. Maternal mortality is an epidemic among the women in your community. The vast majority of women give birth at home, where infection, bleeding, and other complications put their lives and their babies' lives at grave risk. As a provider who knows the community and the culture, you understand why women continue to resist clinic deliveries. While cultural tradition dictates that the placenta be buried by family members immediately after delivery, current protocol at the health clinic does not allow for this, and the post-delivery rest period allowed at the clinic is insufficient for women who have a long, arduous walk home. With these insights at hand, you seek out local policymakers and become instrumental in changing policies to accommodate these conditions and cultural practices. As a result, clinic deliveries skyrocket over the next year. (Based on a report by Amnesty International (Amnesty International, 2006).)

This scenario demonstrates how the direct experiences of reproductive health service providers in developing countries can help shape advocacy priorities, which in turn can improve reproductive health[1] outcomes.

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[1] Reproductive health services include family planning, safe delivery, education, the prevention of STIs including HIV, and safe abortion.

Because they directly witness how barriers to access affect people, reproductive health service providers have the potential to directly link the services they provide to advocacy for changes in policies, systems, and norms that affect the communities they serve.

But how do service-providing organizations measure the results of this combination of advocacy and reproductive health services? While the number of women giving birth in the clinic is easy to quantify, measuring just *how* and *how much* the advocacy efforts of an organization contribute to change is more elusive. On one hand, organizations that provide health services may be more attuned to M&E, particularly those with good practices for measuring the quantity and quality of services they provide. On the other hand, advocacy requires different M&E focus and processes. For example, while an organization may track a continuous ticker tape counting services provided over the course of months and years, there is no corollary "result" with advocacy. Expanding the capacity of reproductive health organizations to monitor and evaluate their own progress can ultimately enhance the effectiveness of their work and help improve health outcomes for the women, men, and children they serve. Moreover, changes in the global development context, including an increased emphasis on measurement and results to justify use of limited resources, underscores the need for effective M&E of programs that combine services and advocacy.

This paper examines the trend of reproductive health civil society[2] organizations (CSOs, or non-governmental organizations) engaging in advocacy for social change, discusses their M&E practices and challenges, and posits M&E strategies that combine both services and advocacy. It first introduces the rationale and requirements for reproductive health service delivery organizations to get involved in advocacy. Next, it examines current M&E practices for services and advocacy in order to understand existing capacity. Finally, it poses some priorities for an integrated M&E approach to services and advocacy, illustrated with the approach of an Ethiopian CSO.

Defining Advocacy

Though the distinction between advocacy and other change interventions is perhaps not always clear-cut, advocacy, as it is being discussed here, has several unique characteristics:

- Advocacy inherently takes place in a crucible of contested space. It revolves around disputes as to whether and to what extent the change sought is legitimate, how it is to be achieved, and who benefits.

- Advocacy inevitably pivots on questions of power. Who has the authority and ability to make, implement, and assess decisions underpins any advocacy situation.

- Action and reaction are often disconnected. Advocacy is about influencing change that one cannot directly or individually control, meaning progress takes place in multiple stages, often with a time lag between the action of the advocate and actual change.

- Changes can occur in different ways, but invariably are manifested at multiple and interlinked levels—involving both systemic change and change to individuals with a stake in the system. In other words, to change a policy or the way an institution or a society operates, you have to persuade a people to think and/or behave differently.

In sum, advocacy is fundamentally relational, operating in a power-charged and contested context, and involving complex, interlinked, and often fluid and shifting chains of influence. *(Coe and Schlangen, 2011)*

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[2]   Civil society refers broadly to social movements, voluntary organizations, non-governmental organizations, grass-roots organizations and other non-state and not-for-profit actors (World Health Organization, 2002).

Changing context: CSOs in the global development agenda

Along with CSOs in other sectors, reproductive health CSOs are participating in development processes, and are affected by the broader development context in terms of funding, accountability, and measuring the results of their services and advocacy efforts. Most relevant to this discussion is the recognition by development agencies, donors, and governments that country ownership of a development agenda is critical and that civil society participation in developing this agenda is necessary. The opinions and influence of these global bodies is significant, as they shape dialogue and action around development—what it prioritizes, how it is funded, who participates, and how success is measured.

Civil society participation in development discussions has expanded over recent decades, most notably since the mass participation of non-governmental actors in the global development summits of the 1990s *(Pianta, 2005)*. A significant recent point in this trend was the 2005 Paris Declaration on Aid Effectiveness, which committed donors to supporting developing countries in designing their own aid priorities, and to harmonizing their funding accordingly. The declaration also identified civil society as key participants in determining and monitoring development programs *(Organisation for Economic Cooperation and Development, 2009, p. 13)*. Subsequent high-level forums in 2008 and 2011 take this inclusivity further,

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recognizing the vital role of CSOs as development and humanitarian actors in their own right *(Björkman & Svensson, 2007; BetterAid, 2010)*. This drumbeat is echoed by the policies of multilateral and bi-lateral donors, who emphasize that among social development and poverty alleviation strategies, "processes of policy and institutional change should be democratically anchored and shaped by active citizenship" *(United Nations Research Institute for Social Development, 2010, p. III)*. Of course, these priorities do not simply translate to expanded space for civil society in individual countries—indeed there are disturbing trends to the contrary in some countries. However, the direction is clear: in the future "the rules of the game and tools of development assistance need to evolve to focus on transparency, results, accountability and…flexible partnerships" *(Shaftik, 2011)*.

The global development stage is also occupied with an intense debate about measuring results. M&E practices are being reconsidered in response to rising concerns about the impact of aid dollars in a shrinking resource environment, and a shocking lack of evidence on effective programs. Development agencies, donors, and CSOs are rethinking systems for monitoring and evaluating results across development programs. The past ten years have seen new challenges to traditional notions of evaluation as these actors explore alternative ways to assess progress and build the capacity of CSOs to measure their own work.

These discussions about measurement and impact are significant because they signal priorities to CSOs. Country ownership of development, and efforts to expand civil society involvement in development, reinforces the need for informed and effective advocates. Resource constraints and demand for evidence mean CSOs need to better understand how to measure the results of their efforts.

Why Does Reproductive Health Matter?

Reproductive health and rights are essential to achieving the Millennium Development Goals (MDGS)—a framework of goals and targets set by 187 countries to coalesce the international response to poverty and development *(Bernstein & Hansen, 2006)*. Yet, access to these services and rights remains inadequate. For example, only about one-half of the 123 million women who give birth each year receive antenatal, delivery, and newborn care. An estimated 215 million women who want to avoid a pregnancy are not using an effective method of contraception *(Singh, Darroch, Ashford, & Vlassof, 2009)*. The result is that unplanned pregnancy is a significant contributor to death and disability among women of reproductive age as well as to infant and child mortality.

The benefits of meeting the need for both family planning and maternal and newborn health services are significant. For example, unintended pregnancies would drop by more than two-thirds, and the healthy years of life lost due to disability and premature death among women and their newborns would be reduced by more than 60 percent *(Singh et al., 2009)*. Reproductive health is also closely linked to poverty, gender equality, and a host of other development concerns *(Chan, 2007; Greene & Merrick, 2005; Sundaram, Epp, Oomman, & Rosen, 2004; "Poverty and Reproductive Health," 2011)*.

Given these stakes, access to quality reproductive health services, and ensuring they are supported by adequate funding and policies, is a vital investment.

Advocacy for Access: from Parliamentarians to Mothers-in-Law

Connecting advocacy to reproductive health service delivery is not a new practice. In the early 1900s, Margaret Sanger provided contraceptives to poor women in the United States in defiance of the 1873 Comstock Law (which prohibited the distribution of contraceptive devices and information as "obscene"). She used the public attention garnered by her subsequent arrests to advocate for women's rights to control their own fertility. This model of syncing reproductive health services with advocacy has evolved and gained traction internationally in recent decades, with increasing emphasis on advocacy by CSOs that provide reproductive health services. Connection between reproductive health services and advocacy is not incidental. As noted in *The Lancet's* Series on Sexual and Reproductive Health, "The increasing influence of conservative political, religious, and cultural forces around the world…arguably provides the best example of the detrimental intrusion of politics into public health *(Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006)*.

For reproductive health service organizations, advocacy is a strategy to challenge barriers at three general levels influencing access to services:

- *Public policy*: The political commitment, policy content, and regulations related to their implementation and budget commitments.

- *Systems*: The constellation of institutions responsible for administering, organizing, locating, promoting, and supporting services, such as healthcare and social development programs.

- *Social norms*: The social and cultural conditions that affect attitudes, acceptability, understanding, and demand for services.

Thus, barriers can include a diverse combination of community attitudes, lack of resources, and limited interpretation of policies and guidelines. They can include national, regional and global priorities, as well as policies and funding. In short, they influence whether services are available and whether individuals use them.

CSOs can use advocacy to address the most immediate or movable barriers to services. Often, it means engaging with parliamentarians and other decision makers around policy issues specifically related to reproductive health. In many cases, the barriers are social or cultural, and education becomes a form of advocacy. Some advocacy efforts are even broader, on the premise that sustainable access requires changes in underlying barriers related to gender and economic and social justice—in other words, addressing the root causes of limited access.

The position of service providers means that they can offer firsthand insights into some barriers to progress toward development priorities. For example, they can:

- **Understand social determinants to health and accessing services:** Social determinants to health broadly refer to the factors that influence health: conditions in which people are born, grow, live, work, and age. They include health systems and factors that determine access, including gender and family dynamics. For example, projects in rural India and Ethiopia used advocacy to engage mothers-in-law about the risks of early childbearing—an issue in places where child marriage may be illegal but widely practiced—or the benefits of child-spacing. In these communities, a married girl or woman may openly seek healthcare services only if her mother-in-law is on board.

- **Identify disconnects between policies, regulatory guidelines and services:** Policies, however sound, only work if they are implemented well. For example, Nigeria has guidelines on the integration of reproductive health and HIV services, aimed at improving both reproductive health and HIV/AIDS outcomes by reducing barriers to services (including those created when a client has to travel to multiple locations for services). However, in practice, credentialing requirements apparently result in a service provider who is trained to provide HIV counseling and testing, but has insufficient training on injecting contraceptives. This creates situations where a patient must see two different service providers—one for the injectable contraceptive and another for HIV services *(Family Health International, 2010; Government of Nigeria, 2009, p. 5; Partners for Health Reformplus (Abt Associates), 2004; United States President's Emergency Plan for AIDS Relief, 2010)*. Another CSO representative discussed Kenya's decision to split the oversight of health services facilities between two ministries following the formation of the coalition government in 2008.[3] This happened "because a political decision was made, not because it is good for services" *(Anonymous advocate, 2011)*. The subsequent confusion has undermined services and reinforced the importance of advocacy.

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[3]   The former Ministry of Health was split into two separate ministries, the Ministry of Medical Services (MOMS) and the Ministry of Public and Sanitation (MOPHS). For more details, see *(Republic of Kenya Service Provision Assessment (SPA) 2010.*

- **Add to the research base about policy impact:** For example, the United States Congress places restrictions on U.S. foreign assistance money that goes to reproductive health services in developing countries. These restrictions, popularly known as the "Global Gag Rule" or "Mexico City Policy", essentially limit the scope of CSO activities, regardless of whether they are funded by the U.S. or another source. Service providers have contributed to the research base about the impact of this policy in cutting off family planning and other reproductive health services *(Center for Reproductive Rights, 2003; Population Action International, 2004; Representative Nita Lowey, 2007)*. Service providers' direct connections to the marginalized communities whom donors and governments and policies intend to serve make their voices critical to conversations about effective policies and systems. In this way, CSOs also may serve as a conduit for women to become directly involved in policy discussions.

These perspectives, combined with the right skills and resources, can help catalyze a change in policy, regulations, administrative restrictions, and norms affecting access. For example, in Malawi, health care providers participated in a policy debate about whether health surveillance assistants (HSAs)—civil servants with ten weeks of medical training—should be allowed to administer injectable contraceptives. Injectable contraceptives, popular with women because they are required only once every three months and afford a high level of confidentiality (as there is no evidence of use), were difficult to obtain. HSAs were not authorized by the government to provide injections, and the severe shortage of medical service providers authorized to do so left women with limited access. A combination of research demonstrating the feasibility of HSA provision of injectables and strong support from other members of the medical community was critical to changing the policy *(USAID Health Policy Initiative, Task Order 1 2010, 38-41)*.

Clearly, CSOs can play a role in addressing gaps and barriers that limit access to services, and advocacy is key. While many providers already work on advocacy to educate communities about services, as one Kenyan service provider pointed out, "We need to start talking to politicians" *(Anonymous, 2011a)*.

Reproductive Health CSOs: Adding Advocacy

Taking on advocacy is a much more complex proposition for service-providing organizations than simply channeling stories of providers and clients to illustrate the effects of a policy. It often introduces organizational issues, such as taking public positions and the potential impact of those positions on services. Implementation requires a set of skills that is often distinct from those of a service provider. Organizational cultures also may need to shift to allow for the adaptability essential to effective advocacy. As such, organizations adding advocacy to their existing service provision are required to make an investment in resources and skills, and to manage risks associated with their expanded vision.

Advocating for access to reproductive health services is not without risk, as providers taking a public position on a controversial issue are vulnerable to virulent and violent attacks. As described in the box on page 2, advocacy operates in a contested context, involving competing priorities and solutions, and power relationships with fluid chains of influence. Advocacy always has a transformative purpose, but the boundaries of what it aims to transform remain flexible *(Hammer, Rooney, & Warren, 2010)*. These conditions are particularly true for reproductive health and rights, which occupies often hotly contested political and cultural space.

Advocacy acumen is not inherent and requires investment in building capacity. Service-providing CSOs engaging in advocacy must understand the barriers and the mechanisms for policy and social change. They need to be clear about power dynamics, relationships between players, and the potential routes to influence the changes they seek. As one informant, a physician with decades of experience working with reproductive health services and advocacy organizations around the world, noted: "If you are a service provider, you have the training, you are clear that you can do the work. You may be a great advocate naturally but you don't have the training and no one says 'here's what you do'" *(Diaz, 2011)*. These skills and strategies are distinct from those required to deliver services, and require resources and support.

Service-providing organizations engaged in advocacy are also beholden to demands for accountability for their efforts and justification of their advocacy claims. As participation by CSOs in public debates around policymaking has expanded, questions are being raised in some circles about advocates' claims to represent particular communities, the benefits they provide, and the quality of their research base *(Hammer et al., 2010)*. CSOs need to invest in evidence-based research or, at a minimum, in robust data collection methods to give advocacy efforts weight. This does not mean dismissing stories, but rather collecting them using more rigorous methods. *(See, for example, the Most Significant Change technique, which systematically engages stakeholders in analyzing data from stories collected from program beneficiaries and identifying outcomes (Davies & Dart, 2005).)* As such, service-providing organizations need to have both the technical skills to deliver advocacy as well as a defensible research and a credible information base from which to make their claims.

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The necessity of collaboration creates further skills needs. Advocacy is rarely a solo effort, and this need is arguably even greater in the case of organizations whose primary mission is not advocacy but service provision. Often, advocacy is conducted through coalitions or networks, adding critical mass to efforts and contributing complementary experiences or skill sets, but also requiring collaboration and coordination. The contribution of service delivery organizations often hinges on their "street credibility" as frontline service providers, who can contribute data and insights that other coalition members may not have. Advocacy collaboration requires an investment of time, resources, and coordination. Given the necessity of joint work, effectiveness directly relates to the quality of relationships among actors in alliances, coalitions, or other partnerships.

Advocacy has been a key strategy in expanding space for civil society participation in development efforts. CSOs are leading processes to advance priorities, hold governments and global institutions accountable, and strengthen the connection between decisions made in the halls of power and the impact on people's lives. Service providers are a critical voice, and to effectively engage in advocacy they need a foundation of institutional commitment, skills, and support. M&E is a critical tool for empowering these service providers to assess their own progress in delivering services *and* engaging in advocacy.

Examples: CSOs combining advocacy and services

As the three examples below illustrate, this pool of organizations is diverse, with wide-ranging levels of resources and infrastructure. "Service delivery providers" may refer to a medical association, an individual provider or organization, network, or clinic whose services are affected by local, national, or global policies. These organizations are supported by a range of donors—private, bilateral, or public. In short, reproductive health CSOs engaging in advocacy are positioned differently vis-à-vis communities, funders, and policymakers, and each has slightly different motivations for integrating advocacy into its ongoing work. *The unifying characteristic of these organizations is that they use advocacy to advance their missions and extend beyond the scope of their normal operating vision.* Another unifying characteristic is that all three organizations aim to use M&E to assess their services and advocacy work for their own learning, and to demonstrate their effectiveness to supporters.

1. Bioeconomy Africa, *Ethiopia*

Since 2003 this non-governmental organization has been developing community-based solutions to poverty, environmental degradation, and poor health. Bioeconomy Africa's programs include sustainable agriculture, climate change adaptation, and health (including HIV/AIDS treatment and prevention and reproductive health). They work in communities throughout Ethiopia and have recently started to replicate their approaches in the Democratic Republic of Congo. Advocacy is integrated in all their programs as a strategy to address political barriers to the success of their programs *(Aseffa, 2011; Bioeconomy Africa, 2011)*. Bioeconomy Africa's approach to advocacy and services M&E is presented as a case study later in this document.

2. International Planned Parenthood Federation (IPPF), *Worldwide*

IPPF is a global organization founded in 1952. It has member associations in 170 countries around the world, which together provide an estimated 36 million services each year, including family planning, HIV-related services, and infertility services. It adopted advocacy as one of the five pillars of its 2005-2015 strategic framework, along with four other service-focused priorities. In doing so IPPF signaled that advocacy was of equal priority to services within its global work. Every member association leverages its direct service provision to engage in advocacy, depending upon its capacity and political context. Within this effort, IPPF's Country Global Pathways advocacy project is aimed at shifting the sexual and reproductive health agenda from "being external and donor-driven toward being nationally owned and led," reflecting global aid effectiveness trends *(IPPF, 2011a, 2010, 2011b)*. IPPF's M&E is based on a common set of global indicators measured across the Federation *(IPPF, 2009)*. A recent effort to build M&E capacity is the piloting of an M&E *Leadership Development Programme* with MEASURE Evaluation and IPPF's South Asia Regional Office. The effort was spurred by a need to position M&E within member associations, rather than as an activity of external evaluators, and to strengthen the connection between data and decision making (*MEASURE Evaluation, 2011*).

3. The Campaign Against Unwanted Pregnancy (CAUP), *Nigeria*

Three Nigerian physicians, concerned with the number of women they treated for severe complications from unsafe, illegal abortions and frustrated with the lack of attention to this public health crisis, formed CAUP in 1991. Despite its illegal status, abortion rates in Nigeria remain high, and unsafe abortion is a major cause of maternal deaths. CAUP was launched as a multi-disciplinary coalition of medical doctors, academics, journalists, and legal advocates. It initially focused on legislative reform, and then expanded to address

the broader dynamics of unsafe abortion, including work with media, sensitizing members of the public, training advocates, and training medical students. After 14 years, CAUP commissioned an independent, external evaluation of its work, published in the journal *Reproductive Health Matters.* The evaluation found that the campaign's multi-level work on both service provider training and cultivation of advocates had helped shift the public discourse around unsafe abortion and elevated the issue's position on the public and political agendas *(Oye-Adeniran, Long, & Adewole, 2004; Whitaker, 2011).*

M&E priorities: The role of donors

Discussion of M&E and CSOs, including reproductive health providers, can be better understood in the context of the role donors play in shaping M&E systems and their support to build the capacity of grantees to implement those systems. International development agencies and other donors have a strong influence on the M&E priorities of CSOs. The M&E systems currently used by many reproductive health service providers have been introduced by the major development agencies or reflect the preferences of their external donors. Further, emphasis on accountability to funders means that M&E often prioritizes reporting and accounting. While introducing consistency and accountability, these systems may inadvertently undermine CSO ownership of M&E and, more broadly, undercut efforts to develop CSO capacity. At the same time, donors play a critical and positive role in supporting innovation of new M&E approaches.

As a policy advisor who consults for CSOs in South and Central America noted:

> *[CSOs] are forced to do evaluation because they have to provide reports to donors. They learned to [evaluate] the way international donors asked for it. [T]hey didn't sit down [and ask] 'How are we going to measure? What will be useful to know? How can we use this learning?' They just do it whenever [they] have to turn in a report.* (Anonymous, 2009).

This emphasis on accountability can be at the expense of internal relevance or learning. A review of organizations funded by the European Commission found that some of these CSOs spent 30 to 50 percent of their time reporting to donors *(Organisation for Economic Cooperation and Development, 2009, pp. 119–120).* Channeling resources in this direction diverts time and energy from actually assessing outcomes, impact, and strategies. Another criticism of mandated M&E is rigid systems that prioritize quantitative indicators. This often means that qualitative information, such as stories of change, are allowed only to play a supporting role *(Canadian Physicians for Aid and Relief, et al, 2005).* In the words of one young project staff in India, the M&E reports she and her colleagues generated were "not for us" *(Anonymous, 2008).* The information reported held little relevance to her work, was not discussed with other staff or managers, and did not feed into discussions about approaches and strategies.

Even the best-conceived and most widely-adopted M&E systems can fall short, particularly if there is a disconnect between the approach and how it is translated at the project level. For example, Canada's International Development Agency (CIDA) emphasizes organizational learning and reflects concerns about downward accountability. However, in a review of its "Results-Based Management" system with CSO partners in Canada and their developing country partners, CIDA found that while the system has many strengths, it was being used by some as a compliance mechanism rather than the dynamic, learning-based approach it was intended to be (*Or-*

ganisation for Economic Cooperation and Development 2009, 118-120). Issues with translating well-conceived systems to practice may be related to CSO M&E capacity, as this doctor and advocate notes:

> *Evaluation is critical for services, for the organization. People [donors] want it but don't fund it. We have been doing this work for 43 years...We do QI [Quality Improvement]. We can count, obviously...but we don't always find the resources or adequate skill set even for services evaluation.* (Diaz, 2011)

While donors may prioritize M&E among grantees and specify requirements, correlating financial support to ensure it is carried out effectively is often insufficient, particularly for smaller or sub-grantee organizations.

Donors can play a powerful and positive role in coordinating resources and coalescing action around a particular agenda. However, while inspiring ambition, donor-*driven* agendas also risk undermining useful M&E (among other issues). Funding conditions may require reporting against outsized or overly ambitious indicators—such a reproductive health service project operating in a limited area of the country reporting against changes in the national population growth rate. Organizations may also accept funding for change they are ill equipped or unlikely to deliver, such as specific policy change within a limited time period.

A related challenge is that advocacy "success" is often measured by results, rather than progress. An advocate working in the Caribbean described a scenario in one country where a donor expected policy and social change as a result of its investment. When the desired outcomes were not delivered, the donor considered the project a failure. Stakeholders in the country disagreed, arguing that significant progress had been made toward raising the public profile of an issue and developing a coalition of effective advocates positioned to take advantage of policy change windows when they opened (*Anonymous, 2010*). This and similar experiences point to disconnects between some donor and CSO agendas and expectations, which also makes it difficult to squarely address measurement that contributes to understanding of whether and how change is happening.

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In this context it is not surprising that to CSOs "evaluation" is often code for "onerous forms to complete and send to the donor". In response to this situation, some CSOs and donors are taking another look at their approaches to ensure they are yielding useful and accurate results, and are appropriate to the organization and program being measured. The past few years have seen an explosion of books, blog posts, and research about aid effectiveness and evaluation, including use of new economics to quantify return on investment dollars. Groups like 3ie (International Initiative for Impact Evaluation) have formed to tackle the problems with evaluation of global development programs. At the same time, there is a push in the aid effectiveness dialogue for more qualitative and participatory approaches to measuring results. This includes looking at broader indicators of social change, such as improvements in gender equality and human rights, and accountability to the intended beneficiaries of development programs *(3rd High Level Forum on Aid Effectiveness, 2008; Organisation for Economic Cooperation and Development, 2009, p. 16)*. While the issues are daunting, recognizing that there is a need for better approaches presents opportunities for innovative thinking.

Evaluation and services: A culture of measurement with room to improve

Systems for consistent collection and review of information about services delivered are typically an institutionalized aspect of reproductive health service provision. Following the lines described above, M&E plans for reproductive health services often utilize standardized, quantitative service delivery output indicators (e.g. contraceptives distributed, community information sessions held, pap tests administered, etc.). These are often organized around tested, widely accepted M&E frameworks introduced by international donors. At the same time, these approaches may have limitations, particularly in terms of inclusion of quality measures and connection to higher-level results. Despite limitations, these practices contribute to a fundamental culture of tracking, measuring, and reporting progress against goals that may not be present in organizations exclusively focused on advocacy.

There has also been a significant investment in knowledge management and M&E support to reproductive health providers, particularly with increased access to social networks and electronic communications. Efforts funded by international development agencies, such as the Capacity Project and Implementing Best Practices Knowledge Gateway, are aimed at facilitating sharing of information and best practices among service-providing organizations all over the world. The Global HIV M&E portal offers providers access to information and support. For example, *The Seven Steps to Use Routine Information to Improve HIV/AIDS Programs: A Guide for HIV/AIDS Program Managers and Providers*, is aimed at facilitating the use of information in decision-making processes about program design, management, and service provision in the health sector *(United States Government & UNAIDS, 2011)*. An online "African Agenda for Reproductive Health Discussion" forum in July 2011 brought together over 400 participants from 66 countries to discuss improving the quality of services and access to reproductive health services, including use of research and M&E. To those who can access them, such forums afford service-providing organizations with support and resources for planning their efforts and assessing results.

The use of structured frameworks is intended to help assess impact across programs. They also provide organizations with a predictable, consistent way of planning activities and measuring results. An approach like Results-Based Management, for example, emphasizes organizational learning and reflects concerns about downward accountability, or prioritizing impact for intended beneficiaries. With proper training and support, such frameworks can be implemented directly by service providers and integrated into their day-to-day processes.

That there is room for improvement is unlikely to provoke disagreement from any quarter. When it comes to implementing M&E, usefulness may have fallen victim to an overemphasis on structured frameworks and rigid tools that leave little room for innovation. Other concerns about current M&E practices are lack of participation by local partners in planning and decision making, systems that don't allow for a diversity of results, and approaches that are not conducive to collective learning. For many reproductive health service providers, the quality of services is neither consistently measured nor reported.

While there is opportunity to expand and improve, reproductive health service providers have a foundation of M&E at some level. They have systems and processes in place for tracking information, measures to demonstrate progress, and have learned the "system" of a donor or Northern partner along with its strengths

and weaknesses. In this sense, they are perhaps a step ahead of organizations that are strictly engaged in advocacy.

Evaluation and advocacy: "Pick up a Sesame Seed but Lose Sight of a Watermelon"

While M&E of reproductive health services is well-explored territory, reproductive health advocacy evaluation is still relatively uncharted. Even groups who specialize in advocacy are challenged to assess their efforts in a way that is both in line with their organization's resources and is accountable to stakeholders. Given this, it is little wonder that service delivery organizations struggle to evaluate their advocacy efforts. When a service delivery M&E culture is based on trust in quantifiable data connected to tested program models and traditional methodologies for measuring public health outcomes, advocacy evaluation may feel elusive.

Records room at a community-based reproductive health clinic, northern Nigeria (2008). The shelves hold client records, which were transcribed into notebooks and then to forms for reporting to donors.

In response, service organizations often simply apply the same M&E approach to their advocacy work that they use when measuring services. While it may seem intuitive to replicate an approach with which one is comfortable, there is not an advocacy corollary to counting clients and services. As a result, many organizations aim to quantify advocacy efforts, filling out logic models with numbers of meetings or newspaper column inches to measure success. As such, advocacy M&E efforts are apt to, as the proverb goes, 'pick up a sesame seed but lose sight of a watermelon'. This approach falls short in measuring the totality of their advocacy work. A linear, cause-effect approach also anticipates results attributable to a particular organization. A reductive assessment of the links between advocacy inputs and outcomes is rarely feasible or desirable. With advocacy it is typically more valuable to step back and try to construct a strategic overview—looking at the watermelon—rather than magnifying elements that are tangible but might not be strategically important—the sesame seeds.

Issues of strategy and planning that may be symptomatic of advocacy inexperience can confound advocacy M&E concerns. Often what is posited as an "advocacy evaluation" problem is actually an inappropriate advocacy agenda. Or as one person put it, "We were funded to do something that made no sense" *(Anonymous, 2010)*. As discussed in the previous section, organizations may take on advocacy priorities not suited to their position or capacity, or may accept funding to deliver advocacy results that are unrealistic or expected within an improbable timeframe.

Advocates are also feeling the pressure to demonstrate quantifiable impact as the broader development discussion around results and value for aid dollars influences the way donors and project managers talk about results. "Advocacy needs to shift from emotional to economic. We need to show the value we're getting for the advocacy money and learn from 'results-based financing' " *(Anonymous, 2011a)*. There is pressure to engage in the type of randomized evaluations undertaken by the Abdul Latif Jameel Poverty Action Lab (J-PAL),

and a sense of frustration that advocates lack the skills to do so. While getting serious about credibility, evaluation that serves advocacy requires fast, usable, and accessible results. While time-consuming and resource-intensive "gold standard" randomized controlled trials and cost-benefit analyses have an important role, the benefit of these approaches to measuring advocacy effectiveness and impact is a critical question.

As with service delivery M&E, lack of capacity also perpetuates a cycle of evaluation for reporting's sake, a focus on limited measurable indicators, and frustration with M&E that doesn't produce meaningful or useful information. As one advocate commented, "Our evaluation is very superficial because we don't have access to the expertise. We could hire an external evaluator, but that costs money. We would rather spend money on another advocacy strategy than an evaluation" *(Anonymous, 2009)*.

Opportunities to innovate

Yet with current challenges, there are clear opportunities for M&E innovation to fit changing needs. There is wide recognition that CSOs need M&E that helps them to measure progress and demonstrate accountability. Current discussions about advocacy evaluations center on the positioning of M&E in service to advocacy and the appropriate form and place of new advocacy evaluation tools. At a time of innovation and experimentation, organizations and advocates have the opportunity to devise creative strategies and experiment with what works for measuring advocacy. There are already promising developments from conversations around advocacy evaluation, development through the lens of complex systems, and developmental evaluation, among others.

For example, one approach draws on complexity theory from the natural sciences as a way to describe an unpredictable and nonlinear system (like the advocacy process). These complex, adaptive systems involve a diversity of actors and causal strands that mutually affect each other, and as a result the "system" evolves over time. Complexity theory has been used recently in the evaluation of social change and capacity-building interventions. *(See, for example, Rogers, 2008, Morgan 2006.)* Used as a model to guide thinking about evaluation of change interventions like advocacy, complexity theory focuses on patterns of a system as it evolves, alongside its dynamics and processes. It is concerned also with the analysis of key moments, tipping points, shifts in direction, the effects of feedback, and the resulting changes in the enabling environment. It may be a useful approach for a program that, for example, provides services and also engages in advocacy to influence both community-level actors as well as national-level policy.

An approach that positions evaluation as complementary to the strategy development process, called Evaluation for Strategic Learning or strategic learning evaluation, also has emerging application to advocacy efforts. Cultivated by the Center for Evaluation Innovation (the publisher of this paper) and others, the concept and supporting principles involve integrating evaluative thinking into organizational decision making, and generating data in real time to inform those decisions. Juxtaposed with evaluation conducted after the fact, which asks 'did we do what we said we'd do, and what happened?' evaluation directed to strategic learning offers feedback to program and organizational strategies as they unfold. The emphasis on the use of data for learning and adaptation makes this approach potentially relevant to evaluation of advocacy and other social change interventions *(Coffman & Beer, 2011; Preskill, 2011)*.

While these emerging approaches address advocacy or social change evaluation from slightly different vantage points, unifying characteristics and themes appear throughout: change is not linear or unilaterally catalyzed, effective advocacy requires adaptation to emergent pathways for change, and the "outcome" is not always policy change. Evaluation of such efforts requires flexibility, timely data, reflection, good intelligence, and judgment. Given the uncertainty of endpoints or firm outcomes in advocacy work, attention to progress and interim changes is a valuable focus of assessment resources.

Advocacy evaluation must reflect this reality. As pointed out in an article on advocacy evaluation in the *Stanford Social Innovation Review*:

> *The real art of advocacy evaluation, which is beyond the reach of quantitative methods, is assessing influence…Advocacy evaluation is a craft—an exercise in trained judgment—one in which tacit knowledge, skill, and networks are more useful than the application of an all-purpose methodology* (Teles & Schmitt, 2011)**.**

As the advocacy evaluation field develops, it is expanding the definition of *"good" evaluation.* The role of evaluation is shifting to become "a driver of effectiveness…capitalizing on the critical thinking skills of advocates and evaluators" *(Coe & Schlangen, 2011).* Repositioning evaluation as a tool for knowledge generation is particularly critical for advocacy. Making evaluation more accessible and relevant to those doing the work will likely benefit service delivery as well.

Doubling down on evaluation: Services + advocacy

Building on the best of services and advocacy M&E creates potential to optimize evaluation efforts by devising strategies that benefit both services and advocacy. The M&E cultures, structure, and coherence of reproductive health service evaluation provide a basis for enhancing approaches. Moreover, by integrating the high-level thinking that is going into the complexities of advocacy M&E, evaluation of services can actually benefit by being more responsive to the realities of both the provider and client. It can, for example, incorporate adaptability and an emphasis on qualitative data and analysis. In other words, M&E can facilitate synergies between service delivery and advocacy.

The next section discusses key differences and similarities between advocacy and services that have implications for evaluation. Next, it proposes some practical considerations for organizations and their stakeholders to consider when developing shared M&E strategies for advocacy and services. Finally, it illustrates how one organization uses an integrated approach to assessing its service delivery and advocacy efforts.

Key differences

A first step toward developing shared evaluation strategies is to be clear about the fundamental differences and similarities between advocacy and services, as well as the differences in their evaluation.

To some extent the challenge of evaluating programs that combine services and advocacy lies with the models of how change happens in each area. Service provision is based on the premise that if services are provided according to tested and effective models, and if they are accessible (reachable, affordable, meeting an identified demand), when scaled-up they should result in improved health outcomes. In contrast, social and

policy change through advocacy is predicated on a "strong, slow boring of hard boards" achieved through collaborative and iterative processes. Thus, advocacy M&E emphasizes processes and innovation, while service delivery M&E typically focuses on numbers of services and links to changes in health outcomes.

A popular analogy illustrating the differences between simple, complicated, and complex models of change may state the same idea in a more accessible way.

Models of change and complexity: *Advocacy is more like raising a child than following a recipe*

Simple	Complicated	Complex
Following a recipe	Sending a rocket to the moon	Raising a child
Recipes are tested to assure easy replication	Sending one rocket to the moon increases assurance that the next will also be a success	Raising one child provides experience but is no guarantee of success with the next
The best recipes give good results every time	There is a high degree of certainty of outcome	Uncertainty of outcome remains

(Patton, 2008; Rogers, 2008)

What we can take away from this is that while services may be like following a recipe—approaches are tested and implementation systematized, advocacy is like raising a child—success with one doesn't guarantee that repeating the same steps will produce the same results.

These differences have implications for M&E. Organizations rooted in more traditional M&E approaches may express discomfort with processes that are more qualitative or hold less promise of an absolute, objective result. Services are typically based on tested, predictable models, often attached to global indicators. Service providers, however, are among the first to say these are not always meaningful. Does it matter, for example, how many tests are administered if no one returns for the results? So, while predictable, quantifiable models may be the typical approach, service providers can also benefit from a more complex, broader point of view that mirrors the evolving dialogue on advocacy M&E.

Effective advocacy runs counter to the idea of a static and replicable advocacy model. The intensity of advocacy activities can fluctuate dramatically, requiring shifts in priorities and resources, while service delivery is generally rolled out in a steady, systematic way. Thus, tracking a logic model that follows a linear pathway of inputs, activities, outputs, and outcomes that may work for components of service delivery often does not work for advocacy. While one organization can deliver service results, advocacy is rarely unilateral and often relies on collective action. Advocacy outcomes are significantly affected by external variables not under the organization's direct control; instead, they are expressed in public opinion and policymaking institutions. This raises questions of attribution of results to individual actors, and M&E's ability to credibly deliver such information. In contrast, service outcomes are more directly connected to organizational performance and internally controlled and thus more easily measured.

Shared priorities

There are also shared characteristics to take into account when constructing M&E strategies that adequately measure and account for both services and advocacy. Both services and advocacy implementation and M&E require:

- Strong leadership and organizational responsiveness to stakeholder and community needs, especially those of intended beneficiaries

- Grounding in a core set of values that prioritize the rights to access health care services

- A connection to regional/global priorities

- A research-based approach

- Realistic timeframes for change, which can differ dramatically and are sometimes resource-dependent.

As increasing numbers of CSOs deliver not only services, but affect change through advocacy as well, there is a need for a shared approach to M&E that fits both areas of work. Such an approach would acknowledge differences in how change happens at the services and advocacy levels, and build on identical needs: for support, participatory practices, and robust information about progress and results.

Getting practical: Considerations for building joint services and advocacy evaluation

What does an integrated approach to services and advocacy evaluation look like in practice? There is not one off-the-shelf model that applies. Rather, this section proposes some practical parameters for developing a joint M&E approach, and includes an illustration of one organization that has seamlessly joined services and advocacy evaluation.

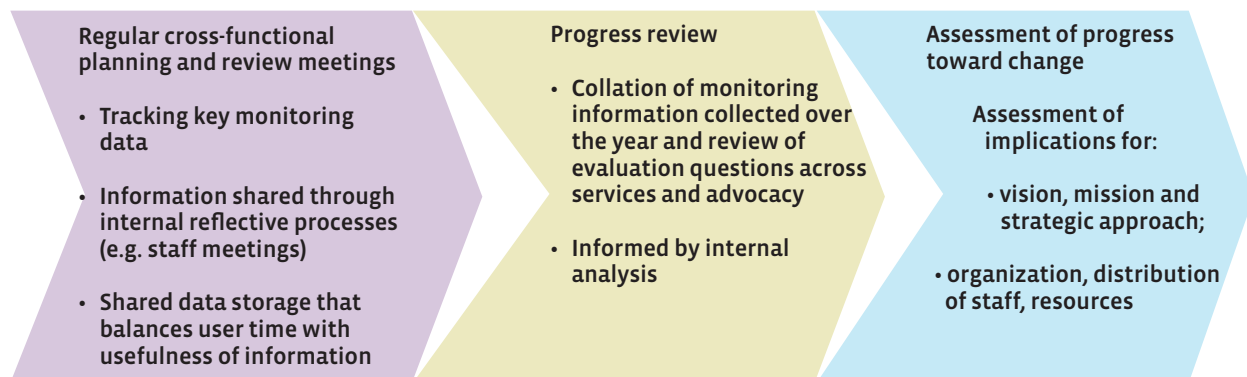### 1. Big 'M,' Big 'E': give equal play to monitoring

As a starting point, we need to balance the M&E equation. "Monitoring" is often the means to the evaluation "end" of ensuring accountability and demonstrating results. In emerging evaluation approaches, such as developmental evaluation and evaluation for strategic learning, monitoring is prioritized as an ongoing process to consider and respond to information, becoming a critical learning mechanism.

Monitoring focuses on progress—i.e., are we moving in the right direction? This focus on progress is really an effort to answer the question: "How do we know we're making a difference?" Advocacy M&E requires consistent and regular review of, and response to, information. Service delivery M&E could benefit from those processes as well. What information is reviewed and who is involved are critical parts of the monitoring process. Approaches should emphasize transparency, and the adoption of a multi-stakeholder approach to capturing information and analysis.

In practice, this could mean implementing "short-cycle" evaluation, or undertaking systematic, regular internal reviews of data for analysis and decision making. Data related to services can be used to identify advoca-

cy needs, and analysis of progress related to advocacy efforts can point to changes that may need to happen with services. With regular opportunities to share feedback, organized around a core set of questions, service and advocacy staff can share what they are seeing and use data from one area to benefit the other.

Figure 1: Example of a CSO's M&E process emphasizing ongoing monitoring review process

Regular cross-functional planning and review meetings

- **Tracking key monitoring data**
- **Information shared through internal reflective processes (e.g. staff meetings)**
- **Shared data storage that balances user time with usefulness of information**

Progress review

- **Collation of monitoring information collected over the year and review of evaluation questions across services and advocacy**
- **Informed by internal analysis**

Assessment of progress toward change

Assessment of implications for:

- **vision, mission and strategic approach;**
- **organization, distribution of staff, resources**

These reflective processes then become part of ongoing M&E efforts, aligned with the varying timeframes for change required of different advocacy and service interventions. For example, as the graphic illustrates, ongoing reviews could cover a basic level of monitoring information with deeper reviews of longer-term questions at intervals appropriate with the timeframe for change. In this way CSOs can introduce an M&E process that is basic and may be accomplished with few resources but which may be augmented as need and capacity allow.

Often monitoring, 'M', is seen as a necessary step to enable evaluation. Monitoring and evaluating joint advocacy and service efforts elevates monitoring to a necessary and equal partner with 'E,' evaluation.

2. Redefine success

CSOs and donors should redefine what success looks like for programs or projects that combine services and advocacy. Joint planning linking advocacy, research, and services should identify shared goals, with both services and advocacy working in support of those goals. Doing so will result in a more coherent connection between the work, progress, and changes related to goals, and, ultimately, improvement in people's lives.

At the same time, planning needs to take into account different timeframes for change related to services and to advocacy, and the ability to measure changes that may be tangible (e.g., more women receiving quality reproductive health services) and relatively intangible (gender sensitivity or a supportive environment). The timeframe is important, because the efforts related to both services and advocacy vary in the complexity and time required to meet their full potential. Some benefits or results will be tangible and more easily measured, such as services provided. Others, likely advocacy results, will be equally significant but less readily quantified, such as improved collaboration with partners and networks, or trust of decision-makers in the organization as a resource.

Developing a benefits matrix, like the sample below, can be a useful way to map out the change to be achieved through both advocacy and services. (Dark areas indicate changes related to services, un-shaded areas relate to advocacy.) It distinguishes between short- and long-term timeframes and identifies tangible and intangible changes.

Figure 2 Sample benefits matrix
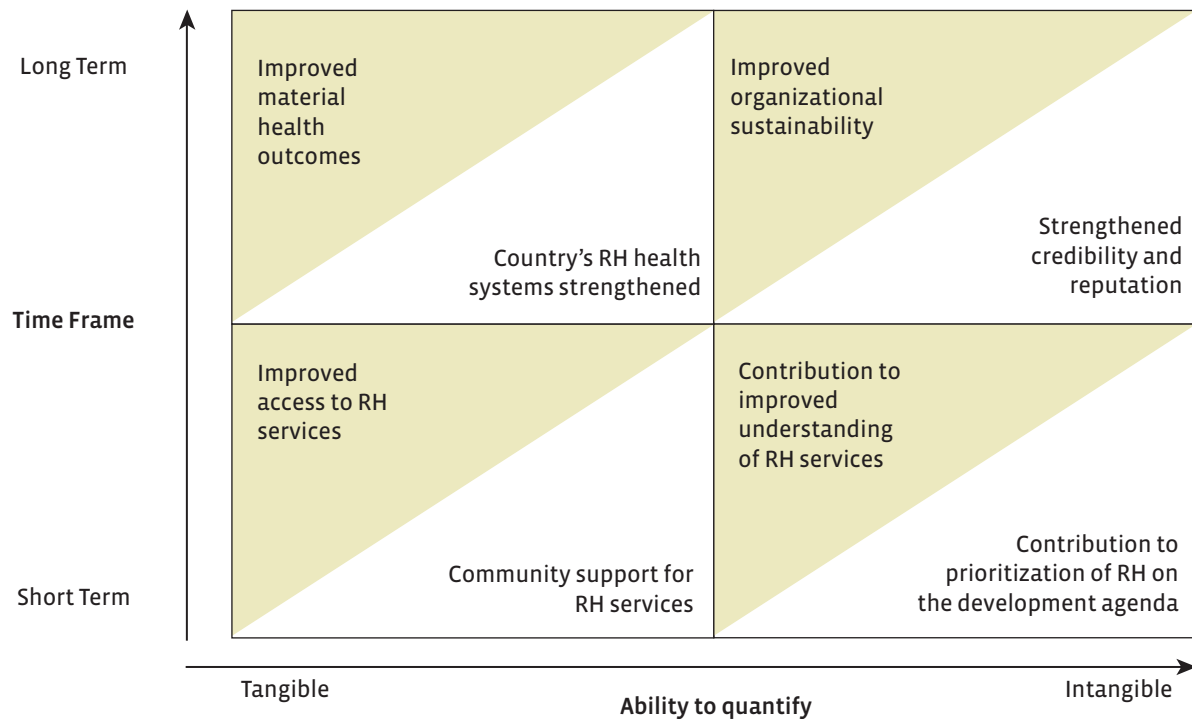
Adapted from (Keys, Malnight, & van der Graaf, 2009).

These cells can be populated with more information or used as a frame for more detailed M&E plans. The basic premise is to address these issues during a planning process, and then to revisit them periodically using a set of guiding questions, such as:

- What clear and powerful short-term benefits are we aiming for and which do we want to measure?

- What are the strategically critical long-term benefits?

- Does the organization have the resources and capacity to drive to both? If not, can such capacity be developed?

- How do these align with what can realistically be achieved with the available resources, capacity, and project timeframe?

- What benefits or results will be tangible and which will be intangible (or difficult to precisely measure with available resources)?

Such a process enables an organization to redefine success by adding dimension to change processes that are often mapped as linear. The plans and evaluation would focus on the complementary and mutually reinforcing benefit exchange between advocacy and services. For example, advocacy aimed at community acceptance of and support for services offered reinforces the access to and utilization of services. A benefits matrix is only a first step, but a significant one in that it pairs services and advocacy while making clear inherent differences in timeframes for changes and the tangibility of results.

3. Tap into non-traditional M&E

The emergence of approaches such as developmental evaluation and Outcome Mapping is a response to calls for feasible methods to assess social change efforts. As evaluation is an important component of CSO capacity, these approaches also consider development of civil society capacity as an important end in itself. Critically, these non-traditional approaches place social change as a broad outcome to which services and advocacy are contributing strategies.

To look at one example, Outcome Mapping is an approach developed by the International Development Research Centre (IDRC) for use with social change projects. According to IDRC, "the originality of this approach lies in its shift away from assessing the products of a program to focus on changes in behaviour, relationships, actions, and activities in the people, groups, and organizations it works with directly" *(Earl, Carden, & Smutlyo, 2001)*. Outcome Mapping focuses on behavior change in *boundary partners*—those to be influenced to take action—or secondary beneficiaries rather than only measuring deliverables and effects on primary beneficiaries. Outcome Mapping has been used to plan, monitor, and evaluate a range of social change programs—land management, influence of research on policy change, education projects—in a variety of developing country contexts *("OM to support project design," 2011, "Browse OM Applications by Region," n.d.)*.

There is, of course, no one-size-fits all method. As one Outcomes Mapping user wryly pointed out, these new approaches are least useful when they are brandished as the "new silver bullet to replace the old silver bullets, now tarnished" *(Murray, 2011)*. In looking at a potential fit with non-traditional M&E approaches, questions raised by Outcome Mapping and other non-traditional approaches are worth considering: Does the method accommodate change that is complex and unplanned? Does it support adaptation? Does it emphasize participation? Will it produce information that will help the organization (or project) understand whether it is making progress and why?

4. Feedback loops as gateway services-advocacy M&E

For a community-based or smaller-scale CSO providing services and engaging in advocacy, M&E can be daunting. Feedback loops that connect intended beneficiaries with the work of the organization can serve as a gateway to joint services and advocacy M&E efforts because they quickly demonstrate relevance and provide payoff in both realms. Proponents of feedback loops also argue that complex problems, such as development issues, are addressed by evolution rather than by a strict predetermined design *(Barder, 2010)*. Feedback loops are critical so that organizations can receive direct and relevant information, select options, and adapt approaches.

Linking these processes with feedback from intended beneficiaries and other stakeholders further validates information and analysis, and reinforces "downward" accountability. Putting data into the hands of providers and adding their analysis could also help shift the dynamic of M&E for the primary benefit of "someone else" to a process that is seen as benefiting and informing ongoing program work.

Community scorecards are one example of a tool that supports feedback loops. Community members score the quality of health care at community health clinics and the reports are made public. Developed by CARE Malawi and now promoted by the World Bank, communities and local providers both separately identify

and rate key aspects of local service provision (e.g., primary health care). At an interface meeting the two groups discuss the findings and plan improvements. After one year, a randomized trial in Uganda found that communities using a scorecard gained many health benefits including a 33 percent reduction in child mortality *(Björkman & Svensson, 2007)*. The results of introducing this simple feedback mechanism were as good as introducing expensive new equipment, medicine, and procedures.

Such feedback loops measure services while facilitating community-level advocacy. Cultivating and using community feedback demonstrates transparency of processes and results to the community. At the same time, they strengthen the delivery of services and ultimately promote improved health outcomes.

5. Donors' support for innovation and change

> *"[CSOs] go where the heart is. No one needs to come from Baltimore to do research for us. We know children are dying. We don't wait for the evidence to act. So we innovate."* — Nigerian service provider (Anonymous, 2011b)

Donors' need for accountability and CSO's need to innovate need not be mutually exclusive. Donors have a tremendous potential to shape M&E priorities, learning, and innovation that serve both advocacy and services. CSOs are recognized for their capacity to innovate *(Gibbs, Kuby, Fumo, & Dept, 1999; fyvie & Ager, 1999; Ulleberg, 2009)*. In addition to supporting the strategies described above, donors should support M&E learning and innovation.

Donors can explore partnership models that allow CSOs increased flexibility over time, depending on their competency and reliability *(Organisation for Economic Cooperation and Development, 2009, p. 120)*. Supporting organizations to experiment responsibly with M&E approaches can result in both stronger civil society and improved evaluation effectiveness.

Given the wide number of advocacy networks and coalitions (organized around reproductive health as well as any number of related issues), and donors' central role in funding them, evaluation focused on collective efforts should also be emphasized. While many evaluation efforts entail measuring individual efforts, few projects or organizations work in isolation, particularly when it comes to advocacy. Measuring progress in isolation, therefore, makes little sense and assessing contribution of one organization has little credibility. As one advocate described her dream evaluation scenario, a radical yet common sense approach would be to collectively review progress toward a collective goal.

> *[It would be a] group of NGOs working toward [the] same objectives, having space to come together and evaluate our overall achievement in the field. What would be really interesting is if it wasn't about attribution or who gets credit for what, but what has collectively been achieved. It also might help diffuse the sense of competition and create solidarity.* (Anonymous, 2009)

There is tremendous potential to spark honest and constructive dialogue among advocates, donors, and evaluators around realistic and useful approaches to evaluating social change efforts. Such efforts could perhaps take some pressure off competition and the contribution/attribution question while helping the CSOs better understand what works.

Case Study: Women Wood Carriers Project: M&E to improve results and change lives

The Bioeconomy Africa case study demonstrates how one organization has utilized beneficiary feedback loops to review progress and identify roadblocks and possible solutions, which the organization then pursues through its advocacy work. Bioeconomy Africa operates under the tagline "People-centered and science-based development to fight poverty and restore the environment." With a reflection of her organization's science and research underpinnings, and compelling compassion for women and children at the farthest margins of Addis Ababa's economy, Executive Director Dr. Selamawit Assefa described her organization's approach to monitoring and evaluating their services and advocacy work, as illustrated through quotes in this case study.

Woman carrying fuel wood, outskirts of Addis Ababa, Ethiopia (2011)

At *Bioeconomy Africa*, M&E is a collective effort that feeds directly into advocacy. Every six months, it assesses progress of its Women Wood Carrier's project, which combines services for over 400 former wood carriers, like farming training, and health care (including family planning and other reproductive health care), with advocacy for supportive policies and funding. *Bioeconomy Africa* uses the results to improve services and advocate for resources and support to address gaps in the project. First, they collect data about the project, measuring how many hectares are plowed, what was harvested, what was sold, what participants did with the money they earned—did they send their kids to school? Did they pay for school fees? During these six-month evaluations they also try to learn about any social or health problems: Is a family member sick? Do they have Malaria? What action did they take? This holistic approach is critical for the women in the project, who lived in extremely marginalized conditions—harvesting wood from protected forests, risking physical attacks by forest guards and gangs, and carrying the wood on their backs to markets 15-20 km away where they were paid about fifty cents for a day's labor.

The M&E team collects and reviews this data and shares it with *Bioeconomy Africa* management to review progress and potential gaps in services or information. Data is also shared with the farmers in order to keep them updated and discuss how the project can improve. "We get their opinion about why the gap is created. They will tell you all the reasons and what they think the solutions are. Wherever there's a gap, we try to address it. What solutions are there to fill the gaps? Do we have to go to other stakeholders or organizations? The government?" They also visit the local government offices and share the information learned through M&E, or facilitate discussions between community members and local government officials so they can directly convey their concerns. "We tell them about any problems we are having, and ask for help filling gaps." The M&E lens is also turned inwards. "We also monitor ourselves on our advocacy work. Did it make any impact? We use

all kinds of mechanisms." With advocacy efforts focused on local policymakers, there are fewer steps between advocacy and policy change than with efforts focused on national or higher-level decision making. As such, progress and results are measured by favorable decisions, policies, and funding, and even by access to useful information. For example, it could be the decision to grant the project more farmland, or intelligence about whether the planned government women's health center was going to materialize. In response to a question about how her organization actually evaluates their advocacy work, Dr. Aseffa was pragmatic: "If we haven't received the demands for the people, we think it is not enough".

The example of the Women Wood Carriers illustrates the role of M&E in helping a program that integrates services and advocacy to constantly adapt and innovate. The initial goal that linked services and advocacy was the use of an on-the-ground program as a trigger to get the government more invested in helping marginalized women. As Dr. Assefa phrased it:

> Not just the policy commitment but having the infrastructure, services, reproductive health commodity supply systems in place. We started with demonstration sites, because in order to advocate for funding and support we needed to have something to show. We organized the women fuel carriers and trained them to farm, giving them tools and seeds and such. Then, they needed land for the women to work.

> To get the land, we did a documentary film and presented it to government officials and local administrators. We said 'Look. This is an issue about women and the environment. We have a demonstration site, we have training. Now you need to give them land.' They said 'yes' and gave the women the land.

The result? After seeing the women produce vegetables, eggs, honey, and other products to support their families, local government officials asked the project to expand to serve 15,000 additional fuel wood carriers.

Another advocacy effort is aimed at securing reproductive health services for the women in the program. While they received information about reproductive health and family planning during their training, local government clinics often did not have the actual contraceptive supplies or services that they were newly empowered to demand. So, advocacy efforts extended to the local Ministry of Health, which initiated construction of a reproductive health center but hit roadblocks. "There were a lot of problems in terms of providing [contraceptive] commodities; there were stock outs. [If the women wait] until commodities come to the government health clinic, they may get pregnant." The group is working on plans to establish an in-house service delivery program.

Bioeconomy Africa's approach to M&E demonstrates positioning M&E within a project, use of service data for learning, and community feedback loops. Importantly, they are constantly using M&E to direct innovation and adaptation to changing needs.

CONCLUSION

Reproductive health services are offered within the context of policies, systems, and social norms that affect whether people can actually access them or not. Advocacy is a key strategy for addressing these barriers and ensuring access to services within this broader context. Organizations that provide services are critical voices to inform advocacy strategies and shape larger debates about policies and systems. As civil society actors increasingly work to facilitate social change through advocacy, they are continuing to affect change through the services they provide. These organizations are bridging worlds, and need innovative and effective strategies to measure their impact on both levels.

While multiple systems that bifurcate services and advocacy M&E miss the opportunity for a collective program review, there are a number of promising approaches and practical starting points. Drawing from the best practices of both services and advocacy M&E, a shared strategy holds the promise of improving learning *and* demonstrating results, bearing accountability to both CSOs and their supporters. By designing and pushing for such innovation in M&E strategies, we will see a shift from M&E as an obligatory effort to one in which it is a collective learning process that has value to all stakeholders. While we are trying to figure out "what works" for the world's most marginalized individuals, investing in the effectiveness and accountability of the organizations serving them seems a good bet.

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REFERENCES

3rd High Level Forum on Aid Effectiveness (2008, September 2). *Accra Agenda for Action. 3rd High Level Forum on Aid Effectiveness.* Retrieved from http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER-FINAL-16h00.pdf.

Amnesty International (2006). *Peru: Poor and Excluded Women, Denial of the Right to Maternal and Child Health.* Amnesty International. Retrieved from http://www.amnesty.org/en/library/asset/AMR46/004/2006/en/08347fa7-d460-11dd-8743-d305bea2b2c7/amr460042006en.pdf.

Anonymous (2008, May 2). Interview with Project Staff, Indian NGO.

Anonymous (2009, December 3). Interview with Policy Advisor, Latin America.

Anonymous (2010, June). Advocacy Advisor, Africa and Latin America.

Anonymous (2011a, June 17). Interview with Manager, African CSO.

Anonymous (2011b, June 16). Interview with Service Provider, Nigeria.

Aseffa, D., Selamawit. (2011, June 24). Executive Director, Bioeconomy Africa.

Barder, O. (2010, October). *Development Complexity and Evolution.* Ethiopia. Retrieved from http://media.owen.org/Evolution/player.html.

Bernstein, S., & Hansen, C. J. (2006). *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. Achieving the Millennium Development Goals.*

BetterAid (2010, August). *Call for CSO Involvement in the 2011 Survey on Monitoring the Paris Declaration. Civil Society Voices for Better Aid.* Retrieved from http://www.betteraid.org/en/news/oecd-dac/372-call-for-cso-involvement-in-the-2011-survey-on-monitoring-the-paris-declaration.html.

Bioeconomy Africa (2011). Bioeconomy Africa. Organization. Retrieved from www.bioeconomyafrica.org.

Björkman, M., & Svensson, J. (2007). *Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda* (No. Working Paper 4268). World Bank Policy Research Working Paper. World Bank. Retrieved from http://vle.worldbank.org/bnpp/files/TF053707wps4268.pdf.

Browse OM Applications by Region. (n.d.).*Outcome Mapping Discussion Forum.* Retrieved from www.outcomemapping.ca.

Canadian Physicians for Aid and Relief, The Center for International Health-University of Toronto, The International Development Institute, & World Vision Canada (2005). *Results Based Management: Are We There Yet? Ever?* (Workshop Report). Toronto, Canada. Retrieved from http://www.worldfish.org/PPA/PDFs/Semi-Annual%20VI/G-6.pdf.

Center for Reproductive Rights (2003). *Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion.* New York: Center for Reproductive Rights.

Chan, M. (2007). Editorial: Gender Justice and the Millennium Development Goals. *entre* nous Magazine, (66), 3.

Coe, J., & Schlangen, R. (2011). *Looking Through the Right End of the Telescope.* Washington, DC: Center for Evaluation Innovation.

Coffman, J., & Beer, T. (2011, June). *Evaluation to Support Strategic Learning: Principles and Practices.* Washington, DC: Center for Evaluation Innovation.

Davies, R., & Dart, J. (2005). *The Most Significant Change* (MSC) Technique: A Guide to Its Use.

Diaz, A. (2011, June 3). Interview with Doctor and Advocate.

Earl, S., Carden, F., & Smutlyo, T. (2001). *Outcome Mapping:* Building Learning and Reflection into Development

Programs. Ottawa, ON, Canada: International Development Research Centre.

fyvie, C., & Ager, A. (1999). NGOs and Innovation: Organizational Characteristics and Constraints in Development Assistance Work in The Gambia. *World Development, 27*(8), 1383-1395. doi:10.1016/S0305-750X(99)00062-5

Gibbs, C. J. N., Kuby, T., Fumo, C., & Dept, W. B. O. E. (1999). *Nongovernmental Organizations in World Bank-Supported Projects: A Review*. World Bank Publications.

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and Reproductive Health: A Matter of Life and Death. *The Lancet, 368*, 1595-1607.

Greene, M. E., & Merrick, T. (2005). *Poverty Reduction: Does Reproductive Health Matter?* (No. 33399). Health, Nutrition and Population Discussion Paper. Washington, D.C.: The World Bank.

Hammer, M., Rooney, C., & Warren, S. (2010). *Addressing Accountability in NGO Advocacy: Practice, Principles and Prospects of Self-Regulation* (Briefing Paper No. 125). One World Trust.

International Planned Parenthood Federation (2009). *Putting the IPPF Monitoring and Evaluation Policy into Practice: A* Handbook on Collecting, Analyzing and Utilizing Data for Improved P*erformance*. Author.

International Planned Parenthood Federation (2010). *Five-year Performance Report 2010* (pp. 51-53). London: Author. Retrieved from http://www.scribd.com/doc/52050502/16/Advocacy

International Planned Parenthood Federation (2011a). IPPF Advocacy. Author. Retrieved July 12, 2011, a from http://www.ippf.org/en/What-we-do/Advocacy/default.htm

International Planned Parenthood Federation (2011b). *Country Global Pathways: A New Approach to Global Sexual and Reproductive Health Advocacy*. Author. Retrieved from http://www.ippf.org/NR/rdonlyres/5A0B7C40-083E-4F7A-8F90-B467E6D4A551/0/countryglobalpathways.pdf

Keys, T., Malnight, T. W., & van der Graaf, K. (2009). Making the Most of Corporate Social Responsibility. *McKinsey Quarterly*, 1-9.

MEASURE Evaluation (2011, September). Leadership in M&E Promoted in SE Asia. *MEASURE Evaluation Monitor Newsletter*. Retrieved from http://www.cpc.unc.edu/measure/our-work/organizational-development/leadership-in-m-e-promoted-in-se-asia-region

Murray, K. (2011, July 25). *When is OM [Outcome Mapping] not helpful?* Outcome Mapping. Response.

OM to Support Project Design (2011, August 5). Global Outcome Mapping Discussion Board.

Organisation for Economic Cooperation and Development (2009). *Civil Society and Aid Effectiveness: Findings, Recommendations and Good Practice*. Better Aid. OECD Publishing.

Oye-Adeniran, B., Long, C. M., & Adewole, I. F. (2004). Advocacy for Reform of the Abortion Law in Nigeria. *Reproductive Health Matters, 12*(24 (Supplement)), 209-217.

Patton, M. Q. (2008). *Utilization-Focused Evaluation*. Thousand Oaks, CA: Sage Publications.

Pianta, M. (2005). *UN World Summits and Civil Society:* The State of the Art (No. 18). Civil Society and Social Movements Programme. United Nations Research Institute for Social Development.

Population Action International (2004). *Access Denied: U.S. Family Planning Restrictions in Zambia*. Access Denied.

Poverty and Reproductive Health (2011). The World Bank. Retrieved from http://go.worldbank.org/BHE5IVUL00

Preskill, H. (2011, May). The Strategic Learning and Evaluation Center. FSG.

Representative Nita Lowey (2007). *The Mexico City Policy/Global Gag Rule: Its Impact on Family Planning and Reproductive Health*. United States Congress. House of Representatives Committee on Foreign Affairs:

U.S. Government Printing Office. Retrieved from http://www.foreignaffairs.house.gov.

Republic of Kenya Service Provision Assessment (SPA) 2010. (2011, May). Government of the Republic of Kenya, Ministry of Medical Services and Ministry of Public Health and Sanitation. Retrieved from http://www.measuredhs.com/pubs/pdf/SPA17/SPA17.pdf.

Rogers, P. J. (2008). Using Programme Theory to Evaluate Complicated and Complex Aspects of Interventions. *Evaluation, 14*(1), 29-48.

Shaftik, N. (2011, May). *The Future of Development Finance*. The Center for Global Development. Retrieved from http://reliefweb.int/sites/reliefweb.int/files/resources/file_Shafik_Future_of_Finance_Dev_FINAL.pdf.

Singh, S., Darroch, J. E., Ashford, L. S., & Vlassof, M. (2009). A*dding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health* (p. 44). New York: UNFPA, Guttmacher Institute. Retrieved from www.unfpa.org

Sundaram, S., Epp, J., Oomman, N., & Rosen, J. E. (2004). *A Review of Population, Reproductive Health, and Adolescent Health & Developmentin Poverty Reduction Strategies*. Washington, D.C.: The Population and Reproductive Health Cluster Health, Nutrition and Population Central Unit, The World Bank.

Teles, S., & Schmitt, M. (2011). The Elusive Craft of Evaluating Advocacy. *Stanford Social Innovation Review* (Summer 2011), 38-43.

Ulleberg, I. (2009). *The Role and Impact of NGOs in Capacity Development: From Replacing the State to Reinvigorating Education*. Paris, France: United Nations Education, Scientific and Cultural Organization, International Institute for Educational Planning.

United Nations Research Institute for Social Development (2010). *Combating Poverty and Inequality: Structural Change, Social Policy and Politics* (p. 380). Geneva: United Nations Research Institute for Social Development.

United States Government & UNAIDS (2011, July 26). Global HIV M&E Information. Global HIV M&E Information. Retrieved from http://www.globalhivmeinfo.org/Pages/HomePage.aspx

Whitaker, C. (2011, May 24). Interview. Reproductive Health Services and Advocacy Specialist.

World Health Organization (2002). *WHO's interactions with Civil Society and Nongovernmental Organizations*. Author.