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ENTRY POINT MAPPING: A TOOL TO PROMOTE CIVIL SOCIETY ENGAGEMENT ON HEALTH FINANCE AND GOVERNANCE

Health Finance and Governance Project

OCTOBER, 2014

The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, \$209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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October, 2014

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ACRONYMS

CBO	Community-based organization
COGES	Comité de Gestion (Management Committees)
CSO	Civil Society Organization
DC	District Commissioners
HFG	Health Finance and Governance Project
MP	Members of Parliament
MSLS	Ministry of Health and the Fight Against HIV
NGO	Non-governmental organization
PETS	Public Expenditure Tracking Survey
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Civil society organizations (CSOs), particularly those working in the health sector, frequently seek opportunities to influence public health policy or share feedback on the quality or accessibility of health services. While these organizations may have important contributions to make, they often are not aware of the most effective and accessible entry points to use.

Entry Point Mapping provides a methodology for systemic review and identification of mechanisms, forums and public platforms by which civil society organizations can participate in health sector policy formulation, program implementation, and oversight. This paper presents an Entry Point Mapping Tool designed for CSOs with advocacy experience and public health officials seeking to expand civil society participation and contains a step-by-step guide for researching and analyzing legal entry points for civil society participation in governance of public health care facilities.

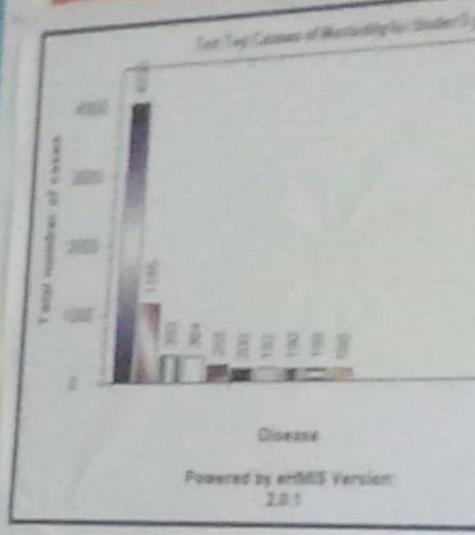
Because CSOs have varied interests, the tool includes a series of steps for individual CSOs to determine the level of government at which to pursue their specific advocacy interest and the process of collecting targeted information on legally required points of entry for their civic engagement. In addition, the Entry Point Mapping Tool offers guidance on analyzing the effectiveness on these entry points and coaches CSOs through the negotiation process of activating or expanding existing entry points, creating new ones, and winning overall collaboration with health officials on improving health policy and service delivery.

This tool also documents the experience of CSOs implementing the entry point mapping methodology in Bangladesh and Cote d'Ivoire to demonstrate how the tool can promote increased civil society engagement on issues of health finance and governance.

WHAT IS AN ENTRY POINT?

An “entry point” in the context of health governance is a legally designated opportunity or requirement for government entities to receive verbal or written input from the public and/or CSOs that represent the aggregated interests of citizens. These opportunities take many forms. Examples include hearings conducted by parliamentary standing committees on health care issues, hospital governance boards that designate civil society representatives as part of their membership, and government invitations for public comment on proposed regulations.





I. INTRODUCTION

I. INTRODUCTION

1.1 Why is the Entry Point Mapping Tool Necessary?

While many donor-funded initiatives create ad hoc opportunities for exchanges between civil society and public health officials (through community scorecards, public hearings, etc.), sustained participation requires institutionalized forums and venues for dialogue. It is also common for donors to set up ad hoc oversight committees for health facilities they develop because they are unaware of legally mandated bodies that could serve the same function were they fully operational. The entry point mapping methodology allows CSOs and governments to identify where civic engagement venues exist; where they exist but are not used for dialogue between government and CSOs; and where new venues may be necessary. These venues might include facility-level governing committees, local government health committees, and national policy forums.

The value of civil society to a healthy democracy is well established,¹ and the important role of good governance in a functioning democracy is widely recognized. It follows, therefore, that civil society's ability to engage government on health issues is beneficial for good governance of the health sector.

¹ See Larry Diamond, *Civil Society and the Development of Democracy – Estudio/Working Paper 1997/101* (Madrid: Center for Advanced Studies in the Social Sciences, Juan March Institute, June 1997); Michael W. Foley and Bob Edwards, "The Paradox of Civil Society," *Journal of Democracy* 7.3 (1996) 38-52; and Suchit Bunbongkarn, "The Role of Civil Society in Democratic Consolidation in Asia," in *Growth & Governance in Asia*, ed. Yoichiro Sato (Honolulu: Asia-Pacific Center for Security Studies, 2004), 137-144.

1.2 What does the Entry Point Mapping Tool Achieve?

Entry point mapping provides users a systematic approach to painting a complete picture of the existing and potential venues for civil society dialogue with public health officials. This picture will help to inform where civil society organizations can engage in sustained dialogue with public health officials on issues of health service quality, accountability, and allocation of resources. At the same time, the exercise may also identify areas where entry points do not exist and new venues need to be established. The tool has some important limitations to its use, however, as listed in the box on the right.



LIMITATIONS OF THE ENTRY POINT MAPPING TOOL

This tool is designed for CSOs that are already inclined to engage government on health care issues and are simply unaware of all of the existing legal and informal entry points for engagement. It does not do the following:

- Instruct on effective advocacy skills.
- Attempt to transform service delivery CSOs into advocacy organizations.
- Claim effectiveness in countries with very little political space (highly limited freedom of association and freedom of speech). Legal frameworks in these countries are unlikely to include viable entry points. Nor are the pre-conditions to collective action likely present.
- Cover entry points for governance of private health care outlets such as hospitals, clinics, or pharmaceutical production and sale, except as provided for in the government boards that regulate these entities.

1.3 What is the End Product?

After the initial mapping exercise, CSOs and health officials will have an inventory of the different types of entry points at different levels of government. At the conclusion of all the steps, CSOs and health officials will have permanent, institutionalized platforms through which to engage regularly on issues of health policy formulation and service delivery. The collaborative process of opening these entry points will strengthen partnerships between health officials and CSOs committed to fulfilling their national health care commitments.

1.4 Who is the Entry Point Mapping Tool For?

The Entry Point Mapping Tool serves two key audiences. First, the tool is targeted at CSOs with an interest in engaging on issues of health governance and finance and at those with public sector advocacy experience. Second, the tool may be used by public health officials seeking to assess the range of public outreach mechanisms for participatory planning, public accountability, or input into policy formulation available at the national and subnational level. Below we discuss the tool's use by each type of audience.

1.4.1 Civil Society Organizations

The primary users of entry point mapping are CSOs with an interest in the quality of public health care at any jurisdictional level of government in their country. The World Bank uses civil society to refer to “the wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. CSOs therefore refer to a wide of array of organizations: community groups, non-governmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.” CSOs engage government entities through activities in the following two ways:

- ▶ **Civic engagement**—Civic engagement CSOs working with others in their community to solve a problem or interact with government institutions comprise the broadest category of CSOs that could use this tool. At grassroots levels, this includes community-based organizations (CBOs) such as community development and pro-poor organizations.

Common activities among these groups include providing voluntary outreach services to enroll children in government nutrition or vaccination programs, organizing fundraising events to support local schools and health clinics, and conducting campaigns to increase enrollment in adult literacy programs.

- ▶ **Advocacy** – Advocacy CSOs have as their primary mission pursuing activities that recommend, argue for, or otherwise support certain policy reforms or improvements to service delivery. Examples include national NGOs that advocate for national health policy issues such as the rights of persons living with HIV/AIDS, and private provider associations that advocate for improved legislation and policies supporting the growth and prudent regulation of the private health sector. At national, regional, or local levels, advocacy CSOs also promote policies to improve health care quality, such as women’s organizations that provide and advocate for quality women’s health care, and associations that promotes the rights of vulnerable people such as the disabled, elderly, and those who suffer from mental illness. Corruption-fighting NGOs, found mostly at national and regional levels, also take up issues of poor governance in the health sector.

CSOs with both missions have the greatest success when they work in concert with each other. For example, in countries with a highly developed civil society, national advocacy CSOs increase their effectiveness by enlisting the support of civic engagement CSOs at all levels. The former inform their advocacy campaigns with substantial data bases of information gathered through collaboration with regional and grassroots civic engagement CSOs. The civic engagement CSOs, whatever their overall missions, commonly perceive a stake in quality health care services and readily join efforts to monitor service provision in public health care and/or advocate for improved service quality.



One example of this cooperation is when grassroots women’s organizations respond favorably to requests from a national women’s health organization to assist in monitoring the availability of women’s health care services in their communities. Another example would be when national corruption-fighting NGOs seeking data on prices charged for local health care services find willing supporters among grassroots pro-poor organizations. These service delivery monitoring efforts often includes initiatives such as community scorecards, public expenditure tracking surveys (PETS), and report cards.

Beyond feeding their data to national-level CSOs, these grassroots organizations often choose to engage government and health officials at their level to address shortcomings uncovered through their service monitoring work. As such, the grassroots women’s organization may seek to engage local government and health officials on means of improving availability of the services found to be scarce when they monitored service delivery at their local public health clinic.

1.4.2 Government and health officials

Public health officials seeking to increase sustained public participation at the national, subnational or facility level may find entry point mapping useful for identifying opportunities and obstacles to engaging civil society organizations. Formal entry points for CSO participation are important for the following activities:

- ▶ **Participatory planning and budgeting** – As health institutions develop regular plans and strategies at the national, regional and local level, formal mechanisms are necessary for engaging citizens and CSOs to identify priorities. The entry points may include public hearings or formal consultations with key stakeholder groups.
- ▶ **Informed policy reform** – Public health officials should seek outside expertise as they develop new health policies or regulations, especially from groups most affected by new policies or regulations. Entry points may include policy or technical working groups, committee hearings, or expert working groups.
- ▶ **Service performance monitoring** – Public officials may seek input from their communities on the quality of services provided by facilities. Entry points may include facility governing boards, local government committees, or coordinating bodies.

1.5 What Skills Are Necessary to Implement the Entry Point Mapping Tool?

Initiating an entry point mapping program requires a lead CSO with the skills to review local legal documents and facilitate dialogue between grassroots organizations and local health officials in each community. This CSO should also have experience in conducting advocacy work at various levels of government or work in close collaboration with an experienced advocacy CSO.

1.6 How much time is required to implement the tool?

The entire entry point mapping process can take anywhere from two weeks to two months to complete, depending on how comprehensively CSOs pursue entry points. For example, a CSO that seeks to engage with health care facilities in their district only may locate and analyze the required documents in less than a week, and then proceed to negotiate expansion of these entry points through only one or two district-level officials. A comprehensive review of entry points nationwide, however, could take at least a month (greatly dependent upon CSO resource availability); subsequent negotiations to expand or create new entry points could require an additional month. And of course, where CSOs meet significant resistance in their efforts, a more prolonged effort is required.

1.7 Where has the Entry Point Mapping Tool been used and to what effect?

Entry Point Mapping has been used in Bangladesh to improve facility-level engagement with civil society groups. In over 30 districts, use of the tool resulted in new or more active mechanisms to allow civil society dialogue with public health officials.² The feasibility of using the tool for a defined health area (HIV/AIDS) has also been tested in Cote d'Ivoire. See Section III below for more details.

² For additional information on the work in Bangladesh, see the USAID Promoting Governance, Accountability, Transparency and Integrity (PROGATI) project final report.





**I. HOW TO USE
THE ENTRY POINT MAPPING TOOL**

2. HOW TO USE THE ENTRY POINT MAPPING TOOL

2.1 Step-by-step Process

The four steps described below will enable users of the tool to map the most common forms of entry points, including the following:

- ▶ Regular meetings and/or ad hoc hearings conducted by elected bodies attached to national parliaments, regional or provincial parliaments, and municipal, district or village level councils.
- ▶ Regular meetings and/or special hearings conducted by governing boards. These boards tend to be attached to the national offices of the ministry of health, public hospitals, and agencies that manage national health insurance programs. Their responsibilities include oversight of hospital management functions including concurrence on major financial and human resource decisions.
- ▶ Regular meetings and/or special hearings conducted by advisory councils or committees. These are commonly attached to public regulatory boards, public health clinics, and specialized health initiatives such as the ministry of health's fight against malaria. As advisory bodies, they provide input on management and service delivery issues, but do not have authority over management decisions.
- ▶ Invitations for written public comments on proposed regulations, which occurs primarily at the national level, emanating from the president's office or the ministry of health.

Step 1: Determine the Level of Government at which to Engage

Depending on CSO interests, engagement may be most effective at national, regional/ provincial, municipal/ district or village level. Although these jurisdictions break down differently among countries, examples of legal frameworks relevant to roughly these four levels of government are instructive.

- ▶ **National:** CSOs engaging at this level may seek to influence budget allocations for the health ministry or for specific health concerns such as HIV/AIDS or family planning. Other CSOs may want to participate in national policy formulation on various health care issues. Common entry points for these forms of engagement are the congressional or parliamentary budget committees and those tasked with formulation and oversight of health care policy. Avenues through the executive branch include presidential/ ministerial committees established to recommend policy. Some countries also publish invitations for written public comment on proposed regulations.
- ▶ **Regional/Provincial:** Opportunities for CSO influence at this level in most developing countries involve monitoring policy implementation and service provision at public health care facilities serving entire regions or provinces. From this level downward, authority to formulate policy or allocate budgets is more limited in deconcentrated systems of government, and more expansive in administratively and fiscally decentralized systems. At this level, CSOs could access committees authorized to determine health care budget allocations and wide-reaching policy.

- ▶ **Municipal/District:** Governing boards and advisory councils are commonly attached to municipal hospitals and public health clinics at this level. Although these bodies' authority over budgetary and policy issues is subordinate to regional levels (except in decentralized systems), latitude for civil society input on service quality can be substantial.
- ▶ **Village:** This level would be of greatest interest to grassroots CSOs that want to monitor and provide feedback on local service provision at public health clinics. These may include outreach services such as mobile vaccination campaigns and home visits for disabled and elderly citizens.

Step 2: Collect Information

The documentation of opportunities for public input on health care policy and performance vary across countries and in accordance with jurisdictional levels. The main question CSOs want to begin with is, “Who needs to know about required meetings and forums for public participation on health care issues?” or “Who would know the kind of people who need to know this information?” By answering these questions, they will set in motion a chain of fruitful inquiries, beginning with informal contacts between CSO members and government officials with whom they have a collaborative relationship, such as officials in the health ministry or administrative offices of municipal, district, regional or provincial governments, elected council members, and hospital board members. Information sources may also be community leaders known for their promotion of social issues, journalists who report on government affairs, and university professors in the field of public administration. Many ministries of health have a legal services unit with a full collection of laws and regulations governing ministry operations.

In countries with vigorous right to information laws in place, internet searches can yield the required documents. In these countries, information officers are often designated for all ministries and can be useful allies. Identifying those public health officials or organizations involved in access to government information can also be an effective strategy. As a last resort, CSOs may need to contract for several days of research assistance from a local lawyer who specializes in government administration.



The types of documents to look for and the level of government at which they are most commonly found include the following:

National

Congress/Parliament: The degree to which parliamentary committee meetings invite public comment and open sessions for the public is set forth in the standing rules or orders for committees of the parliament. The titles for the rules that govern committees vary among parliaments, but the concept is similar across national, representative bodies.

Executive Branch, including Ministries of Health and Executive Agencies (these documents include entry point information for all subnational levels)

- ▶ The organic law¹ for the ministry of health commonly describes all points within the public health care system at which committees must be established to review implementation of health policy, often including the establishment of governing boards and advisory councils attached to public health care facilities. (In some countries, these requirements are spelled out in secondary forms of legislation, such as regulations and decrees.)
- ▶ The national health policy spells out the means through which the health ministry invites civic participation in policy review and implementation.
- ▶ Sub-policy documents specific to the health ministry's plan to fight malaria or HIV/AIDS may include additional civic participation commitments. For example, many countries now have specific committees for recommending HIV/AIDS policy at each jurisdictional level of the health ministry.
- ▶ The organic law that establishes a national health insurance scheme (if relevant) and regulations that mandate means for its implementation.

¹ An organic law is a law that establishes an administrative agency or local government and defines its authorities and responsibilities.

- ▶ Other documents not specifically related to health care prescribe opportunities for public input in planning and budget processes. For example, the organic laws, and regulations emanating from these laws, for planning ministries and/or ministries of finance lay out the full processes of the national budget cycle. This process prescribes multiple steps in the budget planning stage which commonly require meetings of elected bodies from provincial or regional levels down to the lowest jurisdictional levels. These meetings are held to determine spending priorities within the relevant jurisdiction, which includes social spending needs and, in particular, health care needs.

It is important to point out that in deconcentrated systems, decisions rendered at these meetings are often overridden or greatly modified as proposed budgets wend their way upwards through the administrative and political hierarchy. Nonetheless, CSOs seeking to influence budget priorities regarding health care spending find these entry points important.

Regional/Provincial

Government entities that administer health care at this level function through a series of regulations, executive orders or decrees, and other types of directives. Many of these directives are issued at the national level for subnational levels, although others may be issued at this level. Those issued at the regional level most commonly originate in the office of the governor or similar political leadership position. Directives could, however, originate from directors of regional health facilities. An example would be a province-wide directive that annual performance reports on public, primary health care facilities be reviewed by the established advisory boards connected to each facility. Alternatively, an executive order might mandate annual policy and performance reviews on the health ministry's fight against malaria in the province. CSOs can analyze these documents for the degree to which they permit public participation.

Municipal/District

The legal framework at this level generally consists of rules emanating from higher levels (discussed above), with the addition of circulars, notifications, and internal memoranda that direct policy implementation. Examples include specifications for operating hours, means of handling medication shortages, and required compositions for ad hoc advisory councils.

Village

This level follows the regulations and administrative direction issued at higher levels. Any independent legal administrative authority would generally reside under village councils, which have their own sets of by-laws that include requirements for public participation. Some rural communities function under memoranda of understanding for certain public services.



Step 3: Analyze the entry points

A thorough review of the collected documentation will provide the users of the Entry Point Mapping Tool with important data for analysis, allowing CSOs to determine where each entry point is located in the spectrum of possible types described below.

a. Entry points that offer opportunities for the full range of public participation: There are four major types of entry point that offer established, official mechanisms for public participation:

- *Invitations to written public comments on proposed regulations*, which occur primarily at the national level. The invitations may emanate from the president's office or the ministry of health. Deadlines for submissions are the major factor to consider. Required formats and submission addresses are also key pieces of information of which to be aware.
- *Regular meetings and/or ad hoc hearings conducted by elected bodies* attached to national parliaments, regional or provincial parliaments, and municipal, district or village level councils.

Even where these committees do conduct public hearings, they are likely ad hoc, so CSOs need to seek weekly calendars of scheduled committee hearings. Because many elected bodies do not regularly maintain current calendars, CSOs often cultivate contacts within parliamentary or council administrative staff for information on calendar updates. Questions to ask are:

- What types of participation do they permit? Observation only? Or may participants address the hearing?
- Are requirements specified for permission to speak at the hearings?
- Do the committees have subcommittees? These can provide alternative avenues for civil society input.
- May the media attend?

- *Regular meetings and/or special hearings conducted by governing boards*, generally attached to the national offices of the ministry of health, public hospitals, and agencies that manage national health insurance programs.
- *Regular meetings and/or special hearings conducted by advisory councils*, commonly attached to public regulatory boards and public health clinics.

In addition to ad hoc participation or observance of these meetings or hearings, many of these types of entry points offer an established seat at the decision-making table by way of mandated membership composition to include representatives of civil society.

For all meetings and hearings held by elected bodies, governing boards, and advisory councils, analysis should first address the following issues. Learning the membership composition so that CSOs can provide their input through these members. Membership ideally includes representation of facility employees as well as end users.

- Designation of term limits for members enables calculation of when new members may be appointed.
- Determination of the selection process for filling these required membership positions. In most cases, the lead elected or appointed political official for the jurisdiction appoints these positions. For example, the provincial governor is often authorized to appoint the governing board of the provincial hospital, and a municipal mayor or council president appoints members to required advisory council attached to public health facilities within the municipal jurisdiction. Under less

desirable circumstances, the chief administrator of the relevant health facility appoints persons for these membership positions. Analysis of this selection process will illuminate how inclusive and transparent it is.

CSOs should also review documents that mandate entry points for detail on the topics to be discussed at the required meetings or hearings. Determining whether the meeting agendas adhere to these requirements is an important element of assessing entry points. If the meeting agendas tend to be light on issues of significance to health service delivery quality or policy, CSOs may want to pursue negotiations to place more substantive issues on the agenda.

Key questions for analysis are listed in the box below.

KEY QUESTIONS FOR ANALYZING REGULAR MEETINGS OF ELECTED BODIES, GOVERNING BOARDS OR ADVISORY COUNCILS

- At which jurisdictional levels are these meetings held?
- Who is required to attend the meetings and who may attend the meetings?
- Are the meetings open to the public? If so, may the public participate or only observe?
- Are any other forms of public input permitted? This would include written input or sub-committee hearings.
- May the press attend?
- How is the calendar for these meetings publicized, if at all?
- If the calendar is not publicized, through what other means might it be obtained?
- Does the documentation that stipulates the entry point require a set number or frequency of meetings or hearings? Or specify occurrences on which the entry points are to be used? If so, CSOs should inquire as to whether the required meetings or hearings are actually held.
- May extra-ordinary sessions be called? If so, by whom?

“HIDDEN” ENTRY POINTS

Unlike clearly stated entry points that allow for public participation, CSOs may also find opportunities where participation is not explicitly prohibited. For example, district-level health coordinating committee meetings may not specifically allow for public participation, but they may also not preclude such participation. In these cases, CSOs may participate on an ad hoc basis – for example, by providing evidence from targeted social accountability efforts or relevant inputs to already scheduled policy discussions – to create longer term precedent and specific roles for civil society participation.

b. Entry points where public participation is possible: These entry points are common in meetings, deliberations, and hearings that are open to the public. Public participation in these sessions is often tightly controlled, but opportunities for media and the public to observe these decision-making processes are nonetheless informative.

These entry points should be analyzed for the extent to which they permit questions or comments from members of the public, or whether the public may only observe the proceedings. If participation from the public is permitted, CSOs should ascertain whether time limits or other restrictions are imposed so that they can prepare comments accordingly. Moreover, CSOs should find out if the public needs to seek a place on the agenda before the meeting, or if they may interject their input spontaneously. For example, CSOs that have recently conducted a community scorecard and are attending a regularly scheduled meeting of the advisory board for their district family planning clinic may want to announce that they have completed their scorecard exercise and seek permission to present highlights on the findings.

Further analysis may suggest that additional members could be added to the existing composition of advisory boards. This presents an opportunity for negotiation to include civil society representatives.

c. Institutions that do not yet have entry points: The analysis of these institutions begins with identifying the full scope of opportunity for public input into the institution’s processes for policy planning and review. For example, if a regional hospital’s only consultative processes rest with an advisory board whose only members are hospital and health ministry staff, CSOs can begin analyzing two key points:

- The overall intent and purpose of this advisory board
- The general range of information discussed at this meetings (which should be available through meeting minutes or records).

The results of this analysis can become the starting point of CSO negotiation with hospital administrators on the value that CSOs can add toward the overall purpose of the advisory board.



In the following table, we present a strategy for choosing between possible entry points. By reviewing a set of key questions about the location, composition and regularity of venues, CSOs identify entry points that offer the best opportunity for successfully and sustainably advocacy.

Key Question	Entry Point Prioritization
<p>Where? Where is the EP located?</p>	HIGH – EP specifically located at target level
	MEDIUM – EP located at multiple levels, including target
	LOW – EP not located at target level
<p>When? When is the EP accessible?</p>	HIGH – EP meets regularly as required by regulation
	MEDIUM – EP meets regularly but not by regulation
	LOW – EP does not meet frequently
<p>Who? Who participates in EP?</p>	HIGH – Target audience required by regulation to participate in EP
	MEDIUM – Target audience not required to attend EP, but does
	LOW – Target audience rarely attends EP
<p>What? What is the agenda of the EP?</p>	HIGH – EP has established agenda relevant to target topic
	MEDIUM – EP has flexible agenda
	LOW – EP has rigid agenda that does not cover target topic
<p>How? How are participants selected for the EP?</p>	HIGH – Civil society participants are invited to participate in the EP
	MEDIUM – EP invitations are flexible allowing CSO participation
	LOW – Civil society participants are not invited

Step 4: Dialogue with public health officials to create or expand entry points

When the analysis finds that a health institution or policy formulation and review process permits either limited or no entry points to public or civil society input, CSOs using the Entry Point Mapping Tool should initiate a dialogue; the type of dialogue will depend on whether CSOs are seeking to expand or create entry points.

The issues and challenges inherent in expansion and creation are described below.

a. Entry Point Expansion

- *Moribund entry points*—Entry points that permit substantial civic engagement exist but are simply under-utilized; reasons may be that required meetings or hearings are scheduled infrequently or not at all, the membership of the advisory boards or councils was never fully appointed, or the by-laws of the consultative body call for a quorum that is rarely reached.
- *Dormant entry points*—Entry points that permit civil society input are legally mandated but they either never came into existence or ceased functioning some time ago. This is more common than might be expected. Primary or secondary legislation mandates these entry points, but executive branch staff simply never made sure that they function and civil society has not demanded their activation.
- *Entry points designed to permit civil society input actually function in ways that limit this input*—These may include entry points that greatly limit positions designated for non-ministry or facility staff, impose a non-inclusive selection process for positions, or require facilitation by a consultative body that holds its public hearings rarely and/or without advance and/or public notice.

Public participation is possible (explicitly neither invited nor prohibited)—These situations call for making explicit and institutionalizing authorities for civil society participation.

b. Entry Point Creation: At institutions that have no entry points, the task of CSOs is to conduct creative negotiation to establish inroads for participation. For example, a local primary care clinic whose advisory board only permits government officials and a few prominent physicians to serve as members would benefit from awareness-raising by local women’s organizations. These CSOs can point out the value of end-user appraisals in policy review discussions.

Recommended pathways for CSO dialogue with elected or appointed government officials and/or health facility administrators on expanding or creating entry points.

The nature and extent of negotiations will vary greatly according to local political, administrative, and cultural contexts. CSOs will need to rely on their collaborative advocacy skills and experience to determine whether expanding or creating entry points can be accomplished through a short series of meetings with relevant government officials or if they must apply pressure through means they have used effectively in the past.

MORIBUND AND DORMANT ENTRY POINTS

These entry points are among the easiest cases for civil society to negotiate. CSOs can present the document that mandates the entry point to relevant officials and offer to help establish or re-establish the entry point and facilitate its functioning.

Whatever the extent of advocacy efforts, the most successful approach involves the CSO offering the resources of their organizations to support the service or advisory needs of the relevant health care governing body. Taking this step will enhance the give and take of collaborative advocacy.

CSO resources to conduct this negotiation include the following:

- ▶ Existing *communication channels* to CSO members, which can be offered to supplement health facility outreach efforts. This includes the reach that CSOs have to their members, or could also include access to ethnic groups that do not speak the national language or to religious minorities that require special outreach approaches.



- ▶ *Information* – CSOs can offer to poll their members on issues of interest to the relevant health facilities. For example, a grassroots community development organization can supply the district ministry of health office with information on numbers and locations of unvaccinated children in the remote villages they serve.
- ▶ *Volunteers* – CSOs with large memberships, such as informal savings and loan associations, can mobilize volunteers to organize and prepare recipients of specialized health care programs. For example, if the ministry of health is planning visits by its mobile family planning clinics, CSOs can organize their members to ensure that potential beneficiaries gather at the designated clinic stops at the required time, and carry with them relevant health records.

KEY QUESTIONS AND CONSIDERATIONS FOR ENTRY POINT MAPPING

As CSOs consider whether this tool would be useful to their organization's health care advocacy needs, they may consider the following key points about the tool:

Entry point mapping is more sustainable if it is demand-driven. The utility of entry point mapping is greater if it is being applied to respond to a CSO's defined needs to enhance engagement with public health officials. Where the tool is addressing a targeted issue, health program or facility, the greater the chances of success. Where the tool is introduced in absence of a defined need, it is unlikely to lead to sustained engagement.

Entry point mapping should be pursued as a collaboration between CSOs and public officials. Entry point mapping is a joint government and civil society exercise and requires active participation from both entities. Gaining access to government documentation such as call circulars, bylaws and committee terms of references can be difficult without government cooperation. Likewise, if legal required entry points are identified, by both public officials and CSOs, there is a greater likelihood that these meetings or hearings will be used.

Can moribund entry points be restarted? An entry point mapping exercise may identify a range of entry points, from those currently active, to moribund or dormant avenues for participation. CSOs should consider the time and energy necessary to activate moribund or dormant entry, particularly if structural obstacles exist. For example, in Bangladesh, CSOs identified legally required entry points that were not active. They were not active because health officials did not want to involve political leaders who were supposed to chair meetings, for fear of meddling. While health officials were open to engaging with CSOs informally, they would not activate the legally mandated meetings.



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3. ENTRY POINT MAPPING IN PRACTICE

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3.1 The Encouraging Experience of Bangladeshi CSOs

The Entry Point Mapping Tool was used successfully by CSOs in Bangladesh, in 30 districts located in several states. First, a lead CSO mapped health care entry points in their district and shared the findings with CSOs in other districts. This provided immediate leads for the other CSOs in their search for entry point requirements in their districts and generated a number of circulars requiring entry points for civil society engagement. Working with their members and with government officials known by their members, the CSOs obtained circulars that provide instructions to district-level elected and health ministry officials in the establishment and operation of various task forces and advisory councils governing policy implementation and service delivery in the districts' health facilities.

The CSOs then requested initial meetings in their districts with their District Commissioners (DCs) and Health Directors to bring the circulars to their attention and request information on how the circular instructions are carried out. Most DCs were not aware of the relevant circulars and expressed appreciation to the CSOs for bringing them to their attention. In at least five cases, the DCs called for the immediate steps to constitute and convene the task forces required in the circulars. In some cases, the circulars presented by the CSOs were outdated, and the DCs helped locate current versions. In other cases, the DCs realized only after seeing the circulars presented by the CSOs that they called for DCs and/or Members

of Parliament (MPs) to convene, or participate in, more monthly and quarterly meetings of various task forces and committees than was reasonably possible. This prompted the DCs to request CSO assistance in prioritizing and streamlining the entry point forums called for in the circulars so that health issues could be deliberated more efficiently.



The Bangladeshi CSOs expected government resistance to their attempting to enforce requirements for entry point forums. They successfully obtained government collaboration in opening existing entry points for four main reasons:

- ▶ **CSO preparation** – In all collaborative advocacy efforts, CSOs must be well prepared to engage government, and the Bangladeshi CSOs adhered well to this principle. Before their initial meetings with District Commissioners, the CSOs strategized over possible courses that the DCs might take in their meetings and prepared diplomatic, yet feasible, responses that would keep the meetings moving towards their objectives of opening the entry points. Some CSOs role-played prior to the meetings, with one group taking positions that the DCs could take in the meetings and one group offering effective responses. The CSOs also defined the roles each individual should take in the meetings so that they knew who would take the lead for each topic the DC might raise. In one specific meeting, the DC attempted to challenge the CSOs with an untenable request and, per their preparations, the most knowledgeable CSO member on that topic responded with firm, tactful diplomacy that dissuaded the DC from pursuing the request. This helped to keep the meeting on track and in the direction of the CSOs' desired outcomes.
- ▶ **CSO knowledge sharing** – CSOs from various districts compared experiences from their individual entry point meetings. As a result, in one entry point meeting, a District Director expressed reservation about moving forward on opening a specific entry point without authority from her ministry. The CSOs, however, were able to assuage her concerns by citing CSO experiences with entry point meetings in other districts, and how the District Directors of the same ministry had already opened the entry points called for in the same circular.



- ▶ **Action planning** – After initially presenting the entry point circulars, the CSOs developed time-bound action plans with the DCs to implement the steps needed to open the required entry points. This included commitments by both government and CSOs to ensure results on opening entry points.

- ▶ **Elevated stature for the CSOs** – The mere act of CSOs’ informing themselves on legal entry points and asserting the need to open the entry points gained respect for the CSOs in the eyes of government officials. The collaboration offered by CSOs enhanced their standing even more. The officials saw the CSOs as valuable aids in a number of ways. Like many government officials, the DCs and the directors of the district administration and health facilities faced heavy management burdens, and they welcomed CSO support in carrying out their responsibilities. For example, in one district, a social sector director cited the value of CSOs helping her office increase public awareness of the social programs they were attempting to launch. This collaboration early on helped CSOs win the trust of government officials as they worked to open additional entry points.

3.2 Testing the Feasibility of Entry Point Mapping in Cote d’Ivoire

In late 2013, the Health Finance and Governance Project (HFG) conducted a test of the Entry Point Mapping Tool in Cote d’Ivoire to answer the question – Can this tool meet the needs of CSOs in a specific country context with a narrow focus on a specific health issue? In Cote d’Ivoire, HFG focused on seeking entry points relevant to CSOs working on HIV/AIDS. The context in Cote d’Ivoire was different in significant ways from the Bangladeshi contexts, specifically in terms of CSO capacity and experience with engaging with government officials. In Cote d’Ivoire, due to the impact of the recent civil conflict and the lack of intermediary organizations at the regional or district level (between the national and grassroots) there are very few CSOs with experience with strategic advocacy with public officials.



Without accompanying advocacy training, entry point mapping in Cote d'Ivoire was appropriate for only a small group of established national CSOs. In Bangladesh, however, CSOs at the national, regional and local levels have experience with advocacy, which made the tool relevant to a broader audience.

The Test

The HFG test of the Entry Point Mapping Tool included discussions with a range of individuals, CSOs, local government officials, and other groups working to promote civil society participation around two objectives. First, HFG conducted a preliminary rapid mapping of entry points, and compiled an initial set of the most active and relevant entry points at the national and subnational level. Through interviews with CSOs active in HIV/AIDS advocacy, HFG determined the degree to which the range of national and regional CSOs were aware of and used these entry points. Second, by sharing the Entry Point Mapping Tool, HFG determined whether the methodology could be useful to CSOs in their HIV/AIDS work.

Findings

The test of the Entry Point Mapping Tool resulted in three important findings.

1. **Several important legally mandated entry points exist for CSOs working on HIV/AIDS issues. These are mandated either through the Ministry of Health and the Fight against HIV (MSLS) or through legislation on the structure and functions of local government:**
 - Comité de Gestion (COGES or Management Committees) – These are attached to public health facilities at all jurisdictional levels and designate membership positions, which include representatives of civil society. They are dormant, moribund, and/or widely deemed ineffective.



- The Committees for the Fight against HIV/AIDS are a recently developed formal MSLS entry point specifically for HIV/AIDS at regional, departmental and village levels, with mandated representation of civil society.
- Monthly meetings at district levels, which are supposed to include civil society, are to be organized by the Médecin-Chef de District (loosely translated as Health Management Officer) for the management team at each corresponding public medical facility. The Health Management Officer presides over discussions regarding management, planning, monitoring and evaluation, and overall coordination. If properly functioning, these provide some of the most widely accessible entry points specifically on health issues.

- Government leaders at regional and municipal levels are elected and, therefore, convene quarterly meetings of their advisory councils, which are open to the public. These meetings are usually well-publicized in advance. Health issues are common topics at these meetings. It appears that these quarterly meeting also serve the purpose of seeking public input on strategic and budget planning exercises.
- Municipalities use Quartier (neighborhood) liaisons as two-way communication channels for government activities. These are viable means for community-based organizations (CBOs) within municipal neighborhoods to report problems in health care delivery and to advocate for better services.

2. Not all entry points are actively used by CSOs.

Most of the CSOs interviewed engage at national levels of government and, of these, informally with the MSLS.

Only one attempts to work through parliament and one other monitors executive branch invitations for public comment on proposed regulations. This said, much of the engagement with MSLS involves pending legislation or regulations regarding HIV/AIDS issues.

Discussion of entry point use at regional or district levels centered on two common forms of engagement:

- ▶ Use of informal contacts within MSLS health facilities to address stock-outs of HIV/AIDS medications, and



- ▶ Requests from subnational CSOs to national network leaders to intervene with regional government on issues such as stock-outs and the need for price reductions of medicines.

All other entry points described at subnational levels were informal – such as CSOs simply using personal contacts within the health ministry or local government to address what mostly involve complaints of inadequate services.

Most telling among the findings is that not a single CSO mentioned using the MSLS's most common, institutionalized entry point of the COGES. These are management committees attached to most public health facilities, with mandatory representation from civil society. CSOs were either unaware of the existence of COGES, or perceived them as ineffective.

None of the CSOs interviewed was yet aware of the Committees for the Fight against HIV/AIDS at any level of government. No other formal entry points were mentioned in queries regarding entry points that CSOs use to engage government.

Some CSOs reported that they have worked very hard to cultivate effective, albeit ad hoc, informal contacts within the MSLS and local government to address their advocacy issues and/or complaints about service provision. Attempting to activate formal entry points struck them as requiring an amount of time and energy that they were not convinced would obtain the quality of results that they currently receive with their informal contacts. This group shared a common pessimism about government officials' openness to receiving public input even if required through formal entry points.

3. The preconditions for using the Entry Point Mapping Tool are important considerations for how the tool may be used in different environments.

Due to a number of factors, including the effects of the period of conflict from which Cote d'Ivoire has recently emerged, the advocacy skills necessary for using the Entry Point Mapping Tool are limited to a small group of national CSOs. There are fewer groups operating at the subnational (regional or district) level, and those at the grassroots level are oriented toward service delivery. Building advocacy skills of these subnational CSOs is necessary before they could benefit from entry point mapping.

Discussion

CSOs with sufficient advocacy capacity and the experience to use the tool cited no particular needs to adjust it to either HIV/AIDS purposes or the country context. Rather, the major conclusion from the CSOs interviews is that only a narrow portion of Cote d'Ivoire CSOs that work in HIV/AIDS have the advocacy skills to use the tool.

To broaden the use of the tool, many CSOs stated that it would need to include detailed instruction on how to work with reticent government officials to activate entry points that exist only on paper. Based on the HFG assessment, to effectively use the tool, these CSOs would need additional support to build their basic advocacy skills, including awareness of their rights to question authority, their negotiation skills, and the effective use of entry points.





ANNEX A: RESOURCES

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Advocacy Handbook: A Practical Guide to Increasing Democracy in Cambodia, developed by Pact Cambodia. Although written for Cambodia, this guide provides advocacy techniques in a manner understandable to CSOs operation at regional and national levels anywhere. Available at http://www.pactcambodia.org/Publications/Advocacy_Policy/Advocacy_%20Handbook%20_A%20Practical%20Guide_EH.pdf.

Grassroots Advocacy Handbook, developed for CSOs with only primary level education by Pact Cambodia; applicable to principles in any country. Available at http://www.pactcambodia.org/Publications/Advocacy_Policy/Grassroots_Advocacy_Handbook_ENGLISH.pdf.

Networking for Policy Change: An Advocacy Training Manual, developed for health NGOs by the Policy Project of Futures Group. The manual is available in French, Spanish, and English at <http://www.policyproject.com/pubs/AdvocacyManual.cfm>



About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a five-year (2012-2017), \$209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

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