Advocacy and Influencing Impact Reporting Tool

This tool has been developed to gather further information and evidence on CARE's advocacy or influencing win. At CARE, advocacy is defined as "**the *deliberate* process of *influencing* those who make *decisions* about *developing, changing and implementing policies* to reduce poverty and achieve social justice**.[1]" Influencing and advocacy can go beyond government policies, it can include influencing governments, donors or NGOs to adopt a CARE program model or influencing the private sector to change their company policies or operating practices.

This tool captures the significance of the win, the level of CARE and our partner's contribution, who stands to benefit from the change, and what evidence do we have to support a claim of change or impact. With the wide range of successes within influencing work and the various roles CARE may have played in this win, this tool allows us to identify how significant the win is as well as the significance of CARE's contribution and our partners.

Success:	
1. What is the advocacy or influencing win? Include details such as: • A description of the win, and how it was achieved • start date and end date 2012 -2013 Sahsara District 282 AWC 542 CHW; Niti Ayog has recommended piloted in 100000 • any incremental wins that happened along the way • the main decision makers that CARE influenced to achieve this win 2. Why is this advocacy or influencing win significant? What was the reality prior to the advocacy/influencing win that the win aims to address? 3. If this win is part of a larger advocacy or long-term program goal, please describe the larger advocacy/influencing goal?	Influencing Government of India to adopt and upscale digitalisation of reporting system and supportive supervision templates for the world's largest maternal and child health programme that can result in reducing the burden of Community Health Workers (CHWs) in maintaining ten different registers and to enable them to focus more on process leading to impact and outcome level works. The pilot started in 2012-2013 in one of administrative district of Bihar state involving 282 Angan Wadi Centres (AWCs) and 564 number of CHWs covering around 300,000 population. A deliberate Randomised Control Trial was inbuilt in the implementation to create evidence for influencing the system which established that such information communication technology (ICT) interventions at Community Health Workers (CHWs) level has the power to impact in the outcome level as well as in empowering the CHWs. The success of the replicating in 50 focus districts pilot in 8 states reaching 100,000 CHWs whose scale-up is going to cover 1.4 million CHWs over the next two years. Continuous engagement with the Ministry of Women and Child Development and the world Bank especially during the development of bank supported project under the ministry led to replication to 50 districts involving ourselves to support the scale up by ensuring quality of innovative trainings at various level led to an opportunity to influence the scale up to 1.4 million CHWs. By strengthening the reporting at service delivery, we have significantly contributed towards improvement in data driven decision making such as tracking of malnourished children, identification of LBW babies, irregularity in service provision by FLWs at right time. This gave us an opportunity to understand various nitty-gritties in the workflows of reporting from service delivery to policy making. Hence, we engaged with the policy makers to leverage ICT tools to get the reporting at service delivery level. Also, we had an opportunity to design, implement the training component during pilot phase helped us to boost the advocacy at National, State, District and Block level. Based on this positive experience of implementing with 100,000 CHWs, GoI and World Bank have planned to scale up to 1.4 million CHWs as part of their National Nutrition Mission which has been approved and inaugurated by the Prime Minister. The ministry has committed to involve CARE for the

[1] See CARE International Advocacy Handbook for more information

	training of rollout to 1.4 million CHWs and the Gates Foundation has initiated the first phase of this work through a new grant.
Contribution:	
4. On a scale from high, medium, or low, how would you rate CARE's contribution to the advocacy/influencing win? *(please refer to the scale below the table)* 5. Describe CARE's contribution, specify CARE's unique role as well as the role of other main actors including partner organizations and coalitions. 6. What evidence is there that supports our claim that CARE contributed to this win?	It's high, because it was exclusively carried out by CARE. CARE developed the architecture of the required application during RCT. Being the donor of RCT, BMGF took full ownership of advocacy and brought in resources for adaptation of application for scale up. A software development agency DIMAGI INC. was the subgrantee during the RCT phase. The complete programmatic content and technology insight was provided by the thought leaders of CARE India, Bihar in the development and field level implementation of this application called Integrated Child Development Services – Common Application Software (ICDS-CAS). Use of CHWs involved in RCT to talk directly with the leaders of Ministry, world bank, NITI Ayog contributed a lot in them deciding this to taking it to scale. Having data in RCT collected by a third party benefitted significantly in advocating for scaleup.
Potential Impact/Reach:	
7. What is the impact population that is expected to benefit from the advocacy/influencing win? Describe how the win will translate into a better life for these participants? 8. If the change we have influenced is fully implemented, can you quantify the number of lives that could potentially be reached by this advocacy win? *Please explain how you calculated this number.*	It could potentially benefit 105.3 million adolescent girls, 15.7 million pregnant women, 42 million lactating mothers and 164.5 million children 0 – 6 years of age across all states of India. The primary impact will be due to name-based name based real-time tracking of services and behaviour. Potential impact: 15.7 million pregnant women and 42 million lactating mothers (comparable impact data) = 57.7 million
Actual Impact/Reach:	
9. Do we have any evidence to date that these expected outcomes have been achieved? If so, please describe how the win has translated into a better life for the impact population. 10. Can you quantify the number of lives that have been improved to date? *Please explain how you calculated this number.*	Evidence of impact on outcomes is available from the RCT evaluation. Impact of replication to 0.1 million CHWs and the scale up to remaining 1.3 million CHWs are not available. The number of community worker reached by scale up is taken from the Ministry of Women Child Development based on their MIS data. The number of pilot CHW has reached 130,000 and we could estimate the population potentially benefit for population covered by the current coverage. For the purpose evaluating the impact of this, what is planned is an assessment with a sample size of 200 CHWs each in two states namely Madhya Pradesh and Bihar. IFPRI has already planned and conducted Baseline. The endline would be undertaken (tentative) in 2020. Taking into account only those districts where we have had at least more than a year of scale up related intervention: in 41 districts. In these districts, looking at the proportion of pregnant women covered by our intervention blocks, the total number of number of pregnant women who has completed 3 ANC visit is 369,380 **(estimated)**. While upscaling the mHealth across India, we have only one district in Bihar that has overlap. According to our estimation, out of 369, 380 person who has 4 ANC visits, only 40, 762 person has overlap. If we take the overlap away, we can say about **328,618** persons would be benefited from 4 ANC visits.
Reflection and Learning:	

11. What were the main challenges you faced, and were they overcome? If so, how? 12. What influencing tactics were particularly effective/ineffective? 13. What would you do differently next time? 14. What are the next steps/follow-up for this advocacy win?	In the given situation of push for e-governance at National and State level, there was an enabling environment and opportunity in advocating for scaleup. The only critical factor determining the speed of scale is the government's ability to procure mobile phones and server on time. As a next step/follow-up, we will support the rollout across the country to reach remaining 1.3 million CHWs of MWCD. The other initiative that will be arising from this experience is to advocate with Ministry of Health for reaching out to their CHWs as well.

Rating scale[2]:
High: There is reason (evidence) to believe that the change would not have happened without CARE's efforts. This could also include significant actions from partners which we support technically or financially.
Medium: There is reason to believe CARE contributed substantially, but along with other partners
Low: CARE was one of a number of actors that contributed, but this change may have happened regardless of CARE's involvement

[2] This rating scale has been used by Save the Children to measure contribution in advocacy work