

Making a Difference:

Improving Women's Sexual and Reproductive
Health and Rights in South Asia

A RESOURCE BOOK FOR ADVOCATES



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Published by:

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Acknowledgements

The Asian-Pacific Resource & Research Centre for Women (ARROW) would like to express sincere appreciation to the partners of the Women's Health and Rights Advocacy Partnership (WHRAP)-South Asia for bringing this resource book into being. WHRAP-South Asia's national partners include Beyond Beijing Committee (Nepal), Bangladesh Women's Health Coalition (Bangladesh), Centre for Health Education, Training and Nutrition Awareness-CHETNA (India), Naripokkho (Bangladesh), SAHAYOG (India) and Shirkat Gah (Pakistan) and international partner Danish Family Planning Association-DFPA (Denmark).

We would like to thank all the staff of the eight partners of WHRAP-South Asia for their contribution in this advocacy partnership that works towards improving the quality of sexual and reproductive health and rights of marginalised women in South Asia. We would specially like to thank the current and former key persons in the WHRAP-South Asia project:

- Deel Afroze, Rumana Quader, Julia Ahmed, Jahanara Sadeque and Leena Chakma from BWHC, Bangladesh.
- Shireen Huq, Samia Afrin, Tazkera Noor, Manisa Mazumder and Nazmoon Nahar from Naripokkho, Bangladesh.
- Indu Capoor, Pallavi Patel, Smita Bajpai, Anvita Upadhyay from CHETNA, India.
- Jashodhara Dasgupta, Shakuntala Joshi, Ankita Mukherjee and Susheela D. Singh from SAHAYOG, India.
- Anjana Shakya, Sewa Singh, Bobby Karmacharya, Sirjana Shah, Shilpa Pradhanang from BBC, Nepal.
- Khawar Mumtaz, Naureen Tawakkal, Samra Arif from Shirkat Gah, Pakistan.
- Elisabeth Riber Christensen, Tania Dethlefsen, Henny Hanson, Lotte Jensen and Caecilie Bom Kahama from DFPA.
- Saira Shameem, Rashidah Abdullah, Norlela Shahrani, Rosnani Hitam, Nalini Keshavraj, Rodelyn Marte, Nandita Solomon, Luciana Rodrigues, Jenny Acton, Kamayani Bali Mahabal, Nalini Singh and Biplabi Shrestha from ARROW, Malaysia.

We would also like to express our gratitude to Jashodhara Dasgupta, Renu Khanna and Kausar Khan for co-authoring this resource book and sharing the vision and learnings of the WHRAP-South Asia partnership. Thanks to Elisabeth Riber Christensen of DFPA for her insightful inputs and suggestions. Much gratitude to Shirkat Gah for agreeing to coordinate the layout and printing of this resource book.

This publication would not have been possible without the support of the Danish Family Planning Association (DFPA) and the Danish Ministry of Foreign Affairs. ARROW also receives core funding support for our work from OXFAM-Novib and the Swedish International Development Cooperation Agency (SIDA).

List of Abbreviations

AFLE	Adolescent Family Life Education
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARROW	Asian-Pacific Resource & Research Centre for Women
BBC	Beyond Beijing Committee
BCC	Behavioural Change Communication
BPFA	Beijing Platform for Action
BWHC	Bangladesh Women's Health Coalition
CBO	Community Based Organisation
CDC	Community Development Committees
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHC	Community Health Centre
CHETNA	Centre for Health Education, Training and Nutrition Awareness
CMO	Chief Medical Officer
CRC	Convention on the Rights of the Child
DFPA	Danish Family Planning Association
EMoC	Emergency Obstetric Care
GM	Genetically Modified
GO	Government Organisations
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
JSY	Janani Suraksha Yojana
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey

- MMR** Maternal Mortality Ratio
- MP** Member of Parliament
- MSAM** Mahila Swastha Adhikar Manch
- NCSW** National Commission on the Status of Women
- NGO** Non-governmental Organisation
- PAR** Participatory Action Research
- PHC** Primary Health Centre
- PLHWA** People Living With HIV/AIDS
- PoA** Programme of Action
- PRHN** Pakistan Reproductive Health Network
- PSM** Preventive and Social Medicine
- PWDS** Pirbhat Women's Development Society
- RCH** Reproductive and Child Health
- RRC** Regional Resource Centre
- RTI** Right to Information
- SG** Shirkat Gah
- SMC** School Management Committee
- SRHR** Sexual and Reproductive Health and Rights
- STD** Sexually Transmitted Disease
- STI** Sexually Transmitted Infection
- TBA** Traditional Birth Attendants
- UHAC** Upazila Health Advisory Committee
- UHC** Upazila Health Complex
- UN** United Nations
- UNO** Upazila Nirbahi Officer
- WHRAP** Women's Health and Rights Advocacy Partnership
- WTO** World Trade Organisation
- WUNC** Worthiness, Unity, Numbers and Commitment

Women's Health and Rights Advocacy Partnership: An Introduction

The Women's Health and Rights Advocacy Partnership (WHRAP) emerged from ARROW's Strategic Planning Meeting with partners held in 2001, where they identified the need to build a regional advocacy partnership in order to be more effective at both national and international venues of advocacy. The first realization of this vision was in the establishment of WHRAP-South Asia in four countries, namely Pakistan, Bangladesh, Nepal and India.

WHRAP-South Asia brings together women NGO (non-governmental organisation) partners who are committed to strengthening civil society capacity to effectively advocate for sexual and reproductive health and rights (SRHR), especially safe motherhood and young people's SRHR at the local, national and regional levels. It aims to reduce maternal mortality, to ensure that all women have the right to affordable medical care including safe delivery and abortion services, and to raise awareness of women's rights throughout all sectors of society. It also aims to eliminate harmful practices and beliefs which discriminate against women, cause immense suffering and hinder their ability to make valuable contributions to their communities.

WHRAP's strategy is unique in that it pushes for joint and complementary strategic planning, monitoring and evidence-based advocacy for accountable health governance and SRHR issues at three levels: local, national and regional. At the local level, we aim to empower marginalised grassroots women and youth by building their capacities to generate and utilise evidence on the barriers and gaps in accessing SRHR services. At the same time, WHRAP integrates locally-generated evidence with national level advocacy and partnership building in order to reorient policies and programmes related to SRHR, so that they are more accurate in addressing the needs of marginalised grassroots women and young people. Finally, WHRAP aims to contribute towards creating synergies between national level advocacy with advocacy at the regional and international arena to influence decision-making processes with regard to the SRHR agenda and international development aid, through the partnership with ARROW and its network of national organisations across the Asia-Pacific region.

WHRAP-South Asia began implementation in 2003. Since then there has been an expansion of the modality in China in 2008 and in six countries in South East Asia – Burma, Cambodia, Laos, Indonesia, Philippines and Vietnam – in 2009.

WHRAP-South Asia comprises of eight partners, including six national level partners from four countries in South Asia.

Bangladesh Women's Health Coalition



Bangladesh Women's Health Coalition (BWHC), a national NGO, was established in 1980 with the vision of "Equality of Women in a Just and Civil Society." The organisation is a pioneer in establishing a health service delivery model, where community women can access a wide range of health services

for themselves and their children with informed voice and choice. Currently, the organisation runs three major programmes and five pilot projects, through 40 reproductive health centres, which cover five administrative divisions in rural and urban locations. Each health centre follows a two prong service delivery approach covering both clinic and community based activities. The underlying motto of this approach is to expose community people to a wide array of information and services that ultimately complement women development initiatives.

BWHC's overall programme has several distinct components to address major issues such as safe motherhood, child survival, family planning, management of unwanted pregnancies, prevention and control of sexually transmitted infections (STIs) and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), counselling, community based awareness raising leading to Behaviour Change Communication (BCC), adolescent family life education, development and maintenance of volunteer cadre for sustaining the community development programme. All these programmes are being supported by a decentralized functional management information system. The organisation is known for introducing innovative methods. The organisation's values are based on team spirit and adherence to quality of care for people's welfare.

Beyond Beijing Committee



Beyond Beijing Committee (BBC) started to work as a forerunner to advance a civil society collective campaign in preparation for the Fourth World Conference on Women, Beijing 1995 and it spearheaded various activities to carry on the torch of Women's Human Rights. BBC is dedicated towards a nationwide campaign to eliminate all forms of

discrimination against women through research, training, education and monitoring the implementation of various national and international instruments relating to women's human rights. It has been monitoring the implementation of the Beijing Platform for Action since 1995. Similarly, it was involved with International Conference on Population and Development (ICPD) and participated in ICPD +5 and ICPD +10 preparations. For BBC, SRHR is one of the principal issues of empowerment for women. BBC has initiated a nationwide campaign to put pressure on the Government for implementation of SRHR and to monitor progress. BBC also brings up women's issues from the grassroots to the national and the international levels.

BBC was a pioneer in starting to consult beyond Kathmandu in order to be inclusive of its multicultural heritage, minorities and rural populations, as was set by the parent committee for the preparatory process of the United Nations (UN) Fourth World Conference on Women, NGO National Preparatory Committee/ INHURED International, with five developmental regions and at the national level. The main aim of the coalition is to effectively implement the Beijing Platform for Action (BPFA) through a diverse array of activities and programmes at grassroots, national and international levels.

BBC has established both formal and non-formal networks and affiliates throughout Nepal. It works with multilateral agencies and bilateral donors, as well as with national, regional and international organisations on women's rights and social justice issues. BBC has also been doing lots of work strengthening and empowering women political leaders from the grassroots to the Constituent Assembly Members.

Centre for Health Education, Training and Nutrition Awareness



Centre for Health Education, Training and Nutrition Awareness (CHETNA) is a unique resource agency which advocates and mainstreams an approach that embraces the life cycle, gender equality and equity and human rights. It considers the totality of the cultural, economic and social factors that shape the environment, particularly those, which affect people's ability to control and improve their own health and nutrition status. CHETNA advocates for comprehensive gender sensitive policies and programmes at the state, national, regional and international levels and networks and forges strategic partnerships, globally.

CHETNA believes that information is critical for awareness. To facilitate development of people centred policies and programmes, people need to be made aware of their rights and entitlements. Programme implementers, policy makers, and donor agencies need to be aware of the field level realities. When people participate, they gain control over the problems that they face and can gain sight of solutions. Next they need to develop their own space within the given power structure to actualise their rights to development and fulfilment.

Gender discrimination is a crucial reason impacting the poor health of women and girls. Therefore, addressing gender relations and the role of men in communities is central to CHETNA's efforts in enhancing health and development. Indigenous health and holistic healing practices empower and promote health and wellbeing. Women and communities are reservoirs of ancient knowledge of health and healing practices. These practices are intricately woven into people's lives and are based on local resources and context. Promotion of sound practices enhances self-reliance, health and well being.

Currently CHETNA focuses on:

- Valuing the girl child – improving child sex ratio in favour of girls
- Enhancing early childhood health and development
- Addressing health and development of school age children
- Promoting young people's health and development
- Improving maternal health (reducing death, disease and disabilities linked with pregnancy and childbirth)
- Enhancing nutrition and food security in the life cycle.

CHETNA initiated its activities in 1980 under the umbrella of Nehru Foundation for Development. CHETNA designs and implements need based participatory training programmes for community leaders, service providers, trainers, programme coordinators and managers on health and development issues of children, young people and women. Regular follow up support is provided to ensure capacity enhancement. Innovative and appropriate models for community empowerment are documented and widely disseminated to ensure replication in other NGOs and mainstream them in Government

programmes. An Information and Documentation Centre has been established to address the information needs of GO/NGOs, researchers and academicians.

Need based, innovative BCC material is developed for specific clientele. These illustrative and attractive materials are developed in simple local languages. They are field tested with potential users before mass production and extensively disseminated at the state/national/regional and international levels.

CHETNA networks with several NGOs, GOs, CBOs, media and individuals at the state, national, regional and international levels to learn collectively, share information, ideas, experiences and resources. CHETNA engages and dialogues with the policy makers, planners and programme implementers using evidences generated through research and analysis; contributes in preparation of state, national and global policy documents; demonstrates innovative and appropriate programme implementation models. Regular engagement and dialogue with media is one of the key advocacy strategies.

Field interventions of CHETNA are primarily focused in the states of Gujarat and Rajasthan in India. At the national level CHETNA focuses on policy formulation and programme planning, especially effective implementation of National Rural Health Mission (NRHM), a flagship programme of the Government of India. Government of India recognised CHETNA as Regional Resource Centre (RRC) under the Reproductive and Child Health (RCH) programme for the state of Gujarat and union territories of Dadra Nagar Haveli and Diu. The RRC-CHETNA provides capacity building and mentoring support to 90 civil society organisations in all the 25 districts of Gujarat state. The main objective is to mobilize communities to enhance access to health services from the public health system for disadvantaged communities that are unserved by health services and other public facilities.

Naripokkho

নারীপক্ষ Naripokkho is a membership-based, women's activist organization working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice. Since its founding in 1983, Naripokkho has met nearly every Tuesday to discuss problems, issues and strategies related to these concerns. These discussions form the basis for Naripokkho's programmes and activities, which include campaigns, cultural events, training, research, lobbying and advocacy, and the maintenance of a regular participatory discussion forum. Occasionally this leads to a specific project, which is carried out with grant funding. However, most of Naripokkho's activities are voluntary and financed through resources that are earned by the membership. Naripokkho's work is focused on the following five inter-related thematic areas:

- Equality and the Political Empowerment of Women
- Violence Against Women and Women's Human Rights
- Women's Health and Reproductive Rights
- Gender Issues in Environment and Development
- Cultural Politics and the Representation of Women

Naripokkho has extensive experience in developing sustainable networks and alliances

as well as in conducting workshops, seminars, training and national level conferences. In 1991, Naripokkho initiated the International Women's Day Committee composed of women's organisations and development NGOs working for women's advancement. This Committee coordinates and organises the celebration of 8th March in different parts of the country on the basis of a common theme every year.

In 1999, Naripokkho led the initiative to form *Shonghoti*, an alliance of women's organisations, human rights organisations and development NGOs, in order to defend the human rights of sex workers in the face of a violent and illegal eviction of brothels in Narayanganj by the Government of Bangladesh. *Shonghoti* works in solidarity with sex workers' organisations in demanding recognition of their rights as citizens. Although Naripokkho continues to provide the bulk of secretarial support and political leadership in both cases, it has successfully passed on the convenorship of the International Women's Day Committee as well as *Shonghoti*.

Naripokkho has also initiated a national network of women's organisations named *Doorbar* which means "indomitable." Today, a total of 530 local level women's organisations from all over the country are part of this network which has decided to work together on issues of violence against women and women's political empowerment.

SAHAYOG



SAHAYOG is a non-profit voluntary organisation working in India with the mission statement of promoting gender equality and women's health from a human rights framework by strengthening partnership-based advocacy. SAHAYOG was set up in 1992 and has seeded a number of community-based organizations as well as a national resource organization. It has a head office at Lucknow and a project office at New Delhi. Currently SAHAYOG's work is focused on the following areas:

- Women's rights to maternal health services
- Young people's reproductive and sexual rights and health
- Work with men on gender equality, masculinity and ending gender based violence.

SAHAYOG facilitates issue-based partnerships, provides capacity-building and field support, and carries out studies and documentation, as well as information dissemination activities. Through its networking, SAHAYOG also works for policy advocacy, anchors campaigns and engages with the media. In order to increase the participation of communities in decisions that affect their lives and the exercise of their rights, SAHAYOG has been facilitating across 14 districts of Uttar Pradesh state, the grassroots women's organization Women's Health Rights Forum, and the youth group Youth for Change. Within Uttar Pradesh SAHAYOG has close partnership with NGOs in 14 districts, supports HUMSAFAR a support centre for women, and is the secretariat for the organization Men's Action for Stopping Violence Against Women (MASVAW) which involves university youth, media persons and civil society across 25 districts. At the national level, SAHAYOG is anchoring a partnership on maternal health across 9 states, and collaborates in the national partnership Forum for Engaging Men. SAHAYOG is also part of the International Initiative for Maternal Mortality and Human Rights, and the global network Men Engage.

Shirkat Gah – Women's Resource Centre



Shirkat Gah – Women's Resource Centre was formed in 1975 with a purpose of integrating consciousness raising with a development perspective and initiating projects that translate advocacy into action. Shirkat Gah (SG) adopts a participatory approach in its internal functioning and all its activities. It works in all four provinces of Pakistan through its three offices based in Karachi, Lahore and Peshawar. SG is an NGO on the Roster in consultative status with the Economic and Social Council of the United Nations.

SG's mission is:

- To build the capacity of women as rights claimants, able to make informed decisions, as well as to create alternative life choices
- To advocate and mobilize for positive changes in policies and practices from the community to the international arena
- To hold the state accountable and develop a culture of peace, ensuring sustainable and equitable use of resources and full inclusion of rights of all people

SG works at the grassroots, national, regional and international levels. It has an integrated approach to development and women's rights that combines advocacy and capacity building based on research, networking and publications. Bridging the gap between the reality of women's lives and national and international policy, SG:

- Catalyses the empowerment of women through a participatory process, in which NGOs and CBOs are a primary channel for reaching women in their communities;
- Actively advocates at both national, regional and international levels; and
- Undertakes innovative research, documentation and dissemination of information

At the macro policy level SG works with the UN and donor system as well as with relevant national and provincial government institutions focused upon policy changes. At the meso level it focuses on connecting women's groups, networks, and CBOs with other civil society organizations, District to Union Council Government institutions and non state actors. At the micro level SG works with CBO partners to mobilize communities to collectively assert their rights and make duty bearers accountable.

SG aims to promote women's empowerment through a rights based approach that ensures women have access to the rights and services they are entitled to. The SRHR component of SG addresses the linkages between maternal mortality, unsafe abortion, HIV/AIDS and the interface with violence against women by

- Building awareness of SRHR at the grassroots as well as policy levels
- Working to change policies and practices
- Making duty bearers more responsive

SG has a multidimensional approach which views rights and development as

inherently linked, interventions that translate advocacy into actions, and an excellent track record of engaging equally with international themes as with local issues. Moreover, it has extensive experience of working collectively with other organizations and networks, has been the Secretariat of Pakistan Reproductive Health Network (PRHN) since 1999, and has served as the secretariat for various other thematic networks.

SG serves or benefits a range of groups as mentioned below:

- Women in communities, addressing their practical needs
- Women facing legal problems and whose rights are denied or violated in Pakistan (and abroad)
- An average of 50 CBOs and CSOs (in over 35 districts of Pakistan) are helped by SG in their advocacy interventions
- Women in Pakistan linked with those in Muslim countries and beyond
- State institutions
- Interns who join SG for a short-term experience
- Approximately 40-50,000 other people benefit annually from SG's resource centres and publications i.e. students, scholars, media, civil servants etc.

Danish Family Planning Association

DFPA

The Danish Family
Planning Association

Every sexual action should be free from coercion and disease, every pregnancy wanted, and every birth healthy – in Denmark and in the rest of the world. This has been at the heart of the work of the Danish Family Planning Association (DFPA) throughout the past 50 years.

DFPA works to create greater awareness on issues concerning sexuality, pregnancy, contraceptive methods and sexually transmitted diseases. DFPA is committed to ensure that health and sex education are recognized worldwide as human rights, irrespective of age, gender, religion, marital or social status.

DFPA also helps raising health standards and ensure easy access to affordable and safe contraceptive methods to improve people's sexual well-being. Creating a world in which everybody can enjoy or exercise their full sexual and reproductive health and rights is vital for our work. This requires openness and knowledge about sexuality, and therefore DFPA advocates for free dialogue, tolerance and education. We believe that women should have the right to freely decide whether or when to have children. This entails access to safe contraceptive methods, knowledge and good counselling - elements that form a natural part of all of the work strategies of DFPA.

DFPA is a private, non-governmental organisation without religious or political affiliations. DFPA works with associations and organisations within the sphere of sexual and reproductive health and rights. DFPA is a member of the world's leading family planning organisation, the International Planned Parenthood Federation (IPPF).

Asian-Pacific Resource and Research Centre for Women



Asian-Pacific Resource and Research Centre for Women (ARROW) is committed to advocating and protecting women's health needs and rights, particularly in the area of women's sexual and reproductive health. We believe that good health and wellbeing and access to comprehensive and affordable gender-sensitive health services are fundamental human rights. ARROW's work will be done when:

- Health, reproductive health and population policies and programmes are re-oriented to become more accessible, affordable and comprehensive, and include a gender and rights approach;
- The women's movement and civil society become stronger and more effective in holding governments accountable to international commitments, influencing policy agendas on women's health and rights, and gaining sustained representation in decision-making structures; and
- Women's health outcomes and women's lives improve, especially for poor and marginalized women and girls, particularly in the area of sexual and reproductive health and rights (SRHR) and violence against women (VAW).

ARROW is a regional non-profit women's NGO founded in 1993 by Rita Raj and Rashidah Abdullah.

- ARROW's affairs are handled by the Management Team, led by the Executive Director and assisted by an Administration Manager and two Programme Managers
- ARROW is governed by a Board of Directors, made up of five committed and experienced voluntary members and the Executive Director
- The Programme Advisory Committee (PAC), composed of skilled and knowledgeable activists from the region, provides programme advice and direction
- ARROW's programmes and activities are implemented by paid staff
- ARROW also retains a number of consultants who contribute to specific projects and activities

As part of the crosscutting strategy for success, ARROW relies on effective partnerships and collaborations. ARROW's partners are seen as integral to its structure, and capacity building with them—and of ARROW itself—is seen as an important mechanism to facilitate effective participation.

ARROW believes in a united effort to make a difference in women's lives, including their sexual and reproductive health. ARROW's programme strategies are:

- Production and dissemination of innovative materials for advocacy, policy and

programme implementation;

- Policy advocacy with governments and other key stakeholders backed by research-based monitoring of implementation of the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women; and
- Capacity building of women's NGOs and strengthening the women's movement.

Chapter 1

Why SRHR Advocacy, Why Now?

SRHR

Background to SRHR

The notion of sexual and reproductive health and rights (SRHR) came into popular use after the International Conference on Population and Development (ICPD) at Cairo in 1994. It was seen within a framework of comprehensive primary health, gender equality with women's empowerment, and equitable development. Although there have been considerable gains in the language of SRHR in the last fifteen years since 1994, the concrete changes on the ground have not matched expectations. Working collectively, some civil society organizations have made considerable progress in terms of understanding and expanding the Cairo agenda, and reminding governments about their commitments to fulfil SRHR. They have used the ICPD framework to highlight the importance of rights, especially sexual and reproductive rights, for well-being of populations. With concrete examples on the ground, they have often shown how the ICPD agenda may be translated into action. Women's organizations and health NGOs in South Asia have been very active in such efforts, both within their own countries and within regional and global alliances. There continues to be a need for such efforts even as the 20-year time-frame for achieving the ICPD goals comes into its final years.



Some Key Aspects of the ICPD¹

The principles of the ICPD Programme of Action (PoA) are firmly grounded in universal human rights as recognized in national laws and international human rights documents. These provide that all people are born free with equal dignity and rights and have the right to life, liberty, security of person, development and education. Women's human rights are stated in Principle 4, Chapter II as '...integral and [an] indivisible part of universal human rights.' Key to these rights is the eradication of all forms of discrimination on the grounds of sex, and the full and equal participation of women at all levels of society. Specific to health is that, 'Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health...and universal access to health care services.' (Principle 8, Chapter II)

The ICPD PoA defines reproductive health and rights in paragraphs 7.2 and 7.3 of chapter VII as interlinked concepts, which have both a rights and a health perspective. Chapter VII, titled 'Reproductive Rights and Reproductive Health', indicates that this is the overarching framework

1. From Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015 (Malaysia: ARROW, 2004).

within which the discussion on family planning, sexually transmitted diseases (STDs), HIV/AIDS and sexuality should take place. Rights come first in the chapter title as this provides the principles for action. The ICPD PoA explains this concept as 'The rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence...' (Paragraph 7.3) The PoA further agrees that 'governmental goals for family planning should be defined in terms of unmet needs for information and services' and that demographic goals should not be imposed in the form of targets, quotas or incentives for recruitment of clients. Regarding reproductive health services, the PoA agreed that, 'All countries should strive to make accessible through the primary health-care system, the full range of affordable reproductive health services to all individuals of appropriate ages as soon as possible.' (Paragraphs 7.5 and 7.6)

Sexuality and sexual health come under reproductive rights and reproductive health in the ICPD PoA. Sexuality here refers to only heterosexuality – 'Equal relationships between men and women in matters of sexual relationships and reproduction, including full respect for the physical integrity of the human body, requiring mutual respect and willingness to accept responsibility for the consequences of sexual behaviour.' (ICPD PoA, 7.34) Elsewhere in Chapter VII, it is stated that the ability to have a satisfying and safe sex life is implied as part of reproductive health and reproductive health care, and this should also include information, education and counselling on human sexuality (PoA, 7.6). Although the term 'sexual rights' is not used, it is implied that the right to a satisfying and safe sex life is part of reproductive rights. ICPD NGO advocates have decided to use the term 'sexual and reproductive health and rights' to emphasise the centrality of sexual relations in determining reproductive health outcomes and the exercise of reproductive rights.

To summarize, the minimum SRHR requirements² that governments are meant to provide include:

- i. Adequate emergency obstetric care services to enable safe pregnancy and childbirth;
- ii. Access to the full range of information and reproductive health services available in all public primary health care facilities including family planning, maternal health, abortion, infertility, RTIs, STDs sexuality and referrals to include reproductive cancer and HIV/AIDS;
- iii. Contraceptive services irrespective of age or marital status;
- iv. The freedom to decide if, when and how often to have a child and to have a satisfying and safe sex life;

2. Points ii, iv, v and vi come directly from ICPD paragraphs 7.2 and 7.6.

- v. Access to safe, effective and affordable methods of family planning of the individual's own choice as well as other methods of their choice for regulation of fertility which are not against the law; and
- vi. Sexuality information and education on personal relations as well as reproduction and STDs.



Where are we today?

Fifteen years after the International Conference on Population and Development 1994, women's lives have seen only minimal improvement, and there is great need for intensive advocacy efforts to fulfil the Cairo agenda. As the UN Secretary General's report noted at the 42nd session of the ICPD, 'Fifteen years have passed since the ICPD financial targets were fixed. Stocktaking of progress of the Conference 15 years after it was held shows that while resources mobilized have increased, the overall funding is significantly less than necessary to meet current needs and costs, which have grown tremendously since the targets were agreed upon in 1994...' The Report points out that without political will, renewed commitment, and adequate resources to meet current needs, it will not be possible to achieve the goals of the Conference or the Millennium Summit.

Findings from NGO country-monitoring studies in South Asian countries reveal that despite agreements to achieve the clear objectives and strategies outlined in the ICPD PoA, governments have not yet been successful in implementing the majority of actions promised at that landmark conference. While many new population and reproductive health policies have been introduced in the countries that form part of this study, they still do not clearly incorporate a human rights and women's rights framework both at the conceptual and programme levels. In South Asia, even the availability and accessibility of maternal health-care services and quality of family planning services remains a problem, not to speak of the integration of infertility, abortion, RTI, STD and reproductive cancer services. Furthermore, the administration of different reproductive health services continues to be vertically managed in most countries through different departments.

Preventable deaths from maternal mortality have decreased somewhat: yet around a quarter of a million women are estimated to have died from causes related to maternal mortality each year, a significant percent of whom are dying from unsafe abortions. Violence against women is still prevalent within and outside the domestic sphere, as is HIV/AIDS transmission for women and men. Health services for dealing with violence against women are also not available. Specific issues faced by South Asian women include early age marriages and 'forced' marriages. These encompass the violation of their rights to choose partners, and the possibility of brutal violence from the natal family in case of elopements or marriages with men or women who are not of the appropriate caste, class

or religion. The early marriages of girls barely in their teens, leads to non-consensual sex, marital rape, unwanted pregnancy, lack of access to contraceptives or safe abortions, and higher rates of maternal deaths and morbidities.

Fifty years after family planning programmes began in the region, the expressed unmet need of Asian women for contraception is still fairly high. From a reproductive rights perspective, the slow progress is unacceptable as women still continue to have more children than they want and are thus not in control of their bodies and lives. Contraceptive prevalence rates and unmet need assessment continue to focus only on married couples and exclude young people and the unmarried. There is an urgent need to improve this indicator in line with the rights of individuals of all ages to use contraception. Data on contraception availability for unmarried women (adults), divorced, separated and widowed women and disabled women could not be found, and most governments are reluctant to provide contraceptive services to unmarried people, including adolescents. Macro-level issues such as the growing threat of climate change and its impact on environmental conditions around the globe and the current economic crisis are focusing renewed and heightened attention on population dynamics (fertility, mortality, migration and age structure changes) while recognizing or assuming individual rights-based concerns, including the unmet need for contraception.

With the exception of family planning services, the cost of reproductive health services has increased due to the implementation of health sector reforms in all countries. Required resources for ICPD implementation are yet to be fully mobilized by national governments; and there is an even larger gap in committed resources from international donor agencies. All countries in the region now have a neoliberal development agenda as part of the globalised economy, with governments increasingly becoming less responsible for the provision of public services, including health. Growing militarism and national security concerns in Pakistan, Nepal and India have meant less resource availability for the social sector, which includes health. Recently, the report of the WHO Commission on the Social Determinants of Health (2005-2008) highlighted the need to urgently address social equity, education, shelter and environment, livelihoods and social security in order to ensure better health outcomes for the poor.

A related concern is the fact that reproductive health NGOs and women activist NGOs were not centrally involved in the formulation of population or health policies in all these countries although there were some consultations when drafts were being prepared. The extent of NGO involvement in the development of new reproductive health programmes in countries also needs to be assessed. This lack of involvement by women NGOs in policy formulation does not only reflect the views of governments on the role of such NGOs, but also speaks for the poor mechanisms for women NGO participation in policy development as well as the inability of women NGOs to position themselves well for effective strategic policy influence.



Where do we go from here?

It may be appropriate here to quote from the Berlin Call to Action, 2009: 'As urgent as the ICPD agenda was in 1994, it is even more so today as countries, communities, and individuals seek effective responses to financial, political, humanitarian and environmental crises, climate change, insufficient health resources, continuing high maternal mortality and morbidity and the spread of HIV, and inequality in ensuring human rights. It is important to recognize the social determinants of health that are responsible for a major part of health inequities between and within countries. Access to sexual and reproductive health and rights information and services is essential to addressing these issues. The ICPD created a visionary global consensus which confirmed that the best way to improve global health and population policies, support sustainable development, advance human rights and help end poverty is to:

- Invest in health and rights for women and young people;
- Provide comprehensive sexual and reproductive health information, services and supplies for all people;
- Eradicate discrimination against girls and ensure access to all levels of education; and
- Advance gender equality and equity and empower girls and women.

With five years left to implement the ICPD PoA and achieve the Millennium Development Goals (MDGs), which are integrally linked, it is an opportune moment to advocate effectively for establishing and implementing concrete, practical, and fully funded actions for ensuring sexual and reproductive health and rights.'

Within the Berlin Call to Action are several directions for SRHR advocacy that can serve as an agenda for South Asia as well. Civil society groups can promote these advocacy agendas in cooperation with governments, bilateral and multilateral agencies and policymakers and other sectors of the social movements to ensure timely implementation and hold governments accountable for the full realization of the ICPD PoA. The first is advocacy aimed at promoting sexual and reproductive rights as human rights, and advocating for governments to fully recognize and fulfil these rights. Secondly, advocacy is needed to highlight the importance of adequate investment in comprehensive sexual and reproductive health information, supplies and services³ as a priority in health system

3. Reproductive health [...] implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this [is] the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. [...] reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. (ICPD PoA, 7.2)

strengthening. Thirdly, a key area of advocacy in South Asia is to demand that governments ensure the sexual and reproductive rights of adolescents and young people. Fourthly, advocacy needs to expand the spaces for meaningful participation of civil society, especially women and young people, in programmes, policy and budget decisions, monitoring and evaluation. Finally, given the scarcity of resources for social agendas, South Asian advocacy needs to emphasize that national governments and donors must allocate sufficient resources and budgets that meet the needs of all people's SRHR. As HIV/AIDS has dominated allocation of donor funding to SRHR since the ICPD and other health crises have emerged, advocacy with a wide range of stakeholders is seen as extremely important in strategizing how best to allocate scarce health resources. Another way forward is to leverage resources by linking the ICPD PoA to other rights-based agreements including the 1995 Beijing Platform of Action, the Convention on the Elimination of Discrimination against Women, Convention on the Rights of the Child and the MDGs.



What can NGOs do?

NGOs have always been at the forefront of promoting diversity, gender equity and equality and arguing for social justice and human rights. NGOs can see SRHR within the comprehensive framework laid out in the ICPD PoA and global movements to ensure universal access to health care. In addition to providing essential services, NGOs provide health education, encourage uptake of services, and raise awareness of SRHR with users, community leaders and policymakers. Often the first and sometimes only responders to communities in need, NGOs are acutely attuned to the pressures of poverty and the economic crisis. NGOs can thus be knowledgeable spokespeople for issues and populations that are often not addressed by mainstream programmes. In particular, they have to reach those who live far from services and vulnerable and marginalized groups who often avoid the formal health system for fear of stigma, discrimination and in some cases criminal prosecution.

While the role of NGOs is critical in serving marginalized communities, they can also play a strong role in advocating for strengthened and more accountable public health systems. Many NGOs and regional networks are focusing increasing effort on holding their governments and donors accountable. Many already monitor national budgets or work with parliamentarians; some build partnerships with academic institutions to improve their ability to collect and use evidence—medical, legal and demographic—in promoting the PoA. Grounded in local realities, NGOs can use their experiences to inform and impact global health trends. NGOs can use tools such as legal cases and policy advocacy to put forward their agenda, or build wide-ranging alliances to increase their effectiveness and political outreach. They can also work to neutralize the impact of fundamentalist views that violate sexual and reproductive rights, and uphold the secular state, addressing political opposition and issues of cultural differences.



Why this Resource Book?

This resource book is meant to support NGOs within the South Asia region that are already working with advocacy on SRHR issues. In addition to case studies from South Asia, it draws from the experiences of the contributors and reviewers who are from the region, and is an attempt to consolidate the learning gained so far. This first chapter sets out the background of SRHR from the ICPD of 1994, and indicates the importance of NGO advocacy in strengthening the ICPD PoA. In the second chapter, the meaning of advocacy is examined, including what is not advocacy. Some common types of advocacy are mentioned, and the ethics and values on which human rights-based advocacy is based are set out. Finally, the chapter mentions some of the challenges of advocacy and the characteristics of effective advocacy. The third chapter explains how to carry out the essential context analysis before actually starting advocacy. It explains how to use the analysis of available evidence on SRHR to examine the policy, programmes and other provisions for SRHR. This chapter expands on these aspects by first highlighting the importance of understanding 'local context' for effective advocacy on women's health issues, specially reproductive and sexual health. Then it indicates the link between information (data), policies and programmes for identifying advocacy issues. Finally, it illustrates through concrete examples, how context shapes our advocacy strategies in South Asia.

The fourth chapter sets out the basics of how to start doing advocacy for SRHR in South Asia. The chapter sets out how to define the advocacy issue, how to map the stakeholders around the issue, and how to develop advocacy strategies, such as re-active and pro-active strategies, both from within and outside the system. The fifth chapter sets out very practical steps of advocacy such as the starting point of alliance building, followed by details of some methods of advocacy, including legislative and legal advocacy, policy advocacy, media advocacy and social or community advocacy. It ends with describing some of the essential tools of advocacy. The sixth and final chapter sets out the way to plan in a strategic manner for advocacy. It gives a clear framework for evaluating advocacy efforts, in order to prove they were indeed successful. It also throws light on the practical aspect of budgeting for advocacy.

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Chapter 2

Advocacy - Conceptual Critiques

The following chapter is designed to provide basic knowledge about advocacy as a strategy and to give a better understanding of the concept behind WHRAP.

To do so, we will examine the following:

- A. Meaning of advocacy
- B. Ethics and values of advocacy
- C. Challenges of advocacy
- D. Characteristics of effective advocacy

A. Meaning of Advocacy

At its simplest level, advocacy is any act of giving support to a cause. In its broadest sense, advocacy ensures that the cause or idea one feels concerned about dominates public consciousness.

Some other definitions of advocacy are as follows:

- Advocacy is strategic action to initiate a public policy that is beneficial to the community or block one which is expected to be harmful. It aims to influence the content/substance of policy, the people who formulate the policy, the process of policy-making and the monitoring of implementation and evaluation of policy outcomes.¹
- Advocacy is a democratic tool to bring about change – social, political and/or economic.
- An organised, sustained campaign by a section of civil society to get their interest represented and addressed by power centres.²
- Advocacy is a tool, based on organised efforts and actions, that uses the instruments of democracy to strengthen democratic processes; such tools include election related work, lobbying, mass mobilisation, forms of civil disobedience, negotiations and bargaining, and court actions.³
- The promotion of a cause or an issue by a section of civil society to some centres of power in society with the objective of influencing that centre in particular with respect to changes in public policy or changes in practice or projects.⁴

At the end of this section, we will have argued out and proposed our definition of Advocacy.

Public Advocacy is another commonly used term. This refers to efforts

1. Socorro L. Reyes, Local Legislative Advocacy (Philippines: CLD, Dec. 1997) p.2.
2. Jai Sen, Advocacy in India: Some Points Towards an Overview: A Discussion Paper (Lucknow: EDAP Northern Regional Workshop, 1994).
3. David Cohen, Keynote Address at the National Workshop on Indian Advocacy (India: 1994).
4. Jai Sen, Advocacy in India: Some Points Towards an Overview: A Discussion Paper (Lucknow: EDAP Northern Regional Workshop, 1994).

directed towards the benefits of the general public, or a large group of individuals. Public advocacy promotes public good and attempts to bring about social justice. It focuses on the well-being of underprivileged members of society and concerns itself with social change so that weaker sections of society get greater access to political power and economic resources.

Another term that is frequently used in relation to advocacy is **lobbying**. Lobbying can be described as the act of trying to directly influence the actions of government either through private maneuvering and tactics or through public actions, or the combination of the two (for instance, encouraging the public to contact members of a legislature). The goal of lobbying is to convince the government (usually specific segments of a government, such as a particular branch of bureaucracy or legislative committee) to follow policies desired by the lobbyist. Another understanding of the term is that lobbying is basically paid advocacy.

The term **lobbyist** is therefore applied to any person who attempts to directly influence the actions of government. However, it usually denotes a professional advocate who is paid for their lobbying activity. Lobbyists of this type can be self-employed, selling their services to the highest bidder on specific projects, or they can be employed directly by organizations such as corporations that wish to influence policy.

Colleagues in India describe advocacy as an organized, systematic, intentional process of influencing matters of public interest and changing power relations to improve the lives of the disenfranchised. Other colleagues in Latin America define it as a process of social transformation aimed at shaping the direction public participation, policies, and programmes to benefit the marginalized, uphold human rights, and safeguard the environment. African colleagues describe their advocacy as being pro-poor, reflecting core values such as equity, justice and mutual respect, and focusing on empowering the poor and being accountable to them.⁵

What is not advocacy?

Advocacy is not Information, Education and Communication (IEC), BCC, events, movements or lobbying. Many times many of us describe everything that we do in our social development work under the term 'advocacy'. We refer to our IEC or BCC work, or the grass roots mobilising that we do, or a research study dissemination-of-findings workshop, as advocacy.

It is important to recognise that **advocacy is not just a single act of communication, marketing or persuasion** or a one-off event. For instance, we may think that a conversation with a friendly bureaucrat is advocacy, without actually directing the discussion to the policy or

5. Valerie Miller and Jane Covey, *Advocacy Sourcebook: Framework for Planning, Action, and Reflection* (Boston: Institute for Development Research, 1997) p.12.

programme change that we desire. Advocacy is not about the level at which an action is taken; it is about the intended outcome of the action.

Advocacy is also not about finding individual scapegoats for a problem, but about identifying systemic causes of the problem and finding systemic solutions to these through systemic changes. Many activists in India who have organised public hearings on denial of right to health care have realised that often these public hearings result in accusing individual health care providers rather than drawing attention to health system issues like ineffective monitoring systems, weak supply chains, logistic systems etc.

Relationship between movements and advocacy

There are some commonalities between *movements and advocacy*. Both oppose and challenge the given order or policies and projects which represent the interests of more powerful sections. They also use many of the same tactics – mass mobilisation and cultural programmes for consciousness raising. But movements may often be very specifically focused on only opposing the current system without proposing a clear alternative. Many movements tend to be more oriented towards mass mobilisation, mobilisation of public opinion and towards takeover of controlling power, rather than towards policy or programme changes. A recent example of this in South Asia was the mass movement in Nepal that challenged and finally removed the rule of the king. Another example is the lawyers' movement in Pakistan that challenged the Presidential orders against the Chief Justice, which resulted in his re-instatement.

In contrast, advocacy work often strives for policy and programme changes and it does not use confrontational or violent tactics. It also tends to focus on exploring spaces within the existing system through which change can be brought about, rather than rejecting the entire system.

Charles Tilly⁶ argues that there are three major elements to a social movement:

1. Campaigns: a sustained, organized public effort making collective claims on target authorities.
2. Social movement repertoire: employment of combinations from among the following forms of political action: creation of special-purpose associations and coalitions, public meetings, solemn processions, vigils, rallies, demonstrations, petition drives, statements to and in public media, and pamphleteering.
3. WUNC displays: participants' concerted public representation of worthiness, unity, numbers, and commitments on the part of themselves and/or their constituencies.

Movements, social or political, are in a sense advocacy but larger than advocacy – they tend to involve larger groups of people and tend to be

6. Charles Tilly, *Social Movements*, 1768-2004 (Colorado: Paradigm Publishers, 2004) p.262.

more systemic in impact and often because of the nature of change sought, are long-drawn out. The Freedom Movement of India, the anti-slavery movement of US, the working class movement, the greens/environment movement, the feminist movement, the gay liberation movement, the anti-nuclear and peace movements, and of late, access to drugs, anti-globalization, anti-GM and pro-organic foods, and free software movements are some examples.

Movements over a period of time cover vast terrain of ideas and paradigms of thought and tend to be at once diffused and specific over details, as well as being capable of multiple interpretations as to what the movement means to a participant in the movement.

Movements can be categorized as non-violent/violent (by methods of work), by class of its constituency (only workers, only peasant farmers, only Blacks, only Dalits), by values sought to be propagated, by alternative worlds sought, by range (global/local/transnational) and by attempting to influence either individuals or groups (vegetarianism/religious movements).

Advocacy, on the contrary, seeks more limited change; it could be systemic in its impact but would not normally seek to affect changes in the fundamental socio-political fabric of a society/community/nation-state. Advocacy normally does not involve large masses of people but may involve key actors (advocates) at several levels, geographically spread out if necessary, each often playing a different part.

When one is promoting the interests of a private group like an industry or a particular class of individuals, then it tends to get labelled as private advocacy/lobbying, etc. When social action groups like NGOs tend to engage in advocacy, it is mostly *public* advocacy; usually such public advocates tend to speak up for the marginalized, weak and are seen routinely interrogating the Nation-State and its multiple actors. The two definitions of advocacy given below are from the perspective of social activists working in NGOs.

Our definitions of advocacy

Drawing upon some core elements of the definitions mentioned above, as well as the discussion on 'what advocacy is not', we propose the following definitions of advocacy:

- **Advocacy is an organised, deliberate, systematic and strategic process intended to bring about a positive change towards fulfilling, respecting, protecting and promoting human rights of marginalised individuals and groups.**
- **Advocacy is about increasing the voice, access and influence of marginalised individuals and groups in all decision making processes that affect their lives, towards changing existing power hierarchies and relations.**

We propose these definitions in order to highlight certain elements of advocacy that we consider important:

- It has to be well-planned and thought out, using strategic options rather than whatever comes to mind first. *Random or ad hoc responses and single-event interventions are not advocacy.*
- It must move towards the fulfilment of human rights of marginalized groups and individuals. Thus we need to carefully examine what we are aiming at through our advocacy: if it uses 'pro-poor' or 'pro-women' language but ultimately benefits private corporations or consultants, then we cannot call it advocacy.
- Since we are using a rights-based approach here, we have to be very careful about our language and the use of aggression, coercion and violence. Advocacy is about being assertive regarding our demands, but not at the cost of being violent or breaking the law.
- Advocacy may lead to 'adversarial' relations with others but not a relation of enmity. We may confront the government or private corporations, we may argue with other groups who disagree about our cause, but we do not consider them our enemies, to be destroyed.
- It has to enable increased 'voice' and participation of the marginal groups rather than increased prominence of the 'advocate'; in other words it is about bringing forward people to speak on their own issues rather than advocates speaking on behalf of people. It has to make marginalized people aware that they too have entitlements; they have 'the right to have rights.'
- It is about challenging and changing existing power relations: between rural and urban, between the literate and illiterate, between castes, between women and men, and so forth. The process of doing advocacy itself must reflect these changed relations by empowering the directly affected people to overcome these hierarchies.

Rights based advocacy also recognises that human rights are indivisible. One right cannot be achieved if others are curtailed. This means, for example, that those who work on trade or labour issues should at least not negate, if they cannot actually support, women's right issues. It means that we can not advocate for fair (higher) wages and ignore the fact that even if wages are increased there will still be disparity between women's and men's wages. Or then, advocate for higher wage and suggest that funds for the increase are sourced by cutting maternity benefits and maternal care including emergency obstetric care and access to quality services.

Types of advocacy

There are several fields or domains in which advocacy can be done. **Legislative or Legal Advocacy** is aimed at changing laws or bringing about legal reform or at creating a participatory process around law formulation. An example of this is the change in the abortion laws in Nepal

or the reform in the Hudood Ordinances through the Protection of Women (Criminal Laws Amendment) Act, 2006, in Pakistan. **Media Advocacy** is directed towards getting print and/or electronic media to understand and become interested in covering a particular issue, or change their style of coverage, for example, getting them to publish unknown voices of those directly affected. **Social Advocacy** aims to change mindsets of various sections of society. For example, in South Asian societies, where domestic violence is seen as a 'private issue', we could address writers, artistes, opinion makers, academicians and youth towards building a social 'zero-tolerance' towards domestic violence. **Community Advocacy** is about facilitating communities to understand their entitlements and to build advocacy skills; to speak up for their own rights, to break the hierarchies that keep them silent, and to participate effectively in decision-making that affects them.

B. Ethics and Values of Advocacy

Human rights based advocacy has certain values. A human rights perspective espouses respect for human rights of all, therefore the role of human rights advocates is to work positively to expand spaces and create an enabling environment for increasing access, voice and influence of marginalised groups. **Human rights based advocacy** thus subscribes to values of non-violence, non-aggression and avoids coercion and intimidation.

There is a range of methods adopted by public advocates and these are based on what they think is ethical or fair. Some advocates think that the ends justify the means. According to them, the use of methods that are forceful, aggressive or even violent in some way is justified if we are trying to gain something for deprived people. Other advocates feel that if we use violent or coercive methods, we are behaving in the same manner as those we disapprove of. If we want our human rights to be respected, we have to respect the human rights of all, including those who are the target of our advocacy efforts. **Value based advocacy** places emphasis on the means as well as the ends i.e. how we do our advocacy is as important as what we want to achieve through our advocacy.

Most advocates agree that transparency, non-corruption, respect for human rights, gender sensitivity, democratic means of functioning and accountability are norms and values that should be upheld. Another issue in South Asia is that the people on whose behalf advocates work are usually extremely poor and disadvantaged, but those doing the advocacy are often very well-resourced. The great disparity between the lifestyles can lead to unpleasantness at work, so it is better appreciated to lead a simple, low-key lifestyle as an advocate. We also need to recognize that enabling the marginalized groups to play key roles in advocacy, will imply putting support systems in place so that the advocacy work will not add to their existing multiple burdens of caring for the family and earning money. Provisions for child care, transport and so on, must be ensured.

We also need to provide support for those who are empowered and at risk of backlash. For example, survivors of violence who want to come forward for the issue can be at the receiving end of further violence because they are speaking out. Protection for these advocates must be ensured. Similarly, adverse health consequences from overload for advocates from the PLWHA community must be anticipated and provision of health care must be factored in. We also need to emphasize that we have to practice what we advocate for – for example, if we are advocating for a violence free society, we cannot be abusing persons in our own families and organizations!

Some preferred ethical attributes of advocacy⁷ are as follows:

- Fact based work: an avoidance of exaggeration; adherence to truth; in general an attitude of scientific enquiry; biased presentation or selective use of evidence is not ethical to promote a cause.
- Transparency: a complete openness and honesty about the means and ends – including sources of finance and its use.
- Belief in equality, co-operation, justice and freedom: a participatory and democratic approach especially when the issue involves large networks or numbers of people.
- Participation: include people not only for numbers but also involve them in decision making; token participation or representation of marginalised groups is unethical.
- Clear declaration of ideological positions, worldviews, principles as well as biases.
- A 'committed' approach, yet flexible and non-dogmatic; a willingness to debate and learn.
- A readiness to be accountable for one's position and actions.

How we translate these ethical attributes into our ongoing advocacy efforts will continue to be a challenge, something that we must learn along the way from practice. One way of ensuring learning and reflection is to document our advocacy work and to regularly reflect on how we interpret and actualise these ethical attributes.

C. Challenges of Advocacy

Advocacy routinely faces many challenges, for example:

- *Power shift challenges*: when the privileges of powerful elites are challenged by coalitions of women, dalits, minorities or the poor. Or when youth coalitions demand space for their own sexual and reproductive health issues in mainstream SRHR advocacy campaigns.
- *Resource challenges*: where advocates do not always have the

7. S. Srinivasan, Content and Context of Advocacy in India (Unpublished mimeo, 1990).

human or financial resources to respond to an issue. However, even with limited or no resources, advocacy is still possible if commitment to the cause and creativity is there.

- *Response challenges:* like threats to the physical safety or even life of advocates. For example, issues like abortion and sexuality rights may trigger violence from fundamentalists and other groups.
- *Paradigm shift challenges:* advocacy, though it should be focused, should have room for paradigm shifts, for it to be relevant and grounded in realities of constituencies it aims to serve. For example, evolving understanding and notions of sex work/prostitution. Or, what defines a woman? Her biology or her subjective experience as a male-female transgender who identifies as a woman? Or, respect for a young person's evolving capacity when it comes to sexual and reproductive rights decisions, etc.
- *Challenges of political space:* in contexts where it is not legitimate to protest or demand, such as in conflict situations.

A tough challenge comes from within: in 'professionalised' advocacy, we may get so caught up with our tactics and strategies, and so used to addressing powerful people that we may lose touch with those on whose behalf we have decided to do advocacy. Those of us who speak English have a powerful advantage in South Asian societies to interact with the ruling elite. Moreover we may have personal connections with senior officials on the basis of which we try to influence or lobby for certain things. This kind of intervention does not promote participation of the marginal groups, nor increase their access, voice or influence in decision-making that affects their lives. In fact this personality-based style does not challenge power hierarchies, it can actually result in alienation from mass-based movements on whose behalf or for whose cause we have become advocates. The ultimate challenge therefore is to safeguard and extend the political space for effectively advocating the cause of marginalised sections of society.

A related negative aspect of advocacy and of advocates is that they could make 'affected' and marginalised people dependent on them by speaking on their behalf, and not allowing them to represent their own issues. 'Professional' advocates could also exploit them by raising resources in the name of their 'cause' and not encouraging participatory decision-making about the use of such resources.

In contrast to the 'professional' advocates, activists who have come from social movements may be hesitant to forge relationships with other sections of society, namely, the media, the corporate sector or the politicians. Activists generally perceive all politicians to be corrupt, the entire corporate sector to be profiteering and the media to be sensational and irresponsible. Breaking out of this mindset is often difficult, and hampers efforts towards broad-based coalition building.

There is also a need to be watchful and resist agenda-setting influences by certain global players (like the World Bank or WTO or multi national corporations) and various kinds of fundamentalisms. Sometimes the agenda

setting is done in the guise of concern for development issues, which can fool us. Recently the pharmaceutical multi-national corporations have been showing great concern for malnutrition, while their actual intention is to create a market for micro-nutrients, rather than to strengthen food supply distribution to the poor. Another example could be of an agency that invites your organisation to partner in a research project when their hidden agenda is to make a case for privatisation of health care through your report. Or the example of US AIDS funding tied to anti prostitution pledge or abstinence only and reproductive health funding tied to 'no abortion'.

D. Characteristics of Effective Advocacy

Process vs. event

An effective approach in advocacy would be one that successfully integrates various components, such as legislative advocacy, media advocacy, grass roots mobilisation, coalitions, lobbying etc. It is essential to emphasize the integrative and composite nature of advocacy as a **process**, as against advocacy as an **event**.

Effective advocacy can also be seen as a bridge between *micro level social activism* mobilising affected people to demand for change and *macro level policy interventions*. It deals with the system at various levels – from the village to the district and state and the central government.

Characteristics of effective advocacy

Effective advocacy work is characterised by the following values:

1. Developing an 'information culture'. Right to information is demanded not only of the centres of power but our own work has to be fact based and transparent. Systematically organised and disseminated information is a hallmark of advocacy efforts.
2. A 'political culture' that demands and works for accountability and responsibility in every sphere and at every level, including accountability and responsibility from one's own self and from our own sector. An important element of the political culture is decentralised leadership.
3. 'Participation' not only as a programmatic element but also as an attitude of learning from the people that one is working with – an openness to their knowledge and the manner in which their knowledge is produced.
4. 'Constructive Approach': the articulation of viable alternatives – advocacy is about alternatives and not merely opposition to the existing situation.

Another characteristic of effective advocacy is that it incorporates several stages and activities like, Analysis, Strategy Building, Mobilisation, Action, Evaluation and Continuity.

Terms and Definitions

Analysis is in-depth understanding of the problem, the people involved, existing policies, implementation or non-implementation of these policies, channels of access to influential people and decision makers.

Strategy building means direct, plan and focus on specific goals; design clear paths to achieve goals and objectives.

Mobilisation is networking, alliance building, coalition building through events, activities, messages and materials suited to different audiences; grass roots mobilisation and support to bring in grass root voices.

Action is to respond to opposition and developments quickly; planned and continuous activities; keep coalition members informed; media advocacy; hold policy makers accountable for commitments; keep record of successes and failures; monitor public opinion; publicise positives.

Evaluation is to establish process, intermediate and impact indicators; evaluate specific events and activities; document changes based on objectives; document unintended changes; share results with stakeholders.

Continuity means persevere; move onto next stage e.g. after your advocacy results in a new policy, move onto monitoring the implementation of the policy; keep reinforcing change.

Thus effective advocacy calls for being proactive, responsive and flexible and not being merely (or constantly) reactive.

What is required for effective advocacy?

Some elements of a successful advocacy campaign⁸ are:

1. A strong organisation

- a carefully nurtured organisation – maybe formal or informal (both have relative advantages and disadvantages)
- working simultaneously at the apex and the base
- clear goals

8. Elements of a Successful Public Interest Advocacy Campaign (Washington DC: Advocacy Institute, 1990).

- committed people

2. Information and knowledge

- authoritative sources of information
- knowledge of the procedures and processes of institutions and power centres that we are working with

3. Networking constantly

- seeking strong champions and supporting them
- knowing whom you are supporting – following their record of public and private actions and positions
- working not only with public figures but also their staff
- identifying and cultivating friends within other sections including within centres of power

4. Strategy development

- ability to identify opportunities and use them
- developing new tactics constantly
- mastering the rhythms of the process – sometimes it is wiser to do nothing, remain silent or move quietly
- rebounding quickly after losing a battle
- being committed but also flexible, not righteous

Thus, to summarise, advocacy requires a strong evidence base, skills in social and political analysis, strategic planning, communication and influencing skills, mobilising and organising, networking and negotiation. Advocacy can be likened to a long distance race – there is need to develop necessary resources, skills and systems to sustain the effort. Resources required are wide-ranging: managerial, mental/psychological and social in addition to the usual material, financial and human.

Subsequent chapters of this resource book will outline in detail how to go about planning and organising for our own advocacy issue. We will also suggest a tentative framework that can be used for evaluating our advocacy efforts.

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Chapter 3

Understanding the Context

As mentioned in the previous chapter, one of the first stages of effective advocacy is analysis: an in-depth understanding of the problem, the people involved, existing policies, implementation or non-implementation of these policies, channels of access to influential people and decision makers.

In this chapter, we will explain how we analyze the available evidence on SRHR and how we examine the policy, programmes and other provisions for SRHR for our country or province/state/district to deepen our understanding of the local context within which we do advocacy. This chapter will expand on these aspects by firstly highlighting the importance of understanding 'local context' for effective advocacy on women's health issues, specially reproductive and sexual health. Secondly, it will indicate the link between information (data), policies and programmes for identifying advocacy issues. Thirdly, it will illustrate through concrete examples, how context shapes our advocacy strategies in South Asia. The sections in this chapter are:

- A. Meaning and importance of local context for advocacy
- B. Policies, programmes, data and advocacy issues
- C. Context and advocacy strategy

A. Meaning and Importance of Local Context for Advocacy

Meaning of local context for advocacy

The term 'local context' can be said to include all the details of the local situation within which our advocacy issues are emerging; for example, what are the local opportunities and barriers for women to realize their rights to health; who are all the people involved and what are their roles; what has been the history of this issue; what are the laws and policies regarding this issue in the country or state/province/district, are these being implemented, and if not, what are the avenues open for redressal, and so on. A description of local context might look like this:

Local context regarding early age at marriage in the Province X of Country Y

Early marriage is emerging as an area for advocacy since the data shows that the median age at marriage has remained as low as 15 for the last eight years. Young women's health is adversely affected by this, since it leads to withdrawal from school, early or forced sex, unprotected sex, early pregnancy and high risk childbirth. Early marriage is thus a sexual and reproductive health and rights issue in Province X.

Young women themselves are unable to refuse marriage as it is seen as a family decision. Families and communities are in favour of early marriage as a safeguard against 'loss of family honour' from possible sexual relationships that girls might enter into, including rape, and pre-marital pregnancies. Religions such as Hinduism promote the idea of the bride's virginity at marriage, and encourage marriage as early as before menarche. Another factor related to girls' education is that high qualifications in a bride require an even more highly qualified groom, and this means proportionately higher dowry; thus early marriage and withdrawal from school are easier options for the bride's family.

Country Y has a long-standing law specifying the legal age at marriage but this law is not implemented: the girls who are forced into early marriages are unable to access the police; moreover, in Province X, lower rung policemen themselves are mostly in favour of early marriage for girls. Province X has recently passed a new law regarding registration of marriages, which requires that the date of birth be specified for both bride and groom. The current government has also set up a scheme to provide economic incentives to girls who carry on with their education.

Importance of local context for advocacy

The detailed information on the local situation provides the grounding for an advocate to take up an issue. The understanding of the context also enables the advocates to decide which specific aspect needs to be focused on – whether it requires better laws or policies, or better implementation of these. It provides a picture of the affected group, the barriers they face and their access to relief or redressal. This is especially significant for many issues of reproductive and sexual health, since these issues involve strongly upheld community values regarding female sexuality and reproduction. In the example above, the fact that many local policemen themselves uphold the community norm regarding early marriage of girls is a clear barrier to the implementation of the existing law.

A study of the context builds our historical understanding; it also shows possible opportunities and entry-points for effective advocacy. It may also indicate who the best people to address through advocacy activities are. In this example of age at marriage in Province X, we know that this situation has existed unchanged for eight years according to available data: as such it is a deep-rooted and neglected problem. We also realize that law-makers are not the most effective group that can bring about change; change can be brought about by the law-implementation machinery, including administrators, police departments and the judiciary. It may not be sufficient to empower girls to negotiate for delayed marriage;

the advocacy intervention also needs to address community leaders, parents and teachers to understand this issue.

Some of the details in the context may indicate who could be unexpected allies, as for example, groups working on education for girls, or officials in the education department. The scheme of the government aimed at encouraging girls to continue their education can be used to build greater political ownership of the problem of girls dropping out because of early marriage. It can also be used to leverage greater community acceptance of the delayed age at marriage. The new law regarding compulsory registration of marriages can provide an opportunity for the administration to track the age of girls at marriage.

To sum up, a detailed study of the local context enables advocates to identify the key advocacy issues, as well as the critical barriers that are preventing women from accessing their rights to health. The study of the context clarifies the historical background to the issue, and shows up possible entry points or opportunities. It also helps to identify the groups who may be most effectively addressed during advocacy interventions, as well as some others who can emerge as unexpected allies.

It is important to remember that:

- Policy is a product of context
- The context will influence both policy development and the extent to which policy can be implemented
- The context will determine what sort of strategies activists can use

Below we explain ways in which we can study the local context.

B. Policies, Programmes, Data and Advocacy Issues

How to study the local context?

The next question that arises is how can we carry out a study of the local context surrounding our advocacy issue? We need to list out what would be our areas of study and our sources of information. We have to critically analyze laws, policies and programmes in terms of what is available to women, and what prevents women from accessing what is available.

In order to study the context behind a particular health problem, we first need to know the history of health policies in our country or province/district, as well as international policy climates. The following example gives us an idea of health policy making before independence from British rule.

Example 1

India, Pakistan, and Bangladesh have had a common history up until 1947. Under a common British rule they together suffered the impact of colonialism, and in the process also gained valuable experience of resisting colonialism through mass protests, people's movements, sharp political discourse, and shaping of new political leadership. Nepal, however, was fortunate to escape this colonial legacy.

After independence, the aspirations of the people of Bangladesh, India, and Pakistan did not materialize, as political freedom did not bring a better quality of life to the majority of people. The course of development by these countries, along with Nepal, has not yielded well being for the poor in general and women in particular, except for isolated examples such as Kerala, or Sri Lanka. Considerable critique of the health sector is available in India, Pakistan, Bangladesh and Nepal, but it is debatable whether there has been a real health movement in this region, comparable to the women's movements, human rights movements, environment movement (to name a few).

It would be useful to glance at some initiative taken for health before 1947, which perhaps got lost in the mayhem of freedom struggle and the formulation of health policies post independence. India, Pakistan, and Bangladesh inherited a health system that consisted of hospitals and dispensaries in the major cities and also in some small towns. The British Government of India took a major initiative by setting a Commission to assess the health status of the population. A report called the Bhore Committee Report presented the findings and made recommendations in 1946.

The recommendations of this Commission created the foundation for sanitary reforms and public health in India. Sanitary Commissions were set up and from then on some organized data on health and disease particularly vital statistics and disease control was available in their annual reports. An investigative tradition became a part of the sanitary movement, especially after the first systematic enquiry into the 1861 cholera epidemic by the Government of India.¹

The Bhore Committee, amongst several other recommendations, also prepared a National Health Services Scheme. The report and its recommendations are believed to be relevant even today.² It is important to note that health services in the region failed to take care of what the Committee specially singled out as the most

1. Ravi Duggal, Review of the Bhore Committee 1946 and its Relevance Today in *Indian Journal of Pediatrics*, 58:4 (India: 1991) pp.395-406.
2. Bhore Committee Volume II. Quoted in Ravi Duggal, Review of the Bhore Committee 1946 and its Relevance Today in *Indian Journal of Pediatrics*, 58:4 (India: 1991) p.2.

important group – the *tiller of the soil*.³ In fact even today, the *tiller of the soil* is in great stress given the deterioration of the natural environment and widespread rural poverty in South Asia.

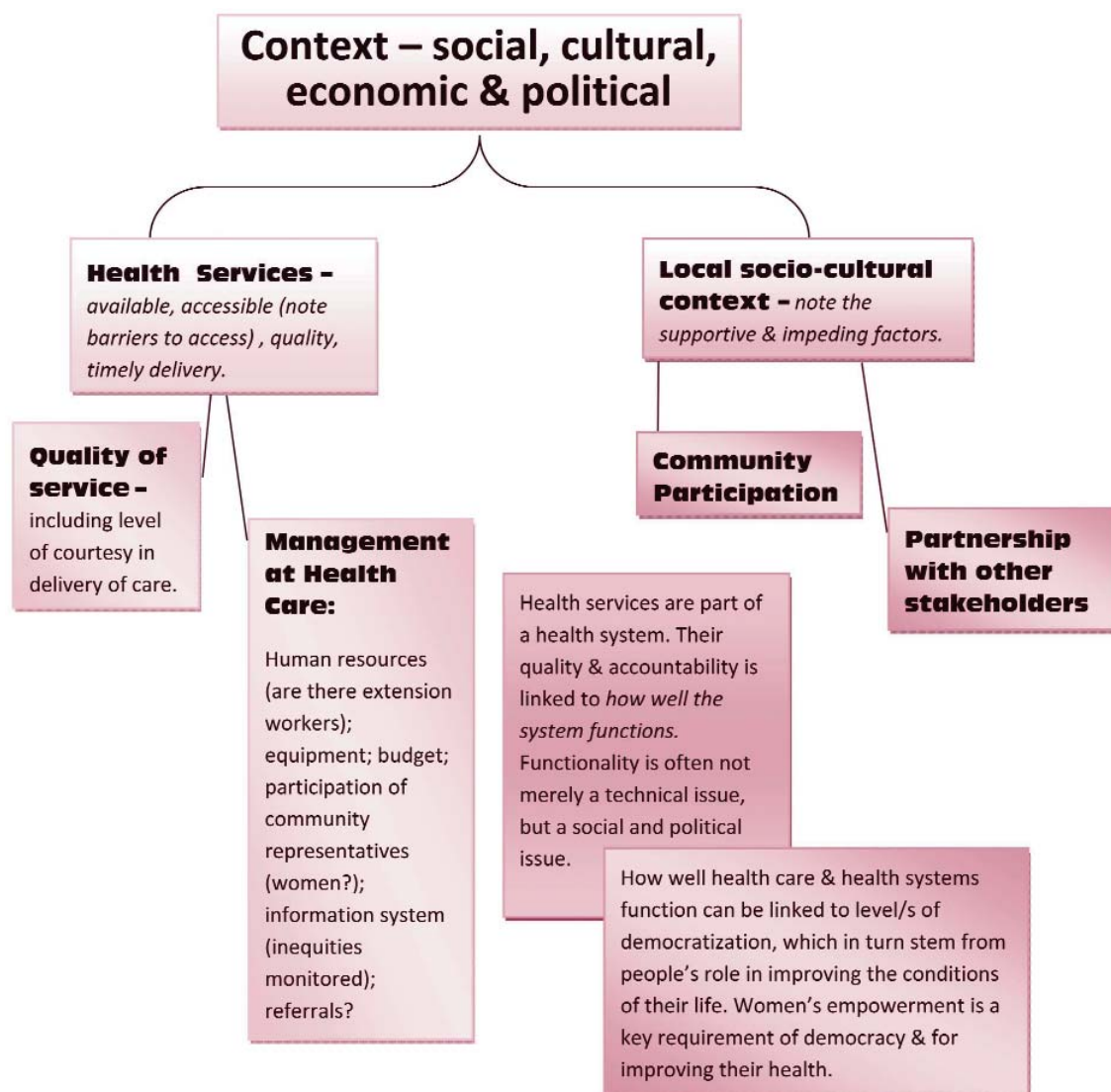
The Bhore Committee of 1946 also identified 'unsanitary conditions' and malnutrition among the cause of death and diseases, along with having inadequate medical and preventive health measures.⁴

In order to understand our context further, we need to find out what commitments have been currently made by the government, and by the non-government sector. Apart from studying these documents, we also need to examine who benefits most from the available policies or programmes, and who does not. Sometimes a policy may declare that it is for the benefit of some people, but in reality they may not be benefiting from it at all.

Policies are made in the corridors of power, but the distance between where policies are made and the homes where the vulnerable women reside is great. A policy may never actually be incorporated in a health programme. Even if it reaches a programme, it may still not be beneficial to all those unable to access the services of the programme. For example, even if emergency obstetric care (EMoC) is available in a health facility, costs and access barriers could still pose a major problem where there is widespread poverty and restrictions on women's mobility. Even if abortions are made legal, the scarcity of providers, travel expenses and issues of confidentiality may force women to use unsafe abortion methods.

3. Bhore Committee Volume II. Quoted in Ravi Duggal, Review of the Bhore Committee 1946 and its Relevance Today in *Indian Journal of Pediatrics*, 58:4 (India: 1991) p.1.
4. Bhore Committee Volume II. Quoted in Ravi Duggal, Review of the Bhore Committee 1946 and its Relevance Today in *Indian Journal of Pediatrics*, 58:4 (India: 1991) p.1.

Figure A



Sources of information

We can map the local context for women's health in terms of the state of health services (laws, policies, budgets, existing health programmes, public and private sector roles, quality of care, etc) and women's existing conditions, in terms of socio-cultural practices, economic conditions and levels of education, mobility and so on. (Figure A)

A good source of information about current government policies, laws and programmes is the newspaper. Most important policies are announced in the national dailies by the government. The Internet is another source, since UN or government department websites may provide copies of their recent policies and relevant laws. Information about relevant older laws and policies may be available with experienced health researchers, or in reports to treaty bodies like the CEDAW Committee. Party Manifestoes often give information on proposed policies and laws, usually before elections. We can scan the websites of the key donors active in our district/state or country for donor policy documents. Similarly, if health sector services are being largely contracted out to the private sector, we need to check on their policies from available sources.

The impact of a given policy or programme on the health status of women requires data and evidence. Mortality, morbidities, injuries and disabilities are measurable, and data in varying degrees is available through government and non-government sources, and through regular and irregular mechanisms. Apart from these, data on the state of health facilities (such as Facility Surveys), both public sector and private, is also useful to understand what quality of care may be expected there for women users. Research institutions dedicated to population and health research also publish studies and surveys on women's health concerns.

Sometimes the national health information systems provide data on some indicators (depending on how comprehensive the system has become). National surveys and census are also useful databases. Periodic surveys with national health research institutes (e.g. Pakistan Medical Research Centre, Indian Medical Research Centre, etc.) gather useful data. Similarly, within each country there is a national research system, whereby data on issues pertinent to health outcomes is available, but there is often little coordination between health research and other national research.

Analyzing the data

While advocates in each country analyze their country policies and available data, it is important to see what information is usually available for measurement of women's health and what information is missing when a rights and equity perspective is taken. A possible reason is the secondary status given to the social determinants of health by health

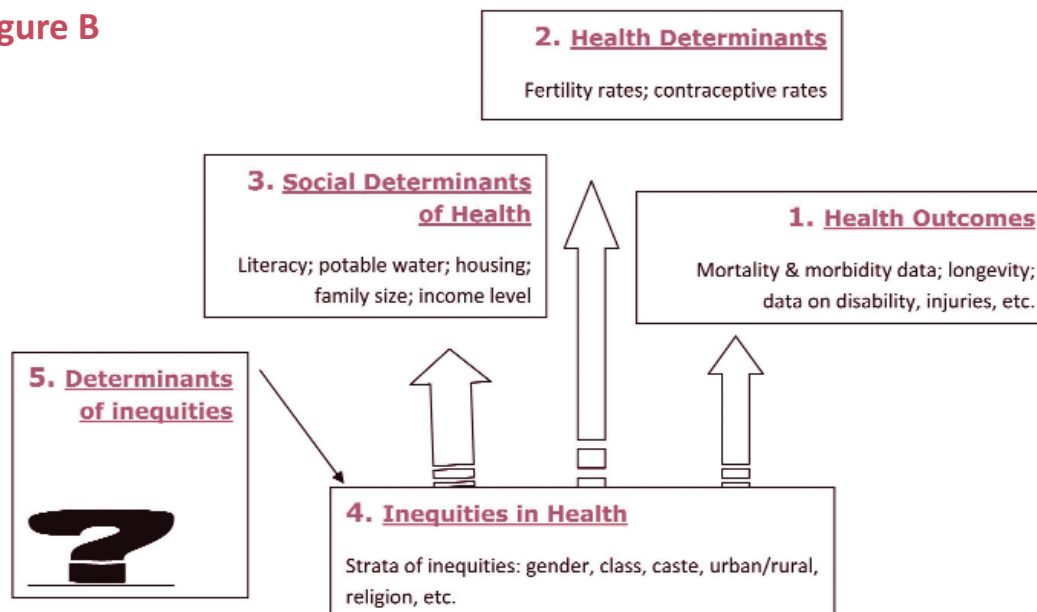
policy makers.⁵ It is very important to consider the social determinants of health such as educational level, site of residence (urban/rural), family size, potable water, sanitation, nutrition, poverty level, caste, gender and so forth, since all of these are related to health outcomes. This consideration helps to recognize that health is not a matter of providing clinical services alone, and that it is as important to track social determinants of health as it is to monitor the delivery of health services.

For example, if a scheme to enable poor women to access maternal health services does not lead to improved outcomes for all poor women, it is important to track the group which got left out: what is the profile of the group that failed to benefit? Was it because of their caste or literacy levels or lack of access to information on the scheme, or because of living in rural areas, or because of working in the unorganized sector? If the scheme has failed to reach certain groups of poor women because of these factors, it has to be re-designed to make it more equitable, to take into account these women's existing disadvantages and ensure that all poor women are able to access maternal health services.

It would be important to assess in each country whether adequate information is available around five levels:

1. Health Outcomes
2. Health Determinants
3. Social Determinants of Health
4. Inequities in Health
5. Determinants of Inequities

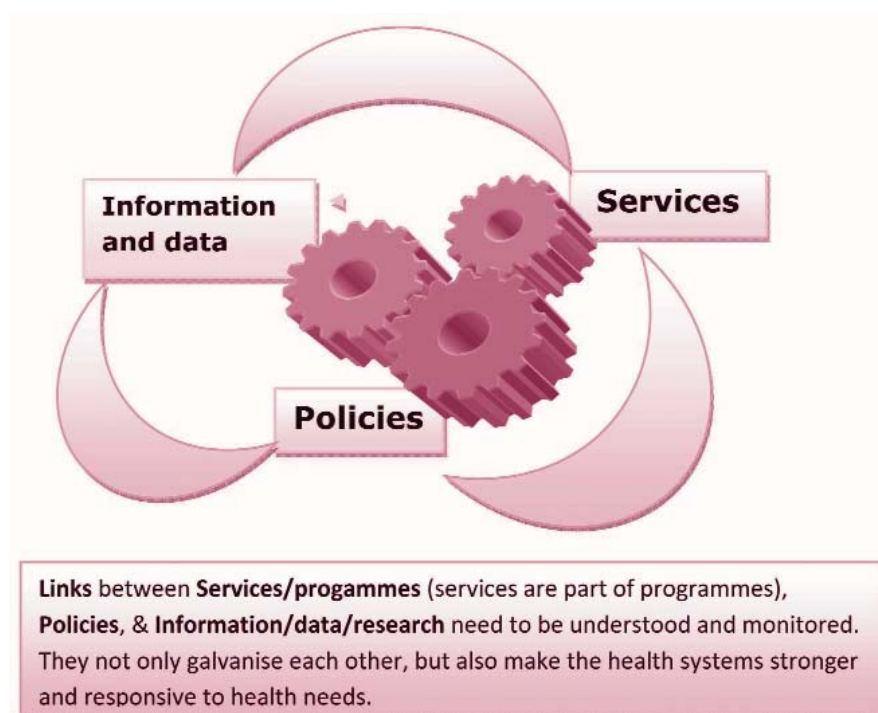
Figure B



5. Analysis of health and related policies in Pakistan, with the help of the tool *Benchmarks of Fairness in Health Care* in Norman Daniels et al., *Benchmarks of fairness in health care reform: a policy tool for developing countries* (WHO Bulletin: June 2000). In Pakistan, the Benchmarks were adapted and the policies and some data were analyzed to show the policy and research gaps when the concept of fairness was used. Presentation Dissemination Seminar, Islamabad (Dec. 2004). Presentation available with Kausar.skhan@aku.edu.

This means, data on health outcomes alone is not enough, it is important to relate it to other social factors. Health advocates need to access such data, so that policies may be scrutinized for gaps. For example, if there is no *information/data* highlighting inequities, it is not likely that *policies* would be made for reducing inequities. This can also work the other way – if there are policies for reduction of health inequities, then data would also need to be generated to monitor the implementation of that policy. If difference is to be made to the life of the most vulnerable women through advocacy for the reproductive and sexual rights of women, it would be important to clarify the nature of data needed. The data available often has serious gaps and unless they are plugged it would be difficult to identify *policy entry points* (specific points for making policies).⁶

Figure C



The above Figure C has three interconnected rings representing the importance of linking the three areas.

It is the State which has the primary responsibility to ensure the fundamental needs of its population, for which the State needs to have an adequate sense of 'public good' and be able to identify the vulnerable groups that require its support (the vulnerable groups being those at greater risk of mortality and morbidities, disabilities, and being victims of injury and violence). When the State is unable to deliver (for whatever reason), then who would champion the cause of the vulnerable groups? Unless researchers wear the additional hat of being health activists (which is not the

6. An adapted version of Norman Daniels Benchmarks of fairness in health care reform (See WHO Bulletin, June 2000) was used by the Benchmarks of Fairness Team of Community Health Sciences Department, Aga Khan University, Karachi, to analyze six policy documents, and three data sets. The purpose was to see whether there were policy and research gaps if health systems were looked at from the perspective of justice. It was found that policies had little to say about Public Safety and Violence; Health Coverage; Environmental and Occupational Health; Gender; Efficiency; Quality and Inter-sectoral Efforts.

case in most developing countries) then this role needs to be assumed by those who are most likely to benefit from policies and programmes meant to benefit them – in other words, the communities themselves.

The other groups that invariably shoulder this responsibility are civil society groups committed to the rights of the vulnerable populations. It thus becomes imperative that the voices of the community be amplified for influencing policies; in giving direction to the research agenda; and in monitoring the programmes being implemented for their benefit.

Thus for health advocates it would be important to develop skills in analysis of data as well as for analyzing policies.

Analysis of policy

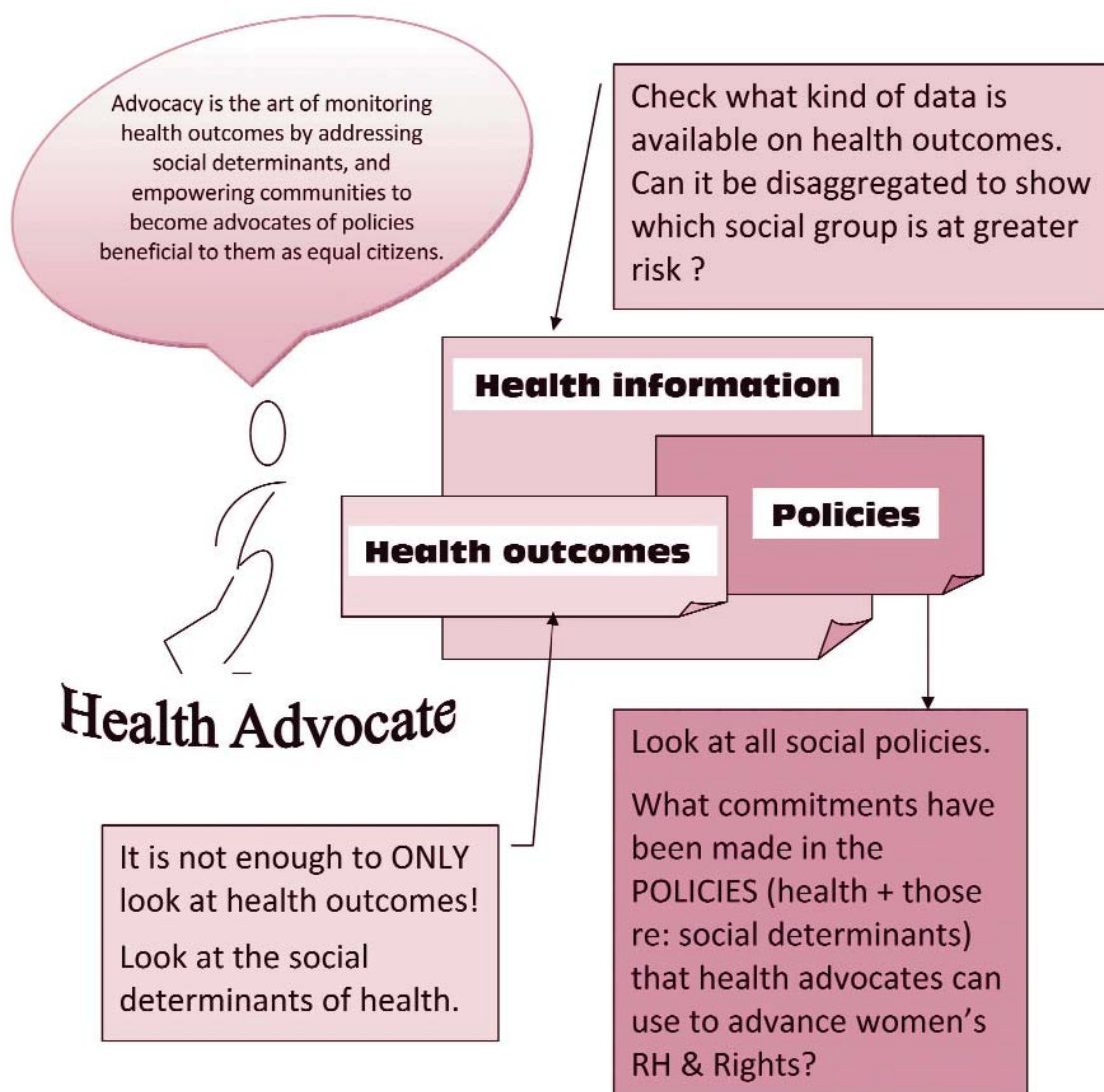
Analysis of policy would mean to examine it carefully to see what in it can be used to hold the planners responsible, and also to identify areas that are vague and need clearer articulation. Just as contents of policy documents can be analyzed, available information (which can be found in different sources) can also be analyzed to highlight policy gaps. Amartya Sen has provided a sound argument for the role of public action in public policy. His study of famine has brought to light that famine has been pre-empted in India because of public action, which includes action by the media, elected representatives and the community. On the other hand, famine has occurred in China because there is little space for public action.⁷

For advocates, it is critical to understand the process of policy formulation and the role of the various actors in the policy arena. Policy making is a political process, and there are many internal and external influencing factors. We also need to analyze what leads to policy formulation. Is it data and evidence, or political agendas, or donor/UN influence, or commercial interests, or people's demands or feminist campaigns? For advocacy it is necessary to be able to identify the actors in the policy arena, understand how they think, and how they can be reached.

When we talk of women's rights to health, it is important to understand how the laws are formulated and how they are being interpreted, since laws become the basis of legally enforceable rights. When we read the laws, policies and programme documents, we need to compare them with earlier commitments to women's rights made by governments at international platforms, such as the ICESCR (International Covenant on Economic, Social and Cultural Rights), the CEDAW and the CRC (Convention on the Rights of the Child), or the Cairo Declaration (ICPD, 1994) or the Beijing Platform for Action (1995). We need to check if the laws and policies are really ensuring the rights of all citizens as set out in our national constitution, and where these seem to be falling short.

7. Amartya Sen, *Development as Freedom* (Oxford University Press: 1999).

Figure D



C. Context and Advocacy Strategy

Developing advocacy strategy from context

Once we have a clear picture of what is available for women (laws, policies, programmes, budgets and so forth) as well as what prevents women from accessing what is available (health data on equity parameters like caste, location, poverty, and so on), we need to analyze this context so as to arrive at an advocacy strategy. The advocacy strategy will be the roadmap based on what are the entry-points, who are the key people to address, what are the acceptable avenues by which advocacy may be done, and in what manner should we phrase our issue

so that it becomes acceptable to the most number of stake-holders. It is necessary to be very strategic about our advocacy because we have limited resources and the agenda of women's reproductive and sexual health and rights is a very complex one, which has many opponents.

The University of Witwatersrand (South Africa) has developed a framework in order to analyze the local context towards strategic advocacy, in which the parameters of analysis are as follows:

1. The political context
2. The economic context
3. The social and cultural context
4. The administrative context
5. The immediate context
6. The international context

These are then categorized on the basis of:

1. Factors that make change difficult, or impede change; and,
2. Factors that make change easy, or facilitate change.

Once we have gathered our information from various sources, we can develop a matrix somewhat like this:

	<i>Factors that make change easy:</i>	<i>Factors that are blocking change:</i>
<i>Economic context:</i>		
<i>Political context:</i>		
<i>Social and cultural context:</i>		
<i>Bureaucratic or administrative context:</i>		
<i>Immediate context:</i>		
<i>International context:</i>		

This is what will enable us to determine our advocacy strategy as strengthening those factors that support change and engaging with those factors that are blocking change. It will also help us to effectively choose the appropriate methods, activities and language.

Some sample questions that may be asked to build our matrix are given in the box below.

However, these are merely samples, and every advocate can change or adapt these questions to suit their reality in their country or province/state.

Context Analysis

<u>Political Context</u>	<u>Economic Context</u>	<u>Administrative Context</u>
• Constitution or legal framework. • Historical nature of political regime – left wing, right wing, democratic, dictatorship? • Role of civil society? • Degree of space for criticism? Space for media; freedom of expression? • Extent of civil society political organizations – trade unions, women's movement, student movement. • Involvement of and representation of women and other marginalized groups.	• Nature of economy – market led, mixed? • Strength of economy, degree of donor dependence, burden of debt repayments. • Priorities in allocation of resources – is equity a factor? • National human resource base, educational levels. • Existence of infrastructure for delivery of social goods, including education, health care, water supply, electricity, transport systems, telecommunications and broadcasting.	• Availability of human resources and skills in the bureaucracy. • Structure of public sector organization. • Relation between national, regional and local level decision-making and administrations. • Existence of independent commissions or other ombudsperson agencies for women/ health/ human rights etc. • Centralized or decentralized allocation of and accounting for resources.
<u>Socio-cultural Context</u>	<u>Immediate Context</u>	<u>International Context</u>
• Position of women; any other specifically marginalized group. • Rural/urban balance. • Predominant social values and norms whether arising from religious or ethnic bases or other historically institutionalized processes. • Predominant ideologies shaping institutional culture and systems of decision making. • The extent to which gender, ethnic or other inequalities are institutionalized. • Rise and impact of fundamentalisms.	• Impact of a change in government and related shifts in ideology. • Impact of war or conflict situations. • Impact of shifts in national identity as a result of either of the above. • Impact of signing of an international agreement – CEDAW, or participation in a UN consensus process – Beijing Conference. • Impact of collapse/boom in the market.	• Impact of international economic agreements. • Proportion of donor funds in national budget; sector-wide or donor specific approach. • Role of international interests in influencing national political orientation and allocation of resources. • Whether the government has ratified key international human rights treaties. • Nature of political, economic or military alliances and commitments. • Cross-border issues, migration.

Developing strategies without knowing the context

There have been instances in South Asia when advocacy on women's reproductive and sexual health and rights issues has been attempted without a sufficiently analytical study of the context. This kind of advocacy is different from the kind that we are proposing in our definition (see Chapter Two), but it does involve trying to influence policy makers and change the way things are done. An example worth studying closely is the advocacy by donors and UN agencies to compel all women to attend hospitals for childbirth, and end the role played by traditional community midwifery (India). Another example is that of replacing community management of a school feeding programme with private contracted services and products (Pakistan).

In the first case, the advocacy is being done as a form of policy and programme influence on the government, and is presented in the language of scientific evidence that shows traditional midwifery is quite worthless and the only way to ensure maternal health is by having all deliveries in hospitals. Since government hospitals will not be able to cope with the large number of childbirths, this will lead to additional demand for private services. This kind of advocacy has missed out on some crucial context factors, such as:

1. Available data: The Indian data on the high proportion of home-births indicates that women do not consider childbirth an illness that requires medical attention. There is also research evidence available that shows women actually prefer familiar surroundings and helpers during the difficult time of labour. Moreover, since childbirth is seen as a social event, it has a complex set of cultural practices surrounding it that are not allowed in hospital settings, so families prefer home births. Since hospitals are overwhelmingly concentrated in urban settings, the poorer rural families also have to struggle to reach them.
2. Medical evidence: The medical evidence indicates that **around one-sixth (15%) of all pregnancies develop complications and require emergency care**. The remaining do not require medical attention. Moreover, having childbirth in hospital does not ensure maternal health. Maternal death and ill-health is caused by complications either during pregnancy, or through abortion or post-abortion complications, or after childbirth. In fact **the largest numbers of complications occur after childbirth** when women are back at home, and families are less likely to take the trouble to transport them to a hospital all over again.
3. Available resource: In keeping with the British colonial tradition of looking down on midwives, post-independence government in India has been neglecting the potential that was available through the large pool of experienced and willing community birth attendants. There has been inadequate investigation into their skills-base and learning styles, which resulted in very alien trainings by doctors and nurses in hospital settings, conducted for Traditional Birth Attendants (TBA)

often without studying the different roles each TBA actually plays in the birthing process. Community based midwifery includes women of the family and neighbourhood, as well as older wise women or local healers, and is usually a continual process that includes elements of post-partum care.

Yet influence is being widely exerted to ensure that all policies and programmes conform to the idea of 'institutional delivery' despite what the context clearly shows. As advocates using a women's rights and human rights framework, we therefore need to be very careful that we have thoroughly examined the context and have a very clear idea of what women really want, before we undertake to do advocacy.

In the second example, in Pakistan, a large national programme is underway to address the nutritional issues in rural girls (ages 5-14). Women in over 4000 sites have been mobilized to manage a school feeding programme in the Government primary schools for girls. The programme has yielded valuable results, for the community's involvement has led to improvement in services, and also led to policy change. But here a dilemma arises. A lobby has emerged which is rigorously promoting the replacement of meals cooked by village women with milk and cookies to be delivered by some contractors. The latter provides opportunity for kickbacks and also renders the community passive. Unfortunately, the Government which had initiated the project in partnership with a university and non-government organizations, is more interested in the milk and cookie approach than appreciating the empowerment of the communities. Here we have the evidence on the ground being sidelined (as in the earlier example) and a contrary policy being pursued that does not empower the user community.

As advocates working for a rights-based approach that empowers women, we need to make a rigorous study of the contextual factors and ensure that the approach we espouse is what women really want. We need to be careful that our advocacy does not have the opposite effect of disempowering women from playing active decision-making roles. One way to ensure that we are basing our advocacy on what women themselves want is to involve communities themselves in the research process that brings out the evidence.

It is known that certain kind of research renders the community powerless, when information is extracted from them and used by the researchers. The challenge to all researchers is to find how communities could be engaged in the use of the research findings. Community involvement in research, action research, and participatory research releases the agency of communities, and often leads to local action. This will also benefit researchers who are sometimes frustrated that the information they have so carefully gathered is not being used at all.

Advocacy strategies and existing space

The foremost aspect that guides our roadmap for doing advocacy is the extent of space available for civil society to intervene and influence decision-making processes. Within South Asia we come from post-colonial societies where there is a clear hierarchy between the rulers and the ruled. When we talk of advocacy that changes existing power relations and hierarchies, and increases the voice, access and influence of marginalised individuals and groups in all decision making processes, we are challenging the existing system. Before we do so, it is relevant to examine what spaces are already available for civil society actors to bring about such a difference. Every South Asian country is likely to have inspiring examples of utilizing available spaces, expanding the little spaces available, and also creating new spaces.

Example 2

Since 1976, the women's movement in Pakistan had demanded a permanent commission on the status of women to address women's unequal status and lack of rights. In July 2000, the military government set up the National Commission on the Status of Women (NCSW) without any prior consultation with civil society. In the view of civil society organizations such as Aurat Foundation and Shirkat Gah the commission seemed doomed to becoming yet another cosmetic body unable to contribute to changing women's current lack of rights. In addition to flaws in the process, serious structural flaws included an unclear mandate, limited powers, lack of autonomy from the state, no clear criteria for appointment of members, and with some appointed members such as religious leaders lacking the attributes and skills to address women's lack of rights.

The intervention

Faced with an already established NCSW, Aurat Foundation and Shirkat Gah strategized to find ways to bring civil society concerns to state processes underway for setting up the NCSW rules and procedures and to hold the NCSW accountable to women's lack of rights. Drawing on their already established authority as key human rights NGOs in Pakistan, Aurat Foundation and Shirkat Gah took up the challenge and set up a consultative process involving government, commission members, civil society organizations, and experts, and aimed at:

- making the NCSW more accountable to women's empowerment interests;
- providing recommendations to strengthen the role and

effectiveness of the NCSW; and,

- influencing policy makers and women's rights activists to interrogate the structure, role, powers and functioning of the NCSW.

Aurat Foundation and Shirkat Gah began their strategic intervention with a two-day International Conference of National Commissions on Women, held in July 2001, and at which representatives of Commissions on the Status of Women and representatives of civil society from other countries – Britain, India, Philippines and South Africa – shared their experiences with delegates from Pakistan, who included members of the NCSW of Pakistan, national NGOs, women's rights activists, and media and government representatives.

This was followed by a consultation workshop of NCSW members. Aurat Foundation and Shirkat Gah then held consultations in four provinces with civil society groups, the government, and the commission member from each province, so as to share the outcomes of the international conference and discuss problems and solutions of the NCSW.

Following the provincial consultations, Aurat Foundation and Shirkat Gah brought together the NCSW members with government and civil society representatives who had participated in the earlier consultations, in order to formulate a set of recommendations emerging from discussions at the international conference and the provincial consultations, that would feed into a process of amending the ordinance in terms of which the NCSW had been set up.

A key component of the Aurat Foundation and Shirkat Gah strategy was to approach the NCSW members and government officials in a non confrontational way, bringing in the experience of Women's Commissions of other countries as a basis for engagement, rather than initiating a full frontal attack on the basis of civil society disgruntlements. This enabled some measure of convergence between civil society and commission members on concerns with the structure, mandate and functioning of the NCSW. Civil society became a resource NCSW members could draw on, rather than a thorn in their side. The terms of the discussion set by the international conference served as the basis for interaction with civil society groups, and for ongoing processes whereby civil society could try to hold NCSW members accountable. That women's interests were the criteria for this accountability was ensured by bringing together civil society organizations concerned with women's rights.

Discussion on the NCSW of Pakistan in the light of these criteria made evident flaws such as the lack of clarity regarding the roles of the NCSW as distinct from that of the Ministry for Women's Development; and that the terms of reference of the NCSW did not

make it a truly independent watchdog body with authority to hold government departments accountable, or to make inputs into government policy. Thus, in addition to problems of accountability there were problems relating to lack of enforcing authority. The NCSW members became aware of the need to address these problems and in order to have further discussion on the issues raised at the national conference they held a two-day workshop with the representatives of women's commissions from the other countries. In this workshop NCSW members discussed in greater detail key issues relating to the commission's independence, its membership procedures and its mandate.

The entire process put in place a consultative process missing from the formation of the NCSW, and this consultative process formed the basis for reviewing the ordinance in terms of which the NCSW was set up, and for elaborating more effective rules of business.

A national gathering of NCSW members and government and civil society participants of earlier consultations formulated a set of recommendations emerging from discussions at the international conference and the provincial consultations. These recommendations pointed to deficiencies with the present structure and powers of the commission and highlighted the need for democratic and transparent procedures in order that the NCSW be accountable to women's interests. Both civil society and commission members stressed the need for the NCSW to have independent status, with enforcing authority and quasi-judicial powers, and a role distinct from that of the Ministry for Women's Development. While the Ministry for Women's Development was seen as aiming to meet women's practical needs, civil society groups stressed that the NCSW's role should be to protect and secure women's strategic interests.

Through their interaction with members of commissions from other countries and from their interaction with civil society groups in Pakistan, NCSW members became sensitized to the key civil society concerns of the accountability and enforceability of the NCSW. The process won NCSW members over to consultative processes. They began to see the need to build support from outside the NCSW, and began to make provision for civil society participation on review committees. NCSW members began to develop a level of responsiveness to the concerns of women and the civil society organizations, as was evident, for example, in NCSW members' intervention in cases of violence against women, and their protests against attacks on human rights activists. The NCSW Annual Report gave prominence to the recommendations developed through the consultative process which, they noted, provided them with "considerable insight and opportunities for interaction and dialogue, as well as valuable information". The

NCSW strongly recommended, in relation to NCSW powers and authority, that accountability and enforceability was necessary for the effective implementation of a gender-equity agenda. Further, the report noted that unless the NCSW had real powers backed by political will at the highest level, it could not truly fulfil its mandate.

Aurat Foundation and Shirkat Gah were able to construct *democratic space* through the international conference, the provincial consultations and the national consultation. They were able to insert civil society concerns into the process of establishing the rules of the NCSW and to win over the NCSW members to realizing the need for more democratic processes and the need to consider women's interests. Moreover, they had been able to do this even after the government had unilaterally set up the NCSW with no prior consultation with civil society groups.⁸

In all South Asian countries today there are various conflict zones where there is military presence; there are groups that may be using violent means, and there is possibly a tense administration trying to control the situation. What forms of advocacy may be possible in such areas? What language of sexual and reproductive rights will be seen as acceptable by those trying to control a fragmented society? How can communities be mobilized to participate in advocacy activities if public gatherings are forbidden?

Not all South Asian countries have a fully functioning democracy in place. Not all countries have always had a free media. In such a situation, what are possible ways for advocates to get their ideas across to a wider public? If the media is not able to play a critical role regarding government policy and programme implementation, and only publishes what is approved by the government, how can advocates publicize their critiques of laws and programmes? Moreover, the role of the judiciary is different in the various South Asian countries. The separation of powers between the executive and the judiciary is critical to the use of legal remedies against the state. If the judiciary is not separate from religious influence, then the adjudication of women's rights becomes increasingly complex. The religion-based Personal Laws that remain in force in South Asia almost entirely adjudicate the private sphere, where women's rights are most severely curtailed. In such circumstances, what are the spaces for advocating on women's legal rights within the family and personal relationships?

8. M. Mukhopadhyay and S. Meer, *Creating Voice and Carving Space: Redefining Governance from a Gender Perspective* (Amsterdam: KIT Publishers, 2004).

Example 3

The Constitution of Bangladesh states that “all citizens are equal before the law and are entitled to equal protection of the law” [Article 27]; and “the State shall not discriminate against any citizen on grounds of religion, race, caste, sex or place of birth” [Article 28 (1)]; and finally “women have equal rights with men in all spheres of the state and public life” [Article 28 (2)]. However, these general principles relating to non-discrimination on the grounds of religion and sex are contradicted by the Family and Personal Law that divide citizens according to their religion of birth and in which women and men's entitlements in the family are unequal and are determined by scriptural tradition. Naripokkho decided to use women and men's unequal rights to guardianship of children in the personal laws of the two main communities, Muslim and Hindu, as a way of raising awareness regarding the contradiction between the equality principles enshrined in the constitution and the international conventions that Bangladesh is signatory to including CEDAW, and inequality inherent in the personal laws that govern relations in the family.

In contemporary Bangladesh, the law relating to guardianship of children, in both the Muslim and Hindu personal laws, deem the father of the child the ‘natural’ guardian. The mother's right to custody and guardianship is limited and conditional. Besides the personal laws, adjudication on guardianship can also take place under the civil law on guardianship which in Bangladesh is the Guardian and Ward Act 1890, a law that has not been amended for over a century. One of the reasons why the father, rather than the mother, is deemed the natural guardian of the child is because the laws relating to property ownership and transfer in both Hindu and Muslim personal law favour men over women. The laws regarding guardianship of minor children (as of their property) ensure that female members of the family (the mother for instance) cannot lay claim to family property. Naripokkho, therefore, decided to raise awareness at a local and national level on the issue of guardianship and to link these ‘voices’ to political arenas in demanding policy change.

Naripokkho's interventions

The main objective of the interventions was to raise awareness and to create widespread public discussion about the unjust laws relating to guardianship and the need for reform. While guardianship was selected as the issue on which to build awareness, the objective was to expose the gender discriminatory nature of the personal laws and government inaction.

Naripokkho worked on public awareness and mobilization of women's organizations at a district and national level. In collaboration with a district level women's organization, Naripokkho surveyed schools, consulted with mothers of school-going children and with the students from the schools selected in the survey, with a view to finding out their opinion about the right of mothers to guardianship of their children and to raise awareness about the issue. Further, at the district level, consultations were held with Municipal commissioners (urban local government representatives) and *Union Parishad* (rural local government body) members with a view to sensitizing elected members so that they could play a more active role in the *shalish* (local courts) committees in their localities to promote women's guardianship rights.

At the national level Naripokkho held consultations/meetings and seminars with different stakeholders, and training events for non-governmental organizations and the national network of women's organizations on personal laws and specifically the guardianship laws. A review of court cases was undertaken to study the process of law, the basis on which guardianship cases are decided and how these judgments' view women's entitlements.

As part of the public campaign Naripokkho developed and disseminated materials on guardianship and personal laws. At the national level Naripokkho collaborated with Doorbar, a network of 400 women's organizations spread throughout Bangladesh.

The campaign and training activities at local and national levels led up to a national seminar on Women's Rights to Guardianship that brought together **legislators**, state officials, lawyers and women's rights advocates.⁹

In areas where there are strong religious fundamentalist groups that are vocal and often violent, how may we frame our arguments on sexual and reproductive rights for women and young people? In areas where women's mobility and decision-making are low, how may we advocate for increasing their access to reproductive health services? In reproductive health and rights, and sexual rights, there is space for some issues and they can be taken forward without too much threat and resistance except from the government itself.

For example, EMoC is a non-threatening issue, and there is ample space to demand it, and persist with the demand without fear of backlash. But in the case of a tough issue like abortion, in Pakistan for example, criticism and threats from religious outfits begin to rise. They would politicize any issue for their political gains. But in the case of Bangladesh, the way out is

9. M. Mukhopadhyay and S. Meer, *Creating Voice and Carving Space: Redefining Governance from a Gender Perspective* (Amsterdam: KIT Publishers, 2004).

to call it something else: safe abortions are available under a different name – regulation of menstrual cycle or MR. In India, rights to comprehensive abortion services are now under threat because of the desire to control widespread sex-selective abortions. A large percentage of people feel that women should not get unrestricted access to abortion services, even though termination of pregnancy is legal in India. In India, the efforts to provide young people with sexuality information has met with a backlash from Hindu right-wing political groups and their sympathizers across the country in 2007, as they felt this will have a corrupting influence on youth.¹⁰

To summarize, advocacy strategy is all about using existing space for civil society action and while doing so, expanding it and opening up further spaces. We need to consider our options carefully and give a lot of thought to the way we frame our issues. Through this, sometimes we can bring large numbers of allies on board to strengthen our cause, and they can support the voice of the marginalized people.

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Chapter 4

Getting Started

The earlier chapters explained how we define advocacy and how we build a preliminary understanding of the context for our advocacy. This chapter will set out the basics of how to start doing advocacy for SRHR in South Asia. It is divided into the following sections:

- A. Defining the advocacy issue
- B. Mapping the stakeholders around the issue
- C. Developing advocacy strategies

A. Defining the Advocacy Issue

In chapter 3 we have learned how to analyze the available evidence on SRHR and how to examine the policy, programmes and other provisions for SRHR for our country or province/state/district. If we recall the definition of advocacy suggested, we see that advocacy is defined as an 'organised, deliberate, systematic and strategic process' which means that we need to be very clear about our goals and about the issue that we are trying to address through our advocacy. In the first section of this chapter, we see how we 'define the advocacy issue' through building evidence, identifying the gaps and problem diagnosis.

Building evidence

At the most preliminary level, based on our organizations past work, experience and strengths we will decide the specific reproductive and sexual health and rights issue that we are going to advocate for. We may broadly know that there are negative situations regarding the health of marginalized women and young people. Our advocacy is intended to 'bring about a positive change towards fulfilling, respecting, protecting and promoting human rights of marginalised individuals and groups.' (See definition of advocacy, Chapter Two)

We first need to identify with marginal groups which of their human rights are not being fulfilled, respected, protected or promoted. Human rights include on the one hand the class of 'economic, social and cultural rights' which includes the right to health. On the other hand human rights include the category of 'civil and political rights' which means the right to be part of decision-making processes through political means, as well as the right to seek legal remedy.

Ordinary people do not see their problems as 'rights violations' so it is simpler to find out what are the most serious problems that people are facing. We can take the help of women who are directly affected to identify and prioritize the biggest problems regarding their sexual and reproductive health. In order to get proof that these are indeed the most serious problems, we can collect additional information from the grassroots, we can document experiences of women and young people, and we can

conduct our own studies. When location specific data is required, it may be good to collect this through participatory action research or PAR, in which the affected people themselves collect the data and analyze it.

Participatory Action Research (PAR)

Rather than the traditional approaches of consulting people to identify their needs, PAR provides for the involvement of people themselves in investigating their problems and issues. Thus PAR is not just about 'research'. It is simultaneously a process of learning and taking action by the communities to address the issues identified by them during PAR. By involving the communities right from the beginning, PAR builds in preparation for advocacy as it acts as an empowering process for the people to raise their concerns themselves.

PAR aims to be active co-research, by and for those to be helped. Nor can it be used by one group of people to get another group of people to do what is thought best for them – whether that is to implement a central policy or an organizational or service change. Instead it tries to be a genuinely democratic or non-coercive process whereby those to be helped, determine the purposes and outcomes of their own inquiry.¹

PAR is *collaborative* with the collaborating group being widened from those most directly involved to directly involve as many as possible of those affected by the practices concerned. PAR *establishes self-critical communities* of people participating and collaborating in the research processes of planning, acting, observing and reflecting. It is also a political process because it involves people in making changes that will affect others. For this reason it sometimes creates resistance to change, both in the participants themselves and in others.²

We also need to find out what the existing research and available data indicates about these problems? We should carry out literature searches: all this informs us about the urgent or neglected aspects of the issues on the ground. **All this information helps us to build 'evidence' that indicates what is going wrong, who is directly affected, and the seriousness of the problem.**

We need to compare the current laws, policies and programmes in our country or province to see what commitments have already been made by government and whether efforts are being made to address the problem. Policies are not always evidence-based or rational; often they do not represent public interest, and if they do, it is couched in vague terms. The available information can be used to analyze policy gaps.

1. <http://www.scu.edu.au/schools/gcm/ar/ari/p-ywadsworth98.html>

2. Robin McTaggart, *16 Tenets of Participatory Action Research*, 1989. <http://www.caledonia.org.uk/par.htm>

Identifying gaps

This 'evidence' shows us that some SRHR and health needs of women and young people are clearly not being fulfilled. Perhaps women's right to participate in making and implementing the policies and programmes is also not being fulfilled. These are the 'gaps' that we need to address through our advocacy. For example:

Evidence

The maternal mortality ratio (according to government data) of Province A continues to be among the highest in the country; women are dying in large numbers due to unsafe abortions and post-partum bleeding and infections.

Current programme - Province A has had a Safe Motherhood programme in place for twenty years, the government is promoting hospital-based childbirth for all women.

Gap - Women's right to maternal health is not being fulfilled; women's right to post-abortion and post-partum care is not being met through provision of services; women are not allowed to choose where they prefer to give birth. The programme has been made without asking women what will address their needs, and whether they would indeed prefer to always go to hospital for childbirth.

Evidence

Documented cases in State B show that women are being compelled to go in for sterilization operations in large numbers at early ages; operations are performed without care for quality standards, leading to failure, illness or death.

Current policy - State B has a policy to control population through forcing people to have only two children and compelling all health staff to 'motivate' a fixed number of sterilization cases in a year.

Gap - This violates women's reproductive right to choose the number of their children, and women's right to information, contraceptive choice and high quality services. The policy has been made without consulting women, although it targets women the most. The policy treats women as objects, as having 'too much fertility' that needs to be controlled.

Evidence

According to studies, women in Country X continue to go in for secret and unsafe abortions, thereby losing their lives or enduring

ill-health for years.

Current law - Country X has had a law legalizing abortion for a long time.

Gap - Women's right to safe abortion information and services is not being fulfilled, policy makers/law makers have not informed women about the law. The lack of publicity about the law deprives women from making informed decisions about their own child-bearing.

Evidence

Young people in Province Y do not have access to comprehensive sexual health information or services either in schools or through mass media; they are having unprotected sex leading to high teenage pregnancy rates (within and outside marriage), high abortion rates among young people and high rates of infection for HIV/AIDS.

Current policy - Province Y has no policy regarding youth sexual health.

Gap - Young people's needs are not being taken seriously; their rights to SRHR information and services is not being fulfilled; their right to participate in making policies that affect their lives is also not being fulfilled.

Problem diagnosis

The gaps that emerge from the evidence indicate which rights of women and young people are being violated. However, even after observing the gaps, we need to look deeper. What is causing the gaps? We need to see both the problems of 'content' and the problems of 'processes'.

By problems of 'content', we mean:

- Poor implementation of a programme or policy or law; lack of insufficient budgets, or lack of quality services or trained personnel, or lack of public education about the programme or law, or lack of sufficient data on the status of implementation and its outcomes.
- Inappropriateness of programmes, policies or laws. Do they need to be modified? Are they linked to the evidence from the ground? Are they being influenced by other external factors?
- Is there a lack of proper programmes, policies or laws on this issue?

Given in the table below is one way of analyzing the 'content' problems from the examples above:

By problems of 'processes', we mean:

	Problem in implementation	Wrong kind	There isn't any
Programme	Province A's maternal health programme		
Policy		State B population control policy	Country Y policy regarding youth SRHR
Law	Country X's law on abortion		

- Lack of importance given to the directly affected people in identifying their needs, no equity consideration for long-lasting disadvantages faced by women or the poor.
- Lack of access, participation and influence of the directly affected people in formulating the law or policy, or in implementing and monitoring them, or in reviewing and evaluating them.

For example:

Province A has a maternal health programme that has not bothered to ask women their real needs, neither has it consulted the women about their choices in childbirth. State B has a population control policy that sees women only as part of the problem; neither has it consulted women about the services they prefer for birth control. It has not investigated why only women are undergoing the sterilization operations at young ages, thus ignoring women's historical disadvantage in controlling their reproduction. Country X has made a law that might benefit women, but it has not involved women in evaluating why there are unsafe abortions despite the law. Country Y has not consulted youth on their needs for information and services for sexual health.

Thus we see that the gaps emerging through our investigation of evidence and current policy or programmes have problems with 'processes' as well as with their 'content'.

Remember:

- In reality, each problem has several causes.
- The problem category is not fixed in time: it will keep changing as we carry on with our efforts and as the external situation changes.

For example, we may do advocacy to get a policy on youth SRHR information, but once it is changed we may find that we have to do advocacy to get properly trained service providers (counsellors and teachers), or to get adequate budgets to implement the law.

Sometimes, the cause of problems appears to be not in state policy, laws or programmes but in the community: in deeply entrenched social customs or religious norms or cultural traditions. In a human rights framework, we need to be careful about putting the entire responsibility for change on the community. While we should acknowledge the role played by the community, we also need to reflect: what actions by the state could have solved the problem? Could the state have brought about change through enforcing a law, or through a mass media programme for educating communities?

The advocacy issue

The advocacy issue is thus more than the original problem – it goes beyond the problem to defining a set of causes. A ‘good’ advocacy issue is focused enough so that it can be linked to a clear policy/programme solution and can be easily communicated to many people.³ If we can clearly define the advocacy issue, we define what solutions could address it. We need to look at ‘content’ solutions as well as solutions for better ‘processes’.

Solutions could be interventions at the level of programmes, policy or law; to either improve implementation, or change the formulation or bring about a new one. Solutions should also include increasing the access, presence and influence of marginal groups in forums where decisions are made that affect their lives, and in monitoring the implementation of these decisions.

Example

Women of Province A face maternal death and illness because of the lack of services and programmes that are poorly designed without consulting their preferences (Issue) – Maternal health programmes must consult women to ensure that they receive comprehensive services of their choice (Solution).

Women’s rights to information, choice and quality services have been violated by the population control approach in State B (Issue) – Family planning programmes should enable women to access quality services and information in order to make their own choices regarding reproduction (Solution).

Women of Country X face unsafe abortion due to lack of information and services (Issue) – Reproductive health programmes should enable women to make safe decisions through

3. Valerie Miller and Lisa VeneKlasen, WHAT IS SUCCESS? Measuring and Evaluating the Impact of Social Justice Advocacy and Citizen Organizing Strategies, 2002.

improved provision of abortion information and services (Solution).

Young people's sexual and reproductive health and rights have not been fulfilled due to the lack of a clear policy, and young people's participation has not been sought on making such a policy (Issue)

– An SRHR policy for youth should be made with youth participation (Solution).

What will happen if we don't define the advocacy issue? We will remain unclear about the cause behind the problem we have identified; our intervention may be at the wrong level, or with the wrong group of people, and we may advocate for a solution that will not really change the situation.

Example

In country Z, abortion is not legal; there is no provision to deal with complications caused by miscarriages and women face unsafe and illegal abortions. All this leads to high maternal deaths that are recorded by data and studies. The women's health NGOs engage in advocacy with service providers and programme managers on the issue, but nothing can be done beyond a point.

Here the advocacy issue has not been clearly defined – it is not caused by lack of attention by service providers but by the lack of a law or policy. Therefore there need to be serious efforts to influence law-makers and policy makers to legalize abortion. In this the service providers and programme managers can actually become allies to convince them that abortion needs to be legalized.

Example

In Province C, health and education NGOs campaign for a youth SRHR policy that can shape the curriculum for sexual health education as well as increase service provision for youth. The provincial government passes a policy in which the focus is on youth as future adults, rather than meeting their current needs for information and services. The curriculum proposed is based on 'abstinence-only' sexual education and there is no mention of dealing with sexual violence faced by girls.

Here the advocacy issue was not clearly defined: it was not only the lack of a policy, but also the lack of youth participation in policy formulation. Therefore there needs to be a review of the policy document by youth themselves and efforts made to bring organizations of young men and women into the policy advocacy arena to voice their priority needs.

B. Mapping the Stakeholders around the Issue

Once we have defined our advocacy issue, we need to identify who are the 'players and actors' or 'stakeholders' closely involved around this issue. They would include, among others:

- The people directly affected – youth or women
- Families or local communities of the directly affected groups/individuals
- Service providers such as doctors and teachers
- The local administration
- Local elected councillors (members of municipalities and *panchayats*)
- NGOs who work on this or related issues, or networks and alliances, unions
- The programme planners who manage the services, line departments
- The law makers or policy makers (parliamentarians and senior bureaucrats)
- Judiciary and lawyers
- Donors, financial institutions and UN agencies who affect policy making
- Researchers and consultants who provide the evidence for policies and evaluations
- Religious or fundamentalist or extremist groups who exercise influence
- Commercial interests such as pharmaceutical companies or corporate health providers

It is useful to name as many people or groups as possible, so that we can be precise in our advocacy. We need to analyze who stands where: who will agree with us about the problem and its possible solution? Who can become our allies in the advocacy? Who is easy to approach and who is comparatively difficult to reach? Who will disagree with us on the problem? Who might oppose our solution? These are complex questions, because people are often not what they seem or because people change positions from time to time. There may be ongoing debate around these questions, but the questions must remain to guide our advocacy process.

Apart from these there could be other people who are not yet directly involved but have the capacity to influence the debate around this issue, for example:

- Professional associations (nurses, teachers, doctors etc.)

- Media persons
- Academicians and researchers
- Large youth networks or women's associations (even if they do not yet work on this issue)

By writing down all these names of institutions, groups and individuals, and marking out those who are especially powerful, we can map out the current situation regarding the problem and assess how easy or difficult it will be to advocate for the solution we propose. Segmenting the audience for the advocacy helps in customizing the advocacy messages as well as the advocacy strategies, activities and tools.

Example

Country Y has no policy regarding youth; young people do not have access to comprehensive SRHR information or services either in schools or through mass media; they are having unprotected sex leading to high teenage pregnancy rates (within and outside marriage), high abortion rates among young people and high rates of infection for HIV/AIDS.

Here the stakeholder map⁴ may look as follows:

Stakeholder who could become allies	Stakeholder who may oppose us	Presently not in the debate
• Youth groups/networks • Minister and ministry officials for Youth Affairs, for Health (P) • Younger/ women parliamentarians (P) • Medical associations • Family Planning Associations • Officials in national youth programmes or projects • UN agencies (P)	• Religious groups that oppose sex education or access to condoms(P) • Pro-right wing political people • Parents from traditional communities (P) • School or university Teachers' Associations	• Sociology or health researchers • Media persons, especially youth magazines, radio or FM channels (P) • Teacher training institutions • HIV/AIDS donors • Manufacturers of condoms, sanitary towels etc • General public

4. 'P' indicates specially powerful stakeholders in a hypothetical situation.

C. Developing Advocacy Strategies

Advocacy strategies can be broadly divided into three categories based on the classification of the stakeholders:

1. Building alliances with 'those who could become our allies'
2. Convincing 'those who have not joined the debate' that they should get involved and take a position in our favour
3. Trying to neutralize the opposition of 'those who are likely to oppose us'

In terms of timing or sequence, it is most strategic to build up strong alliances before we try to tackle the opposing forces on our own. Sometimes our allies themselves can be strong enough to tackle the opposing forces, and we may not need to do it directly.

For example:

If we wanted to bring in legislation favouring women's right to abortion, and there is strong opposition from certain religious groups, we may not have the capacity to neutralize these groups. In that case we need to create forceful and influential allies that can tackle these religious groups: for example, someone very high up in the political hierarchy, or some strong organizations of service providers. These allies can effectively neutralize the argument of religious groups, while we stay in the background.

We also need to make some strategic decisions and choices on exactly how we will do any of the above, especially choices about a reactive or proactive strategy, and choices regarding engagement and confrontation. These decisions are based on the advocacy issue, the local context, and the organization leading the advocacy.

1. Reactive and proactive advocacy strategies

Sometimes as an advocacy organization we want to engage in 'pro-active advocacy', in terms of constantly creating a positive perspective on our issue among as large numbers of people as possible.

For example:

We regularly hold seminars and dialogues on our issue, or we regularly provide data on our issue to the media, or widely disseminate our briefing materials among as large numbers of people as possible, or we celebrate a particular day each year and make it a popular event, and so on.

Remember:

This sort of advocacy can be done on a regular ongoing basis and needs resources and systematic planning. The difficulty lies in measuring the impact of such sustained long-term advocacy. But it is sometimes the only way, as when we want to bring in a new law, or gain visibility for an issue which has always been ignored.

At other times we engage in 'reactive advocacy' – we react to a particular situation or opportunity and work quickly to use it to build a positive opinion on our issue.

For example:

A bill is announced and there may be a consultative process soon; or a criminal case or incident comes up that clearly illustrates our argument, or there is something in the media which can shock people into taking up our cause, or an important high-level international meeting related to our issue is coming up, in which our country will be participating.

Remember:

This is a very short-term opportunity and needs quick planning and flexibility to respond immediately to advocacy opportunities. We have to be very alert about timing. The advantage is that the high energy and the sense of urgency can lead to creative efforts; the problem may be that often resources are not readily available, and it is difficult to make the right decisions so quickly. However, it is usually easier to assess the impact of such advocacy as you can see the result in a short time frame.

There are of course some situations that are almost impossible to anticipate. Nevertheless, good advocacy planning means that we anticipate as many of such opportunities as possible, and plan pro-active strategies in advance. To do this, we should keep a keen look out for information on such opportunities.

For example:

If we know that a bill is being drafted or that certain elections are coming up or that there will be an international meeting on our issue, we can prepare in advance to do advocacy around that. We can mobilize resources and alliances, produce our advocacy materials, disseminate widely to key stakeholders and plan our public events accordingly.

II. Engagement and confrontation

As we gather evidence on our issue, we realize the extent of rights violation and our sense of anger and frustration may be very strong. Often we have to make a choice here regarding whether we want to 'engage with' or 'confront' the people we want to change. In 'engagement' we do not directly blame the person for the problem, but try to make the person aware of the problem, see our logic and become part of the effort to solve it. In 'confronting', we force the person into accepting blame for a particular situation and put pressure on the person to solve it using 'naming and shaming' tactics, litigation or slogans and banners.

For example:

There is very high maternal mortality in the province: We can either 'engage' with the health programme managers or force them to accept accountability for the poor maternal health services. Thus we would either have meetings with them, show evidence and try to convince them this is a serious issue; or, if we want to be 'confronting', we could have demonstrations and protest marches against the health department, and issue strong statements against them in the media.

Remember:

Both strategies have their advantages and disadvantages: when we engage, we cannot guarantee that the person will really change and we have to be very patient and adopt a long term perspective. When we confront someone, we will probably make this person an enemy and it will be difficult to work together again. The person may also react and try to oppose our effort.

The strategic choice here is to decide when and with whom we want to engage with, and whom to confront or put pressure upon. If we want a particular stakeholder within the system to become our ally to convince other stakeholders to change, then we need to adopt an 'engaging strategy' with her or him. It is almost impossible to make someone our ally after we have used pressurizing or confrontational strategies with them!

If we have identified a certain group who are definitely opposing our efforts, we have to make a strategic choice about how to deal with them. Sometimes we may get angry and want to confront them, but this may not help our issue. It may be more strategic to identify someone in that group with whom we can engage, who would be willing to listen to evidence and logic. Alternatively, it may be more strategic for us to withdraw from direct advocacy and let one of our powerful allies engage with the opposing groups.

In some political situations and organizational cultures, the 'confronting'

strategy is not acceptable, and may lead to severe reaction.

In terms of time, the 'confronting' strategy is best tried as the last option – beyond this there is very little space left to negotiate.

Finally the seriousness of the issue is also a criterion – there are certain situations in which it is almost impossible to adopt a 'patient, long term approach' – as for example, delayed justice for someone particularly vulnerable.

III. Advocacy from within and from without

Sometimes one has to make a strategic choice about doing advocacy within the system or staying outside the system. This usually comes after we have been working on our issue for some time, and we are well recognized. It happens more easily with service provider organizations who have a good track record. But it may happen as a result of strong pressure generated by the advocacy efforts.

For example:

Our organization may be invited to the committees and consultations that are very important for the issue, or be invited to be part of a government delegation, or be asked to be part of preparing a monitoring report or some recommendations. We may choose to accept, or we may choose to remain outside.

Remember:

It is a great opportunity to influence a policy process because it gives us access within the system. It is also an official recognition of our capacities. On the other hand, it is also 'invited space': we may not be able to control who else will come into that committee, such as representatives of directly affected people.

We may be sitting among people with many other different views on such a committee, or we may be among the very few NGOs in a committee full of government officials or donors or commercial groups. What we say or write may not be part of the final decisions or document, yet our presence will be recorded. Sometimes this is used to 'silence NGOs' and diffuse criticism.

Our other colleagues in the advocacy effort may not agree with our participation on the committee, they may see it as 'co-option.' Alternatively, they may not agree that we should represent the network if we have been invited in a personal capacity. Or it may seem like too much time investment. There may be some agencies such as the World Bank or some donors whose policies we usually challenge: how would we react to

an invitation from them? How would we manage to retain our independence and critical position?

It is very important to be transparent about such invitations with our other colleagues in the alliance or network, and deal honestly with the disagreement. If there is agreement that we can participate and represent the network or alliance, we should start a consultative process so that we truly represent the issues and interests of the network. We should also set up an 'accountability-feedback system' and sharing our experiences so that they can benefit others in our alliance or network.

Once we are inside the space we can work hard to expand opportunities for those who are directly affected, by suggesting public hearings or special meetings. We should also network with others (NGOs, researchers) who are within that space to work together so that the interests of disadvantaged people may be upheld and protected.

IV. Possibilities and limitations

Once we have made these strategic choices regarding our advocacy, we have to take a hard look at our possibilities and limitations – if we don't do this we may make a very unrealistic advocacy plan. Moreover, advocacy is not a fixed time intervention – it usually throws up the need for doing more advocacy! We need to realistically assess our numbers, skills, financial resources, time constraints, complexity of the advocacy issue and so on. The next step is to consider which of these we can change. Only then can we start planning it more concretely, as is shown in the next chapter.

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Chapter 5

Practical Aspects of Advocacy

This chapter will set out some practical aspects of advocacy for SRHR in South Asian countries and contains useful information on:

1. Building alliances
2. Methods of advocacy
3. Tools of advocacy

A. Building Alliances

Is advocacy more effective if we work on an individual basis or as a single organization, or is it better to work through groups and alliances?

One strong activist or one very strong organization can make far-reaching changes with their influence and hard work. However, if we define advocacy as an organized and strategic process by which we strengthen the voice of marginal groups and individuals in decision making, then it follows that alliance building is a key component of advocacy. No single organization can deal with all the complex factors that affect an advocacy issue. Moreover there is greater pooling of strengths and resources in an alliance which may not be possible even through one large single organization.

Alliance building may include organizing federations of affected groups, relationship building with key stakeholders and forming civil society networks.

1. Organizing federations of affected groups

Our first allies in advocacy are the people who are directly affected by the issue. They need to come forward and raise 'voice' around the issue. Our role is to facilitate. Since they are the most affected, they should have the opportunity to be involved in the important decisions of the advocacy process.

This participation itself will be an empowering experience as it sharpens their political understanding and skills. Some of the ways in which the participation of affected groups can be enhanced are as follows:

a) Identifying affected people

This means:

- We need to identify who are the people most affected by our issue: for example, it could be youth, or teenage girls or women of child-bearing age or women who have used government clinics or any other such group.

- We can identify specific people if we have documented case studies of their experiences, or done studies with them, or if they use our services such as clinics or educational services. Additionally, we can identify groups of the affected people, such as youth groups or student associations or community women's organizations and so on.
- If our organization or our advocacy partners are working directly with communities affected by the issue, it is easy to get in touch with the affected people. But if we are a research organization or a specialized advocacy group that does not have direct grassroots contact, then it is important to first identify some allies or partner organizations who work in the affected communities. These people need to be brought into the advocacy efforts and enabled to speak for themselves.
- Sometimes it is difficult to identify 'directly affected' people; for example if we are working on an SRHR issue such as abortion, it may be difficult to identify women or girls who have been affected by unsafe abortions or by the lack of abortion services. Other difficult issues are sexual violence or marital rape: women survivors may not be willing to come forward individually to do advocacy around such sensitive issues. In that case we can work with community based women's or young people's organizations who think this is an important issue and will speak up for it.

b) Ethics of working with affected people

There are some ethical issues about working with directly affected communities. For one, we must be very clear about our intentions right from the start and not make any false promises. Sometimes NGOs tend to assure survivors of rights violation that they will get them 'justice' if they agree to work together: this may be misleading. We must state very clearly that each individual case may not get 'justice' but we are working to change the system so that such cases do not occur in future.

The other important ethical dimension is not to 'use' people to get a point across and then forget about them. Directly affected people have the right to be heard and to inform decision making around the issue – which means that they have to participate in the entire advocacy effort, not be there to make a token appearance, or just passively listen and observe.

c) Organizing affected people

It is preferable to work with organized groups and not only single individuals who are affected by the issue. A single individual may have to face certain pressures or end up with other priorities, and may not be able to continue the advocacy for the length of time needed. Moreover, single individuals (especially those with traumatic experiences) need far more emotional support than we may be able to give them; being part of

a large group makes it easier for them to sustain the advocacy and the inevitable struggles.

We may have a number of small groups of affected people in different areas that may not be used to working or thinking together. It is a good idea to build federations of groups so that they can work together for the issue and have some bargaining power because of the larger numbers they represent. This will build their confidence and help them speak with a 'loud' voice.

d) Building capacities of affected people

It is useful to bring affected people together in workshops to build their capacities to directly engage in advocacy. These workshops could start at the local level, and then some chosen representatives could meet others from groups in other locations at district or province level workshops. A sample design of such a workshop is given below.

Design of a workshop for group representatives to meet others

Suggested sequence of sessions (length and detail depends on time available):

- Welcome, short introductions, longer introductions and ice-breakers (important to give enough time to know and start trusting each other)
- In small groups, come up with expectations; consolidate into objectives of the workshop
- First working session: introduction to the issue, sharing experiences of the situation around the issue in their own areas, coming up with a shared understanding of the problem and how serious it is
- Second working session: background to the issue – some of the causes (facilitator will need to play a role here), and inputs regarding the existing provisions (such as government programmes or schemes, policies or laws)
- Third working session: sharing earlier efforts, what has been tried already to solve the problem: has it worked well, if so why? What other ways could we try to solve the problem?
- Fourth working session: importance of working together, creating a collective identity, defining a shared objective and developing a structure, including basic rules about how to work together (especially how to communicate and how to take decisions)

- Workshop follow-up – deciding on next steps, division of roles and responsibilities with time frame
- Workshop evaluation and closure on a positive, energizing note.

In a federation of directly affected people, we should be very careful about how we develop leadership. It is not wise to promote one individual as a ‘leader’ or sole spokesperson for the federation. This will lead to power dynamics and may break the unity of the effort. A better way is to facilitate capacity building of a group of leaders who take important decisions together and take turns in being the spokesperson. These leaders should enjoy the confidence of the larger group and if possible, be selected by and be accountable to them.

People need time to develop rapport. Our role is to give them plenty of opportunities to meet and deliberate, preparing them for collective action.

II. Relationship building with key stakeholders

When we map out the stakeholders, we have a list of stakeholders who could become our allies. The first step is to build relationships with as many of the most powerful ones as possible, so that they understand and support our cause. Some of them may actually have opportunities to do something to directly promote our cause, for example, raise a question in the parliament, or constitute a committee, or convene a meeting on the issue, or support our position during a debate. Some may not have a direct role immediately but as influential people, we may want to brief them to make them sympathetic to our issue.

A useful sequence to follow is:

a) Start well

Create a database or complete list of the contact information of each of these organizations or people, including full names, designation or position, all phone numbers, addresses, contact information of others who work closely with them such as a personal assistant or secretary, and a small note of why they are important to our cause or what role they could play. In order to be better prepared, we should study the background of the key people and their earlier actions and opinions.

Seek opportunities to get to know or meet them, for example, look for possible contact persons who could help you to get an appointment or get an invitation to an event where they will be present. If nothing else works, look for times when they meet the public, or just pick up the phone and try to make an appointment. If there is a fax number, send a letter requesting an appointment. Don’t forget to give clear information about how you may be contacted to confirm the appointment. If that doesn’t work, try to meet

the people they are close to, who may be easier to meet.

Be prepared with a short background note about your issue that uses language or references that this person can easily understand (do not use jargon or short forms that they will not know); at the end of the background note there should be clear information about how you may be contacted (name of organization or advocacy group, complete mailing address and fax/phone numbers or email).

b) Build the relationship

When you do get the chance to go and meet the person, be prepared to say the most important thing first, do not start with a lengthy background. Try to get their attention, and arouse their interest in your issue. Be prepared for questions with up-to-date information or data. They may not agree with you right away, so you have to be patient and very polite. Remember always which perspective they are coming from (which may not be an NGO or activist perspective) and try to speak with that in mind, not from your own point of view, so that they understand what you are saying and it is easier to come to a common ground.

If you can establish a common ground, and the person agrees with what you have to say, come out with exactly what help you need and ask how they might support you. Try to get another appointment to convey more information or to get an update on how much they have been able to do.

If they do not agree with what you have to say, be patient and ask for another opportunity where you can meet them with more evidence, or maybe arrange a direct contact with the situation on the ground. It is important not to give up easily and to be persistent and polite. You can be friendly even if you don't agree.

If the person is completely and strongly opposed to what you are saying, maybe they are not a good choice as an ally. You can give up after trying, but remember not to get angry and create a negative relationship. This reflects badly on your cause. Who knows, you may need to meet the person again for some other cause!

c) Follow-up

After the first interaction, remember to follow up immediately so that they don't forget you – send a thank you letter, and look for opportunities for further interaction. You can invite them to one of your meetings, or remind them of what they promised and ask for an update. Try to send additional information after a while so that they do not forget your issue.

Don't forget them after they have delivered on their promises: maintain and nurture the relationship. Keep writing or sending information and look for opportunities to link them more closely with what your group is doing.

III. Forming civil society networks

If we belong to strong influential NGOs we may have preferred to do advocacy on our own without involving other civil society organizations. We may even be effective in reaching some of our advocacy goals and be invited to committees where our concerns are included. Why then do we need to network with other civil society organizations? We need to network for practical and ideological reasons. Practically speaking, two heads are better than one: more people in a network can come up with better analyses, better strategies and fresh ideas. More organizations mean more human and other resources, more possibilities of being able to influence through various different forums; it also means a stronger united front in case of possible opposition. If one organization is unable to put in a strong effort at some point in time, other organizations will make up the gap.

On the ideological front, we need to work through networks so that we can be accountable and transparent about our advocacy. The issue does not 'belong' to any one organization; it is a broader social question. If only one organization is doing advocacy single-handedly on the issue, they are not answerable to anyone for the decisions they make, for the strategies they adopt and the arguments they use. If they are successful, they alone will get the benefit; but if they make a mistake or fail or have to give up midway for some reason, it may impact on many others. They may have harmed the cause to the extent that another organization will find it difficult to take it on. Perhaps if they had worked with others and consulted others about their strategies, a better way might have been discovered.

Nonetheless, many large NGOs do prefer to do advocacy on their own, without working through a network. One reason is that it is difficult to work in a group where people may disagree, where there are divergent approaches and where they may be ego-clashes.

In order to work effectively through networks, some points have to be kept in mind:

- Network formation cannot be rushed – people need time to get used to working together. There should be plenty of opportunities to meet and discuss; this may need resources.
- Networks don't happen 'by themselves' – somebody needs to facilitate the network in the initial period. Later that role can be played by other partners. Facilitation needs an essential set of skills and good management. (See BOX 1)
- Networks do not always have to be the same 'sort' of people; they do not always have to be NGO networks, they can include media persons, lawyers, doctors, researchers, local organizations and other interested people. They may have different approaches and different ideas. But what they must share is a keen interest in the issue and commitment to changing the situation through working together.

- To be effective, a network should have a shared leadership consisting of a group of people who are able to work collectively together and take decisions despite differences of opinion. As far as possible, leadership and decision-making should not be concentrated in the hands of one person or one organization. There should also not be very large differences between members in terms of experience or resources, for that may lead to a power hierarchy.
- There is usually a variety of members, some of whom are organizational and some individual. Organizational members may nominate one or two others who could attend in their place. It needs to be ensured that everyone is updated about the network's planning and activities.
- While inviting members to the network, one should be careful about people who do not respect others' opinions or are unwilling to take part in shared responsibility. Even if they have subject matter expertise, they are probably better as advisors or consultants rather than as network members, for they may create unnecessary hierarchy or conflicts.
- Advocacy networks are different from issue-based networks or information networks: here the focus is on developing advocacy strategies that lead to action. As such the network must carry out collective interventions such as evidence gathering or campaigns or pro-active advocacy with the media or policy makers. These collective actions will strengthen the group-building process as members learn how to work as a team. Merely meeting a few times each year will not build an advocacy network.

Box 1

Facilitation of an Advocacy Network

Preparation

You will need sufficient resources to organize a few meetings. This will depend on if people can pay for their own travel, board and lodging, or if it is too expensive.

Bring together people who can form the nucleus of the network, and facilitate them to be able to have sufficient discussion on the objective of the network, its values, structure, membership and key strategies. These discussions may need to be revisited and revised later.

Before every meeting send out a draft agenda so that members can prepare for discussion; if there are any background notes, send those out as well. Before the meeting begins, give everyone a chance to comment on the agenda.

Functioning

Every meeting must start with a brief recapitulation of the decisions taken at the last meeting and monitoring of progress and problems. This serves for context-setting and gives people time to tune into the process. It is also good to end each meeting with a list of decisions taken, so that everybody is clear about what has been committed to.

During discussions look out for participation: is anyone dominating the discussion or is anyone left out or too quiet: why?

As the group gets sufficiently large, encourage them to formulate some basic rules of the network: rules for frequency of meetings and attendance, communication and information flow, decision-making and conflict resolution. Ensure that these rules are followed, and deviations discussed. Informal networks work well for a while, but may lead to ad hoc decisions that not everyone agrees to.

Take all possible opportunities to remind members about the key objective of the network: it can be the header for all documents or a by-line to the name of the network.

With every decision, there needs to be a delegation of responsibility, and a time-frame for implementation. Ensure that responsibilities are divided equitably, so that everyone feels involved. If some people feel they are doing too large a share of the work, they may lose interest in being part of a network ('your net, my work').

Follow-up

Every meeting must be followed up with a quick reminder about responsibilities taken on and other decisions. If this reminder is delayed, people will forget what was discussed at the meeting, and may come to the next meeting without any progress, which will be frustrating for everybody.

Rotate as many roles as possible, rather than doing them all yourself. Promote shared leadership, shared responsibilities, shared opportunities to represent the network and increasing ownership of the process. Try to make people enjoy being part of the network; they also need to feel positive and involved.

B. Methods of Advocacy

As mentioned in Chapter Two, there are several fields or domains in which advocacy can be done. These include:

- a) Legislative or legal advocacy
- b) Policy advocacy
- c) Media advocacy
- d) Social advocacy
- e) Community advocacy

Given below are some of the ways in which advocacy is done in these domains:

a) Legislative or legal advocacy

This field of advocacy is aimed at laws. It can either be for changing an existing law or bringing about legal reform or at creating a more participatory process around law formulation. It can also be for using legal cases to come up with judgements that create precedents or landmark rulings. Given the definition of advocacy that we propose, the unique element would be the participation of affected people in the advocacy activities.

Example

Advocacy to change an existing law: The law that made abortion a criminal act was changed recently in Nepal, and now abortion is legal within certain parameters. In one state of India there was a law that debarred candidates from contesting local council elections if they had more than two children: this was changed through civil society advocacy against coercive population norms.

Advocacy for legal reform: In Pakistan, the Parliamentary Commission of Inquiry for Women has criticized the Hudood Ordinances and recommended their repeal. The Commission also stated that 95 percent of the women accused of adultery are found innocent in the court of first instance or on appeal. The Commission highlighted that the main victims of the Hudood Ordinances are poor women who are unable to defend themselves; the laws also have been used by husbands and other male family members to punish their wives and female family members.

Advocacy to create a more participatory process around law formulation: In India, a lawyers' group held nationwide consultations with all stakeholder groups (HIV-positive people,

women's groups, doctors, lawyers and so on) towards a law on human rights and HIV. Similarly, women's groups in India refused to accept a recent Bill on Domestic Violence tabled by an earlier government that had a provision for husbands to hit wives in 'self defence'; the Domestic Violence law that was finally passed was based on a draft put up by feminist and legal groups, and even includes forced sex within marriage as violence.

Using law to create precedents or landmark judgements: In India, a case of gang-rape of a Dalit woman during work was dismissed by a state court and the accused were acquitted. A group of activists took it up in the Supreme Court and got a judgement on protection of women from 'Sexual Harassment at the Workplace', which became binding in all workplaces that have women workers. Similarly, an activist lawyers' group and a reproductive rights advocacy group in India put up a Public Interest Litigation in the Supreme Court about women who undergo sterilization operations in government facilities with very poor quality of care. This led to a ruling that compelled the government to provide insurance coverage and compensation to all women who undergo sterilizations as well as upgrade the quality of services.

b) Policy advocacy

Policy advocacy includes all the interventions made to influence the formation, review or revoking of a policy. It would also include budget monitoring and advocacy. It can include government policies at various levels, donor policies and sometimes even the policies of private or commercial bodies, such as hospital corporations or drug companies. Here too, given the definition of advocacy that we propose, the unique element would be the participation of affected people in all the advocacy activities.

Some ways of doing this would include:

Efforts with political parties, especially before important elections: Since policies are made on the basis of the political priorities of the ruling party or coalition, it is relevant to try to influence the priority-setting of political parties themselves. This may be done for instance by providing clear recommendations to the key people in the party, or by launching 'People's Manifestos' or 'Women's Manifestos' before elections, or by negotiating with all parties or candidates to publicly promise to fulfil certain minimum demands through announcements at public meetings and so on.

Consultations with important stakeholders around a policy: Sometimes the government may announce in advance that it is formulating a policy around a certain issue or a policy may be put up on government websites for comments within a certain time-limit. At this point, civil society groups can organize consultations with the various stakeholders around that issue to build a broad public opinion and come up with sound recommendations. This can also be done after a policy had been

announced. The recommendations can be sent to the policy makers or they can be invited to the final session to hear the recommendations. Later, key recommendations can also be made public through the media.

Dialogues with policy makers: If some civil society groups have good enough relationships with representatives of the government to bring them to attend a meeting, they can organize policy dialogues with policy-makers. The different aspects of a policy (or budget) can be discussed and debated, and policy-makers can have the opportunity to hear those who are (or will be) directly affected by the policy, or hear some evidence that they had not heard before.

Policy analysis/budget analysis on the basis of certain parameters: If a policy or budget has already been announced, it can be analysed according to certain parameters that are already accepted by the government, and the analysis can then be shared widely or published. For instance, if the government has ratified the CEDAW or the CRC, this can become the basis to analyse a certain policy or budget. Pre-election commitments or manifestos or other public agreements can also be the basis of analysis.

Policy/budget monitoring through studies: The implementation of a policy or budget can be tracked by monitoring studies. These would be a kind of research that examines whether the policy implementation or budget outcome is leading to the same goals that they set out to achieve. An example of this is the 'gender budgeting' that has been announced in some parts of India, and aims to make gender-sensitive budgets that equitably respond to women's needs.

Meetings to lobby for policy or policy change: Sometimes wider discussions and debates may not be possible, and a delegation has to meet the policy-makers on an individual basis. These meetings are usually possible if there are some existing relations with the policy-maker, but are also possible by seeking appointments. These meetings are a way of lobbying each policy-maker with evidence and recommendations to bring about a policy or a policy-change.

c) Media advocacy

Media advocacy is directed towards getting print and/or electronic media (including newspapers, journals/magazines, radio stations, TV channels, news agencies and web-based journalists) to understand and become interested in covering a particular issue or cover an issue from a particular angle. Media advocacy is important because today there are so many subjects that are competing for public attention that sexual and reproductive health and rights issues by themselves do not get any space.

Media advocacy is different from merely getting media coverage for an event or for our organization. Media advocacy would mean engaging with the media to such an extent that they are interested in independently covering the issue without our direct inputs. It would mean that the media

is now promoting a more 'women-centred angle' on an issue rather than the angle usually held by experts or the government or by the more traditional viewpoint. It would also mean getting the media to change their style of coverage, for example towards getting them to publish unknown voices of directly affected women as human interest stories rather than just the expert comments of well-known people.

Example

In Province A, following police attacks on men who have sex with men, the media was covering the issue of male same-sex relationships as a 'sex-racket' which was 'destroying society.' After civil society groups sent strong protest letters to the newspapers, did a fact-finding of the police attacks, and held press-briefings regarding the fact-finding report, the media coverage changed. The media was now willing to examine the role of the police more closely and start a debate on whether the police attacks were indeed legal.

In Country B, the common way of taking revenge on young women or girls who did not accept a young man's proposal was to throw acid on her face, leading to death or terrible disfigurement. Initially the young women themselves were stigmatized and their 'character suspected', for having attracted the attentions of these men in the first place. Then women's organizations began to present the acid survivors before the media so that they could tell their own stories. This had a powerful effect and their moving stories of struggle became centre-stage. Many other organizations took up the issue of acid violence and helping the acid survivors became a global cause.

Some ways of engaging with the media on our issues are as follows:

Media briefings and press releases: When we have information to share with the media, we may do it either through sending out press releases to important newspaper offices and television channels, or organizing briefings where media-persons themselves can come to pick up the press release and ask questions on the issue. If we have one or more key spokespersons to address the media, we can organize a formal press conference too.

Media events: If we have mobilized a large number of people, especially directly affected people, we can creatively organize public events that directly present our issue to the media. These would include demonstrations with theatre or tableaux, street marches with clever slogans and visuals like costumes or candles, presentation of personal testimonies, and launches of reports or posters or campaigns. These are more interesting in terms of media coverage than a group of people talking in a room.

Media orientation workshops/seminars: If we wish to bring media persons together to spend time understanding the various aspects of an issue and if we have an adequate number of expert resource persons available, we can organize media orientation workshops or seminars. These are most effectively done with young journalists and the field-level reporters (including rural reporters) since senior journalists or editors are likely to have less time to spare.

Media field-visits: We may invite media persons to accompany us to the field when we wish to get coverage of specific aspects of the situation on the ground. For example, we can bring them to see the state of public health services in rural areas, or we can take them to meet grassroots women leaders who have been struggling to improve the local health services. If we are going to attend a rural event where there will be large numbers of directly affected people, we may take media persons along with us. Media persons can also be part of the fact-finding team when we go to investigate a reported incident.

Media features and Letters to the Editor: Apart from news about current affairs, the media also publishes feature stories and articles that can take a more in-depth treatment of the issue. Feature writers usually have a little more time to understand the various aspects of an issue than busy news-reporters. Another non-news space in a newspaper is the 'Letters to the Editor' section. We can send our letters of agreement or protest individually or as larger groups of civil society individuals or organizations. They are effective in informing editors of public opinion even if they are not always printed.

Case study of media advocacy in Uttar Pradesh

Rama (name changed), a 24 year-old Dalit woman residing in a village on the outskirts of Lucknow, was at home with her mother in her first pregnancy. Though illiterate, she went to the hospital to confirm the due date. When the labour pains started, her mother and brother rushed her to the Government Community Health Centre. Rama was admitted and the attendants took an advance of five thousand Rupees. The attendants abused and beat Rama during labour. Later she was thrown out, because her mother was not able to afford an additional five thousand rupees, which the attendants demanded, saying the case was complicated and an operation was needed. Within five minutes of being thrown out, she delivered outside the hospital gates. Unfortunately, the baby was still-born.

A crowd had gathered at the gates and they raised their voice against the inhumane treatment meted out by the hospital staff. The staff hurriedly admitted her, carried out

certain formalities and after giving her some medicines, discharged her. The agitated public lodged a First Information Report at the nearby police station and the local newspapers highlighted this incident, forcing the Chief Medical Officer (CMO) to send an investigation team to her home. Rama states that the lady doctor did an internal examination which was unbearably painful, and felt that her tissues were being torn apart.

SAHAYOG got information about this incident from the media. With the help of a media person, SAHAYOG documented the case and persuaded Rama to get admitted to the female hospital in Lucknow. Initially it was very difficult to get her admitted in the Government Hospital because of medico-legal complexities. Only after the local police from her area provided a copy of the FIR was the medico-legal examination done and the report made; she was eventually admitted at 1 a.m. in the night. After many requests to the Director General, Medicine and Health, the hospital treated her free of cost.

The network on reproductive health, Healthwatch Forum also organized a press conference where Rama's mother and another woman gave an eye-witness account. The media played a pivotal role in this case; within a month, three similar cases had been exposed. Communities now took upon themselves the task of further action. Rama became a role model as the victims of the other three cases gained the confidence to speak out about their plight. Over 30 articles in various newspapers highlighted the sordid tale, with the electronic media pitching in too.

The profile of the case was built further through engaging with various other actors to support her plight. The local MLA provided full support to the case and put pressure on the government to conduct a proper enquiry. When Rama's mother met the Principal Secretary, Medicine & Health along with the SAHAYOG team, he assured her that he would enquire into this case. As Rama belongs to the Dalit community, her mother also approached the Scheduled Castes/Scheduled Tribes (SC/ST) Commission (that investigates atrocities against Dalits) for compensation and to set up an inquiry against the doctors of the investigation team. The SC/ST Commission took up the case and set a two month deadline to hold the errant officials accountable. The District Magistrate assured Rama's mother that she would get compensation very soon, but she didn't.

On the anniversary of the first press conference, another

press briefing was held to highlight the struggle of this poor family. Since they were being given a constant stream of information, the print media continued to show keen interest (asking the activists for updates by phone) and kept writing articles about the rampant corruption and lack of quality care in government health centers. After a year-long struggle Rama got Rs. 50,000 as compensation by the SC/ST Commission, and the charge sheet was filed against the accused doctor and staff of the health centre.

The campaign had the added benefit of creating a new 'human interest story' for the print media, which also began to investigate what the government was doing in response. The number of similar cases of poor women being denied maternal care being highlighted by the media rose steadily every year from 2004, until in the year 2008-2009 there were around 70 cases of maternal health reported and nearly two hundred articles in the print media in Lucknow the capital of Uttar Pradesh, which has created an undeniable pressure on the government to improve the situation.

d) Social advocacy

Social advocacy aims to change a predominant mindset within various sections of society. It is addressed to the public rather than particular individuals. However, even within the general public we may address some particular individuals as opinion makers, such as public figures, artists, writers or musicians. Social advocacy is related to social beliefs and practices rather than to a government law or policy.

Some common examples of such beliefs and practices around reproductive and sexual health and rights in South Asia are:

- Seeing domestic violence as a private affair
- Considering abortion to be the 'murder' of the foetus
- Linking sex education to early sexual activity
- Preferring to have at least one male child to 'carry on the family name'
- Blaming women for having 'invited' sexual violence
- Marrying daughters at an early age will ensure that they are virgin brides
- Males who have sex with males do not have sex with females

A large number of these social beliefs and practices relate to patriarchal control over women and their sexuality. They have been upheld by popular culture and religion, and are often defended in the name of 'tradition' – efforts to change them are seen as threats to the social fabric itself. Social

advocacy aims to change such beliefs in order to promote the human rights of women and young people and enable them to participate meaningfully in decision-making within communities.

A popular method of social advocacy is public campaigning. This would include use of the media; use of certain special days in the year; statements by public figures at public events; wide distribution of pamphlets, posters or other information materials; working with schools, colleges or universities to address students and teachers; issue-based film festivals, opinion polls or other collective events; marches and public demonstrations and so forth.

It is crucial to formulate effective messages for such public campaigns. The message needs to be one that the largest number of people can identify with, in language that most people recognize. It needs to be based on evidence that people cannot deny; on evidence that compels people to stop and re-think their belief systems. Social advocacy is not promoted through accusatory or confrontational messages; rather, the message needs to be one that engages and invites people to be part of the change process.

However, sometimes public campaigning can backfire if there are reactionary and fundamentalist groups who wish to uphold these social beliefs. There have been several instances in South Asia where films or books about certain issues have been banned or faced violent protests by such groups, or school sex education programmes have been opposed. Therefore it is preferable to engage in social advocacy only after we are in a position of strength: in that we have mobilized powerful allies or built strong networks.

As mentioned in Chapter Two, advocacy is a long-distance race and we need to develop the stamina to last it out without getting tired. Most of these beliefs have been around for generations, and we do need to put in sustained, long-term and systematic efforts to change them. Perhaps due to this, the impact of social advocacy is the most difficult to evaluate.

e) Community advocacy

Community advocacy is about facilitating communities to understand their entitlements and develop specific advocacy skills: to speak up for their own rights, to break the hierarchies that keep them silent, and to participate effectively in decision-making that affects them. It is a critical component of advocacy according to our definition, which states that advocacy is about increasing the voice, access and influence of marginalised individuals and groups in all decision making processes that affect their lives, towards changing existing power hierarchies.

Community advocacy is also about building specific skills within the community of affected people so that they can lead the advocacy process on their issues. This must be done as soon as possible, and will lead to a gradual change in our role as facilitators. Very often we assume that

community members are not literate enough or empowered enough or do not have enough exposure to actually engage in advocacy themselves: this is a mistaken assumption. Community women leaders and young people are quite capable: we need to help them to build practical skills in addressing the media, writing and submitting petitions, organizing public events, building allies and dealing with hostile stakeholders. Community members need to learn how to look for evidence and build their arguments around it.

A spectacular example of community advocacy that has led to new laws and new citizen rights in India is the 'Right to Information' movement that started in a village in Rajasthan. Initially, the campaign led to a full-fledged Right to Information Act being passed for Rajasthan State, but later a law was passed for the entire country.

The Right to Information Movement

The Right to Information movement started in the mid-nineties from a village in Rajasthan called *Dev Dungri* through the efforts of a local organization of poor workers and peasants, the *Mazdoor Kisan Shakti Sangathan* or MKSS. It evolved from a realization that the money for small development projects intended to provide the poor with employment was actually reaching the pockets of the petty bureaucrats, contractors and elected village council leaders who were involved in the implementation of these projects. The accounts and verification process were shrouded in 'official' secrecy beyond the reach of ordinary villagers, despite a rule in the state *Panchayati Raj*¹ Act.

The people's movement demanding access to information about development projects gradually built up strength to demand transparency and accountability in governance. One aim of the campaign is to root out corruption at the local level and demand accountability from the development establishment. The movement used several forms of direct action such as demonstrations, rallies and so on, and very effectively used the Public Hearing as a mode of verification and evaluation of official information. MKSS is perhaps most renowned for its creative conduct of *Jan Sunwais* (public hearings), which served as the platforms through which MKSS members and constituents first exposed corruption in public development projects in rural communities in India.

Aside from being a practical weapon to eradicate corruption at the village level, the public hearing is a creative exercise in government for the people by the people. It is a small but significant step towards the transition from representative to participatory democracy: it also marks a transition in poor people's roles: from

1. Local elected councils.

merely voting representatives into decision-making positions to a direct participation in democratic processes. A remarkable feature of the public hearing is its constructive and orderly tone. The hearings have a factual atmosphere and are not confrontational; however, there is no hint of compromise with fraud.

C. Tools of advocacy

A skilled advocate has to be equipped with certain tools in order to do effective advocacy on SRHR. Some of the basic tools include databases, documentation, information dissemination strategies, event management skills and use of windows of opportunity.

Databases – Advocates need to collect contact information and updated lists of their allies, partners, relevant stakeholders, media persons, important government officials and elected representatives. These databases become more effective if they are annotated with qualitative remarks, for example, which officials were responsive, which leaders were against the issue, which media persons are asking for information repeatedly, which network partners are most regular in following up their responsibilities, and so forth.

Documentation – Advocates need to have updated documentation on their issue: this should include latest data, all the relevant policies, laws and international agreements, programme documents, programme evaluations and reviews, lists of recommendations, studies and evidence from the ground. Some of this information is available from the Internet and some has to be collected with help from resource organizations. Advocacy organizations should also encourage community members and local media persons to provide current information on the situation at ground level, for example through documenting incidents and cases of rights violations.

Information dissemination strategies – Advocates deal primarily with evidence and information, therefore it is very important to have well-planned systems for disseminating information. For example, when we have some evidence of the situation on the ground, how do we share that information to strengthen our advocacy efforts? What are the ways of rapid dissemination through the print media or through the Internet? How do we immediately alert our allies and network partners to new data or new policies? What formats will work well with our different audiences? For example, pamphlets may work with people on the street but policy makers will need better produced policy briefs.

Event management skills – A considerable amount of advocacy is centred on events that have to be organized: such as meetings, consultations, policy dialogues, public hearings, media conferences, community workshops, demonstrations and so on. Advocates need to be equipped with the skills to manage events, or there should be a team of

colleagues within advocacy organizations who are skilled at this. Badly managed events affect the advocacy impact and may deter some people from coming again. Some common errors are lack of planning regarding roles, inadequate preparations for resource people, delayed media releases, confused transport logistics and poor follow-up after an event.

Windows of opportunity – Advocacy can be both pro-active and reactive. With both kinds of advocacy we need to be alert to ‘windows of opportunity’ that are briefly available to us. These are the occasions when it seems topical for us to raise an issue: for example, on 8th of March when International Women’s Day is being celebrated, we can raise an issue of women’s rights and we will get people’s attention quite easily. Sometimes there are mid-term programmatic reviews by donors, or announcements of a research report, or a new policy or a new law, which provide us with a perfect opportunity to launch a media campaign on our issue. Forthcoming elections are also an opportunity for us to lobby with the political parties to include our advocacy issue in their election manifestos. Being ‘pro-active’ is to plan ahead to avail such opportunities and being ‘reactive’ is to be able to respond quickly when an opportunity presents itself.

Chapter 6

Strategic Planning for Advocacy

In the earlier chapters we have learnt to define advocacy; to analyze the context within which we have to advocate; to identify the advocacy issue and do a stakeholder analysis; and to select advocacy strategies and methods.

In this chapter, we will examine how to plan for our advocacy initiative, how to monitor and evaluate the advocacy, and how to budget for it. It is therefore divided as following:

- A. Strategic planning for advocacy
- B. Monitoring and evaluating advocacy
- C. Budgeting for advocacy

A. Strategic Planning for Advocacy

Need for strategic planning

As advocates working on SRHR in South Asia, there are a number of issues, methods, as well as approaches we can work on. Often we are too busy to plan: we rush into action making ad hoc decisions. We use our limited means to try and change something that has strong forces supporting it and will resist change. It is quite possible to scatter our energies by simultaneously tackling a number of issues and using up our resources in a number of 'fire-fighting' activities and one-time events without making significant long-term changes anywhere. Lack of planning and impact may also lead to frustration and burn-out among partners of an advocacy network.

Since, as advocates and advocacy organizations we have limited energies and limited resources, we need to be especially strategic in planning our advocacy. We need to be very focused about our issues and what changes we want to bring about within our given context, we need to think carefully about what evidence we need, which methods of advocacy will most effectively serve our purpose, and how best to utilize our human and financial resources. We need a way of tracking and recording our achievements, however small, to give ourselves continued energy in this long-distance race. All this requires is collective brainstorming and careful planning before we start; something many of us feel is a waste of time. But time spent in strategic planning may lead to more rewarding experiences later, as our advocacy begins to show positive results.

However, being focused about our issue is not to say that we should turn away from other burning issues that may arise. It is important to respond to emerging concerns as and when they occur. Sometimes these provide us with 'windows of opportunity' to establish our advocacy efforts. But after immediate responses, we need to make longer-term 'strategic advocacy plans' around these emerging issues as well.

To sum up, strategic planning for advocacy implies a close study of the situation, making careful choices, and trying to do what is most effective in order to bring about change.

Steps in strategic planning

Step One: Strategic planning for advocacy starts with a detailed study of the context around our issues of concern. We need to understand the history, study the current situation including the current policies and their impact, the available data on health outcomes for marginal groups, and finally analyze all these to identify the contextual factors that will facilitate change and those that will hinder change. We also need to realistically assess how much space we have for doing advocacy on difficult issues or in difficult areas.

Step Two: The next step is to identify our specific advocacy issue and the change-based solution we are working towards. Towards this we need to build evidence of what is going wrong, who are the affected people and what are the gaps in existing laws, policies or programmes. Our problem diagnosis needs to examine gaps in 'content' as well as 'processes' such as participation and influence of the marginal groups.

Step Three: Having defined our advocacy issues and solutions, we have to map out the stakeholders and their positions and possibilities, and decide on our strategies with them: whether we will be reactive or pro-active as well, whether we will engage or confront, whether we will work within the system or from outside.

Step Four: At this stage we need to plan our concrete activities: organizing the affected groups and community advocacy, relationship building with key stakeholders and forming civil society networks. We have to also choose our preferred methods of doing advocacy: whether we will work with legislative or legal advocacy, whether we will engage with the media, whether we will focus on policies, whether we wish to do social advocacy or not. In order to do these activities effectively we will need to develop our own 'advocacy tool-kit' for this particular issue. Strategic advocacy also takes advantages of opportunities that come up. Thus, while our advocacy plan should be structured and time bound, it should also have inbuilt flexibility and responsiveness to significant events happening in the environment.

Step Five: This is a stage that is often neglected: assessing our overall time schedule and planning how we will evaluate our impact and how we will monitor our progress. Once this is done, we can make estimates of our expected requirements of human and financial resources, and decide how these will be obtained and managed.

[The details of the steps 1-4 of strategic planning have been given in Chapters 3, 4 and 5].

BOX 2 at the end of the chapter (p.101) gives a case study of the strategic

planning for advocacy done by an organisation working with the urban poor in a particular state and city in India.

Time planning

While advocacy is an ongoing and long-term process, like any other systematic project, our advocacy initiative should be time bound. There is a need to set deadlines for the completion of contextual analysis, evidence generation, coalition building, major advocacy events, stocktaking and review and so on. The time planning should have the flexibility for rapid response to significant developments in the policy and programme environment. We may also need to do 'backward planning' to take advantage of the windows of opportunity to launch our campaigns.

B. Monitoring and Evaluating Advocacy

As mentioned above, advocacy is an ongoing process directed to bring about some significant change in the arena of public policy. These kinds of changes are not easy to bring about or then they take long years of sustained struggle. Thus, it becomes difficult to measure the impact of any advocacy effort. It is, however, very useful to measure small victories through process indicators. Every advocacy can also be separately evaluated in terms of attendance, range of constituencies and stakeholders represented, the quality of participation and so on. We give below a framework for evaluating process changes through our advocacy efforts.

A Framework for Evaluating Advocacy Efforts

1. Constituency: Who was the directly affected group? Was it part of the advocacy effort? How was it involved at various phases, such as planning phase, implementation phase, evaluation phase, and so on?
2. Did the advocacy effort address specific rights violations? Was the advocacy initiative rights based in its approach?
3. Did the power relations change as a result of the advocacy effort?
4. New Consciousness and Awareness? Was the advocacy able to bring new consciousness to more people, media, and people in the judiciary/legislature/bureaucracy?
5. Gender Aspects: How did the content and process of the advocacy effort see women and men? Did women and men remain in stereotypical roles? What did it do gender equations

within the campaign and in the larger society with respect to the issue?

6. Research and Analysis: Was adequate research and analysis built into the advocacy process? Were the advocates seen by others as informed, authentic and credible?
7. Long-term Sustainable Processes: Was the advocacy effort able to create long term processes for continuing the work initiated? Were vertical and horizontal linkages created and sustained?
8. Was new ground broken and new knowledge created? Was the analysis of the original issue accordingly reformulated in the advocacy plan?
9. Was the campaign sufficiently fine tuned and proactive with respect to larger changes nationally and internationally?
10. Have civil society networks and directly affected groups been strengthened and built more skills in addressing the advocacy issues at the level of laws, policies and programmes?

C. Budgeting for Advocacy

As mentioned in Chapter 5 (A. Building Alliances: III. Forming Civil Society Networks), effective advocacy can only be done through an organized set up – every coalition or network needs a secretariat with human resources dedicated to reaching out, providing information to members as well as making sure that members are keeping to the schedules for planned activities. While it is desirable that all members of the coalition integrate advocacy in their other tasks, a core secretariat group is required to push the process forward. This inevitably means budgeting for resources.

In addition to the secretariat and substantial communication costs, certain advocacy events have to be also budgeted for – public hearings, workshops and meetings do require resources. Advocacy materials like posters, policy and media briefs, short films and presentations will also need resources for production. While coalition members can be encouraged to contribute their time and technical expertise, it is good to have an earmarked fund for travel expenses in case members need to travel to present the coalition's viewpoint at meetings organized by others. A budget head for research and small studies to build the evidence is also useful.

While making budgets for activities that will involve partners of a network, it is necessary to specify which work will receive compensation for time and which will be considered voluntary. The network secretariat may have full-time staff that will be paid, or it may work through volunteers or students. Sometimes, writing up reports or conducting studies are extremely time-consuming and require specific skills: the network

members may consider paying someone to do this if no one is willing to volunteer.

Finally, a few words of caution: if resources are raised on the credibility of a coalition, the use of the resources should be kept completely transparent with all the partners of the coalition. Moreover there should be a consensus on the management of the resources and the accountability of the hired staff or consultants: a good way to do this is to divide management roles among partners through setting up smaller committees. If these aspects are not clarified at the start, they can lead to suspicion and breakdown of the coalition.

The following BOX 1 gives some suggested budget heads for doing advocacy.

Box 1

Suggested Budget Heads

- Secretariat Costs – staff, communications, internet and postage, stationery and other office expenses
- Community organization – staff time and travel to attend meetings
- Community leaders' capacity building workshops
- Advocacy events (Policy Dialogues, Public Hearings, Workshops, Press Conferences, Film Shows)
- Advocacy materials (Pamphlets, Policy Briefs, Exhibition, Website)
- Specialized consultants for media advocacy services
- Meeting and consultations among stakeholders
- Travel and local conveyance
- Research and documentation costs, researchers/consultants to help with evidence building
- Administrative overheads

Example of strategic advocacy planning

BOX 2 gives a case study of an organisation¹ working with the urban poor – specifically children and the youth – in a particular state and city in India, as well as the review of evidence related to select maternal and child health issues.

1. SAHAJ 2005, Project Proposal for Evidence Based Advocacy, Vadodara.

Box 2 Strategic Planning for Advocacy

Steps of Strategic Advocacy Planning	Example of how it was done
<i>Step One: Strategic Planning for Advocacy starts with a detailed study of the context around our issues of concern. We need to understand the history, study the current situation including the current policies and their impact, the available data on health outcomes for marginal groups, and finally analyze all these to identify the contextual factors that will facilitate or hinder change. We also need to realistically assess the space we have for doing advocacy on difficult issues or in difficult areas.</i>	<u><i>Political, Economic and Social Context</i></u> ⇒ Rapid urbanization in India – 3.11% urban population growth rate ⇒ Increasing migration into cities resulting in 30% of urban being poor ⇒ Health status indicators for urban poor are worse than for rural poor ⇒ Greater disparities in cities – malls and multiplexes for the rich, demolished slums and displacement of the poor ⇒ Nexus of politicians and real estate developers ⇒ Right wing government In this context, SAHAJ has opposed the demolition of slums through legal actions. The organisation has helped to rehabilitate families in alternative locations. <u><i>Evidence about Health: National</i></u> ⇒ Only 15% population in urban slums have access to safe drinking water, toilets and electricity [National Sample Survey (NSS), 2002] ⇒ Neonatal Mortality Rate: 31/100 for urban India, 40/100 for urban poor ⇒ While 36% of the population was below the poverty line, they received only about 24% of public financing for curative services <u><i>Evidence about Health: State</i></u> ⇒ Over the decade (1991- 2001) population density has decreased ⇒ 37.35% of the population is urban, 15% are slum dwellers ⇒ The National Family Health Survey (2002) revealed i. No ANC for 10% births - 25% of the poor and 22% of the illiterate had no antenatal check up ii. 85% in urban Gujarat who did not get ANC believe that it is not necessary

Steps of Strategic Advocacy Planning	Example of how it was done
	iii. 16% births had ANC only in the third trimester iv. 30% deliveries at home in urban areas, of these only 25% by TBAs v. Child mortality (1-5 years) increased in urban areas: Urban 27, Rural 22 per 100,000 live births <u>Evidence about Health: City</u> ⇒ 14% slum population lives without water and sanitation ⇒ MICS surveys in 1999 to 2001 showed a decrease in fully vaccinated children from 72% to 67% <u>Policy and Programme Context</u> In view of the increasing urbanization and growth of slums and low income population in the cities and recognizing that the RCH indicators of urban slums are worse than the overall urban statistics, the Government of India has identified 'urban health' as one of its thrust areas in the Tenth Five Year Plan, National Population Policy 2000, National Health Policy 2002 and the forthcoming 2nd Phase of the Reproductive Child Health Programme and the Jawaharlal Nehru National Urban Renewal Mission. The Government of India in line with its commitments of the Millennium Development Goals, is also placing emphasis on the need to reduce Maternal and Infant Mortality Rates.
<i>Step Two:</i> The next step is to identify our specific advocacy issue and the change-based solution we are working towards. Towards this we need to build evidence of what is going wrong, who are the affected people and what are the gaps in existing laws, policies or	The above data shows violation of several human rights. ⇒ Citizens are entitled to a decent standard of living with basic infrastructure like safe housing, access to water, drainage, toilets and electricity. This right to determinants of health is being violated. ⇒ Citizens are entitled to the highest standard of health care: accessible, affordable and quality services. This right is being violated.

Steps of Strategic Advocacy Planning	Example of how it was done
programmes. Our problem diagnosis needs to examine gaps in 'content' as well as 'processes' such as participation and influence of the marginal groups.	Based on an analysis of the above and in line with the urgent policy directives to reduce MMR and IMR, SAHAJ decided to limit its advocacy agenda to 'Better implementation of programmes to improve access to basic Maternal Health care (antenatal care, safe deliveries and post natal health) and health services for children up to the age of 3 years'. To refine the advocacy agenda further, we need to know ⇒ Where do women go for ANC, safe deliveries – to public or private health facilities? ⇒ What is the quality of care like in these facilities? ⇒ How much do women spend for these services? What is the affordability?
<i>Step Three:</i> Having defined our advocacy issues and solutions, we have to map out the stakeholders and their positions and possibilities, and decide on our strategies with them: whether we will be reactive or pro-active as well, whether we will engage or confront, whether we will work within the system or from outside.	i. Community level ii. Municipal Corporation iii. Health service provider iv. Others: media Within the community, three groups or categories were further identified: the Community Development Committees of local men and women, the Children's Governance Committee, and the Adolescent Girls and Boys Peer Educators. All three are part of the existing Community Development Programme of the NGO, SAHAJ. Within the Municipal Corporation, the advocacy would be directed towards the Municipal Commissioner, the Health Officers and the Corporators or elected representatives. Advocacy would be directed towards the Health Service Providers of the Municipal Corporation's health facilities as well as the private practitioners to whom the women are going. In the example above, five organizations/groups were identified as supporters of 'Advocacy for Increasing Access to MCH Services for the Urban Poor of Vadodara City'. These groups ranged from the Department of Preventive and Social Medicine within the local medical college

Steps of Strategic Advocacy Planning	Example of how it was done
	to a radical civil liberties group opposing the demolitions and displacement of the city slums. The 'opposers' were identified as the Municipal Corporation officials including Health Officers, the private practitioners and other service providers. However, even within private practitioners, there were sensitive and sympathetic individuals so the strategy was to recognize friends within the enemy camp and to enlist their help in reaching the ears of the 'opposers'. There was an analysis of the strengths and resources that each coalition member brought in for the cause. For example, the PSM Department had the technical resources, the civil liberties group had the rights perspective, a federation of women's self help groups had the strength of numbers.
<i>Step Four:</i> At this stage we need to plan our concrete activities: organizing the affected groups and community advocacy, relationship building with key stakeholders and forming civil society networks. We have to also choose our preferred methods of doing advocacy: whether we will work with legislative or legal advocacy, whether we will engage with the media, whether we will focus on policies, whether we wish to do social advocacy or not. In order to do these activities effectively we will need to develop our own 'advocacy tool-kit' for this particular issue. Strategic advocacy also takes advantages of opportunities that come up. Thus, while our advocacy plan should be structured and time bound, it should also have inbuilt flexibility and responsiveness to significant events happening in the environment.	

The table below details for the above mentioned example, the objectives of the advocacy, the activities to be conducted and the tools that can be used at each level.

	Objectives	Activities	Tools
1. Community level a. Community Development Committees	Increase awareness of Health Care as a Right	Meetings and workshops. Involvement in PAR and Facility Survey.	Pamphlets, Posters on Right to Health Care
b. Children's Governance Committees	Increase awareness of Health Care as a Right	Debate and essay competitions on Right to Health Care	

	Objectives	Activities	Tools
c. Peer Educators	Increase awareness of Health Care as a Right. Develop advocacy material with the peer educators.	Involvement in PAR. Workshops to develop street theatre scripts posters, pamphlets, fact sheets.	Letters to the Editor
d. City public	Increase awareness of Health Care as a Right	Public Hearings	Fact sheets, Posters
2. Municipal Corporation	Disseminate findings of the PAR and other evidence. Demand commitment and plan of action including a transparent budget and a Charter of Rights. Review of mutually agreed upon plan. Up scaling of pilot interventions.	Meetings between coalition members and Municipal Corporation representatives – a series of 3 meetings	Testimonies of affected people, Power point presentations, Photo exhibitions.
b. Health Service Providers	To arrive at a consensus about how to improve quality of services provided.	Meetings and Workshops for Persuasion and Negotiation	Social audit by CDCs, Children's Committees, Peer Education groups
3. Media	Dissemination of findings of studies.	Press Briefing with network of development journalists	Media briefs
(Strategy will be to first highlight positive stories of access to quality health care for the urban poor. This will pave ground for highlighting the gaps)	Inform them of major advocacy events (Public Hearings, Children's Competitions, Street theatre shows, Meetings with corporation representative).	Invite to every event	Press releases, Photo exhibits

Case Studies

BWHC's Advocacy for Adolescent Health Policy, Bangladesh

Background

Bangladesh's population is relatively young. According to the National Census of 2001, at least 36.3 million Bangladeshis (23% of the population) are adolescents i.e. 10-19 years of age. More recently, the Population Reference Bureau's (PRB) 'World Youth



Database 2006' estimates that there are 45.7 million youth (age 10-24) in 2006, comprising 32% of the population. This will increase to 52.2 million by 2025 (27% of the population). According to the current fertility rate Bangladesh Demographic and Health Survey (BDHS) 2004, on an average, women will have 22% of their births before

reaching the age of 20. The data from the BDHS 2000 showed that in rural areas 35% of the adolescents have begun childbearing.

Reports in Bangladesh have shown that most of the adolescents lack information on SRHR and access to its services. Adolescents appear to be poorly informed about their sexuality, physical wellbeing, health and their own bodies. The Obstetrical and Gynaecological Society of Bangladesh reported that 50% adolescent girls lack knowledge about their menstruation. The information they do have is incomplete or inaccurate. Low rates of educational attainment (although progress has been made in this area, particularly addressing gender inequality in education), limited sex education, and a deep-rooted socio-cultural behaviour with inhibited attitudes towards sex further add to this ignorance. These barriers limit adolescents' ability to protect themselves. This is further aggravated by the existing male dominant practices which put girls more at the risk of sexual violence and unwanted sexual activities resulting in the high numbers of unsafe abortion and increase in the rate of maternal mortality.

BWHC's Strategy – starting from grass root reality

The Ministry of Youth and Sports has a youth policy, covering major areas including education, training, health, environment, culture and art. Under this Ministry, a very limited and basic school health programme is incorporated. The concept of adolescent

health first surfaced in the fifth year plan (1998-2003) of the Bangladesh Health and Population Sector Programme (HPSP). The Government of Bangladesh also ratified the international commitments like CEDAW, BPFA and ICPD which also address adolescents' SRHR issues. However, these commitments remain unimplemented.

Hence, BWHC adopted a strategy of evidence based advocacy to influence policy makers at the national level. The strategy began with creating awareness on SRHR among community people and adolescents. According to this plan, they designed a yearly curriculum with the title 'Adolescent Family Life Education' (AFLE) for adolescents in schools from class VII to IX. The topics of the curriculum included Primary Health Care, Social Awareness and Reproductive Health.

Preliminary steps included meetings with school teachers encouraging them to include AFLE in their regular school curriculum, and orientation and training of the staff members who would potentially be involved in the intervention. The inclusion of sessions by youth educators in the school's yearly action plan was proposed to the School Management Committee (SMC).

As a culmination of BWHC's effort through the schools, a quarterly meeting with SMC was scheduled to address and resolve matters arising regarding adolescents' SRHR. Gradual change in the school authorities was observed who were initially not comfortable with this approach of BWHC. Eventually they recognized AFLE as an essential course for adolescents.

As a result of teaching AFLE in schools, the adolescents were not just aware of SRHR but also became empowered to talk about it and the disadvantages of early marriage with their family members and among their peers. This also encouraged them to seek more information about SRHR. Teachers were also motivated to provide adequate information to their students.



Youth volunteers of Bangladesh Women's Health Coalition conveying a message on SRHR through a song composed by themselves. Polash District, Bangladesh. — Photo by Biplabi Shrestha

The SMC has been especially supportive. When some of the students revealed that their parents did not support them in learning and talking about SRHR, BWHC's local group introduced this topic at parents meetings as well. This further helped in expanding AFLE to out of school adolescents.

From action to policy advocacy

Enriched by the experience of AFLE programme at the local level, BWHC was encouraged to scale-up this model to the national level. In 2003, WHRAP provided an important strategic opportunity to BWHC to pursue its advocacy goal of achieving *Adolescent Health Policy*.

BWHC initiated its advocacy at the national level entitled 'Formulation of National Adolescent Health Policy and its Implementation.' BWHC presented an evidence based model from the local level to convince policy makers and government officials that adolescents can be exposed to information on population, reproductive health, early marriage, birth control, family planning, unwanted pregnancy, gender discrimination and issues surrounding reproductive health.

As a result of this initiative, BWHC was invited to be a partner of a national network 'Ensuring Adolescent Reproductive Rights and Services.' Other members of this network included government officials, representatives from UN bodies and adolescents. The members of this committee regularly met for two years with identified agendas. The network also organized regular issue specific dialogues with relevant stakeholders to mobilize their voice. Finally they organized a conference titled '*Adolescent and Youth Reproductive Health and Rights*' from 24-25 November, 2004, in Dhaka. The conference was attended by the relevant stakeholders including civil society representatives, women activists, women's rights organizations, NGOs with reproductive health programmes, and media. This was a very crucial platform for BWHC and its local partners to present their papers of the evidence gathered from the ground.

A proposal for developing a National Adolescent Reproductive Health Strategy was proposed in this conference. A working committee was formed which developed an 'Adolescent Reproductive Strategy' paper which was then passed by the Ministry of Health & Welfare in May 2006.

Naripokkho's Advocacy Effort to Reactivate Upazila Health Advisory Committee, Bangladesh

Background

In Bangladesh, access to health care services during illness, especially in government hospitals is limited. This problem is even acute in remote rural areas including Union and Upazila level. Upazila Health Complex (UHC) is the only main health resource for people at the village or sub district level when they need a thorough check up and medical assistance more than primary health care service. There are 413 UHCs at the sub-district levels, which is the first-level referral centre for the population. Each UHC has about 30-50 beds and covers on average population of 250,000 to 300,000 people. But the fact is that with the existing facilities, Upazila Health Services are incapable of delivering the required services. Naripokkho identified that the Upazila Health Advisory Committee (UHAC) can play a significant role in addressing and solving these problems.

About Upazila Health Advisory Committee

UHAC is a committee that is formed by the Ministry of Health & Family Welfare. The committee comprises local public representatives, government officers, local elite and NGOs. It is chaired by a Member of Parliament (MP) of the respective sub-district. The committee is scheduled to meet monthly to address emerging problems and explore ways to resolve them locally. If the solution is identified to be taken to a higher level, the committee has the authority to refer it to the appropriate level. However, the UHAC had



A staff member of Naripokkho conducting a meeting with community women. Bangladesh. — Photo from ARROW Photo Bank

remained inactive in many sub districts resulting to poor health service deliveries from the UHCs which further caused the minimum utilization of the services by the population.

Naripokkho's initiative to reactivate the UHAC

The main purpose to reactivate UHAC was to ensure maximum utilization of local health facilities and resources by the community people. This could be achieved only when people were assured of quality, adequate and proper service deliveries from the UHC. Naripokkho believed that UHAC could play an effective and vital role in improving the services of the UHC its reactivation was essential.

Naripokkho initiated its effort from Pathorghata UHAC with the help of Sangkalpa Trust, a local NGO in 2001. One of the first steps of both was to meet the Upazila Nirbahi Officer (UNO) of the sub district who is also a member of UHAC. He promised that if authorized by the MP he would take the initiative to convene the meetings regularly. With his suggestions, Naripokkho met the MP of the sub district who then gave a written consent nominating the UNO to take a lead in reactivating the UHAC.

This resulted in one of many UHAC meetings taking place every month followed by various improvements in the services and environment of Pathorghata UHC. For example, the hospital's environment was improved with a better infrastructure. Regular and proper food supply to patients was organized and duty bearers became more accountable in their services not only in terms of their duty hours but also in their attitude towards patients. Furthermore, a regular class on health education was initiated. This helped in increasing the number of people receiving health services from the UHC, from 50 or 60 to about 100 a day, with a significantly high number of female patients.

Naripokkho shared this successful advocacy effort in Pathorghata, with the Health Minister in 2003 and recommended that there was a need of attention on the proper management of UHCs from the Ministry. Naripokkho also suggested to the Minister to fill the vacant posts of physicians in the UHCs and provide medical instruments, ensure that the UHAC meetings took place regularly and find other ways to strengthen the Committee.

In the following meeting with Naripokkho, the Health Ministry issued inquiries about the status of UHAC's regular meetings. After this inquiry many of the local MPs took initiative in reactivating the UHAC through regular meetings. This has helped in identifying and appropriately addressing the existing problems in UHCs. With UHAC's further efforts the allocation of the expenses per bed increased from 10 to 35 TK since 2004. (Source MOH-FP) In addition, more physicians were appointed in each UHC since July 2005 (Source MOH-FP). In the current working areas of Naripokkho there are now 6 to 7 physicians in each UHC. All in all, the quality of health services has improved and more females are receiving health services.

After the accomplishments in Pathorghata, Naripokkho extended its coverage to 10 more Upazilas of Borguna and Patuakhali districts with the same strategic tool of advocacy. Among the ten UHACs, six are already reactivated and continue playing important roles in ensuring accountability to the duty bearers and providing support for adequate service delivery. It has helped that MPs as well as other public representatives, committee members, NGO representatives and journalists feel accountable to the UHC and can now identify their own roles and responsibilities.

Beyond Beijing Committee's Advocacy Effort on Safe Abortion, Nepal

Background

In Nepal, a study in five hospitals revealed that more than 50% of maternal deaths were from abortion complications. One-third of rural women and one-fifth of urban women reported experiencing unwanted pregnancies, helping to fuel a hidden market for abortion services. Despite the legalization of abortion in 2003, unsafe abortion is still a serious and pervasive problem in Nepal. Records maintained by the National Maternity Hospital in Kathmandu for 2002, show that nearly 10% of the 18,000 gynaecological cases admitted to the hospital were abortion related.

Even in Makawanpur, a district which lies at the central-southern part of the country, the situation of women and young people is worse. Although Hetauda, the district headquarter of Makawanpur, is an important industrial, commercial as well as communication centre of the country and the district is not very far from Kathmandu, the capital of Nepal, majority of all places in the Makawanpur District suffer poverty, illiteracy and ill-health. This is aggravated by the fact that Makawanpur is close to the top in the high risk zone of trafficking and HIV/AIDS.

A base line survey conducted in 2004 among young people in the district revealed that a significant number of adolescents were exposed to sexual activities in their early age resulting in pregnancy. A community study estimated the abortion rate to be 117 per 1,000 women of reproductive age per year and that 20-48 % of all gynaecological admissions in hospitals are due to abortion related complications.

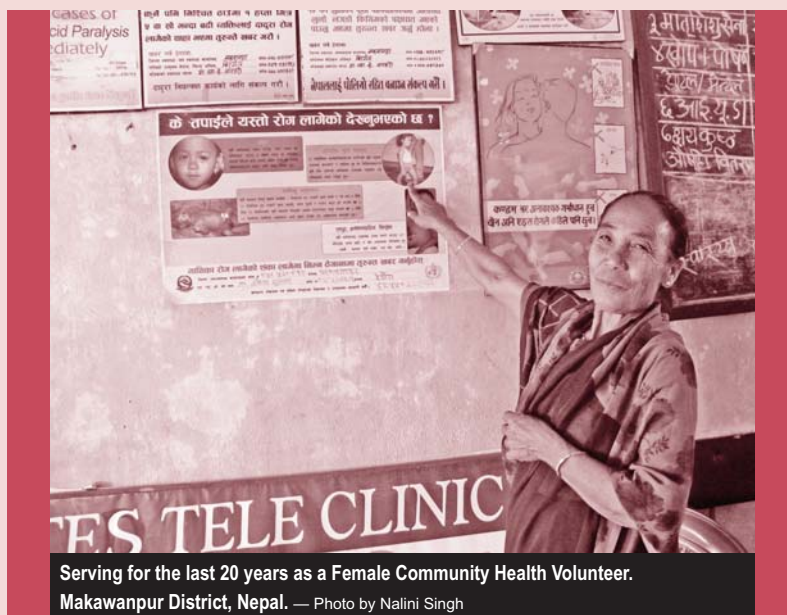


Learning together: Community women from Youth and Mothers' Group participating in a meeting conducted by the CBOs of Beyond Beijing Committee. Makawanpur District, Nepal. — Photo by Nalini Singh

Experience

The study also revealed that most of the unsafe abortions occurred in villages at the hands of untrained traditional birth attendants, traditional healers, and untrained nurses. They also happened by taking herbs and drugs without a certified doctor's prescription. Some cases of unsafe abortion also took place across the border in

India. Hence, BBC's focus was on the advocacy of Sexual and Reproductive Health Rights with safe abortion as a major issue.



BBC's advocacy effort

BBC made its advocacy effort based on the case of a girl named Munu Biswakarma. Munu, a dalit girl of 17 years old, lost her mother when she was very young. She was sold to a brothel in India by a trafficker where she used to serve 12-15 people in a day. During that time she was not aware of contraceptives and continued having unsafe sex. When she got pregnant, the brothel owner forced her to take some pills to abort the child. But the pills didn't work and she was thrown out of the brothel. She was helped by a man from her neighbouring village to return home. But her misery continued when her father and step-mother refused to let her in the house. Finally, her cousin-sister took her in.

ASHMITA, WHRAP-Nepal's CBO partner in the district, came to know about her. When the team met Munu she said that she wanted to have an abortion. She was helped to get a medical check-up where it was found that she had an STI too. However, the doctor refused to perform the abortion saying that the pregnancy was already in its second trimester. According to him it was not just complicated but also illegal.

Thereupon the four WHRAP-Nepal CBO partners together met with BBC to discuss Munu's case. They decided to launch a campaign to advocate and lobby for her abortion. They did a stakeholders mapping and formed a network with other like-minded NGOs, CBOs and civil society. This was preceded by setting goals and strategies to have her rights redressed. The issue raised was focused on one of the clauses of the Abortion Act stipulating that abortion was permitted for pregnancy from incest, rape or similar circumstances even if it had exceeded three months.

Rounds of discussions and dialogue were taken place focusing on the rights of the victim with the concerned agencies including District Health Office and District Administration Office. Her family members also supported and took part in demonstrations and sit-ins. During this process her family and community also accepted

her. She had her abortion and also received care from a rehabilitation centre in Hetauda for a week. After she returned home she resumed her studies as well.

Reflection

The advocacy effort was successful. Munu won her health, happiness and dignity back. It became possible through the strategy of working in a network with likeminded organizations towards a focused goal.

Overview

The story illustrates theoretical aspect of advocacy in the following terms:

- The context analysis is of prime importance for any advocacy. BBC used the evidence of Munu who was trafficked to India for commercial sex work.
- Stakeholder mapping is critical in advocacy as it helps in identifying the forces to build pressure on policy makers and implementers.
- The messages for advocacy specially to use in rallies and demonstrations have to be succinct, accurate and focused.
- It is essential to maintain and strengthen networks with NGOs, CBOs and civil societies outside WHRAP periphery as well. The awareness raising through the use of evidence based data from the grassroots served the purpose of empowerment of the marginalized and the community at large which contributed to them joining the campaign of their own volition.

CHETNA's Advocacy Effort for Recognition of Dais, India

Background

In rural India, Dais (Traditional Birth Attendants) are one of the most acceptable, available and affordable resource – 70% deliveries take place at home of which 42% are assisted by Dais. However, from 1995 to 2000, global thinking on Maternal Mortality went through a change, which focussed on Skilled Birth Attendants and Emergency Obstetric Care and stated clearly that Traditional Birth Attendants (TBAs) are ineffective in averting maternal death. As a result, public health system thinking at the national and state level also underwent a change with their favour against further promoting training of Dais and recognising them as resource in maternal health programmes. The State governments and NGOs were in a dilemma regarding the future direction on the issue. Meanwhile, funds were also unavailable to advocate on that topic although of most the stakeholders had already built capacity of Dais at the grassroots.

Advocacy Effort

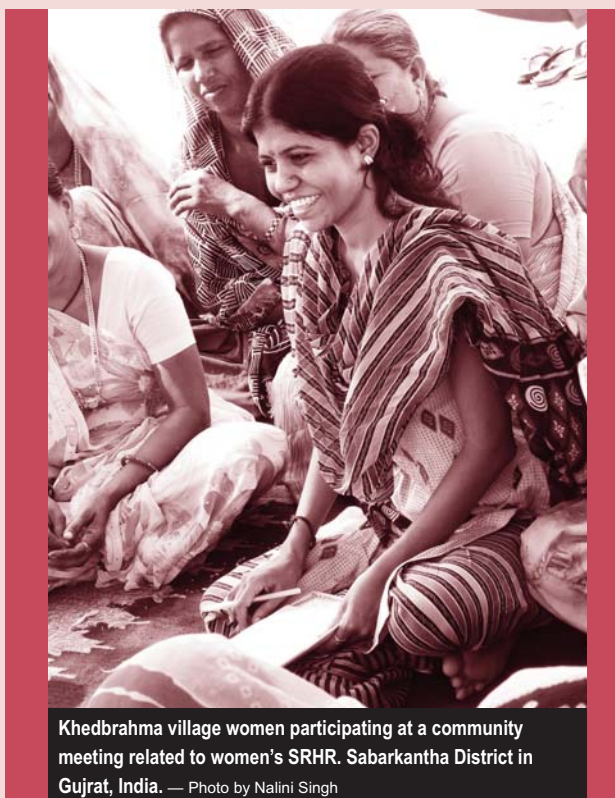
In 2001, CHETNA started its advocacy effort through stakeholders in two different states of the country namely, Gujarat and Rajasthan. Different NGOs with experiences of working with Dais and having faith in their role in maternal health came together in this



Khedbrahma village women participating at a community meeting related to women's SRHR. Sabarkantha District in Gujarat, India. — Photo by Nalini Singh

effort. With their collective effort of advocacy, other stakeholders including the government, committed also to continue their conviction in supporting the effort to recognize Dais' roles in community health. Because the stakeholders had clarity in addition to their commitment on the issue, they could clearly assign roles and responsibilities amongst themselves in this effort. Each of them lobbied at different levels. The advocates decided that they would deliberately be using the word Dai instead of TBA as this undermined their critical role in childbirth.

One of the key factors of their advocacy campaign was to convince the government stakeholder at the policy level. This effort was comparatively easier in Gujarat as the NGOs there already have immense credibility with the government and bureaucrats. Through them, the collective action of Dais was brought to the fore. This proved to be a catalyst in generating positive changes among the policy makers. The dialogue continued at all levels of the stakeholders which helped in keeping the issue alive and visible. Though it had been a time consuming process, this strategy was welcomed by all the stakeholders. Hence, the effort resulted in creating a successful example of advocacy in a totally unfavourable policy environment.



Khedbrahma village women participating at a community meeting related to women's SRHR. Sabarkantha District in Gujarat, India. — Photo by Nalini Singh

The following points describe the main realized advocacy activities (in chronological order) and successful outcomes of the vigorous efforts in the state of Gujarat as well as Rajasthan.

In the State of Gujarat

- ✓ A committee of NGOs working for recognition of Dais was formed in 2000, which aimed to work for the recognition of Dais at the state and national level. The committee identified recognition of Dais as one of the key advocacy issue in the People's Health Movement.
- ✓ A leading NGO and member of this committee organized Dai mela (Fair) in the states of Gujarat, Rajasthan and Madhya Pradesh in 2003.
- ✓ During the National Safe Motherhood Day on 11 April, 2003 a Dai Consultation Meeting was organized in collaboration with the Government of Gujarat, civil society organizations and Dais.
- ✓ Based on a curriculum review, the State Department of Health & Family Welfare recognized the Dais trained by two leading NGOs in Gujarat in 2003.

- ✓ A state level Task Force was formed to look into Dai and safe motherhood issues in 2003.
- ✓ A Dai Association (Sangathan) - Gujarat was formed on 9th June 2005 which has a membership of about 5000 Dais and 12 NGOs from the state.

In the State of Rajasthan

- ✓ The Government of Rajasthan initiated Dai training in all the 32 districts of the state.
- ✓ A campaign on role of families in saving mothers' lives was implemented in seven districts of Rajasthan through 11 Community based NGOs during 2001-2002.
- ✓ SUMA-Rajasthan Surakshit Matritva Gathbandhan, State White Ribbon Alliance for Safe Motherhood was launched in 2003. SUMA organized a State Level Policy Dialogue on the role of Dais in Safe Home Deliveries. The dialogue took place in Jaipur on 24 November, 2003.

At the National and International Level

- ✓ The White Ribbon Alliance India (WRAI) was launched to create awareness and advocate for Safe Motherhood in 2000.
- ✓ Based on the efforts made by several NGOs, the Ministry of Health & Family Welfare announced commencement of Dai training in 142 districts where safe delivery incidence was less than 30%.
- ✓ Dais were honoured at the National Conference on Safe Home Births organised by WRAI in 2000.
- ✓ The issue of advocacy for recognition of Dais was identified at the National People's Health Assembly (NPHA) and the International PHA in 2000. The discussion continues among the steering committee members of the International Public Health Assembly.
- ✓ A national debate on the role of Dai and Skilled Birth Attendance was initiated in various forums.



A member of the *Mahila Swastha Adhikar Manch* participating in a meeting organized by SAHAYOG. Varanasi, India.

— Photo by Nalini Singh

SAHAYOG's Advocacies through Mahila Swastha Adhikar Manch, India

Background

In many parts of India, the implementation of maternal health policies and programmes at the grassroots level has been negatively affected by widespread corruption, lack of accountability and poor quality of services. Therefore, it became important to get a reality check on these issues. Since 2004 a group of NGOs in Uttar Pradesh have been working together with the aim of improving provision of maternal health services for rural low-income women. Their major objective was to build the capacity of grassroot women to enhance their skills in obtaining and demanding better and adequate sexual and reproductive health services.

On May 26, 2006, a group of NGOs organized a campaign on women's rights to maternal health called Puri Nagarik Pura Haq (Complete Citizens Total Rights). As a result of this effort, Mahila Swasthya Adhikar Manch (MSAM-Women's Health Right Forum) was formed, a grassroots women's organization committed to advocacy and monitoring of women's rights to health in Uttar Pradesh. MSAM enables rural women to recognize their own entitlements as 'rights holders' and to identify the 'duty bearers' who are accountable to ensure their right to health. It started off in eight districts of Uttar Pradesh. Currently it has around 7000 women members in ten districts of UP and is expanding into other districts as well.

SAHAYOG has promoted the formation and expansion of the MSAM as part of its mission of working through a human rights framework on women's health.

Advocacy effort by SAHAYOG through MSAM

SAHAYOG supports the women members of MSAM to take local action to improve the quality of health service provision by engaging with local providers, health managers and elected representatives. The women also work with their own village panchayat heads to ensure improvement in health and nutrition services. They monitor the health service provisions by providers in sub-centers, Primary Health Centres (PHC) and Community Health Centres (CHC). They also monitor if there are cases of denial of services to poor women or any form of negligence in service delivery. These are then documented by the local NGOs. MSAM has also reviewed the entitlements for healthcare, nutrition and livelihood.

Advocacy activities to improve maternal health services

- ✓ On January 28, 2008, in Banda district, MSAM women presented a written petition of demands to the CMO. These demands included facilities for childbirth at every health center, action against staff that demands informal payments at Atarra and Naraini CHCs, ensuring respectful behaviour towards women patients, action against providers who deduct a portion of women's *Janani Suraksha Yojana* (JSY) - a cash incentive for childbirth in institutions.
- ✓ From January to March 2008 MSAM members from Banda district filed a 'Right to Information' (RTI) application to find out the number of deliveries taking place in government institutions and at home, as well as the quality of care provided.
- ✓ On March 17, 2008, 50 women from Naugarh block in Chandoli district went to the local PHC to demand that all women receive their government-guaranteed JSY as many women were denied this cash allowance.
- ✓ In Bantikula village of Gorakhpur district, an ANM (Auxiliary Nurse Midwife) was irregular in the performance of her duties and she demanded extra money for her services. In response to this, on March 25, 2008, 15 MSAM women from Bantikula district visited the PHC and demanded that the head doctor take action against this.
- ✓ On March 27, 2008, MSAM women from Gorakhpur district visited the CMO to demand safe delivery services at sub-centers. Their written demands also included documentation of all cases of maternal death, government action against providers' asking for money illegally from patients and



Members of Mahila Swastha Adhikar Manch at Candle Light March event, 2009. India. — Photo from <http://www.sahayogindia.org/>

implementation of insurance policy for the cases of sterilization.

- ✓ In Baheri village of Banda district, MSAM women informed health officials of an episode of chickenpox. In response to that, the health officials visited the village and gave immunizations.

Results

- ✓ The elected representatives in Badausa village of Banda district, who had previously ignored the needs of women in their community, now recognized MSAM women by taking their demands seriously. They also took actions based on their demands.
- ✓ In Banda district, a social audit sharing meeting took place during which block-level legislators promised to meet the demands of MSAM members and offered themselves to become a part of MSAM forum.
- ✓ In Naugarh block of Chandoli district, 50 women of MSAM met with the block-level legislator of their area and complained that people in the area were not getting their entitled JSY benefits from the doctor. In response, the elected representative made a phone call to the doctor and the doctor immediately agreed to give the women their JSY allowance.
- ✓ On March 8, 2008 in Azamgarh, block-level legislators attended MSAM women's social audit sharing meeting for the first time. He promised to meet their demands and to provide five hundred thousand rupees to build a hall for community meetings.

Conclusion

SAHAYOG adopted the strategy of advocacy through grassroots women. This strategy of empowering women and supporting them to be independent for the demands of their rights proved to be an effective advocacy effort. With this, SAHAYOG has set up an example of success achieved by involving grassroots women from the process of planning to implementation.

Shirkat Gah's Experiences of Advocacy as WHRAP, Pakistan

WHRAP in Pakistan was implemented at the local level in partnership with three Community Based Organizations (CBOs), namely Pirbhat Women Development Society (PWDS), Peri Urban Welfare Association and Umeed Trust.

Case Study 1

'Silro Goth' is a village located within Shahdadkot in rural Sindh. During the WHRAP baseline survey it was identified that the main barriers of access to quality health in this area are lack of knowledge on reproductive health and rights, family planning and practices of home deliveries through unskilled birth attendants. As it is a male dominant society, women lack decision making power too which further deteriorates the situation. Intervening in this community was a challenge as people were extremely conservative and illiterate. Shirkat Gah chose PWDS to intervene in this area as the latter was already popular and reputed in this area through its work of improving the quality of life of the people.

The initial strategy of intervention in the area included activities like focus group discussions, awareness raising sessions and meetings with community people. In the beginning people were not open to discuss and share their problems on these issues. But eventually the sessions led the people to think, discuss and clarify their understandings related to reproductive health, rights and family planning. As an outcome of this effort, there was an increase in the number of people accessing the nearest available health services and a decrease in the number of deliveries at home. It was also observed that women were becoming prompt about regular routine check-ups under the provision of a trained health care provider like a doctor, Lady Health Worker (LHW) or TBA.

While on the one hand access to nearest government health facility increased, on the other hand doctors on duty refused to treat the people at the hospital and instead encouraged them to visit their private clinics where they charged excessive fees. To address and overcome this issue, members of PWDS along with members of the community, formed a pressure group. They held meetings and consultations with the elected



My child and I also need all health care services and rights! District Kambar Shahdadkot, Sindh, Pakistan. — Photo by Shirkat Gah

representatives of the local bodies and the government representatives to seek their support and cooperation. The issue was also highlighted in the local newspapers. The representatives of the local bodies and government along with the pressure group then visited the government health facility and monitored the provision of health services. They took strict action in the

form of warnings and terminations of the health personnel found involved in the unethical practices.

The involvement of the community people from the very beginning and throughout the process made this advocacy effort successful. They identified the problems and worked together to address and overcome the barriers. They increased their capacity to access health services and demanded quality services at the government health facility. This advocacy campaign also gave an opportunity to learn that it is very essential to be patient while working in a remote place with people having no awareness on reproductive health and rights. It is also essential to understand the sensitivity of the situation and the challenge of socio-cultural and gender biased responses from the community. Today, the community of 'Silro Goth' and adjoining villages in Shahdadkot under the WHRAP umbrella are empowered and motivated. They enjoy control over the decisions about their lives, strive for betterment of maternal health, and enforce high vigilance of local health providers.

Case Study 2

Civil society organizations have started their advocacy to include Reproductive Health and Rights in the MDGs since 2000. This was further reiterated at the WHRAP regional NGO seminar held in Dhaka from 4 -7 March 2005.

A Pakistan Group was formed comprising Shirkat Gah and other leading NGOs and individual experts working on reproductive health and rights. This strengthened networking between participating organizations who then collectively decided to advocate at the national level through the Pakistan Reproductive Health Network (PRHN), for the inclusion of SRHR indicators into the MDG framework. Further members joined in the efforts and to develop a lobby document "Millennium Development Goals- MDGs *Expanding the Agenda*" through a consultative process.

To launch the document, Shirkat Gah, in collaboration with the Marie Stopes Society and Family Planning Association of Pakistan, held a National Policy Dialogue in Islamabad on 20th July 2005. The event was extremely well attended, with over 200 participants including government stakeholders of relevant ministries, parliamentarians, bureaucrats, funding agencies, international and national experts, NGOs, CBOs and media. The timing for the advocacy was considered appropriate as the government was in the process of preparing for the MDG Summit in September 2005. The discussions, recommendations and endorsements of this consultation reaffirmed the commitment of the government to the critical role of universal access to sexual and reproductive health and rights in meeting the MDGs.

The greatest achievement of the meeting was the endorsement of the lobby document by the Chief of Planning Commission, the body appointed by the government for planning and monitoring progress on the MDG framework. The Chief of Planning Commission affirmed that the proposed indicators were relevant and 'doable'. He promised that the WHRAP Pakistan core group would be involved in the government's next planning phase of the MDGs. In the mean time UNAIDS and National AIDS control programme also offered to collaborate with the WHRAP group for additional indicators at the country level.

The overall strategy adapted for the advocacy campaign proved very successful as it strengthened networking and partnerships amongst multiple levels of stakeholders from civil

society organizations as well as between public and private sector. Additionally, the collaboration between three national NGOs attracted a large target audience which resulted in much extensive dissemination of the lobby document as well as deliberations and recommendations of the dialogues reaching even to the highest levels of policy makers and implementers. Participation of various stakeholders e.g. NGOs, government, parliamentarians, politicians, bureaucrats, international agencies, donors, academicians, etc. enriched the discussions and provided a broader perspective. The provincial consultation meetings helped in engaging more stake holders at the provincial level leading to increased mobilization and sensitization at all levels.



নারীপক্ষ

